The Health of Parental Caregivers in Ghana

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Abstract

The proportion of people over the age of 60 is increasing in Ghana, creating a population that must contend with a burgeoning older group while still addressing the concerns of its population who suffers from infectious diseases. Using Wave 1 of the 2007/2008 WHO SAGE data for Ghana, this paper attempts to assess the current caregiving and health circumstances of those who provide care to parents or parents-in-law. The study examines whether those who are providing a considerable amount of care vary in their perceptions of caregiving. The study also evaluates the differences in the prevalence of poor health, as defined by self-reports of hypertension and measured blood pressure. Finally, the study assesses whether perceptions of the caregiving experience account for health differences. Preliminary findings suggest that a growing number of caregivers, particularly in rural areas, are experiencing physical and mental issues related to caring for their parents or parents-in-law.

Introduction

Ghana, as is much of sub-Saharan Africa, is experiencing significant changes in the age structure of its population. Recent studies have shown that Ghana has one of the highest proportions of age 60 and over population in Sub-Saharan Africa (Mba, 2010), which suggests large increases in the older population in the coming years. In fact, the population of older Ghanaians is expected to double between 2000 and 2030 (Smith and Mensah, 2003). With this increase in the older population comes a need to examine both chronic health conditions and the nature upon which these individuals receive care. Although Ghana's health policies have improved over recent years, issues such as limited access to primary care facilities has led man to seek assistance from orthodox or alternative forms of care, particularly in rural and less populated areas (Apt, 2013).

With a lack of formal health care in some regions, many older people will have to rely on family members for care. The aging structure, coupled with a still youthful population coping with infectious diseases such as HIV/AIDS and malaria, adds a new dimension to the burden of care, as many caregivers will have to cope with those suffering from both chronic and infectious diseases (Aboderin and Ferreira, 2008; Ferreira, 2006; Aboderin, 2011). As younger people migrate to more urban locales both within and outside of Ghana, the filial obligation to care for parents becomes unclear.

This paper attempts to assess the current caregiving circumstances of Ghanaians who provide care to parents or parents-in-law as it relates to caregivers' health. The study examines whether those who are providing a considerable amount of care vary in their perceptions of their caregiving experience. Then, the study evaluates the health of parental caregivers by specifically evaluating the differences in the prevalence of self-reported health and physical health, as defined by self-reports of hypertension and measured blood pressure. Finally, the study assesses whether perceptions of the caregiving experience account for differences in health of the parental caregivers.

Data, Methods, & Expected Findings

Data

Data used for this study is derived from Wave 1 of the World Health Organization's (WHO) Study on Global Aging and Adult Health (SAGE). Conducted in 2007 and 2008, the SAGE Ghana Wave 1 data is a nationally representative sample of respondents age 50 and over, with an additional, albeit smaller, sample of younger adults (ages 18-49) (Kowal et al., 2012). The SAGE Ghana Wave 1 is a stratified, multistage cluster sample providing information on both household- and individual level data (N= 5,662). Respondents represent the rural and urban Ghanaian regions of Ashanti, Brong Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta, and Western. The dataset provides a wealth of information on sociodemographic characteristics, economic circumstances, caregiving, health status and healthcare utilization.

Respondents were selected based on whether they indicated that they provided care (financial, physical, health, social/emotional) to a parent or parent-in-law. In addition to socio-demographic characteristics (rural/urban, work status, education, age, household composition), a host of caregiver questions were used to assess caregiver burden. Whether a respondent provided care less than or more than 6 months indicated length of caregiving. Respondents were also asked the average hours per day on the days in which they provided care. Finally, a composite variable representing respondents' perceptions of the impact of caregiving was created. Specifically, respondents were asked, as a result of providing care over the last year, how much difficulty they had with the following:

- Obtaining enough sleep
- Eating enough food
- Having enough energy to do extra work
- Taking care of own health
- Paying for medication or treatment for their own health conditions
- Having enough time to visit friends or relatives as much as before
- Sharing feelings about caregiving responsibilities
- Experiencing financial problems
- Knowing the correct care they should provide
- Experiencing stigma and problems as a result of providing care.

Caregiver health outcomes are derived from self-assessments of health and biological, or biomarker, information. Respondents were asked whether a doctor or medical professional had told them they had hypertension. Blood pressure readings were also taken to obtain whether respondents were hypertensive (140 mm/Hg or higher systolic blood pressure and/or 90 mm/Hg or higher diastolic blood pressure). Waist-to-hip ratio and depression, as classified by the ICD-10, were additional measures used in the analyses. Smoking, alcohol consumption, and physical activity were used as control variables.

Statistical Analyses & Expected Results

Basic descriptive statistics are initially used to assess parental caregivers, with a particular consideration of rural vs. urban dichotomy. Next, two sets of logistic regression analyses are used to examine both the associations between the amount of care and perceptions of the caregiving experience as well as the amount of care and adverse health outcomes. Preliminary findings suggest that rural and urban differences play a role in the caregiving experience, with rural respondents reporting adverse caregiving experiences and poorer health. Further analyses will be done to uncover explanations behind the differences and to examine gender differences in who gives and receives care.

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