

Graduate School of Development Studies

**INVISIBILITY OF THE ELDERLY IN HIV/AIDS:  
Policy and Practice in Ghana**

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## DEDICATION

To my dear husband Mike for his invaluable support during my stay at the Institute. I could call you in the middle of the night and you were always ready and listened to me. I sincerely appreciate you from my heart.

Our twenty two months old son Nuku was simply amazing and full of exuberance any time we spoke on phone. Thoughts of him as I dreamt each day and night focused me to know I had something to work hard for; this encouraged me to forge ahead and press on each day. Nuku's songs especially gave me a lot of comfort, peace and laughter.

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***This work is dedicated to you all.***



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**To all of you I say, *Akpe na mi loo***

*Dzinedzormi W.A. Dzakuma*

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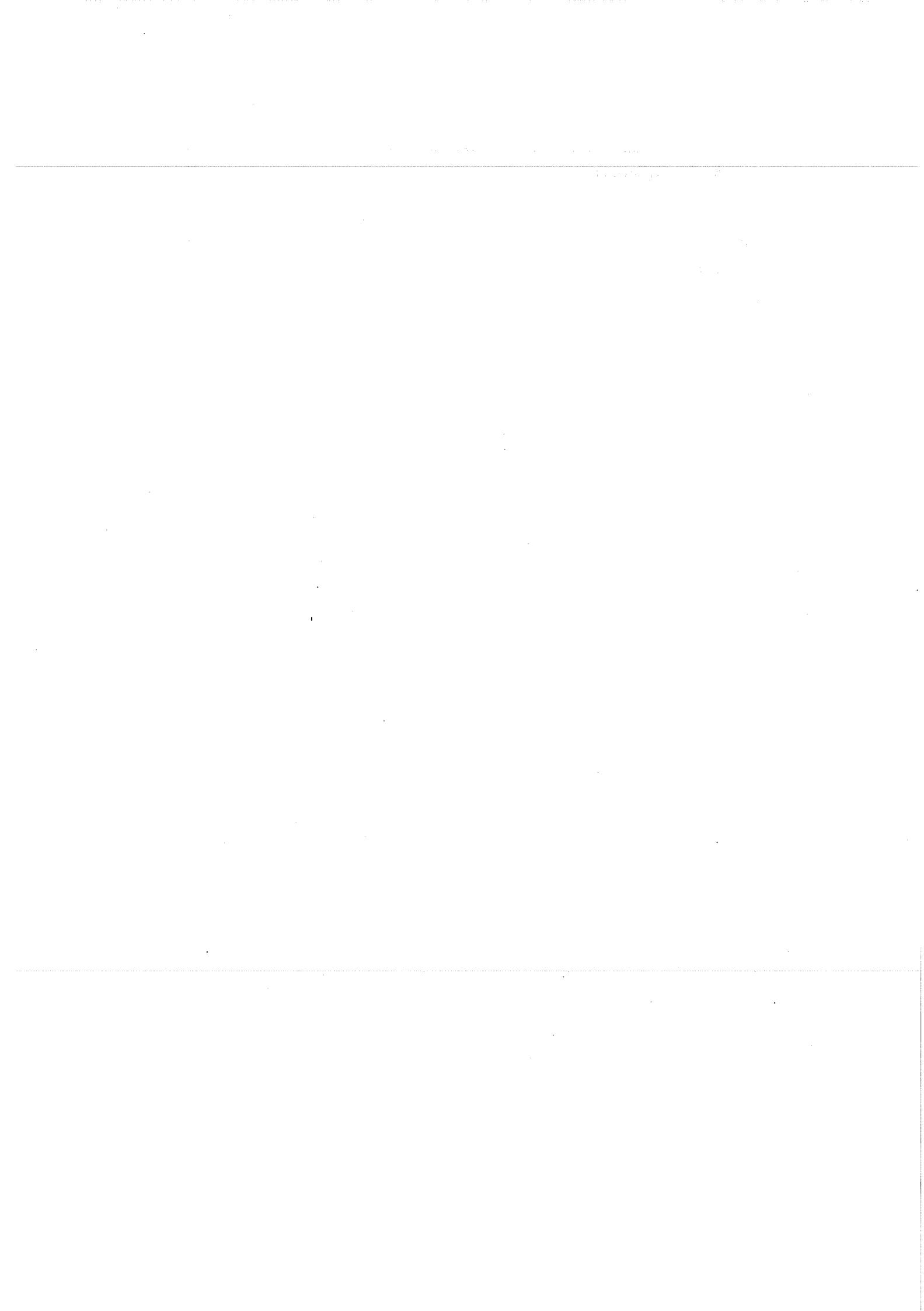


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## LIST OF ACRONYMS

AIDS	-	Acquired Immune-Deficiency Syndrome
ART	-	Anti Retroviral Therapy
ARV	-	Anti Retroviral
BCC	-	Behaviour Change Communication
CRS	-	Catholic Relief Services
DCU	-	Disease Control Unit
FBO	-	Faith Based Organization
FHI	-	Family Health International
GAC	-	Ghana AIDS Commission
GDHS	-	Ghana Demographic Health Survey
GHS	-	Ghana Health Service
GSMF	-	Ghana Social Marketing Foundation
GNA	-	Ghana News Agency
GLSS	-	Ghana Living Standards Survey
HAG	-	Help Age Ghana
HIV	-	Human immunodeficiency Virus
MOH	-	Ministry of Health
NACP	-	National Advisory Council on HIV/AIDS Programme
NACP	-	National AIDS/STI Control Programme
NGO	-	Non-Governmental Organization
PLWHA	-	People Living with HIV/AIDS
PMTCT	-	Prevention of Mother to Child Transmission
SSNT	-	Social Security and National Trust
STD	-	Sexually Transmitted Diseases
STI	-	Sexually Transmitted Infections
UNAIDS	-	United Nations Programme on HIV/AIDS
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organization



## ABSTRACT

The study zeroes in on an important but neglected issue of HIV/AIDS provisioning for the elderly in Ghana. The paper aimed to bring to the fore the invisibility of the elderly in accessing intervention services. This was done based on the framework of Devereux and Cook (2000), *'Does Social Policy Meet Social Needs'*? Constraints that the elderly PLWHAs encounter are illuminated. Alternative ways of service provisioning and non-contributory pensions have been advocated for. These mechanisms when put in place, it is believed, will enhance the inclusion of the elderly.



# **CHAPTER ONE**

## **PROBLEM STATEMENT AND RESEARCH ISSUES**

### **1.0 INTRODUCTION**

Persons infected with HIV have increased in Ghana since the first case was identified in the mid 1980s. In 1994, the general recorded infections in the country were estimated at 118,000 and in the year 2000 the number rose to 350,000 made up of 330,000 adults and 20,000 children. By the year 2004, the figures had risen to 404,000. From the above it is explicit that the number of infected persons more than tripled from the 1990s to 2004 (Ministry of Health, 2001).

Ghana AIDS Commission (2004) asserts that 80 percent of all infection occurs through heterosexual contact in the country. The spread of HIV has been slower in Ghana than in many African countries especially the Southern African countries. This relative slow rate notwithstanding, its impact has been devastating on all sectors of the country's economy. Even though the future trend of infection is not known, a possibility of the rate of increase being the same as in other parts of Africa cannot be overemphasized (*ibid*). Therefore, there is an urgent need for appropriate and sustainable intervention measures, especially HIV/AIDS policies that meet particular needs of the people in order to stem the spread of the infection.

In Ghana the epidemic affects both the productive and reproductive sectors of the population and has a negative impact on the development process of the country. The economic impact includes 'a depletion of the workforce in all sectors in terms of numbers, skills and personal productivity. The consequences are enormous: for instance in the food and agriculture sector, HIV/AIDS prevalence among workers has led to a reduction of local food production and effectively threaten the food security of the entire nation. In the education sector, the targets for manpower development and training are unlikely to be met and the rate of replacement may never match attrition due to either premature or increased loss from service. This may ultimately affect the quality of the educational system currently in the country' (*ibid*: 8).

### **1.1 WHO ARE THE ELDERLY?**

This paper focuses on the elderly, which is placed at 50 years and above. As Sen (1994) comments, the 'term old age in purely chronological terms has always been debatable'. She further alludes to the fact that the ages of '60 or 65 have been commonly adopted as the beginning of old age, although definitions vary across countries, cultures and in time' (*ibid*). Chronological age although cannot be the sole determinant for examining the ageing process becomes useful when differences in ageing across societies have to be examined (*ibid*). Again, Sen argues that people in developed and developing countries experience ageing differently due to their livelihood systems which makes the latter experience ageing quickly. Another major factor which determines who is old in a country is the life expectancy which in Ghana is 56 years for men and 58 years for women according to United Nations Programmes on HIV/AIDS, (2007) and the official age for retirement is 60 years (Mba, 2004). In this context, it is valid when 50 year

olds are considered as elderly persons in Ghana. In this paper, I will use elderly person/people synonymously with the aged or older persons/people or elderly People living with HIV/AIDS (PLWHA).

## 1.2 THE ELDERLY AND HIV/AIDS

According to Avert (2007), 'few people would picture the face of the HIV pandemic as a wrinkled one'. Yet the figures paint a different picture as UNAIDS estimate that 'around 2.8 million adults aged 50 years and older were living with HIV in 2005' in the world (ibid).

The sexuality of elderly persons in Ghana especially women unlike men is shrouded in secrecy and stigma. Women are often stereotyped as sexually inactive when they are past the age of menopause. There is therefore a denial amongst people in Ghana towards the sexuality of older women although the older men have the liberty to exercise their sexuality till they die and society accepts this behaviour recognizing it as *normal* or *just being a man*. If protection is not used during sexual intercourse, their sexual partners will be exposed to the HIV virus.

This is the case in Ghana as Ghana Health Service (2005) reported that, of the HIV/AIDS infected elderly, 835 (5.8 percent) were in the age range of 50-54 years, 362 (2.5 percent) are in the 55-59 age category and finally 402 (2.8 percent) are 60 years and above. This substantiates the claim that HIV is evident amongst the elderly.

## 1.3 GOVERNMENT EFFORTS TO CURB HIV/AIDS

The Government of Ghana, the National Advisory Council on HIV/AIDS (NACP) and the Ghana AIDS Commission (GAC) are making some effort to contain the HIV epidemic through policy-oriented measures for all who have been infected by the disease or affected by it. The government has developed a 5 year comprehensive and 'far-reaching National HIV/AIDS and STIs policy to address the very serious health and developmental challenges posed by HIV/AIDS. This policy will provide the framework for Ghana's strategy to reduce the spread of HIV infection' according to (GAC, 2004).

In addition to the national HIV/AIDS policy framework, a number of strategies have been adopted to disseminate information and create awareness about the disease. These include mass media campaigns, billboard adverts, talk shows etc. In addition, in collaboration with international organizations and local organizations and institutions such as United Nations Programme on HIV/AIDS (UNAIDS), World Health Organisation (WHO), Family Health International (FHI), GAC, Ministry of Health (MOH) among others, the government has been able to put in place effective programmes such as prevention, care, treatment and support services to those who have been infected with or affected by HIV/AIDS (Ghana Health Service, 2005).

The support of churches and mosques has been sought in the effort to make young people alter their attitude and behaviour regarding sex by way of adhering to religious doctrines. Condoms are distributed at HIV/AIDS programmes to participants and also made widely available in pharmacy shops and hotels etc. More importantly, Antiretroviral (ART) drugs are being made available at health centres at subsidized prices to HIV patients. These efforts have, however, been selective. The elderly have largely been left out of intervention measures.

## 1.4 INDICATION OF THE PROBLEM

The life expectancy in Ghana over the last twenty years has been impressive. Data shows that life expectancy for men and women between 1984 and the year 2000 increased. Figures for males increased from 50.3 years in 1984 to 55.4 years in 2000. On the other hand figures for females show an increase from 53.8 years in 1984 to 59.6 years in 2000. Consequently, the proportion of the elderly above 65 years has increased steadily from 3.6% in 1970 to 4.0% in 1984 and 5.3% in 2000. This rise in life expectancy could be attributed to availability of medical services; good nutrition, better housing and most importantly increase in socio-economic development in the country. The country could in the near future experience population ageing<sup>1</sup> since, according to Ghana Demographic Health Survey (2003), fertility and mortality rates have declined. Mba (2004) confirms this assertion and says the phenomenon is even more pronounced among females than males as women live longer than men. This population ageing in Ghana might become a dream which will not come true because the elderly who make up 7% of the total population of (20 million people) are getting infected with the virus as indicated by the Ghana Health Service (GHS) above.

The death toll HIV has on the population is phenomenal. Since the advent of the disease in the 1980s to the year 2000, 160,000 people have been reported dead (NACP, Disease Control Unit, Ministry of Health, 2001). It has been estimated that between the years 2000-2014, 660,000 PLWHAs could die and HIV deaths will account for 28 percent of all deaths in 2014. Without AIDS the population of Ghana is predicted to be 25 million in the year 2014 but if there are still increasing deaths due to AIDS, the population is estimated to be 23.8 million (*ibid*). Many people are dying of AIDS; in 2005 alone, an estimated number of 29,000 (8.3 per cent) died as a result of the disease (Global Health, 2005). Mba (2004) again argues that 'under the prevailing mortality conditions 23.4 per cent of Ghanaians aged 60 years and 75 years and above will die of AIDS. These deaths could have a considerable effect on the current increasing life expectancy the country has now and may cause it to reduce if more elderly people get infected and as a result die. For this reason it is only prudent if awareness is created about HIV/AIDS to conscientize the people about its impact in totality.

Secondly, the age structure of the country depicts that the age groups of 15-64 years make up 53.35 percent of the country's population signifying they are in the majority, whereas the 0-14 and 65 years and above make up 41.18 and 3.4 percent respectively (Ghanaweb accessed on 4 November, 2007) and the 15-64 age groups are the people being infected with the virus. Again the dependency ratio of the country is 15-64 years (AARP, 2007); signifying the importance of this category of people in the country as they are the working group and the 0-14 years and 65 years and above depend on them for their survival. The elderly especially according to (Barrientos et al. (2003) 'play a key role in sustaining their households by contributing income, services, care and leadership'. The elderly PLWHA which the paper concentrates on is within this category of people showing their importance in the society as they are still considered as the working group as the dependency ratio indicated. Barrientos et al. (2003) shows that because of 'acute economic need and the absence of pension plans and formal old age support ensure that many older people continue in paid work' especially the elderly who live in the

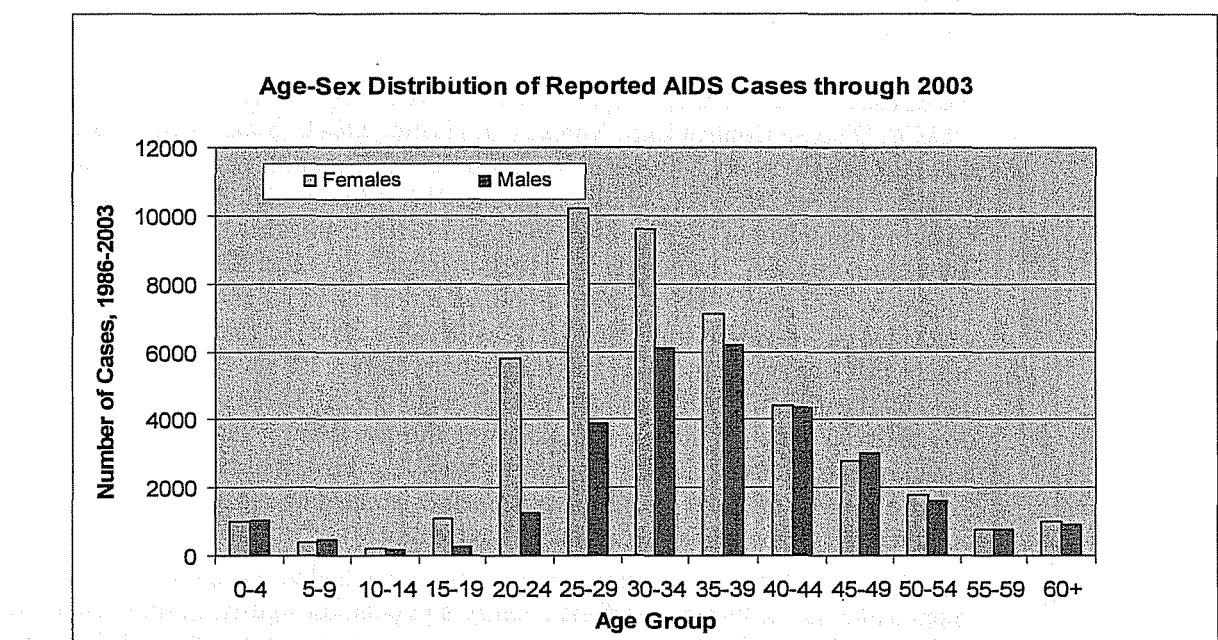
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<sup>1</sup> See also Mba (2004) on population ageing in Ghana

rural areas who are more than those in the urban areas. However they lack the attention and services they need as HIV/AIDS patients. Barrientos et al. (2003) suggests that the 'restrictions in access to health care experienced by older people often result from policy priorities which explicitly undervalue the benefits of treating this group'.

Although the rate of infection among the elderly is higher than children from 0-9 years and youth from 15-19 years (GHS, 2005), HIV/AIDS interventions do not target the elderly because of a shift in policy priorities. Ghana's HIV/AIDS Strategic Framework of 2001-2005 and 2006-2010 does not focus on persons who are 50 years and above. The objective of the former framework includes 'reducing new HIV infections among the 15-49 age group and other vulnerable groups, and especially among the youth' (GDHS 2003: 3). This signifies their exclusion even from the policy level.

Figure 1.0 highlights the assertion that elderly persons also get infected with HIV.



Source: Ghana AIDS Commission September 2004

The graph shows that older people have a higher prevalence rate than all age groups below the age of 20. This shows that they equally engage in sexual activity, which is the highest mode of transmission (GAC, 2004) and other practices that might expose them to HIV infection. The question then is; if these people are being infected, why are they not accessing intervention programmes and why are they not targeted for these programmes?

Figure 1.0 also depicts a higher prevalence rate among females especially those below the age of 40 years. This indicates that more females than males during their adolescent years get infected. Further, the infection rate reduces among both sexes between age 40 and 44 years; even here women are disproportionately affected by whatever circumstance that caused the reduction in their numbers. It can also be observed that the rate of infection is

higher among the age group 0-4 years than, say, between 5-9 year olds. This may be attributed to mother-child transmissions which are reflected in the number of infected adults above the age of 20 years who perhaps bore these children and infected them with the virus. Thus in the absence of effective treatment mechanisms, these infected children do not survive past the age of 5 years reflecting in the low infection rate between 5-9 year olds as compared with 0-4 years. According to GAC (2005) prevention services are normally targeted at children below 15 years because they are the hope of the country. Similarly in preventing parents from infecting their children, a lot of intervention services are focused on adults, especially pregnant women (GHS and GAC, 2004).

The graph further shows that women are disproportionately affected with the virus and even among the elderly, women have a higher prevalence rate of HIV than men.

## **1.5 RELEVANCE AND MOTIVATION**

The prevalence of the disease among people above 50 years is growing rapidly and it has recently been realized by the government, media and the community based organizations that both the old and the young are equally at risk of infection.

The Government, NGOs and Faith Based Organisations (FBO) have introduced many intervention programmes since the HIV/AIDS epidemic emerged in Ghana in 1986 but no programme has specifically targeted the elderly. These interventions such as Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), educational programs such as Behaviour Change Communication (BCC), distribution of free condoms and treatment with Antiretroviral Therapy (ART) for infected persons, all had the objective of the well being of infected persons. Yet the continued exclusion of the elderly, in spite of these revelations, underscores the significance of this study. The assumption behind the neglect has roots in the persistent myth that older people do not have risky sexual lives or are not sexually active, or even if they indulge in sex they protect themselves to avoid getting infected. Stall and Catania (1994) think otherwise as they reiterate that, 'despite the fact that HIV infection is clearly present among those past the age of 50 years, a small proportion of individuals in this age group take behavioural risks for HIV infection' this exposes them to infection. This research hopes to shed light on the exclusion of the elderly people and bring their vulnerability to the fore as they are continually not able to access prevention, treatment and care programs in the country as the younger ones.

## **1.6 RESEARCH OBJECTIVES**

The overall objective of this study is to explore how and why HIV interventions continue to exclude the elderly and to show the implications of their exclusion. Further, to examine the extent to which the elderly are involved in the intervention programmes since there is a universal policy for all citizens to access HIV/AIDS provisioning.

### **1.6.1 Research Question**

The main question this research attempts to answer is:

To what extent and why are the elderly excluded from HIV/AIDS intervention services?

### **1.6.2 Specific Questions**

In an attempt to answer this; the following questions will be explored.

- To what extent do recent government and NGO prevention, treatment and care programs benefit older people and are available to them?
- Do elderly people have knowledge about intervention services?
- What factors hinder elderly people from equally accessing services?

## **1.7 METHODOLOGY OF RESEARCH**

### **1.7.1 Sources of Data**

The main source of data was primary data which was based on purposive sampling. The elderly people who took part in the interviews were not selected by a random procedure but were purposively selected from two government hospitals based on certain characteristics such as the age and the HIV/AIDS status which were of paramount interest to the study. The regions were Greater Accra and Eastern region and these were chosen because they are representative of the high prevalence of HIV cases in the country and accordingly have attracted a number of HIV intervention services (Ghana Health Service 2005) as compared with other regions.

### **1.7.2 Limitations**

The research only covered elderly people in the two regions which are developed (urban) areas because of the limited time involved in doing the research. It was also cost effective doing research in these areas because they were fairly accessible by transport and close for the convenience of the researcher.

### **1.7.3 Process of Data Collection**

Thirty elderly People Living with HIV/AIDS (PLWHA) and four key informants, of which three works with HIV/AIDS organisations and one from an organisation that sees to the welfare of older people in the country, were chosen purposively for the study. The elderly and organisations were chosen because they satisfy the criteria of the study. According to Kumekpor (1999: 135), this is an important factor to consider when doing research in order to get the right information for a successful research. In addition to sampling purposively, a convenience sampling method was used to select the elderly PLWHAs; convenient because only those attending clinic on that day were chosen to participate in the interviews.

The 30 elderly people who participated in the interview were between the ages of 50 and 65 years old. The selection of the elderly was made such that only people who were 50 years and above were qualified to take part. Before the selection of the elderly people was done, the directors of the HIV/AIDS units in the hospitals were informed and involved in the project and the proposed interviews. The directors then informed nurses on duty at the HIV/AIDS units to help with this exercise. The nurses then informed the elderly persons who had

come to seek medical attention about the interview. It was however not mandatory for the chosen elderly PLWHA to participate but those who did were informed that the research was for academic use and all details given would be kept confidential which Laws et al. (2003:241) refer to as 'rights to confidentiality and anonymity'.

In addition to the generational difference between the respondents and the researcher the subject matter for discussion is in itself a sensitive one; one which is shrouded in secrecy and stigma. It was difficult to discuss such a sensitive and private issue with people one hardly knew. Past working experience in the field however made it easy to surmount these initial difficulties. This experience included working and partnering with NGOs and regular contacts with several PLWHA. It also included sharing offices with some of these persons who were colleagues and as a result interacting with them on a daily basis. The rapport established and confidence and skills and guts acquired in this regard over the years came in handy in the course of conducting the interviews for this project. This 'pleasant and confident approach' Kumekpor (1999: 198) was adopted to very good effect. Another advantage to this study was the choice of unstructured interviews which enabled the use of less sensitive questions to create a congenial atmosphere before posing further and more personal questions into the subject matter.

In all, nineteen women and eleven men were surveyed. Because of the nature of the interviews interviewees had ample freedom to narrate their story from any angle they felt comfortable although the standard questions were still stuck to. Sometimes questions went beyond what had been put down. This happened often when clarification was sought on certain responses.

The organizations involved in the study included the GAC which is an umbrella organization for all organizations in Ghana that have HIV/AIDS programmes. It was established by the government to make HIV/AIDS policies, coordinate efforts and create awareness about the disease. Help Age Ghana (HAG) is an organization which sees to the welfare of the aged in the country and Ghana Social Marketing Foundation (GSMF) promotes the usage of condoms and creates awareness about the disease through educational programmes and finally Catholic Relief Services (CRS) engages in various programmes for HIV/AIDS patients. These are therefore organizations whose activities revolve around the subject matter which is both HIV/AIDS and the welfare of the elderly.

Unstructured interviews were conducted with the key informants also to know about their programmes and activities and whether programmes are targeted specifically towards certain age groups while neglecting others. This form of interview was chosen over others because it gave room for the interviewer to proceed in any order deemed appropriate; it was a very flexible tool which allowed for additional questions and explanations which were not originally planned for Kumekpor, (1999: 186). The information gathered was important because it was used to triangulate some responses that the elderly made during their interviews. Impressions and observations from the interviews were written down to help with the analysis of the paper. Finally, the responses of the key informants and the elderly were categorized under themes for the analysis of the study.

## 1.8 SECONDARY DATA

Data was gathered from the Ghana Statistical Service and GAC. The Ghana Demographic Health Survey (GDHS) also provided useful data which was employed. Other secondary sources include: Ghana Policy Document on

HIV/AIDS; Help Age International HIV/AIDS documents on the elderly; and Ghana HIV Sentinel Survey Reports. Relevant books on HIV/AIDS and the aged were also used from the library and rich information from lecture notes was also employed. Information and data from all these sources was integrated in the study.

### **1.9 STRUCTURE AND ORGANISATION OF THE PAPER**

The paper aims to provide an insight into the invisibility of the elderly in HIV/AIDS policy and practice in Ghana. In doing this it tries to unravel the possible ways of *how* and *why* the elderly are excluded in HIV service provisioning. A second aim of the paper is to show the implications of not targeting the elderly as their infection has consequences not only on themselves but their households and communities as a whole. Chapter 2 presents an in-depth literature review of intervention programmes in Ghana and around the world revealing the gap of the elderly in accessing HIV programmes because they are not prioritized and targeted. Chapter 3 provides an insight into gender power relations in negotiating safe sex on the part of women which is engendered by socio-cultural practices which is why they are especially disproportionately affected by the disease. The ways in which the elderly face discrimination and vulnerability are also discussed. Chapter 4 provides the framework in which this study will be situated and some of the forms in which the elderly are excluded. Chapter 5 places the discussion in the analytical framework of Devereux and Cook. Three criteria (access, quality and fit) were employed from their framework on social policy and social needs to assess provisioning of services and how these meet the needs of the elderly. The reasons why NGOs and the National HIV policy do not focus on the elderly are made explicit. Finally, chapter six weaves the discussion together into a conclusion.

## **CHAPTER TWO**

### **LITERATURE REVIEW: UNDERSTANDING THE PRACTICALITY OF HIV/AIDS AND THE ELDERLY**

#### **2.0 HIV/AIDS AWARENESS**

About 25 million plus people have died since the epidemic was discovered and these were living in developing countries as with the 14 million plus orphans who have also died. The first people who got infected with the virus were gay men, injecting drug users, commercial sex workers, long distance truck drivers who were mostly involved in risky sexual behaviour. However, HIV spread quickly worldwide through heterosexual means and other forms of transmission. Africa, Asia and Latin America cumulatively account for 95% of the 40 million infections worldwide. In 2001, 5 million people were newly infected and out of this 3.4 million were in Sub-Saharan Africa according to Singhal and Rogers (2003: 40).

In America, the HIV/AIDS epidemic is changing and government agencies, media and community-based organizations have come to the realization that 'HIV doesn't discriminate'; as 10-15 per cent of the infection occurs among people above the age of 50 years and the percentage of the infection is rising in this age group. In the United Kingdom 8 per cent of adults who have tested positive to HIV are above 50 years Avert (2007). And without any more spread of HIV infection among this age category, the death toll estimated for them is equivalent to the number of Americans killed during the Vietnam War. This is clear evidence that HIV is present in the people above 50 years (Stall and Catania, 1994).

In Uganda, one out of five people who were above 50 years who went for Voluntary Counselling and Testing (VCT) in 2004 were diagnosed HIV positive. However, older people are 'ignored' by HIV/AIDS intervention programs and also international data on infection rates stops at age 49, excluding the prevalence rate for the elderly (HelpAge International, 2004).

HIV/AIDS is also increasing the number of orphans and according to De Waal (2006: 18), 'this is tragedy enough and sufficient warrant for our concern'. Barnett and Blaikie (1993: 272) simply put the condition of orphans as '[t]here is an orphan problem'. About 40 percent of children born to infected parents will die before they see their fifth birthday says (Akeroyd: 1997) and 'many of them are living painful and short lives' (De Waal, 2006:83). In Zambia, one in four children is an AIDS orphan who either lost one parent or both, the latter De Waal calls 'double orphan' and in Zimbabwe, 45 percent of children under the age of 5 are HIV positive which is 'one of the most heart-tugging tragedies of the world epidemic'. Half the number of children under the age of 15 years are losing their parents to AIDS and nearly two thirds of people under 25 years are getting infected. The current trend of the infection is developing a new form of family structure. In Uganda for instance

children are now becoming heads of the family likewise grandparents (Akeroyd: 1997), composing 'skip' <sup>2</sup> generation households.

Who should care for HIV orphans has become a big debate in the current course of the epidemic. In Uganda for example many influential people think the children should be cared for by the extended family since this is the tradition rather than sending them to community-based foster institutions which provide only education, nutritional health and child care services. What these arguments ignore is the fact that members of the extended family especially grandparents who are currently bearing the brunt of the epidemic in caring for their grandchildren, are also getting infected and dying and sooner than later these children will grow up with non-relatives (Barnett and Blaikie, 1993: 273). In South Africa, it is evident that almost three quarters, (about 23 percent) of the older population who are above 60 years are care givers to orphans and most of them are women which is analogous to Zimbabwe and Thailand. Across Africa most caregivers are more than 50 years old and of this 70 percent are more than 60 years old (Poku, 2005:92).

## **2.1 INTERVENTION PROGRAMMES FOR TARGET GROUPS**

The 15th International AIDS conference held in Bangkok 2004 had the theme 'Access for All' – to prevention, treatment and care interventions. Older people were given the platform to advocate extensively for their inclusion in HIV policy and intervention programmes since many times they have been sidelined (Help Age, 2004).

Intervention programmes have the capability to reduce HIV incidence and relatively risky behaviours by up to 80 per cent according to (Prabhat Jha et al. 2001). Intervention programmes have proliferated and targeted specifically unique populations such as commercial sex workers, orphans etc. Also, targeted programs usually take place at the ports, prisons and peacekeeping locations, which are the perceived 'hotspots' of HIV infection. The government of Senegal initiated HIV educational programmes from the onset of the epidemic to its army since it realized that they had a high degree of mobility. Free condoms are often available and STD screening is compulsory as the HIV prevention for these target groups is critical (Singhal and Rogers, 2003).

## **2.2 INTERVENTION PROGRAMMES IN GHANA**

In Ghana there has been a comprehensive strategy package of HIV Intervention programmes to reduce HIV transmission in the country. The Ghana Health Service report for 2005 lists these intervention programmes as follows:

i) Voluntary Counselling and Testing (VCT): This service is provided for people who upon their own free will visit centres that offer this service to know more about HIV and to get tested. This programme has received a lot of patronage and in 2005, out of a total number of 30,046 who went for testing, 18 percent of them were found to be positive and of which, 64 percent were women. In most situations people who fall within the ages of 15-49 access this service.

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<sup>2</sup> Households comprising of only the elderly or only children or both

In 2005, ARV was available for the first time in Ghana. Adults making up of 3,914 and children 146 received ARV in Ghana. Condom promotion was targeted at the youth, sex workers, truck drivers and other people considered to have risky behaviour. This was to engender behaviour change amongst these categories of people.

The Children and the youth between the ages of 6-14 years are considered in some literature as the 'window of hope' (GAC, 2004:12) and as 'window of opportunity' according to (Ng'weshemi et al, 1997: 166) as they may curb the HIV pandemic if they are educated about HIV. Therefore they are considered as priority and targeted for intervention programmes which are held in schools. It is believed that 'catching them young' will prevent them from engaging in risky behaviour and this can eliminate HIV from this age cohort and their future generation (*ibid*).

The Ghana Health Service acknowledges the transmission of HIV from mother to child thus: it contends that '[w]ithout prevention and treatment interventions, about 30-40 percent of infants born to infected mothers will themselves be infected'. About 78 percent of a total number of 20,296 of pregnant women received Nevirapine in 2004. Not only are prevention services provided for the mothers but also care and support services to improve the condition of the children (GHS and GAC, 2004: 5).

HIV educational programmes designed specifically for the elderly are needed in Ghana. In the words of Feldman (1994), these programmes for the elderly will serve a dual purpose; reducing the HIV infection rate in this group since they are at risk of getting infected and also sending a message to the youth that if the elderly population is at risk of HIV infection, then they are too. The unfortunate issue is that health care providers and NGOs working with HIV/AIDS do not realize that the elderly are at risk and need appropriate prevention intervention and treatment programmes specifically targeted at them. Thus in the mean time, this group of people will have to make do or 'squeeze' into existing HIV services provided for other people (Shippy, 2004) which are not suited for their needs.

### **2.3 LIMITATIONS IN THE LITERATURE**

Many African governments, NGOs and the health providers do not see or realize the elderly to be at risk of HIV infection. Therefore, none or relatively few programmes have focused on the needs of the elderly. However, governments in the developed countries such as America and United Kingdom have recognized the fact that the elderly are a high risk group and efforts for HIV services have to be concentrated on them as well.

Empirical evidence suggests that in spite of the efforts at preventing or reducing the rate of infection among younger people, they are dying and leaving behind their children who become the sole responsibility of the elderly. A lot of literature is therefore concentrated on the elderly as care givers for orphans and vulnerable children rather than highlighting their risk to HIV infection and targeting them for intervention programmes. This research is mainly to fill this gap.



# **CHAPTER THREE**

## **GENDER POWER RELATIONS/ NEGOTIATING FOR SAFE SEX**

### **3.0 INTRODUCTION**

The lack of equal economic opportunities for women in the labour market coupled with entrenched traditional practices is addressed in this chapter. The consequences of these are seen in the marginalisation and subjugation of women because of the male dominance which is accepted in the society and gives men absolute control over women. Women need to be empowered to change the trend of these gender disparities they experience which is also why they have a higher HIV prevalence than men.

### **3.1 RIGHTS AND OLDER PEOPLE**

Many elderly people suffer discrimination, exclusion and are mostly not able to exercise their rights. According to Help Age (2007) 'poverty and social exclusion remain the main stumbling blocks to the realization of the human rights of older people worldwide. Older people face abuse, neglect, exclusion and poverty, which deny them access to, and benefit from their rights and entitlements. Gender... and age can create a cocktail of discrimination, leading to marginalization of older women and men from their families, communities and society'. There are many barriers that make it difficult for older people to claim their rights. These are negative social attitudes, poverty of the elderly, lack of national policies on ageing and, last but not least, a lack of awareness about issues among the older people themselves and the society at large (ibid).

A consensus was reached at the Madrid International Plan of Action on Ageing which was adopted at the Second World Assembly on Ageing; this calls for government, civil society, international and local organizations to work together to achieve the objectives regarding the action plan for the elderly. It advocates the rights of the elderly and has taken on board more than 160 governments who are in favour of the plan. The 'plan' has many issues such as poverty of the elderly which is to be halved by 2015, HIV/AIDS, violence and abuse to social services which include health care and social protection. It is explicitly outlined in the 'plan' that issues of ageing should be mainstreamed into global development policies and national social policies and that the aged should enjoy the country's resources equally as everyone else as they have the right to these (ibid). Help Age Ghana in this regard has raised awareness about the rights of the elderly in the country and these issues are being mainstreamed in national policies. Through its activities many of the elderly are getting conscientized about their rights and many rights-based organizations are focusing and addressing violations of the elderly people's rights. However, programmes are concentrated in only two regions due to financial constraints (HAG, 2007) which limit the scope of their activities and also they have not been successful with the policy concerning HIV/AIDS and the elderly. HAG does not have HIV/AIDS programmes specifically targeting the elderly. One would have thought that, being geared solely towards the welfare of the elderly, some

attention would be paid to the elderly PLWHA. This is perhaps reflective of the general attitude of society to the subject.

### **3.2 GENDER/OLD AGE POVERTY IN GHANA**

The elderly 'face spiralling debt, hunger, isolation and destitution...as well as difficulties in accessing health care and other essential services, increasing the likelihood of older people becoming and remaining poor' (Help Age, 2007). This typifies the world situation regarding the elderly. It has been estimated that 100 million older people live on less than a dollar a day and they are normally disproportionately at risk of being affected by chronic poverty. 'Skip' generational households (composed of children and the aged) are mostly affected by severe poverty since one in three households is headed by older people. It is evident that poverty during old age impacts the whole family therefore older people and their dependants should be targeted for social protection (ibid).

There is widespread poverty characterized by low quality and quantity of employment opportunities in Ghana. Out of 177 countries listed in the 2004 Human Development Index, Ghana rates 131. The country's per capita income is about US\$ 380. The lack of job opportunities and income generation rendered almost 40 per cent of the population to live below the poverty line in 1989/99 according to the Ghana Living Standards Survey (ILO, 2005).

Employment status of both men and women as recorded by the (GDHS 2003:36) indicates that 0.5% of women within the 45-49 ages are not working and 1.4% of men of the same age are also not employed. The difference in the employment status could be attributed to women being employed in the informal sector where their activities are not properly recorded whereas the unemployment of men could be the result of lack of jobs in the formal sector. The elderly are especially more vulnerable to becoming poor because of general economic hardships in the country. Whereas 2.1% and 1.0% respectively of elderly men between the ages of 50-54 years and 55-59 years are not employed there is no data on employment or unemployment of women in these age categories (ibid:2003:37). It could be assumed that men in this category are still expected to be working that is the reason why their joblessness is an issue whereas the women can stop work when they are 50 years old or as mentioned above, there are no records on their reproductive work. Again, about 19% of elderly men work at skilled jobs whereas only 12% of women are employed to do skilled work. Skilled jobs as compared with the unskilled, is more rewarding; signifying that women are more disadvantaged than the men<sup>3</sup>.

In Ghana most of the elderly live in the rural areas and urban slums, which have little or no social amenities to enhance their well-being. Many of the men by virtue of their gender and age are heads of the family and this position allows them to hold onto some entitlements such as land; allowing them to engage in agriculture activities even in their old age, which is the main stay of the country and the livelihood of about 70 per cent of people in the country. Agricultural activity takes a lot of time and energy and provides little income for those who engage in it, because it is mostly done on a subsistence basis. However, the men are at a greater

<sup>3</sup> See also (ILO, 2005), where mention is made of poverty affecting women disproportionately across virtually every sector of the economy

advantage than women. They can earn some money from farming because they own land, or hire out the land for other people to farm for a wage. Women's disadvantage in all these is entrenched in culture, which, because of patriarchy, does not allow women to inherit land, or if they will, they inherit smaller portions than their men counterpart since it is believed that women will leave home to marry<sup>4</sup>.

Thus women's poverty makes them most vulnerable to HIV infection because they become dependent on men for their survival which coupled with cultural practices compounds their already deplorable position (NACP, Disease Control Unit and the Ministry of health, 2001).

### **3.3 SOCIO-CULTURAL/TRADITIONAL PRACTICES IN RELATION TO GENDER POWER RELATIONS**

In the absence of a cure, it would perhaps be more beneficial to society if focus were to shift to behavioural practices which perpetuate the disease. Poku (2005: 73) argues that some socio-behavioural factors have been demonstrated to increase the incidence of HIV/AIDS and these practices are entrenched in traditional practices. He further states that the bottom line for the eradication of HIV among populations will be to change the sexual behaviour of people; this is a valid point if this disease is to be eradicated. It is therefore obvious that 'HIV/AIDS is not a medical problem' but a 'behavioural change problem' echoes (Singhal and Rogers, 2003:373).

There are several factors that engender the subordinate position that women experience in the Ghana, these include 'cultural practices, which give men the exclusive right to decide when, how and why to have sex with women in or out of marriage...these cultural practices are reinforced by the dependence of women on men for their needs, both financial and material' (Ghana News Agency accessed on 21 Oct, 2007). The domineering nature of men when it comes to sex as many literatures show indicates the fact that '[i]t is men who drive the HIV/AIDS epidemic. Men are the vehicles through which HIV is transmitted' says (FHI, 2006). They further claim that 'even the best prevention campaigns targeting women are rendered ineffective when male partners refuse to change their risk behaviours or use condoms. More often than not, men's behaviour and refusal to change are rooted in their own beliefs and society's expectations about what it means to be a man' (*ibid*). Thus many women in Ghana fall victim to these men because they lack the power to negotiate for safe sex which makes them highly vulnerable to HIV infection. An interesting revelation from Harcourt (1997) on the lack of Ghanaian women's negotiating for condom use reveals that women fear that their husbands will suspect them of having extra marital affairs. She further states that '[t]here is a common view that a woman should quietly submit to her husband any time he demands sexual relations'. According to her this 'powerlessness on the part of the woman...is a far more complex issue'. This is because family cohesion is highly valued by women in the Ghanaian society; therefore they are very careful not to strain their relationships with their husbands (*ibid*) since a misunderstanding can end up in a divorce which is highly

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<sup>4</sup> See also Messkoub (1997: 14), where reference is made to land tenure and gender insensitivity

undesirable. As a result of these factors 'women suffer gender-specific forms of status subordination, including sexual assault...which are injustices of recognition'<sup>5</sup> Fraser (2003: 21). They become vulnerable to traditional pressures in the society for these reasons. It is reported that in Ghana, two out of every ten women experienced their first sexual intercourse through force; which means the decision to have sex was not taken out of their own free will. Two out of five are coerced or harassed when they refused their partners and three out of ten are forced by their partners to have sex sometimes. This clearly indicates the powerlessness of women over their sexuality in the country (Ghana News Agency, 2005). 'Simply put, women's exposure to the danger of contracting HIV/AIDS is reinforced by their lack of the right to negotiate safe sex' (ibid, 2005). Although traditional practices are to be cherished and sustained, the advent of HIV/AIDS infections will have to inform and change the attitudes of both men and women but especially women that they have to be empowered to stand up to the men and fight for their rights especially in negotiating for safe sex since most people contract the virus through sex. The NACP 'supports efforts that will empower women to recognise their vulnerability to HIV infection' (NACP, Disease Control Unit and MOH, 2001).

In the light of this '[i]t was therefore right when Ghanaian women leaders during the celebration of the International Day of Elimination of Violence against Women in 2005 strongly advocated that women must have the right to negotiate for safe sex if the HIV/AIDS prevalence level among women were to be cut down' (ibid, 2005). The Government has to intervene and enforce laws to protect and empower women who find themselves in these relationships and also women who 'suspect their husbands of having multiple partners' (ibid) to refuse them sex if they refuse to use protection.

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<sup>5</sup> '[T]argets injustices it understands as cultural, which it presumes to be rooted in social patterns of representation, interpretation and communication' Fraser (2003).

# **CHAPTER FOUR**

## **THE FRAMEWORK AND THE VARIOUS FORMS IN WHICH THE ELDERLY EXPERIENCE EXCLUSION**

### **4.0 INTRODUCTION**

This section throws light on the ways in which the elderly in particular suffer exclusion in Ghana. Social exclusion refers to the complex ways in which some individuals in the society are unable to enjoy social rights without help, suffering from low self-esteem and inadequacy in their capacity to meet their obligations, long-term unemployment, the risk of long term relegation to the ranks of those on social benefits and stigmatization (Rodgers, 1995). It is also a 'process by which certain groups are systematically disadvantaged because they are discriminated against on the basis of their ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live' (DFID, 2005). This exclusion occurs at the level of public institutions such as the health services, education institutions as well as the household etc (ibid).

Although this concept came up from the French Literature (developed country) in the 70s to refer to people who were excluded from the welfare state and not integrated to access such services as education and health, the elderly are in similar situations in Ghana which is a developing country. The elderly experience a lot of social ills and are perceived as vulnerable, poor and because of this fact, face stigmatization and discrimination in all spheres of life in the country.

### **4.1 POVERTY OF THE ELDERLY/HOUSEHOLD POVERTY AND CARE OF THE ELDERLY**

Poverty determines the level of consumption level of individuals in a society, including the services they purchase themselves or that which is provided through public channels. Normally, exclusion from the consumption of services is due to the lack of purchasing power of certain categories of people in the society especially the elderly (Rodgers: 45); they are mostly poor and in Ghana about 97 per cent of them are not in any active employment because of the reduced opportunities available for them in the labour market.

There is no system for non-contributory pension scheme in Ghana therefore there is no social protection for the elderly what-so-ever. It is only retired civil servants or white colour employees (who constitute a minority) who are entitled to social security benefits. Messkoub (1997) affirms this assertion that in the developing countries many older people face poverty because governments can not afford pensions<sup>6</sup> for those over 60 years like the rich nations. In the circumstance they rely on informal networks such as the extended family, which play a vital role to care for them. Evidence shows that caring for the elderly is a burden on some

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<sup>6</sup> See also Tracy (1991: 23) on social pensions and (Ayalew, 2004).

members of the family who are experiencing the overwhelming current trend of the ageing population with their meagre incomes; these institutions will need some support from external aid to continue to care for the elderly in the best possible way Brown (1999). Tracy (1991:7) also shares the views of Brown on the limited resources of family members when he comments that '[i]n reality many families...in developing countries do not have the resources to meet the needs of the elderly'. HIV/AIDS infection of a member further compounds the problem of these households since most families spend a lot of money to take care of sick relatives. They spend huge amounts on funerals and because of the number of hours one has to care for sick persons, some family members give up their economic activities which further throws the family deeper into poverty without redemption. Therefore, the buffer system for the aged, which is the extended family, with time becomes very weak and has all its resources stretched and weakened (ibid). It can be said that HIV/AIDS is breaking the social fabric of the extended families as some members of the family who cannot keep up with caring for the aged any longer leave the household to the detriment of the elderly while some are keeping nuclear families without extending support to the elderly reiterates Tracy (1991:30)

Therefore it is very important for the state to realize the vulnerability of the aged and move away from 'romanticizing traditional extended systems' (Dadzie, 2004) as institutions which should care for the elderly; rather, governments<sup>7</sup> should provide adequately for the elderly in their old age (ibid). As a panacea for their strained finances a non-contributory social security system should be provided by Government to serve as a form of social protection for this group of people. The Government of Ghana currently has the School feeding programme in which school children are provided with free meals by the state. In the same vein if this issue of the elderly were prioritised funds would be sourced to implement it.

#### **4.1.1 Vulnerability/Discrimination and Stigmatization of the Elderly**

A study done by Brown (1999) on the elderly in Ghana and Japan revealed that most Ghanaian elderly people have a negative view about being old in the society. The study showed that majority of people viewed ageing as a 'period of hardship and misery and a period of financial problems'. HIV/AIDS is exacerbating their already deplorable situation especially elderly women as mentioned earlier. These difficulties notwithstanding many women infected with HIV still carry on their wifely duties such as caring and cooking for their husbands and normally, they are mostly malnourished as compared with the men who are also carrying the virus because tradition makes it mandatory for the man to be served the best part of the food, leaving the rest for the women and children if any is left at all says Messkoub (1997:15).

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<sup>7</sup> See also Tracy (1991:7) why myths on extended family caring for the elderly tends to deny the need for government intervention in supplying income, health care and social needs of the elderly.

#### **4.1.2 Location of HIV/AIDS Services**

Location is a factor, which determines whether certain people will suffer exclusion from public goods and services in the society. Most clinics, which offer VCT services, require the public to come over to the centre on their own accord to get informed about HIV/AIDS and get tested. These public clinics are few and are normally located in the centre of town, which requires a person to move a long distance before getting access to services. Many of the elderly people who are in need of these services are forced to travel to the service providers for this service. In addition, HIV prevention programmes are normally held in schools during school hours to sensitize the youth about the disease. This excludes the elderly because they cannot easily get access to such information. Information about HIV/AIDS should be brought closer to the elderly in their communities. The NACP reports of scaling up efforts to increase VCT sites in all localities across the country to ensure universal access as a way of reducing the infection rate of HIV in the country (GHS, 2005: 10).

#### **4.1.3 Delivery of information on HIV/AIDS**

Public services are available to people who have the knowledge about and connections to access them (Rodgers, 1995). The NACP has an agenda in pursuance of its policy of making information on HIV available to a larger segment of the population. In doing this it made available information about the disease and distributed it in the form of educational materials to all stake holders and the general public as a way of sensitizing and empowering them to be informed about HIV/AIDS (GHS, 2005: 31). Ghana has a high illiteracy rate. The majority of the elderly fall within this category of people. About 75 per cent of them are illiterate and had not had any formal education (Brown, 1999). Therefore if information on HIV is in the form of literary material, its purpose would be defeated as far as most of the elderly are concerned.

ARVs have a strict regimen as to how the drug is to be administered and how many pills should be taken in a day with its complex combinations. For the drug to be effective people have to avoid a prolonged interruption of the treatment once they start. This obviously posses a problem for the elderly who often do not know the names of the drugs they are supposed to take and are likely to interrupt treatment as a result (Corridor Organization, 2005). All the above factors signify the disproportionate disadvantage the elderly face in one way or the other either in their families or the society at large.

### **4.2 ANALYTICAL FRAMEWORK**

The practical framework advocated by Devereux and Cook (2000) for assessing whether social policies meet social needs will be adopted for this study. Four specific criteria underlining this framework are *access*, *quality*, *relevance* and *fit*. However, this paper will make use of three criteria (*access*, *quality* and *fit*) to assess the inclusion of the elderly in HIV/AIDS policy and practice. *Relevance* is not applicable for this paper therefore it was not used for the analysis.

Table 1: Criteria for assessing the invisibility/exclusion of elderly from HIV provisioning in Ghana

Access	Are HIV services designed to assist the elderly in terms of physical coverage and cost?
Quality	Are HIV services provided to the elderly of an adequate and appropriate standard?
Fit	Are the design and delivery mechanisms of HIV services sensitive to the livelihood systems, activities and constraints of the elderly?

[Source: Devereux and Cook (2000:66) modified by adding the issue of HIV/AIDS and the elderly and eliminating the relevance aspect]

*Access* in this paper specifically analyzes whether HIV intervention services are in the coverage of the elderly. Showing the constraints involved in accessing services especially in terms of location and the financial barriers involved. Secondly, are the services provided of good quality to satisfy the elderly who use it? This is what *quality* addresses. Finally, the last element which is *fit* weighs the level of the sensitive nature of services provided in relation to the daily activities and livelihood systems of the elderly who use it. The three criteria will serve as the framework to engage the analysis of the paper.

## **CHAPTER FIVE**

### **ENGAGING THE DISCUSSION WITH ACCESS, QUALITY AND FIT**

#### **5.0 INTRODUCTION**

This chapter focuses on the responses from NGOs and Government Institutions and the elderly who are living with HIV/AIDS. This information was gathered from interviews from the field. It aims to address the objectives of the study while engaging the framework. The findings from the interviews give an insight into the activities of NGOs, government institutions and agencies which are involved in HIV intervention programmes or with PLWHA. The chapter also highlights the 'implicit' nature of the HIV/AIDS universal policy and of provisioning of intervention services and relating these to why the elderly are made invisible. Insight is also given to what informs the programmes of institutions to work especially with 'vulnerable' groups.

Particular attention has been paid essentially to the responses of the elderly regarding the access, quality and the appropriateness (fit) of intervention programmes which they are involved in. Also discussed are the adverse effects HIV has on their family and community.

The analysis as it unfolds will be supported with verbatim responses as it was gathered; this throws light on the nature of the situation regarding issues concerned in the view of the institutions and on the other hand the distress encountered by the elderly in accessing services as well as the level of stigmatization and poverty of the elderly as they continue to fight for survival one-day-at-a-time with the deadly virus. *All names of the elderly are pseudonyms.*

#### **5.1 LACK OF FUNDS INCITE 'PRIORITY OR IMPLICIT' TARGETING IN A UNIVERSAL POLICY**

Even though Ghana has a universal framework on the HIV/AIDS policy which serves as a guideline to government and NGO activities, GSMF and CRS officials say they mainly concentrate their activities on sex workers, truck/carte pushers, orphans and pregnant women because of limited funding for projects. The organisations rate these groups of persons as the most vulnerable who should be prioritized to participate in their programmes which are obviously a shift in priorities as it contradicts statements to the effect that they have programmes for 'all infected' persons. It was surprising to observe that HAG which is the only organization which deals solely with the welfare, care and support of the elderly ironically does not have any programme for HIV/AIDS patients because of lack of funds although it appreciates and realizes the fact that the elderly are getting infected with the virus. The organization's popular package for the aged is a day care programme<sup>8</sup>. Old people are housed during the day and their families pick

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<sup>8</sup> This programme is not tailored exclusively for HIV/AIDS elderly victims.

them up at the end of the day to their various homes and bring them back the following day if they so wish. The elderly who patronize this programme have the opportunity to meet their peers and have a social life with other older people. On the basis of the above, it is obvious that the HIV/AIDS universal policy of the country has not covered the elderly what-so-ever. The biased nature of the framework was reported by UNAIDS (2007), when it highlighted that '[w]omen and young people were among the priorities for the year. However, other people most likely to be exposed to HIV...had limited coverage in the national response'. This should be of concern to all since every one has to be covered in order to fight the menace. The 'implicit' targeting nature of the policy framework and activities of the NGOs re-echoes the assertions made earlier in the literature from Singhal and Rogers (2003) that HIV services mainly focus on groups with risky behaviour. Whereas, Ng'weshemi et al, (1997:166), GAC (2004:12) and GHS, (2004) all assert that HIV programmes are mainly concentrated on orphans and pregnant women among others. Therefore it can be said that 'social policy does not deal with all groups equally well' says Pambel (1998:7).

For a universal policy for provisioning of health services to be effective in Ghana and benefit the whole populace certain vital elements have to be put in place to engender the effectiveness of the policy. With this view reflects the thoughts of Okwany (2007) when she points out factors necessary for a universal coverage which she says include 'strong commitment to universalism in terms of policy and provisioning, wide geographical coverage of social service facilities, investment in improving quality of care provisioning and policy commitment to meeting increased demand via supply efficiencies'. When these factors are totally satisfied then universal policies can reach everyone equally.

It could be inferred from the above that the supposedly universal coverage of HIV provisioning in the country has been turned into what could be termed 'priority' or 'implicit targeting' of specific groups which obviously defeats the purpose of universal provisioning, placing the elderly at a disadvantage in the enjoyment of the services provided. Therefore 'universalism remains a long-term strategy' Okwany (2007).

### **5.1.1 Decision of Elderly not to participate in HIV Provisioning from NGOs**

Eighteen of the elderly said they feared to be associated with an HIV/AIDS NGO. As associating with them will make people suspicious and speculate as to their HIV status. Consequently they tend to de-link themselves from these NGOs. Although 2 said they had received some food items from these groups in the past, they have stayed away from these organizations so as to avoid the stigma and public scorn and moreover they explained that these food aid programmes were not regular. The only option the elderly have at hand are the government health centres which offer some intervention services for infected persons and they patronise these because stigma is highly reduced at the HIV units since they are all infected persons. All 30 said they found consolation in this and felt very much at home with each other. It was interesting to hear them say that they believed no one

in their household would suspect that they were visiting the hospital for HIV treatment – this alone was great relief to them, they said.

### **5.1.2 Extent of Involvement of the Elderly in HIV Provisioning at public hospitals**

Monday, Wednesday and Friday are ‘clinic days’ and for that matter very important days for those living with HIV/AIDS. These are the days PLWHA consult doctors for free at the government hospitals. At the health centre the elderly said they receive general treatment from the doctors, purchase ARVs and access counselling services from the nurses. Five of the women said they received family planning services also. Regular checking of patients’ weight is part of the services rendered at the clinics. According to the persons surveyed, weight monitoring informs the health attendants of the well-being of the patient; appropriate advice is then given based on the weight. The overall impression gathered was that services are available to those who seek it. Nevertheless, because services are not specifically targeted to meet the needs of the elderly, they continually experience various forms of constraints while accessing the services e.g. queuing for long hours (on average about 5 hours) amongst others which were shown by the ratio of the younger ones and the elderly who compete to seek medical attention.

### **5.1.3 Distance as Determining Factor to Access Services**

Government hospitals are not situated within residential areas where PLWHA live and since there are no mobile clinics in the country, the elderly have to find their way to health facilities. Distance is a major determining factor to attend a health facility for treatment Devereux and Cook (2000). The elderly complained about the distance they had to travel when seeking treatment. Commuting by public transport is popular amongst them and it becomes expensive when they live further away from health centres. Eight live about 5km away from the health delivery centres, 16 and 6 of them live about 10kms and 15kms away respectively. Signifying that majority of them live far away and getting access to services is difficult in terms of the time spent travelling and the transport cost which increases with the distance travelled.

### **5.1.4 Financial Constraints Hinder Regular Access to Services**

The deplorable financial situation of the elderly is another major factor in accessing services. They complained that although consultation is free they still have to pay for their ARV and laboratory tests which obviously are indirect medical costs they have to bear. They expressed dismay that they had to pay exorbitantly for the medicine which is (5 Ghana cedis) equivalent to (5 euros) and when the drug is two or more which is determined by one’s sero-status, the price increases; 8 said they pay 15 euros for their drugs which they find very difficult to do. Twelve of the elderly PLWHAs said they sold all their possessions upon discovering that they were HIV positive. They had the perception that they were going to die as one elderly woman said.

'I sold all my possessions including my hairdressing saloon and equipment because I thought I was going die, now I am alive and life is so hard I can not even afford to feed let alone pay for my medication' says (Mama Akos).

Twenty two said the price of ARV deters them from visiting the centres regularly on a monthly basis; rather they attend once in every three months. This absenteeism should not be encouraged because irregular intake of the drug/drugs renders its impact negligible (Devereux and Cook, 2000). Six of them said they have resorted to the use of herbal medicine which is cheaper when they can not make it to the hospital to collect their dose of ARV. They believe that herbal medication also relieves them of some pain. Barrientos et al. (2003) made an assertion based on a study done by HelpAge International in Ghana that 'for those in poverty, hospital or clinic treatment was the last resort after self-care or traditional medicine had been tried'. As such some of the elderly as shown are having alternative modes of treating themselves. It is possible that these herbal medicines relieves them of some pain but what is not clear is to what extent the delay in seeking medical care in the end becomes more harmful.

Seventeen are currently unemployed; amongst them are 2 pensioners. The rest who are working are into jobs like petty trading, which 4 of them are engaged in, 3 are bakers, one accountant and one human resource manager. Four are into voluntary work which does not generate regular income. Barrientos et al. (2003) reiterate that 'employment opportunities decline steeply with age, and are ... often precarious and poorly remunerated'. They further state that lack of access to employment is a 'key indicator of older people's distance from markets' (ibid). Thus 'Financial barriers' according to Devereux and Cook (2000) are major reasons why people are unable to access public goods and services therefore money remains significant in accessing services and this they suggest 'favour those who are better-off' (ibid, 2000) to afford it. It is clear from these figures that financial constraints make it difficult for a majority (20) of them to access medication. They tend to depend on family as care-givers.

'Going to the hospital every three months is ideal for me because I have to mobilize money from my family to purchase ARV, which I can not do in a month because some of them do not give you the money immediately because they do not have it and you will have to go back for it when they have it' said (Mama Agnes).

While 10 said they had no body to care for them – in addition to this one man said he has only God to look up to. As their age is an issue compounded by HIV, advocating for employment policies for them is not prudent but rather the need for a non-contributory pension scheme which adequately caters for their needs. This is the only way to reduce the strain on their financial positions and encourage them to access services regularly. Meanwhile this calls for urgent need for the Social Security and National Trust organisation (SSNIT) to intensify its education for those in the informal sector to voluntarily contribute towards their pensions in their old age. This could cushion elderly people who were self employed during their working years and alleviate some of these identified burdens.

### 5.1.5 Quality of Services Provided at Public Health Centres

For PLWHAs to benefit from intervention services, services have to be of good quality. If the quality of services is poor their 'effective impact is negligible' Devereux and Cook (2000). To begin with - the (doctor/nurse) to patient ratio

makes it difficult to access treatment in a short duration. This is because of brain drain in the medical profession. It was reported that 'out of 871 medical officers trained between 1993 and 2000, 604 (69.3 per cent) left the country, leaving 267 for the entire nation' (The Head Heed, 2003). The report further states that consequently the 'situation has put health delivery beyond the reach of the common man, besides widening the doctor patient ratio to approximately 1- 67,416' (ibid). In order to avoid the long queues the elderly said they try to get to hospital before 7am to be registered. The time spent in seeing doctors is so much and is a source of worry to many of them since they forfeit doing anything except to attend hospital on these particular days. Most of them said they feel faint and weak if they wait for a long time this is due to lack of food and rest. As regular meals are essential for the well being of PLWHAs, spending long hours in the health centres and skipping essential meals such as breakfast and lunch is not healthy for them; they need to eat frequently and take lots of rest. According to Boto et al. (2004), 'HIV/AIDS has direct impacts on nutrition...moreover, nutrients are lost from vomiting and diarrhoea' these illnesses some of them indicated they experience. Therefore it is necessary they do not spend a lot of time when seeking health care perhaps the health institutions should provide some food for them considering time spent in the health centre and also some food/drinks to take home to replenish their energy. According to IRIN (2007), some HIV patients in South Africa receive a monthly supply of fortified cereals with their free ARV to boost their immune systems.

The elderly also complained that other symptoms they experience are ignored by the doctors. Perhaps due to the fact that the consultation is free, health practitioners give them the minimum attention they deserve. Eighteen of them said they have at different occasions complained about stomach pain, itchiness and swollen limbs, pain in the breast among others but the doctors only treated them for HIV related diseases such as STIs and diarrhoea. It would appear from the above narrative that doctors are not sensitive to these other ailments they complain about due to the large numbers being attended to.

### **5.1.6 Livelihood Systems of the Elderly in Relation to Services Provided**

According to Devereux and Cook, (2000) social services which are provided to meet the needs of intended beneficiaries should fit with their activities and forms of livelihood, social services should as much as possible be 'elderly friendly' such as mobile clinics which will make services available for easy access to fit into their livelihood systems. Most often the 'design of services frequently fails to do this for their intended beneficiaries' (ibid). This means that if services do not fit with the livelihood systems of the elderly the purpose will be defeated because they will not patronise it. Clinic starts at 9am to 2pm and held only on working days; the times should be more flexible (include Saturdays and Sundays) to cater for the needs of the beneficiaries who might not be able to make it during week days. HIV/AIDS policies should be mainstreamed into organisational policies to ensure the rights of people living with the disease this will pave the way for them to get the necessary support from management. A man responded that

*'my employers will not allow me to absent myself from work every month because I have to see the doctor. This is because I spend the whole day at the hospital without going to the office'* says (Mr Yawson).

Even those who might not be working think it is a waste of their time to travel to seek medical treatment as that time can be used profitably doing something or resting. A woman explained that

*'I cannot afford to travel every month to the hospital just to collect my drugs. And any time you go, you forfeit doing any thing at home because you will have to get out early in order to see the doctor and then come back very late because of the number of patients and transport problems. Hardly anything else apart from seeing the doctor is achieved in the day' (Mama Yaa).*

Further thought about alternative ways of restructuring the health service delivery mechanisms for PLWHA is relevant to ensure that the livelihood systems of the elderly fit into existing structures.

### **5.1.7 The Reasons Why HIV Knowledge does not reflect in Older Peoples Way of Life**

It was interesting to note that 22 of the elderly had primary education, vocational/technical, secondary education and 2 of them had tertiary education. Only 6 of them signified not having any education at all. On average the elderly PLWHA said they heard about HIV/AIDS about 10 years ago when education about the disease commenced on the TV, radio and newspapers this coincided with the time the realization about HIV was at its peak in Ghana and there was a lot of sensitization programmes going on about its devastating nature. Before this realization could be widespread, 5 of the elderly confessed that they were already infected and 3 said they got infected 5-7 years ago. The rest of them got infected 1-4 years ago. This period actually coincides with the time the heat of HIV/AIDS advocacy, education, condom promotion was widespread and also the era that saw the rapid establishment of many HIV/AIDS NGOs all with the same vision and mission to fight the epidemic.

The elderly upon knowing their HIV status said they were thrown into a state of confusion. They have different views about what the disease is. Only 8 emphatically said they knew of the disease as a killer disease and one that can be sexually transmitted or acquired through sharp objects; 20 however knew the side effects of it as one that gives swollen feet, body rash, diarrhoea, coughing, a disease that makes you loose weight and one that causes pains in the body etc but they could not say what it really was. One person simply said HIV/AIDS is a modern disease while another one said she has heard about the disease but still does not think there is anything like it. The responses of the 22 PLWHA are a matter of concern; it shows their ignorance amidst all the education and other intervention programmes. This raises thought-provoking questions about the extent of success of the dissemination of the information about the disease to this age category. Barrientos et al. (2003) confirmed that, '[h]ealth care priorities in developing countries are primarily focused on young children ...and seldom target the health needs of older people They further said that '[e]xisting inequalities in the distribution of public resources ... also operate to restrict access by older people' (ibid). It is clear that majority of the elderly involved in this study are literate but lack adequate information on the disease.

It could be observed generally that the elderly are getting infected not because they are illiterate but because they do not get the right information and appropriate education that targets them directly as a group. Gateway's (2000) assertion that '[t]he elderly consider HIV/AIDS to be a problem for adolescents' is valid.

### **5.1.8 How the Elderly deal with Stigma and Discrimination**

Changing people's attitude to HIV/AIDS is the way to progress in overcoming stigma and discrimination associated with the epidemic (Boto et al. 2004). In Ghana the initial education about HIV in the 1990s portrayed a picture of the disease as promiscuity related and one which is also associated with stigma. To substantiate this statement 22 of the elderly PLWHAs would not want any one to know their status not even their children or the extended family because they would be shunned although they did not live promiscuous lives to get the infection; but this would be the impression once people get to know their status.

*'I am not revealing my HIV status to anyone, I am afraid my children will be shunned in school and in the community in which we live; they will not have friends'* revealed (Mama Akpene).

This attitude on the part of the elderly shows that they lack knowledge of their rights in society therefore they need to be educated to be assertive and challenge the discrimination, stigma and the denial they face each day in the society (Boto et al. 2004).

## **5.2 IMPLICATIONS OF HIV/AIDS ON THE ELDERLY, THEIR HOUSEHOLD AND COMMUNITY**

HIV has a profound impact on the elderly and inhibits their joy of a satisfying old age as their socio-economic status is seriously affected when they get infected with the virus; their households and the community also bear the brunt of the disease. For the former when a spouse gets the virus he/she infects the other because of lack of protection etc and being HIV positive put a lot of strain on their finances as some still have to take care of dependants. Impact on the community is such that these elderly are still sexually active and thus engage in casual relations exposing their partners to the virus.

### **5.2.1 Lack of Safe Sex Negotiation between Spouses**

Nine out of eleven men confessed they infected their wives. This revelation supports studies made by Family Health International, (2000) which referred to the fact that men are normally the carriers of the disease and infect their wives or girl friends. To buttress this point further the remaining two men although have HIV, said they were currently in relationships with women who are HIV negative, and engage in unprotected sex with these partners. The reason why one man does not use protection is because he wants a baby. (A baby he believes will be born without the disease). This brings us into the discussion of the lack of will power of women in 'negotiating condom use' reports (Ghana News Agency: 2005; Harcourt: 1997) etc. Six women said they can not refuse their husbands sex because they are legally married to them. One man confirmed this as he said he does not use condom because he is legally married to his wife so there was no need to patronise condoms. From these responses one can infer that protection is the only way women can prevent themselves from getting infected. It is simply unfortunate that even in this era of HIV/AIDS these women still cling unto their traditional beliefs and not stand up for their rights to refuse the men sex or insist that they protect themselves. To further substantiate the above statement all the married women said they got the virus from their husbands except one who believes she got infected through her hairdressing job which she quit after knowing about her HIV status. It

can be said that the inability of women to negotiate safe sex with their spouses is associated with the need for security to keep their marriages or relationship as refusing men sex or forcing them to protect themselves will only cause problems and strain the relationship which confirms Harcourt's assertion. Thus 'fear of violence or abandonment often prevents women from discussing fidelity with their partners or asking their partners to wear a condom' said (Boto et al. 2004).

### 5.2.2 Impact on Household

From the data gathered only one woman had never been married and does not have a child. Twelve are married with children. For 8, divorce followed their announcement of having HIV to their spouses. Five women and two men are widowed and 2 men are in casual relationships. The findings further depict that although females had a higher HIV prevalence rate and are disproportionately disadvantaged than the men, the men die early compounding the situation for the women who have to take care of the household without the support of their husbands which throws them in deeper poverty. According to Barrientos et al. (2003) 'older women are twice as likely as men to be widowed due to their greater longevity' this is evident from the life expectancy of men and women shown in chapter one. All the PLWHA said they had spent a lot of money to treat themselves which made it difficult to take care of the needs of their dependants adequately. People in these households range from five persons and above and this includes children who are 8 to 10 years who depend on their parents.

One man who said he was infected 8 years ago said he has an 8 year old son who is also HIV positive. The child is also on treatment which is also very costly and because of constant ill health he is always absent from school. Living conditions have become so unbearable for 7, to the extent that 2 were compelled to withdraw their children from school as they can not afford to keep them in school any longer. Two women said they sold their properties due to financial constraints; properties which they acquired over the years and which they would have wished to bequeath to their children was sold to enable them to pay hospital bills, cater for the home and sponsor their children in school.

Some households have adopted coping mechanisms such as the adult children starting a trade of some sort to help the parents take care of the house. This is becoming the trend, because the findings showed that 15 of the elderly said their adult children are their caregivers although they added that the extended family played a part especially mothers of the elderly PLWHAs who are alive and also their siblings are helpful in providing food and sometimes money and shelter for them.

### 5.2.3 Impact on the People in the Community

The communities in which the elderly live are also bearing the brunt of HIV/AIDS and are greatly at risk of infection as some elderly persons still engage in unprotected sex. It is evident that although many about (98%) of people in Ghana are aware of HIV and its consequences, many people are still vulnerable and are getting infected (GDHS, 2003).

The findings show that 18 of the interviewees are still presently sexually active. Of this number 10 are males and the remaining are women. While eleven of them presently do not have any interest in sex and seldom engage in it and only one does not any more. Of those who are still sexually active, 9 uses the male condom, 9 on

the other hand do not use any protection and only one woman said she used the female condom in addition to the male condom to protect herself from further infections. A man who said he does not use protection had this to say, '*this disease can not stop me from doing the things I love*'. Therefore the men especially continue to live their lives as if everything was perfect. An elderly woman who is no more interested in sex said she tries to make love to her husband because she fears he will go out and in so doing infect other women with the virus. In another case, the elderly man did not want to infect his wife when he discovered he was infected. Thus under the pretext of not wanting any more children he stopped being intimate with the wife and for the past three years as he said, he had kept a girl friend and also takes his ARVs in the house of this woman. His HIV status is unknown to the wife nor to the fiancée too who is at risk of getting infected by him. Many people especially women do not encourage their partners to use condoms because it is a very 'contentious issue for couples, even if the partner is known to be promiscuous' according to Gateway, (2000). This is because talking about sexual issues is a taboo in the country and not an 'integral part of the Ghanaian culture' (ibid). In order to break the cycle of infections it is necessary to target the elderly people in order to give them the right information because their partners are at risk when they do not protect themselves during their sexual activities. Lessons can be learnt from America where the New York City's department has taken the initiative to educate the older people about HIV/AIDS and encourage them to patronise the use of condoms; condoms were distributed to them during an HIV educational programme. This is because the authorities have realised that the ignorance about 'HIV among seniors can lead to new infection' (USA Today, 2007).



# **CHAPTER SIX**

## **CONCLUDING REMARKS: ROUTES FOR THE INVOLVEMENT OF THE ELDERLY**

### **6.0 INTRODUCTION**

The aim of the study was to show how and why and the extent elderly persons are made invisible in HIV/AIDS policy and the provisioning of services and show the implications their exclusion engenders. This chapter ties the whole discussion from the study together and sheds light on alternative ways to enhance their involvement in HIV/AIDS intervention. Social protection for both elderly and their households is advocated in this section as it is realised from the previous chapters that financial barriers are major constraints in accessing services.

### **6.1 A CALL FOR A MORE INCLUSIVE UNIVERSAL HIV/AIDS PROVISIONING**

There is no doubt that the government is making efforts to curb the HIV/AIDS epidemic. This is made visible through its national strategic framework 2006-2010 which was developed to 'provide an overall planning guide for a vastly expanded effort to deal with the epidemic including improvements to the supporting environment, preventing infections, targeted behaviour change programmes to the general population as well as specific vulnerable groups, mitigation of impact through treatment, care and support, and combating stigma and discrimination' (HIV Sentinel Survey Report, 2005). However, as discussed from previous chapters not everybody is reached with this policy interventions especially the elderly. They are sidelined in health provisioning both from government institutions and the NGOs as there is a mis-match between their needs and accessing services which was made obvious by assessing the mode of service delivery with the three criteria of Devereux and Cook (2000).

Briefly re-visiting the issues raised in chapter 5, it was found that the needs of the elderly PLWHA were not met as they had various constraints to access services. Constraints in terms of financial barriers and the location of services were major hindrances for them as discussed in the preceding chapter. Okwany (2007) rightly argues that a key learning point of universalising education 'is not enough to throw open the doors to schools...removing one access barrier but others remain'. Drawing from this argument it could be said that it is not enough to universalise health provisioning when specific needs of the elderly both physical and financial which will facilitate their participation in health care provisioning is overlooked. The free health care is not free as it has a lot of indirect costs. The ARV is expensive and laboratory tests have to be paid for; the elderly are not exempted from these payments although they do not have the income and this hinders them from seeking medical care regularly. Due to the limited number of doctors who see patients, other diseases or illnesses the elderly complain about are ignored; health practitioners cannot attend to all these complaints because of the overwhelming number of patients they have to attend to. Sidelining complains does not encourage them to visit the health centre'. Signifying, that consulting health practitioners is not very important for them...all they do is to prescribe the

medication. This attitude does not encourage them to seek help. Last but not the least assessing services with the 'fit' criteria shows that the design of HIV provisioning fails to fit with the livelihood systems of the elderly in that it restricts them in accessing services. This 'calls for a more flexible approach to ensure a better fit' (Okwany, 2007) with their livelihood systems.

Making HIV provisioning inclusive for the elderly needs political will in prioritising their social needs and making HIV provisioning more responsive to their needs. This includes allocation of resources equitably, effective planning having in mind the three criteria of access, quality and fit; thus policies/programmes should be sensitive to the conditions of the elderly. Diversifying health services for a more 'elderly friendly' participation will enhance their involvement. It was obvious that NGO programmes were not patronised by the elderly as at the time the study was done, no elderly confirmed his/her involvement in activities of NGOs. This calls for an urgent re-structuring of NGO programming to be designed sensitively in order to meet the needs of the elderly as they are totally invisible in their activities. Volunteers should be trained to give door to door information about the disease. Finally, since government and NGO activities are mainly funded by donors, it should be impressed upon donors to increase aid to enhance and increase their capacity to ensure that all persons are covered and treated equally. As the lack of funds is engendering what one may term 'implicit/priority' targeting which is not inclusive.

### **6.1.1 Why the Elderly should be exempted from Paying for their Drugs**

It is obvious that the elderly have difficulty paying for their drugs; they can afford it only when there is money. Thus, for as long as they do not get money to pay, they do not have access to the medicine. Their inability to purchase drugs on time may interrupt the course of the medication which could have consequences on the person. IRIN (2007), shares the same concerns when it said '...the treatment must be taken religiously for life. Once you stop, you start breeding resistance'. This could happen to the elderly if they are always not able to pay for their drugs regularly. On the other hand, if the drugs are free through the public health system, they will all endeavour to have their medication regularly without interruptions (*ibid*). Lessons can be learnt from Cuba which gives free medication<sup>9</sup> to HIV patients. This strategy saw considerable improvements in infection rates which reduced drastically from 24 per 100,000 in 2000 to 5 per 100,000 in 2006 (Cubaminrex, 2007). Another form of easing their financial difficulty which might allow them to pay for services without a lot of pain is to make available a form of social protection for them, if accessing health care will continually be on a 'cash and carry' basis.

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<sup>9</sup> See also free supply of ARV rollout in South Africa,  
<http://www.irinnews.org/report.aspx?reportid=49376>

### **6.1.2 The Need for a Non-Contributory Pension for all Elderly**

As mentioned earlier in the paper, there is no non-contributory pension scheme in Ghana provided by the government for people over 60 years old. It is only retired white colour workers who are entitled to pensions. Therefore a lot of old people face poverty in their old age because government does not provide pension<sup>10</sup> for informal workers whilst they are in the majority. Without money, the elderly can not have access to ARV as many are not working or are in low paying jobs such as petty trading as indicated above. It is only when people work and have income or are on social pensions that they can afford to pay for their health services with less stress. It is suggested that the mandatory payment for ARV does not suit the livelihood systems of the elderly bearing in mind their unemployment status. As a panacea for their strained finances a non-contributory social security system should be provided. According to Barrientos et al. (2003), '[a]ccess to employment is an important means of starving off poverty and coping with unexpected expenses' such as taking care of ones self when you are HIV positive since the disease demands very good nutrition, having a lot of rest and taking the drugs to boost the immune system all these require money. Therefore the government has to intervene with appropriate policies to meet the needs of these people because they are in no position to find employment. The African Union in 2006 developed a comprehensive policy framework to facilitate advocacy for the need for social protection mainstreaming in country policies for the benefit of a category of vulnerable people in society. Social cash transfers have been seen to be important in reducing poverty amongst the poor in Southern African countries such as Lesotho and Namibia as 'it plays a key role...in relieving suffering...increase human capital by helping families maintain health' says HelpAge International (2006).

### **6.1.3 The Need to Strengthen External Family Systems**

It was evident from the findings that many elderly depend on their informal networks such as (mothers, fathers, uncles, children, siblings and spouses) for assistance in various ways. These family members have to squeeze the little resources they have to provide for the PLWHA. The study made references to how some members of the family leave their jobs solely to cater for the elderly and on the other hand those who shut their doors because they can not provide for them again signifying the financial difficulty families face in providing for the sick. The glaring fact is that the mothers, fathers and uncles offering help to these elderly PLWHAs are themselves old and need to be supported rather than helping others with their limited finances. As (Dadzie, 2004) rightly said, governments should realize the vulnerability of the elderly and provide for them in their old age because traditional extended systems are being stretched especially if they have to look after HIV patients. Brown (1999) advocates for the strengthening of the extended family system with external financial aid so that the social fabric of this most cherished system will not break down by the epidemic. Successful lessons on cash transfer schemes from Zambia<sup>11</sup> (targets 10 per cent of poorest households) and

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<sup>10</sup> See also Tracy (1991:23:24) on social pensions and universal approach to welfare

<sup>11</sup> The Kalomo pilot cash transfer scheme (HelpAge International, 2006)

Tanzania<sup>12</sup> (targets older people, HIV-affected households etc) can be adopted by the Ghana government to provide social protection for the elderly PLWHA and their households.

Those elderly who support themselves without seeking help from their families do not find it easy either. As they have to accumulate the money for some time because they are not in well paying jobs to afford their drugs and also for their upkeep. (Mama Peace) had this to say:

‘I usually pay for my drugs in instalments. Attending hospital every three months gives me time to work, accumulate the money to pay and collect new drugs’.

This response highlights the difficulty they face in buying their medicine because of lack of finances. According to Barrientos et al. (2003), the elderly face these financial crisis because ‘[t]he depth and persistence of poverty in later life is profoundly underestimated in current research and policy’. This needs urgent government support.

#### **6.1.4 Re-thinking Alternative Health Care Provisioning for the Elderly: Home Based Care/Geriatric Clinics for ‘Elderly Friendly’ Services**

Health care delivery is highly inaccessible for the elderly as pointed out in the discussion although it is imperative for them to seek medical attention because of old age ailments coupled with the additional burden of HIV/AIDS. They do not have separate clinics and are therefore forced to share limited facilities with other age categories. ‘It is therefore not uncommon to see the stress and struggle the elderly people are subjected to in ...public hospitals as they go through the necessary procedures before they are attended to’ (Homecare Ghana, 2005). The physical location of health centres makes it extremely difficult and expensive for the elderly to access health care. The findings showed that more than half of the elderly lived about 10- 15km away from health facilities and could only reach it by means of transport. According to MBA (2004), ‘elderly people...can often only reach health facilities by using public transport (locally called *trotro*), which is expensive and not adapted for easy access’. This calls for urgent responses from the government to see how best to structure health systems to allow the elderly to have easy access to services. It could be suggested at this juncture that government and civil society should consider putting in place mobile clinics to enhance the efficiency of home health care services for the elderly as alternative health care systems. Home based care has been practiced and is still being successfully practiced in the United States, United Kingdom, Canada and other developed countries; and it has a lot of benefits for the elderly because it meets their specific health needs (Homecare Ghana, 2005). This system ‘allows the individual to remain in a familiar environment, especially for elderly patients...that encourages continued independence’ (ibid). This system is feasible<sup>13</sup> to develop in Ghana and

<sup>12</sup> See four pillars in the National Strategy for Poverty Eradication and Growth (MKUKUTA) HelpAge international, 2006)

<sup>13</sup> In America in the 1700’s, ‘home health care was the only practical system for providing health care services in an undeveloped country’ (Home Care Ghana, 2005).

when it is put in place will allow for ‘elderly friendly’ services which would be sensitive to the health needs of the beneficiaries.

Another alternative system that could be suggested to ease the constraints of the elderly is to establish a geriatric clinic which would cater for only elderly specific health problems. This will allow them the exclusive right to a health facility which is designed solely for them to ensure their total well being since ‘physicians who are truly interested in them as people will encourage them to report new disturbing symptoms as soon as they appear’ (Homecare Ghana, 2005). Also they can have special days dedicated to them at the health facilities to see doctors. The reality of the situation as it stands currently is disturbing, as the health practitioners do not see to other symptoms which the PLWHA complain about as discussed in chapter 5.

### 6.1.5 Directing HIV/AIDS Education to the Elderly

HIV programmes designed specifically for the elderly to enhance their knowledge and participation<sup>14</sup> in HIV/AIDS activities is needed in Ghana. This is because their knowledge does not translate into behaviour change. Examples should be drawn from America where the initiative to educate the elderly is high on the agenda as they realised the vulnerability of the elderly to the disease (USA Today, 2007). Chapter 2 sheds light on HIV/AIDS interventions which included educational programmes which have a wide coverage in the country. It is estimated by (GDHS: 2003), that 98 percent of the population have knowledge about HIV although many people are still vulnerable to it. The study confirms this assertion as the elderly although have affirmed to have knowledge of HIV from programmes on (TV, radio and newspapers), a considerable number of them still indulge in unprotected sex. (GAC, 2004; Ng’weshemi et. al. 1997; Corridor Reference Document, 2005; Barrientos et al. 2003) pointed to the fact that intervention services do not target the elderly directly as the needs of children, youth and pregnant women are prioritised over theirs. Therefore even though they all have the knowledge for the fact that issues concerning them are not prioritised to educate them specifically, there will be this gap between having the information and applying it. Gateway (2000) pointed to the fact that the elderly perceive the disease to be a disease of the adolescents; this is the information they get. It is essential that the government, NGOs, civil society and donors amongst others come to the realisation that the elderly are equally at risk and need specific HIV education which should be targeted at them in the country. This is the only way they (elderly) will come to know that HIV infection has no barriers but can infect any one who gets exposed to it. Sheppard et al.<sup>15</sup> assert that ‘preventive action is more likely among those who feel vulnerable to the disease. This suggests that people have to perceive themselves at risk of HIV infection in order to take preventative action to safer sexual behaviour, such as monogamy and condom use’.

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<sup>14</sup> As in HIV workshops

<sup>15</sup> See [http://educationclearinghouse.nairobi-unesco.org/docs/gender\\_and\\_risk\\_of\\_hiv\\_uganda\\_ghana.pdf](http://educationclearinghouse.nairobi-unesco.org/docs/gender_and_risk_of_hiv_uganda_ghana.pdf)

### **6.1.6 It Takes Two: Empowerment of Women and the Involvement of Men in Sex Negotiation**

Evidence from the findings showed that all the women except one confirmed that they got the infection from their husbands and nine out of eleven men said they infected their wives this confirms the general trend of infection in the country as more women are infected by men. An extensive discussion on gender power relations portrayed the fact that women's inability to negotiate for safe sex practices was entrenched in cultural/traditional practices as Harcourt (1997) and other authors confirmed this in chapter 4 and 5. The lack of sex negotiating skills is highly engendered by the patriarchal system in the country which empowers men to have full control over sexual issues, such as when and how to have sex. Special education programmes need to target men especially to learn and appreciate the need to negotiate with their spouses and also appreciate condom use especially when they know they are infected with the virus. Family Health International (2006) pointed out that all efforts to curb the disease would be rendered ineffective without targeting men. Women have to be empowered also and try to be assertive; they should know the limits to which to abide to traditional practices and act rationally in their sexual lives in this era of HIV/AIDS, negotiating safe sex with the 'emergence of an egalitarian condom pedagogy could provide genuine democratic resources for a journey of hope for many women' asserts Bhavnani (2003). Women will only destroy themselves if they continue to follow these traditional practices blindly for example as illustrated in the previous chapter that they are legally married to their spouses and therefore can not use condoms. Another important factor which has to be addressed to facilitate the empowerment of women is the need to address the 'gender differences in access to economic opportunities' (NACP, DCU and MOH, 2001). This calls for the government and NGOs to put in place appropriate structures such as the non-contributory pension scheme to serve as a form of social protection for women especially because they are always disproportionately affected in the labour market.

### **6.1.7 Addressing Stigma - When Stigma is Gone, People will Participate**

Avoiding stigma was a big issue for the elderly. This was the reason why those who formerly participated in NGO activities stopped, as, they feared they would be stigmatised by the community when they see them associating with an HIV/AIDS organisation and 22 of the elderly would not want anyone to know their status for various reasons which were made obvious in chapter 5. Although extensive education on stigma has been on-going in the country to allay fears of people that talking, eating together, sitting in the same car, shaking hands and hugging (GSMF: 2003) etc with an HIV patient does not put one into danger, these strategies however have not changed the mentality of people. More effort is needed to address this issue extensively for as long as stigma is still strong in the communities, many PLWHAs will live in denial and continue to live 'normal' lives as though they do not have the infection. When stigma is successfully eradicated, many elderly PLWHAs will participate in HIV/AIDS activities and members of their households will also not be shunned as a lot of them showed concern for their families.

### **6.1.8 Herbal medicine and Western medicine**

The findings of this study are inconclusive as to whether or not patients have faith in herbal treatment for HIV/AIDS as six of them use it simultaneously with the ARV. It may well be that they would have resorted to or stuck with Western medicine if it were affordable and have turned to herbal treatment as a means of last resort. Given that herbal medicine was not the focus of the study and given the lack of expertise on the subject, this paper will not be in a position to vouch for the efficacy or otherwise of herbal medicine for the treatment of HIV/AIDS. Suffice it to note however that herbal medicine has been an integral part of Ghanaian society long before contact with the West and the trend has not changed much, particularly with the older folk. The medical profession has made it clear that no known cure (that is to say Western medical cure) has been found for HIV/AIDS yet. Claims by African traditional medical practitioners that they have found a cure for the condition appear not to have been proven scientifically. These claims ought to be thoroughly investigated. Collaboration between herbal and Western medical practitioners is long overdue. This observation is made bearing in mind the fact that the root of medicine; (orthodox and traditional) is natural organic substances (plants and animals).

Nevertheless, as research has shown that ARV prolongs the lives of PLWHAs, it is only prudent for the government to have the drugs free (case of South Africa) for the elderly considering their financial positions to enhance their access to it. Government should also invest in the production of simple drug regimens as the use of a combination of ARVs is not conducive, particularly for the elderly who have to take other medication for age related ailments. Alternatively, efforts should be developed to manufacture medicine for use by the elderly taking into account their other ailments.

### **6.1.9 Reflections**

The study has provided a significant revelation about the root causes of why the elderly are invisible in HIV/AIDS provisioning. Although the sample was not representative, they provide insight into the ease with which services are available. It could be inferred from the paper that services are available to those elderly who seek it although it is not targeted and made sensitive to their specific needs. I have argued for an all inclusive universal HIV policy which will benefit the whole populace and which will not target certain people implicitly to the disadvantage of others. A dire need for alternative forms of service provisioning to facilitate the access to the services the elderly need was strongly advocated for. It is only in the interest of the government especially to take urgent action to involve this category of people in policy and intervention programmes since it is evident that they are a 'subtle' threat to their families especially spouses and community in which they live. GDHS (2003) reported that Ghana is experiencing population ageing, based on this fact and the relatively high life expectancy of the country, the government need to shift its focus to the needs of the elderly as the whole country at large could suffer the brunt of their infection as this could reduce the relatively high life expectancy the country is enjoying at the moment.

Although the paper did not touch on the elderly who are affected by HIV, it is noteworthy that research shows they especially are currently bearing the brunt of the epidemic by looking after households with orphaned<sup>16</sup> children. It is therefore imperative for the government to provide financial assistance through non-contributory pensions for the elderly as they are becoming both infected and affected by HIV/AIDS.

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<sup>16</sup> See also Help Age (2006), grandparents as caregivers for orphaned children

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## ANNEXES

### ANNEX A

#### HIV Prevalence by Region- Confidence Intervals

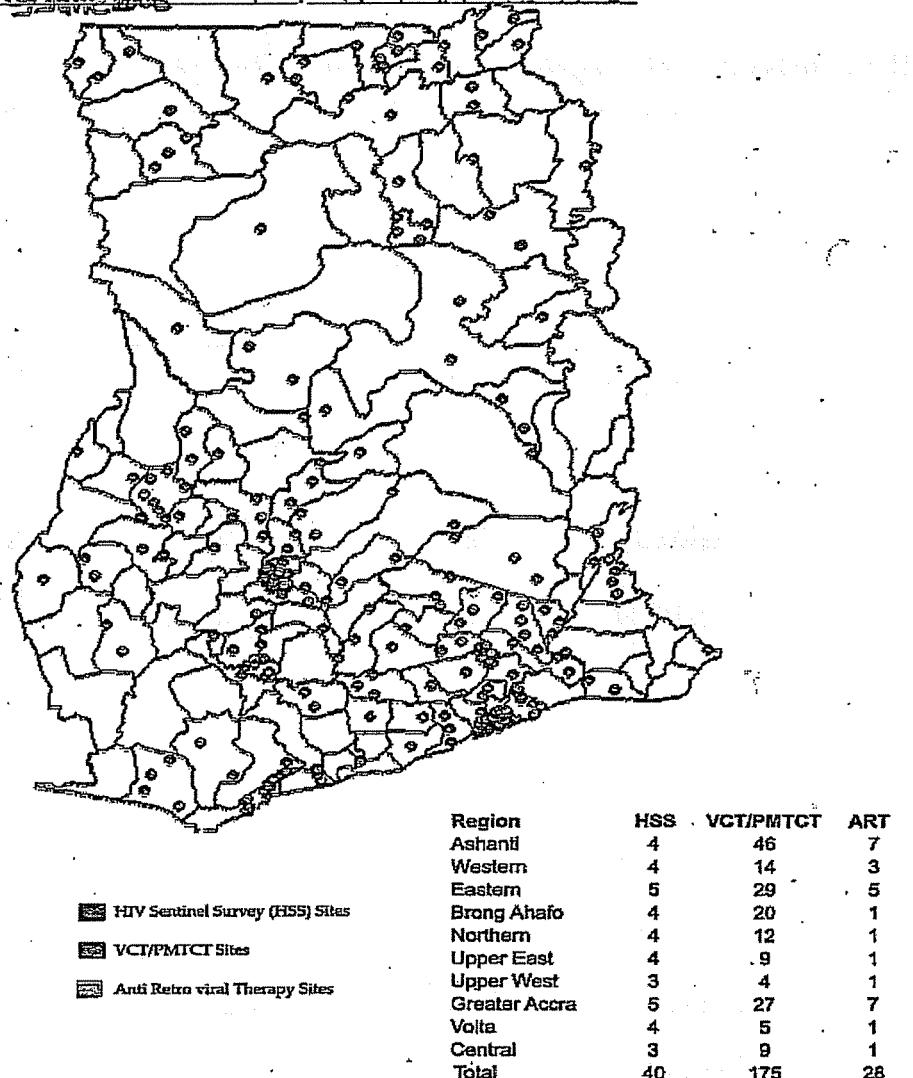
Region	Screened	Total		Prevalence
		Sample	Frequency	
Ashanti	1946		58	3.0
Brong				
Ahafo	1468		48	3.3
Central	1494		44	2.9
Eastern	2280		107	5.5
Gt. Accra	2233		48	3.2
Northern	1791		22	2.1
Upper				
East	1929		51	1.2
Upper				
West	1368		36	2.6
Volta	1708		31	2.6
Western	1902		56	1.9

[Source: HIV Sentinel Survey Report, 20005]

## ANNEX B

Fig. 12: Map showing proposed HSS, VCT/PMTCT and ART sites

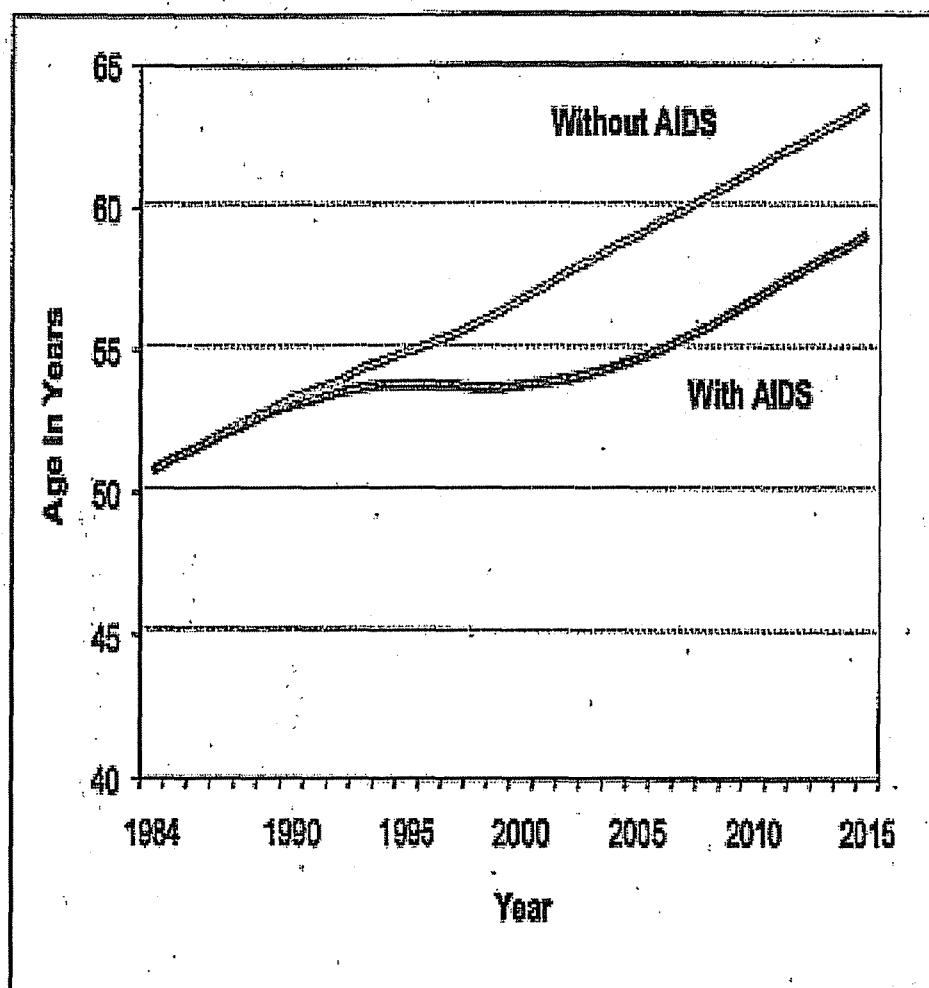
by June 2005



[Source: Ghana Health Service, 2005]

## ANNEX C

### Projected Life Expectancy at Birth, 1984-2015



[Source: HIV Sentinel Survey Report, 2005]

## ANNEX D

### INTERVIEW SCHEDULE FOR INSTITUTIONS

1. Name of Organisation.....
2. Year of Establishment.....
3. What programmes do you engage in?
  - a. HIV/AIDS testing
  - b. Clinical Services
  - c. Condom Promotion
  - d. HIV/AIDS Advocacy
  - e. Coordination of HIV/AIDS programs
  - f. HIV/AIDS Policy formulation
  - g. Support for PLWHA
  - h. Housing/Caring for PLWHA
  - i. Others (specify).....
4. For how long have these programmes been running?
  - a. <1yr
  - b. 2-5 yrs
  - c. 6-9 yrs
  - d. 10-13 yrs
  - e. Other (specify).....
5. How do you make your programmes known to the public?.....
6. Who are the target groups for your programmes?.....
7. What are their ages?
  - a. 0-9
  - b. 10-19
  - c. 20-29
  - d. 30-39
  - e. 40-49
  - f. 50-59
  - g. 60+
  - h. Others (specify).....
8. Give reasons why you chose these specific age groups?.....

9. Have the programmes been effective?

- a. Yes
- b. No

10. If yes, please state the number of people who have benefited.

- a. < 50
- b. 100-200
- c. 300-400
- d. 500-600
- e. >1000

11. Are the intervention programmes easily available to target groups?

- a. Yes
- b. No

12. If No, please state reasons why some target groups are left out?.....

.....

13. Are you aware that the elderly have HIV/AIDS?

- a. Yes
- b. No

14. If Yes, are there any special programmes for the elderly with HIV/AIDS?

- a. Yes
- b. No
- c. Others (specify).....

15. If Yes, please state these programmes.....

.....

16. If NO, please give reasons.....

17. How many of them have enrolled or benefited?.....

18. How do the elderly get access to these programmes?

- a. Come to the service centre
- b. House delivery

19. Do they incur costs when accessing programmes?

- a. Yes
- b. No

20. If Yes, please state the type of costs that they incur.....

21. How many times do they access programmes and services?

- a. Daily
- b. Weekly
- c. Bi-weekly
- d. Monthly
- e. Others (specify).....

22. Are there reasons why the elderly may not access intervention programmes?

- a. Poverty

b. Distance

c. Lack of caregivers

d. Fear of stigmatization

e. Language barrier

f. Other (specify).....

23. During your programmes, do you discuss topics on sex?

a. Yes    b. No

24. If Yes, how do you discuss sex with the elderly?

.....

.....

25. Do you encounter difficulties during the discussion?

a. Yes

b. No

26. If you do not have specially tailored programmes for the elderly, do you have future plans to include them?

a. Yes

b. No

27. If Yes, please give reasons

.....

.....

28. If No, please give reasons

.....

.....

[This interview is strictly for the purpose of academic work. All information given will be kept confidential]

**THANK YOU**

## ANNEX E

### **QUESTIONNAIRE**

### **INVISIBILITY OF THE ELDERLY IN HIV/AIDS POLICY AND PRACTICE IN GHANA**

The sole purpose of administering this questionnaire is to gather for an academic/research work. As such, respondents are assured of confidentiality and all responses given will remain anonymous. This questionnaire targets the elderly living with HIV/AIDS. Kindly answer the questions to the best of your ability. Thank you.

#### **SECTION A: DEMOGRAPHIC DATA**

1. Sex of Respondent      a. Male      b. Female
2. Age: .....years
3. Hometown/Town of Resident
4. Highest Level of Education:
  - a. No Education      e. Vocational /Technical
  - b. Primary      f. Tertiary
  - c. Middle School      g. Apprenticeship
  - d. Secondary      h. Others
  - i. Not Applicable
5. Past Occupation:.....
6. Present Occupation:.....
7. Marital Status:
  - a. Never Married      c. Divorced
  - b. Married      d. Widowed
8. Number of Children:.....
9. Ages of children:.....
10. Are they in school? a. Yes   b. No c. Other.....

#### **SECTION B: MARITAL/SEXUAL BACKGROUND**

11. Which of the following best describes the intimate relationships you have been involved in?
  - a. Monogamous marriage      b. Polygamous marriage
  - c. Monogamous marriage with extra marital affairs
  - d. Polygamous marriage with extra marital affairs
  - e. A live-in arrangement
  - f. Casual sexual relationship
  - g. Bearing children but never married to the spouse
  - h. Others (specify).....      i. Not Applicable

### SECTION C: KNOWLEDGE OF HIV/AIDS ISSUES

23. When did you first hear of HIV/AIDS?.....

24. What did you hear about it?.....

25. From which of the following sources did you obtain the information above?  
a. Relatives      b. Friends      c. Community      d. Radio  
e. TV    f. Posters    g. Newspapers      h. Others (specify).....

26. How long have you been living with HIV/AIDS?.....

27. Are you aware of any programmes/support services being run for PLWHAs?  
a. Yes (state programme).....  
b. No

28. How did you hear of these programmes? (from who/source).....

**SECTION D: PROGRAMME AND SUPPORT SERVICES (P/SS) FOR  
PEOPLE LIVING WITH HIV/AIDS (PLWHA)**

29. Do you access any of the P/SS provided for PLWHA?  
a. Yes      b. No

30. If Yes, please give details of P/SS  
accessed.....

31. Which organization(s) provides this P/SS?  
.....

32. For how long have you been accessing the P/SS?.....

33. What is the distance of the P/SS from your home?  
a. <5 kms      b. 5-10 kms      c. 10-15 kms      d. >15 kms      e. Not  
applicable

34. What is the mode of accessing the P/SS?  
a. Providers come to our houses  
b. PLWHA commute to service centres

35. Are there any problems associated with this?  
a. Yes    b. No  
If Yes, explain.....

36. What is the procedure for accessing the P/SS.....  
(e.g. Registration, Consultation etc)

37. Does the procedure involve any financial costs?  
a. Yes    b. No

38. If Yes, how much is it?.....

39. How often do you access P/SS?  
a. Every 2 weeks      b. Monthly      c. Bi-monthly      d. Every three  
months  
e. Others (specify).....

40. How long do you stay at the Service Centre during each  
visit?.....

41. During your visit, how are you treated?.....

42. How does this encourage/discourage you from accessing the  
P/SS?.....

43. What do you do to keep  
healthy?.....

44. Do you know of other adults living with HIV/AIDS in your community or house who do not access any Support Service?  
a. Yes b. No

45. How would you access or rank the P/SS provided?  
a. Very low b. Low c. Average d. High e. Very high

46. How would you describe the change in your health status since you joined the programme?  
a. Very low b. Low c. Average d. High  
e. Very high f. Others (specify).....

47. As an elderly living with HIV/AIDS, what are your major challenges?.....

.....

48. What suggestions would you give to providers of care or the government?.....

#### **SECTION E: CAREGIVER SUPPORT FOR PLWHA**

49. Who do you live with at home?  
a. Alone b. Spouse alone c. Spouse and children d. Children alone  
e. Children, spouse and other relatives f. Others (specify)

50. Who is your principal caregiver?.....

51. What care/support do you receive from members of your household?  
a. None b. Meals c. Money d. Shelter e. Personal hygiene care (e.g. bathing) f. running errands g. Others (specify).....

52. What are your major responsibilities in the home?  
a. Providing financial support b. Household duties  
c. Others (specify).....

53. Do you have dependants?  
a. Yes b. No

54. How many are they?.....

55. If you are not working, how do you provide for your dependants?  
Specify.....

### **SECTION F: HEALTH STATUS OF PLWHA**

56. In the last month, have you been sick or bedridden and unable to perform your responsibilities?

a. Yes    b. No

57. If Yes, what was the cause of the illness?

a. Malaria    b. T.B    c. Diarrhoea    d. Hypertension  
e. STD (specify).....    f. Other (specify)    g. Not applicable

58. What is your current state of health?

a. Healthy    b. Average    c. Sick    d. Very sick/bedridden

### **SECTION F: COMMUNITY RESPONSE, VULNERABILITY AND STIGMATIZATION**

59. How many people in the community know about HIV/AIDS?

a. No oneb. Few    c. Many    d. Everyone

60. How do people in your community view or react towards PLWHA?

a. Readily accepted    b. Shunned    c. Others (specify).....

61. Where are HIV/AIDS issues discussed among community people?

a. Never discussed  
b. At religious services (specify).....  
c. In the home  
d. At the community centre  
e. Gong gong (Public Announcement)  
f. At health centres  
g. Others (specify).....

62. How are sexual issues discussed among spouses?

a. Never discussed (taboo)    b. Mentioned briefly  
c. Discussed in detail

with the help of the mean and variance of the random variable itself. The following example illustrates this.

Example 1. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = aX + b$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = a\mu + b \quad \text{and} \quad \text{Variance of } f(X) = a^2\sigma^2.$$

Proof.

Let  $Y = f(X) = aX + b$ . Then, the mean and variance of  $Y$  are given by

$$\text{Mean of } Y = E(aX + b) = aE(X) + b = a\mu + b \quad \text{and}$$

$$\text{Variance of } Y = \text{Var}(aX + b) = a^2\text{Var}(X) = a^2\sigma^2.$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = a\mu + b \quad \text{and} \quad \text{Variance of } f(X) = a^2\sigma^2.$$

Example 2. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^2$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^2) = \mu^2 + \sigma^2 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^2) = \text{Var}(X^2 - \mu^2 + \mu^2) = \text{Var}(X^2 - \mu^2) + \text{Var}(\mu^2) = \text{Var}(X^2) + \text{Var}(\mu^2) = \text{Var}(X^2) + 0 = \text{Var}(X^2).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^2 + \sigma^2 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^2).$$

Example 3. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^3$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^3) = \mu^3 + 3\mu\sigma^2 + \sigma^3 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^3) = \text{Var}(X^3 - \mu^3 - 3\mu\sigma^2 - \sigma^3 + \mu^3 + 3\mu\sigma^2 + \sigma^3) = \text{Var}(X^3 - \mu^3 - 3\mu\sigma^2 - \sigma^3) + \text{Var}(\mu^3 + 3\mu\sigma^2 + \sigma^3) = \text{Var}(X^3 - \mu^3 - 3\mu\sigma^2 - \sigma^3) + 0 = \text{Var}(X^3 - \mu^3 - 3\mu\sigma^2 - \sigma^3).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^3 + 3\mu\sigma^2 + \sigma^3 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^3 - \mu^3 - 3\mu\sigma^2 - \sigma^3).$$

Example 4. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^4$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^4) = \mu^4 + 6\mu^2\sigma^2 + 3\sigma^4 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^4) = \text{Var}(X^4 - \mu^4 - 6\mu^2\sigma^2 - 3\sigma^4 + \mu^4 + 6\mu^2\sigma^2 + 3\sigma^4) = \text{Var}(X^4 - \mu^4 - 6\mu^2\sigma^2 - 3\sigma^4) + \text{Var}(\mu^4 + 6\mu^2\sigma^2 + 3\sigma^4) = \text{Var}(X^4 - \mu^4 - 6\mu^2\sigma^2 - 3\sigma^4) + 0 = \text{Var}(X^4 - \mu^4 - 6\mu^2\sigma^2 - 3\sigma^4).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^4 + 6\mu^2\sigma^2 + 3\sigma^4 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^4 - \mu^4 - 6\mu^2\sigma^2 - 3\sigma^4).$$

Example 5. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^5$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^5) = \mu^5 + 10\mu^3\sigma^2 + 15\mu\sigma^4 + \sigma^5 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^5) = \text{Var}(X^5 - \mu^5 - 10\mu^3\sigma^2 - 15\mu\sigma^4 - \sigma^5 + \mu^5 + 10\mu^3\sigma^2 + 15\mu\sigma^4 + \sigma^5) = \text{Var}(X^5 - \mu^5 - 10\mu^3\sigma^2 - 15\mu\sigma^4 - \sigma^5) + \text{Var}(\mu^5 + 10\mu^3\sigma^2 + 15\mu\sigma^4 + \sigma^5) = \text{Var}(X^5 - \mu^5 - 10\mu^3\sigma^2 - 15\mu\sigma^4 - \sigma^5) + 0 = \text{Var}(X^5 - \mu^5 - 10\mu^3\sigma^2 - 15\mu\sigma^4 - \sigma^5).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^5 + 10\mu^3\sigma^2 + 15\mu\sigma^4 + \sigma^5 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^5 - \mu^5 - 10\mu^3\sigma^2 - 15\mu\sigma^4 - \sigma^5).$$

Example 6. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^6$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^6) = \mu^6 + 15\mu^4\sigma^2 + 45\mu^2\sigma^4 + 15\sigma^6 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^6) = \text{Var}(X^6 - \mu^6 - 15\mu^4\sigma^2 - 45\mu^2\sigma^4 - 15\sigma^6 + \mu^6 + 15\mu^4\sigma^2 + 45\mu^2\sigma^4 + 15\sigma^6) = \text{Var}(X^6 - \mu^6 - 15\mu^4\sigma^2 - 45\mu^2\sigma^4 - 15\sigma^6) + \text{Var}(\mu^6 + 15\mu^4\sigma^2 + 45\mu^2\sigma^4 + 15\sigma^6) = \text{Var}(X^6 - \mu^6 - 15\mu^4\sigma^2 - 45\mu^2\sigma^4 - 15\sigma^6) + 0 = \text{Var}(X^6 - \mu^6 - 15\mu^4\sigma^2 - 45\mu^2\sigma^4 - 15\sigma^6).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^6 + 15\mu^4\sigma^2 + 45\mu^2\sigma^4 + 15\sigma^6 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^6 - \mu^6 - 15\mu^4\sigma^2 - 45\mu^2\sigma^4 - 15\sigma^6).$$

Example 7. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^7$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^7) = \mu^7 + 21\mu^5\sigma^2 + 105\mu^3\sigma^4 + 105\mu\sigma^6 + \sigma^7 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^7) = \text{Var}(X^7 - \mu^7 - 21\mu^5\sigma^2 - 105\mu^3\sigma^4 - 105\mu\sigma^6 - \sigma^7 + \mu^7 + 21\mu^5\sigma^2 + 105\mu^3\sigma^4 + 105\mu\sigma^6 + \sigma^7) = \text{Var}(X^7 - \mu^7 - 21\mu^5\sigma^2 - 105\mu^3\sigma^4 - 105\mu\sigma^6 - \sigma^7) + \text{Var}(\mu^7 + 21\mu^5\sigma^2 + 105\mu^3\sigma^4 + 105\mu\sigma^6 + \sigma^7) = \text{Var}(X^7 - \mu^7 - 21\mu^5\sigma^2 - 105\mu^3\sigma^4 - 105\mu\sigma^6 - \sigma^7) + 0 = \text{Var}(X^7 - \mu^7 - 21\mu^5\sigma^2 - 105\mu^3\sigma^4 - 105\mu\sigma^6 - \sigma^7).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^7 + 21\mu^5\sigma^2 + 105\mu^3\sigma^4 + 105\mu\sigma^6 + \sigma^7 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^7 - \mu^7 - 21\mu^5\sigma^2 - 105\mu^3\sigma^4 - 105\mu\sigma^6 - \sigma^7).$$

Example 8. Let  $X$  be a random variable with mean  $\mu$  and variance  $\sigma^2$ .

Let  $f$  be a function of  $X$  such that  $f(X) = X^8$ .

Then, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = E(X^8) = \mu^8 + 28\mu^6\sigma^2 + 168\mu^4\sigma^4 + 28\mu^2\sigma^6 + \sigma^8 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^8) = \text{Var}(X^8 - \mu^8 - 28\mu^6\sigma^2 - 168\mu^4\sigma^4 - 28\mu^2\sigma^6 - \sigma^8 + \mu^8 + 28\mu^6\sigma^2 + 168\mu^4\sigma^4 + 28\mu^2\sigma^6 + \sigma^8) = \text{Var}(X^8 - \mu^8 - 28\mu^6\sigma^2 - 168\mu^4\sigma^4 - 28\mu^2\sigma^6 - \sigma^8) + \text{Var}(\mu^8 + 28\mu^6\sigma^2 + 168\mu^4\sigma^4 + 28\mu^2\sigma^6 + \sigma^8) = \text{Var}(X^8 - \mu^8 - 28\mu^6\sigma^2 - 168\mu^4\sigma^4 - 28\mu^2\sigma^6 - \sigma^8) + 0 = \text{Var}(X^8 - \mu^8 - 28\mu^6\sigma^2 - 168\mu^4\sigma^4 - 28\mu^2\sigma^6 - \sigma^8).$$

Thus, the mean and variance of  $f(X)$  are given by

$$\text{Mean of } f(X) = \mu^8 + 28\mu^6\sigma^2 + 168\mu^4\sigma^4 + 28\mu^2\sigma^6 + \sigma^8 \quad \text{and} \quad \text{Variance of } f(X) = \text{Var}(X^8 - \mu^8 - 28\mu^6\sigma^2 - 168\mu^4\sigma^4 - 28\mu^2\sigma^6 - \sigma^8).$$