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CARE OF THE ELDERLY IN GHANA: AN EMERGING ISSUE

ABSTRACT. Data are presented on the social and economic conditions influencing the care of the elderly in Ghana. The data consist of research findings, personal observations, and field studies of University of Ghana social work students as well as information from case studies of HelpAge Ghana's "Adopt a Granny Program". Changes in the traditional family pattern indicate that the nuclear family, including grandchildren, is taking on a crucial role in the care of the elderly.

Key Words: Ghana, elderly, family caregivers

INTRODUCTION

For a long time, the myth about the extended family in Africa – that its structures and patterns of family solidarity and blood ties would render virtually insignificant the problem of aging – has prevailed. Although there is not substantial empirical evidence to support conclusively the contrary view, observers of the African scene note irreversible social and economic trends that could have detrimental effects on the aging situation if no serious efforts are made to forestall them.

This paper investigates the care of the elderly in Ghana, a West African society. Currently care of the elderly in Ghana is a much discussed topic in the national press. The popular view is that young people these days have no regard for their elderly, a view which is yet to be substantiated. The paper presents data on the social and economic conditions influencing the care of the elderly in Ghana. The data consist of research findings, personal observations, and field studies of University of Ghana social work students as well as information from case studies of HelpAge Ghana's "Adopt a Granny Program."

CARE OF THE FEEBLE AND THE DESTITUTE

Between 1948 and 1954, national surveys on destitution in Ghana conducted by the Department of Social Welfare and Community Development (1954) in eleven towns found that the elderly represented 11.2% of the total destitute population at the time. These elderly people were reduced to begging because of insufficient family support. The general conclusion arrived at in this study was that in Ghana, destitution is mainly a question of old, feeble minded, or sick people. This study led to the establishment of the first National Destitute Infirmary at Bekwai in the Ashanti region to take care of all referred destitutes, young and old, in the country.

In 1971, my interest in elderly Ghanaians without family support led to my

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examination of the records of the 218 elderly destitutes then admitted in the Infirmary. Their ages ranged from 50 to 65 years. Though a greater proportion were immigrants from neighboring African countries, they had lived in Ghana practically all their growing years. Among the 218, however, were 15 indigenous Ghanaians, mostly from the northern sector of the country where rural poverty is more extreme resulting in extensive migration to the south. The number of indigenous Ghanaians has since increased fourfold to include many southerners. No matter how small a percentage in 1971, the glaring fact is that even then, there were some homeless elderly people in Ghanaian society with no one to take responsibility for their welfare.

An examination of the admission records of the total number then in the Infirmary showed that most referrals came from hospitals, and on admission, a majority needed regular medical supervision. These elderly people whose care was virtually in their own hands without any family help or assistance prior to their admission into hospitals were grouped in my study into three distinct categories as follows:

A. Those who had some interested family or relatives. These known relatives themselves nevertheless were too poor or lacked adequate resources e.g., housing, to be able to take over the care of the elderly destitute.
B. Those who had no known family or relatives alive in Ghana or elsewhere.
C. Those who were completely out of contact with existing kin either in Ghana or elsewhere in another African country. In this group were mainly elderly people who had either immigrated with their parents when very young or been born later and who obviously had no contact whatsoever with their kinsfolk outside Ghana other than knowing the name of their original homeland.

Of the 15 indigenous Ghanaians living in the Bekwai Infirmary in 1971, a majority was classified under categories A and B above.

Annual reports of Hospital Welfare Services indicate since 1966 an increasing concern of the incidence of "dumping" or abandonment of old people in hospitals. Many old people between the ages of 60 and 80 experience difficulties on being discharged from hospitals because of their relatives' reluctance to take them home and provide the purely geriatric care that they need. Ghana has no geriatric wards, hospices, or any special institutions that cater for the ill elderly.

The incidence of elderly destitution seems to be increasing in Ghana's capital city of Accra as in other larger towns. The St. Vincent de Paul Society, a member organization of HelpAge Ghana, has established welfare programs for such old destitutes at Korle Wokor, Achimota, and Madina, suburbs of the city of Accra. Most recently, this society with assistance from HelpAge International opened the first Day Center for the elderly in Accra. The Korle Wokor Society currently provides food, clothing and health care to 42 elderly destitutes. Most of the destitutes live off the streets with no real homes. For exapmle, Mr. Kwame, who has partial paralysis, lies on a bench surrounded by his personal

belongings in an alcove between two buildings at Korle Wokor. The Society has no trace of any family members. Another case is Ofebia, a widow, brought to the notice of HelpAge Ghana in 1990 by the Sisters of Hope Centre, an affiliate of HelpAge Ghana. Ofebia, then 78 years old, was ejected from her accountant son's house in Accra by the son who claimed the mother did not give him any peace of mind and did not respect his privacy. He blamed her for the problems he was having with his own (nuclear) family. Ofebia slept outside the house and sometimes on a neighbor's verandah. Ofebia had another son living in England but had no contact with him. A daughter also working in Accra would have nothing to do with her. Ofebia had a sister and two nieces living in the city who were also not prepared to take her in.

St. Vincent Society's efforts to involve known relatives of the destitutes in their welfare programs are often met with resistance. The Madina section of the Society caters presently for 24 elderly people half of whom live in family houses with relatives. Even though they live in the midst of relations, they lack care and companionship. The Welfare group make home visits and often take them out to church and other social events. The real destitutes without homes are provided with food and other essentials. Shelter is their biggest problem.

FAMILY CARE

Presently in Ghana, due to the lack of a comprehensive social security system for all, the family continues to be the dominant source of care for the aged. During the colonial era this responsibility was shared by the greater family. Traditionally, the Ghanaian family is described as an extended family of three or four generations descended in a direct line of female members (matrilineal – Akan ethnic groups) or male members (patrilineal – northern ethnic groups and the Ewes and Gas of the southern coast). The extended family often includes brothers and sisters and their children, grandparents, cousins, and in-laws. The extended family as it previously existed was like the modern social security system. Its members are obliged to assist each other in times of crisis and to share the achievements and glory that individual members bring. In this regard, the old, young, and infirm are equally taken care of when the need arises.

An important characteristic of the traditional Ghanaian family system is the subordination of the younger members to the older members. Within the family structure, there are norms and patterns of behavior between the old and the young. It is expected, for example, that one shows respect to one's elders and is friendly and courteous to one's peers and juniors. Within the family domestic group (household), members are expected to share relationships based on respect, courtesy, and assistance to one another. This social arrangement enables the young and old to engage in productive intercourse and share intergenerational experiences; the young have something to learn from the old, and the old are given a helping hand.

Under the traditional system, the aged are respected because they never cease to be productive. They occupy important places in the family system. They are

consulted by the young, and this interaction gives them a sense of self-worth. Besides, most communities are small, and, therefore, the aged can get along according to their capabilities, and they are better able to master their environment.

This situation has been changing in recent times as the nuclear family assumes the greater part of the burden of providing care to the elderly (Apt van Ham 1989; Brown 1985; Okraku 1985). In a study of the views of Ghanaian youth on aging (Apt 1991), it was evident that young families will not be living with their elderly much longer as 81% of the youth interviewed were of the opinion that this arrangement was not feasible these days.

Although the responsibility for the elderly is not resented by the young, the ability of modern families to care for their elderly in the urban context is seriously impaired by limited financial resources. Social indicators show an alarming decilne in the living standards of a majority of Ghanaians in the last one and a half decades. Unemployment and under-employment, inflation, falling external trade, mismanagement of wealth and the rising cost of living have had considerable impact on individuals as well as on the attitudes and abilities of young people who have to fend for themselves, their children, their elderly parents and a host of other dependents in extended families. Family care for elderly people in Ghana, as in most countries of black Africa, therefore needs to be evaluated from an economic viewpoint that takes into account the well-being of the whole family.

In 1962, the first ever survey of the aged revealed that of all children ever born (to the aged in the survey), "only 35% had become what their parents regarded as good providers" (Birmingham, Neustadt, and Omaboe 1967: 159). Moreover there was an indication that "in a ninth of all rural families and a sixth of urban ones, no help had been forthcoming in old age (p. 159)." The results of later studies (Apt 1971, 1991, 1992; Brown 1984) while supporting these findings have placed the burden of care on spouses and children. Further indications however are that children's monetary contributions to elderly parents are meager and infrequent. Indeed, a major disappointment of pensioners studied by Okraku (1985) was that they could not count on their adult children for financial support. Only 7% of his sample admitted receiving regular financial support. Thus, in fact, while children place a high value on support to aging parents, the extent to which they do, in fact, provide financial support will of necessity depend on their own economic means and situation.

Food, clothing, medical care, and medical expenses as well as housing form part of children's support to elderly parents. The extent and overall economic assistance of children to their elderly parents can best be appreciated from the results of a recent study of mine (1989) in the central region of Ghana in which elderly respondents were asked to indicate children's economic contributions (Table I).

When asked about the regularity of these contributions, 54.1% stated that they received these contributions regularly. In this particular study, 46% of the respondents received meager financial support irregularly from relatives other

TABLE I
Children's contributions to elderly parents

Types of assistance	Receiving N	Contributions %	N of respondents
Pay rent/provide housing	34	3.4	1003
Provide money for food	876	91.5	957
Pay medical bills	499	52.2	956
Provide clothing	260	27.2	957
Provide other things	40	5.0	40

Source: Apt van Ham 1989.

than their children, mostly brothers and sisters or nephews, nieces, and grandchildren. Such contributions from extended family members were much less frequent in urban areas (78.5% of rural elders compared to 26% of urban elders).

Elderly people also receive financial support from their spouses. Spouse income could be either maintenance/household allowance from a husband or a contribution to household money from a working wife. Okraku's findings (1985) show that one pattern of response by Ghanaian public service pensioners to the deteriorating economic situation is to have a working wife. According to his report, working wives typically engage in private business, trading in a variety of goods and commodities except in the senior ranks where many of the wives work in professional fields such as nursing and teaching.

Relationships with children and grandchildren in old age are very crucial and form a useful basis for the social care of the old in Ghana. The usual pattern is for the young and dependent children of the elderly to live with the parents. Many elderly people themselves are parents in the child-rearing stages of the family life cycle. Some of the children of elderly males are as young as 1 year old (Okraku 1985; Apt van Ham 1989). Migrant children of old people contribute to the social support of their parents through visits and consultations. Visits range from daily and fortnightly when children are living in the same locality and from monthly to occasionally when living in distant places. In my 1989 study of the Central Region I investigated patterns by visits of children. Elderly informants were asked about the frequency of visits by their eldest and youngest migrant children. On the day of the interview, 5.6% of the elderly had been visited by their eldest migrant child and 12.0% by their youngest. However, 12.1% could not recall when they had last seen their eldest child and similarly 7.0% could not recall the last visit of their youngest child. When asked to state how often they had been visited that year by their eldest and youngest children living in distant places, 11.0% stated no visits for eldest children and 11.6% stated none for youngest children. In this study, the predominant pattern of visits by migrant children dependent on distance was of monthly to occasional visits.

Grandchildren also contribute to the social care of old people in Ghana. From various data, personal field observations, and informal discussion with members of elderly people's households, it was clear that both grandchildren and dependent children living with the elderly assist with household activities, such as cleaning, cooking, dish washing, and laundering. They also assist in the economic activities of the elderly, often selling and helping in their farming and other economic ventures. Besides children, grandchildren, and spouses, elderly people are in close contact with their siblings and the children of their siblings. In general these contacts are closest with female relatives namely, sisters and nieces, although strong links also exist between brothers.

CASE STUDIES

The case studies that follow are of 4 old Ghanaians living with family members. They were recorded under my supervision in the academic year 1990/91 by final year University of Ghana Social Administration students as part of their field work experience in family welfare studies. Students lived in the households of elderly people for 3 weeks during which time they observed the household and had informal discussions with some of its members including the elderly. Students were (1) to define the problems of the aged, (2) to indicate the carers of the aged, and (3) where applicable, to indicate traditional beliefs and practices that have mitigating effect on the care of the aged. Altogether 22 case studies were recorded from all regions of Ghana both urban and rural. The 4 cases following are of 2 male and 2 female subjects living in Ghana's three ecological zones. Their cases are selected to show regional cultural differences as well as different socio-economic backgrounds. The cases are used in an attempt to illustrate in qualitative terms the position of the elderly within the family as well as to show different ways of coping in old age in modern urban settings.

Zinabu

Zinabu Wumbli is a woman of approximately 60 years. Her real age is unknown. Zinabu is presently staying in the Kukuo Witches Home in the Bimbilla district in the Northern region. Zinabu looks much older than her age. She is married with 7 grown-up children, 4 males and 3 females.

The first son is a subsistence farmer married with 6 children. The second son is a labourer at the Nanumba Traditional Council in Bimbilla. He is married with 2 children. The third son lives in Accra, the capital city. He works in the Accra Timber Market pushing a cart to earn a living. The first daughter is married to a farmer at Yendi about 43 miles from Bimbilla while the second daughter is also married to a bicycle repairer in Bimbilla town. The third daughter aged 12 is in the 6th grade in Bimbilla.

Until 5 years ago, Zinabu was living with her husband (aged about 70) and her sons, their wives, and children in their patrilineal family house in Bimbilla town. Why is Zinabu now living as an outcast in the witches home? She said there had been an outbreak of cholera in the section of the town where she used

to live with her family resulting in massive deaths of young adults and children. Through soothsayers, she was accused of being the witch responsible for the deaths and was banished to the Witches Grove.

Zinabu now lives in a single small round room roofed with thatch. There is hardly any furniture in the room. She lives with one of her grandchildren, a girl of 8 who is the child of her oldest son, the subsistence farmer. Zinabu sleeps on a mat with the granddaughter. This old woman virtually lives from hand to mouth by her own initiative and that of her granddaughter. In order to eat she either goes to help the village chief on his farm in return for food or gathers firewood for sale. The granddaughter assists in collecting firewood. She is also responsible for the sweeping and cleaning of Zinabu's room including washing, cooking utensils and fetching water for drinking, cooking, and bathing. Zinabu does the cooking and washes her own clothes as well as those of her granddaughter.

Of her husband, Zinabu says that because of old age he can no longer provide for her, and her sons too are having problems caring for their wives and children. The stigma of being declared a witch no doubt also keeps the family away from Zinabu. Occasionally her brothers and sisters send some gifts of nuts and vegetables.

Zinabu has not been treated for illness in a hospital or a clinic since her childhood. Currently anytime she is ill she self-medicates using local herbs. If her condition does not improve, she visits a local herbalist for treatment. The last time she fell ill was in December 1990. She was down with a severe cold. Zinabu prepared her own herbs with the help of the granddaughter and after drinking the preparation for three days fully recovered. In times of severe illness, her brothers and sisters in Bimbilla come to visit and bring her medicine. According to Zinabu's own assessment, her general health condition is sound except during unfavorable weather conditions such as harmattan (seasonal dry winds from the Sahara) and heavy rainy seasons when she usually develops colds and fevers.

This old lady is facing a number of problems which include stigmatization and banishment as a witch, poverty, malnutrition, and desertion by her family. She is her own caregiver with social assistance from her granddaughter and occasionally from her brothers and sisters.

Nabali

Nabali is an old man from a Moslem family and a predominantly Moslem community. Believed to be in his 90s, Nabali is alleged to be the oldest person living within his community in the Upper West Region. His age was inferred from the narration given about his birth which was placed before the two world wars. Due to his advanced age, he enjoys some degree of respect from the community. On the first day of the study this respect was evident from the number of visitors who dropped by just to say "hello." Nabali, as he is popularly known both within his family and in the community, means great grandfather in the Wala language.

Nabali has 6 living children, 4 males and 2 females. The daughters live with their husbands in the same community while the sons along with their children and their children's children live together with Nabali. A total of 33 family members lives in Nabali's 10-hut compound. Nabali is looked upon as the central authority although during family meetings he is not actually consulted. His sons feel that he should not be bothered with the stresses of running the family. The real authority, therefore, is delegated to Nabali's eldest son.

Nabali sleeps alone in his hut. His grandchildren and greatgrandchildren used to sleep in his hut but stopped when he became incontinent and wet his bedding. Incontinence, however, is only part of the reason for their departure. The real reason is the traditional belief among this ethnic group that the closest grandchild usually dies almost immediately after the death of a grandparent. That is, the child who sleeps in the same room and runs errands for the grandparent is the one most likely to die. This belief has immense influence on the care and attention given to elderly people in this region. As an elderly person gets older, his grandchildren become more detached. This detachment influences the provision of physical care and intimate interaction on the psycho-social level. In Nabali's case, the cleaning of his hut and the washing of his bedsheets and personal clothing are done reluctantly not on a daily basis but at least once a week by his daughters-in-law or by a grandchild upon instructions from a mother. This instruction is almost always met with resistance.

Nabali's 5 daughters-in-law prepare his evening meal on a rotation basis. A child of whichever daughter-in-law cooks the meal for the day washes the food bowls. Nabali purchases his breakfast and lunch with money provided by his sons from his daughters-in-law, who themselves sell food on the street. By tradition Nabali's care and protection should be the sole responsibility of his eldest son, but his youngest son provides funds most frequently because he is better off financially than his brothers. The youngest son also handles the infrequent hospital bills. In actual fact, Nabali relies on herbs for much of his health care. He is very apprehensive about hospitals and vehemently condemns modern drugs. He insists that he will not have any problems with his health if he sticks to herbs about which he has in-depth knowledge. Nabali feels that he is in perfect health. His vision and hearing appear good, and he has strong full teeth.

Socially his major problem is loneliness. All day long his sons are out working; his daughters-in-law are out selling their food, and the older grandchildren try as much as possible to avoid contact with him. His daytime companions are the youngest children under 4 years old who are left at home by their mothers when out or busy working. Nabali himself feels restricted and shows a need for adult companionship. He loves to recount his past experiences, but his family members have no interest in these stories which they have heard often enough.

Nabali has no primary caretaker – rather the responsibility is shared by his sons and their families. His daughters-in-law provide his meals; his grandchildren serve him grudgingly and unpredictably depending upon who is available and willing. His senior daughter-in-law does most of his cleaning and

washing though this is not solely her responsibility. Nabali himself feels well cared for by his family. In my opinion much more could be done.

Nene

Nene, a widow aged about 90, lives at Santokofi Gbodome in the Hohoe District of the Volta Region. She lives with a 9-year-old grandson and a 7-year-old greatgrandson in a one-room mud house roofed with aluminum sheets. In spite of her advanced age she is still physically strong and gets around the village supporting herself with a walking stick. She can still cook a variety of dishes.

Nene has 2 surviving married sons and 3 daughters all living in the same village as peasant farmers and sharing responsibility for her maintenance. The daughter who lives closest to Nene and who is most responsible for her care would prefer that Nene live with her, but any time Nene moves in with her daughter, she returns to her own dwelling after a short stay. Nene emphatically does not want to live permanently with any of her children because, she explains, she feels idle and bored when living in their homes. Her children do not allow her to do certain chores, such as sweeping and polishing the kitchen floor with yellow clay, chores that she is used to doing in her own home. Besides, Nene is used to visiting the sick in her own neighborhood to wish them well, but her children discourage her from this habit.

Nene does her own housekeeping. Her 2 grandsons are not much inclined towards such work though they normally fetch water for the house. A granddaughter who lives close by with her mother washes Nene's clothes and bedding while her food is provided by her daughter and the daughter-in-law living nearest to her. Nene is not currently engaged in any economic ventures. Her sons provide pocket money and, occasionally, some clothing. Nene is reasonably satisfied with her life. She is active for her age and enjoys a good social life surrounded by her children and grandchildren.

Nene's main health problem is hemorrhoids which occasionally disturb her. During such times the daughter who lives closest to her becomes much more attentive and renews her pleas for Nene to move in with her permanently. Like Nabali, Nene prefers local herbs when ill. She has her own concoction of herbs that she drinks routinely every morning. She abhors hospitals and has instructed her children not to send her to the mortuary when she dies.

Odoi

Odoi, a widower, was 81 years old in August 1990. He has 4 living children, 3 daughters and 1 son, and lives in Accra, Ghana's capital city. His children, all married, live with their families in different sections of the same city.

Odoi was a tailor in Sekondi in the Western Region all his adult life till he became weak with age and decided to come back to Accra, his home town, in 1975. Since returning, he has lived at Osu, a suburb of Accra, in a house owned by his sister. The house is rented to 8 tenants who pay monthly rent to the sister who lives with her family in another section of the city. Odoi has no family members living in the house. He lives there rent-free, occupying a single room

furnished with a bed and four table-chairs. A trunk of his personal belongings and a foot-machine [a sewing machine with a foot treadle] are packed in a corner of the room.

Occasionally Odoi's children pay him a visit and give him some money. A 12-year-old grandson living with his parents in Labadi, a section of Accra close to Osu, visits him more often, coming once a week to keep Odoi's house. This grandson washes the old man's dirty linen and clothing and does periodic house cleaning. Apart from these weekly visits, Odoi sends for him whenever he urgently needs something to be done. In addition a young male tenant living in the house does Odoi's ironing. Most of the tenants, with whom Odoi has a cordial relationship, are willing to help in any way possible to make life a little easier for him. Each morning he calls on any one of the tenants, most of whom are young men, to sweep his room or fetch water for a bath. They also share responsibility for warming up his food and washing his eating bowls.

Odoi's daughter (mother of the 12-year-old grandson) prepares his food, normally soups and stews. She usually prepares enough to last him a week. In addition she brings uncooked rice, yam, and plantain to last him a week. Each day Odoi's co-tenants cook some of these staples for his lunch and supper and heat the daily portion of soup or stew for him. For breakfast Odoi likes tea for which he himself heats water. Occasionally his other children visit and provide him with pocket money. It is obvious, however, that the daughter and grandson living at Labadi carry the burden of Odoi's care. Once in a while his church members send him presents of cash and food. He also has 2 close friends who periodically visit him and bring some refreshments; sometimes they give him money.

When Odoi falls sick, he goes to a private clinic in his neighborhood run by one of the sons of a niece. Odoi feels that Accra hospitals, apart from being too far from his place of residence, are much too expensive for his pocket. In his relative's medical clinic he receives free medication, and often times the doctor, a nephew, gives him medical treatment at home. Every now and then the doctor also gives him pocket money. A few years ago Odoi broke his arm in an accident. His nephew sent him to another clinic and paid the bill himself. Odoi has a good memory and sharp hearing although he complains of eye trouble. His most worrisome health problem is aching feet that, he says, have worried him all his life.

Odoi spends his leisure time telling stories to small children in the house. Sometimes he sews for his grandchildren to fill in time. Other times he receives friends and visitors from his church and most recently from HelpAge Ghana. In Odoi's opinion the government should assist people while they are still young to acquire affordable housing. Having no house of his own appears to worry him a great deal.

CONCLUSION

In the past caring for the elderly was an accepted responsibility of the greater family. This responsibility now must increasingly be shouldered by the immediate family, i.e., spouses and children. Children's contributions towards the social and economic well-being of their parents are to a large extent related to their own well-being as well as to the location of their residences. Migration and urbanization have both separately and jointly been pinpointed in Africa as contributing to the destabilization of the values that in the past sustained the elderly in a closely-knit age-integrated society. As the case studies illustrate, daughters and grandchildren play a prominent role in the care of the widowed elderly. In fact grandchildren emerge as crucial means by which adult children provide caretaking to their parents in Ghana.

Changes in the traditional family patterns have been extensive, and the nuclear family has assumed a critical role in providing care to the elderly. Changes in school attendance, migration, and employment together with severe economic hardships have led to some reduction in extended family obligations. One important conclusion from the Ghanaian data is that the 'worker' role and the 'parental' role have major implications for security in old age. Working well to generate a good and secure income in one's old age and being a responsible parent towards one's children will normally ensure reasonable care in old age.

As to the future, the question of change is still important. At the moment the generation of people 60 years and older has children and other relatives to provide care and is more secure than its own children and grandchildren are likely to be when they are old. In other words things will gradually get worse for the next generation of older people in Ghana if no effort is made to face the problem of longer life expectancy and to make it worthwhile to live longer.

REFERENCES

Apt, N.A. 1971 The Socio-Economic Conditions of the Aged in Ghana. Accra: Department of Social Welfare and Community Development Monograph.

Apt, N.A. 1991a Ghanaian Youth On Aging: A Survey Report. BOLD 1(3):18–21. (Malta).

Apt, N.A. 1991b Who Is Caring for the Elderly in Ghana? BOLD 1(4):5–10. (Malta).

Apt, N.A. 1992 Family Support to Elderly People in Ghana. In Family Support for the Elderly: The International Experience. H. Kendig, A. Hashimoto, and L.C. Coppard, eds. Pp. 203–212. New York: Oxford University Press.

Apt van Ham, N.A. 1989 Impact and Consequences of Social Change on Aging in Ghana: A Study of the Central Region. Doctoral Dissertation. Sociology Department, University of Ghana. Legon.

Birmingham, W., J. Neustadt, and E.N. Omaboe (eds.) 1967 A Study of Contemporary Ghana. Vol. 2. London: Allan and Unwin.

Brown, C.K. 1984 Improving the Social Protection of the Aging in Ghana. Institute of Statistical, Social, and Economic Research Monograph. Legon: University of Ghana.

Brown, C.K. 1985 A Survey of the Elderly in the Accra Region. African Gerontology 3(4):11–33.

Department of Social Welfare and Community Development 1954 Report of Enquiry into

Begging and Destitution in the Gold Coast. Accra: Government of Ghana.
Department of Social Welfare and Community Development 1963 Annual Report. Accra: Government of Ghana.
Okraku, I.O. 1985 A Study of Ghanaian Public Service Pensioners. Report presented at the XIIth International Congress of Gerontology, New York.

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