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RESEARCH ARTICLE

ASSESSMENT OF THE RELATIONSHIP BETWEEN CAREGIVER PSYCHOSOCIAL FACTORS AND THE QUALITY OF LIFE OF THE ELDERLY AT HOME IN NORTHERN REGION, GHANA

[1,*]Prudence P. Mwini-Nyaledzigbor, [2]Diana Bazaadut, [3]Luguterah Albert, [4]Belinda E. Adzimah-Yeboah, [5]Robert Kaba Alhassan, [6]Judith Anaman and [7]Worlali Nyaledzigbor

[1, 2, 4, 5, 6]School of Nursing and Midwifery, University of Healthand Allied Sciences, Ho, Ghana
[3]University of Development Studies, Ghana
[7]Seaside International School, Prampram, Accra, Ghana

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ABSTRACT

This study examined the quality of life of the elderly, and relationship between caregiver psychosocial factors and the quality of life of the elderly. A multistage sampling method with a sample of 400 elderly and their caregivers was used. A modified Older People's Quality of Life scale, in addition to a structured questionnaire, were used to collect the data. The data was analyzed using the Statistical Package for Social Sciences (SPSS) version 16 software. The findings of the study showed that, the quality of life of the elderly is above average. Age, gender and educational level had a significant influence on the quality of life of the elderly. Psychological and Emotional well-being, Independence, Freedom and Health were the most significant factors influencing the quality of life of the elderly. Caregiver psychosocial factors were significantly negatively correlated to the quality of life of the elderly. Thus, the higher the caregivers' stress, the lower the quality of life of the elderly and vice versa. The study further revealed that all the caregivers were related to the aged either by blood or by marriage. Age, gender, educational level and duration of care of caregivers had a significant influence on the quality of life of the elderly.

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INTRODUCTION

The ageing population is increasing globally due to improved medical technologies available for the management of chronic diseases including hypertension, type 2 diabetes, the cancers and others, leading to increase life expectancy and decreased mortality rates (World Population Ageing, 2009). According to a World Health Organization (WHO, 2002) report on demographic revolution, the proportion of people aged 60 years and over is growing faster than any other age group, and it is estimated that, by 2025, there will be a total of about 1.2 billion people over the age of 60 years worldwide. Almost 400 million of these live in developing countries and by 2025 this figure will increase to approximately 840 million representing 70% of all older people in developing countries (WHO, 2002). Such a rapid growth will require far-reaching economic and social adjustments in most countries especially, developing countries like Ghana.The emerging growth of the elderly population is seen as an achievement to medical advancement but a serious threat to governments all over the world including Ghana.

Corresponding author: Prudence P. Mwini-Nyaledzigbor,
School of Nursing and Midwifery, University of Healthand Allied Sciences, Ho, Ghana.

In Ghana, the 2010 Population and Housing Census (PHC) put the figure of those aged 60 years and over at seven percent, a marginal decline from the year 2000 with 7.2 percent. Thus, Ghana, like other developing countries, is undergoing the demographic transition, which may pose serious policy challenges. It is imperative that state actors and communities promote health and quality of life of older adults. Ghana is culturally heterogeneous with different ethnic groups and varied cultural backgrounds. The perception of care for the elderly is similar among the cultural groups. The challenges of inadequate social and health services to cater for the needs of the elderly, the inability of governments to cope with the payments of pensions to retired formal workers and a predominantly agrarian population, pose threats to food security, standard of living and quality of life of the elderly with mounting pressures on health care delivery services (Aboderin, 2008; Okoye and Asa, 2011). Again, the elderly in Ghana are faced with the paradigm shift from the extended family system cohesion to nuclear family system practicesas more women are entering formal job markets, children leaving home for work in cities, declines in widowhood inheritance practices and others, (Mba, 2002). Such previously cherished

socio-cultural practices will result in inadequacies of family supports, social exclusions and isolation, emotional abuse and neglect. The lack of social supportsand amenities in Ghana and the National Health Insurance Scheme (NHIS) providing an unclear and ambiguous servicesfor Ghanaians make the elderly moreprone and susceptible to poverty, diseases and frustrations. A most prominent likelihood challenge of an aging population is the increase in social support needs, especially, home healthcare services. With regards to the existing low socio-economic infrastructural development of Ghana, meeting the needs of older people in a developing world such as Ghana will be a daunting task. There is a need for research about the elderly that will provide evidence-based knowledge on the Quality Of Life (QOL) of the elderly in society.Complete cure from chronic diseases may not be possible and besides, the elderly may require anchors to live safe, honorable and humane lives at home and only visit health facilities when required for health assessment and appropriate care.

MATERIALS AND METHODS

Research Method and Design

The study design was a single cross-sectional household survey. A cross-sectional design involves the observation of a sample, or a section of a population or phenomenon that are made at one point in time. They are often used in exploratory and descriptive studies and are useful for establishing associations rather than causalities and for determining prevalence rather than incidence, (Franzen *et al.,* 2007; Carillo *et al.,* 2009).

The Study Setting

The study was conducted in a capital city of the Northern region located within the Guinea Savannah belt and the fourth largest city in Ghana with a population of 371,351 comprising 185,995 males and 185,356 females and with a growth rate of 3.5% (Ghana statistical service, 2010). Also the Population and Housing Census (2010) put the population of the aged, 60 years and above, at 23,360. Most economic activities in that region revolve around farming and petty trading. There are also a number of people working in the formal sector. These people are engaged in the banking, health and educational sectors as well as the public services.

According to the Ghana Living Standard Survey 4 (GLSS4), the Northern Region is one of the three poorest regions in Ghana. The city is cosmopolitan, attracting populations from all walks of life in and out of the country. The city is traditionally an indigenous community characterized by multiple generations of families living together in large family houses popularly known as compound houses. However, different population sub-groups of other ethnicities from other parts of the country have moved into this traditional area over the years to influence its settings. There are a considerable number of health facilities, both public and private in the metropolis. The city has a Teaching Hospital that is the biggest and most equipped health facility in the Metropolis. It serves as a referral center and provides specialist care involving skill and competence. In addition, there are two other public hospitals (the Regional Hospital and a suburb Hospital) in the Metropolis to care for the clinical needs of people together with a Psychiatric unit. There are also a number of Private hospitals, clinics and Maternity homes to take care of the reproductive and other health needs of the people.

The Target Population

The target population studied consisted of elderly people (60 years and above) and their informal care givers living in the Township. All individuals (male and female) 60 years and above, with their informal care givers 18 years and above and living in that Township were then eligible for the study. According to the 2010 population and housing census report, there are 23,360 people aged 60 years and over in that Metropolis. Using the Yamane formula, (Yamane, 1964), the sample size for this study was calculated with a 95% confidence interval: The estimated sample size was 393 which was rounded-up to the nearest hundred (400). Thus a sample size of 400 was used in this study.

Ethical considerations

Approval for the study was granted by the institutional Review Board of the Noguchi Memorial Institute for Medical Research at the University of Ghana with number DF22. A letter for site approval to conduct the research was subsequently obtained from the School of Nursing of the University of Ghana, addressed to the Metropolitan Director of Health Services, the Metropolitan Chief Executive, the Assembly men, and household heads.

RESULTS

Demographic Characteristics of the Elderly

As shown in Table 1, majority of the elderly (53.5%) were females. About one third (31.00%) of the respondents were within the age 60-64 years category and an overwhelming proportion (83.00%) were Muslims. More than half of the respondents (57.00%) were married, while 62.00% had never been to school.

Table 1. Demographic Characteristics of the Elderly

Variables		Frequency (n)	Percentage (%)
Age	60-64	124	31.00
	65-69	105	26.25
	70-74	77	19.25
	75-79	53	13.25
	80+	41	10.25
Total		400	100
Gender	Male	186	46.50
	Female	214	53.50
Total		400	100
Religion	Muslim	332	83.00
	Christian	65	16.25
	Traditional	3	0.75
Total		400	100
Marital Status	Single	15	3.75
	Married	228	57.00
	Divorce	35	8.75
	Never married	2	0.50
	Widow(er)	120	30.00
Total		400	100
Schooled	Yes	152	38.00
	No	248	62.00
Total		400	100

The agreement between the original OPQOL scale and the modified and parsimonious OPQOL scale was assessed using correlation. The correlation between the original quality of life

scale and the modified quality of life scale was very high, about (95%) and very significant (p-value= 0.000) indicating that the modified quality of life scale agrees very much with the original OPQOL scale. The modified quality of life scale was thus adopted for all the statistical analysis under study.

Table 2. Comparison between Original QOL Scale and Modified QOL Scale

Statistic	Correlation	Approx. T value	p- value
Pearson R	0.945	57.436	0.000**
Spearman rho	0.954	63.563	0.000**

** p<.001, Correlation is very significant

Table 3. Scoring Category of Quality of Life Scores

Score range	Percentage	Interpretation
105-125	80 to 100	Very good
90-104	65 to79	Good
75-89	50 to 64	Fair
65-74	40 to 49	Poor
0-64	Below 40	Very poor

Table 3 represents the categorization of scores for quality of life obtained by each elderly person using the modified quality of life scale. The distributions of the quality of life of the 400 respondents are shown in Table 4, each ranging from very good to very poor. Out of the 400 respondents, 42.0% rated their overall quality of life as good and fair while 14.5% of the respondents rated their quality of life as poor and very poor. This suggests that the quality of life of the elderly in Tamale is generally above average.

Table 4. Quality of Life of the Elderly in the Tamale Township

Variable		Frequency (n)	Percentage (%)
Quality of life	Very good	6	1.50
	Good	168	42.00
	Fair	168	42.00
	Poor	50	12.50
	Very poor	8	2.00
Total		400	100

The factors influencing the quality of life of the elderly are presented and ranked in Table 5.Table 5 reveals that all the factors influencing the quality of life of the elderly are positively significant to their quality of life. Thus a better health, social relationship, independence and freedom, home and neighborhood, psychological and emotional well-being, financial circumstances and leisure and activities scores are associated with a better quality of life. These factors although all significant, are thus rated based on the strength of the correlation.

Table 5. Factors Influencing Quality of Life of the Elderly in the Tamale Township

Variables	Pearson correlation	p-value	Rank
Health	0.683**	0.000	3
Social Relationship	0.345**	0.000	7
Independence and Freedom	0.720**	0.000	2
Home and Neighborhood	0.664**	0.000	4
Psychological and Emotional well-being	0.727**	0.000	1
Financial Circumstance	0.662**	0.000	5
Leisure and Activities	0.360**	0.000	6

**p<.001

The association between the socio-demographic characteristics of the elderly and their quality of life is presented in Table 6.In assessing some of the characteristics of the elderly that were associated with their quality of life, Age (p-value = 0.001), Gender (p-value = 0.003) and Educational level (p-value = 0.010) were significant at the 5% significance level. Conversely Religion (p-value = 0.694) and Marital status (p-value = 0.100) were not significant to the quality of life of the elderly in Tamale.

Table 7. Sample Means for Significant Characteristics in the QOL of the elderly

Variable	Level	Means	SD
Age	60-64	90.37	9.958
	65-69	86.98	10.258
	70-74	85.70	9.291
	75-79	86 26	9.798
Gender	Male	87.5430	10.47575
	Female	86.0794	10.56028
Educational level	never been to school	85.0534	10.45246
	dropped out at primary	88.5000	11.82612
	standard 7	88.9821	10.06071
	form 4	91.6098	7.67749
	Secondary	99.0000	4.24264

Further to the significance of age, gender and educational level of the elderly to their quality of Life, Table 7 indicates that, generally the older the elderly, the worse their quality of life; except for the age group 75 to 79 years. Again, quality of life increases with higher education and Males have a better quality of life than females. Over a third of the caregiver respondents (35.50%) were in the age range of 24-29 yearswhereas, over two thirds of the caregivers (68.00) were females and an overwhelming majority also being Muslim (83.25%). Again, almost half (49.00%) were married and a large majority (73.25%) have ever attended school.

Table 8. CaregiversRelation to the Elderly

Variable	Elderly	Frequency	Percentage
Relation	Father	111	27.75
	Mother	113	28.25
	Uncle/Aunty	41	10.25
	Spouse	40	10.00
	Other (in-laws)	93	23.25
Total		400	100
Duration of Care (years)	2-4	81	20.25
	5-7	171	42.75
	8-10	62	15.50
	11-13	13	3.25
	14+	73	18.25
Total		400	100
Paid to care	Yes	21	5.25
	No	379	94.75

Table 8 reveals that all the respondents were related to the elderly either through blood or marriage. More than half of the respondents (56.00%) were caring for their parents. About a quarter (23.25%) were caring for their in- laws and a tenth for their spouses. Of all the caregivers sampled, 42.75% have been caring for their elderly relatives for a period of between 5-7 years. Nearly all of the caregivers (94.75%) were not receiving any form of payment for the care they were rendering.The psychosocial factors which were the measure of caregiver strain, were significantly negatively correlated with the quality of life of the elderly (r = -0.346, p = 0.000). This means that the higher the strain on the caregiver, the lower the quality of life of the elderly that is being cared for. Table 9 indicates that the Age of the caregiver (p-value = 0.024), the Gender (p-

value = 0.016), the Educational level (p-value = 0.007) and the Duration of care in years (p-value = 0.017) were significantly associated with the quality of life of the elderly. Marital status (p-value = 0.657) of the caregiver and whether they were paid or not (p-value = 0.175) were not significant to the quality of life of the elderly.

Table 9. Test of Association between Care Giver Characteristics and Modified QOL

Variable	Value	Degree of Freedom	p-value
Age	232.84	192	0.024
Gender	71.26	48	0.016
Duration of care (years)	236.04	192	0.017
Marital status	136.60	144	0.657
Educational level	350.83	288	0.007
Paid or not	57.03	48	0.175

Similarly, Table 10 indicates the relationship between the significant caregiver characteristics (Age, Gender, Educational Level and Duration of Care giving) and the quality of life of the elderly they care for. The sample means posits that; younger caregivers are associated with better quality of life of the elderly. Again, except for those with the JHS/JSS educational level, higher educational levels of the care giver are associated with higher quality of life of their elderly. Additionally, the longer the duration of care giving, the worse the quality of life of the elderly. Male care givers are associated with higher quality of life of their elderly.

Table 10. Sample Means of Caregiver Characteristics Significant to the QOL of the Elderly

Variable	Level	Mean	SD
Age	18-23	88.39	9.822
	24-29	88.25	10.178
	30-34	85.05	11.594
	35+	82.29	10.260
Gender	Male	88.7656	10.43275
	Female	85.8162	10.46675
Educational level	less than primary	84.5429	10.75517
	primary school	86.4706	11.81482
	JHS/JSS	84.4070	10.21461
	SHS/SSS	86.6228	9.87478
	Tertiary	94.3115	7.38138
Caregiver duration	2-4	88.7037	10.12354
	5-7	86.9883	10.66660
	8-10	86.5645	10.39486
	11-13	82.1538	10.80005
	14+	85.0548	10.49589

Table 11 identifies the support services caregivers receive from family members in the care of their elderly relatives. Most of the caregivers (69.0%) received financial support from other family members for the upkeep of their elderly relatives.

Table 11. Support Received from family members for Care of the Aged Person

Variable	Frequency	Percentage
Financial	276	69.0
Physical	69	17.25
Psychological (encouragement)	15	3.75
No support	29	7.25
Housing/nutrition/clothing	11	2.75
Total	400	100

The knowledge of available services for the elderly and their caregivers is presented in Table 12.

Majority of the caregivers (61.25%) did not know of any other service, apart from the National Health Insurance Scheme (NHIS), for them and their elderly relatives; more than a third of the caregivers (36.5%) were not sure whether there were any services for them and their elderly relatives. In response to the question asked at assessing the readiness of caregiver to use professional help, an overwhelming majority of the caregivers (88.25%) said even if there were nursing homes in the Tamale, they would not patronize it. Caring for the elderly is seen as a social/family responsibility.

Table 12. Additional Services for the Elderly and Caregivers

Responses	Frequency	Percentage
Yes	9	2.25
No	245	61.25
Not sure	146	36.50
Total	400	100

Table 13. Use of Nursing Homes for the Elderly

Respondent	Frequency	Percentage
Yes	47	11.75
No	353	88.25
Total	400	100

DISCUSSION

The quality of life of the elderly in the study is generally above average (61.76%). This confirms Mba (2007) who reported that the prospects of the elderly in developing countries such as Ghana tend to bethat of solitary living. There istherefore, the need for support and care for the elderly. The findings also confirmed that of the Ghana Living Standards Survey (2013) that describes the three Northern Regions of the country as poverty endemic and hence, the vulnerability of the elderly population in these regions toabject poverty. Thus, to understand the reason underpinning the above average quality of life scores of the elderly in the study area, it is relevant to examine the factors influencing their quality of life.According to Bowling and Gabriel (2004), people of different age, health status, and residential arrangements may have different priorities when judging their QOL. The factors influencing quality of life identified by Bowling (2009) were used for this study. All eight factors influenced the quality of life of the elderly positively and were significant (p-value = 0.001). Psychological and economic well–being of the elderly were the most associated, with their quality of life. Followed by Independence, Control over life and Freedom, Health, Home and Neighborhood, Financial circumstances, Leisure and Activity and Social Relationship in that order. The study is also consistent with an explorative study by Milte *et al.* (2013) which shows that safety and dignity/treatment and help as well as health, independence and psychological and emotional well –beingwere most important values for the elderly.

Well-being is a positive physical, social and mental state; it is not just the absence of pain, discomfort, and incapacity. It arises from not only the action of an individual, but from a host of collective resources and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in societal activities as marriage and naming ceremonies which are cherished social activities usually performed by the elderly in the study area. Psychological and emotional well-being contributes 72%

(p <.001) to the quality of life of the elderly. One reason that may account for this is the older adults' roles played in the study areathat tend to be optimistic and tolerable coping strategy for age-related stress, as respondents were more likely to accept whatever state they were in and hope for the better. The results were consistent with Akashi's, (2013) study on the Psychological well-being among three Age Groups of older Americans living in acommunity, whotend to manage and accept the aged related changes that occur with ageing. Also being the first and important factor, Psychological well-being was identified as one of the factors most significant in the quality of life of the elderly in Kathy, O'Shea, Cooney and Casey's, (2007) study. Another rational for being most important is that older adults, compared to younger adults, are likely to prefer emotionally meaningful and purposeful goals which keep them in the balance.Again, being a highly religious and predominantly Muslims community, the participants tend to belief in predestination: that everything that happens to an individual was already planned by God the Almighty and one has to accept it and move on in life. This strong belief therefore influenced the waysthe participants interpret things and how they face events and circumstances in their lives. As a result, this attitude has greater influence in every aspect of their lives and it is believed to have influenced the outcome of the study. Studies by Gabriel and Bowling (2004) and Grewal *et al.* (2006) identified that personality characteristics, perspective and attitudes of individuals affect their actions and lives. People with a higher psychological and emotional well-being, seem to have better attitudes to face the challenges of life. Their perception of a health issue is more positive; they participate more in social activities, in their neighborhood and family roles.With regards to independence, control over Life and freedom, the study established that, the aging process is associated with increased susceptibility to chronic conditions, disability and co- morbidity, which often results in the reduction of a person's Quality Of Life (QOL). Physical activity has been consistently associated with enhanced QOL (McAuley *et al*., 2006; Netz, Wu, Becker andTenenbaum, 2005). Independence and control is therefore threatened by poor health and mobility, as people age. The results revealed a high correlation (r = 0.720 p<0.001) between independence and freedom on the quality of life of the elderly. Traditionally, the people of the Northern region are strong and very active, engaging in farming, trading and other vigorous occupations in their youthful days. Thus a restriction in any form during old age affects their moral and well-being. Hence, being independent is a source of happiness and joy for most aged people in the area, they want to be able to do things by themselves and not rely on others. During old age family members want to say what and how the aged should do things, they would want the aged to do their bidding. This they feel should be so as they believe the aged is not capable in many ways; they feel their thoughts are blurred, their ideas stunted, their strength no more and that, they are limited in various ways.

This finding is similar to Fry's (2000) study, where it was asserted that personal mastery, autonomy, self-sufficiency, life style choices and privacy are the most important indicators of QOL for community-residing older people. In old age therefore, mobility and self control is highly valued by the individual. In their study, Gabriel and Bowling, (2004) reported that avoidance of dependency on others was a commonly-held value among older community-dwelling people. On the contrary, in making negative evaluations about their quality of life, elderly individuals (65 years) stressed on dependency and functional limitations in the current study.When quality of life is considered in the context of health and disease, it's commonly referred to as health-related quality of life (HRQOL) (Healthy People, 2010). Health is one of the most important factors in the quality of life of older people, irrespective of a disability and especially to those with a disability (Kathy *et al*., 2007). Health contributed 68.3% to the quality of life of the elderly studied. Even though, classified as the third of the three important factors to the quality of life of the elderly in the study, it is usually classified as the first and most important factor in the quality of life in most studies (Kathy *et al.,* 2007; Milte *et al.,* 2013). Health is ranked third in this study because most of the participants were community dwellers and active at the time of data collection. Respondents may have considered themselves lucky compared to their counterparts that were on admission as being able to do things by one self was an indication of a good state of health. In assessing some of the characteristics of the elderly and their quality of life, age, gender and educational level were significant. Conversely religion and marital status were not significant to the quality of life of the elderly. This reaffirms the importance of socio-economic status of people within the Ghanaian society.

The age of the elderly is significant to their quality of life. The older the elderly, the worse their quality of life; except for the age group of 75 to 79 years. The reason for this is simple; as one grows old, his/her functional state declines. Activity level decreases while dependency and vulnerability to chronic illness increase. This point is succinctly made by Freund and Ebner, (2005), when they observe that, as people age, gains decrease, and losses increase, therefore the older one gets the weaker they may be. However, for the age group of 75-79 years, their quality of life increased slightly. This could be due to chance or a reflection of the fact that the respondents in this age category may have adjusted to the age related changes and could therefore tolerate things better.

Gender had a significant influence on the quality of life of the elderly. Males had a better quality of life compared to females. It is possible that elderly women may be more responsible in family roles of caring for their grandchildren, or concerned about other family members and disregards their own well-being; thus probably still assuming the traditional role of caring for the household. Elderly women's lower QOL may also be due to some level of depression and anxiety related to circumstances or events. In this particular geographical location and setting of the study, older women are more likely to be branded as witches than their male counterparts. Being branded as a witch can often lead to social exclusion. This has the potential of triggering anxiety and depression, leading to a more subdued outlook about life and consequently a lower QOL. This finding is consistent with previous studies (Hsu, 2007; Koch *et al.,* 2004) of gender differences in health-related quality of life among the elderly. Elderly women had a lower QOL compared to their male counter parts and further research should be conducted to explore the reasons for branding older women and widows as witches in their old age. Educational level had a positive and significant influence on the quality of life of the elderly. Quality of life increased with higher education. A high level of education influences the way individuals perceive and react to things around them. It is widely accepted that people with high levels of education have a better quality of life, as they may have earned higher income

and invested to enhance their well being. Educated individuals are more likely to be liberal minded and tend to have a better psychological well-being than those that are not educated (Ross and Zhang, 2008; Mette, 2005). The results regarding this variable tell a silent story for the elderly being studied in the current investigation where illiteracy dominates in every fabric of that society.Caring for the aged with or without long-term illness or disability affects not only the aged in need of care, but also his or her relative rendering the care. The study showed that psychosocial factors, which is a measure of caregiver strain, with higher scores indicating higher care giver strain was realized. Psychosocial factorsinversely correlated with the quality of life of the elderly (r = -0.346). This implies that, the higher the strain on the care giver, the lower the quality of life of the elderly they care for; while lower strain on the caregiver impacts positively on the quality of life of the elderly. Various studies have identified caregiver burden as a risk for institutionalization of their care receiver (Yaffe *et al.,* 2002), as care giving task and burden increases with advancing age, coupled with the development of chronic diseases. It is inferred that, the reduced quality of life of the elderly due to increased caregiver burden may be the reason for institutionalization in most developed countries. However, for the respondents

Caregivers are often called the invincible patients when they are nursing frail elderly relatives, and are very critical to the quality of life of the elderly. The study showed that, Age, Gender, Educational Level and Duration of Care giving are significantly associated with the quality of life of the elderly being cared for.Younger caregivers are associated with better quality of life of the elderly they care for. This findings on caregiver age, is in contrast to a study in Nigeria that found younger caregivers to be more stressed with the care giving roles than the older caregivers (Okoye and Asa, 2011). Older caregivers may have a better understanding of the care giving role and may be more tolerable than younger caregivers (Roscoe *et al.,* 2009). Conversely in this study, younger caregivers were associated with a better quality of life of the elderly probably because, younger individuals are more likely to be emotionally attached to the elderly they care for, than older counterparts. They are also likely to allow themselves to be controlled by the elderly out of respect and obedience forthem; this may enhance the well being of the elderly as they cherish mentorship, autonomy and independence. Another explanation is that, resolute respect is often accorded to the elderly in consonance with the Northern tradition and culture according to the practice in the study area

Again, the results showed that, male care givers are associated with higher quality of life of their elderly. This is congruent to the Northern culture when sons and their wives constitute the true family lineage and hence, tend to provide overall assistance to their parents, especially “hand-on” services, and tend to cope with care giving much better especially mostly in the absence of their female siblings who also constitute the family lineage for others. This explains why in the traditional northern families; daughters’ in-laws are expected to take care of their spouses’ elderly relatives. Male care giving is not only welcoming news, but needs to be encouraged in the light of this revelation of their “better” service. The analysis found that, except for those with the JHS or JSS educational level, higher educational levels of the care giver are associated with higher quality of life of their elderly. Findings in previous studies suggest that the level of education of caregivers have an effect on the level of stress being experienced during care giving (Kolmer, Tellings and Gelissen, 2008; Okoye and Asa, 2011). Caregivers with lower educational attainment have a higher chance of reporting caregiver stress than their educated counterparts, and caregiver stress can impact negatively on the quality of life of the elderly. In Ghana, people with lower education level are also most likely to be those with low income, and may be engaged in stressful income generating activities which may increase their care giving stress as well. Studies have revealed that caregivers with high income are more likely to experience less stress than those with low income (Andrén and Elmståhl, 2007).

The study also revealed a direct relationship between the duration of care giving and the quality of life of the elderly. This may occur as a result of the continuous changing challenges that usually occur with advancing age. Caregivers may feel burdened or stressed at a point in the care giving relationship. The kind and quality of care may also be influenced as a result of the burden or satisfaction one receives in care giving. Experience shows that, the chronic nature of frailty and providing care to the aged entails increasing intensive care task over prolonged period of time which can lead to caregiver burden and reduced quality of life.The traditional family system in Ghana used to consist of the extended family members and the nuclear family members living together in large family sizes. The extended family in traditional Ghanaian society served as a form of a safety net for the elderly. Even though, studies have reported that, the extended family system, along with its traditional functions like care and support to older members, is gradually fading, (Aboderin, 2006). The study revealed that all the respondents were related to the elderly either through blood or marriage. Previous studies have shown that in Taiwan, the traditional family caregivers are female spouses and daughters-in-law (Huang, Lee, Shyu, Yeh, and Weng, 2007). The reason is not farfetched. The traditional family has been the most natural and favorable social organization for the care of the elderly. The role of caring for the elderly in this study area is a highly valued responsibility that was carried out by children, daughter in-laws and spouses. This care giving was supported by the emotional bonds of relationship arising out of blood or affine relation. Again, due to the traditional values and behaviours, social significant roles assigned to older people in the society such as caring for their grandchildren, it has become a norm, practiced as a routine and sacred, to cater for the elderly. It is believed that, being a moral and necessary responsibility, it is considered to bring material success and spiritual salvation to those that care for their elderly relatives (Aboderin, 2008). This belief is strongly held in Ghana, hence the existence of very few nursing homes.

Furthermore, virtually all of the caregivers 94.75% were not receiving any form of payments for the care they were rendering. This was similar to, Ratcliffe *et al.* (2013) study who defined caregivers as relatives, friends or neighbors who take care of someone without being paid because it is an expected responsibility by family members. Of all the caregivers sampled, 42.75% have been caring for their elderly relatives for a period of between 5-7 years. Previous studies have estimated that informal caregivers spend an average of 4.3 years providing care to older adults (Cho, Kim and Lee, 2013). This may be an indication that, most of the elderly in the arealooed stretched or fatigued and need some form of assistants or support either physically, financially or otherwise

to help care for their elderly. The caregivers on the other hand also need some form of training in caring for the elderly, but their roles have been over looked by society and governments, including the health sector. Financial support was the highest (69.0%) support that family members gave for the upkeep of their elderly relatives. Children now play the most important role in providing economic security for their parents in old age. Most of the elderly respondents did not have any formal education and had no pension to rely on, hence, depend on their children and other family members for financial support. Again, due to migrations to the Southern part of Ghana in search of jobs and education, children of most of the elderly in the North only provide financial support to their elderly relatives back home. It is intriguing to note that, although the study areais the hub for NGO's in the country, very little is done by these organizations for the aged population in the metropolis. There is need for further research in this aspect.In terms of support systems in health, majority (61.25%) of the respondents, both caregivers and the elderly, had no idea of any other service apart from National Health Insurance Scheme NHIS. The LEAP programme which the government of Ghana instituted in 2008 to help alleviate poverty and targeted to the poor and older people in deprived areas appears not to have been heard of by the elderly studied. One would have expected at least some of the participants to mention this programme as part of governments support for the aged, but this was not so. The reason may be that, the metropolis, being the capital for the Northern region and an urban community, was not part of the target population for the leap programme; attention may have been focused on the rural communities in the North.A large majority of the caregivers (88.25%) would not take their elderly relatives to Nursing Homes to be cared for by professionals or trained staff: even if there were such Homes in the region. They see it as a social or family, cultural and spiritual responsibility and it would be an insult to have ones relative taken to a nursing home. This is consistent with a study of informal care in farming families in Northern Ireland, where Heenan (2005) found that there was resistance to becoming involved with formal social services (nursing homes) and individual carers took pride in being able to look after their own family members in old age.

Conclusion

The growth of the elderly population due to higher life expectancies, has gained recognition by researchers, policy makers and governments globally. The growing elderly population poses challenges to society and all. Ageing is inevitable, and predisposes one to chronic conditions, as, increased dependency on family and friends, with reduced economic activity and increased economic burden on society. Thus, examining the quality of life of the elderly provides information that enables health providers, policy makers and the community to collaborate the care for the elderly and their caregivers.

Recommedations

Family as well as Health workers especially nurses should encourage a positive and an optimistic attitude in life towards the elderly. Family health nursing should be extended to the elderly in society instead of creating aged homes away from their familiar environments. Also, emphasis on health promotion and primary care for non-communicable diseases should target our population groups.

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