

Opinion 2

The need for geriatric care services in Ghana

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Abstract

Population ageing is occurring world-wide. However, a country's economic, political and other needs mean that the health-care needs of its elderly citizens may be regarded as "non-urgent." This piece examines the provision of health-care services to elderly Ghanaians and makes suggestions for the development of a system of dedicated health care that is both cost-effective and acceptable to these persons.

Introduction

Developing countries, such as Ghana, are beset with major health issues, such as infectious diseases, diarrhoeal diseases, high maternal and infant mortality, and poor sanitation. Proposals to develop services for the older population in these countries are therefore likely to be met with rebuffs such as "There are more pressing issues needing more urgent attention than spending limited resources on trying to keep frail elderly people alive longer."

It is particularly pertinent as we approach the 21st century, to acknowledge and address the need for improved health-care services for older adults in developing countries. This piece briefly considers the effects of demographic changes on the older population of Ghana, and makes out a case for acting now and not "paying later."

Demographic changes

The rate of population ageing in developing countries is such that the proportion of the population aged 60 years and over will treble from 1980 to 2025. In Ghana, the number of older persons will increase from 548 000 to 1.7 million over this period (Apt, 1997). Similar increases are projected for the rest of the West African sub-region. Average life expectancy in sub-Saharan Africa is also expected to increase. In Ghana, life expectancy at birth is currently 56 years for men and 58 years for women, and is expected to rise to 61 and 63 years, respectively, by 2025 (Apt, 1997).

Although a large increase may be expected in the absolute numbers of older persons in African countries generally, about half of the populations of these countries at present comprise persons aged 15 years and younger. Thus the section of the populations aged 60 years and over will continue to constitute only a relatively small percentage of the total population for some time to come. Currently, which will be even more likely to be the case in the future, only a very small proportion of resources are available for the development of services for elderly citizens.

During the past twenty years in Ghana, the success of the Expanded Programme of Immunization has resulted in a significant reduction in infant mortality. The training programme offered to traditional birth attendants has also contributed to a reduction in maternal mortality. The success of these two programmes has shown that it is possible to achieve good results with limited resources, as long as there is a political will. Ghana's primary health-care programme has achieved some noteworthy goals since the Alma Ata declaration. It is timeous to consider the challenges of the next millennium which require strategies to address demographic transition processes and population ageing.

Migration and urbanization

The processes of migration and urbanization have been assessed as contributing to the destabilization of traditional African values which previously sustained elderly people in closely-knit, age-integrated societies (Vatuk, 1996). The migration of younger people from rural communities to urban areas has left numerous older people behind in rural areas without the social and family support systems which previously existed for them. Migration not only creates a physical distance but also an emotional distance between family members, particularly between the young and the old.

Migration also results in the burden of agriculture being left to the old. Older rural persons whose children have migrated have similar problems as older persons who are childless, or as those whose children are unwilling to provide care or material and financial support for them. Older persons also bear the main burden of infrastructural deficits: they need to carry water and firewood, and to transport household provisions – in the absence of compensating social relationships for undertaking these tasks (cf. Apt & Grieco, 1994).

The effects of migration have not had a purely negative impact on the elderly in Ghana. Each year the Ministry of Finance and Economic Planning points out that a substantial proportion of Ghana's foreign exchange comes from monies sent into Ghana by relatives living abroad. Locally there remains a strong bond between families that ensures that migrant adult children continue to visit their elderly relatives in the rural areas. Issues regarding the elderly often evoke public sympathy, which is a major resource which needs to be exploited to the advantage of older people.

Existing pattern of care

The health-care system in Ghana, as in many developing countries, is of two distinct types. For the majority of rural

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dwellers, a first measure taken by individuals to ameliorate any illness will be self-medication, which usually includes herbal concoctions taken as drinks, pessaries or enemas. If self-medication is not effective, the next port of call will be the local herbalist or a traditional healer. Formal health-care services provided by polyclinics, district general hospitals, regional hospitals and, finally, tertiary regional centres and teaching hospitals are available for the main part but are rarely accessible.

Ghana's primary health-care system provides at its most basic level a health centre which is usually run by a team, led by a medical assistant. A medical assistant is usually a senior public or community health nurse with special training in the diagnosis and treatment of minor ailments. There may also be a midwife and an additional nurse, as well as several health-care assistants. The next level of care is a polyclinic, and so forth. Not even the teaching hospitals have a geriatrician or dedicated geriatric services. Any attempt to provide health-care services to the elderly in most developing countries has to take this lack of infrastructure and resources into account.

Both the medical and the international community of Ghana are rich in experience in providing care to meet the needs of different people. It thus makes good sense to adopt the general principles from established western medical systems and to adapt the principles to meet local needs, whilst promoting appropriate local services.

Regarding local services it is crucial that the informal aspect of health and social care in developing countries be critically assessed and fully integrated into any new models of care which are proposed. For a long time, a myth has prevailed that the extended family in Africa with its structures and patterns of family solidarity renders the problems of ageing in Africa as virtually insignificant. However, with increased ease of travel, migration and urbanization the traditional welfare system, i.e. the extended family, has begun to fragment and disintegrate. Internal and external forces, including television, cinema and the print media, have all altered the social fabric of African societies, especially the family structure, and have contributed to a disintegration of the intergenerational support system which the extended family provided.

The family has been the bedrock of social welfare arrangements. The role that the elderly played in the family ensured that they were valued and revered members of society, rather than a burden on the system. Contemporary policy making and the establishment of any service must recognize this legacy and seek to incorporate it in the development of rural, regional and national welfare programmes for which there is likely to be an increasing need as the population ages.

In traditional Ghanaian society the old were greatly valued for their role in symbolic life – for example, they were central to the performance of social and religious rituals. Historically they had control over critical household assets which preserved their social and economic influence within the context of multi-generational exchanges of the extended household. The control over ancestral property, ancestral lands, marriage and the christening of children enabled older persons to protect their welfare and to continue to make a positive contribution to the society (Apt, 1997).

Local medical problems

The medical problems of the elderly are similar the world over but in Ghana certain specific areas require special attention. A large reliance on self-medication strategies and the informal health sector for the treatment of "minor" ailments by the majority of the population means that often treatable conditions only present at formal health services at an

advanced stage of the disease. In addition, a general acceptance that old age equates ill-health means that elderly people are often reluctant to seek attention for illnesses.

As the population ages and efforts to prevent and control infectious diseases improve, there will be a greater prevalence of chronic diseases, which have hitherto been thought to be uncommon in Ghana. A policy of education and preventive medicine is the way forward. Attention to nutrition, exercise, avoidance of tobacco use and excessive consumption of alcohol, and a general focus on life-style modification will lead to a baseline of a healthier adult and elderly population. Public education, specifically education of informal health-care workers – i.e. herbalists, traditional bone-setters and other traditional healers – is essential. The early recognition of "failed treatment," the identification of what is beyond the scope of a practitioner's practice, and how to access the appropriate channels for seeking medical help require training on the part of these traditional healers. In Ghana the training of traditional practitioners in midwifery has been successful in the case of traditional birth attendants. It is proposed that the same principle may be applied in developing services for the elderly.

Research needs and advocacy

It is important that Africans and people in developing countries generally fund and encourage research in order to evolve a system that can optimize the use of limited local resources. Without appropriate evidence based on research it will continue to be almost impossible to convince the powers-that-be that preserving the independence, integrity and health of older persons is a worthwhile pursuit financially. Research will generate a greater interest in the study of medicine relating to old age. The resource constraints experienced in Africa make it imperative that networks of policy makers and researchers be formed to develop continental policies on ageing (AGES, 1995).

Conclusion

While the establishment of geriatric services in Ghana may not be regarded as a pressing need at present, it is important to make provision for projected demographic and epidemiological transition outcomes. The rich human resource potential in the country needs to be recognized and harnessed, particularly in the context of limited financial resources. While it is important not to "re-invent the wheel," it is equally important that we do not simply try to impose a system which has worked elsewhere, but that we evolve a local and appropriate system which will best serve the health-care needs of our elderly persons.

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