KWAME NKRUMAH UNIVERSITY OF SCIENCE

AND TECHNOLOGY

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

MSc IN HEALTH SERVICE PLANNING AND MANAGEMENT

THE HEALTH OF THE ELDERLY AT KPESHIE SUB-METRO, ACCRA

A DISSERTATION TO COMMUNITY HEALTH DEPARTMENT SUBMITTED TO THE KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF A MASTER OF SCIENCE IN HEALTH SERVICE PLANNING AND MANAGEMENT.

CYNTHIA CHARITY OBBU

FEBRUARY, 2004

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CERTIFICATION

The undersigned do hereby certify that this work has been read and recommend to the department of Community Health for the acceptance of this entitled, The Health of the Elderly at Kpeshie Sub-Metro, Accra, presented by Cynthia Charity Obbu in partial fulfilment of the requirements for the award of a Master of Science in Health Service Planning and Management.

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Cynthia Charity Obbu

(Student) Date

DECLARATION

This work has been the result of the field research I undertook, except for references to other people's work, which have been duly acknowledged. It has not been submitted for any degree, nor has it been concurrently in candidature for any other degree. I hold the responsibility for the views expressed and the factual accuracy of the contents.

Signed.....

Cynthia Charity Obbu (Miss)

DEDICATION

This work is dedicated to Professor (Mrs) Ernestine Akosua Addy and my son Jonathan Atuahene Ofori.

AKNOWLEDGEMENT

To God be the glory, for the great things He has done. Amen

I am most grateful to Prof. (Mrs) Ernestine Akosua Addy, under whose supervision this research was carried out. Her criticisms and suggestions made this work a success. My sincere thanks also go to Dr Felicia Plange-Brew, Medical superintendent of La Polyclinic as well as the Sub-Metro Director of Health Services and Mr Raphael Mensah, a research fellow and staff of Community Health Department, Korle Bu, for their inspiration and corrections.

I am indebted to Mr Kwasi Osei Ofori for his enormous support in bringing this work this far. I also wish to express my sincere thanks to Lecturers of the Community Health Department of KNUST and my colleagues for being there for me when the going got tough.

Finally, I am eternally grateful to my parents and siblings for their prayers, support and encouragement throughout the course.

DEFINITION OF TERM

HEALTH: WHO in 1948 defined Health as 'a state of complete physical, mental and social well-being and not only the absence of disease or infirmity'.

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ABSTRACT

This study was undertaken to assess the health status of the elderly in the Kpeshie Sub-Metro of the Greater Accra Region.

The study was a descriptive one. The sample was made up of one hundred elderly, fifty caretakers and five Key Informants. There was however one Key Informant from Accra Metro Health Directorate. The questionnaire was designed using close and open -ended questions, using mostly face-to-face interview. The respondents were selected using both convenience and purposive sampling methods. Data was analysed and presented using percentages, pie and bar charts. The data that were not easy to quantify were described.

Findings revealed that majority of the elderly (60%) and their caretakers (84%) have some form of knowledge in nutrition with some of the elderly (32%) explaining it to be "foods which when eaten in their right quantities will make them healthy". 74% of the elderly agreed that knowledge in nutrition can go a long way in helping the aged to lead a normal life once again.

The study also revealed that majority of the elderly is not affected by food accessibility (geographical). 74% explained that the food they took when they were children happened to still be their favourite foods after attaining 60 years and over because it was their delicacy,

thus, giving them satisfaction (38%). Even-though, they appreciate their delicacy, 49% complained of difficulty in eating (dental decay or tooth removal), which was taken into consideration during food preparation (61%). It was confirmed when four options were questioned and chewing (36%) happened to be the worst problem experienced.

The findings on their health seeking behaviour showed that 66% use the government health facility mostly because of financial difficulties. As to the drugs prescribed, 35% said they wait and go back to the doctor after 2-3 days for the necessary help. 86% also stated that they regularly take their medications, which was confirmed, by 88% of caretakers who stated the same thing. Hypertension was the most rated chronic disease (45%).

The research also revealed that majority (46%) lived with family members who happened to meet their food needs (39%). Almost half of the caretakers (50%) explained that they took the elderly for sightseeing and / or when the need arises.

Findings revealed that policies and programs outlined by those involved in this area were:

- Working out new modalities to enhance the smooth implementation of the exemption policy.

- To initiate education for both the elderly and their families towards retirement
- To approve the introduction of the health insurance scheme.
- The sector Ministries (MOH and Min. of Manpower Development and Employment) advocacy for lands to construct various recreational parks for the aged throughout the country.

From the above findings, the researcher concluded that the managing of the health of the elderly was on the average. The researcher therefore recommended that national health programs on ageing in order to educate the general public in the future as well as conduct more scientific research on the development of sound policies for the aged.

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

"Elderly citizens play an important part in modern society due to their rich experience and as such, we are to try and keep them fit. There is an old person in every third house in any town and it must be the prime aim of all of us especially those in the health sector to endeavour to keep older people healthy in their homes. (Anderson 1976)"

Globally, adults are now surviving longer largely because during the past half – century, when they were children, epidemics of infectious diseases such as Tuberculosis and respiratory diseases have been controlled. The continuing gains in the survival of infants and young children means that the adult population is increasing. Currently, just over half the population is of working age that is, 20 – 64: by 2025, the population will have reached 58%. The population of older people requiring support from adults of working age has increased from 10.5% in 1955 to 12.3% in 1995 and is expected to increase to 17.2% by 2025. The health of the adult population will be virtually important if the working age group is to support growing numbers of dependants, both young and old (WHO 1998).

It is reported that, by 2025, there will be more than 800 million people over the age of 60 in China alone -------- more than the total present population of the United States. Increases of up to 300% of the older population are expected in many developing countries, especially in Latin America and Asia, within the next 30 years (WHO 1998).

A statistical survey done in 1994 in Japan indicated that Japan has the world's highest rate of ageing with people over 65 years of age constituting about 14% of their population. In addition their average life expectancy in 1991 was the highest in the world reaching 76.1 years for men and 82.1 years for women. This increased population of the aged in the developed countries owes little to curative medical treatment. It has mainly been due to two factors --------- the decline in the birth rate, which is partly good and partly bad, and the steep decline in infant and childhood mortality, which is entirely good and which means that once you are born, you are very likely to enjoy a reasonable duration of life.

According to International Population report (1993), although the change in percent elderly in Sub-Saharan Africa from 1990 to 2010 is barely perceptible, the size of the elderly population is expected to double from 14.6 million to 28.9 million persons. Furthermore expectations of life at birth in most African countries are around 55 – 56 years. Yet, as recently as 1990, the average individual was fortunate to survive to an age of 50 (Banga 1996).

In Ghana, the elderly, from 65 years of age and above, form about 3.7% of the total population and this has been increasing by 3.35% per-annum (Ahenkora et al, 1999). Life expectancy, which is 56.2% in males and 59.9% in females, is still below the average of 65 years for all developing countries (Ahenkora et al, 1999).

In most of the wealthy countries, most of the old and frail people cannot meet more than a small fraction of the costs for the health care they need let alone what they need to take care of their feeding and social expenses. In the coming decades, few countries will be able to provide specialised care for their large population of the ageing individuals. Some European countries already acknowledge the fact that there is insufficient provision of resources to meet with dignity the needs of all those over the age of 75, who currently consume many times more medical and social service, than those under 75 (WHO 1998). Developing countries, such as Ghana, will therefore be facing even more serious challenges, given the economic difficulties and the rapidity with which the population age, the lack of social service infrastructure as well as the decline of the traditional caring provided by family members which is increasing due to the gradual breakdown of the extended family system.

1.2 STATEMENT OF THE PROBLEM

Improving the total quality of life, rather than simply extending the duration of life is now assuming an increasing priority as a health promotion objective. One of the major goals in "Healthy People2000" in the United States of America (DHHS, 1992) was to increase the span of healthy life of Americans. The emphasis is gradually shifting from extending the duration of life to reducing the impact of morbidity and disability in the latter years of life and thus "maintaining physical, emotional and intellectual vigour until shortly before death (Katz et al, 1983).

Currently, this goal set by the United States of America, which had certain traces of it in Africa, particularly in Ghana, is yet to be achieved. This is because most policies and programs outlined by the central government to ensure a total quality of life have a lot of shortfalls (ineffective exemption policy, delay in SSNIT pension schemes, etc.). Also family members, whose responsibility was to see to the various needs of the elderly, sometimes overlook these needs and neglect them. All these factors have led to the continued suffering of the aged mainly because of lack of information on ageing and health of aged. The reason for this lack of information is due to the fact that problems of the aged in Ghana have not received much research attention as the other socio-economic issues of the day.

There is therefore the need for all stakeholders to provide a comprehensive care for the elderly, hence the need for this research.

1.3 RATIONALE OF THE STUDY

The study will provide procedures to solving managerial problems as well as know how best to use these procedures to increase their mode of operations to help improve the total quality of life for the elderly. The study will also provide data on ageing and health of aged for planning health services and health promotion activities for aged. It will also serve as a baseline future work.

1.4 RESEARCH QUESTIONS

1. What is the level of nutrition education required by the elderly?
2. How much food is available to the elderly in their locality?
3. How accessible are health facilities to them?
4. What type of health facility do they access as well as their level of accessibility?
5. How often do they take their prescribed drugs?
6. What social support services are available to them?
7. What is the relationship between them and their relations?
8. What are the organizations involved in activities concerning th elderly doing to improve the health status of the elderly?

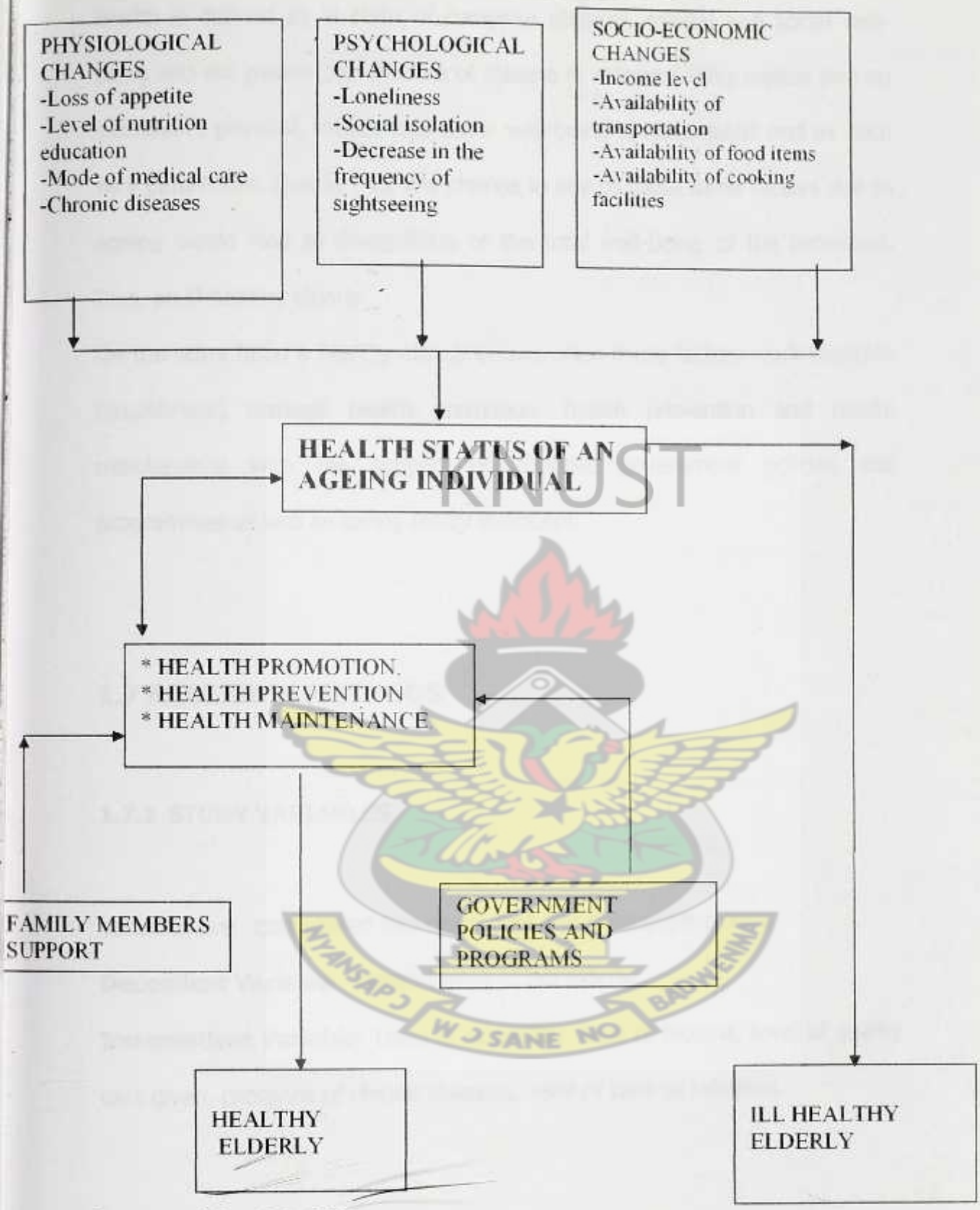
1.5 MAIN OBJECTIVE

To assess the health status of the elderly in the Kpeshie sub – metro of the Greater Accra Region.

1.5.1 **SPECIFIC OBJECTIVES:** To determine

1. The level of nutrition education of the elderly.
2. The food ingredients accessible as well as eating patterns.
3. The quality of care.
4. The attitude of the elderly towards medication.
5. Recreational facilities available to them.
6. The policies and programs outlined by appropriate organisations working in this area.
7. To make recommendations to appropriate organisations.

FIG 1.6 CONCEPTUAL FRAMEWORK



Source: Obbu, C.C, 2002

Health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This means that an individual's physical, mental and social well-being is interrelated and as such very paramount. Due to this, any change in any of these three factors due to ageing would lead to disequilibria of the total well-being of the individual, thus, an ill-healthy elderly.

On the other hand a healthy elderly occurs when these factors work together (equilibrium) through health promotion, health prevention and health maintenance with the support of effective government policies and programmes as well as caring family members.

1.7 RESEARCH METHODS

1.7.1 STUDY VARIABLES

Variables are categorised into dependent and independent ones.

Dependent Variable: Health Status of the elderly.

Independent Variable: Level of education, level of income, level of quality care given, presence of chronic diseases, level of care by relations.

VARIABLE	OPERATIONAL DEFINITION	SCALE OF MEASUREMENT
1. Health Status	Physiological, psychological and social well-being of the elderly	V. good = Physio, Psycho and social> 70%. Good = Physio, Psycho and social> 60-70%. Satisfactory = Physio, Psycho and social> 50-60%. Not Satisfactory = Physio, Psycho and social> 40-50%. Poor = Physio, Psycho and social < 40%.
2.Level of education	Educational level should be up to MSLC or JSS level or above.	V. good = Tertiary level Good = Secondary level Satisfactory = Middle level Not Satisfactory = Primary level Poor = No education

3. Level of income	Income level after retirement should be between ₵250,000 – ₵400,000 or more per month.	V. good =₵ 500,000.00 or above Good = Less than ₵500,000.00 Satisfactory = Equal to₵ 200,000.00 Not Satisfactory = Less than ¢200,000.00 Poor = Less than ₵100,000.00
4. Access to facility	Should not take more than one (1) hour to gets to the facility for services. Should be 30 – 40 minutes after visiting the last department, probably the dispensary. Presence of less than three drugs needed by the elderly.	Continuous in seconds or minute or hour Continuous in seconds or minutes Continuous in seconds or minutes Discrete (one or two drugs)
5. Chronic disease	Disease associated with ageing.	Discrete {one or two disease(s) present}
6. Level of care by	Should have at least one	Discrete (one or two persons)

relations	person staying with him or her. Should go for sightseeing at least twice a month.	V.good = 4x per month Good = 3x per month Satisfactory = 2x per month Not Satisfactory = when the need arises. Poor = once per month
7. Eating pattern	Should have at least one person to cater for food needs.	Discrete (one or two persons)
	Should be able to move about 10m away from the home to shop or purchase food items.	Continuous
	Should be able to eat at least two portions a day.	Discrete / Continuous

1.7.2 **STUDY TYPE**

The study was descriptive cross-sectional type involving both qualitative and quantitative approaches that focused on the issues pertaining to the health status of the elderly in the Kpeshie Sub – metro of the Greater Accra Region.

1.7.3.1 DATA

The study began with a review of literature to gain access to information from secondary data. The primary data was collected using both the interview and questionnaire administration techniques. A structured questionnaire with both close and open-ended questions was administered. Interview guide was used to interview Key Personnel from various government and non – governmental departments to retrieve information as to how resources from their outfit are channelled to the well being of the health status of the elderly, taken into consideration the increasing rate of the elderly population.

1.7.4 STUDY POPULATION

People aged 60 years or above (for the elderly), caretakers between 18 to 59 years old and health professionals were involved in the study. The age cut off point was influenced by the fact that, the age of the elderly constituted both the retiring and the retired populace in the area of study.

1.7.5 SAMPLING

The study units were selected by different non-probability sampling methods.

The Elderly: The 100 elderly were selected using convenience sampling technique. This was because the technique gave room for selecting the cases with ease, since getting the elderly at the time the study was being conducted proved very difficult. 25 elderly were selected from each of the following areas: Tenashie, La, Teshie, and Nungua to ensure that the characteristics to be studied in the population were fairly distributed.

Caretakers: The 50 caretakers used were selected purposively.

Key Informant: The 5 Key Informants was selected purposively.

1.7.6 PRE – TESTING

All data collection instruments developed were pre – tested for errors and problems. Questionnaire was tested on a sample of five elderly in a community outside the Kpeshie Sub- metro. With the Key Informant, the interview guide was pre- tested on three people precisely from an NGO, government and private hospital also outside the demarcated area of the study. This helped the necessary adjustments and corrections to be made in the questionnaire as well as the correct procedure for the administration of the questionnaire. The actual data was collected from 1st – 31st August, 2002 excluding weekends.

1.7.7 DATA HANDLING

The questionnaire was numbered to make easy identification for any corrections, which occurred.

1.7.8 DATA ANALYSIS

The collected data was presented in pie and bar charts and analysed using percentages. Implications of findings for policy and the need for further research were recommended to the appropriate organisations.

1.7 SCOPE OF STUDY

The scope was limited to the health status of the elderly. According to WHO (1948), Health was defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The scope of the study included two different categories, thus, the client (elderly) and caretakers on one side, and key informants on the other side. The latter included

1. Metropolitan Director of Health Services, Accra.
2. Sub- Metro Director of Health Services, Kpeshie Sub-Metro.
3. Medical – Superintendent of La Polyclinic, La (doubles as sub-metro director).
4. Med- Officer in Charge of Manna Hospital, Teshie.
5. Director in Charge of Christian Medical Centre, Nungua.
6. Director in Charge of Police Hospital, Cantonments

1.9 PROFLE OF KPESHIE SUB-METROPOLITAN AREA

The Kpeshie Sub-Metro District is the political name given to four cluster areas on the eastern part of Accra along the coast of the Gulf of Guinea. Subsequently, it is one of the six (6) Sub-Metropolitan Districts, which form the Accra Metropolitan District of the Greater Accra Region.

The four areas are Tenashie, La, Teshie and Nungua. The boundary starts from West of Fisheries Department fence, moves northwards to include Okodan Street and continues along the Okodan Street to include the Ring Road East. From there it turns left along the Ring Road passing through Danquah Circle to Sankara Overpass. It turns right on the Liberation Avenue through 37 roundabouts to Tetteh Quashie Circle and turns right again along the Motorway to hit the Johnson Wax Factory road and turns along the Spintex or Batsoona road to hit the Accra-Ashiaman road towards Nungua to meet the Tema road. It then runs along the Tema road to the Nautical College road junction and runs along the Nautical College road to hit the Mokwei Lagoon and follows to the sea and then runs along the coast to the starting point.

The Sub-Metropolitan Medical Officer of Health (SDMOH) plans, implements and evaluates a comprehensive and holistic health services and the Urban Primary Healthcare in the Sub-Metropolitan within the policy guidelines of the Ministry of Health.

She runs the day-to-day administration of the Health Services in the Sub-Metropolitan. Clinics are held daily at the La Polyclinic, Private Maternity Homes and Clinics, Traditional Birth Attendance, Manna Mission Hospital (CHAG), Private Hospital (Christian Medical Centre) and at the Police Hospital (a quasi-government hospital).

Maternal Health Services are integrated and made accessible to all women in the Sub-Metropolitan within the context of the Primary Health Care through the implementation of the Risk Detection Approach plus strengthening of the referral systems.

DEMOGRAPHIC BACKGROUND

The sub-Metro has a projected population of 339,709 from the 2000 Census and has an annual growth rate of 4.4%.

TARGET GROUP	% OF TOTAL POP.	LA	TESHIE	NUNGUA	TENASHIE	KPESHIE
CHN. 0-11 MTHS	4%	4348	4824	3207	1209	13588
CHN.12-23 MTHS	4%	4348	4824	3207	1209	13588
CHN. 24-59 MTHS	12%	13045	14472	9621	3628	40765
CHN. 5-14 YRS	27%	29351	32561	21646	8163	91721
WOMEN 15-49 YRS	20%	21742	24119	16034	6047	67942
MEN 15-49 YRS	20%	21742	24119	16034	6047	67942
MEN & WOMEN 50-60YRS	8%	8697	9648	6414	2419	27178
MEN & WOMEN 60+ YRS	5%	5435	6030	4008	1512	16985
TOTAL POP. (APPROX.)	100%	108,707	120,597	80,171	30,234	339,709
EXPECTED PREGNANCIES	4%	4348	4824	3207	1209	13588
EXPECTED DELIVERIES	4%	4348	4824	3207	1209	13588

Source: Kpeshie Health Area / Population Year 2002

HISTORICAL BACKGROUND OF TOWNS

LA

The people of La migrated from BONNE in Nigeria in 1690. When they arrived at North Legon, they saw the Nungua people occupying the present town of La and waged war on them and drove them to their present place – Nungua. The relics of their occupancy are the fetishes Djobu that they left behind and the stream they named Obenesu, which is behind the Polyclinic. They used to collect water from it every year for their Kpele Djoo festival.

TESHIE

The first settlers were Numno Trebi, a fisherman from Tema and his followers. They occupied Leshie (Lele shishi). They were later joined by Nii Okang Nmashie (Mankralo of La) who fled with his people to settle at Teshie because of dispute between him and the La Chief.

NUNGUA

As already mentioned, the Nungua people were the first to settle at the present town of La and were driven away by the people of La in a war led by Gborbilor Owah- Captain of La and Borkete Larweh – Captain. Consequently, the boundary between Nungua and La people was at Brigade –Junction.

ETHNICITY

The people of Kpeshie Sub-Metropolitan District are mostly Gas and therefore speak the Ga Language. The Sub-Metro can be properly described as ethnically composite as all other tribes can be found co-existing peacefully.

OCCUPATION

They are mostly fishermen, "Trotro" drivers, artisans, farmers, and civil and public servants.

FESTIVALS

The Nungua people celebrate the Annual Kpele Djoo, first Saturday in July, La and Teshie celebrate Homowo in August or September.

TABOOS, CUSTOMS AND BELIEFS

Apart from Tuesday when fishermen do not go to sea, most of the taboos and customs cannot be enforced because of modern socio-economic trends.

CLIMATE

The climate is relatively warm and dry with a mean temperature ranging between 28oC-32oC. It is generally warm and humid during the day but cool winds blowing inland from the sea gives a striking contrast to the weather in the evenings.

THE RAINFALL PATTERN

The major rains start in April and end in July. The minor rains start mid September and rain intermittently till the end of November.

INFRASTRUCTURE

The old townships are unplanned with very high population density, poor housing and no major drains or gutters. Household water just collects between and behind houses. Apart from being unsightly it serves as breeding places for mosquitoes. This is the cause of high incidence of malaria among the population. Teshie benefited from the urban (2) project and therefore has the bench- road tarred.

POLITICAL STRUCTURE

With the enactment of the local Government Law establishing the District Assemblies, the Sub-District Assembly became the highest political body in the Sub-Metropolitan District. The day-to-day administration is in the hands of the Sub-Metro, Political Head (Chairman of the Sub-Metropolitan District), Assistant Director and the Assemblyman of the thirteen (13) Electoral areas. La has five (5) Electoral Areas, Teshie and Nungua have four (4) each.

Politically, the Sub-Metro enjoys peace and tranquillity with all various interest groups (Classmates, La Mansaamo Kpee, Teshie Noyaa Kpee e.t.c.) working together for the progress of the Sub-District.

HEALTH INSTITUTION/ACTIVITIES

The La Polyclinic occupies a unique position within the framework of Health Care Delivery, being the only government health institution overseeing the work of both private and quasi-government hospitals in the Sub-Metropolitan area. The Polyclinic was established in September 1963 and there were preparations to upgrade it to District Hospital in March 1999. This was not achieved due to financial constraints. The Principal medical Officer also the Sub-District medical Officer of Health is the head of the La Polyclinic as well as the Kpeshie Sub-Metro.

The integrated Health Services being rendered in the Sub-Metro are as follows:

1. Daily Ante Natal Services
2. Daily Delivery Services
3. Daily Family Planning Services
4. Daily Immunisation
5. Daily ORS Administration (ORT)
6. Daily Health Education Talks
7. Daily Nutrition Rehabilitation
8. 24hrs. OPD & Emergency Services since July 1997.
9. Dental Services
10. X-Ray Services
11. Laboratory Services

KPESHIE CATCHMENT AREA

1. Tenashie
2. Burma Camp
3. South La Estates
4. La Proper
5. Cantonments
6. Airport
7. Kotoka International
8. Trade Fair Site
9. Teshie
10. North Teshie
11. Teshie-Nungua Estate
12. New Nungua
13. Nungua Proper

IMPORTANT LANDMARKS

1. The Kotoka International Airport
2. The Ghana International Trade Fair
3. The Military Academy
4. The Nautical College (Now the Regional Maritime Academy)
5. The Headquarters of the Ghana Police Service
6. The Headquarters of the Ghana Fire Service
7. The first 5 star Hotel (Labadi Beach Hotel)
8. The most popular Beach Resort (The La Pleasure Beach)

1SOCIAL ACTIVITIES

There are several recreational centres in the district where most people spend their leisure hours after work. Most of these recreational centres are privately owned.

There are nightclubs, video centres, cinema halls and hotels, which have contributed in no small way in entertaining the people of the district.

Subsequently, the two five star hotels in the country are situated in the district. Labadi Beach Hotel and La Royal Palm Hotel. The popular La Pleasure Beach Resort is also in the district.

COMMUNITY CENTRES

1. La Neighbourhood Centre - Gonsee
2. Teshie Neibourhood Centre - Gbugbla

RELIGIOUS ACTIVITIES IN THE SUB-METRO

The Kpeshie Sub-Metro is predominately a Christian area; though there were Moslems, Traditionalists and other worshippers. Every person living in the Sub-Metro enjoys a religious freedom and may practise his or her faith without interference from the community.

Churches and religious societies of all kinds may own property, run schools and spread their faith.

The Council of Churches plays an advisory role and acts through consultation and co-operation among its member churches in the Sub-Metro. The Moslems have a representative body known as The Moslem Representative Council (MRC). It is the only recognized supreme authority on all matters affecting the religion.

ROADS; The Sub-Metro has a relatively good road network that links the various parts of the District. There are three types of roads in the Sub-Metro. These are first class, second class and feeder roads.

The first class roads are those treated with bitumen. These first class roads are linked with a number of second- class roads net - work in the Sub-Metro. Thirdly, there has been a central government attempt to open up certain areas of the Sub-Metro through the construction of a network of feeder roads throughout the Sub-Metro.

Responsibility for the maintenance of all these categories of roads has been that of the Engineering Division of the Kpeshie Sub-Metropolitan Assembly, which is under the Accra Metropolitan Assembly, which is also responsible for the feeder roads.

TRANSPORT FACILITIES

There is a good network of transportation in the Sub-Metro. There are many privately owned mini-buses and taxis operating in the Sub-Metro. Apart from these, the Sub-Metro having a typical city profile has a large variety of privately owned cars, which decorate the streets of the Sub-Metro. There is also an international airport (Kotoka International Airport) within the Sub-Metro.

POST AND TELECOMMUNICATION SERVICES

Communication is mainly by road and recently through high technology systems such as telephone (including mobile phones) fax and electronic mail. The Internet is also available.

There are five main Post and Telecommunication areas in the Kpeshie Sub-Metro. These are La, Teshie, Teshie/Nungua, Cantonments, and Nungua. The people of the Sub-Metro receive their mails through their own Post Office boxes or through the nearest postal agent. News reaches them through wireless sets, television, radios and newspapers.

ELECTRICITY SUPPLY

The Akosombo Hydro-electric dam is the main source of electricity supply in the Sub-Metro and in the country as a whole.

LAW ENFORCEMENT AGENCIES

The Police Force constitutes the mainstream of the government's Internal Law Enforcing Agencies. Administratively, Police Operational areas are termed "Regions" and headed by an Assistant Commissioner of Police.

STATIC AND SATELLITE CLINICS

STATIC CLINICS	SATELLITES ($N_{O.}$)
1. La	15
2. Teshie	19
3. Nungua	21
4. Teneshie	11
5. Police Hospital	2
6. Military Hospital	3
7. School Clinics	6

SCHOOL HEALTH SERVICES

The School Health Service is designed to promote the health of school age children in all the schools of the Sub-Metro. School health teams have been formed to render the following services:

1. Regular physical examination with emphasis on Pre-school, P1, P3, JSS 1, SSS 1 students.
2. At risk detection
3. Immunization

4. Health Education and Family Life Education.

5. Treatment of minor ailment including dental care.

6. Maintenance of hygienic school environment.

The teams comprise of Public Health Nurses, Community Psychiatry Nurses, Nutrition Officer and Environmental Staff.

PHARMACIES AND CHEMICAL SHOPS

LA

NAME	**LOCATION**
1. Ewur Pharmacy	La Market
2. Church Street Chemical Store	La Bethel Presby Church
3. S.K. Mensah Chemical Store	Abbey Maternity Home
4. Hotta Chemical Store	La Shell Filing Station
5. La Chemist	La Market
6. St. Stephen's Pharmacy	La Police Station
7. E.S. Pobee Chemical Shop	Luu Furniture
8. Sam Bright Drugstore	Apaapa Circle Station
9. Greorgeo Pharmacy	Amen House
10. Kingsley Chemical Store	Jordan Maternity Home
11. Freddy's Chemicals	Kojo Sardine
12. Trade Fair Pharmacy	La Cemetery
13. Palm View Chemist	Palm Wine Junction
14. BIBS Pharmacy Ltd.	Mobil Filing Station La
15. Mokat	Jomo
16. Dayden	Jomo

TESHIE

NAME	LOCATION
1. Beach Road Pharmacy	Teshie- Adom
2. Modern Pharmacy	Abotsi-Hanya
3. Christian Pharmacy	Teshie-Tafo
4. Bright Pharmacy	Teshie-Nungua Estates
5. Jilak Chemist	Lascala Cinema
6. Brethern Chemical Shop	Abordo-Teshie Old Town
7. Newbet Chemical Shop	Bukoshie-Teshie Old Town
8. New Era	Teshie North Cluster of School
9. Obeng Chemical	Event Photos
10. K.N. Chemical Store	Fertilizer Factory
11. SABS Chemical Store	Teshie Tsuibleoo Last Stop
12. Faith Chemical Drug	Teshie Tsuibleoo Last Stop
13. Ropheka Chemical Store	Century Shop
14. Connie's Chemical Shop	Teshie Zongo
15. Magvichen Drug Shop	Des-salam Teshie Zongo
16. Mengostan Pharmacy	First Junction Teshie –Nungua
17. Juliana's Chemical Shop	Mawado

NUNGUA

NAME	LOCATION
1. Fabby	Blekese Gonno near Barrier
2. Diplomat	Post Office Channel 5 junction
3. St. John's Pharmacy	Channel 5
4. Grace Chemical	Nautical Road
5. Bediako Chemical	Channel 5
6. P.A. Bortier	Yeiaman near Star Cinema
7. Arnold .B. Anum	Sanshie
8. Mike Lois	Adogonno
9. Hope Star Chemical	Gborbukoonaa
10. Providence Chemist	Adogonno
11. E.Y. Twum Chemical Store	Zongo
12. Mary's Chemical Shop	Zongo

TOWN DEVELOPMENT COMMITTEES

Town Development Committees exist in almost all the communities of the Sub-Metropolitan District. These committees exist alongside political organs. The main functions performed by the committees include mobilising the communities for communal labour, clean-up exercises, and constructional programmes e.t.c.

Apart from the committees, there are also some Non-Governmental Organizations or Voluntary Organisations, which work alongside the committees for the welfare of the Sub-Metro. Some of these groupings are classmates, La Mansaamo Kpee, Teshie Noyaa Kpee e.t.c.

HEALTH CARE DELIVERY

La Polyclinic caters for a Sub-Urban population of about 325,392 (projected from the 2000 census) in the Kpeshie Sub-Metro. The clinic is the only Government Health Institution of the Sub-District which renders the following facilities; Medical Care, Dental Care, Maternal and Child Health, Nutrition, Community Psychiatric Services, Environmental Services and Laboratory Services.

ENVIRONMENTAL SANITATION

General sanitation in the Sub-Metro is quite unsatisfactory. The Sub-Metro does not have adequate places of convenience and this leads to indiscriminate defecation around the towns. Waste water run around houses and subsequently, creates gorges and ditches on the few untarred roads. Almost all the gutters are choked with refuse and human excreta which looks unsightly.

a. HOUSING:

Types of structure mostly present are

1. Swish: This is found in the old towns of La, Teshie and Nungua.

2. Cement: This is found in the estates and residential areas as well as newly developed areas.

ROOFING:

1. Corrugated iron sheets

2. Asbestos Sheets

b. WATER SUPPLY:

All the communities have access to good drinking water, which was, pipe borne with the main supply from the Kpong water works. A few wells can be found in some homes. Storage was by plastic tanks, plastic buckets, drums and underground tanks or reservoirs.

1.10 ETHICAL CONSIDERATIONS

A letter requesting to undertake the research was handed to the people for the Key Informant interview. Informal (oral) agreement to take part in the research was solicited from the aged / elderly selected to be part of the sample after they had been briefed on the significance of the study. They were informed that participation was voluntary and that all responses will be kept confidential.

1.11 LIMITATIONS

The principal researcher faced the following problems.

1. Language barrier because most of the elderly felt comfortable using the Ghanaian language which the researcher did not have much control over.
2. Resources e.g. energy and time were scarce therefore the researcher had to employ research assistants, who were paid at the end of the collection of the data

1.12 ASSUMPTIONS

The following assumptions were made while carrying out the project:

1. The sample size chosen represents the study population.
2. Responses from the participants represent the situation on the ground.
3. All selected participants will participate fully for a correct assessment to be made.
4. The ages of the elderly people were approximated, as they did not know the

   Exact dates, hence important events were used to ascertain their dates of birth.

2.0 LITERATURE REVIEW

2.1 THE DEMOGRAPHIC TRENDS OF THE AGED

Societies worldwide are ageing. Since 1950, life expectancy has increased by 22-years, to 66 and is projected to extend by an additional 10years by 2050. In addition, global fertility levels decreased since the late 1970's. These two trends caused the shift towards a higher median age within societies also known as "ageing". Whereas there are 600 million older persons today, there will be nearly 2 billion by 2050. The share of persons 60 years and older will increase from, currently 10% to 21% in 2050. (UNGA, 2002, p1).

Although currently, one in five Europeans is 60years or older, the increase of the elderly in developing countries will be much more dramatic --------- it is expected that between 1998 and 2050 the share of older persons will increase nine fold. Worldwide the group of the oldest old (80 years or older) will be the faster growing segment of the older generation.

Population statistics has revealed that

- The number of elderly women exceeds that of elderly men (life expectancy at birth in 1978 was 7 to 8 years more for females than for males and 4 to 5 years more at age 65).

- The majority of elderly females who were married are widening, whereas most elderly men are still married. Men thus may have an advantage over women if therapy at home required some assistance or supervision.
- Ninety-five percent of all older persons live in the community. Most of them live independently in their own homes or apartments. About one in six older persons live in a household with relatives other than their spouse.
- About one-fourth of all elderly have incomes at or below the designated poverty limit.
- Many urban elderly live in older parts of cities with restricted access to medical care, stores, churches, clubs, transportation, and other needed facilities (Cape et al, 1983, p4).

Currently, just over half the population is of working age, 20-64; by 2025 the population will have reached 58%. The population of older people requiring support from adults of working age was 10.5% in 1955 to 12.3% in 1975 would be 17.2% by 2025. The health of the adult population of working age will be now vitally important if this age group is to support growing numbers of dependants, both young and old (WHO report, 1998, p4). On the other hand, by 2025 there will be more than 800 million people over 65 in the world, two-thirds of them in developing countries.

There will be 274 million people over the age of 60 in China alone – more than the total present population in the United States. Increases of up to 300% of the older population are expected in many developing countries, especially in Latin America and Asia, within the next 30 years (WHO report, 1998, pp5).

According to statistical survey done in 1994, people over 65 years of age constituted 14.1% of the Japanese population. In addition, the Japanese average life expectancy in 1991 was the highest in the world, reaching 76.1 years for men and 82.1 years for women (Suzuki et al, 1997)

In Ghana, three main religious groupings are presented: Christianity, Islam and the Traditional. Nationally, Christianity is dominant with over two-thirds (68.8%) of the population claiming affiliation with the Christian faith, followed by Islam, with 15.9%, and Traditional religion, with 8.5% adherents. A significant proportion (6.1%) reports affiliation with NO religion (GSS, 2002). While literacy can be acquired through reading and private informal channels, the formal schooling system remains the best process for improving access to information and broadening the horizon of the people. It is encouraging; therefore, that early childhood development and learning services have become a significant part of the educational process, particularly in the cities and large towns.

Not only are these pre-school institutions providing child care services for working mothers but they are also giving the children a jump-start towards the preparation for entry into the primary level of basic education. The numbers of children at pre-school are not too great, but its benefits are so important that it should be encouraged throughout the country. The rather large proportion of the population that attained primary (18.6%) as the highest level is not encouraging, since the effects of education do not begin to manifest until beyond the basic level (GSS, 2002, pg 8)

The four major occupations, in Ghana, are agriculture and related work (49.2%), production and transport equipment work (15.6%), sales work (14.2%) and professional and technical work (8.9%). This general pattern is true for the majority of regions, with slight change; in Greater Accra, the order is completely changed, with sales work taking first position, followed by production and transport equipment work, professional and technical work and services. In the case of males, the major four occupations are agriculture and related work (50.0%), production and transport equipment work (18.0%), and professional and technical work (10.2%) and sales work (8.3%).

Females also show a pattern that is not only different from the national but also different from the males, with one exception: agriculture and related work (48.3%) is the single major occupation for all regions, besides Greater Accra. The next three, at the national level are sales work (20.2%), production and transport equipment work (13.2%) and services (7.7%).

2.1.1 GERIATRICS: ITS DEVELOPMENT AND MEANING

Geriatrics in Great Britain effectively came into existence from the inception of the National Health Service in 1948 when the extensive re-organisation of medical services brought the problems of the elderly in hospital to proper notice. These were in the main the major changes in population structure, mortality patterns and morbidity, which had occurred throughout the century. In 1901, there were 1.7 million people over 65 in Great Britain representing 5 percent of the total population. By 1951, their number had risen to 5.3 million and the proportion to 11 percent (Hodkinson, 1975, p1).

This change had resulted almost entirely from falling mortality rates in childhood and middle life, due principally to prevention and effective treatment of infections, and not to any significant gain in longevity, in old age.

As the old make disproportionately large demands on medical services, the hospital services has had to adapt to the different problems posed by elderly patients who have come to occupy some two-thirds of the total beds, hence, the development of the geriatric department in the hospital (Hodkinson, 1975, p2)

Geriatric is not easily defined. Unlike other specialities it does not deal with a circumscribed group of diseases, like rheumatology or with a system like neurology or group of techniques like radiotherapy.

According to the British Geriatrics society, "Geriatrics is the branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of the elderly". Its aims are to

- Enable the elderly person (s) to lead full and active live (s).
- Prevent disease, or to detect and treat it early.
- Mitigate suffering due to disability and diseases, and to minimise pre – death dependence.
- Provide sympathetic medical care and social support in the terminal phase of life.

Preventive geriatrics is essentially a primary care activity involving especially the general practitioner (GP), the practice or district (Community) nurse, the health visitor and the social worker. This is achieved by or through health education, use of available social benefits (Financial help and services) and early recognition and treatment of disease and disability (Coni et al, 1993, p1).

2.2 NUTRITION KNOWLEDGE OF OLDER PEOPLE

People acquire a basic pattern of food selection and knowledge of food through a lifetime of experience. For those older individuals with few years of formal schooling, nutrition knowledge has generally been acquired through informal sources such as newspaper or magazines or friends or acquaintances.

In some instances food beliefs are based on traditional concepts about food (e.g. milk is primarily for children) that may not be accurate. Factual knowledge regarding nutrient requirements and appropriate food sources is limited among most adults (Schlenker, 1984, p230).

In 1975, the Food and Drug Administration evaluated the nutrition knowledge and food beliefs of 1664 adult food shoppers. Nutrition knowledge related to both age and years of schooling.

Low scores were most common among those with less than a high school education, those above age 50, and men. Sixty-five percent of the older persons with low knowledge scores belonged to a lower socio-economic group. Most participants are not familiar with good food sources of vitamins and minerals. Individual food content was not always associated with the appropriate physiological function. Milk was considered important for building red blood cells, whereas beef and enriched bread were thought to be related to strong bones and teeth. Most shoppers know foods that could be substituted in place of bread; however, milk and pork and beans were not recognised as protein sources that could be substituted for meat (Schlenker, 1984, p 230).

Individuals avoiding acid gas-forming fruits or vegetables need to recognize alternative sources of vitamins or fibre. Alternative sources of nutrients should be an integral part of a nutrition education program.

Nutrition knowledge is essential for planning an adequate diet; however, nutrition knowledge may not be reflected in actual practice. Although older people know what foods should be included in the diet, cost of physical disability may interfere in food selection or preparation (Schlenker, 1984, p23).

2.3 LEVEL OF FOOD INTAKE AND PREFERENCE WITH AGE

Activity tends to fall with age in the higher age groups (Durvin, 1973). Other changes are that lean body mass and skeletal mass tend to fall in response to relative disuse but fat deposit commonly increases so that total body weight may be maintained. In response to falling energy expenditure, gross calorie intake tends to fall with age, although less steeply than is suggested; longitudinal studies indicating that falls are unimpressive provided that can fall substantially if health becomes impaired (Exton-Smith and Stanton, 1965; Stanton and Exton-Smith, 1970). The fall in total calorie intake is achieved by eating less food, the general evidence being that this quantitative change is accompanied by remarkably little in the way of qualitative change. As energy expenditure may decline to a far greater extent than lean body mass, this leads to a situation where nutrients whose requirements relate to the latter come to be provided less generously. The risk of deficiency of such nutrients therefore becomes greater (Hodkinson, 1975, p73).

Low body weight is a predictor of subsequent mortality in elderly people (Exton-Smith, 1988) Low food intake not only leads to weight loss, but also increases the probability that the intake of other nutrients will be inadequate; if the problems are untreated, it is likely to result in weight loss and nutrient deficiency in elderly people.

Undernutrition and its consequences can be avoided in many elderly people by the appropriate use of nutritional supplements and artificial feeding methods. Greater awareness of the range and effectiveness of these nutritional support measures could play a part in reducing the high prevalence of malnutrition amongst sick elderly people (Webb et al, 1996).

Food preferences are moulded by ethnic, cultural and religious backgrounds. Older people prefer foods associated with pleasant experiences or related to home or place of origin. Preferred foods may have been given a special treat or served on holidays or special occasions. Age – appropriate behaviour influences food selection. Low milk consumption can symbolize rejection of a food associated with children and dependency. For lonely aged, food cravings may reflect the need for emotional gratification. In my experience one older woman regularly ate bread spread with butter and sprinkled with several teaspoons of sugar. Although traditionally linked to particular ethnic groups, "soul food" in a broad sense may be any food that has emotional significance. When planning a diet for an older client, it is pertinent to both recognize and respect individual food preferences. Such an approach is more likely to produce a diet that will be followed rather than accepted politely and then ignored (Scalene, 1984, p188).

Non-communicable disease is currently rapidly increasing in Ghana. The prevalence of diabetes had risen from 0.2% in 1958 to 4% in 2000; and hypertension and its complications, particularly strokes, accounted for 10% of deaths in urban centres and were the second leading cause of adult death in such areas. Ghana, like most developing countries, was in epidemiological transition. While the burden of communicable diseases had been reduced, the increase in life expectancy, the adoption of Western-style dietary habits and unhealthy lifestyles had led to the emergence of non-communicable diseases. The rapid growth in consumption of fast food in Ghana was an example of the negative impact of globalisation. Ghana had developed a national policy and strategy for the control of non-communicable diseases, which included strengthening public education, introducing legislation to counter common risk factors, such as drug and tobacco use, monitoring morbidity and mortality patterns, standardizing diagnostic and management structures and processes, and developing health education materials on physical activity and diet. Ghana has followed the celebration of World Health Day 2002 by instituting a monthly national walk to encourage the habit of walking (Afriyie, 2002)

Lifestyles were closely linked to the cultural, social and culinary values of community. It was therefore difficult to identify appropriate health actions and introduce healthy eating habits that would be acceptable to different people and, in particular, different generations.

Such changes could, of course, only be introduced when the population had access to appropriate food and physical activity facilities, always bearing in mind that throughout the world, there were children and adolescents suffering from malnutrition as a result of a lack of basic foodstuffs (Castillo, 2002). A recent study on the burden of disease in Thailand had demonstrated that non-communicable diseases related to diet and physical inactivity were responsible for 35% of years of life lost among men and 49% among women, of which 9% and 13% respectively, were due to cardiovascular diseases. Policy-makers had therefore introduced additional primary prevention and healthy lifestyle measures, including, "Exercise for Health" for 2002 and beyond, in line with WHO "Move for health" campaign. Moreover, the benefits of a healthy diet had been widely publicized through the media. Borwom, 2002 warned that dietary supplements were increasingly being promoted in a way that was misleading and surveillance and proper regulation were needed; slimming aids, in particular, were no substitute for physical activity.

As people get older they may not be able to prepare their own food or look after themselves. Many such people rely on the support of friends, relatives and community services to help with the shopping and to prepare meals. Only four per cent of the elderly population live in residential accommodation run either by the private and public sector (COMA, 2002).

SPECIAL DIET

1. Foods should supply a range of nutrients. Older people need slightly less energy than younger adults, but requirements for nutrients stay the same. Meals and snacks should therefore be nutritious, and should provide a range of nutrients. In general, healthy eating guidelines should be followed – older people should eat less fat, especially saturated fat, less sugar and more starchy fibre-rich foods.
2. Make sure there is adequate intake of fibre and fluid. This is essential to prevent constipation. Good sources of fibre include whole-meal bread, whole-grain breakfast cereals, pulses, fruit and vegetables. Raw wheat bran should not be added to foods as it contains phytates, which may interfere with the absorption of calcium and iron. For people who have difficulty in chewing, fruits and vegetables can be pureed.
3. Make sure there is enough iron in the diet. To help prevent anaemia, older people should be encouraged to eat iron-rich foods such as red meat, liver, oily fish, fortified breakfast cereals, bread and pulses. Food and drink rich in vitamin C should be included with the meal to increase iron absorption, particularly if the meal does not contain meat.
4. Make sure there is enough calcium and vitamin D in the diet. Older people should eat foods that are rich sources of calcium, such as milk and cheese to help keep bones healthy.

Vitamin D helps in the absorption of calcium, and is formed in the skin by the action of sunlight, so older people should be encouraged to sit in the sunshine, as well as eating foods which are good sources of vitamin D such as oily fish, eggs and fortified margarine (COMA, 2002)

Some older individuals become increasingly sensitive to digestive upset and abdominal distress. Consequently, gas – forming, spicy, or fat – containing foods will be consumed seldom, if at all. A common complaint is intolerance of gas - forming foods such as legumes, which are good sources of dietary fibre. In a survey of older Michigan women, 17% avoided dried cooked beans, 9% avoided onions, and 5% avoided cabbage. Avoiding particular vegetables therefore does not necessarily lead to reduce fibre intake. In the relatively healthy individual food intolerance should not seriously affect the nutrient quality of the diet (Schlenker, 1984, p 193). Data from the National Diet Nutrition Survey show that over 75% of institutionalised elderly people in Britain have extremely heavy levels of plaque deposits, associated with tooth decay and gum disease, and these levels were higher than in those living at home (Schlenker, 1984).

2.4 QUALITY OF CARE

Quality assurance is an important framework within which medical care should be delivered. This is because the service once delivered cannot be recalled for a better service later.

According to Crosby (1964), quality assurance involves doing things right the first time. Quality is an intangible concept seen from both the client and provider's perspective. In clients view, quality may be measured by "physical administrative attributes such as space, comfort, cleanliness, seating arrangements and convenience of opening hours" (Phillips, 1990: p 207). When clients are satisfied with health care services, they are more likely to continue using them. The health of individuals and communities improves with the use of the services. From the providers point of view quality involves levels of professional care, drug availability and attitude of staff towards clients (Ben Sira, 1976). Health service providers become satisfied with their jobs when required resources are made available, making work smooth and leading to better results for their clients. Thus, both clients and service providers have standards they desire to have achieved in all aspects of health care and the level of quality of clinical care resulting ultimately influences utilization. Client's view of what quality is, affects whether or not they use a facility.

In developing countries, drug supply is sporadic, especially in lower level facilities, due to foreign exchange constraints and poor distribution systems. It is obvious to most health managers that there is a strong correlation between drug availability and use of service – which is seen in variations in occupancy and outpatient visits during the course of each year. When drug availability is high, service use is high than when it is low. In a World Bank study conducted in Ogun State, Nigeria, the findings shown that facility use increased with the percentage of time during the year that drugs were available (Akin et al., 1999). This study found in addition that if services charges were doubled, use of services declined by 4% - however, if the fee increase was used to ensure essential drug availability, the use of services increased by 35%.

2.5 EXTENT OF DRUG USE BY THE OLDER PERSONS

Older people are among the chief users of drugs in the United States. Although they comprise 11% of the population, they consume 22% of all prescription drugs. Cardiovascular preparations (i.e. digitalis, anti-hypertension agents, tranquillisers, diuretics and sedatives account for about half of all prescription drugs sold to older people (Schlenker 1984, p 146).

A 3 – year follow – up over 1700 persons age 65 and over living in the community suggested that 77% of older persons use at least one drug on a regular basis and drug use increases with age.

Those under age 70 used one to two different drugs, whereas those above age 84 used two to three. Drugs most commonly used were anti-hypertension agents, vitamins and cardiovascular agents. In another community group 65% were taking one to three prescription drugs and 20% were taking four to nine prescribed drugs. Use of OTC drugs was not reported. Common drug categories with examples are defined in the table below. Drugs for treating arthritis and tuberculosis as well anticonvulsants, cardiovascular agents, diuretics, and hormones are frequently prescribed for long-term maintenance. Many drugs in these categories are capable of inducing vitamin or mineral deficiencies (Schlenker, 1984, p 146 – 147).

OTC drugs can be obtained without the advice or prescription of a physician. Among the aged, analgesics are used most commonly for relief of headache, backache, and muscle pain. Other OTC drugs include antacids, laxatives, sedatives, and vitamins or minerals supplements. It is assumed that all populations groups use OTC drugs to some extent. However women and older people of both sexes have the highest user rates. Expenditures for both description drugs and OTC items exceeded 8 billion dollars. (Burgen et al, 1978)

Types of drugs used, therapeutic action and some examples.

Type	Therapeutic Action	Example
Analgesic	Acts on central nervous system (CNS) relieves pain without causing sleep.	Salicylates narcotics, no steroidal anti–inflammatory agents
Sedatives and tranquillisers.	Acts on CNS; reduces level of excitement and relieves tension or anxiety; does not usually impair normal mental function.	Chlorpromazine, barbiturates, chloral hydrate.
Anti – depressants	Stimulates CNS by activity on the general feeling of well – being.	Amitriptyline, desipramine, nortriptyline, monoamine. Oxidase inhibitors
Anti – infective agents	Used to treat or prevent infection	Penicillin, tetracycline, neomycin, isoniazid sulphonamides

Cardiac drugs	Increases strength of contraction of the heart muscle.	Digitalis derivatives.
Anticonvulsant	Prevents seizures or convulsions; used in treatment of epilepsy.	Phenobarbital. Phenytoin.
Anti – lipemic	Lowers blood lipid levels by increasing excretion of bile acids; many interfere with lipoprotein synthesis or excretion	Cholestyramines, clofibrate.
Diuretics	Increases formation of urine with net loss of sodium and water.	Mercurial, spironolactone, ethacrynic acid, furosemide, thiazides, triamterence
Anti – hypertension agents	Acts to reduce blood pressure; may inhibit sympathetic stimulation or act as a vasodilator.	Diaz oxide, s hydrazine, captopril.

Source: (a) Burgen et al, 1978 (b) Cummings, J.H, 1974 (c) Roe, D.A, 1976: 1982

Drug therapy of the elderly is particularly hazardous because of poor renal function, reduced active body mass and the increased vulnerability of body systems, particularly the central nervous system.

The hazards are made greater by the liability of ill old people to make mistakes in taking their prescribed drugs and by the frequency with which the elderly are subjected to multiple prescribing (Dail, 1970: Hurwitz et al, 1969: Wade, 1972).

Prescribing for the elderly needs to be undertaken with particular care both in regard to starting treatment and in continuing it on a maintenance basis. The total number of drugs needs to be kept within bounds as their increase leads to errors in taking them and a disproportionate risk of adverse effects and interactions. Treatment should be started only when it is likely to improve the patient's quality of life. Treatments of dubious benefit or marginal relevance should not be undertaken; the elderly are very unsuitable as the subjects of ill – considered, uncontrolled experiments inspired by undue therapeutic optimism (Dail, 1970: Hurwitz et al, 1969: Wade, 1972).

2.6 SOCIOECONOMIC CHARACTERISTICS OF THE OLDER POPULATION

The general public associate old age with poor health, illness, and disability, which often leads to the assumption that the majority of older people live in institutions. In fact 95% of all aged live within the community with either a spouse or other family members or alone.

Seventy five percent of older men are married. In contrast, over half of older women are widows. This difference in marital status is reflected in the living

arrangement of older persons: about one- third of older women live alone and one – fourth live with someone other than their spouse. About 5% of the people aged 65% and above are institutionalised with majority (about 1 million persons) of the institutionalised living in nursery homes, although about one sixth are in hospitals or community houses designed for the mentally handicapped or psychiatric patient. Over half of those in nursing homes are at least 80 years of age (Schlenker, 1984, p6).

Older persons are more likely to live in rural or suburban locations than in densely populated areas. Although over 60% reside in metropolitan areas, less than one-third live in Central cities, with the others in surrounding communities. Living arrangement can contribute to the food problems of older people. An individual who lives alone and is bored may not bother to prepare a meal. An aged widow who never learned to drive and lives in a rural area is dependent on friends or relatives for transportation to a food store. Although older people in the inner city have greater access to services, they are less visible and therefore easily overlooked (Schlenker, 1984, p6).

Because of their physical, mental and social disabilities, the old often need the support of other people to carry on their lives in the community. Families supply a great amount of such support but are too often accused of neglecting their old relatives despite the findings of objective studies which have shown that rejection of the elderly by their families are altogether exceptional (Lowther and Williamson, 1966; Isaacs, 1971). Often the caring relations are elderly themselves.

If the patient is 95, the daughter caring for her may be well within the geriatric group. Children may be too far away to help, a penalty of modern social mobility. In the absences of family, neighbours, home – helps, "meals – on – wheels" and the district nurse can play a vital role. Bereavement or illness of a helper can strike a severe blow to the ill or disabled old person both in terms of the loss of physical help and effect on morale (Hodkinson, 1975, p 8).

2.6.1 AGEING- LIVE LONGER AND FEEL BETTER

All runners start the race together, but as they jump over and occasionally hit the obstacles, they slow down and some drop out. Similarly, human life has a starting point with high hurdles placed along the way. In life man encounters one hurdle after another. Each jump makes him weaker and in time he gives up. The higher the hurdles the sooner he drops out and dies.

In this modern world people can now choose to stay in the race of life longer.

This is because man has been able to identify the hurdles and also lower them. Some of the main hurdles or factors affecting man's life are habits, environment and medical care.

Thus the more sound your habits, the healthier your environment and the better medical care you have the lower those hurdles become and the longer your life may last.

Although people's circumstances vary, virtually everyone can do something to lower the hurdles in his or her life. There are habits that affect life's track record. Indeed, changing our eating, drinking and smoking, sleeping and exercising habits can lower the first hurdle.

Engaging in regular exercising goes a long way to improve health during ageing. Studies show that simple exercising in and around the home help the elderly to regain strength and vitality. Exercise slows the process of ageing, prolongs life and reduces the period of dependency that most often precedes death.

Mental exercise also helps the older people to continue to have rich healthy mental lives. The truism of the adage "use it or lose it" does not only apply to muscles but also to the mind. What older persons can do to keep the mind alert and active is by engaging in reading, travelling, taking courses and joining clubs and professional associations. It is believed that such activities not only lift the spirit but also energize/revitalize brain.

There is also the need for a healthy social and religious environment. Social environment is made up of people, with whom you live, work, eat, worship and play. One's social environment improves when one had access to valued company. Being able to share one's joys and sorrows, dreams and frustrations with other people lowers the height of the hurdle and helps one run a longer course. A lack of companionship may cause loneliness and social death. One tends to wither if one exists without receiving expressions of care from the people around you.

Truly, loneliness is one of the major conditions that constantly threaten the well being of the elderly. Although one may not be able to remove the circumstances that make one vulnerable to illness such as retirement, declining mobility, the loss of long time friends or the death of a spouse, one can still take some steps to lower this hurdle to a manageable height. Keep in mind that, feeling lonely is not caused by old age, some young people feel lonely as well, but being socially isolated is the problem. What one can do to prevent slipping into isolation is by making it pleasant for people to be with you.

Religious environment also counts when old age sets in. Evidence suggests that religious activities help older people to find meaning in life and to experience happiness, a sense of usefulness and greater life satisfaction. In addition religious activities bring older people in contact with other people thus reducing the possibility of social isolation and loneliness.

Availability of low cost medical care with high care rates has lowered the hurdle of medical care. A growing number of older people are making use of health care that is available. One has to take a personal interest in one's health problems and seek medical attention when necessary. The chances of staying healthy and living longer when old sets in can be improved by following advice such as eating a balanced diet, if one drinks alcoholic beverage, should do so in moderation or stop.

The elderly traditionally played an active part in the community, but modernization, education, urbanization and migration were undermining that traditional role. In many countries, ageing was widely perceived as times of mental and physical decline and loss, and persons over the age of 60 years were considered to be economically unproductive.

Retirement usually led to a sharp drop in income and living standards and it became difficult for older people to afford basic clothing, housing or good health. In Nigeria, care for the elderly was being provided to a lesser and lesser extent by families owing to rapid social changes and the downturn in the economy. That situation was exacerbated by tribal conflict and the emergence and re-emergence of certain communicable diseases despite all the advances achieved in the twentieth century.

Nonetheless, life expectancy had increased in Nigeria and the elderly population was growing. Ageing issues had therefore forced their way into the national consciousness and a national plan of action for the elderly had been formulated, whose main objective was to secure the participation of the older persons in all aspects of national life, to ensure their access to health services and to sustain their creativity and participation in society. The plan, implemented at central, state and local levels, was a national response to the Declaration from the Fourth Global Conference on Ageing (Montreal, 1999), in that it sought to ensure the well being of the elderly and took into account physical, mental, social, spiritual, cultural and environmental factors (Asagba, 2002)

2.7 CONTAINING COST OF EXEMPTIONS: WHAT SHOULD CONSTITUTE THE BILL

The decision to exempt some categories of patients from the payment of hospital fees dates back to the inception of user fees. The Hospital Fees Act, 1971(Act 387) and the subsequent Hospital Fees Regulation, L.I. 1313 made provisions for three broad categories of exemptions.

These were:

1. Exemption from ALL fees for:
    a. Patients suffering from Leprosy and Tuberculosis
    b. Immunization against any disease (excluding vaccination for international travel)
    c. Storage of bodies at the request of any department of state.
2. Exemption from all fees except for the cost of prescribed drugs for:
    a. Meningitis
    b. Cholera
    c. Malnutrition
    d. Typhoid
    e. Venereal diseases
    f. Rabies and
    g. 18 other conditions usually referred to as diseases of public health importance.
3. Exemption from all fees except the cost of hospital accommodation and catering services for:

a. Ante-natal and post-natal services

b. Treatment at child welfare clinics (Adams, 2002)

The regulation did not make explicit provisions for paupers and indigents, however, with respect to health service personnel including trainees, the act provided exemption for all services rendered in a hospital except for amenities (the regulation does not define these special amenities).

The act also provided that where the release of a dead body is delayed due to post mortem examination, the coroner's report or difficulty in tracing the relatives, the medical officer in charge may use his discretion to waive the fees for cold storage.

It must be noted that even for diseases of public health importance the regulation did not exempt the payment for drugs and antenatal and postnatal services were practically not exempted during out- patient services (Adams, 2002). Over the years the scope of the exemption facility has undergone changes, which even though not backed by law, have been accepted within the health sector. In the same way the different interpretations of the provisions of the policy have also been modified through several circulars and accepted norms. A major interpretation and review was also done in 1998, when the sectional address to parliament by the President and the Ministerial Executive Committee introduced other categories in the same year. Thus currently the ministry operates six clearly defined exemption facilities. These are:

1. Exemption for disease deemed to be of public health importance (which in principle should include all the 24 conditions outlined in the L.I.1313)
2. Exemption for Antenatal services
3. Exemption for children under five years
4. Exemption for the elderly (defined as people above 70 years)
5. Exemption for paupers and indigents
6. Exemption for snake bites and bites by dogs suspected or confirmed to be rabid.

These services are expected to be provided by the health facility to all eligible patients and be reimbursed upon the presentation of a bill (Adams, 2002)

This arrangement has been in place for some time and particularly within the last three to four years has run into several difficulties ranging from the modalities for the reimbursement to the interpretation of the provisions of the policy. However one of the biggest drawbacks in recent times has been the quantum of bills presented for reimbursement. Not only has this outstripped the exemption budget but it is also growing at a rate, which may soon be difficult to contain.This may be due in part to the increases in numbers of patients being exempted and/or the expansion of the scope of the exemption services. In some regions the effect of increased number of exempted cases contributed much more to the increase in the cost of exemptions. However in other regions the reasons may be more of the increased scope of services.

For instance between the year 2000 and 2001, the number of exempted patients in the Western Region increased by 0.3% but the amount spent on exemptions went up by 65% (Adams, 2002).

It appears that health facilities put in claims for reimbursement based on the expected revenue from a patient for whom similar services have been rendered. There are several schools of thought as to the scope of reimbursement that government should provide to health facilities. Some of the main questions are:

"Should facilities be reimbursed for potential lost revenue when services are provided for exempted patients?"

"Should facilities be reimbursed only for the recurrent expenditure on exempted patients? In other words should government pay for the replacement cost of materials used to take care of exempted patients?"

Other more radical questions that have also been raised have to do with whether government should pay for exemptions at all considering the fact that most of the items used in patient management (excluding drugs) have been provided for under the budget and even in the case of drugs, a mark-up is allowed which in principle can be used to offset the bill of exempted patients (Adams, 2002).

3.0 RESULTS AND ANALYSIS

In this chapter, the findings of the study were analysed. Tables, percentages, doughnut, bar and pie charts as well as chi-square statistic were used to explain the data. The findings were presented under the following headings:

3.1 Background Information.

3.2 Level of Nutrition Education.

3.3 Food availability, Dental formulae and eating pattern.

3.4 Quality of Care.

3.5 Attitude towards Medication.

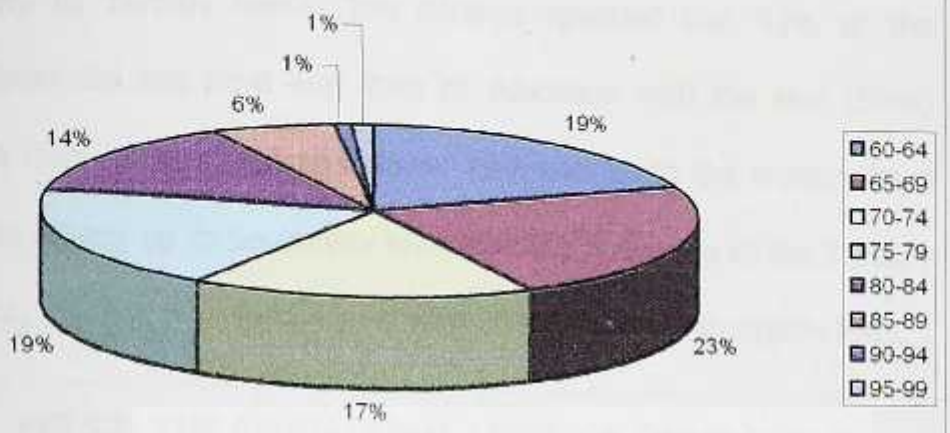
3.6 Recreational Facilities.

3.7 Policies and Programs channelled into the caring of the health of the elderly.

3.1 BACKGROUND INFORMATION

3.1.1 AGE: The age group data was categorized into five year interval.19% fell within 60 – 64 years, 23% between 65 – 69 years, 17% between 70 – 74 years, 19% between 75 – 79 years, 14% were between 80 – 84 years, 6% between 85 – 89 years and 1% each were between 90 – 94 years 95 – 99 years. This means that about 58% of the aged used in this study were those who qualify for the exemptions whenever they visited a government health facility.

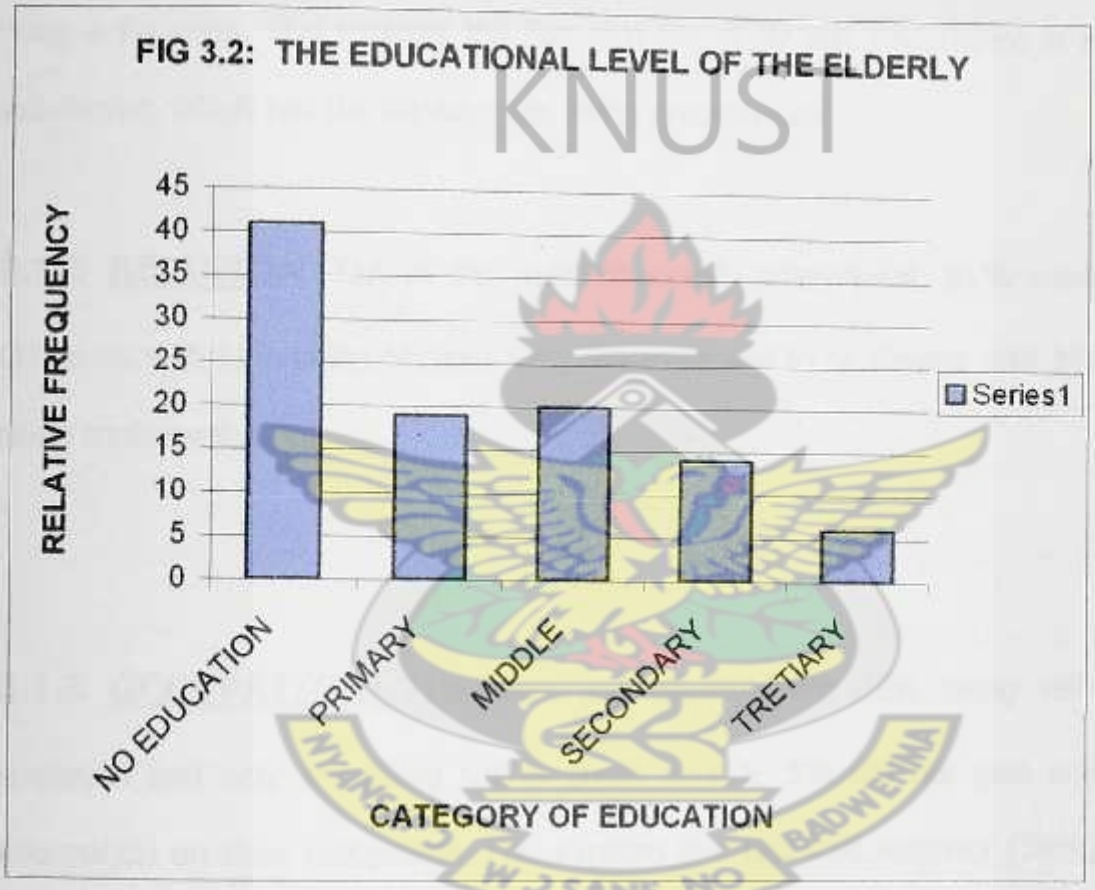
FIG 3.1: THE AGE-GROUP OF THE ELDERLY



Source: Field Survey, 2002

3.1.2 SEX AND MARITAL STATUS: Among the 100 respondents interviewed, 65% were females with only 35% being males. This is confirmed by their level of marital status where almost half (45%) of the total sample size used was widowed with the females being more than males. There were 6% who were single, 45% were married, 3% were separated and only 1% divorced.

3.1.3 EDUCATIONAL LEVEL: The level of educational attainment ranged from No education through Non-formal, Primary, Middle, and Secondary to Tertiary levels. The findings revealed that 41% of the respondents did not have any form of education with the rest (59%) having a form of education as follows: 19% had up to the primary level with 14% having up to Secondary level and 6% having up to the Tertiary level. Only 2% had Non-formal level with 20% having up to middle level.



Source: Field Survey, 2002

On the part of those elderly who have caretakers, out of the 50 respondents interviewed, 46% of them had Middle school level with 28% having Secondary education, 12% each having up to Primary and Tertiary levels with 2% having No educational status.

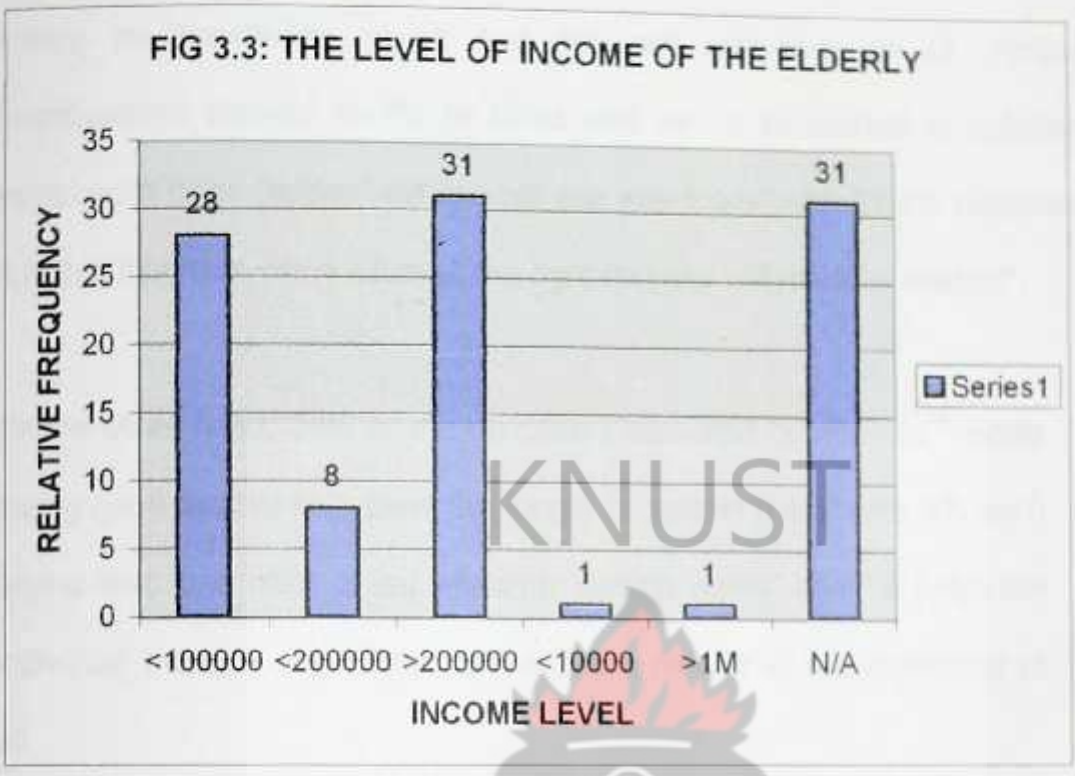
3.1.4 ETHNICITY: As many as 75% of the elderly were Ga/Adangbe with 9% each being Akan and Ewe. 3% each were Fulani and Hausa with only 1% being a Busanga. This explains the fact that the study was undertaken in a sub-district, which has the Ga/Adangbe being predominant.

3.1.5 RELIGION: Out of the hundred elderly interviewed, 81% were Christians with 11% being Moslem. Only 5% were said to be Pagans with 3% being traditionalist.

3.1.6 OCCUPATION: 71% were unemployed, with 23% being self-employed and only 1% being still in public service. 5% did not give any information on their occupation. This explains the fact that majority (58%) were within age 70years and over, thus would find it difficult or unpleasant to do active work.

3.1.7 INCOME: The income level of the elderly range from those who earn "nothing" to those who earn "over one million cedis".

FIG 3.3: THE LEVEL OF INCOME OF THE ELDERLY



Source: Field Survey, 2002

69 of the elderly earn some form of income. Out of this percentage, there are only 46% earning more than 200,000.00 with the remaining 54% earning less than 200,000.00.

However, 74% of the elderly responded positively to be receiving some form of financial subvention with only 26% answering negatively. Out of the 74% who answered positively to financial subvention, 41% had it regularly with 33% receiving it occasionally. Further investigation revealed that, 20% each said that it is 'inadequate' or 'it is good' and 26% decided not to answer at all.

3.2 LEVEL OF NUTRITION EDUCATION

Majority of the elderly have had knowledge in nutrition (60%) with only 37% having no knowledge at all and 3% not answering at all. Further investigations showed 46.7% of those who had a knowledge in nutrition, explained it to be "eating well and not one way foods" with 53.3% explaining it to be "food that when eaten at the right quantity will make us healthy".

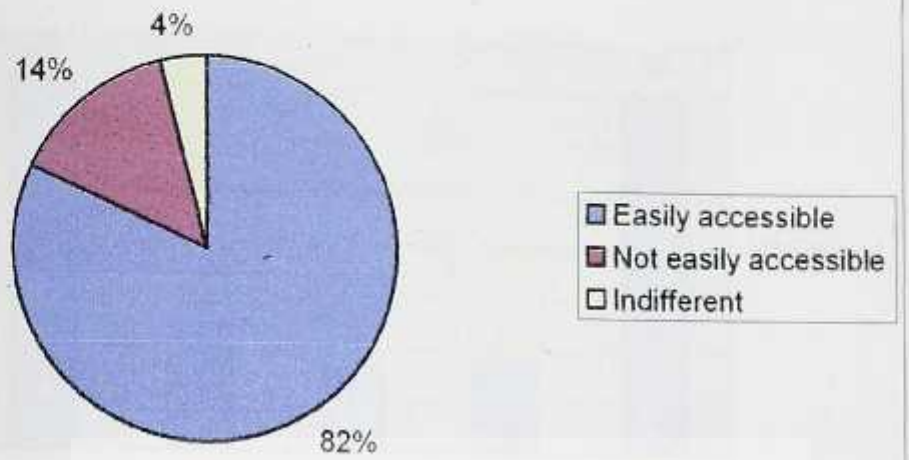
On the other hand, 84% of the caretakers explained nutrition as "people eating good food to help them live longer or sustain them" with 4% each saying that "one need to eat whatever He/She wants" and " it helps the individual mentally and physically", with the rest (4%) not explaining at all.

3.3 FOOD ACCESSIBILITY AND EATING PATTERN

The various food items which happened to be the favourites for the elderly ranged from Fufu with the various soups (light, groundnut and palm nut), Rice and palaver or tomato sauces, Banku and okro soup, Kenkey, fish and pepper relish, Red – Red, Tuo Zafi and Ampesi with others stating that "anything goes".

As many as 81% of the elderly responded that their favourite foods had their ingredients "easily accessible" with only 14% saying it is "not easily accessible" 4% were indifferent.

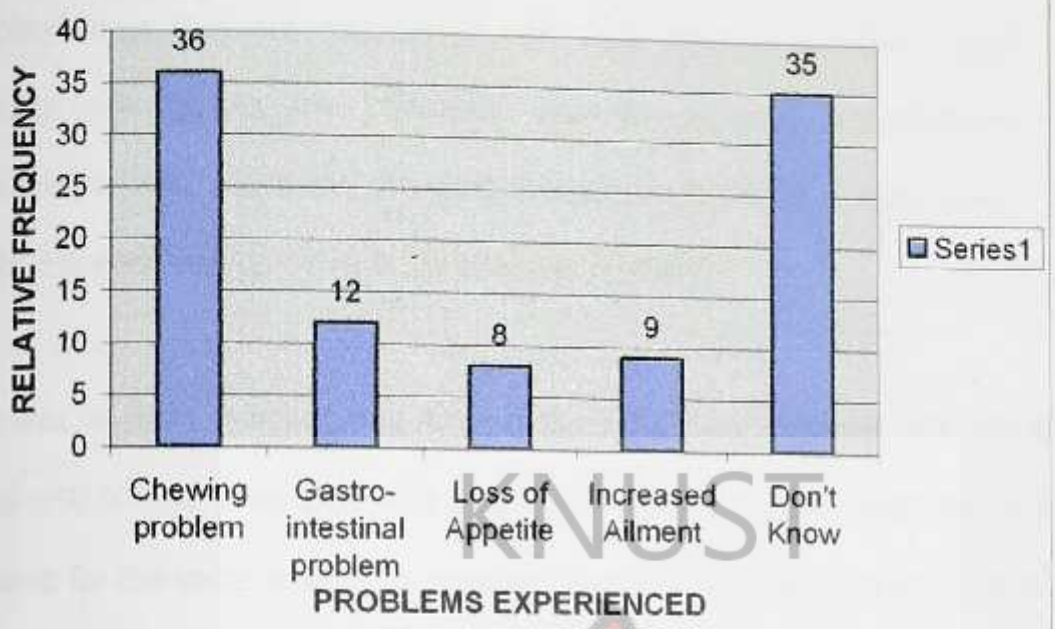
FIG 3.4: FOOD ACCESSIBILITY TO THE ELDERLY



Source: Field Survey, 2002

Further investigations revealed that majority of the elderly still take their various favourite foods after attaining age 60 and over with the main reason being that "they get satisfaction when they take it". Other reasons are that "the food is cheap" or "it happens to be their delicacy" or "it gives them the necessary nutrient" or "it takes a long time before getting hungry again", as well as "for instant relief". The few who replied negatively had reasons as "cannot chew some of the ingredients used" or "don't have appetite" as well as "do not have the means to purchase them since it is now expensive".

FIG 3.5: CHANGES IN EATING PATTERN OF THE ELDERLY



Source: Field Survey, 2002

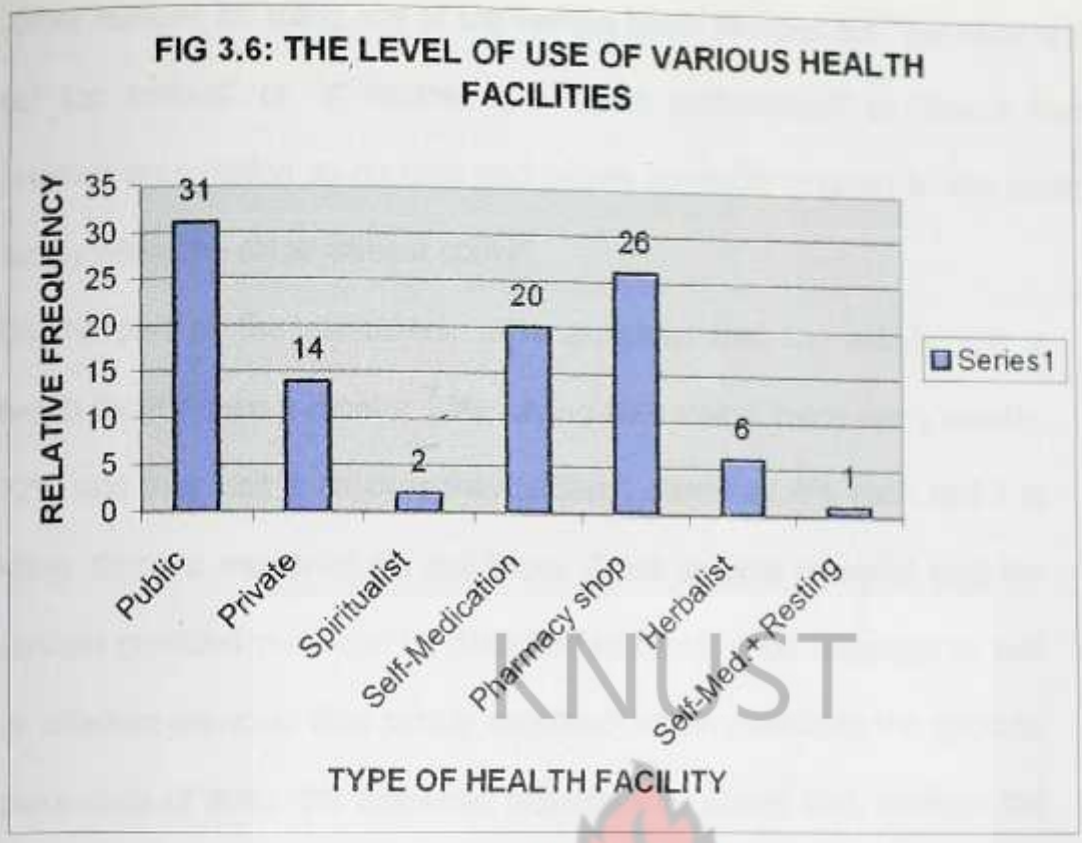
From figure 3.5, majority (36%) attributed their change in eating pattern to chewing problem (dental decay or removal) with 12% attributing it to gastro-intestinal problem and 8% attributing it to loss of appetite for food of any kind. 9% said it was due to increasing ailment, with 35% not answering at all.

3.4 QUALITY OF CARE

As many as 65% of the respondents said they use the government health facility when they are seriously ill with 25% using the private health facility. 6% go to any pharmacy shop to purchase un-prescribed medicines, which to them can cure them through personal experience, with 2% each visiting either a spiritualist or herbalist.

Further analysis revealed that 43% of the elderly pay between ¢10,000.00 and ¢50,000.00 when they visit a government health facility with only 13% paying for the same amount for services rendered them in the private setting. About 4% who visited the public and the pharmacy shops have to pay between ¢55,000.00 and ¢100,000.00. 7% who visit the private health facility pay between ¢105,000.00 and ¢165,000.00 and for Herbalist pay between ¢10,000.00 and ¢50,000.00. 1% each visited the various health facilities and paid various sums of money.

A majority of 45% of the elderly reported of hypertension as the disease chronically worrying them with 35% reporting of diabetes. Only 20% reported of both hypertension and diabetes as their persistent ailment. On the other hand, when asked where they go when they are mildly ill, 31% said they visit the government health facility, 14% visiting the private hospital, 26% visiting the pharmacy shop, 20% using self-medication, 6% visiting the herbalist, 2% visiting the spiritualist with 1% using self-medication and resting / sleeping.



Source: Field Survey, 2002

Further investigation revealed that a majority of 14% of the elderly use the pharmacy shops with the main reason being that "it is less costly and also the distance to cover happens to be short so one can go and purchase without sending anyone". 8% who use self-medication also had the same reason but added that one would not cover much distance because the individual happens to be in the house with the medicines. 3% each who use self-medication and the pharmacy shops explain that they do not have enough money to go to the health facility for proper diagnosis. 4% who visit the herbalist think that "God created the leaves for us to use to cure our ailment; they are good unless you do not know; they are not for sale".

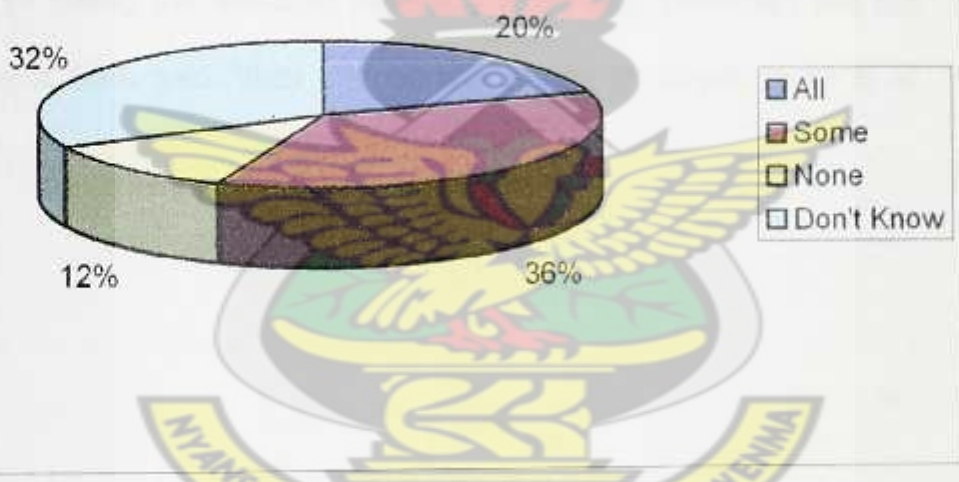
Other reasons for using any of the various heath facilities are "the ailment is not too serious" or "a relative is a health professional" or "learnt from previous prescription so no time and money to waste in going to the health facility when the same ailment starts".

On the part of the caretakers, 40% explained that the elderly visit a health facility once a month; 20% saying they visit it twice every month; 32% said they visit it anytime they (elderly) complain; 4% each said it is either thrice a month or do not know. Cross analysis revealed that the services provided them can be described to be of "good reception as well as effective services, thus simply excellent" which constitute the majority percentage of 80%. 3% answered negatively by saying that, because the services were very poor and also, sometimes health professionals yelled at them, among others. This can be attributed to the fact that the health professionals who have practiced Geriatric Medicine are very few making their work very tedious and as such make them sometimes shout at them (elderly).

3.5 ATTITUDE TOWARDS MEDICATION

Asked whether drugs prescribed was gotten from the dispensary department, majority of 56% said YES, 38% said NO and 6% said they do not know. Out of those who answered YES, had 20% saying they get all of the drugs from the dispensary department; 36% saying they get some with 12% saying they get none and 32% not answering at all.

FIG 3.7: A PIE CHART OF PRESCRIBED DRUGS RECEIVED AT HEALTH FACILITY

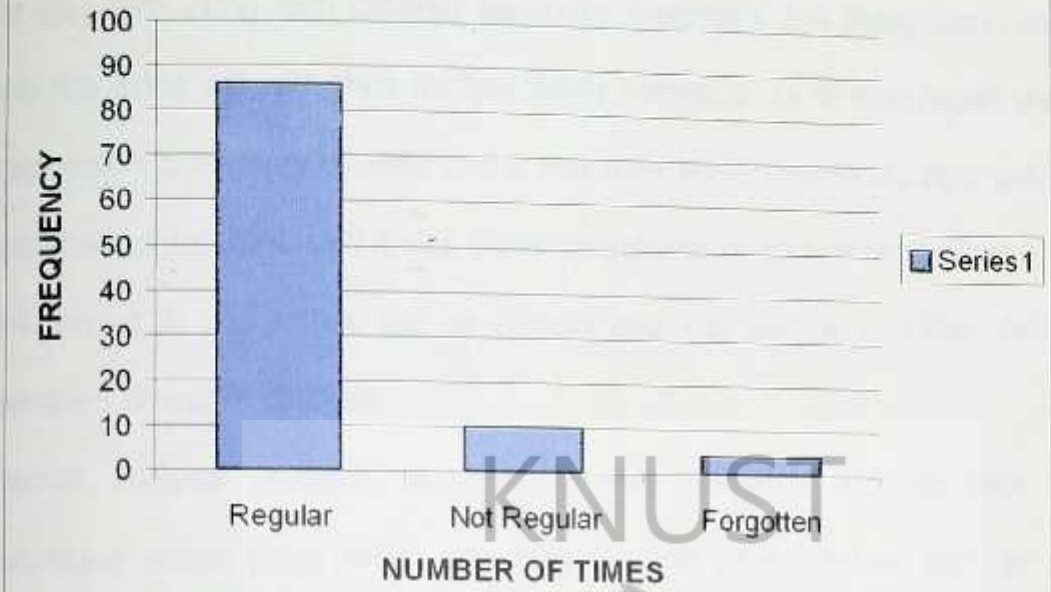


Source: Field Survey, 2002

Out of the 48 respondents who got some or none of the drugs from the health facility, a majority of 35% said they "wait and go back 2-3 days later to see the doctor"; 22% said they "keep on looking for the rest or all of the drugs at different chemical shops"; 13% each said they "do not bother to buy the rest" or "wait till they get it" or "depend on herbs". 4% also said "they forget about it and pray to God".

Further analysis revealed that, 86% regularly take their dosages prescribed with only 10% saying they do not regularly take it and 4% not answering at all. Those who do not regularly take the drugs (10 respondents) had the following explanation: 40% said "they sometimes get tired of taking the medicine especially when their reminders are not around" and 60% said "they intentionally decide to forget about it all together".

FIG 3.8: THE NUMBER OF TIMES MEDICINE IS TAKEN



Source: Field Survey, 2002

A further confirmatory analysis done on the responses of the caretakers as to whether their aged take their medicines, 88% out of the 50 respondents said the aged take their medicines regularly with only 9% taking the medicine at breaking intervals with only 3% saying they do not know. This confirms the majority percentage of 86% of the aged who said they take their medicines regularly.

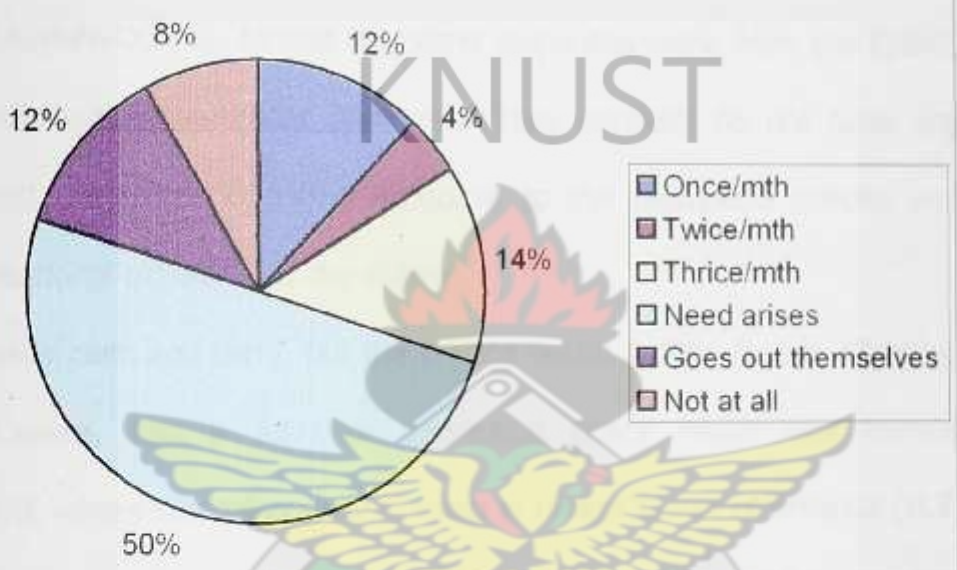
3.6 FAMILY SUPPORT AND RECREATIONAL FACILITIES

As many as 46% were living with their family members, 28% living with spouse, 16% living with children especially daughters, 6% living alone with only 4% living still with their nuclear family members. As to who meets their food needs, a majority of 39% said it was their family members, 28% said it was themselves, 12% said it was either themselves or spouse or children with 8% saying it was either self or spouse and 4% said it is either family members or self or children.

Further analysis revealed that, those who answered YES to their nutritional needs being taken into consideration gave reasons such as "food they can not chew well are mashed (5%)"; "foods which are good for them are what they prepare for them (45%)"; "they know the elderly do not like certain foods therefore they would not give that to me (6%)" and "the two of us are trying to live healthy and longer therefore they minimise their salt and oil intake (5%)". Those who answered NO had 10% saying "I eat whatever I get; I have no choice; I can die anytime", 8% said "I tolerate any food unless I have problem with it", 2% said "all members eat from the same pot irrespective of the age" and 4% said "because they care less about me". Only 15% did not answer at all.

Majority of the caretakers (50%) said that the elderly go for sightseeing "when the need arises especially when they complain about it", 14% saying it occurs thrice in a month; 12% each saying they go out themselves, or once in a month with 8% not going out at all. Only 4% said they go out twice in a month.

FIG 3.9: THE FREQUENCY OF SIGHTSEEING



Source: Field Survey, 2002

On the part of the government and NGO's, Help Age Ghana (HAG) has a day centre as well as various programs (get-together) for their members (elderly) towards sightseeing as well as socialising. On the government side, they tend to organize get-together and awards night for deserving elderly mostly on Republic Day, that is, 1st July, but government had very few places to house the destitute elderly.

3.7 POLICIES AND PROGRAMS CHANNELLED INTO THE CARE OF THE HEALTH OF THE ELDERLY.

The policies and programs outlined to help the elderly was directed to directors and medical superintendent of various health facilities such as Christian Medical Centre (Private Hospital, Nungua), Manna Mission Hospital (CHAG, Teshie), La Polyclinic (Government Hospital, Tenashie), Police Hospital (Quasi-government, Cantonments) and Metro Director of Health Services (Asylum-Down). Almost the same responses came from the CHAG, Private and Quasi-government personnel. They normally do not have any policies and programs pertaining especially to the exemption policies and other recreational activities for the elderly.

It was mostly cash and carry, but the private health facility, that is, Christian Medical Centre, had a form of exemption policy which was termed GHANACARE where Ghanaian citizens living in United States of America (U.S) pay a certain amount/ quota towards the upkeep of the medical services provided their aged parents or families in Ghana. This means that if one does not have anybody in U.S who was involved in this kind of scheme and as such visit the facility, the person would be compelled to pay for every penny of the services provided.

On the part of the Government Hospital and Metro Directorate, the responses given were as follows: "The government was supporting various NGO's involved in the care of the aged in Accra and other places"; " they were linking up with the retired staff association of various civil servants to see how best certain problems pertaining to the aged can be solved especially, the boredom and/or isolation"; "also a policy was being looked at to contract those who seem to be still strong to work"; "there is also the revising of the exemption policy to cater for the medical services; 'the exemption policy was being considered to cover the age 60 – 70'. Also the " government has taken it upon itself to give lectures and symposium towards preparation for retirement in both public, civil and private sectors employees to prepare their minds towards the changes which will come their way"; "the education of the masses on the benefit of health insurance was on-going".

Based on the various policies and programs listed above, the Key Informants also stated that the Ministry of Manpower and Development Planning could perform the following functions to help the destitute aged in the various communities:

- There should be better planning and preparation of activities and programs towards retirement.

- Family members of people who are yet to retire should be educated because their family member, who is about to retire, need them badly in terms of them treating them nicely in all ways especially emotional, nutritional, psychological among others. This can be done through the media or through the use of seminars and symposia where the general public can be invited.
- There is a need for the Ministry to assist the pensioner to work out their pension plans as well as the social security.
- There should be the need to educate individuals to at least learn a trade, which comprises skill development so that after leaving the white-collar job, the individual can trade their skill to earn something for a living.

According to the Key Informants, almost all of them said the Ministry of Health (MOH) was performing at an average with only one, that is, Christian Medical Centre, saying, the MOH was not doing much to help the aged. With those who replied on the average, they think there should be more improvement on the way the re-imbursement of the exempted scheme was done; also there was the need for better management (planning, organizing, implementing and monitoring) of the health insurance scheme to cater for the large lapses existing in our health system payment;

also the need to increase health education especially health promotion and prevention through newspapers and radio or TV on topics such as nutrition, exercises among others; should lease with NGO'S, not only those working in the area of the aged but also those working within the areas of sanitation, nutrition among others, so that indirectly the education would go a long way in helping the individual when he or she gets to the aged range; various recreational parks for the aged just like that for children, for example, Effua Sutherland's Children's Park should be created to avoid them from getting into overcrowded places.

4.0 DISCUSSIONS

4.1 BACKGROUND INFORMATION: - The study revealed that as many as 53% of the elderly and 86% of their caretakers had Primary and Secondary educational levels; their educational level can be considered to be high. This was not in accordance with the final reports of the 2000 population and housing census which explained that majority of the people have not attained any education (43.4%) with only 4.2% being in the preschool level taking into consideration the population of the under 5 which was about 14.7% of the total population (2,769,421). The census report also stressed that the rather large proportion of the population that attained primary (18.6%), as the highest level of education, was not encouraging, since the effects of education do not begin to manifest until beyond the basic level.

Furthermore, the GSS 2002 report that Christianity happened to be the dominant religion, which confirms the results from the study. The sex differentials were in line with GSS 2002 report, which said that there were more females than males. The figures given were as follows: 9,357,382 for males and 9,554,697 for females. This was also confirmed by the figures given by the various communities in the Sub-Metro as follows: **La**: 39,726(males) and 41,958(females), **Nungua**: 30,827(males) and 32,075(females), **North Teshie**: 27,815(males) and 29,134(females) and **South Teshie**: 17,279(males) and 18,131(females).

4.2 NUTRITION EDUCATION

Specific objective one showed that majority of the (elderly) had some form of knowledge in nutrition (60%). This was in line with Schlenker (1984) who stressed that "people acquire a basic pattern of food selection and knowledge of food through a lifetime of experience.

For those older individuals with few years of formal schooling, nutrition knowledge had generally been acquired through informal sources such as newspaper or magazines or friends or acquaintances. According to Schlenker (1984), nutrition knowledge tends to be essential to planning an adequate diet, for instance, if meat, fish and poultry cannot be included in their diet on a daily basis because of cost, lack of information regarding other sources of protein such as milk or legumes will compromise the nutrient intake.

On the other hand, the elderly eating pattern was closely linked to their beliefs and cultural practices. This was in line with Castillo (2002), who observed that, lifestyles were closely linked to the cultural, social and culinary value of a community. Due to this, it became difficult to identify appropriate health actions and therefore advocated for healthy eating habits that would be acceptable to different peoples and in particular, different generations. He further said that such changes could, of course, only be introduced when the population had access to appropriate food and physical activity facilities.

Borwom (2002) indicated that non-communicable diseases relating to diet and physical inactivity were responsible for 35% of years of life lost among men and 49% among women, of which 9% and 13%, respectively, were due to cardiovascular diseases.

4.3 FOOD ACCESSIBILITY AND FOOD HABITS

Findings showed that out of the 100 elderly sampled, 82% had their favourite foods easily accessible. This was achieved through shopping just around their various localities from petty traders thus making it easier than going to the market which most of the time looks overcrowded.

This was not in accordance with Schlenker, (1984), who explained that physical limitation, lack of transportation, and the changing locations of supermarkets / petty trading shops presents problems in food shopping.

Schlenker, (1984) stressed that 70% of older people reported problems with food shopping while only 20% having difficulty with meal preparation after ingredients was brought into the home.

Findings further showed that majority of the elderly still ate the foods they were taking during their "youthful" days because they feel "satisfied" when that particular food was taken. Also they feel their food preferences were moulded by their ethnic, cultural and religious backgrounds. According to Scalene (1984), older people prefer foods associated with pleasant experiences or related to home or religion.

Findings showed that the eating pattern of the elderly tend to diminish during their late years, that is, 60 or over due to problems pertaining to dental decay or teeth removal (36%) with the rest attributed to gastro-intestinal, loss of appetite as well as increase of ailment. This was supported by Durvin (1973), who said that activity tends to fall with age pillar in the higher aged-groups. Hankinson, (1975) further supported Durvin by explaining that the fall in total calorie intake was achieved by eating less food, the general evidence being that this quantitative change was accompanied by remarkably little in the way of qualitative change. Exton-Smith, (1988) also explained that low body weight was a predictor of subsequent mortality in elderly people and that low food intake not only cause weight loss, but also increases the probability that the intake of other nutrients will be inadequate. Webb et al, (1996) said, if the problems are untreated, it was likely to result in weight loss and nutrient deficiency in elderly people. Malnutrition and its consequences can be avoided in many elderly people by the appropriate use of nutritional supplements and artificial feeding methods. Greater awareness of the range and effectiveness of these nutritional support measures could play a part in reducing the high prevalence of malnutrition amongst sick elderly people.

4.4 QUALITY OF CARE

Findings revealed that 65% of the respondents use the government health facilities. This was confirmed by the fact that about 58% of the 100 elderly were within the age range of 70 years or over thus qualifying for the exemption policy. Adams (2002) stated that in 1971, the Hospital Fees Act (Act 387) and the subsequent Hospital Fees Regulations made provisions for three broad categories of the exemptions. It was in 1988, when a major interpretation and review was done and in the sectional address to parliament by the then President and the Ministerial Executive Committee, introduced other categories in the same year, which included the exemption for the elderly (defined as people above 70 years).

The findings revealed that 43% who used the government health facility did so because the cost involved range between ¢10,000.00 and ¢50, 000.00, which to them was manageable due to the exemption of certain services given them. This was in line with Heller (1983) who observed that, with increasing income, individuals sought to use the same quantity of private rather than public health services even though private services had higher services charges, due to their perceived quality. However, even poor people may be quite selective when it comes to deciding who should care for them when they are sick. A statement made to one of the premises of the Bamako Initiative stressed that," "Even poor households will pay for health care, provided they perceive the services to be of good quality,

which they usually gauge in terms of availability of essential drugs and positive health worker attitudes.

Findings revealed that when the elderly were mildly ill, majority of them (31%) visit the government health facility with 26% visiting the pharmacy shop. The medical superintendent from one of the government health facilities revealed that because the re-imbursement of the funds was not regular or late, most of the time, the policy was not applied because their monies get locked-up for months or years, which rendered them financially ineffective. The Metro Director of Health Services also explained that re-imbursement was late because the health facility combines all those exempted e.g. children under 5, paupers etc, therefore making it difficult to work out the aged-exemption separately. This was supported by Adams (2002), who stressed that the arrangement for the service to be provided by health facility to all eligible patients were to be re-imbursed upon the presentation of a bill. However, for the past three to four years, the system/ policy has run into several difficulties ranging from the modalities for re-imbursement to the interpretation of the provision of the policy. According to Adams (2002), the biggest drawbacks in recent times have been the quantum of bills presented for re-imbursement. Not only has this outstripped the exemptions budget, but it has also grown at a rate, which may soon be difficult to contain.

Bertha et al, (2002) also supported Adams by stressing that the exemption policy has proven administratively difficult to implement in practice because of several factors, including financial, administrative, logistics and behavioural factors. One of the critical issues was inadequate dissemination of information on exemptions. Delay in re-imbursement, rather than lack of exemption funds, affected the effective implementation of the exemption policy. At facilities operating multiple points of payment, financial accounting was inconsistent and inadequate at some points, and users in exempt categories ended up paying for one or more services to which they have free entitlement. For most health managers, effective management was defined in terms of ensuring high revenue generation and free services to users in exempt categories without assurance of immediate refund of money, which was also considered as ineffective financial management.

From the study, hypertension happened to be the most chronic disease affecting the elderly. This was in accordance with Afriyie (2002) who stated that, non-communicable diseases were rapidly increasing in Ghana with the prevalence of diabetes rising from 0.2% in 1958 to 4% in 2000; and hypertension and its complications, particularly strokes, accounting for 10% of deaths in urban centres and were the second leading cause of adult death in such areas. Ghana, like most developing countries, was in epidemiological transition.

While the burden of communicable diseases had been reduced, the increase in life expectancy, the adoption of Western-style dietary habits and unhealthy lifestyles had led to the emergence of non-communicable diseases. The rapid growth in consumption of fast food in Ghana was an example of the negative impact of globalisation.

Findings showed that 58% use the health facilities they visited and assess it to be "just right" as to the waiting time. Phillips (1990) said, "Quality was an intangible concept seen from both the client and provider's perspective. He said in the clients view, quality may be measured by "physical and administrative attributes such as space, comfort, cleanliness, seating arrangements and convenience of opening hours". Sira, (1976) also explained that when clients are satisfied with health care service, they are more likely to continue using them. MOH, (1997) stated that time spent waiting to / for consultation was a suitable indicator of the quality of service in terms of waiting time. For instance, Atibie Hospital, the Kwahu Government Hospital, their Quality Assurance Research found out in 1994 that only 28% of their points were seen to within two (2) hours of arriving at the hospital but by 1996, this figure rose to 86%, signifying a great improvement in waiting time. This was in line with Sira, (1976) that stated before that when the service provided is to client's satisfaction they are more likely to continue using the facility.

4.5 ATTITUDE TOWARDS MEDICATION

Findings revealed that 36% got some of their prescribed drugs from the dispensary department. Barnum et al, (1993), confirm this by stressing that, in developing countries, drug supply was sporadic, especially in lower level facilities, due to foreign exchange constraints and poor distribution systems.

It was obvious to most health managers that there is a strong correlation between drug availability and use of services ----- which was seen in variations of occupancy and outpatient visits during the course of each year. When drug availability was high, services use was high and when it was low, service use was correspondingly low. This was in line with Akin et al, (1991), in Ogun State, Nigeria where it was found that facility use increased with the percentage of time during the year that drugs were available. The study found in addition that if service charges were doubled, use of services declined by 4% ------ however, if the fee increases were used to ensure essential drug availability, the use of services increased by 35%. Schlenker, (1984), also stated that cardiovascular diseases accounted for about half of all prescribed drugs sold to older people.

Findings further revealed that, 86% of the elderly took their dosages regularly. Schlenker, (1984), stressed that in a three (3) year follow-up program for over 1700 persons age 65 and over living in a community, 77% of older persons use at least one drug regularly. Those under age 70 used one to two different drugs, whereas those above age 84 used two or three.

4.6 FAMILY SUPPORT AND RECREATIONAL FACILITIES

Findings revealed that as many as 46% of the clients were living with family members who took into account their nutritional needs. This was not in line with COMA, (2002), which explained that, "as people get older they may be able to prepare their own food or look after themselves. Many such people rely on the support of friends, relatives or community services to help with the shopping and to prepare meals. Schlenker, (1984), also stressed that about 95% of all the aged lived within the community with either a spouse or other family members or alone. Lowther and William, (1966), stressed that because of their physical, mental and social disabilities, the old often needed the support of other people to carry on their lives in the community. Families supply a great amount of such support but are too often accused of neglecting their old relatives, because more often the caring relations are elderly themselves.

Further findings revealed that majority of the elderly nutritional needs are taken into consideration by their family members or caretakers. This was in line with COMA, (2002) which stressed that foods should be supplied to the elderly taking into consideration the range of nutrients because older people need slightly less energy than younger adults.

Also there was the need to make sure that there was adequate intake of fibre and fluid, which was essential to prevent constipation. Also enough iron in the diet to help prevent anaemia was very essential therefore older people should be encouraged to eat iron-rich foods such as red meat, liver, oily fish, among others, as well as food and drink rich in vitamin C to help in the absorption of iron. There was also the need to make sure that Calcium and vitamin D can be gotten from sunlight, they should be encouraged to sit in the sunshine to trap some of these vitamin D.

Findings also revealed that majority (50%) of the aged requested for outings when the need arises. Otoo, (2002), stated that there was the need for a healthy social and religious environment. Social environment, according to him, was made up of people with whom one live, work, eat, worship and play. According to Him, one's social environment improves when one had access to valued company. He said being able to share one's joys and sorrows, dreams and frustrations with other people lowers the height of the hurdles one was in and helps one run a longer course. A lack of companionship may cause loneliness and social death, because one tends to whither if one exists without receiving expressions of care from the people around them. He said, truly, loneliness was one of the major conditions that constantly threaten the well being of the elderly. Although one may not be able to remove the loneliness such as retirement, declining mobility, the loss of long time friends or the death of a spouse, one can still take some steps to lower this hurdle to a manageable height.

Tremethick, (1997), supported Otoo's assertion by stressing that the elderly are at risk of deficits in social support; therefore, health care providers must realize the importance of social support for the elderly, assess for deficits in support, and provide appropriate options to bolster support system. This process goes beyond the traditional survival environmental assessment of safety and function and facilitates the potential for health and growth. On the other hand, Dr Asanga explained that in Africa, the elderly traditionally played an active part in the community, but that modernization, education, urbanization and migration were undermining that traditional role. He said that in many countries, ageing was widely perceived as a time of mental and physical decline, and persons over the age of 60 years were considered to be economically unproductive.

5.0 CONCLUSION

5.1: CONCLUSION

The study aimed at assessing how the health of the elderly can be managed properly in the Kpeshie Sub-Metro of the Greater Accra Region. Based on the findings, the following conclusions were drawn:

The educational level of the elderly is not encouraging because 41% have No form of education as well as 19% and 20% having up to Primary and Middle, thus rendering them inadequate when it comes to the realities of life. According to the GSS, 2002 report, the effects of education does not begin to manifest until beyond the basic level taken the way the world is moving towards information technology. This is in agreement with the level of occupation that they are engaged in with majority (71%) being unemployed after age 60, but it was seen that some elderly after their pension, are able to go into contracts or consultancy jobs earning them something due to their level of education which happens to be higher than the basic level and as such earn something more than ¢ 200,000.00 (54%).

Based on this, even-though majority (60%) tend to have knowledge in nutrition, their low level of education tend not to help them to apply this skill very well, thus, their poor balance of nutrient intakes manifest in their health as observed by the principal researcher.

On the other hand, even-though they happen to rely mostly on their family members for their meals, these caretakers most often happen to be in the geriatric group and therefore cannot cater for them effectively or take into consideration what should go into their food preparation, among others. Also because they do not earn much, they patronise the public health facility more (65%) to benefit from the exemption policy. On the other hand, if they had their own way, they would patronise private health facility where the services are far better than the other type of health facility. Heller (1982) stressed that, "even poor households will pay for health care, provided they perceive the services to be of good quality which to them usually gauge in terms of availability of essential drugs and positive health worker attitudes. A majority of 45% reported that hypertension was their ailment.

In developing countries, drugs supply is sporadic especially in lower level facilities, due to foreign exchange constraints and poor distribution systems, which were manifested in the number of the elderly who had some or none of the drugs (48%) when they visit the health facility. For the frequency in drug usage, which was a bit behavioural as well as attitudinal, it has become a problem in that, the elderly are mentally weak therefore the need for someone to remind them of what to do at certain times.

Because the majority of the caretakers happen to be the ones who have to work and provide their needs, it becomes impossible for them to take them for sightseeing most of the time thus the majority (50%) saying when the need arise.

The Ghana Population Policy seeks to address the country's population problem. There is a general consensus that, rapid population growth may not necessarily prevent economic growth, but rather economic well being of the population. Due to the rapid changes in the population especially the aged, the government and some Non governmental organisations are in the process of designing various policies and programs to support the disadvantaged group, e.g. aged and the disabled".

CHAPTER 6 – RECOMMENDATIONS

6.1 RECOMMENDATIONS

1. Focus on prevention and healthy living by the aged and their caretakers can substantially cut healthcare costs. Such approach should have exercise and healthy nutrition as its cornerstone, as well as universal and equal access to health services, thus, the need to increase health education and health prevention programs.

2. The health sector should enhance capacity building of health personnel and renew attention to the promotion of physical and mental health, the prevention of disability, provision of rehabilitation and palliative care, and support for the grieving process. In addition, MOH should encourage an adaptation process ensuring the healthcare environments, which are age-friendly and offer good working conditions for personnel.

3. Health Planners (MOH) should bear in mind that the manpower base in the health sector happens to have less of the professionals practicing in geriatric medicine, therefore, they have to liaise with the educational institution like the Universities who are into the training of these professionals so as to include this area in their program.

Aside, collaborating with the educational institutions, the ministry also need to see to the proper rationing of these trained geriatricians around the country to make even distribution of these geriatric professionals to the other individuals living outside the various metropolises.

4. A strong primary healthcare system and a continuum of care can help the older population to remain active and independent, thus, emphasis on the care within the family can be highly valued and attempts made to improve support for informal caregivers through National Family Caregivers Support Program. Also the aged should be allowed the maximum degree of independence in the homes and encouraged actively to contribute to family life.

5. The government of Ghana should make the existing policy on ageing to focus on the positive interventions in the next five years to deal with the structural and other factors that were instrumental in reducing the quality of life: seeking practical solutions, protecting social rights and striving for equality, thus, the policy should take into account the social needs in overall terms rather than focusing on specific groups; providing equal opportunities to enable people lead a full independent lives.

6. Policies to encourage rural development and self-sufficiency should be intensified by the government of Ghana and all stakeholders in order to make the young people remain in the rural areas in the years to come. This is because migration of the young people from the rural agricultural areas to the cities have increased (out-migration syndrome), leaving behind the elderly which has resulted in a pool of care providers diminishing.

7. There should be the introduction of National Health Programs on full ageing (life to the fullest). For example, Immunization against Influenza had successfully prevented disease among the over-60s in recent years; therefore, MOH should carry out epidemiological research in order to analyse mortality and morbidity trends among the elderly more accurately. HIS should also cover questions relating to ageing.

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Sex distribution of Kpeshie sub-metro

	MALE	FEMALE	TOTAL
LA	39,726	41,533	81,684
NUNGUA	30,827	32,075	62,902
NORTH TESHIE	27,815	29,134	56,949
SONTH TESHIE	17,279	18,131	35,410

Source: GSS, March 2002

Age distribution (60 yrs or above) of the Kpeshie sub-metro

		NATIONAL		MALE		FEMALE
AGE-GROUP	%	Number	%	Number	%	Number
60-64 YRS	1.9	366,351	1.9	177,347	2	189,004
65-69 YRS	1.4	258,709	1.4	129,090	1.4	129,619
70-74 YRS	1.2	255,158	1.1	106,513	1.2	118,645
75-79 YRS	0.8	144,830	0.8	74,268	0.7	70,562
80-84 YRS	0.7	140,847	0.7	66,941	0.8	73,906
85YRS and Over	1.2	229,396	1.3	121,268	1.1	108,128
Total	7.2	1,395,291	7.2	675,427	7.2	689,864

Source: GSS, March 2002

APPENDIX 1

FORM A

QUESTIONNAIRE FOR THE ELDERLY (CLIENT)

INTERVIEWER'S NAME.....

INTERVIEW CODE .....

DATE .....

TIME STARTED .....

TIME ENDED.

PART 1: Socio-economic / Background Information

1. Age.

2. Sex.

3. Marital Status

(a) Single ( ) (b) Married ( ) (c) Widowed/Separated/Divorced ( )

4. Place of Residence .....

5. Highest Educational Level

(a) No Educational ( )

(b) Non- Formal ( )

(c) Primary ( )

(d) Middle School ( )

(e) Secondary School ( )

(f) Tertiary Institution ( )

6. Ethnicity

(a) Ga/Adamgbe ( ) (b) Akan ( ) (c) Ewe ( ) (d) Others (specify) .....

7. Religion

(a) Christianity ( ) (b) Traditional ( ) (c) Moslem ( ) (d) Other (specific).....

8. Occupation

(a) Unemployed ( ) (b) Retired ( ) (c) Others (specify) .....

9. What is your total income?

(a) Less than 100,000.00 (b) Less than 200,000.00

(c) Greater than 200,000.00 (d) Other (specify).....

10. Do you receive any form of financial subvention?

(a) Yes (b) No

11. If yes, in what form?

(a) Regular (b) Casual

12. How adequate is your remittance?

(a) Inadequate (b) Fair (c) Good

PART 2: Level of nutrition education, accessibility of food and dental problems

13. Do you have any knowledge or education in nutrition?

(a) Yes ( ) (b) No ( )

[Answer questions 14 – 16, if yes]

14. In your view, what do you understand by the term Nutrition? .....

15. Name some of the various classes of nutrients that we have in Ghana?

.....

16. Do you think knowledge in nutrition can go a long way in helping an individual, especially the aged to lead a normal life once again?

(a) Yes ( ) (b) No ( )

17. If yes or no, give reasons?.....

18. What was your favourite food? .....

19. How accessible are the ingredients of this food to you?

(a) Easily accessible ( )

(b) Not easily accessible ( )

(c) Indifferent ( )

20. Is it still your favourite food after attaining 60 years and over?

(a) Yes ( ) (b) No ( )

21. If yes or no, why .....

22. Do you have problems or difficulty in eating (chewing)

(a) Yes ( ) (b) No ( )

23. Which of the following do you think is the major cause of this inability to eat well in your later years? (Rank them)

(a) Loss of teeth (chewing)

(b) Gastro- intestinal problems / crumbs

(c) Loss of Appetite

(d) Increased severity if disease / ailment

PART 3: Quality of care and prescribed drugs

24. Where do you go when you are severely ill?

(a) Public ( )

(b) Private ( )

(c) Spiritualist ( )

(d)Self-medical / treatment ( )

(e) Pharmacy / Dispensary shop ( )

(f) Herbalist ( )

(g) Others (special) .....

25. Where do you go when you are mildly ill?

(a) Public ( )

(b) Private ( )

(c) Spiritualist ( )

(d) Self-medical / treatment ( )

(e) Pharmacy / Dispensary shop ( )

(f) Herbalist ( )

(g) Others (special) .....

26. If not Public and Private Health facilities, then why do you patronise any of the options?.....

27. How long does it take you travel to the health facility or place of health service?

(a) Less than 1 hr ( ) (b) 1 – 2 hrs ( ) (c) 3 – 4 hrs ( )

(d) 4 – 5 hrs ( ) (e) above 5 hrs ( )

28. By what means do you get there? By

(a) Walking ( )

(b) Taxi / Trotro ( )

(c) Private ( )

(d) Bicycle ( )

29. What is the average cost of transportation? .....

30. How much do you normally pay for the services rendered to you.....

31. What do you think of the length of waiting time during service delivery?

(a) Too long ( ) (b) Just Right ( ) (c) Don't know ( )

32. What was the attitude of the staff towards you?

(a) Cordial ( ) (b) Indifferent ( )

(c) Harsh ( ) (d) Don't Know ( )

33. How understandable is the explanation of your illness by the health personnel to you?

(a) Very well understood ( )

(b) Partially understood ( )

(c) Not understandable at all ( )

(d) Don't Know ( )

[If private or public health facility, answer questions 35 – 37]

34. Do you normally get the prescribed drugs from the dispensary?

(a) Yes ( ) (b) No ( )

35. What portion of all the drugs prescribed do you obtain from the pharmacy shop?

(a) All of them ( )

(b) Some of them ( )

(c) None of them ( )

(d) No response ( )

36. If you get some or none of the drugs prescribed, what do you do then?

....

37. What is your level of understanding of the dosage of drugs given to you at the service point?

(a) Very well understood ( )

(b) Partially understood ( )

(c) Not understandable at all ( )

(d) Don't Know ( )

[If not well understood, don't answer question 38]

38. If not well understood, how do you go about taking the dosage? By asking

(a) Friends ( )

(b) Relatives ( )

(c) Caretakers ( )

(d) Others (specify) .....

39. Do you regularly take your dosage?

(a) Yes ( ) (b) No ( )

40. If No, why .....

PART 4: Social support for the elderly

41. Whom are you living with?

(a) Alone ( ) (b) Spouse ( ) (c) Living with family ( )

(d) Others (specify) .....

42. If alone, how do you go about your daily chores? .....

43. Who meets your food needs?

(a) Self ( ) (b) Family Member ( )

(c) Formal services (care workers, community support etc) ( )

(c) Other (specify) .....

44. If family members or others how do they go about it? .....

45. Do they take into consideration your nutrients requirement in connection with your health needs?

(a) Yes ( ) (b) No ( )

46. If yes, how? .....

.....

47. If no, why? .....

.....

.....

FORM B

QUESTIONNAIRE FOR CARETAKERS

TIME STARTED.....

TIME ENDED .....

QUESTIONNAIRE NUMBER .....

1. Place of Residence

   (a) La ( ) (b) Teshie ( ) (c) Tenashie ( ) (d) Nungua ( )

2. Age .....

3. Marital Status

   (a) Single ( ) (b) Married ( ) (c) Widowed ( ) (d) Separated ( )

   (e) Divorced ( )

4. Highest Educational Level

   (a) No education ( ) (b) Non – Formal Education ( )

   (c) Primary ( ) (d) Middle School ( )

   (e) Secondary ( ) (f) Tertiary Institution ( )

5. Occupation .....

6. Religion

   (a) Christian ( ) (b) Moslem ( ) (c) Traditionalist ( ) (d) Others .....

7. Ethnicity

   (a) Ga / Adamgbe ( ) (b) Akan ( ) (c) Ewe ( ) (d) Others .....

8. What is your level of nutrition education as pertains to the health of the elderly? .....

9. How often do the elderly visit a health facility in a month?

(a) Once ( ) (b) Twice ( ) (c) Thrice ( ) (d) Others .....

10. Do you accompany him / her when visiting the facility?

(a) Yes ( ) (b) No ( )

11. What can you say about the services given him / her when visiting the facility?.....

12. How often do he / she take his / her medication?

(a) Regularly ( ) (b) Not regularly (specify number of times).....

13. What is your relationship with the elderly?

(a) Father ( ) (b) Mother ( ) (c) Auntie ( ) (d) Uncle ( )

(e) Other (specify).

14. How often do he / she go out for sightseeing or social gatherings?

(a) Once in a month ( ) (b) Twice in a month ( )

(c) Thrice in a month ( ) (d) Other (specify) .....

15. what in your view would be the best procedure used in managing the health of the elderly? .....

.....

FORM C

INTERVIEW GUIDE FOR KEY INFORMATION

All interviewees will be personnel in the area of the caring of the health of the elderly at Kpeshie Sub – Metro.

Date of interview .....

Time started .....

Time ended .....

Interview number .....

1. Profession .....

2. Age.

3. Sex.

4. Duration of service .....

5. What policies and programs have been outlined in your outfit to help the elderly in living a normal life after age 60?

6. How are these policies and programs going to benefit both the elderly and the society as a whole?

7. Since health is a triad, has the policies and programs taking into consideration the social aspect of the triad in terms of recreational areas / centres since the physical and to some extent mental aspect are being catered for by the exemptions (to some extent).

8. How often does the re-imbursement of funds work with the exemptions given to the elderly?

9. In practice, is the exemption actually working at all?

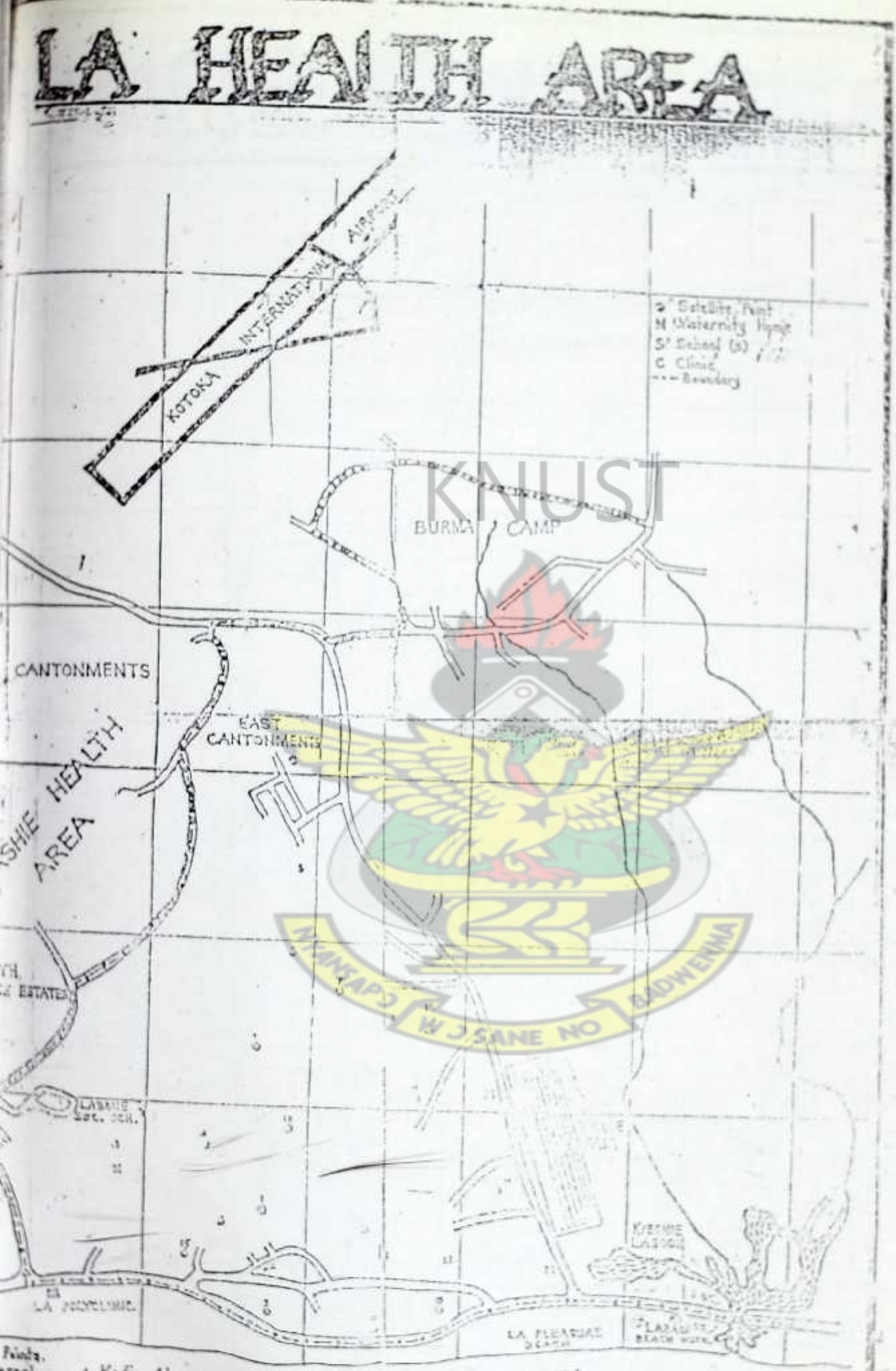
10. What in your view, should be done by the Ministry of Manpower Development and Planning in order to help those destitute aged in our various communities?

11. In your view, what is the performance of the Ministry of Health in helping to managing the health of the elderly?

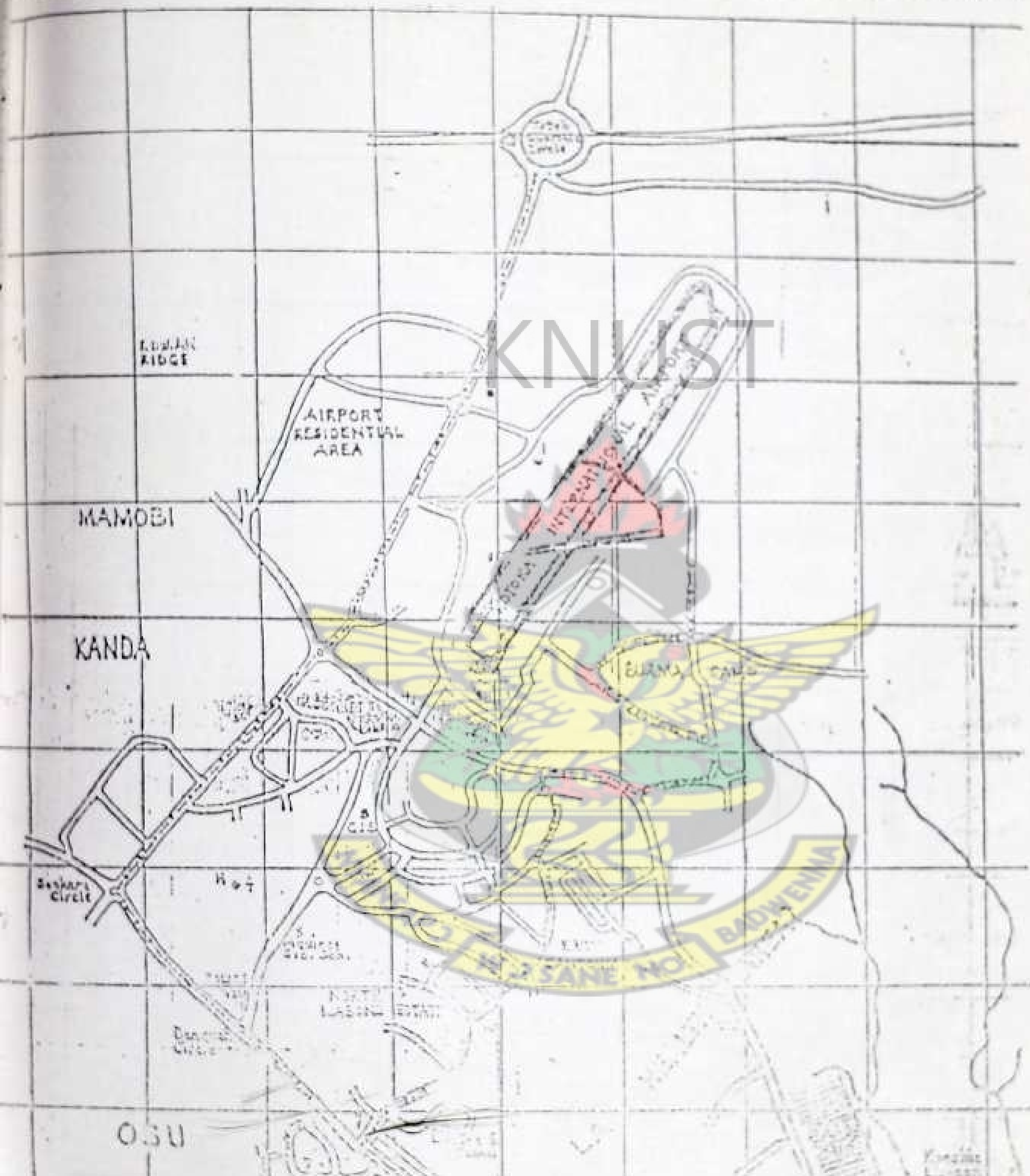
12. What do you think can be done to strengthen the performance of the Ministry of Health as well as other sector ministries in helping the elderly in managing their health?


ESTENTIAL AREA
ROMAN RIDGE
AIRPORT RESIDENTIAL
KOTOKA INTERNATIONAL AIRPORT
TESHIE
TESHIE NUNGUA ESTATE
CANTONMENTS
BURMA CAMP
TESHIE CAMP
NUNGUA
TESHIE
TESHIE TOWNSHIP
NORTH LABONE ESTATE
LABADI
TRADE FAIR
ACCRA METROPOLITAN ASSEMBLY
HOUSING WORKS DEPT
P. O. BOX 772
ACCRA

LA HEALTH AREA



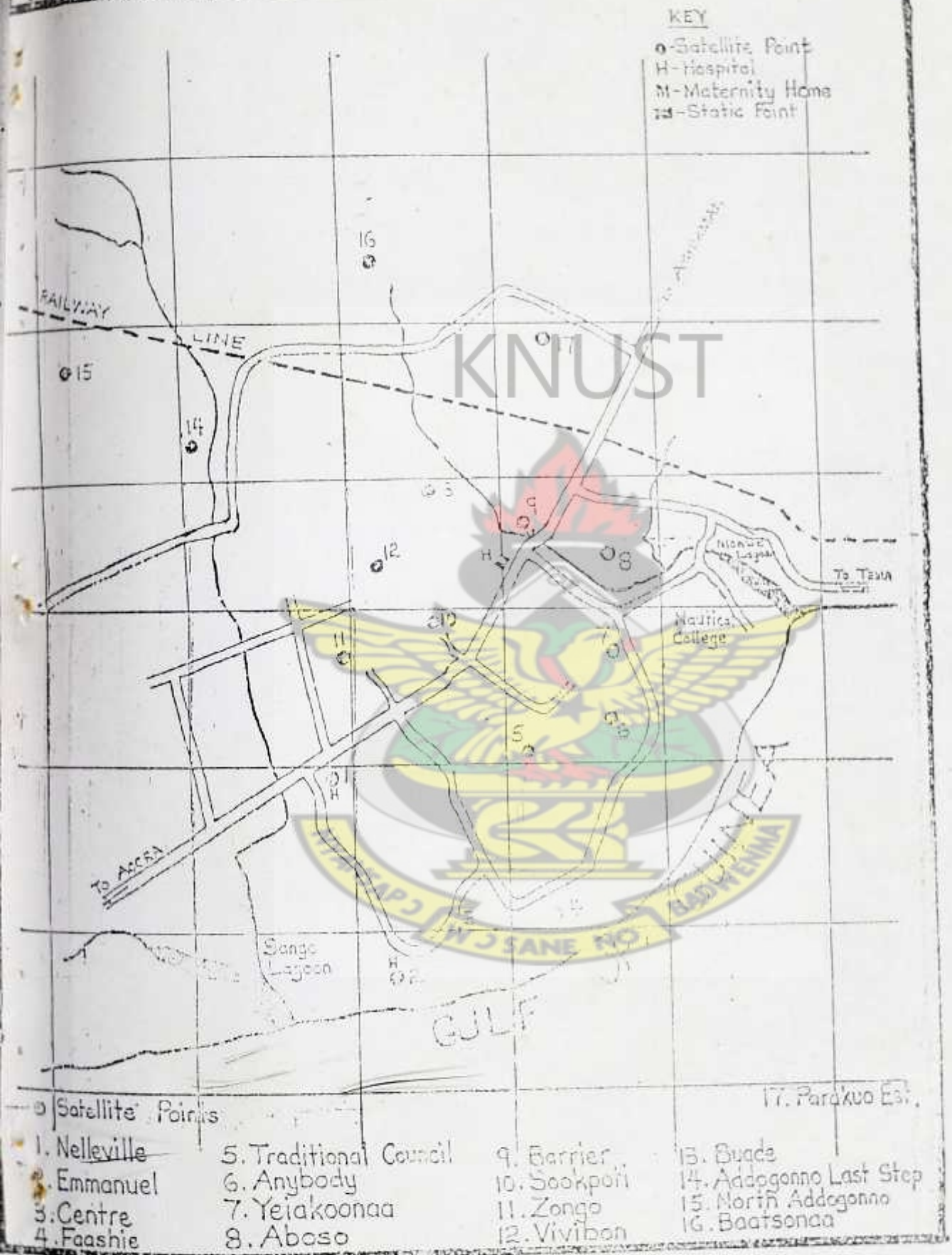
ENASHIE HEALTH AREA



ellite Points	
Airport	6. La Polyclinic (Static)
oajanar	7. Nyaniba
kklemadu	8. Manheam
umedji	9. Osu Children's Home
Dr. Larsey	10. CEPS Barracks

TESHIE HEALTH AREA

NUNGUA HEALTH AREA



Satellite Points

1. Nelleville
2. Emmanuel
3. Centre
4. Faashie
5. Traditional Council
6. Anybody
7. Yeiakoonaa
8. Aboso
9. Barrier
10. Sookpoli
11. Zongo
12. Vivibon
13. Buade
14. Addogonno Last Step
15. North Addogonno
16. Baatsonaa