Ageing in Ghana

Akye Essuman and C. Charles Mate-Kole

Abstract Ghana's population is steadily ageing in tandem with global trends. Improved health care, reduced fertility and improvement in survival have placed Ghana's older adult (60+ years) population among the highest in Sub-Saharan Africa. The estimated older adult population of 4.5% in 1960 increased to 6.7% in 2010 and is expected to reach 9.8% by 2050. This trend presents challenges to the care of older adults in Ghana. Studies have shown that the majority of the older adult population lived in rural settings, with fewer employment opportunities to earn adequate income. Literacy rate and educational status were generally low among older adults with few attaining higher education. Most people depended on the traditional extended family support systems where children and younger family members were expected to reciprocate the care received from their ageing parents and relatives.

Globalization and industrialization have however led to a shift in the traditional social support system. Unemployment of young people in Ghana with consequent migration to urban areas in search of better jobs, the quest for higher education by young females who usually cared for their aged parents, and increasing work demands on the young are some factors contributing to increasing isolation of the aged. Older adults experience a higher prevalence of chronic diseases and are easily susceptible to infectious diseases. Abuse and stigmatization of older adults is a challenge in Ghana.

Holistic care for the aged population in Ghana is largely rudimentary, but efforts are being made by both government and the private sector to address this challenge. Modest achievements in this direction include the formulation of the National

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Ageing Policy to oversee the total care of the older adult population, the National Health Insurance exemption policy for the aged and core poor, the emerging elderly home care industry, the Geriatric Medicine fellowship programme to build capacity for clinical care, and the Centre for Ageing Studies for academic and research capacity building.

Keywords Ageing · Geriatric medicine · Ghana · Homecare · Older adults · Policy · Stigmatization

Demographic Trends

Ghana is in West Africa occupying an area of 238,540 square kilometers with an estimated population of 30.4 million (Fig. 1). It is categorized as a lower middle-income country with a gross domestic product (GDP) per capita of US$ 2202.1 (World Bank, 2018 & 2019). Demographically, Ghana has an intermediate age structure (median age 21.4 years) and an estimated average life expectancy at birth for 2020 as 68.2 years (65.6 years for men, and 70.8 years for women) (Central Intelligence Agency, 2018). Like the rest of the world, Ghana's population is gradually but steadily ageing (Table 1). The proportion of persons aged 60+ is among the highest in Sub-Saharan Africa. With an older adult population of 4.5% in 1960, the proportion increased to 6.7% in 2010 and is expected to reach 9.8% by 2050 (Ghana Statistical Service [GSS], 2013; United Nations, 2017). Improved health care, treatment of acute and chronic diseases, better nutrition and hygiene, reduced fertility and improvement in survival have increased Ghana's share of elderly persons.

Despite the growing urban population, sociodemographic characteristics of older people in Ghana indicate the majority (59%) live in rural settings. Compared to women, most men (83.6%) are married, while almost half of the women are widowed. This rate may be explained by a higher female life expectancy and the tendency for men to marry younger women. Literacy rate and educational status is

Table 1 Global ageing trends: percentage of population aged 60 years and above

Region/Country	1950	1975	2000	2025	2050
Asia	6.7	6.6	8.6	14.8	24.4
Europe	12.1	16.5	20.3	27.3	33.6
Latin America/Caribbean	5.6	6.5	8.4	14.9	25.0
North America	12.4	14.6	16.3	24.7	27.0
Oceania	11.2	11.0	13.4	19.1	23.5
Sub-Saharan Africa	5.2	4.8	4.8	5.5	8.3
Ghana	4.1	4.5	5.2	7.2	11.9

Source: World population prospects, the 2010 revision (UN DESA, 2011)

Fig. 1 Ghana country profile – BBC News. (Source: https://www.bbc.com/news/world-africa-13433790)

generally low among older adults with wide sex differentials. Three quarters of the female older adult (76.2%) compared to half of the males (53.5%) had received little formal education (i.e., less than primary or no education). A negligible proportion had higher education (tertiary) particularly among the women (Table 2).

Ghana is a very religious country. Over 90% of all older adults aged 60 years and over were affiliated with a religion, with females having a preponderance. Churches, mosques and other religious institutions and organizations provide social protection to them and their families, while they are able to improve their social lives through the networks and interactions of others who share the same faith.

Ageing Research in Ghana

de-Graft Aikins and Apt (2016) detailed the history of ageing research in Africa beginning in the 1970s with UN sponsored pilot surveys for low- and middle-income countries. The first African conference on ageing was held in Dakar, Senegal in 1984 by UNESCO, UNFPA and the Government of Senegal. This led to increased interest in matters relating to the older adult population and research in the social sciences and humanities. Research organizations like the African Gerontological Society (AGES) and African Research on Ageing Network (AFRAN) were established to support and disseminate ageing research findings across the continent (Aboderin, 2005; Apt, 2005). A significant achievement in policy occurred in 2001 when the African Regional Office of HelpAge International successfully included ageing issues on the agenda of an African Union (AU) meeting. This led to the formulation of a Draft Policy Framework and Plan of Action on Ageing in Africa.

Ageing research in Ghana however began in the 1950s. In a bibliographic study on research conducted on ageing in Ghana since the 1950s, de-Graft Aikins et al. (2016) identified six empirical areas where research had focused. These were

Table 2 Selected sociodemographic characteristics of older people (50+ years) in Ghana disaggregated by sex

Characteristics	Male (%)	Female (%)	Total (%)	N
Location				
Urban	40.7	41.5	41.1	1770
Rural	59.3	58.5	58.9	2537
Age group				
50–59	40.6	38.8	39.7	1712
60–69	26.9	28.1	27.5	1184
70–79	22.3	24.0	23.1	993
≥80	10.2	9.1	9.7	418
Marital status				
Never married (and not cohabiting)	1.2	1.3	1.3	54
Currently married	83.6	30.1	58.2	2505
Cohabiting	1.1	0.6	0.8	36
Separated/divorced	7.1	19.2	12.8	553
Widowed	6.5	48.3	26.4	1135
Education				
No education	43.4	65.5	54	2309
Less than primary education	10.1	10.7	10.4	443
Primary school completed	12.3	9.4	10.9	468
Secondary education completed	5.8	2.1	4.0	172
High school (or equivalent completed)	23.3	10.4	17.1	732
College/university completed	4.8	1.9	3.4	147
Postgraduate degree completed	0.3	0.1	0.2	7
Income quintile				
Q1 (lowest)	16.3	20.4	18.2	785
Q2	17.2	21.1	19.1	821
Q3	19.6	21.4	20.5	880
Q4	21.5	19.7	20.7	889
Q5 (highest)	25.3	17.4	21.6	927

Source: SAGE study (Biritwum et al., 2013)

demographic profiles and patterns of ageing; the health status (physical, mental, sexual) of older adults; care and support for older adults; roles and responsibilities of older adults; social representations of ageing and social responses to older adults; and socio-economic status, social and financial protection, and other forms of support. The authors further identified trends for future research in Ghana and the Ghanaian diaspora. They indicated that published studies reflect a transition towards collaborative research, with multi-authored publications replacing the single author publications of the early decades. Doctoral training and institutionalized multidisciplinary research seem to be the trend in the immediate future. Another trend identified by the authors is the emerging research on older migrant Ghanaians. An obvious research gap however exists in the multifaceted health service delivery to older adults in Ghana.

Socio-economic and Cultural Aspects of Ageing in Ghana

Ghanaian cultural values play a major role in the lives of the older adults. There is the traditional sense of reciprocity where adult children are in turn expected to care for their aged parents or relatives. An adage in the Akan language says "When your parents take care of you for your teeth to erupt, you in turn take of them until their teeth come off".

Living arrangement was typically the 'compound house' that provided accommodation for different generations of a household and was often governed by an identified family head. Family heads were highly respected elderly persons who among several functions provided daily subsistence for large households and acted as adjudicators when disputes arose among family members. The traditional pattern of living ensured a home to live in when one grew old and the benefit from the obligation of family members to respect them and to provide social, economic, and spiritual support. Studies showed that most older adults in Ghana were either household heads (62%) or spouses of heads of the households. Children, aged less than 15 years, formed a third of the households while those in the productive ages (15–59 years) ranged from 39 to 45%. About a tenth of older adults stayed alone. House ownership was quite low among them with a high proportion dwelling in compound houses, with limited access to sanitation facilities and amenities (Ghana Statistical Service [GSS], 2013).

There are emerging challenges to these cultural values, however. Globalization and industrialization have led to a shift in the extended family way of living. Ageing in rural Ghana has been negatively affected in several ways. Although Ghana is 56.71% urbanized (World Bank, 2019), the majority of older adults continue to live in rural settings (Table 2). Unemployment of the youth in rural areas, even though able-bodied and qualified, deny them the opportunity to earn income and provide for their aged parents and relatives. Migration of the youth from rural areas to seek better job opportunities in urban areas and sometimes abroad has led to increasing isolation and neglect of older adults. Additionally, increasing demands on the youth in the workforce have contributed to older adults being left on their own for longer periods. The departure of the caregivers, mostly women, through the quest for education and employment as providers within the family and household presents a further problem for the aged. There is an increasing tendency for children working abroad to refuse to support ageing parents. This new trend contradicts the cultural expectation of reciprocity in social and economic support that is embedded in the social context of majority of Ghanaians and Africans (Apt, 1993; Apt, 1997; Agyemang, 2015; Essuman et al., 2018).

According to the 2010 population and housing report (Ghana Statistical Service [GSS], 2013), a relatively high proportion of older adults (58.5%) were economically active, but the proportion declined as people grew older. The proportion of economically active elderly males was slightly more than females who were thought to be more engaged in the greater social reproduction responsibility. The majority (84.8%) of economically active elders were employed in three major occupations:

agricultural and forestry, service and sales, or craft and related trades. Only a small proportion (6.2%) of the elderly were engaged as professionals, managers, technicians, and associated professionals due to their low level of educational attainment. Nine out of ten economically active elders were engaged in the private informal sector and earnings were generally low among the self-employed. The report further stated that older adults in rural areas were more active economically (63%) compared with those in urban centres (46%) and over 80% were engaged as skilled agricultural and forestry workers.

Ageing and Spirituality, Elder Abuse and Stigmatization

As stated earlier, religion and spirituality are prominent life determinants among the elderly in Ghana. Studies have found a positive relationship between various measures of religiosity or spirituality and high levels of morale, life satisfaction, psychological health, successful ageing, and other indicators of wellbeing (Sapp, 2010; Ayete-Nyampong, 2014). Recent perceptions toward older adults in Ghana and other parts of Africa have however become infused with negative attitudes. Stigmatization (ageism) of female older adults is prevalent, with some being labelled as witches and blamed for every misfortune in the family and community. This attitude is reinforced by superstitious cultural and religious beliefs in some parts of Ghana. The emerging neo-prophetic religious groups in Ghana have an impact on the perceptions of their adherents about the aged. Unfortunately, some of these religious groups believe that older persons and those with mental disabilities are possessed by evil spirits that should be exorcised (Baffoe & Dako-Gyeke, 2013; Ayete-Nyampong, 2014). Efforts are ongoing by government (Ministry of Gender, Children and Social Protection), NGOs, and other stakeholders to address the problem.

Ageing and Health in Ghana

The health status of the older adult is central to discussions on ageing policy in Ghana. The adage ‘Health is Wealth’ is equally applicable to the older adult. This is reiterated in the Global Strategy and Action Plan on Ageing and Health (2016–2020) which stated that by 2050, 1 in 5 people will be 60 years or older (WHO, 2017a). A longer life brings great opportunities. Yet the extent to which individuals, and society more broadly, can benefit from these extra years depends heavily on one key factor: health. However, evidence suggests that older people are not experiencing better health than previous generations. The overarching goal of the global strategy is to ensure a Decade of Healthy Ageing from 2020–2030 and the underpinning principles are human rights, equity, equality, and non-discrimination (ageism), gender equality, and intergenerational solidarity.

The opening statement of Section 3.5 of Ghana's National Ageing Policy subtitled 'Old Age and Health Challenges'; states that "Good health is vital for economic growth and the development of societies. Older people's capacity to earn a living and participate in national development, and community and family life to a large extent depends on their state of health" (Government of Ghana, 2010).

Two landmark reports among existing literature on health status of the older adult are the Study on Global AGEing and Adult Health (SAGE) wave 1 (Biritwum et al., 2013) and the Ghana Country Assessment Report on Ageing and Health (WHO, 2014). These reports among others highlighted a high prevalence of chronic general medical conditions among the older adult population in Ghana. Significant among them were hypertension (54.6%), arthritis (13.8%), cataracts (5.3%), diabetes (3.8%), and strokes, angina, edentulism (lacking teeth), chronic respiratory diseases, nutritional disorders, and depression. In addition, there were geriatric-specific conditions (geriatric syndromes) such as falls and mobility issues, urinary incontinence, cognitive impairment and dementia, and functional decline. The functional status of the aged is depicted by the activities of daily living (ADL), be it advanced activities like practicing a profession or trade, or instrumental activities like using the telephone or taking medications, or basic activities like mobility and toileting. The World Report on Ageing and Health (WHO, 2015) indicated that more than 50% of older people aged between 65 and 75 years in Ghana required some assistance with activities of daily living. This trend increased to 65% for those aged 75 years and older. Compared to a developed country like Switzerland, only 5% of older adults aged 65–75 required assistance with ADL, and 20% aged 75 years and older required such assistance.

There has been a deleterious effect of the Covid-19 pandemic on the older adult population in Ghana as the rest of the world. Older adults are more likely to have underlying co-morbidity and are therefore more susceptible to the fatal consequences of the virus. Social distancing and the exclusion of the aged from public gatherings have contributed to increasing isolation of older adults (Sepúlveda-Loyola et al., 2020).

Data on available health services for older adults in Ghana is limited. Systems of care for older adults are rudimentary compared to developed countries. At facility level, there are challenges to the delivery of health care for older people characterized by lack of skilled health delivery to the older adult, lack of preferential services in most health facilities, and lack of geriatricians and geriatric-oriented physicians and nurses. There is limited staff training on the issues of older people. The situation in the district and rural settings is even more challenging. Community-based long-term care systems are emerging but not adequately developed.

Modest Achievements

There is historical evidence of a range of policies, programmes and plans developed for the aged since the colonial era (de-Graft Aikins & Apt, 2016), but implementation of programmes has always been a challenge for governments. However, in recent times, some modest achievements have been made in the areas of policy, infrastructure, training and research, and service.

Ghana adopted a policy on ageing in July 2010 to address the health, poverty and living environments of the aged (Government of Ghana, 2010). The policy document is titled: 'National Ageing Policy: Ageing with Security and Dignity.' The caption suggests that security and dignity are important components of the ageing experience in Ghana. The policy is currently a bill in Parliament waiting to be passed into law. Other policies targeted at the elderly include the National Health Insurance exemption policy for older adults 70 years and above to cover basic care (http://www.nhis.gov.gh/membership.aspx) and the Livelihood Empowerment Against Poverty (LEAP) which provides social protection for the poor and needy (https://www.mogcsp.gov.gh/projects/livelyhood-empowerment-against-poverty-leap/). At the time of writing, author AE was actively consulting with the Ghana Health Service to develop a 'National Health and Nutrition Programme for Older People' for implementation by a newly created Department of Geriatrics within the Service.

In terms of infrastructure there is an emerging industry of community-based nursing homes and homecare services in Accra and other parts of the country that needs support and regulation. Ghana has been cited as one of few sub-Saharan African countries with some form of organized long-term care for older adults (WHO, 2017b). Our district health system is quite robust and well organized from the district hospitals and polyclinics to the health centres in the sub-districts and the CHPS (community-based health planning and services) compounds at the community level. We can leverage on this structure to provide both acute and community-based long-term care for the aged.

For training and research, Faculty of Family Medicine, Ghana College of Physicians & Surgeons in collaboration with the Department of Family Medicine, University of Michigan started a fellowship programme in General Geriatric Medicine in June 2016 with the author AE as the coordinator. The aim of the programme is to produce physicians with the requisite knowledge, skills, and attitudes to provide specialized care for older adults and to have the competency to teach and conduct research in geriatrics and gerontology (Essuman et al., 2019). In August 2016, the Centre for Ageing Studies (CFAS) was established in the University of Ghana with the co-author CCM-K as the founding director (Essuman et al., 2018). CFAS aims to advance multidisciplinary research and educational programmes consisting of multifaceted approaches to ageing that will promote wellbeing in the aged population. Key activities include education, research, and clinical service (in collaboration with the geriatric medicine fellowship programme). Other activities of the Centre are dance and fitness programmes, community outreach and promotion of public discourse and dialogue. At the undergraduate level, there are existing

curricula in gerontology in the Schools of Nursing and Public Health and in the social sciences of the University of Ghana. There is introductory level teaching of geriatrics in some medical schools in Ghana. Training of caregivers for home and institutional care has been undertaken by private institutions in various parts of the country.

In terms of service, the fellowship programme runs a weekly geriatric and memory clinic at the Korle-Bu Teaching Hospital in Accra in collaboration with the Centre for Ageing Studies. Some trainees in the fellowship programme have started running services in their respective hospitals and polyclinics in Accra and other parts of the country. Geriatric services are also available by two geriatricians in the Eastern and Ashanti regions in Ghana. Home and institutional care for the elderly are being provided by the respective emerging industry.

Conclusions and Recommendations

The apparent lack of concern about the older adult in Ghana may be attributed to the small proportion that they constitute of the total national population. However, the rapidly progressing pace of ageing in developing countries may offer Ghana less time to adjust to the consequences of population ageing. It is critical that the Ageing Bill be passed into law in the shortest possible time. A policy on mandatory annual medical checks for older adults under the National Health Insurance Scheme should be considered, as pertains in some jurisdictions.

There are several settings and models of service for both acute and long-term care of older adults in other jurisdictions. Acute care consists mostly of outpatient ambulatory care and inpatient care. Long-term care settings mostly include adult day care homes, skilled nursing facilities, retirement communities, hospice and end of life care and homecare. We recommend two of these models of service for adaptation by lower and middle-income countries (LMICs) like Ghana: The Acute Care for Elderly (ACE) Units and the Program of All-inclusive Care of the Elderly (PACE) Units. The ACE Unit is an inpatient service dedicated to the care of very ill older adult patients. Patient-centred care is delivered by a dedicated multidisciplinary team, to improve the functional status of the older adult and decrease admission to skilled nursing homes (Bodenheimer, 1999; Hayashi et al., 2017). The PACE Unit is a Community-Based Long-Term Care (CBLTC) facility. Long-term care consists of activities undertaken to ensure that people with, or at risk of, a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms, and human dignity. A long-term care facility therefore provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living (WHO, 2017b). The PACE Unit is an Adult Day Care facility that provides ongoing medical care, physical and occupational therapy, and psychosocial support for older adults within a defined community. It may extend homecare services to its clients when necessary. We recommend ACE Units for the regional and teaching

hospitals, and PACE Units for the district hospitals and polyclinics across the country. At the community level, family support systems could be enhanced and incorporated into CBLTC facilities suited for that context. While we anticipate the establishment of the above models, administrative arrangements could be effected in primary care facilities for preferential routine care of older adults visiting health facilities. There could be institution of separate clinical services for older adults in the district hospitals and polyclinics.

Funding is needed to support training and research activities of the geriatric fellowship programme and the Centre for Ageing Studies. Existing curricula for teaching of geriatrics in the medical, nursing, and allied schools should be reviewed and new curricula developed where none exist. Support and regulation are needed for private sector participation in the emerging industry of homecare and skilled nursing homes. Healthcare assistants (HCA) could be retrained and certified for nursing homes and homecare. As part of short-term measures, capacity building workshops for doctors, physician assistants, nurses, physical/occupational therapists, clinical psychologists, social workers, and homecare givers could be organized periodically over the next 2–3 years.

Advocacy, public discourse, and dialogue should be continually engaged with key stakeholders to sustain gains made so far and to advance the course of ageing in security and dignity in Ghana.

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