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Double Burden, Single Response: The Irony of Ageing with Disability in Ghana

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Abstract: Ghana faces a demographic paradox: a rapidly ageing population, projected to reach nearly 10% by 2050, collides with systemic unpreparedness to address the intersecting vulnerabilities of ageing and disability. Through a narrative review of literature anchored in the lived experience of Alima, a 68-year-old grandmother with arthritis and post-stroke disability, this paper examines the "double burden" of health decline and socio-economic precarity exacerbated by fragmented policies and cultural dissonance. Findings reveal stark regional disparities; mobility impairments are notably more prevalent in poorer northern regions than in urban areas. Environmental factors, such as coastal flooding and entrenched social norms in patrilineal northern communities further isolate elders with disabilities. Cultural ideals that emphasize family reciprocity stand in sharp contrast to policy inaction. National health schemes often omit rehabilitative care, and public investment in older adult health remains marginal. Women, especially in rural areas, experience intensified caregiving burdens and economic strain, while widowed urban women face increased health risks. To avert a looming public health and social care crisis affecting millions of older adults by mid-century, this paper proposes actionable reforms: expanding national health coverage to include geriatric services, institutionalizing gerontology training, and prioritizing rural community-based rehabilitation. Aligning these strategies with international development goals on health and equality is vital to transforming cultural respect for elders into concrete, rights-based support systems.

Keywords*: Ageing, Disability, Ghana, Socioeconomic Vulnerability.*

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I. INTRODUCTION

Alima's experience is not unique. Ghana, like many low- and middle-income countries (LMICs), faces a demographic paradox: Its population is ageing rapidly [1], yet systems designed to support older adults remain stagnant, clinging to fragmented policies and idealized notions of familial care [2]. Globally, the ageing population is increasing significantly, a trend that especially pronounced in many low and middle-income countries [3]. The United Nations estimated that there were 962 million older adults worldwide, with projections indicating that this number could double to 2.1 billion by 2050. According to them, between 2017 and 2050, the number of older persons is expected to grow fastest in Africa, with a projected 229 percent increase, followed by Latin America and the Caribbean [1]. As the global older population continues to expand, the number of those living with disabilities is also expected to rise in the coming decades. In 2010, an estimated 101 million older adults were severely disabled, with projections suggesting that this number could rise to 277 million by 2050 [4]. The risk of acquiring a disability significantly increases as individuals transition into older adulthood.

Ghana's elderly population has grown significantly over the past six decades, increasing from 213,477 people (4.5% of the population) in 1960 to approximately 2 million by 2021, a nearly tenfold rise [5]. This group comprises 861,830 men (43.3%) and 1,129,906 women (56.7%), with a majority (59%) residing in rural areas where access to critical services remains challenging. According to [1] projections, older adults are expected to account for 9.8% of Ghana's population by 2050, reflecting a continued upward trend in ageing demographics.

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As the population of older people continues to grow, so will the number of older adults with disabilities who require tailored care arrangements and support to mitigate the compounded vulnerabilities they face. This demographic shift calls for urgent attention. The needs of older persons with disabilities are frequently overlooked. Generally, older adults require functional ability to participate independently in society. However, functional decline, characterised by sensory loss and a greater risk of chronic non-communicable diseases (NCDs), is prevalent among the ageing population [6].

This paper explores the compounding vulnerabilities of ageing with disability in Ghana, a "double burden" of intersecting health decline, socio-economic precarity, and systemic neglect, against a backdrop of siloed policies, superficial interventions, and societal responses starkly disconnected from lived realities. Examining the causes of disability, barriers to care, and fragmented support structures, it reveals how this dissonance erodes the quality of life for older Ghanaians, rendering their dignity collateral in a nation unprepared for its demographic transition.

➢ *Setting the Scene: A Contradiction of Life*

While conducting fieldwork in Ghana's Upper East Region, I met 68-year-old *Alima Abagaye* (name changed for anonymity), who lives in a clay-and-thatch home with her grandson, Nyaaba (also anonymized). She wakes early, despite arthritic knees and a stroke that weakened her right side, to fetch water and care for the boy. "*I am his legs, and he is my hands*," she said, with a bitter laugh.

Her daughter works in Accra as a head porter (*kayayei*) and sends money irregularly. A few weeks ago, Alima walked eight kilometres to a clinic, clutching her National Health Insurance Scheme (NHIS) card. She received only painkillers, but when she asked about physiotherapy, the nurse simply said, *"We don't have those services here."* Her hypertension medication, only partly covered by NHIS, took nearly half of her LEAP (Livelihood Empowerment Against Poverty) grant.

Her story echoes that of many elderly Ghanaians I met—battling chronic illness, weakened family support, and a limited healthcare system. She still keeps her NHIS card, but told me quietly, *"It doesn't help with what I really need."*

II. METHODOLOGY

This paper adopts a narrative review methodology to synthesize existing evidence on ageing with disability in Ghana, emphasizing sociocultural, economic, and policy dimensions. The review draws from qualitative insights, quantitative surveys, and grey literature. Sources were selected based on their relevance to three central themes:

- The prevalence and drivers of disability among older adults;
- Intersectional vulnerabilities, particularly rural–urban disparities and gendered patterns of caregiving; and
- Policy gaps in Ghana's healthcare and social protection systems.

Although the review does not employ strict systematic inclusion or exclusion criteria, it prioritizes studies offering primary data from Ghana and those illuminating intersectional vulnerabilities. Alima's case study, drawn from fieldwork observations, anchors the narrative and exemplifies systemic gaps through lived experience.

III. DISABILITY AND AGEING

Inspired by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the Africa Protocol on the Rights of Persons with Disabilities, defines disability as physical, mental, intellectual or sensory impairment which, in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others [7]. Disability is conceptualized through various frameworks, primarily the medical and social models. The medical model frames disability as an individual pathology arising from physical or mental impairments, such as injury, illness, or congenital conditions, that require medical treatment and care. In contrast, the social model rejects this individualized lens, arguing that disability stems not from bodily differences but from socially constructed barriers and exclusionary practices. Rather than prioritizing medical solutions to "fix" impairments, this model demands systemic change to dismantle discriminatory attitudes, inaccessible environments, and inequitable policies that marginalize people with disabilities [8].

Preceding both is the moral or religious model, which attributes disability to divine causes. In this view, disability may be seen as punishment for sin, either by the individual or their ancestors [9, 10]. Some interpret disability as a test of faith or a means of spiritual redemption, while others see it as an opportunity granted by God for the development of virtues such as patience, resilience, and bravery. Although the moral or religious model of disability is not as widely accepted today as it was in pre-modern times, its fundamental ideas still shape the way many people, particularly in Ghana, perceive and respond to illness and disability.

Ageing, on the other hand, has been explained by the [11] as the process of getting old from birth to death. It is a natural, inevitable process characterized by gradual changes that occur throughout life, leading to physiological decline and increased susceptibility to death [12, 13]. Ageing is marked by visible signs such as greying hair, wrinkled skin, and functional disabilities [12] which is influenced by both genetic and environmental factors, resulting in differences between people and species [14]. Globally, an older person is typically defined as someone aged 60 years or above, a threshold reflecting the United Nations' benchmark for ageing populations [1]. Ghana has adopted this definition to categorize its elderly citizens. However, the lived experience of ageing in Ghana transcends mere chronology. As individuals cross this threshold, they confront a heightened risk of functional impairments, physiological declines rooted in natural aging processes, compounded by socio-economic

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inequities and inadequate healthcare infrastructure. Accordingly, [5] operationalizes disability among older adults through six key domains: seeing, hearing, mobility (walking/climbing stairs), communication (speaking), self-care, and cognition (remembering/concentrating).

Older adults with disabilities in Ghana face significant challenges, including financial insecurity, social isolation, and health issues. Older adults with disabilities may resort to activities like street begging or subsistence farming as a way to cope with the challenges they face.

IV. PHYSICAL HEALTH AND DISABILITY BURDEN

Ageing in Ghana is closely tied to a high prevalence of disability and chronic health conditions, creating a dual burden of biological decline and unmet healthcare needs. Functional impairment and disability are widespread among ageing populations globally [15], yet Ghana's context is uniquely shaped by intersecting vulnerabilities. Reference [6] found that 38.4% of adults aged 60+ live with disabilities, a figure that escalates with advancing age. This aligns with the findings of [16], whose nationally representative study of 1,610 older Ghanaians reported a 44.6% prevalence of functional disability using the World Health Organization Disability Assessment Schedule (WHODAS II), a a standardized metric that captures limitations in daily functioning. Further qualitative insights from [17] reveal that 90% of older adults experience severe functional difficulties, particularly in domains such as mobility, self-care, and cognition. Chronic conditions such as hypertension, arthritis, stroke, and dementia dominate the health profile of this population, with comorbidities amplifying disability severity. For instance, [18] identified stroke as a key predictor of deficits in both basic (e.g., bathing) and intermediate (e.g., meal preparation) self-care functions, while [19] linked obesity to heightened risks of instrumental activity limitations.

Functional tasks are typically classified as Activities of Daily Living (ADLs), such as bathing, toileting, dressing, and eating, and Instrumental Activities of Daily Living (IADLs), which include more complex activities like preparing meals, doing housework, and managing transportation. Contrary to conventional definitions, some researchers [20, 21] argue that ADLs encompass more complex activities necessary for independent living, while IADLs pertain to basic self-care tasks. Regardless of the classification used, both are essential indicators of functional independence. Many older adults with disabilities require assistance with these tasks, and such reliance often leads to further physical decline and reduced wellbeing [22].

The "double burden of disease", a term coined by [23] in her study of older women in Accra, refers to the coexistence of infectious diseases like malaria and chronic non-communicable conditions such as hypertension and diabetes, particularly prevalent in sub-Saharan Africa. This phenomenon is exemplified in Accra, where older women grapple with both tropical and chronic illnesses. The duality reflects broader systemic failures: geriatric care remains siloed within a healthcare system ill-equipped to address the multifactorial nature of ageing-related disabilities.

V. SOCIOECONOMIC VULNERABILITIES

Socioeconomic inequities in Ghana amplify the "double burden" of ageing with disability, disproportionately affecting rural and low-income populations. Globally, socioeconomic determinants, such as education, income, and social support access, shape the likelihood of experiencing disability in old age, with disparities starkest in low- and middle-income countries (LMICs) [15, 24, 25]. Alima's story epitomizes this: her NHIS card, touted as a lifeline, fails to cover physical therapy or hypertension medication, forcing her to spend nearly half of her LEAP (Livelihood Empowerment Against Poverty) grant on co-payments. This reflects broader systemic failures. Disability burdens vary regionally: 44% of older adults in the impoverished Upper East Region report mobility impairments [5], compared to 29% in wealthier Greater Accra. Coastal communities face unique challenges, such as flooding that isolates elders with disabilities [26], while northern patrilineal clans disproportionately exclude widowed women from care networks [27]. Clinics lack specialists and medications, while unpaved roads delay emergency care [6]. Empirical studies reinforce these challenges, revealing that rural residence itself is a significant risk factor for disability [28], with 41% of rural elders suffering lower extremity impairments linked to agrarian labor and untreated injuries [29]. Many rural older adults rely on subsistence farming, but age-related disabilities make this increasingly difficult. As a result, they become dependent on family support, which is often inconsistent due to financial strain on younger relatives. Without stable income, pension benefits, or social safety nets, older adults in rural areas are at high risk of poverty and neglect [30, 31].

Urban-rural disparities are stark. In Accra, caregivers juggle inflated living costs and informal work, while rural elders like Alima walk 8 kilometres to under-resourced clinics. Visually impaired older adults in rural areas describe themselves as "*campaign objects*" neglected after elections [32]. Economic precarity intersects with health behaviours: poverty-driven poor nutrition and physical inactivity heighten risks of obesity and multimorbidity, accelerating functional decline [16]. Protective factors like education and marital status offer limited respite. Educated individuals better navigate health systems, while spousal support fosters resilience, yet these advantages remain inaccessible to most rural elders [6]. For urban women, however, marital status itself becomes a liability: widowhood exacerbates disability risks, as [27] found that urban women's Activities of Daily Living (ADL) difficulties, such as toileting and bed transferring, are closely tied to the loss of spousal support and economic stability. Meanwhile, rural women face a double marginalization, with studies showing they consistently report higher disability rates than men due to gendered inequities in resource access and caregiving burdens [27].

Income insecurity remains a critical barrier. While higher monthly income is protective against disability [33],

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rural elders rarely benefit from such buffers. The LEAP program's stagnant grants, untethered to inflation, fail to address the 37% prevalence of upper extremity disabilities in rural areas or the 0.83% long-term injury-related disability rates nationwide [29]. These gaps underscore a cruel paradox: systemic neglect transforms cultural ideals of familial care into a source of vulnerability, leaving elders like Alima to navigate ageing and disability with neither dignity nor adequate support.

VI. HEALTHCARE AND CULTURAL NORMS

Ghana's ageing population faces a cruel irony: while cultural traditions revere elders, systemic failures in healthcare and policy perpetuate their marginalization, particularly for those with disabilities. This duality, where respect coexists with neglect, creates a double burden of biological decline and structural exclusion.

Cultural perceptions of ageing in Ghana are deeply rooted in traditional beliefs that simultaneously elevate and undermine older adults. Old age is traditionally associated with elevated social status and authority [34], yet these privileges are unevenly distributed. Older women, in particular, face systemic discrimination, are confined to restrictive domestic roles and are subjected to heightened abuse [34]. Reference [27] corroborate this gendered inequity, revealing significant disparities in Activities of Daily Living (ADL) disability rates, with women reporting higher risks of functional limitations than men.

Access to healthcare is also shaped by cultural norms. Many older adults, especially in rural areas, rely on traditional healers or informal kinship networks often due to distrust in biomedical systems [34]. This reliance is often driven by "pull factors" such as personal health beliefs and perceived efficacy of traditional medicine, rather than mere dissatisfaction with biomedical services [35, 36]. The cultural stigma around mental health exacerbates these challenges, discouraging help-seeking behaviours and perpetuating untreated conditions [34]. Cognitive impairments like dementia are frequently dismissed as "normal ageing," leading to underdiagnosis and inadequate treatment [37], while rural clinics lack specialists and essential medications. These systemic gaps in healthcare access are not accidental but symptomatic of broader policy inertia. Ghana's policy landscape reflects a paradox.

VII. CULTURAL CONTEXT AND SOCIAL SUPPORT

In Ghana, the cultural ethos of abusua (family reciprocity) idealizes caregiving as a sacred, intergenerational duty. Elderly care is enshrined in traditions where adult children, particularly women, are expected to repay the care they received in childhood [38]. Yet, the state's failure to support families transforms this cultural strength into a source of vulnerability. Take Alima, a 68-year-old grandmother in Ghana's Upper East Region: weakened by arthritis and a stroke, she cares for her grandson Nyaaba, relying on sporadic remittances from her daughter, a kayayei (head porter) in Accra. "*I am his legs, and he is my hands*," she says, capturing the essence of informal caregiving rooted in mutual dependence, a system strained by urbanization, gendered expectations, and systemic neglect.

This system, devoid of formal eldercare infrastructure like nursing homes, places immense strain on families. Women bear the brunt: 78% of caregivers report economic hardship, sacrificing income-generating opportunities to prioritize care [39]. For urban women, this burden is compounded by marital status. [27] found that widowhood significantly heightens disability risks among urban women, as the loss of spousal support exacerbates Activities of Daily Living (ADL) difficulties like toileting and bed transfers. Alima's daughter, for instance, navigates Accra's precarious informal economy, sending money only when work permits, while grappling with the stigma of being a widowed caregiver in a city where kinship networks are fraying.

In rural areas, cultural norms collide with gendered inequities. Rural women not only shoulder caregiving duties but also face higher disability rates than men, a disparity rooted in limited access to healthcare and economic resources [27]. Reference [29] quantify this burden: 41% of rural elders suffer lower extremity disabilities from untreated injuries and agrarian labour, yet clinics lack rehabilitative care. The psychological toll is stark: 78% of caregivers experience severe stress, with dementia caregivers facing extreme emotional exhaustion [40]. Cultural stigma amplifies this crisis. Cognitive decline is dismissed as a "spiritual failing," deterring families from seeking medical help [37], while stroke survivors in rural areas are labelled "cursed," isolating them from rehabilitative care [32].

Urban migration further strains these traditions. As youth relocate to cities, elderly parents like Alima are left in rural areas with fragmented support networks. Urban caregivers, meanwhile, grapple with overcrowded slums where 75% of income is spent on rent, leaving little for healthcare [26]. Ghana's cultural reverence for elders thus exists in tension with a reality where families are celebrated for upholding traditions yet abandoned by the state. The irony is profound: *abusua*, once a source of resilience, now underscores the fragility of a system that venerates elders in proverbs but fails them in practice.

VIII. POLICY AND SYSTEMIC ISSUES

While cultural traditions idealise familial care, systemic neglect leaves caregivers overburdened and under-resourced. Ghana's policy landscape reflects a paradox of progress and neglect, marked by structural inertia and a glaring disconnect between policy rhetoric and practical action. Initiatives like the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme (NHIS) represent institutional acknowledgment of ageing needs. However, both programs have critical shortcomings. LEAP, for instance, excludes adults aged 60-64 despite constitutional recognition of this group as elderly, while NHIS's exclusion of rehabilitative care reflects systemic bias toward acute conditions, neglecting the chronic needs of older adults.

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Corruption exacerbates this: 30% of NHIS funds are lost to administrative inefficiencies [41], while rural clinics lack geriatric-trained staff due to urban-centric resource allocation. Politically, ageing remains low priority. Only 1.2% of Ghana's health budget is directed toward older adults [25], as government attention is often skewed toward maternal and child health to align with donor agendas [31]. These deficiencies mirror systemic issues across Sub-Saharan Africa, where ageing policies lag behind demographic shifts, relegating older adults to the peripheries of development agendas [42, 43].

This exclusion is compounded by a disconnect between demographic trends and legislative action. Reference [30] critiques the "shallow inclusion" of older Ghanaians, noting that policies like the *National Aging Policy* remain underdeveloped, leaving critical needs unaddressed. For example, geriatric care is absent from primary healthcare systems, forcing families to rely on under-resourced informal networks [44]. Similarly, [23] highlights how gender-sensitive policies for older women—often subsumed under broader maternal health agendas—fail to address intersectional vulnerabilities like widowhood or caregiving burdens.

The fragmentation of Ageing and disability frameworks exacerbates these gaps. While the *African Protocol on Rights of Older Persons* and the *UN Convention on the Rights of Persons with Disabilities (UNCRPD)* provide robust normative guidance, their domestication remains incomplete. Ghana's failure to domesticate these frameworks violates its international commitments, perpetuating exclusion and weakening the legal foundations needed to ensure comprehensive protections for older adults and persons with disabilities. Ghana's NHIS excludes long-term care services, and community-based rehabilitation programs are scarce outside urban areas, reflecting a systemic preference for visibility over sustainability [32]. This policy fragmentation mirrors the exclusion of disability advocates from decision-making processes, where programs prioritise short-term electoral gains over enduring structural reforms. The consequences of this policy fragmentation are starkly evident in the deteriorating quality of life for older Ghanaians.

IX. IMPLICATIONS FOR QUALITY OF LIFE

The intersection of Ageing and disability in Ghana leads to a profound erosion of quality of life (QoL), affecting physical, psychological, social, and environmental domains. Globally, population ageing is recognized as a transformative social force, reshaping labor markets, financial systems, and demand for essential services [45]. However, in low- and middle-income countries (LMICs) like Ghana, this demographic shift collides with systemic unpreparedness, deepening disability-related disparities in QoL.

- *Physical and Psychological Health*

Functional limitations and chronic conditions directly undermine physical health, but their psychological toll is equally debilitating. Debpuur [46] revealed a paradox in self-reported health among older Ghanaians: while many rated their health as "good," those with higher functional limitations, particularly the oldest cohorts, perceived their health as poor. This dissonance reflects cultural stoicism and normalized suffering, where ageing-related disability is accepted as inevitable rather than addressed. Nantomah [47] quantified this decline, demonstrating consistently low quality of life (QoL) scores across all domains, with older adults reporting chronic pain, fatigue, depression, and anxiety. These findings are compounded by studies showing that 41% of rural elders suffer lower extremity disabilities linked to untreated injuries and agrarian labor [29], while urban older adults face sensory impairments like vision loss exacerbated by pollution and overcrowded living conditions [26].

The type of disability also influences QoL outcomes. Mobility impairments, prevalent in both urban and rural areas, limit access to communal spaces, accelerating social isolation. Rural residents, for instance, face a 0.83% long-term injury-related disability rate [29], often resulting in untreated fractures or arthritis that curtail independence. In contrast, sensory disabilities like blindness correlate with higher stigma, as rural communities label affected individuals "spiritually cursed" [32]. Cognitive disabilities like dementia are doubly neglected, hidden by families due to shame and untreated due to a lack of diagnostic tools. Interestingly, those with physical disabilities tend to report marginally better QoL than visually impaired individuals [47], likely due to greater social inclusion and physical autonomy, though this advantage remains precarious in regions lacking rehabilitative care.

Gender and geography further stratify these burdens. Rural women, already overrepresented in caregiving roles, exhibit higher disability rates than men [27], with 37% experiencing upper extremity impairments from repetitive labour [29]. Urban settings present a different challenge: widowhood exacerbates Activities of Daily Living (ADL) difficulties like bed transfers and toileting for women [27], intensifying psychological strain. A cross-sectional study by [26] underscores how environmental factors in Ghanaian urban slums, overcrowding, pollution, and lack of green spaces—deepen isolation and respiratory illnesses, eroding both physical and psychological well-being.

The interplay of biological decline and systemic neglect creates a cycle where disability fuels despair. Chronic pain from untreated injuries, stigma-driven isolation, and the invisibility of cognitive conditions like dementia reflect a healthcare system ill-equipped to address the holistic needs of ageing Ghanaians. Without interventions that bridge medical care, social support, and cultural sensitivity, the physical and psychological toll of ageing with disability will remain a silent epidemic.

- *Economic and Social Dimensions*

The compounding effects of poverty and disability create a cyclical trap. Inaccessible healthcare and inadequate pensions force many older adults to remain economically active despite their deteriorating health, as noted by [47]. This aligns with global patterns observed in China, where rising

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life expectancy has intensified pressure on public health systems to manage ageing-related disabilities [48]. China's centralized strategy, Ghana's fragmented response forces older adults into survival economies—selling goods on streets or farming with diminished capacity, while managing chronic conditions such as hypertension or arthritis.

Socially, the loss of functional autonomy and eroded kinship networks amplify isolation. Steptoe et al. [49] established that diminished social interaction directly correlates with poorer QoL, a pattern starkly evident in Ghana's urbanizing landscape. Older widows, for instance, often face dual marginalization: the loss of their caregiving roles due to children's migration and societal stigma labeling them as "burdens" [27]. Rural older adults, meanwhile, grapple with environmental barriers, inaccessible transportation and lack of assistive devices, that confine them to homes, severing community ties [32].

- *Systemic Neglect as a Catalyst*

The QoL crisis among older Ghanaians with disabilities is not merely a health issue—it is a failure of governance. While developed economies invest in age-friendly infrastructure and palliative care, Ghana's policy inertia perpetuates exclusion. The *National Aging Policy* remains shelved, and the NHIS excludes critical services like physical therapy, forcing families into catastrophic health expenditures. This neglect mirrors broader LMIC trends, where ageing is treated as an afterthought rather than a rights-based imperative [16].

X. CONCLUSION

Ghana stands at a critical juncture in addressing the needs of its ageing population, a demographic that embodies both cultural reverence and systemic neglect. The story of Alima, an elderly woman grappling with chronic illness, disability, and fragmented familial support, mirrors the plight of thousands who face the collision of biological decline, underfunded policies, and strained kinship networks. By 2050, nearly 10% of Ghanaians will be over 60, many living with disabilities that demand urgent, tailored interventions. To dismantle this contradiction and align policy with cultural values of abusua (family solidarity), Ghana must adopt a holistic, rights-based approach anchored in actionable reforms.

First, reforming the National Health Insurance Scheme (NHIS) is imperative to ensure equitable healthcare access. Currently, only adults aged 70 and above qualify for free registration, leaving those aged 60–69, a cohort often transitioning into vulnerability, without support. Expanding eligibility to all citizens aged 60+ would remove arbitrary age barriers and facilitate early intervention for age-related conditions. Equally critical is broadening NHIS coverage to include long-term geriatric care such as physical therapy, dementia management, and rehabilitative services. Chronic illnesses like hypertension and arthritis, which disproportionately affect older adults, require continuous care that families often cannot afford. By integrating these services, Ghana can alleviate the financial and emotional burden on caregivers while improving health outcomes for elders.

Second, addressing the dearth of geriatric expertise within Ghana's healthcare system demands institutional change. Medical and nursing curricula must integrate mandatory gerontology modules to equip professionals with skills to manage complex age-related conditions, polypharmacy risks, and mobility impairments. Simultaneously, training community health workers in rural areas to deliver home-based care would bridge gaps in accessibility, particularly for bedridden or isolated elders. This dual approach, strengthening formal education and decentralizing care, ensures that ageing populations in underserved regions are not left behind.

Third, expanding the Livelihood Empowerment Against Poverty (LEAP) program is vital to safeguarding economic dignity. While LEAP provides cash transfers to vulnerable groups, stagnant grant amounts, unchanged for years despite soaring inflation, undermine its effectiveness. Indexing payments to inflation and increasing monthly allocations would preserve purchasing power for older adults and their caregivers. Additionally, prioritizing older adults with disabilities as primary beneficiaries would channel resources to those most in need, reducing intergenerational poverty cycles. Such reforms recognize that financial security is inseparable from health and social well-being.

Fourth, Ghana must move beyond symbolic policy gestures and commit to fully implementing the National Aging Policy through specific budget allocations. Establishing community-based rehabilitation centers in rural districts—funded by earmarked resources—would provide critical services such as physiotherapy, counseling, and subsidized assistive devices like wheelchairs and hearing aids. These centers can also serve as social inclusion hubs, reducing isolation and stigma. Domestication of international frameworks like the African Protocol on the Rights of Older Persons and the UN Convention on the Rights of Persons with Disabilities would legitimize these actions and anchor them within a global human rights framework.

Underpinning these reforms must be a societal reckoning with stigmatizing narratives that reduce disability to "spiritual failing" or frame ageing as "natural decline." Public education campaigns, led by elders and disability advocates, can shift perceptions to emphasize dignity, rights, and interdependence. This cultural shift is not ancillary to policy but foundational, a recognition that ageing with disability is a collective responsibility, not an individual burden.

The stakes could not be higher. Without urgent action, Ghana risks leaving 2 million older adults behind by 2050, betraying its ethos of compassion and solidarity. Alima's struggle to afford medication or access rehabilitative care is not unique; it is a symptom of systemic inertia. By aligning reforms with the Sustainable Development Goals (SDG 3 and SDG 10), Ghana can transform irony into equity, ensuring elders are not merely survived but truly seen, heard, and

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valued. The time to act is now, for those who once nurtured the nation, and for a future where ageing with dignity is a universal promise.

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