Informing evidence-based policies for ageing and health in Ghana

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Introduction

Population ageing presents challenges and opportunities and requires action on the part of national policy-makers.1 However, in low- and middle-income countries, which often have high rates of maternal mortality and infectious diseases, effective responses to the health needs of older people need to be prioritized. In addition, evidence on health systems interventions for the ageing population and evidence-based responses are often not available or applied in these countries.2,3

To bridge the gap between evidence and policy in the field of ageing, the World Health Organization (WHO) with the support of Age UK, produced a knowledge translation framework on ageing and health. This framework is based on the SUPPORT tools for evidence-informed health policy-making4 and the EVIPNet methods designed to support the development of policies based on existing research.5 In 2012, the Government of Ghana requested technical support to help revise and improve its existing policy and implementation plan on ageing and health. This provided an opportunity to trial the framework in a middle-income country. This paper describes the process used and the main lessons learnt.

Approach

We defined priority health problems by assessing the needs of older people and the national health system and policy context. We did an initial informal assessment of the political environment and found that the use of knowledge translation in the country was favourable with a national ageing policy released in July 20106 and an implementation plan in place. There was also good local epidemiological data on older people’s needs from the Study on global ageing and adult health, which includes a nationally-representative sample of 3923 Ghanaians older than 50 years.1 Ghana has a well-structured health system that could be extended to meet the health care needs of older people, although expertise in ageing is scarce. In 2010, 6.7% of the population in Ghana were older than 60 years (6.0% men; 7.3% women) and the proportion of older people is increasing. The country is undergoing an epidemiological transition with the emergence of noncommunicable diseases as the major cause of disease burden in this age group.

Using epidemiologic evidence, review of policy documents, site visits and interviews with key informants, we first drafted a country assessment report that identified priority problems. Second, we synthesized evidence on effective health system interventions for each identified problem. Information was obtained from the WHO package of essential noncommunicable diseases interventions for primary health care in low-resource settings7 and from the McMaster Health Forum’s health systems evidence database.8 Time and resource constraints limited our searches to only one global database. The McMaster database is the most comprehensive, free access source to evidence on how to strengthen health systems. It contains AMSTAR (A Measurement Tool to Assess Systematic Reviews)-graded systematic reviews of research about ageing interventions in low- middle- and high-income countries.

Third, the Ghana Health Service, with WHO support, organized a three-day policy dialogue to discuss the identi-
identified problems. This meeting involved representatives from key ministries, the Ghana Health Service, teaching hospitals, professional bodies, HelpAge Ghana and WHO. The dialogue was structured around clarifying the problems and framing policy options. The meeting began with an interactive plenary session on the global and African status on ageing and health as well as key findings of the assessment report and progress made during the implementation action plan of the Ghana National Ageing Policy. Groups were then formed for each problem. Participants signed up for one of the groups based on their interest and expertise. Afterwards we reviewed the composition of the groups to maintain homogeneity in numbers and the profiles of participants. The group identified the scope and underlying causes of each priority problem and reviewed which of our synthesized evidence on health interventions could be implemented in Ghana. Basic concepts of evidence-based policy-making were covered in didactic presentations by WHO staff.

Fourth, together with a small group of experts and policy-makers for Ghana, we developed policy briefs for each problem, with recommended actions for the Ministry of Health and the Ghana Health Service. This project cost approximately 100,000 United States dollars.

Results

Using the country assessment report, we identified six priority problems, based on prevalence, impact on health, amenability to change within the country context and alignment with the 2010 Ghana National Ageing Policy: (i) undiagnosed and untreated hypertension; (ii) high prevalence of respiratory problems; (iii) limitation of physical function affecting social participation and quality of life; (iv) poor utilization of health-care services by older people; (v) inadequate preparedness of the health workforce to care for older people; and (vi) obesity.

Participants in the policy dialogue replaced obesity with visual and hearing impairment. While the latter did not emerge as a priority from the available epidemiologic data, these conditions are common elsewhere. Studies from Ghana suggest that approximately 8.0% of outpatients reported hearing issues, and experts believe that the proportion of people with visual impairment is high.

Similarly, while dementia was not identified as a priority problem, participants felt it should be specified within the limitation of physical function priority. This is because there is a low awareness of the problem and there are limited services for people with dementia.

When participants were divided into working groups, there was no interest in the respiratory diseases problem. Consequently, this problem was not addressed. The exclusion of respiratory problems from the agenda does not mean they are not a prevalent and important health concern for the people in Ghana, but that the context did not support a policy response to this problem at this time.

The groups developed a more nuanced understanding of the problems and reframed some of them. For example, the problem of undiagnosed and untreated hypertension was reframed as high prevalence and low control of hypertension, since the problem was not simply under-diagnosis, but also inadequate long-term treatment. The Study on global ageing and adult health showed that 57% of people older than 50 years in Ghana had hypertension on clinical examination. However, only 23% of them were aware of their condition and of these people, 4.1% were on long-term treatment. This highlights the gap between awareness and control as well as the need for better adherence to treatment. Participants suggested that inadequate ongoing treatment may be due to low health insurance coverage in Ghana. Other participants discussed the difficulty of conveying the concept of chronic conditions and the need for ongoing treatment within the older people’s belief systems. Understanding of chronic disease and curability varies for different population groups in Ghana, with complex relationships between knowledge, beliefs and health practices. Consequently, the problem of hypertension was reframed from limited access to screening and drug treatments, to an issue concerning older people’s understanding of the nature of chronic disease and chronic care.

The working group’s final definition of the five priority problems were (i) undiagnosed and untreated hypertension; (ii) functional impairment and social isolation; (iii) poor utilization of healthcare services by older people; (iv) inadequate preparedness of the health workforce to care for older people; and (v) high level of sensory impairment (visual impairment and hearing loss) which are undetected and/or unmanaged among the elderly.

As a next step, the groups considered policy options and interventions using evidence on cost-effective health systems responses to ageing. Direct evidence for such responses in middle-income countries is limited and generalization from higher income settings may not be appropriate. Another challenge arose from how the priorities were selected, since the selection process was mainly based on epidemiologic studies and not a health systems approach. Participants therefore restructured the meeting to allow further discussion on how to build health systems that would address the selected priorities and the health systems weakness. This led to a list of key interventions (Box 1) to be included in policy briefs. The policy

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**Box 1. Recommended interventions for ageing and health in Ghana**

- Sensitize the community to the health needs of older adults; targeting information and education efforts to the public, carers, community leaders and religious organizations.
- Integrate ageing and health in the community health workers’ programme.
- Build workforce capacity at all levels in the health system.
- Create age-friendly health facilities.
- Broaden insurance coverage by increasing the range of services and the number of people who are eligible.
- Make devices for hearing and visual impairment available to people in need.
- Create and empower support groups to assist with screening, education, management and care of older people in communities.
briefs recommended relevant health systems responses.

The policy briefs were presented at the strategic planning retreat of the Ghana Health Service in August 2013 and key policy recommendations on ageing were incorporated into its five-year operational plan.

Discussion

This is the first use-case of WHO’s knowledge translation framework for ageing and health. Our experience shows that the framework can be useful in a middle-income setting to guide the development of evidence-informed policy. The process engaged a wide range of stakeholders and provided a systematic and transparent approach to the appraisal, evaluation and use of evidence in decision-making. It was timed to inform the operational plan of the Ghana Health Service.

However, several challenges arose in the knowledge translation process. While the policy dialogue was well-attended, engagement of key stakeholders was difficult due to competing demands on their time. Most participants were not experienced in using research findings and could not relate to the terms used in the SUPPORT tools and EVIPNet methods. We therefore revised the tools during the meeting to include more familiar language, to enable participants to stay engaged in the knowledge translation process. Finally, the lack of evidence on health systems interventions for middle-income settings resulted in the use of more anecdotal evidence to inform the policy briefs.

In conclusion (Box 2), this project suggests that a knowledge translation approach to develop a policy on ageing and health can be useful in middle-income settings. However, the framework needs to be adapted to local settings and more health systems research in low- and middle-income countries is needed.

Competing interests: None declared.

Lessons from the field

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Box 2. Summary of main lessons learnt

- The framework was useful for engaging stakeholders in a middle-income country to develop evidence-informed policies on ageing.
- The terms used in the tools need to be adapted to local contexts.
- Lack of research on health systems interventions for ageing populations in middle-income countries is a significant barrier and flexible knowledge translation methods are needed for policy development in these settings.

ملخص

الإبلاغ عن السياسات المسندة بالبيانات من أجل الشيخوخة والصحة في غانا

المشكلة: تبلغ نسبة السكان المسنون في غانا 8% في عام 2011. ومع ذلك، طلبت الحكومة غانا الدعم التقني من منظمة الصحة العالمية لتطوير السياسات الوطنية بشأن الشيخوخة والصحة. السؤال: كيف يمكن استخدام إطار ترجمة معارف منظمة الصحة العالمية للمساعدة في وضع السياسات المسندة إلى البيانات؟

الطريقة: أولاً، قمنا بتحديد المشكلات ذات الأولوية وأجراء تقييم الدور المستهدف يمكن استخدامه في السياسات المحلية بشأن الشيخوخة والصحة. ثانياً، قمنا بجمع البيانات الموجودة بشأن تدخلات نظم الصحة الفعالة في البلدان الواردة. ثالثاً، قمنا بتجميع البيانات بشأن تدخلات نظم الصحة الفعالة في البلدان. أخيراً، قمنا بتقديم تقارير موجزة عن السياسات وتقديمها إلى الخدمات الصحية في غانا.

النتائج: يمكن استخدام الإطار لبناء القدرات المحلية بشأن الشيخوخة والصحة. ومع ذلك، يجب إجراء تقييم فوري للبيانات الواردة واستعراض السياسات والتشريعات البلدية واكتساب معرفة بسياسات البلدان الأخرى. إن هذا الإطار يمكنه تحسين تعلم السياسات حول الشيخوخة والصحة في غانا.

المؤشرات المتلقي:

نوع السياسة: دبلوماسي

المصادر: منظمة الصحة العالمية، الحكومة غانا

البيانات المتناهية:

- عدد السكان المسنون في غانا
- تقارير موجزة عن السياسات
- تقييم الدور المستهدف

التعليمات العملية:

- استخدام إطار ترجمة معارف منظمة الصحة العالمية
- تجميع البيانات حول تدخلات نظم الصحة الفعالة
- تقديم تقارير موجزة عن السياسات

المؤشرات المتلقي:

- تحسين تعلم السياسات حول الشيخوخة والصحة
- توصية بإنشاء إطار ترجمة معارف منظمة الصحة العالمية

المراجع:

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摘要

加納老龄化和卫生政策

加納人口正在老龄化。2011年，加納政府请求世界卫生组织（WHO）提供技术支持以帮助修订有关老龄化和卫生的国家政策。

方法: 我们应用WHO有关老龄化与卫生的转化框架来帮助加纳的循证决策。首先，我们通过执行国家流行病学数据评估、政策评估、现场走访和面对面访谈信息提供者来定义优先级问题和卫生系统的回应。其次，我们收集低收入和高收入国家有关有效卫生系统干预措施的证据。第三，召集利益相关者参与政策对话。第四，编制政策简报并呈递给加纳卫生局。

当地状况: 加納卫生系统结构完善，通过调配能够满足老人人的卫生保健需求。

相关变化: 入选的优先问题有几个，然而在政策对话后，
La población del Ghana está envejeciendo. En 2011, el gobierno del país solicitó la asistencia técnica de la OMS para revisar sus políticas nacionales relacionadas con el envejecimiento y la salud. El envejecimiento de la población de Ghana es una realidad que los gobiernos deben enfrentar para garantizar el desarrollo de políticas de salud que respondan a las necesidades de la población envejecida. La Organización Mundial de la Salud (OMS) proporcionó la asistencia técnica necesaria para ayudar a revisar las políticas nacionales sobre el envejecimiento y la salud en el país. El análisis de los datos epidemiológicos, una revisión de las políticas existentes y el desarrollo de nuevas políticas se llevaron a cabo con el objetivo de crear una política de salud que sea factible y efectiva en el contexto específico de Ghana. El enfoque fue coherente con el modelo de traducción de conocimientos de la OMS, que se adapta a las condiciones locales y favorece la creación de políticas de salud que sean factibles y efectivas en el contexto del país. La introducción de políticas de salud factibles y efectivas en Ghana es un paso importante para garantizar el bienestar de la población envejecida y promover el desarrollo sostenible del país.
lugar, se desarrollaron y presentaron informes de políticas a los Servicios de Salud de Ghana.

**Marco regional** Ghana tiene un sistema de salud bien organizado, capaz de adaptarse para atender las necesidades de asistencia sanitaria de las personas mayores.

**Cambios importantes** Se seleccionaron seis problemas como prioridades, sin embargo después del diálogo sobre políticas, las partes interesadas acordaron solo cinco de ellos como prioritarios. Las principales partes interesadas redactaron recomendaciones políticas basadas en datos empíricos que se usaron para desarrollar informes sobre políticas. Los escritos se presentaron al Servicio de Salud de Ghana en 2014.

**Lecciones aprendidas** El marco puede utilizarse para potenciar las capacidades locales en la formulación de políticas basadas en datos empíricos. Sin embargo, las herramientas de traducción de conocimientos necesitan un mayor desarrollo para emplearse en los países de ingresos bajos y en el ámbito del envejecimiento. Los términos y el lenguaje de las herramientas deben adaptarse a los contextos locales. Los datos empíricos acerca de las intervenciones del sistema de salud sobre el envejecimiento de la población son muy limitados, sobre todo para los contextos de ingresos bajos y medios.

**References**

1. Global population ageing: Peril or promise? Geneva: World Economic Forum; 2012.
2. Kowal P, Kahn K, Ng N, Naidoo N, Abdullah S, Bawah A, et al. Ageing and adult health status in eight lower-income countries: the INDEPTH WHO-SAGE collaboration. Glob Health Action. 2010;3(0) Suppl 2. doi: http://dx.doi.org/10.3402/gha.v3i0.5302 PMID: 20959878
3. Knowledge translation on ageing and health - A framework for policy development. Geneva: World Health Organization; 2012.
4. Oxman AD, Lavis JN, Lewin S, Fretheim A, editors. SUPPORT tools for evidence-informed health policymaking (STP). Oslo: Norwegian Knowledge Centre for the Health Services; 2010.
5. Evidence Informed Policy Making [Internet]. Geneva: World Health Organization; 2014. Available from: www.who.int/evidence/en/ [cited 2014 Oct 9].
6. National Ageing Policy: ageing with security and dignity. Accra: Government of Ghana; 2010.
7. Britwum R, Mensah G, Yawson A, Minicuci N. Study on global AGEing and adult health (SAGE) Wave 1. The Ghana National Report. Geneva: World Health Organization, 2013.
8. Package of essential NCD interventions for primary health care: cancer, diabetes, heart disease and stroke, chronic respiratory disease. Geneva: World Health Organization; 2010. Available from: http://www.who.int/cardiovascular_diseases/publications/pen2010/en/ [cited 2014 Oct 9].
9. McMaster Health Forum [Internet]. Hamilton: McMaster University; 2014. Available from: http://www.mcmasterhealthforum.org/ [cited 2014 Oct 24].
10. Amedofu GK, Awubah P, Ocansey G, Antwi B, Brobby GW. Utilization of hearing aids by the hearing-impaired in Ghana. Trop Doct. 2004;34(2):118–20. PMID: 15117152
11. Lloyd-Sherlock P, Beard J, Minicuci N, Ebrahim S, Chatterji S. Hypertension among older adults in low- and middle-income countries: prevalence, awareness and control. Int J Epidemiol. 2014;43(1):116–28. doi: http://dx.doi.org/10.1093/ije/dyt215 PMID: 24505082
12. Addo J, Agyemang C, Smeeth L, de-Graft Aikins A, Edusei AK, Ogedegbe O. A review of population-based studies on hypertension in Ghana. Ghana Med J. 2012;46(2) Suppl:4–11. PMID: 23661811
13. de-Graft Aikins A, Boynton P, Atanga LL. Developing effective chronic disease interventions in Africa: insights from Ghana and Cameroon. Global Health. 2010;6(1):6. doi: http://dx.doi.org/10.1186/1744-8603-6-6 PMID: 20403170