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The Health Condition of Older Women in Ghana: A Case Study of Accra City

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Abstract

In the context of increased rural-urban migration, social exclusion of some of the recent urban arrivals and the sharp change in life style in urban communities, some of the most critical health problems of older people may be found in cities. This paper attempts to characterize the general health condition of older women (50 years and over) in Accra, Ghana's capital city. It employs **s**econdary analysis of data from the Accra Women's Survey, 2004. The findings broadly suggest that an overwhelming majority of older women lack basic education, are not in any form of paid employment, and are widowed, separated or divorced. 3% the women rate their general health condition as excellent, 18% as very good, 41 % as good. 35 % believe there health condition has worsened in the last 12 months. Such perception of deterioration in health status is associated with increasing age. Almost 4 in 5 older women have difficulty climbing stairs and have pains in their joints; 53 % have malaria, 42 % have high blood pressure, and 8% have diabetes. Thus, older women in urban Ghana are experiencing a double burden of disease. They are afflicted with the common tropical diseases such as malaria, while simultaneously experiencing chronic illnesses such as hypertension and diabetes. Older persons' concerns have remained marginal to the major social and economic debates in the country. Health services need to be oriented to responding to chronic as well as infectious diseases among ageing individuals.

Keywords: women and health, Ghana, urban conditions

Introduction and Rationale

The numerical growth of elderly persons around the world is an eloquent testimony not only of reductions in fertility but also of reductions in infant and maternal mortality, improved nutrition, reduction in infectious and parasitic diseases, as well as improvement in health care, education and income. Global total fertility rate has declined from 5.0 live births per woman in 1950-1955 to 2.7 live births per woman in 2000-2005, and is expected to further reduce to replacement level, that is 2.2 live births per woman by 2045-2050 period (United Nations, 2003; 2001). Also life expectancy has increased from 46.5 years in 1950.1955 to 66.0 years in 2000-2005, and is expected to rise to 76 years by the 2045-2050. In sub-Saharan Africa, the corresponding fertility values are 6.7 live births per woman in the early 1950s to 5.5 live births per woman by early 2000s and 2.4 live births per woman by 2045-2050 period. Similarly, expectation of life at birth rose from 36.7 years in the 1950s to 48.4 years by 2000-2005, and is projected to peak at 68.4 years during the 2045-2050 period. Ghana's fertility and mortality profile is similar to that of sub-Saharan Africa. This is because fertility fell from 5.8 to 4.5 live births per woman in one half century, and is expected to fall to replacement level during 2045-2050

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period while life expectancy increased from 38.5 to 40.2 years in five decades, and is expected to reach 65.1 years by 2045-2050 period (United Nations, 2003)[2].

Because the ageing phenomenon is occurring more slowly in Africa than elsewhere in the world and because Africa's populations are characteristically youthful (Population Reference Bureau, 2006; United Nations, 2003) the problems that are manifest among children and young adults are thought to be more significant. As a result, very little attention is paid to ageing in Africa by both the research community and policy makers while disproportionate consideration is given to other aspects of the age spectrum (e.g., infant and childhood, adolescence and childbearing ages).

The African continent is overwhelmingly rural and the least urbanized region of the world (United Nations, 2004). At the same time, one of the major demographic problems in the region is the rapid rate of urbanization and the inability of the urban place to play a sufficiently dynamic role in the process of development[3]. The few studies conducted on the health and morbidity of the older population in Africa have largely been restricted to rural areas. This rural bias is understandable because of three main reasons: first, majority of Africa' populations (61 percent) live in rural areas (United Nations, 2004); secondly rural populations in Africa suffer from poorer health than their urban counterparts (World Health Organization, 2004a); and thirdly the rural areas furnish a relatively more stable population for follow-up studies particularly in case of longitudinal investigations (Mba, 2005; 2004a).

However, some of the most critical health problems may be found in cities and not in rural areas both because of the increase of migration to cities, social exclusion of some of the recent arrivals in the cities and because of the sharp change in life style in urban communities. The extended family can no longer offer broad support in the way that is possible in villages with large compounds and many co-resident relatives.

The growing elderly population across Africa coupled with limited knowledge about family structure and functioning among African countries makes this study especially important and timely. Consequently, the present research examines differences in the overall health condition among elderly population of with a view to contributing to knowledge and further raising awareness about the plight of the older population in Ghana and other parts of Africa.

Methodology

Data Source and Procedure

The present paper examines the general health condition of urban women in Accra of Ghana. The data for this study are part of a comprehensive community-based study of women's health designed to identify the magnitude of the burden of non-communicable and communicable diseases among urban women in Accra, Ghana. The cross-sectional study covered a representative sample of 3,200 women aged 18 years and over usually resident (for at least 12 months preceding the survey) in Accra in 2004. The protocol comprised a household roster, an individual interview with eligible women on

[2] Additionally, the latest nationally representative sample survey findings indicate that total fertility rate fell from 6.4 live births per woman in 1988 to 4.4 live births per woman in 2003 (Ghana Statistical Service, Noguchi Memorial Institute for Medical Research and Macro International Inc., 2004).

[3] The proportion urban has consistently risen from 15 percent in 1950 to 39 percent in 2003 and is projected to peak at 54 percent by 2030 (United Nations, 2004).

self-reported health status, a comprehensive medical history, and a full physical examination with blood tests and laboratory evaluations. The survey was one of the first major community-based studies of women's health in an African city. The broad goal is to treat the baseline data as the starting point for a longitudinal cohort study to assess differentials and changes in the health of the urban women over time.

An initial interview was conducted at home to obtain basic personal, demographic and socio-economic information on the household. Once the eligible woman in each sample household was identified, an interview with the selected woman followed. This included a full history of marriages and pregnancies, and detailed information about self reported general health and selected specific conditions. Women were then invited to attend a nearby public clinic or hospital. There, a nurse conducted a comprehensive medical history and a qualified medical doctor conducted performance tests (vision, hearing, and mobility), as well as a full physical examination of the women.

Study Area and Population

The study was conducted in Ghana's administrative and commercial capital city, Accra, in Greater Accra Region, which is one of the ten administrative regions of the country. The area chosen for the study is the administrative unit known as Accra Metropolitan Area. The responsibility for the health, welfare and governance of this population rests with the Accra Metropolitan Assembly. According to Ghana's 2000 Population and Housing Census (Ghana Statistical Service, 2002), the metropolitan area contains about 1.7 million people and 366,000 households. The area extends from some 11 kilometres north of the University of Ghana at Legon to the coast and some 20 kilometres from Teshie and La on the east to Korle Bu and Dansoman on the west. It excludes the satellite centres of Madina and Adenta in the north, Ashiaman and Tema in the east, and Dome and Gbawe in the northwest and west, respectively.

There is clearly considerable socio-economic and cultural diversity within the Accra Metropolitan population to draw out some differentials in health status and associated exposure variables and risk factors. The 2000 census data for Accra metropolis shows that mean household size ranges from 3.9 to 5.1 persons. A cursory inspection of the housing figures reveals major contrasts between the high-income areas such as Airport Residential and East Legon, the crowded informal settlements of Nima, Mamobi, James Town and Ussher Town.

Analytical Methods

Both because of the nature of the study and the small sample size, rigorous statistical techniques could not be applied to the data. Nevertheless, simple cross tabulations and proportions are used to ascertain levels and patterns, as well as elucidate differentials with respect to key background characteristics and indicators of the general health condition of the older women in urban Ghana.

Conventionally, older persons or the aged or elderly people refer to individuals who are aged 60 years and above (United Nations, 2001; Mba, 2005; 2004a; 2004b; Mbamaonyeukwu, 2001; Apt, 1996). However, in this study, women aged 50-59 years have been included for two main reasons. First, the age group 50-59 years is the age group closest to the elderly age group of 60+ years and therefore persons in that age

group are the most prospective elderly persons[4]. Including them in the analysis will help throw some light on observed levels, patterns and differentials of the characteristics of the elderly population as they will serve as a control group. Secondly, because the survey from where the empirical information for this study is generated was not focused on only elderly women but women aged 18 years and over, limiting the investigation to women aged 60+ years only will result in a sample size that is too small to warrant meaningful analysis.

Results

The background characteristics of the respondents are presented in Table 1. The results of the analysis indicate that there are consistently more women at younger than older ages. Over 50 percent of the women are aged 50-59 years, while 26 percent of them are aged 60-69 years, 14 percent aged 70-79 years, and 8 percent aged 80 years and over.

Close to 50 percent of the women have no education, while only 11 percent have secondary or higher education. It should be noted that education affects with whom one interacts and what kind of information one receives on various issues, some of which border on health, ageing and household relationships.

Overwhelming majority of the women are self-employed (45 percent), generally engaging in petty trading, buying and selling of food products and foodstuffs since the table further shows that the occupation of 37 percent of the women is trading. It is striking that 38 percent of the women are not working. Because a substantial proportion of them did not go to school, it is implausible to assume that they are pensioners; in fact, the table suggests that only 5 percent of the women are retirees. Also, only 4 percent of them are housewives. The implication of this is that a significant proportion of the women are dependent on others for support and care. Unfortunately, no information on living arrangements or means of economic and financial assistance was collected during the survey. Therefore, it is not possible to state with pinpoint accuracy how these women survive. Although the extended family is still seen as the principal source of support for the elderly in the African traditional system, the influence of modernization and urbanization is seriously threatening this support system (Mba 2004a; Mbamaonyeukwu, 2001; Apt, 1996; Berquo and Xenos, 1992). With rapid socioeconomic development,

[4] This sentiment is further inspired by the World Health Organization's current work on *Developing Integrated Health Care Systems Response to Rapid Population Ageing in Developing Countries* (World Health Organization, 2004b).

Table 1: Distribution of Respondents by Background Characteristics, Accra, Ghana, 2004.

Background Characteristics	Number	Percentage
Age		
50-54	179	34.4
55-59	91	17.5
60-64	81	15.6
65-69	55	10.6
70-74	47	9.0
75-79	28	5.4
80+	39	7.5
Education		
No Education	231	44.4
Primary	55	10.5
Middle/JSS	169	32.6
Secondary	35	6.7
Higher	23	4.5
Employment Status		
Government Employee	19	3.7
Non-government Employee	20	3.9
Self-employed	234	45.1
Housewife	18	3.6
Retired	24	4.7
Not Working	132	38.1
Occupation		
Seamstress or Hairdresser	46	8.8
Trader	192	37.0
Professional	18	3.4
Housework or Childcare	20	3.9
Low Skilled Labour or Office Work	17	3.2
Artist/Artisan	2	0.4
No occupation/Not stated	294	43.3
Marital Status		
Never Married	10	1.9
Married/Living together	161	31.1
Separated/Widowed/Divorced	313	60.3
Ever Married, current status unknown	28	5.5
Religion		
Christianity	423	81.4
Islam	63	12.2
Traditional	3	0.6
Other Religion	13	2.6
No Religion	15	2.9
Ethnicity		
Akan	26	5.0
Ga	28	5.5
Ewe	49	9.4
Others	389	75.3
Total	519	100.0

Source: Women's Health in Accra Study, Ghana, 2004.
Note: Total may not add up to 519 (and 100 percent) because of missing cases.

urbanization and industrialization, the traditional extended family system is gradually changing towards a nuclear family system in which some elderly family members are being left on their own. In particular, because of increasing nuclearization of the family and high costs of living, urban conditions are not conducive to the practice of extended family system.

On one hand, the findings support the contention from other studies (Ghana Statistical Service, Noguchi Memorial Institute for Medical Research and Macro International Inc., 2004; Mba, 2002) that marriage is universal in Ghana as only 2 percent of the women are never married. On the other hand, it is striking that about three out of every five women are divorced/separated/widowed. Mortality is generally high in most developing countries and usually occurs earlier for men than for women. Thus a substantial number of Ghanaian elderly women are widows. Furthermore, it is common knowledge that the marital status of elderly persons strongly affects their living arrangements, support systems and individual well-being. Intact husband-wife families constitute a multiple support system for spouses in terms of emotional, financial and social exchanges. Research elsewhere has shown that married elderly persons tend to enjoy higher levels of survival, mental health, use of the health services, social participation and life satisfaction than their counterparts who are not married (Angel and Angel, 1997; Olson, 1994; Bond and Coleman, 1990).

More than 80 percent of the respondents are adherents of the Christian faith. Although Akan, Ewe, and Ga-Dangbe are the three major ethnic groups in the country, 75 percent of the Accra women belong to other ethnic groups. This supports the argument that Accra metropolis enjoys considerable socio-cultural diversity. As the nation's capital city, people from all walks of life flock to it in search of better opportunities for employment, education, healthcare, *et cetera.*

Table 2 presents the percentage distribution of the overall health condition of the respondents as reported by them. The general health condition of the younger women (50-59 years) is better than the older age groups. While 7 percents of women aged 50-59 years believe that their overall health condition is excellent, 6 percent of those aged 60 – 69 years and 0 percent of those aged 70+ do. Similarly, while 44 percent of women aged 50-59 years view their general health condition to be very good, the corresponding values for the women aged 60-69 years, 70-79 years, and 80+ years are respectively 33 percent, 28 percent and 10 percent.

On the other, perceived poor overall health condition generally increases with advancing age, rising from 2 percent of women aged 50-54 to 4 percent of women aged 65-69 years, and then to 8 percent of those aged 80+ years. The results support the argument that ill health and frailties are a function of age.

Women were asked during the survey to assess their current health condition in relation to 12 months before the survey. Their responses are shown in Table 3. As should be expected, the highest proportion of respondents whose perceived health condition compared to one year ago is much better, 11 percent, are aged 50-54 years, while the least proportion, 0 percent, are aged 80+ years. Older women are more likely than their younger counterparts to have their health condition compared to one year ago somewhat worse and much worse. In general, only 7 percent of the total respondents see

Table 2: Percentage Distribution of Perceived Overall Health Condition of the Women, Accra, Ghana, 2004.

Age Group	Perceived Overall Health Condition					Total	Number
	Excellent	Very Good	Good	Fair	Poor		
50-54	4.5	19.8	48.0	25.4	2.3	100.0	177
55-59	2.2	24.4	44.4	26.7	2.2	100.0	90
60-64	3.7	18.5	40.7	34.6	2.5	100.0	81
65-69	1.9	14.8	33.3	46.3	3.7	100.0	54
70-74	0.0	13.3	33.3	42.2	11.1	100.0	45
75-79	0.0	14.8	29.6	51.9	3.7	100.0	27
80+	0.0	10.3	33.3	48.7	7.7	100.0	39
Total	2.7	18.3	41.3	33.9	3.7	100.0	513

Source: Women's Health in Accra Study, Ghana, 2004.

Table 3: Percentage Distribution of Perceived Health Compared to One Year Ago, Accra, Ghana, 2004.

Age Group	Perceived Health Compared to One Year Ago					Total	Number
	Much Better	Somewhat Better	About the Same	Somewhat Worse	Much Worse		
50-54	11.2	15.7	38.8	33.1	1.1	100.0	178
55-59	5.5	19.8	44.0	26.4	4.4	100.0	91
60-64	5.0	15.0	45.0	32.5	2.5	100.0	80
65-69	5.7	15.1	35.8	37.7	5.7	100.0	53
70-74	6.3	8.3	31.3	45.8	8.3	100.0	48
75-79	3.4	6.9	34.5	51.7	3.4	100.0	29
80+	0.0	10.5	34.2	39.5	15.8	100.0	38
Total	7.0	14.7	39.1	35.0	4.3	100.0	517

Source: Women's Health in Accra Study, Ghana, 2004.

their health much better than the year before, while as much as 35 percent of the women think that their health condition has somewhat worsened compared to the situation 12 months ago. This perception is reinforced by the findings presented in Table 4, which indicates that a substantial proportion of the women experience difficulties in climbing

Table 4: Percentage Distribution of Limits to Climbing a Flight, Typical Day, Accra, Ghana, 2004.

Age Group	Limits			Total	Number
	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all		
50-54	28.7	44.9	26.4	100.0	178
55-59	27.5	40.7	31.9	100.0	91
60-64	41.2	38.8	20.0	100.0	80
65-69	47.3	36.4	16.4	100.0	55
70-74	60.9	26.1	13.0	100.0	46
75-79	78.6	17.9	3.6	100.0	28
80+	84.2	13.2	2.6	100.0	38
Total	42.1	36.8	21.1	100.0	516

Source: Women's Health in Accra Study, Ghana, 2004.

Table 5: Percentage Distribution of Respondents Who Have Pains in Body (30 Days), Accra, Ghana, 2004.

Type of Pain	Responses			Total	Number
	Yes	No	Missing		
Pain in Joints	72.1	27.6	0.3	100.0	519
Pain in Back	49.0	50.8	0.2	100.0	519
Pain in Head	52.4	47.4	0.2	100.0	519
Pain in Stomach	24.0	75.8	0.2	100.0	519
Pain in Chest	23.9	75.2	0.9	100.0	519
Other Pain	11.4	61.8	26.8	100.0	519
Total	47.3	46.8	5.9	100.0	519

Source: Women's Health in Accra Study, Ghana, 2004.
Note: Other Pain includes waist, neck, eyes, toe, knee, thigh, shoulder blade, and muscle pains plus general malaise.

(ranging from 29 percent for those aged 50-54 years to 47 percent for those aged 65-69 years, and to 84 percent for those aged 80+ years).

Taken together, close to 4 out of every 5 women in Accra have limitations of one kind or another with respect to climbing flights. Even the few women who do not have climbing limitations are much more concentrated in the younger age groups.

Table 5 shows the distribution of respondents who have pains in their body by type of pain in 30 days preceding the survey. The most prominent type of pain is pain in joints (72 percent), followed by headache (52 percent), back pain (49 percent), and stomach pain and chest pain (24 percent each). In general, about 47 percent of the women have one form of pain or the other.

The percentage distribution of respondents diagnosed with non-communicable diseases by type of disease is presented in Table 6. The most prevalent diseases among the older women are malaria (53 percent), high blood pressure (42 percent), arthritis or joint pain (23 percent), diabetes (8 percent), and asthma (7 percent).

Table 7 shows the main source of care of the older women. Overwhelming majority of them patronize Clinic or Health Centre (67 percent), followed by Hospital Outpatient Department (20 percent), while 4 percent of them go to a chemical shop, and 3 percent employ the services of pharmacists.

Table 6: Percentage Distribution of Respondents Diagnosed with Non-communicable Diseases, Accra, Ghana, 2004.

Disease Diagnosis	Responses			Total	Number
	Yes	No	Don't Know		
High Blood Pressure	42.1	56.4	1.5	100.0	519
Diabetes	7.9	90.4	1.7	100.0	519
Heart Attack or Shock	1.7	97.0	1.3	100.0	519
Stroke	3.3	96.5	0.2	100.0	519
Chronic Lung Condition	1.0	98.5	0.5	100.0	519
Asthma	6.5	93.3	0.2	100.0	519
Depression or Anxiety	1.6	98.2	0.2	100.0	519
Cancer	0.5	97.6	1.9	100.0	519
Malaria	53.2	46.6	0.2	100.0	519
Obesity	5.3	94.2	0.5	100.0	519
Urinary Incontinence	1.7	98.0	0.3	100.0	519
Broken Bone	2.9	96.9	0.2	100.0	519
Arthritis or Joint Pain	23.1	76.7	0.2	100.0	519
Schizophrenia	1.1	98.8	0.1	100.0	519
Epilepsy, Seizure or Fit	0.0	99.8	0.2	100.0	519
Cataract	2.2	86.7	11.1	100.0	519
Total	47.3	46.8	5.9	100.0	519

Source: Women's Health in Accra Study, Ghana, 2004.

Table 7: Distribution of Type of Usual Source of Care of Respondents, Accra, Ghana, 2004.

Type of Usual Source of Care	Number	Percent
Clinic or Health Centre	349	67.4
Hospital Emergency Room	2	0.5
Hospital Outpatient Department	102	19.6
Maternity Home	0	0.1
Pharmacist	14	2.6
Chemical Shop	19	3.7
Self Medication	6	1.1
Church	1	0.2
Spiritualist	2	0.5
Some Other Place	3	0.6
Missing	20	3.8
Total	519	46.8

Source: Women's Health in Accra Study, Ghana, 2004.

Discussion

The paper has attempted to characterize the general health condition of older women in urban Ghana, with particular reference to the elderly women aged 50 years and over in Accra, Ghana's capital city. The findings broadly suggest that an overwhelming majority of them lack basic education, not in any form of paid employment, and are widowed/separated/divorced. A little over 60 percent of the women think that their general health condition is okay while 35 percent of them believe there health condition has worsened in the last 12 months. Worsening health condition increases with age, while almost 4 out of every 5 older women have climbing limitations and have paints in their joints. Also, 53 percent of the women have malaria and 42 percent have high blood pressure. It is apparent that older women in urban Ghana are assuming a double burden of disease. They are afflicted with the usual tropical diseases such as malaria and other vector-borne illnesses, and they are now experiencing chronic illnesses such as hypertension and diabetes.

Empirical evidence from the Ghana Statistical Service (2002) suggests that Ghana's ageing population has more than tripled in about 30 years (1984-2000). Unfortunately, this has occurred without a corresponding social care for the aged (Mba, 2004b). In spite of the demographic shift, older persons' concerns have remained marginal to the major social and economic debates in the country. As a result, many older people, particularly women, are faced with inadequate healthcare, poor shelter, isolation and inadequate and insecure income. Therefore, while attention is largely focused on other aspects of the age spectrum particularly children below 15 years of age due to the youthful structure of Ghana's population, the elderly especially females must not be forgotten in the scheme of things. Concrete steps should be taken by the government and other stakeholders to address the healthcare and other needs of older persons in the country.

Furthermore, the women tend to experience reduced social status on losing a husband. Thus, older women are more likely to be economically dependent on their

families than men, having had less access to income-generating opportunities and assets, and lower wages. Worse still, the older women may find themselves rejected by family and community once they are unable to earn an income, as they are seen as unproductive and their care-giving or other support roles may not be recognized. Consequently, it is feared that great loss of status and respect may be associated with retirement from productive work due to ageing or poor health. These vulnerable members of the family must be supported in old age through a number of interventions including building of more nursing homes and financial assistance to families with elderly persons who have no visible means of livelihood.

It should be stated that an important characteristic of the traditional Ghanaian family system is the respect and honor accorded the elderly members[5]. The elderly persons are regarded as the bastion and repository of wisdom and, as a result, occupy a high and enviable position in the family. Consequently, they are supported with food, shelter, financial and physical care within the context of the extended family network. In this respect, the extended family system has served as a viable alternative to the social security system in the traditional African context. The extended family is currently at the receiving end of unbridled and consistent social and economic changes that weaken its strength and threaten its continued existence particularly in urban areas. Modernization is impacting adversely on the traditional African system.

The modernization theory of aging is predicated on the effects of technological advancement, industrialization, and the spread of modern education (see, for example, Berquo and Xenos, 1992; Treas and Logue, 1986; Cowgill, 1986; Goode, 1963). This is because the development of health technology raises longevity, which in turn results in prolonged retirement of the older population that is often accompanied by a noticeable loss of income and social prestige. Also, industrialization requires a separation of work from home and a highly mobile work force, which weakens familial ties to a particular geographical location. Similarly, modern education leads to changes in values and intellectual development across generations as younger people place greater emphasis on self-fulfillment as individuals rather than on their responsibilities toward their relatives. It can therefore be argued that modernization renders living in extended family households less essential and economically less viable and therefore facilitates the transition to conjugal or nuclear family living arrangements. As Ghana respondents to the changing social and economic environment, it is important to address the needs of the older family members who have been left to fend for themselves.

Formal education is critical to the attainment of economic security in old age as societies respond to the modernization process. The results of the analysis suggest that only a handful of the older women attended formal schooling[6]. Since an overwhelming majority of the elderly women did not acquire formal education, the government should encourage girls especially (and boys) to pursue higher education for their own good and that of the society.

[5] The younger members of the family see themselves as subordinate to the older ones and this is reflected in the speech patterns, manners and behavior.

[6] The 2000 Census of Ghana further presents a dismal picture of educational attainment in the country as 43 percent of the population do not have any formal education (many of whom live in rural areas) and only 7 percent have post-secondary education (Ghana Statistical Service, 2002).

It is gratifying to note that successive governments of Ghana have shown some concern for the aged. For instance, July 1, Ghana's Republic Day has also been declared as Senior Citizens Day, which is one way of responding positively to the concerns of the elderly and a clear indication of national commitment to the well-being of the aged. Similarly, the revised national population policy stipulates, *inter alia,* that "deliberate measures shall be taken to alleviate the special problems of the aged and persons with disabilities with regard to low incomes and unemployment" (Republic of Ghana, 1994: 39). Also, the government of Ghana has put in place a new National Health Insurance Scheme (NHIS) under which some exemption benefits for the aged that will take into account their vulnerability and special circumstances will be made provided (*Daily Graphic,* 2003). The scheme is expected to go a long way toward defraying the medical bills of the elderly sick. In the same vein, efforts to address issues impacting negatively on older people through a National Ageing Policy are underway[i]. However, efforts should be made to attain this objective at the shortest possible time to alleviate the sufferings of the aged. Not all elderly persons have access to health services, especially in the rural areas. Currently, the cash-and-carry system (a user-fee scheme that entails full cost recovery for medical attention) affects all population subgroups. As a result of the economic situation in the country and its concomitant low standard of living and poor quality of life, the average rural elderly person finds it increasingly difficult to pay hospital bills. It goes without saying that ill-health slows down agricultural activities. The ageing process exposes individuals to increasing risk of illness and disability. As Ghana is a poor country, lifetime exposure to health problems means that many Ghanaians may enter old age already in chronic ill-health. Personal health consistently ranks alongside material security as a priority concern for the aged. Indeed, physical health is for many urban elderly persons their single most important asset, bound up with their ability to work in their petty trading, to function independently and to maintain a reasonable standard of living. Illness in old age is therefore an ever-present threat. Moreover, the cut-off point for the qualification under the proposed NHIS scheme for the aged should be reviewed to cover the elderly persons aged 60 years and over since that is the official retirement age in the country.

The government further supports various non-governmental organizations working for the aged. These organizations, which include HelpAge Ghana and Christian Action on Ageing in Africa have been very instrumental in bringing to the fore the problems that confront the aged in our society, and helping to create national awareness about the responsibility of the young toward the welfare of the elderly. But these organizations are few and operate very few old-age institutions (old people's homes). Thus, more old-age organizations which provide support and assistance to the elderly should be encouraged in the country. This is important because increasing frailty which is associated with advancing age especially among females may contribute to abandonment and domestic violence against the elderly. The health and psychosocial implications of such conditions are obvious.

The findings of this study should be accepted against the backdrop of the study's limitations. The sample size is indeed small and therefore may not be a valid reflection of the overall health condition of the Accra women in Ghana. Also, women generally are reluctant to report conditions that are seen to be shameful and private. Furthermore, there is no empirical information bordering on the living arrangements or household structure

of the women although it is well known that the extended family cannot furnish broad support in urban areas in the way that is possible in villages with large compounds and many co-resident relatives.

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[i]The draft National Ageing Policy was submitted to the Cabinet in March 2003; it is yet to be considered by the Parliament.