

Exploring the type of social support available to aged male hypertensive clients in Ghana



Original article

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Abstract: **Objective:** To explore the social support available to aged hypertensive male clients in a municipality in Ghana.

Methods: The inclusion criteria were as follows: age ≥ 60 years and are known hypertensive patients. Data were collected from 186 selected aged male hypertensive patients for 3 months. The questionnaire was self-developed and open-ended. The data were processed and analyzed using SPSS version 23. Some of the variables were subjected to statistical tests and ranks in the order of importance to respondents. The enrolled respondents were allowed to participate in the study after their informed consent was obtained. It was evident that respondents do not obtain much support or help in taking care of their condition.

Results: The result revealed that the respondents have no support to help take care of their condition as evident by the responses in the study. The scores on average mean for some variables are (AM = 2.25, SD = 0.381) more than the test value of 2.50. Some of these supports were on feeding support (M = 3.97, SD = 0.278, $n = 186$), health support (M = 2.87, SD = 0.167, $n = 186$), and cleaning support (M = 2.59, SD = 0.868, $n = 186$). Supports such as clothing, socialization, medication, washing, transportation, and financial support were lacking.

Conclusions: Based on the finding that certain forms of support were lacking, the study concludes that steps undertaken by the government, community, religious bodies, and family toward improving these supports can be of immense help for aged male hypertensive patients living in the Ejura-Sekyedumase municipality.

Keywords: aged male • Ghana • hypertension • social support

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1. Introduction

Hypertension is a universal health problem which affects about 1 billion individuals worldwide and causes 7.1 million deaths annually.¹ It is noted that hypertension is the leading risk factor for other diseases and the most important risk factor for cardiovascular disease (CVD) and other peripheral vascular diseases.² Hypertension

or high blood pressure is a single risk factor for stroke and constitutes 45% of the deaths from heart diseases,³ and contributes to one-third death globally in adults.⁴

Practitioners in Ghana use certain ascribed indices of hypertension such as cholesterol level, body mass index, and blood pressure to evaluate the effectiveness

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of the management of hypertension.² Adherence to prescribed medical treatment plays an important role in sustaining health and well-being of people. World Health Organization (WHO) believes that the degree of adherence of individuals can assume several forms, and these include taking medicines, adhering to dietary plan, and lifestyle modifications that correlate with health improvement.⁴

Social support for hypertensive patients is an area that it is very important, but the literature survey reveals that not much attention has been paid to the role of social support in health promotion.⁵ The document added that social participation is a central component of the health plan of the aged population. In addition, the authors maintain that remaining active does not involve merely physical well-being but encompasses being active in the social, cultural, and psychological spheres. Social support comprises interactions with siblings, associates, same-age mates, and neighbors as well as networks that are created during working, entertainment, and other forms, or through communal services.⁶ There are many evidences to support the view that social support is critical for sustaining and improving health, functioning, and longevity in the social species.⁷

Aging is a story of change in individuals and families, a story of loss of physical and mental function, loss of family and friends, and loss of spouse.⁸ All these implicitly or explicitly influence the health of the aged patients, especially those with hypertension. McKenzie et al.⁹ posit that both women and men have strong social connections with their health, especially in their old age, indicating that, for different reasons, there is quite a different experience of aging for women than for men. It is also perceived that health at older ages develops or brings changes within a social context and within intimate partnership. From literature, there is clear evidence that social support of patients has a true connection in promoting one's health.¹⁰ The aged are a heterogeneous group who are vulnerable to physical, mental, and social matters.¹¹ This implies that the health of the aged is related to several social problems.

The health and well-being of the aged, especially in the hypertensive patients, depend on others. Research revealed that one of the important elements for ensuring good health among the aged is social connectedness, which promotes good social support.¹² A lot of studies have focused on treatment¹³ and prevention;^{14,15} however, little or no research has been performed on the effect of social support on the treatment of hypertension. In urban Ghana, older people may be systematically less likely than younger generation members to receive family resources to meet their needs.¹⁶ The Ghanaian literature documents that the major factor linking poverty to old age is a normative hierarchy of generational priorities in the

allocation of scarce resources. This hierarchy, which has crystallized in the overall context of economic constraint, is perceived as legitimate and "natural," and gives clear priority to the needs of the young (self, spouse, and children), before those of older parents or relatives. Rather, it is that the young represent "future life," and that the old have no "right" to absorb resources needed by them.¹⁶ A second, additional factor to limit the family resources made available to older parents is that adult children are increasingly making the extent of support to parents dependent on their judgement of the parents' past conduct and care and thus his or her "deservedness." Where children consider a parent to have been neglectful, they increasingly withhold some, and sometimes all, support.¹⁷ Rural and urban Ghanaian evidence suggest that such "retaliation" affects above all older fathers, that is, men, often leaving them exposed to a dependence on charity.¹⁶ Older women, though not so much affected by retaliation, are, in the West as in other African regions, increasingly exposed to accusations of witchcraft, which limit the family support given to them.^{18,19} Again, on observation, when the aged visit the clinic for their reviews or for routine drugs, the male complain of poor care and neglect from their children and significant others, and thus arises the interest to use only male hypertensive patients in the study. The aim of this study is, therefore, to explore the type of social support available to aged hypertensive male clients in a selected community in Ghana.

2. Methods

Quantitative descriptive design was used for this study, a scientific method which involves observing and describing the behavior of a subject without influencing it in any way.¹⁶

The selected community has settlement population of 70,807 people and occupies the largest maize-producing district. The people are predominantly farmers. The population of the aged in the selected municipality was estimated by the District Planning Office to be 8365.¹⁷ Inclusion criteria were: all aged individuals in the designated area aged ≥ 60 years as at December 2019 and those with hypertension. The sampling of 186 aged individuals was agreed upon out of 8365, based on the Krejcie and Morgan sample size determination table with its appropriate confidence level and confidence interval.¹⁸

The instrument for collecting data for the study was a close-ended type questionnaire. The questionnaire consisted of a list of question statements relating to the research question to be verified and answered, to which the respondents were required to answer in writing. The instrument used in collecting data for the study was divided into 4 sections on a 4-point

Likert scale arranged according to the agreement level (strongly agree, agree, disagree, and strongly disagree). Section A tackled the background information of the respondents, while Section B measured items on the types of socio-economic support systems for the aged. Section C considered perceptions of the aged about the support systems available for the aged, and Section D focused on ways by which social support systems can be improved for the aged. The items on the questionnaire were scored as strongly agree (SA) = 4, agree (A) = 3, strongly disagree (SD) = 2, and disagree (D) = 1.

To ensure the accuracy of the content and construct, the developed questionnaire was evaluated by an expert in test and measurement for their input. The face validity of the instrument was also determined by the expert after construction to ensure that it measured what it is supposed to measure. This was done according to the measure test subjectively.¹⁹

Ten questionnaires were later piloted in a sub-district adjacent to the municipality, to test for its reliability and internal consistency. Cronbach α is in a range of 0 to 1.00, where the mean value scored was 0.89.

An introductory letter was sought from the Department of Science Education, University of Cape Coast, Cape Coast, explaining the reason for the research to the authorities in the Municipal assembly and the Ghana Health Service. The purpose and significance of the study were clearly explained to the participants and the various facility authorities. Participants were also made aware that their participation was voluntary and that they were free to withdraw their participation at any time. The selected aged individuals in the Municipality had the opportunity to fill their questionnaires privately to ensure confidentiality. In dissemination of results, measures were taken to ensure privacy, anonymity, and confidentiality of all participants by ensuring that the names of the participants were not used or revealed throughout the study. A letter of consent from the researchers expressing our gratitude for the respondents' consent to participate in the study was given to the aged as a courtesy shown to them, and also as a means of ensuring that their informed consent to participate in the study was acknowledged.

The questionnaire was administered to the aged at the institution whenever they came for a review or for their medication, without any undue influence. They were guided and given ample time to complete the questionnaire. Data collection was done within 3 months. All questionnaires were administered face to face and were collected on the spot.

Data were managed by coding, editing wherever appropriate, entering the data into the Statistical Package for the Social Sciences (SPSS), version 23, to generate results, and finally cleaning the data to remove

any forms of outliers that may have gone unnoticed. To account for descriptive nature of the research, it was agreed that the researchers would employ descriptive statistics (means and standard deviations) for analysis. The analysis was based on the 100% return rate of 186.

3. Results

3.1. Demographic information of respondents

Demographic variables for the respondents included their age and marital status (Table 1).

The finding showed that the majority (36.1%) of respondents were aged within the 60–65 years group. Those aged from 66 years to 70 years were the least, with 31.7%. Regarding marital status, the majority (66.7%) of the aged, hypertensive, male patients were married, with only 6.4% being single.

To understand the mean scores, items/statements that scored a mean of **0.00 to 2.49** are regarded as items with low social support. Those items/statements that scored a mean from **2.50 to 4.00** are regarded as high social support.

Table 2 presents results on the types(s) of social support available for the aged hypertensive male patients. The results give evidence that, generally, respondents do not get all the social supports that they need. This was evident after the responses from the study, where scores on average mean for some variables are (AM = 2.25, SD = 0.381) more than the test value of 2.50. Some of these sparse supports were feeding support (M = 3.97, SD = 0.278, $n = 186$), health support (M = 2.87, SD = 0.167, $n = 186$), and cleaning support (M = 2.59, SD = 0.868, $n = 186$).

The following social supports were not available for respondents: clothing support (M = 2.28, SD = 0.379, $n = 186$), socialization support (M = 2.27, SD = 0.378, $n = 186$), medication (M = 2.13, SD = 0.168, $n = 186$),

Variables	Frequency	Percentage (%)
<i>Age (years)</i>		
60–65	67	36.1
66–70	59	31.7
≥71	60	32.2
<i>Marital Status</i>		
Single	12	6.4
Married	124	66.7
Divorces/Separated	34	18.3
Widowed	16	8.6

Source: Field Data (2019)

Table 1. Percentage distribution of age and marital status of respondents ($n = 186$).

Types(s) of Social Support	M	SD	MR
	Statistic	Std0. Error	
Feeding	2.97	0.278	1 st
Health	2.87	0.167	2 nd
Cleaning	2.59	0.868	3 rd
Clothing	2.28	0.379	4 th
Socialization	2.27	0.378	5 th
Medication	2.13	0.168	6 th
Washing	2.17	0.375	7 th
Transportation	2.25	0.437	8 th
Financial	2.21	0.179	9 th
Mean of Means/Std	2.25	0.381	

Note: M, mean; StD, standard deviation; MR, means ranking; n, sample size.
Source: Field Data (2019).

Table 2. Descriptive analysis of the types(s) of social support available for the respondents ($n = 186$).

washing support ($M = 2.17$, $SD = 0.375$, $n = 186$), transportation support ($M = 2.25$, $SD = 0.437$, $n = 186$), and financial support ($M = 2.21$, $SD = 0.179$, $n = 186$).

3.2. The perceptions of social support by the respondents

Table 3 shows that most aged hypertensive male patients perceived that their children ($n = 168$, 90.3%), relations ($n = 121$, 65.1%), spouse ($n = 159$, 85.5%), friends ($n = 167$, 89.9%), and the government ($n = 130$, 69.9%) should be held responsible for providing them with their required social support.

The majority (68.8%) of respondents averred that they did not prepare for old age and further pointed out that they are not happy in their situation since most of them are rejected (89.9%), dejected (91.3%), and saddened (85.5%) based on their condition. The results also gives evidence to the idea that family members [children (90.3%) and relatives (65.1%)] are the major providers of informal support to the aged.

4. Discussion

Marital status is associated with health and survival outcomes among the aged. The separated aged experience poor health, are not accorded respect, and often stigmatized and marginalized on things that can benefit their health.²⁰ This is explained by the majority of respondents who were married. The results also agree with the work of Shiba et al.²¹ who asserted that a social support system is the informal social support system

Statements	Yes, F (%)	No, F (%)
<i>Perception of whom to provide the need for respondents</i>		
Self	33 (17.7)	153 (82.3)
Children	168 (90.3)	18 (09.7)
Relation	121 (65.1)	65 (34.9)
Spouse	159 (85.5)	27 (14.5)
Friends	167 (89.9)	19 (10.1)
Government	130 (69.9)	56 (30.1)
Others	171 (91.9)	15 (8.10)
<i>Did you prepare for old age?</i>	58 (31.2)	128 (68.8)
<i>How does it feel to be your client's caregiver?</i>		
Dignified	12 (06.5)	174 (93.5)
Honored	33 (17.7)	153 (82.3)
Respected	15 (8.10)	171 (91.9)
Rejected	167 (89.9)	20 (10.1)
Saddened	159 (85.5)	27 (14.5)
Dejected	169 (91.3)	17 (08.7)
Others	130 (69.9)	56 (30.1)

Source: Field Data (2019).

Table 3. Percentage distribution on the perceptions of the provision of existing caregivers ($n = 186$).

provided by families or households, friends, and other organizations such as religious groups. This system varies greatly among families and organizations, and between countries. The family social support is the most popular informal support system, especially in developing countries.

Similarly, the family provides love, affection, respect, security, and the sense of belongingness, which enhances the emotional well-being and promotes the self-esteem of the aged.²¹ The aged in turn also help busier younger relatives by attending to their children, thereby showing that they are still useful and needed by the society. The majority (68.8%) of respondents averred that they did not prepare for old age, and this could explain why most of them were in need of assistance.

Family members are the major providers of informal support to the aged, especially daughters and daughters-in-laws. Older people receive financial and other support from adult children and that support is reciprocal.^{22–25} It is well-known that in countries where there are well-established pension programs, many older adults willingly give support and care to their children and grandchildren.²⁶ In countries where there are no well-established pension schemes, and the aged never worked in formal jobs but have invested in capital ventures and other long-term projects, they offer support to their children and grandchildren.

Similarly, there is evidence that the family support system is the provision of a befitting burial to the dead, especially death at old age, the last obligation of one's own children and relatives.²⁷ However, the greatest weakness of the family support system is that it is informal. While most Ghanaians are willing to take care of their aged parents, young people often complain of their financial inability to care for their aged relatives as much as they would wish.²⁴ The effect of modernization is the pressure on the nuclear family of younger wage earners to provide for themselves, with little left for aged parents who may be at a distance.²⁸

Ways that these support systems can be improve for respondents

The question of ways of improving these supports for respondents was received based on their health or condition. Some agencies exist that help them with some support, and it was recounted that most of the respondents believed that the family and the community could play a significant role in improving the support systems. Others suggested that the social welfare in collaboration with the government could play a significant role in improving the support for them. According to their responses, the government must institute some measures to make provision for the aged. In finding out what could be done to make the family more effective in supporting the aged, the results show that education of the family could be very beneficial. Respondents also believe that the family can be effective when the NGOs and the government support them. Others shared a common view that programs should be organized in the community to expose the family to some level of knowledge on how to care for the aged, for the family to be more effective in supporting their aged. The results indicated that the aged are offered some informal support by non-governmental organizations. Religious organizations/bodies offer both social and spiritual support to the aged.²¹ The document added that a number of religious societies and groups have elaborate programs where members of the society pay regular visits to the aged and people indisposed in their religious groups, and also provide occasional rationing in terms of food supply to the aged and destitute in their midst (e.g., St. Vincent de Paul and Legion of Mary societies in the Roman Catholic Church). They also offer regular prayers for the aged in their societies.

The main findings from the study showed that respondents did not obtain some basic supports that would help them take care of their condition. For example, clothing

support, socialization, medication, laundry, transportation, and financial support were lacking.

Most of them perceived that their children, relatives, spouse, friends, and the government should undertake the responsibility for providing social support. Finally, it was revealed that in improving these supports for aged men, the government, the community, religious bodies, and the family could help improve support systems.

5. Conclusions

The informal social support system is the main support system available to respondents. Again, the major responsibility of care for the aged has shifted from the extended family system to the nuclear family, where daughters, sons, and daughters-in-law play leading roles. Also, there is inadequate social support for the aged, especially with regard to cash remittances and visits when the aged are sick. The aged also realize that they cannot continue to rely on their children at all time for the needed support. This is also viewed within the context of the desire of the aged to continue working even at their retiring age, as well as their demand for an improvement in the availability of social support.

Limitations

The findings of this study are limited to studying the social support available to male hypertensive patients in a farming environment. Since it applied a quantitative method, the findings could be generalized to all patients who are male and hypertensive. The weakness of the study is in fact that it has a bias toward men.

With reference to the findings of this study, the nursing implication could be that practitioners and community members need to acknowledge the existence of a problem concerning male hypertensive aged individuals, in relation to the availability of social support. There is the need to create awareness programs through outreach services in schools, churches, and use of mass media to these ignored social responsibilities. There should be better strategies between practitioners/caregivers and patients to enable a better understanding of the problem.

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JKZ conceived the study, was the principal investigator, and made most extensive contribution to the research. PW, IKA, AAD, and AEN were involved in the conception of the research, and guided the development of the proposal. IKA and AEN revised the research and developed the manuscript, and together take responsibility for formulating its intellectual and professional content.

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Ethical approval

Ethical issues are not involved in this paper.

Conflicts of interest

All contributing authors declare that no conflicts of interest exist.

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