Healthcare challenges of older people with and without dementia in Ghana: An exploratory pilot study

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Abstract. Dementia prevalence in those aged over 60 is increasing worldwide. Relevant literature shows that, in Ghana, the proportion of the elderly is growing comparatively faster than in developed countries and other parts in Africa (Agbényiga and Huang, 2012). There is, however a dearth of controlled research addressing dementia in Ghana (Quansah and Karikari, 2016). This study aims to identify current healthcare challenges facing older people and people with dementia in Ghana. The methodology used combined a quantitative and qualitative approach in its explorative, descriptive design. One hundred and seventy-one (171) questionnaires were retrieved from Ghanaian nursing students; five expert-interviews were conducted in Ghana and one in Germany. Quantitative data have been deployed in respect of descriptive methods; transcribed interviews were examined using content analyses. Despite low life-expectancies in sub-Sahara Africa this study revealed that people in Ghana live beyond 60 and become correspondingly more vulnerable to dementia than is often supposed. To this day, sufficient structures and adequate assistance facilities for the elderly do not exist. A lack of awareness of the ageing process results in stigmatisation of the aged and people with dementia. Alarmingly, Ghanaians still accuse older people and people with dementia of witchcraft. Consequently, these people living socially excluded lives in witch-camps, are often beaten or even killed. Ghana's healthcare system remains unprepared for demographical changes. Missing specialists and aged-care facilities present a relevant deficit to sufficient health care for older persons. A shift in public awareness of understanding dementia as an illness instead of witchcraft seems imperative. Lack of knowledge of ageing and dementia need to be addressed as a priority in the national agenda. Further research is strongly recommended.

Keywords: Dementia, awareness, stigmatisation, witchcraft, Africa.

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Introduction

Between 1950 and 2000 the mean age of world populations increased from 23.9 to 26.7 (Goldstein, 2009). Recent publications predict an increase to 38.1 years of age by 2050 (ibid.). In sub-Sahara Africa (SSA) life-expectancy is growing together with the risk of developing dementia (Mavrodaris, Powell, & Thorogood, 2013; Kalaria et al., 2008). Within the population 60+ the relationship between dementia prevalence and age is consistent, with rates doubling every 5.1 years (George-Carey et al., 2012; Jorm, Korten, & Henderson, 1987). Moreover, it should be stressed that dementia can occur in people below the age of sixty (60) as well, such as the case of younger adults living with HIV-associated dementia (Habib, et al. 2013). Until now no cure has been found and dementia is among the most feared diseases of older people (George-Carey et al., 2012; Kessler, Bowen, Baer, Froelich, & Wahl, 2012). Recent estimates indicate that the number of people with dementia living worldwide will double every 20 years; this means that by 2030 there will be 65.7 million People with dementia, increasing to 115.4 million by 2050 (World Health Organization, 2012). Nearly two-thirds (60 % in 2001) live in developing countries; with the figure expecting to rise to 71 % by 2040 (Prince, Livingston, and Katona, 2007). Due to low life expectancies most SSA countries are excluded from debates about population ageing (Goldstein, 2009).

Table 1. Projected population ageing in the world, low-income countries, Africa, SSA regions and Ghana from 1950 to 2050

	Population 60+ (million)			Population 60+ (% of total population)		
	1950	**2015**	**2050**	**1950**	**2015**	**2050**
Low-income countries*	6.6	33.2	114.8	5.0	5.2	8.3
Africa	12.1	64.5	220.3	5.3	5.4	8.9
Sub-Saharan Africa**	9.4	30.6	161.1	5.2	4.8	7.6
Eastern Africa	3.3	18.9	72.4	4.9	4.8	8.3
Middle Africa	1.6	6.9	24.4	5.9	4.5	6.6
Southern Africa	0.9	4.7	11.5	6.0	7.5	14.7
Western Africa***	3.6	16.0	52.8	5.1	4.5	6.6
Ghana	0.2	1.4	4.8	4.1	5.3	9.7

Source: United Nations, (2015).

*The country classification by income level is based on 2014 GNI per capita from the World Bank.

**Sub-Saharan Africa refers to all of Africa except Northern Africa.

***This includes, Saint Helena, Ascension, and Tristan da Cunha.

However, it is established that a percentage growth in the population 60+ will increase more in African than in Asian countries (Kowal et al., 2010) Ghana, a developing country describing itself as a lower middle-income country, is witnessing a greater rapid growth in its older persons than in other parts of Africa (Agbényiga, 2012). In last decades the proportion of older persons in Ghana increased rapidly (Mba, 2010). By 2050 the population 60+ is expected to more than triple (see Table 1) (United Nations, 2015).

Current estimates point out that the percentage of the population 60+ in Ghana will also age in the future (United Nations, 2015). Moreover, the current average life expectancy is 62 years and is higher than the average life-expectancy in other SSA-countries (59.2 years) (ibid.). Noteworthy to observe is that epidemiological literature on dementia in Africa is very limited – the dementia prevalence or incidence has not been subject to either study or research in Ghana (Quansah & Karikari, 2016; George-Carey et al., 2012; World Health Organization, 2012,). Estimates can, however, be used from other West-African studies conducted in Benin (Paraiso et al., 2011; Guerchet et al., 2009), Nigeria (Gureje, Ogunniyi, Kola, & Abiona, 2011; Uwakwe et al., 2009) and Senegal (Toure et al. 2012) these yielded prevalence figures varying widely between 2.6 % (Guerchet et al., 2009) and 8.9 % among persons aged 65+ (Toure et al., 2012). The demographic patterns referred to above give an indication that in the coming decades Ghana´s People with dementia is likely to rise steeply (George-Carey et al., 2012); this fact coupled with the absence of meaningful scientific research bedevils attempts at the higher policy levels to address the healthcare challenges of People with dementia. It is the purpose of this paper to explore such healthcare challenges in an endeavour to generate hypotheses for use in future studies aimed at improving the quality of People with dementia lives.

Material and methods

Study design

Using an explorative, descriptive study design, a mixed-method approach, by combining qualitative and quantitative research methods, data were collected to generate hypotheses facing healthcare challenges of Ghana´s older persons with and without dementia. Data collection took place in two urban areas of Ghana (Greater-Accra; Central-Region) in March 2012 and in Germany in August within the same year, grounded on an expertise on ageing and cultural beliefs in Ghana. Participants were selected according to the following criteria: formal integration in the health care sector, as well as awareness and knowledge of ageing and dementia in Ghana. Older persons were defined as those aged 60+. Dementia was defined based on typical signs and symptoms of the disease, such as memory loss and loss of independence in daily tasks as described by the World Health Organization (World Health Organization, 2012). Persons with dementia and people without knowledge on ageing or dementia were excluded from the study.

Ethical considerations

Ethical considerations were addressed at the Alice-Salomon University of Applied Sciences. Participants were anonymous, participated on a voluntary basis and were free to decline or terminate participation at any time. No harm or disadvantage of any sort threatened them.

Quantitative study

Sample

A convenience sample of students of three nursing colleges in the area of Cape Coast, Central Region was selected during March 2012. The area was choosen because one of two existing nursing schools specialised in mental health. Questionnaires (n=175) were distributed to those enrolled in a degree for nursing at the three nursing colleges in this area.

Outcome measures

A standardised written questionnaire was developed to collect general descriptive data about awareness on ageing and dementia. The questionnaire, based on the issues formulated in the introduction of this paper, was divided into three areas: 1) demographic information; 2) information on aged healthcare situation; and 3) information about respondents´ awareness of old people with and without dementia. Two questions gave opportunity for further exploration: Why do you think a) older people and b) dementia diseases need more attention? The questionnaire was pre-tested using a sample of 25 nurses in Ghana, and consequently the content and wording of the questionnaire was modified.

The "Approach to Dementia Questionnaire" (ADQ) – developed by Lintern, Woods and Phair (2000) was used to measure attitudes towards People with dementia. The ADQ is a 5-point Likert-scale from (1) strongly agree to (5) strongly disagree with 19 items measuring a global score (19-95) and two sub-scores, 'hope' (8-40) and 'personhood' (11-55). A higher global score indicates more positive attitudes. The subscale 'hope' (8 Items) indicates levels of hope, greater hope with higher scores. The second subscale measures recognition of 'personhood' (11 items). Higher scores indicate greater recognition that People with dementia are sentient human beings.

Statistical analysis

Basic characteristics of participants were described using descriptive statistics, e.g. absolute numbers, simple percentages, mean and median. Correlations among ordinal variables were examined by Pearson's and Spearman's correlations. Chi-square tests, Fisher's exact test and t-tests were also used to analyse the data. Explanations to the open ended questions were coded and catagorised in relation to the content: including (a) demographical aspects, (b) the health care situation of older people and People with dementia, (c) awareness and understanding of dementia, and the issue on stigmatisation and discrimination. The categorized answers were finally quantified in numbers and percentages. Significance

(nominal p-value) was set at p<.05. All statistical analyses were carried out using SPSS® (V20.0).

Qualitative study

Sample

A convenience sample of interviewees based on expertise and knowledge of ageing and dementia aimed to obtain a fair representation of key stakeholders involved in ageing and dementia care. Experts were selected on the basis of having worked for at least four years with the Ghanaian healthcare sector involving ageing or dementia. Such experts working in the field of dementia in Ghana are limited. In this regard one German expert was selected for the interview in setting up a NGO in Ghana and the knowledge of cultural aspects and ageing. Exclusion criteria include missing awarness and knowledge of ageing and dementia.
Of eight identified experts, six agreed to participate. The guided interviews were conducted with five Ghanaian experts in March 2012 and one German expert in August 2012 (see Table 2). The first author (SS) conducted the interviews. Persons with dementia have not been interviewed.

Table 2. Characteristics of the interviewees

IP 1	Researcher and deputy director of *United Nations Regional Institute* for population studies in Ghana, senior lecturer at *University of Ghana*
IP 2	Lecturer for mental health at a nursing and midwife college (Central Region Ghana)
IP 3	Assistant director of policy planning, monitoring and evaluation at *Ministry of Employment and Social Welfare* (Accra; Ghana)
IP 4	Governing social worker at the NGO HelpAge Ghana
IP 5	Medical director *o*f a psychiatric hospital (Central Region Ghana)
IP 6	German historian, founder of an association and a vocational training school in Ghana

Expert interviews conducted in Ghana (IP 1 – IP5) in March 2012 and Germany (IP 6) in August 2012. IP: Interviewee partner; NGO: non-governmental organization.

Semi-structured expert interview

The method of semi-structured interviews was used to obtain the individual views of the interviewees on an issue. The developed interview guide was lightly structured with the expectation that the interviewee reply as freely and as extensively as they wish. A number of questions were prepared to cover the intended scope of the interview. The interview guide constructed on current research and the fomulated problem:

(1) general information on aged care and dementia in Ghana;
(2) Ghana´s healthcare situation and treatment of old persons with and without dementia;

(3) deficits in the healthcare of older people and People with dementia;
(4) experts´ views of future perspectives.

Data analysis

Transcribed interviews were examined using manifest and latent content analyses based on Mayring (Flick, 2011; Mayring, 1983). Segments of the interview data were coded on the topic including the same themes used for open ended questions of the questionnaires (a) to (c).

Results

The quantitative and qualitative results are summarised in the same three categories: a) demographic aspects, b) healthcare structures and c) awareness of ageing and dementia diseases and its linkage to witchcraft stigmatisation.

Quantitative results

In total 171 questionnaires were completed. Slightly more females participated in the study (59.6 %; n=102) with an average age of 22.9 years (n=166) (see Table 3).

Table 3. Characteristics of respondents (n=171)

Characteristics	Classification	n	%
Sex	Female	102	59,6
	Male	69	40,35
Age	> 20	17	10,2
	21-29	146	87,9
	30-45	3	1,8
Year of training	2nd	101	59,4
	3rd	58	34,1
	4th	11	6,5

Questionnaires were handed out to Ghanaian nursing students (n=175) at 3 different nursing colleges in the Central Region in March 2012. The research field represents more an urban area.

The ADQ questionnaire was fully completed by 90 % (n=154). Within these answers, significant differences between respondents' gender (Fisher Exact Test, p=1.0) or age (t-Test, p=.962) have not been found. 98.8 % of the responding nursing students were of the opinion that older people (n=168) and dementia diseases (n=163) need more attention. The majority gave further exploration why older people (86 %, n=146) and why dementia diseases (81.3 %, n=138) require more attention. Those argued along demographical aspects (e.g. older age as a risk for developing dementia), the poor healthcare situation for older persons, awareness of ageing and dementia and its linkage to witchcraft stigmatisation.

Demographical aspects:

Results of the survey revealed that people in Ghana reach ages above 60 years. Respondents indicated an average age of 80.3 (±13.9) for their grandparents. About 18 percent acknowledged that grandparents in their family suffered from dementia symptoms, such as memory loss and loss of independence in daily tasks (see Table 4). 21.9 % (n=32) argued that the risk of developing dementia is the reason as to why older people need more attention (see Table 5).

Table 4. Age of the grandparents with and without dementia symptoms of the respondents

	Mother´s side		**Father´s side**	
	Grandmother	**Grandfather**	**Grandmother**	**Grandfather**
Mean age	79.3	80.1	80.5	81.6
Median age	79.0	80.5	80.0	81.0
Valid data	n=121	n=106	n=107	n=91
With dementia valid data	13.5 % (n=23) n=124	9.9 % (n=17) n=112	11.7 % (n=20) n=101	10.5 % (n=18) n=94
Mean age	84	82	81	81
Age median	83	80	80	80
Valid data	n=23	n=15	n=14	n=11

Survey of nurses: Questionnaires were handed out to Ghanaian nursing students (n=175) at 3 different nursing colleges in the Central Region in March 2012. The research field represents more an urban area.

Table 5. Three main categories of answers quantification to the open-ended questions of the surveyed nurses (n=171)

Reasons why older people need more attention (n=146)	**Reasons why age-related diseases need more attention (n=138)**
a) Demographical aspects –prone to dementia	
21.9 %; n=32	15.9 %; n=22
Many people especially those in the rural areas [are prone to dementia]. During that age, they tend to lose concentration in their surrounding and behave childishly. Due to the condition they at times behave as children and will this they require much care and attention. They need care because they are prone to dementia.	There are a lot of people with dementia in Ghana. It is now on the increase. Everybody is predisposed to as soon as one gets to the age 60+. Most old people might have suffered the disease but they might not be aware and have no insight into the disease.
b) Healthcare structures – need of care	

52.1 %; n=76	19,6 %, n=27
Most of these aged are always needy and poor and sometimes lack proper living homes and therefore need to be given attention by other and the nation as well. Some do not have people to care for them so aged care facilities should be put up for them. No care or specific facility is being offered to them. Because most family members find it difficult to care for them.	A lot more of the aged groups are not being cared for. They need more care since they can´t undertake activities on their own. It is a disease and it must be treated and managed. Most of them are not cared for and are neglected. The government does not include mental patients (demented clients) in the drawing.
c) Awareness of ageing and dementia and the issue of witchcraft	
13.0 %; n=19	34.1 %; n=47
Old age is mostly not understood by people. They are sometimes neglected by family and people in the society. Most are being neglected by their relatives hence they need more attention and support from amateurs. Some of these people are branded as witches and wizards and are left alone by their families. We turn to neglect them and call them witches. People neglect them due to problem associated with ageing and relate it with witchcraft. The aged are sometimes considered to be witches and wizards and so they are neglected and sometimes society says they are the cause of their own predicaments.	People in Ghana does not have much knowledge about dementia. There is inadequate education about dementia. People try to neglect them due to their behaviour. There is a need for an awareness to be done on the condition since most people, who find themselves in such state do not have the insight and therefore effective care is not given. People don´t know the disease and associates it to witchcraft. Normally when dementia occurs in the aged, people often attribute it to witchcraft neglecting them. Most old people in Ghana with dementia are being classified as witches and are being maltreated at all times.

Nota bene. Questionnaires were handed out to Ghanaian nursing students (n=175) at 3 different nursing colleges in the Central Region in March 2012. The research field represents more an urban area.

Moreover, respondents had significant contact with People with dementia – 35.2 % (n=56) in their private field and 70.2 % (n=120) in their working environment. ADQ mean values (Global: 66.6; Hope: 24.5) are located in the middle third of the value range and indicate positive attitudes of nurses towards People with dementia and a moderate level of hope. The average value for recognition of personhood (∅ 42.1) is in the top third and indicates an even more positive attitude of respondents towards People with dementia in terms of they are recognised as sentient human beings.

Healthcare structures:

Respondents referred to people they met who were in need for permanent care (47.3 %, n=79), the majority (62.6 %, n=57) suffering from dementia symptoms. 9.9 % (n=16) referred to nursing homes, but named psychiatric hospitals (n=9) instead of places where older people are cared for. The majority (52.1 %, n=76) see a need for care for the aged and aged-healthcare structures that barely exist (Table 5). Moreover, assistive devices and aids are difficult to organise. 54.1 % stated being able to obtain canes or walking sticks. About 30 % felt there were opportunities to obtain walking frames, wheelchairs or incontinence materials.

Awareness of ageing and dementia and the issue of witchcraft:

Nearly all participants (95.8 %, n=159) indicated that the term dementia was part of their nursing curriculum. 34.1 % (n=47), suggested a lack of knowledge of dementia among Ghanaians and referred to resulting stigmatisation of People with dementia, e.g. through not knowing their condition and behaviour (Table 5). The obvious neglect of older people was quoted by 13.0 % (n=19) of participants to be another reason to increase the focus on older people. Accusing older people (5.5 %) and People with dementia (13 %) of witchcraft appears to be a major stigmatisation issue. Furthermore, results revealed that neglecting older people and People with dementia is not only an issue among other community members; it also occurs within the families.

Qualitative results

As with the quantitative data, the results of qualitative data collection based on six expert interviews (Table 3) are summarised in the same categories.

Demographical aspects:

Interviewees (IPs) pointed out that Ghana´s population becomes increasingly older. "Ghana is gradually ageing as the proportion of older people doubles out every ten years". (IP3) "[…] older people need more attention because of advancing age". (IP1) Reasons for rapid ageing in Ghana according to experts are the decline of fertility rates, improvements of life conditions and better viabilities of Ghanaians (IP1; IP6). Reduced infant mortality and high numbers of children with better viabilities indicate that more elderlies will live in Ghana in the future (IP6). Furthermore, all interviewees pointed out that Ghana's population show effects of urbanisation, e.g. the extended family system is breaking apart. Younger Ghanaians see chances in big cities like striving for better education and perspectives (IP1; IP5) or looking for ways going abroad for better life-standards in developed countries (IP6). Additionally, younger persons do not want to live extended-family ways anymore. Nowadays they use family planning methods. "People want their privacy […]. They want to go the nuclear family way." (IP1) Because of urbanisation older Ghanaians will stay behind in rural areas without any help to counter their problems. "Now, more older people living alone, because other family members migrated […]." (IP5)[…] if you are an older person how will you survive? Because first you are not working, you are not having any stable source of income. So, you just become […] a pop-up on the streets. (IP3)

Healthcare structures:

All interviewees stated that aged care facilities and geriatric wards in hospitals are virtually non-existent. "They [older people] are provided with general healthcare like any other age group." (IP3)

> We don´t have a geriatric service-centre for older people. And that is a must. […] that is something we should have. (IP3)
> So, whether the family likes it or not, they have to live with them. Or they have to get people to live with them. (IP4)

Furthermore, there are few geriatric-experts, so the diagnoses for dementia is rare. Especially the population without medical training would have difficulties in identifying dementia symptoms. People define anything mentally abnormal as madness.

> I don´t think we have any procedure for diagnosing dementia in Ghana. We only look at your age and the behaviour you putting like and diagnose that as dementia. But it will be difficult for Ghanaians. (IP2)
> Nobody screens for dementia. To the Ghanaians' society those things are in code madness. Nobody screens for madness. (IP5)

Awareness of ageing and dementia and the issue of witchcraft:

The interviewees also spoke about the lack of knowledge and awareness of the ageing process. Older people and People with dementia are seen as useless with the result that these people are left alone.

> There is a mentality that when somebody gets the age of 60 the person is useless. […] The person should just go home and sit somewhere and wait for the time for them to die. (IP3)

Strong traditional beliefs are a reason why people in Ghana still accuse and condemn People with dementia with practicing witchcraft. Especially older females are regarded as witches. Medical explanations – like memory problems, confusion, and wondering during menopause – are rarely used.

> […] it is a belief concept that we have about the aged. That especial the female aged are considered to be witches. (IP2)
> People start behaving strangely […]. We believe that is witchcraft. (IP4)
> When women get to their menopause period they act funny. Sometime[s] their behaviour can be abnormal and because of that, people accuse them of witchcraft. (IP3)

Being accused as a witch has enormous consequences for older persons, and even more if family members reject them and stop to care for them.

> People will just accuse them [people with dementia] wrongly that they are witches. And then more treat them, mistreat them in a lot of ways, some people are killed and some people are banned. (IP3)
> If you go to the prayer camp, because of the signs and symptoms of dementia, some are confessing they are going out of delusion, they are saying they are witches. They will even take the family members away from them. […] if you are a witch, means you are not somebody that will get help by the family. (IP2)

Discussion

Ghanaian nursing students and healthcare experts indicate several challenges concerning the healthcare situation of older persons with and without dementia. The responses to the questionnaires had a high response rate from the nursing students who were predominantly female and, with an average age of 22, tended to reflect the views and attitudes of the younger generation. The healthcare experts, although predominantly male and demographically older, expressed views and attitudes which were very similar.

United Nations Population Estimates and Projections (2015) show Ghana´s current life expectancy is slightly over 60 years (United Nations, 2015); in contrast, responses to the questionnaire show that many of the nursing students perceived their grandparents to be aged over 80. This discrepancy is difficult to analyse not least because prior to 1965 there were no proper procedure of registering birth and death (Mehta & Assie, 1979; Ghana: Act No. 301, 1965). However, the fact remains that Ghana´s younger population is growing and younger Ghanaians discern older persons living in the country. Improved living standards and better viabilities of the older population will steadily rise and will continue to do so in the future (United Nations, 2015; Mba, 2010). Abgényiga and Huang (2012) conclude that Ghana is one of the most rapidly ageing countries in Africa (Agbényiga, 2012); the Wolrd Health Organization (2014) believes that the ageing population in Ghana is growing faster than in many developed countries. Furthermore, many of the survey respondents had contact with People with dementia within their work environment and their private field. Low life-expectancy and high fertility rates should not eliminate the fact that people in Ghana can reach to old age and are prone to dementia.

Dementia prevalence is understudied in Ghana, but studies from other West-African countries like Benin (Paraiso et al., 2011; Guerchet et al., 2009), Nigeria (van et al., 2011; Uwakwe et al., 2009) and Senegal (Toure et al., 2012) show that Ghana, with its higher life-expectancy (United Nations, 2015), is highly likely also to have a higher dementia prevalence. This hypothesis demonstrates that dementia should not, be seen only as a 'white people's disease' relevant for study only in Western or developed societies. The demographic changes referred to above require national policies designed to meet the needs of older persons with and without dementia. Yet Ghana's healthcare system fails at present to address these challenges; as still, Ghana´s health-care infrastructure is inadequate, supply of medicine insufficient and health-care facilities and providers are in a short supply (World Health Organization, 2014). In this respect, results of this study show that aged-care facilities and

geriatric wards are to this day, non-existent, and assistive devices like walking sticks or a walking frames are extremely difficult to organise.

Family assistance becomes, in this context, much more important and yet the extended family-system – an important traditional system caring for the older members of the family – is breaking apart (Apt, 2001; Apt, 2002). Younger Ghanaians look for better education in cities or trying to go abroad. Consequently, older persons are left behind in rural areas. This issue is also addressed by other studies (Mba, 2004; Van der Geest, 2002). In rural areas the healthcare situation is much more frightening and can impair the health condition more negatively. Apt (2001; 2002) described the neglect of older people because of the changing family-system. Ogwumike and Aboderin (2005) identified a higher risk of older people living in poverty and that they are much more likely to depend on family support than younger adults. It may be assumed that the number of younger people aiming to go the 'nuclear family' way and using family planning methods will increase in the future. Furthermore, Ghana´s women now have access to education, training schools and universities. Universities in Ghana have embarked on strategies to increase the enrolment of female students (Kwapong, 2007). This empowerment of women could influence their involvement in taking care of older family members, with the consequence that the number of older Ghanaians, with and without dementia left behind and living alone in the rural areas will increase and they will be left helpless (Apt, 2002). Experts in geriatric care who diagnose dementia diseases are extremely rare in Ghana, so even those families wishing to understand and deal with dementia do not have access to relevant information.

The failure of Ghana´s policy makers to provide adequate care for older persons with and without dementia (in distinction to the extant 'ageing policy') is hard to understand (Yiranbon et al., 2014). The rights of persons with disability to treatment is enshrined in Chapter 5 of Ghana´s Constitution as a 'fundamental right'; it is prescribed that persons with disabilities have the inherent right not to be subjected to differential treatment in virtue of their disabled condition as well as the right to be protected from discriminatory, abusive or degrading treatment (Art. 29 (2) & (4)). The reason why the general lack of awareness of the linkage between ageing and dementia among the Ghanaian public (as supposed to the nurses and health professionals) proves particularly problematic for People with dementia is the widespread belief in witchcraft (Ofori-Atta et al, 2010). Witches are believed to possess the power to cause sickness, blight their enemy´s crops, cause impotence and sterility and death; the secrecy of their identity creates in people paranoia and suspicion especially against older women (Bannerman-Richter, 1982). Older women with and without dementia are still often stigmatised as witches (Badoe, 2012). Higher stigmatising attitudes towards people with mental illness are related to lower educated people (Barke, Nyarko, & Klecha, 2011). This study reveals a connection between witchcraft accusations and living with dementia because people do not understand symptoms of dementia such as memory loss and loss of daily tasks. For example in the Northern part 'Gambaga' over 3,000 women are condemned as witches and excluded from society and family by being forced to live in witch-camps – gloomy tiny huts without clear water and lacking hygiene (Badoe, 2012). Aboderin (2006) observes that the stigma was also often attached to older women lacking the support by their own children (Aboderin, 2006). Ofori-Atta et al. (2010) further conclude that those suffering symptoms of

menopause are also subject to similar treatment (Ofori-Atta et al., 2010). A further example is the story of a *72*-year-old woman, who was burnt alive to death for being a witch. Her son explained that his mother was never a witch but was only exhibiting signs of forgetfulness and other symptoms of old age (Smith, 2010).

A way forward is shown by the surveyed nurses who, in the light of their training, showed a more positive attitude towards People with dementia which could indicate that they will treat them in better ways. This should help to counter the inhumane effect on older people and People with dementia resulting from the prevailing cultural beliefs′, and contribute to the realisation that older persons living with and without dementia deserve to be treated with dignity and humanity. This survey has been limited to a small sample and has also suffered limitations because of the language barrier. English is the official and educational language but within families the spoken language varies strongly in terms of cultural backgrounds. Survey-participants represent one urbanised region. Nurses from other country-areas may not get lessons on dementia and beliefs or attitudes towards older people with and without dementia could be different, especially in rural areas where traditional beliefs seem to be stronger than in the Northern parts where the accused witches live (Badoe, 2012).

Conclusion

Ghana′s healthcare system remains unprepared to address the ageing population and the related increase of age-related diseases like dementia, as evidenced by the lack of specialists, and the absence of aged-care wards in hospitals. Debates about this issue should not be hampered in SSA simply by the perception of low life-expectancies and high fertility rates as this study shows that SSA is home to older persons and People with dementia than it is commonly assumed. The absence of debate and the corresponding lack of public awareness lead to stigmatisation and accusation of witchcraft. In this regard, awareness campaigns are required as a matter of urgency through which healthcare workers and geriatric experts need to raise public consciousness. In the absence of such public awareness and the input of experts on geriatric care older persons with and without dementia are unable to enjoy the right to live the kind of dignity and absence of discrimination that the Constitution of Ghana guarantees to them.

Acknowledgments: We would like to acknowledge the nursing schools which allowed the survey and all of the nursing students who completed our survey, as well as the interviewees which gave their expertise. We thank Frank Panford QC for drawing our attention to the constitutional and human rights law dimension of the problem. In addition, we would like to express our appreciation that ‘Alzheimer′s and Dementia Namibia and Alzheimer′s and Related Disorders Association of Ghana’ are significantly contributing to improving awareness of dementia in their countries.

Authors’ contributions: According to ICMJE guidelines, all authors 1) have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; 2) have been involved in drafting the manuscript or revising it critically for important intellectual content; 3) have given final approval of the version to be published; and 4) agree

to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. SSp: Study design, data collection, data analysis, manuscript preparation. EK: study design, manuscript preparation. AM: data analysis, manuscript preparation. KWO: Study design, data analysis, manuscript preparation. All authors read and approved the final version.

Disclosure: The authors have reported no conflicts of interest.

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