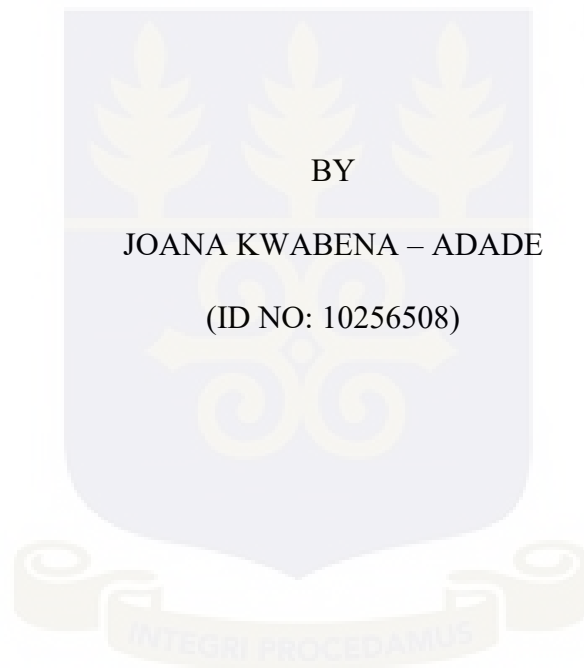


UNIVERSITY OF GHANA

COLLEGE OF HUMANITIES

HOME AWAY FROM HOME: THE EMERGING FORMS OF AGED CARE IN THE
URBAN CENTRES OF THE GREATER ACCRA REGION OF GHANA



BY

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THIS THESIS/DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
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OF PHD SOCIOLOGY DEGREE

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DECLARATION

I, Joana Kwabena - Adade, hereby declare that, except for references to other people's works which have been duly acknowledged, this thesis is the result of my own research work conducted at the Department of Sociology, University of Ghana, Legon, under the joint supervision of Prof. Akosua Keseboa Darkwah, Dr. Margaret Delali Badasu, and Prof. Ama de-Graft Aikins. I also declare that as far as I know, this thesis has neither in part nor in whole been published nor presented to any other institution for an academic award.

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DEDICATION

This work is dedicated to my beloved mother, Mrs Joyce Pearl Odoley Budu; my lovely husband Andrews, and our beautiful children Ellwin and Lemuel Kwabena - Adade.

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I am first and foremost thankful to my Maker, the Lord Most High and only Wise God for His unfailing love and care for me throughout the course of pursuing a higher education. If I were to recount all that He has done for me in the course of this phase of my life, the accounts cannot be contained in this whole volume. Indeed, He has shown me great mercy and favour.

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ABSTRACT

Globally, population ageing is occurring at a period when the extended family support system which has been a safe haven for the Ghanaian aged is fast eroding as a result of the impact of social change. The increasingly failing domiciliary eldercare is making way for residential non-domiciliary eldercare in the urban centres of Accra. This study is a contribution to the growing literature on aged care in Ghana with a focus on the activities of residential aged care facilities and how the phenomenon is being rationalized by families patronising them.

The objectives for this study were as follows: first, to identify the different types of systems of care currently available in the urban centres established to meet the care needs of the elderly people; second, to explore the kinds of activities of care provided by the residential aged care facilities to the elderly who access them; third, to describe the circumstances under which the aged are admitted into the residential aged care facilities; fourth, to find out how the elderly accessing these facilities make sense of the decisions made to delegate their care to residential aged care facilities; and finally, to examine how the family members of the elderly accessing the non-domiciliary systems of care evaluate the decision they have made to delegate the care of their aged persons to a formal institution.

This study adopted a qualitative mixed methods approach. Fifteen elderly persons at two residential aged care facilities comprising of twelve females and three males were purposively selected and interviewed. Other key informants were six family members of the residents, two administrators, two facility operators, and six caregivers making a total of thirty-one interviews. In addition, observational notes were made of 57 field visits. The data was analysed using thematic network approach.

Two types of care are available to the elderly in urban Accra. They are care within their usual dwelling places and care out of home. Eldercare out of home consist of non-residential

nd residential aged care facilities. The residential aged care facilities are owned by individuals who have lived and worked abroad. The residential aged care facilities employ not more than six caregivers at any given time with majority of them being females. There are two types of caregivers at the facilities; trained caregivers who deliver direct acts of caring and untrained caregivers who act as support staff. The facilities operate a 24-hour service, seven days a week for the residents. They also operate an 8-hour routine five days a week for elderly persons accessing the facilities for recreational purposes. Between two to four elderly people share a room depending on the size. The daily activities of care mostly performed for the elderly are intimate and non-intimate technical, medical, and emotional care. The bulk of activities of care for the elderly is performed in the morning. Material care is provided by the family members of the elderly to ensure their continued support at the facility. The circumstances under which the elderly are admitted at the residential aged care facilities are varied but largely boils down to the elderly persons' need for long-term technical and medical care, which cannot be sustained within the domiciliary context. The elderly persons had been admitted after they had suffered from complications associated with their chronic diseases. The four major medical conditions at the facilities were hypertension, stroke, diabetes and dementia.

Majority of the elderly agreed to access the residential aged care facilities based on the negative circumstances they were facing accessing domiciliary care. Four mothers who were providing childcare to their grandchildren prior to their illness rejected the decision. The relationship that existed between them and their children has been characterized by generalised reciprocity whereby as parents, they looked after their children with expectations that their actions would generate gratitude and an open-ended, diffuse obligation for the children to return the gesture someday. However, when parents serve as caregivers for grandchildren, they then expect their gesture to be reciprocated in a balanced

way. When the favour is not returned, it is viewed resentfully as negative reciprocity. Accessing the residential aged care facilities is associated with a sense of abandonment at three specific points: when the elderly were initially informed about the decision made, arrival at the facility and lastly when the elderly do not get visits or phone calls from family members.

The presence and the availability of the facilities favour the career oriented middle aged adults who are responsible for addressing the care needs of their elderly persons. They end up enjoying a balanced life and the relative peace of mind needed, knowing that their elderly person's achievement of activities of daily living (ADL) is not dependent on their physical presence to provide hands-on care or supervise the care provided for them. The benefits of accessing these facilities, comes at a cost which some are not able to sustain over a very long period, thereby withdrawing their elderly persons from the facilities. For those who can afford the costs, however, the traditional notions of care-giving are now replaced with care-managing and both parents and adult children are largely satisfied with this care arrangement.

The study therefore recommends that the state prepares a document regarding the nature and basic tenets of an eldercare institution to guide the design of private initiatives. The Department of Social Welfare should assess the operations of these facilities periodically to ensure that they operate per the stipulated rules of engagement. It should also champion the cause of public education and the acceptance of residential aged care facilities in Ghana. The Government of Ghana should set up public residential aged care facilities for families who require out of home care for their elderly persons but cannot afford cost of private residential aged care facilities currently available in urban Accra.

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LIST OF ABBREVIATIONS

ADL	Activities of Daily Living
AFRAN	African Research on Ageing Network
AGES	African Gerontological Society
AU	African Union
BP	Blood Pressure
GNA	Ghana News Agency
IADL	Instrumental Activities of Daily Living
ILO	International Labour Organisation
ISSA	International Social Security Association
MIPAA	Madrid International Plan of Action
MGCSP	Ministry of Gender, Children and Social Protection
NGO	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
NCDs	Chronic Non-Communicable Diseases
SSNIT	Social Security and National Insurance Trust
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
USA	United States of America

CHAPTER ONE

AGEING AND THE ISSUE OF AGED CARE IN GHANA

1.1 Introduction to the Study

Population ageing is occurring in almost all the countries of the world (United Nations, Department of Economic and Social Affairs, 2013, 2015). This numerical increase of older persons is a result of a demographic transition resulting from decreasing fertility and mortality, improved nutrition, reduction in infectious and parasitic diseases, as well as improvement in health care, education, and income (Mba, 2010a; Ghana Statistical Service, 2013; de-Graft Aikins et al., 2016). Population ageing has led to a relative reduction in the proportion of children and an increase in the share of working class persons and of older persons in the population (Mba, 2010a; United Nations, Department of Economic and Social Affairs, 2013; 2015).

According to the United Nations Department of Economic and Social Affairs Report (2009), the population of older persons is growing at the rate of about 2.6% per year. This growth rate is considerably faster than that of the population as a whole, which is increasing at 1.2% annually. Globally, the percentage of older people aged 60 years and above increased from 9.2% in 1990 to 11.7% in 2013 and this growth is likely to continue (United Nations, Department of Economic and Social Affairs, 2013). The 2015 United Nations, Department of Economic and Social Affairs, Report states that between 2015 and 2030, the number of people in the world aged 60 years or over is projected to grow by 56%, from 901 million to 1.4 billion, and by 2050, the global population of older persons is projected to be more than double its size in 2015, reaching nearly 2.1 billion (United Nations, Department of Economic and Social Affairs, 2015, p.2). Oldest persons are projected to exceed the number of children for the first time in 2047 (United Nations, Department of Economic and Social

Affairs, 2013, p.xii). Population ageing is poised to become one of the most significant social transformations of the twenty-first century, with implications for nearly all sectors of society, including labour and financial markets, the demand for goods and services, such as housing, transportation and social protection, as well as family structures and intergenerational ties (United Nations, Department of Economic and Social Affairs, 2015, p.1).

The average life expectancy globally is expected to rise to 75 years by 2050 (Beard, et al., 2012). Globally, the number of people aged 80 years or over, is growing even faster than the number of older persons overall (United Nations, Department of Economic and Social Affairs, 2015). The 'share of older persons aged 80 years' within the older population was 14% in 2013, and is projected to reach 19% in 2050 (United Nations, Department of Economic and Social Affairs, 2013, p.75). Projections indicate that in 2050 the 'oldest-old' (elderly persons aged 85 years and above) will be 434 million, three times the number since 2015 (United Nations, Department of Economic and Social Affairs, 2015, p.2).

According to the United Nations Department of Economic and Social Affairs Report (2013), the older population in the low-income regions is growing faster than in the high-income regions. Currently, about two-thirds of the world's older persons live in low-income countries. It is expected that the older persons will increasingly be concentrated in the low-income regions of the world. By 2050, nearly 8 in 10 of the world's older population will live in the low-income regions (United Nations, Department of Economic and Social Affairs, 2013). Over the next 15 years, the number of older persons is expected to grow fastest in Latin America and the Caribbean with a projected 71% increase, followed by Asia (66%), Africa (64%), Oceania (47 %), Northern America (41%) and Europe (23%) (United Nations, Department of Economic and Social Affairs, 2015, p.2).

Furthermore, the older population is growing faster in urban areas than in rural areas. At the global level between 2000 and 2015, the number of people aged 60 years or over increased by 68% in urban areas, compared to a 25% increase in rural areas. As a result, older persons are increasingly concentrated in urban areas. The oldest-old are even more likely to reside in urban areas (United Nations, Department of Economic and Social Affairs, 2015, p.2).

The process of ageing is characterised by a gradual decline in the efficiency of reflexes and decrease in physical and mental abilities. These observations are subject to social, environmental and physiological factors. Majority of old people have chronic health conditions, reduced mobility and functioning that often results in difficulty with basic tasks such as lifting objects or walking (Adler & Constantinou, 2008). Elderly persons therefore face a number of challenges to remaining socially included. In addressing these multiple needs, the elderly persons may receive support from their family members and social networks (Cornwell & Waite, 2009). Globally, population ageing is expected to present a range of challenges for the global community. The major challenges hinge on income security, health status and the gendered nature of problems associated with ageing (de-Graft Aikins, & Apt, 2016).

Globally, 40% of older persons aged 60 years and above live independently. Independent living is far more common in the high-income countries than low-income countries. About three-quarters of older persons in the high-income regions of the world live independently, compared with only one-quarter in middle-income countries and only one-eighth in the low-income countries (United Nations, Department of Economic and Social Affairs, 2013). The phenomenon of the elderly living alone or with a spouse only is expected to become common as countries develop.

Even though Ghana's population can still be classified as youthful (Apt, 2001; de-Graft Aikins, & Koram, 2017), reductions in fertility and mortality have resulted in an increase in the number of elderly persons in the population (persons aged 60 years and over) as evidenced by census results and estimates from other sources (World Population Prospects, 2004, 2006; Ghana Statistical Service, 2013). Ghana has one of the highest proportions of persons aged 60+ years in sub-Saharan Africa (de-Graft Aikins & Apt, 2016). With continued campaigns to reduce fertility and mortality, it is expected that this proportion may rise in the coming decades (Mba, 2010a; de-Graft Aikins & Apt, 2016). Researchers have argued that in the near future, population ageing in Ghana is likely to increase, like other African countries, at a rate that exceeds that of high-income countries of Europe and North America (de-Graft Aikins, et al., 2016; de-Graft Aikins & Apt, 2016).

Over the past 60 years, the population of persons aged 60 years and above in Ghana has increased by more than seven-fold, rising from 213,477 in 1960 to 1,643,381 in 2010 when it constituted 6.7 percent of the total population (Ghana Statistical Service, 2013; de-Graft Aikins & Apt, 2016). Over half (56%) of the elderly population are females, an indication of higher life expectancy of the female population. In Ghana, a higher proportion (54%) of the elderly dwell in rural areas (Ghana Statistical Service, 2013), where health and social services are inadequate (Debpuur, et al., 2010; Ayernor, 2012). According to the Ghana Statistical Service Report (2013), about 3 out of every 4 of the males are married as compared with only 1 out of every 3 of the females (Ghana Statistical Service, 2013). Literacy rate and educational status is generally low among the elderly. Sex differentials in educational status is wide among the elderly in favour of males. A negligible proportion has tertiary education particularly among the females (Ghana Statistical Service, 2013). A relatively high proportion of the elderly (58.5%) are economically active, with the bulk of them aged between 60 and 64 year-olds. This proportion decreases with increasing age

(Ghana Statistical Service, 2013). The proportion with disability increases with advancement in age. Disability is slightly more prevalent among the rural dwellers than their urban counterparts. The commonest types of disability include sight (29%), physical (18.4%), emotional (13.4%), intellectual (11%) and hearing (11%).

The rate of chronic illnesses increases steadily with age, thus, poor health becomes associated with old age (Quadagno, 1999). Debpuur, et al., (2010), notes that chronic diseases and disability are disproportionately high among older people thus; a growing elderly population will increase the demand for health care and other social services. According to the World Health Organization (2004), chronic non communicable diseases (like cardiovascular disease, cancer, chronic respiratory disease and diabetes) cumulatively caused 29 million deaths worldwide in 2002 and it is expected that this trend will continue in the near future with the low-income countries of Africa, Asia and Latin America experiencing the biggest impact of this rising global burden of chronic diseases (Ayernor, 2012). Research findings indicate that elderly Ghanaians are more likely to suffer from high blood pressure, heart attacks and arthritis than other diseases (Darkwah, 2000). Over the last fifty years, there has been a documented increase in the prevalence rates of chronic diseases such as cardiovascular diseases, hypertension and diabetes in Ghana (de-Graft Aikins 2007; de-Graft Aikins & Koram, 2017). Generally, the incidence of chronic non-communicable diseases increases rapidly with advancement in age (Ayernor, 2012). The prevalence rates of chronic non-communicable diseases (NCDs), neurodegenerative disorders and disability are expected to rise among the older populations with implications for health systems and health and social care at the community and family levels (de-Graft Aikins & Apt, 2016).

The socio-economic and socio-cultural challenges associated with ageing in Ghana require interventions and policies that address the multifaceted needs of older Ghanaians (de-Graft Aikins & Apt, 2016). The critical issue emerging from the population ageing phenomenon is how best to provide economic and social support for the aged. The family and the state are the two important support structures. The demographic challenge to family care is two-fold: new demands are constantly generated by different elderly persons on one hand and on the other hand changing values and aspirations of younger generations and steady reduction in family size (Chattopadhyay, 2004). These services and policies, as regional and global experts observe have to be context-specific and based on evidence informed by robust multidisciplinary programmes of research that examine ageing issues from micro to macro levels (de-Graft Aikins & Apt, 2016).

The family is very important in the traditional Ghanaian society with each member playing a significant role as a result of the mutually shared responsibilities and assistance that constitutes the basis for social protection (Karlberg, 2003; Nukunya, 2014; Alidu, et al., 2016). Traditionally, the role of the elderly has been to transfer knowledge, skill, experience, expertise to the younger ones and also to function as advisors in every day matters, as well as in important decisions (Tonah, 2009). Additionally, they also handle arbitrations and settle disputes in families and communities at large. Through these activities they reduce the level of social unrest, civil strife and encourage community development (Tonah, 2009). The role of the elderly persons has been changing. It has been argued that currently, it is only when there are important issues that the elderly are consulted (Karlberg, 2003). The younger population on the other hand, are expected to care for the daily and personal needs of the elderly. This shared responsibility is currently under threat by a number of social change factors such as urbanisation and migration and the gradual

nucleation of the family system in Ghana (Apt, 2001; Aboderin, 2004; Tonah, 2009; Domfe & Aryeetey, 2016).

The extended family system serves as social security for people who live in a country that does not have a developed social welfare system. In the extended family, one is obligated to help a member in need and offer moral support (Apt, 2001; Domfe & Aryeetey, 2016). Thus, the upbringing of the children was not the duty of the parents only but it involved all adults around including grandparents (Apt, 1996; Nukunya, 2003; Karlberg, 2003; Silverstein & Giarrusso, 2010). Hence, the children always had an elderly person present at home and the elderly also had someone to help run errands for them. The main duty of the adult child towards his or her parents is to take care of them when they are old, as they had taken care of him/her when they were growing up. The basis for providing such support is enshrined in the customary moral code and encapsulated in the proverb “when your elders take care of you while you grow your teeth, you must in turn take care of them while they are losing theirs” (Apt, 1996; van der Geest, 2002a, 2002b; Nukunya, 2003; Tonah, 2009). In the past, family was responsible for ensuring the economic security of the aged in the absence of formal welfare systems in Ghana (Aboderin, 2004, 2005; Tawiah, 2011). Despite the effects of modernisation and urbanisation, the family continues to be the primary institution equipped to provide support and care for the elderly in Ghanaian society (Ardayfio-Schandorf 1995; Apt, 1996; Mba, 2002b).

An ageing population, however, poses a threat within society because families are increasingly having fewer descendants available to care for the increasing number of surviving elderly persons. Additionally, urban wage earners, whose incomes are continuously declining in real terms owing to unfavourable economic conditions, are

finding it increasingly difficult to remit resources to the aged relatives in rural areas (Aboderin, 2004; Mba, 2010a). In the absence of universal social security, the processes of modernisation, urbanisation and migration have been eroding the traditional social welfare system (Apt, 1996; Mba, 2002; Ayernor, 2016). Research has shown that there are signs to show that for many of the aged, the family support provided them no longer suffices to meet their basic needs (Aboderin, 2004; de-Graft Aikins, et al., 2016).

1.2 Problem Statement

Over the years, the myth about the structures of the extended family systems in Africa rendering virtually insignificant the problem of ageing has prevailed (Apt, 1996; Tonah, 2009). This assumption is challenged in the face of increasing urbanisation, migration, and the breakdown of the cultural systems and the family structure. Despite these changes, majority of the elderly persons continue to live with their family members (Aboderin, 2004). However, destitution and impoverishment of elderly persons has become increasingly evident in the urban centres (Aboderin, 2004). Poverty rates of older persons tend to be higher than the population average in a number of countries. Poverty rates are likely to increase among the older populations especially in countries with limited coverage of social security systems (de-Graft Aikins & Apt, 2016).

Admittedly, caring for the aged population is the responsibility of both government and society at large. In the high-income regions of the world, there are systems in place to ensure that the elderly are well catered for until they pass on (Novak, 2006; Beard, et al., 2012). However, in the low-income regions of the world, the process of population ageing is setting in at a time when Sub-Saharan African countries, for example, have not made enough economic progress and therefore have to prioritise and invest in their young populations

especially in the areas of health, education and other components of the social sector (Ghana Statistical Service, 2013). As such, addressing the care needs of aged persons within the Ghanaian society at the national level has been relegated to the background.

In many low-income societies, alternatives to traditional aged support systems are absent or at best limited, making it risky to consider social protection for older people without due recourse to what the traditional social solidarity system and community structures can offer alternatively or in combination with formal state-led protection programmes (Doh, et al., 2014). When society does not achieve the desired outcomes as a result of market failures, persistent poverty and human degradation occur among different groups within society. With time, society then develops other alternative means of addressing the needs of people through the institutions of community and state (Doh, et al., 2014).

Charitable organisations such as HelpAge Ghana have emerged to respond to some of these problems by offering day care services to the aged. Established in 1988, HelpAge Ghana works to promote the prospects of older persons in Ghanaian society. It is a full member of HelpAge International which is based in United Kingdom and is a global network of age care organisations (Agbényiga & Huang, 2012; de-Graft Aikins & Apt, 2016).

Since 2013, media reports in Ghana have suggested that apart from HelpAge Ghana, an alternative means of meeting the care needs of the elderly, in the form of domiciliary and non-domiciliary systems of care is emerging in the urban centres of the national capital. These systems of care are being operated by a number of Non-Governmental Organisations (NGOs), and private entrepreneurs who “seek their own solutions to the crisis of elderly care, knowing that little can be expected from a government that does not even seem to

know or chooses to ignore what takes place on the ground” (van der Geest, 2016a, p.15). Some of the private initiatives set up to operate as elderly home care agencies in response to the challenges associated with domiciliary care of the elderly are Akrowa Aged-Life Foundation, Compassionate Africa, Careplus Ghana, Healing Hands Home Care, Ripples Health Care and Ubuntu. Additionally, Coe (2016), talks about the emergence of a new occupation of the carer in Ghana at a time “when norms of cultural capital are shifting and multiple occupations are undergoing changes in their prestige levels due to changes in education, economic trends, and migration” (Coe, 2016, p. 49).

Given the pervasiveness of the customary moral code which entrusts care for the elderly in the hands of family members, the emerging care facilities in the Ghanaian context presents an enigma worthy of scholarly investigation. While scholars such as Aboderin (2004, 2005), and Agyemang, et al., (2014), acknowledge the lapses in the customary moral code, little attention has been paid to the nature of the alternative systems of care that are emerging in Ghana. Additionally, not much is known about the conditions under which such systems will be sought and the ways in which families evaluate their breach of the customary moral code regarding care for the elderly. This thesis seeks to contribute to the literature on ageing in Ghana by interrogating the newly emerging phenomenon of non-domiciliary care facilities for the aged. Additionally, to provide research evidence that can support policy to address the associated challenges.

1.3 Research Objectives and Questions

The aim of this study is to understand the emerging phenomenon of formal non-domiciliary systems of care within urban Ghanaian society.

1.3.1 Specific Objectives

- a) To identify the different forms or types of systems of care available in the urban centres set up to meet the care needs of the elderly people.
- b) To explore the kinds of activities of care provided by these systems of care to the elderly who access them.
- c) To describe the circumstances under which the aged are admitted into residential aged care facilities.
- d) To find out how the elderly accessing these facilities make sense of the decisions made to delegate their care to non-domiciliary aged care facilities.
- e) To examine how the family members of the elderly accessing the non-domiciliary systems of care evaluate the decision they have made to delegate the care of their aged persons to a formal institution.

1.3.2 Research Questions

The objectives of the study translate into the following research questions:

- I. What types of care exist in the urban centres of Ghanaian society for the ageing population and how do they compare with each other?
- II. Under what circumstances are aged persons admitted to residential non-domiciliary aged care facilities?
- III. What is the structure of residential non-domiciliary aged care systems available in the urban centres of the Greater Accra Region?
- IV. What do the elderly make of the decision on the part of their kin to delegate their care to a formal institution?
- V. How do kin evaluate their decision to delegate care of their aged relative to a formal institution?
- VI. What are the representations of ageing in Ghana?

- VII. How does the traditional norms of reciprocity compare with the elderly accessing care from non-domiciliary aged care facilities?

1.4 Definition of Key Concepts

The concepts defined in this section are care and caregiving, activities of daily living, instrumental activities of daily living, social support, living arrangements, and old age.

1.4.1 The Concept of Care

Van der Geest (2002a, 2002b), points out that ‘care’ as a concept and as a practice is highly ambiguous. Van der Geest (2002a, 2002b), points out that the term ‘care’ has two basic constituents; practical and the emotional.

Practical/Technical/Physical care - refers to carrying out concrete activities for others who may not be able to do them alone. As in parents feeding their children, providing shelter, educating and training them, and so forth. Healthy people take care of sick ones and young people of old ones’ (van der Geest, 2002b, p. 235). According to van der Geest (2002b), technically, care has a complementary character, one person completes another one. ‘Care’ also has an emotional meaning; it expresses concern, dedication, and attachment. To do something with care or carefully implies that one acts with special devotion (van der Geest, 2002b). The practical/technical/physical activities of care are the concrete activities of care performed for the elderly. They include provision of food, bathing, washing of clothes, helping them to visit the toilet, nursing them when they fall sick, and countless chores such as sweeping and running errands (van der Geest, 2002a).

Emotional care - refers to a show of concern, dedication, and attachment. Emotional activities of care mainly focus on keeping the elderly company and is usually absent in the healthcare context. Van der Geest was of the view that depending on a given context, practical/technical care may dominate emotional care or indeed overrule, the other (van der Geest, 2002a, 2002b).

Apart from the practical/technical and emotional activities of care, other activities which are carried out in support of the elderly are: sending them money or consumables for their upkeep and organizing a fitting funeral for them. Organizing a befitting funeral for an elderly person was described by van der Geest (2002a, 2002b), as the most decisive form of care which the extended family is supposed to perform for the elderly members.

According to Novak (2006), 'activities of daily living limitation' includes a physical, mental or emotional problem that causes a person to need help with bathing or showering, dressing, eating, getting in or out of bed or chairs, walking and using the toilet (Novak, 2006, p.112).

Activities of Daily Living - ADL are the basic activities of daily life needed by an elderly person to live alone or to live a good quality life. Examples are bathing, preparing of food, feeding, dressing, getting in and out of bed, walking, transferring from one place to the other, and toileting (Quadagno, 1999; Novak, 2006). These activities are about the same as what van der Geest (2002a, 2002b), refers to as 'concrete activities of care' (van der Geest, 2002a, p.7).

Instrumental Activities of Daily Living - IADL refers to home management activities or activities that enhance an elderly person's quality of life. Examples include light housework or housekeeping, using the phone, taking medication and transportation, shopping, visits to the hospital (Quadagno, 1999; Novak, 2006). Novak (2006) argued that limitations may

range from a mild problem such as trouble dialling the phone to more serious problems such as the inability to eat or to use the toilet. Even though the bulk of the IADL are not mentioned by van der Geest (2002a, 2002b), probably because they were out of the context of his study, they are equally used as concrete activities of care for the purposes of this study.

Social support - refers to the help and assistance that individuals give to or receive from others. The elderly in society benefit from the support they get from family members, friends and neighbours and organisations (Novak, 2006). Examples are emotional support, companionship; help with household chores. **Social support systems** refer to the network of relatives, friends and organisations who provide emotional and instrumental support to the elderly such as making the individual feel loved or comforted and instrumental support, which refers to help in managing ADL (Quadagno, 1999; Novak, 2006).

Living arrangements – refers to the household structure of the elderly within a given society (Palloni, 2001). When an elderly person is living alone or with a spouse only or is not married and not living with kin, the term **living alone** is used to refer to their household structure (Palloni, 2001). When they are living with at least one child (or other kin), the term ‘co-residence’ is used. **Co-residence** also could mean an elderly person living with an adult child and the family (multigenerational household), living with grandchildren only (skipped generational household) and then living with others beside family (Sokolovsky, 2001; de-Graft Aikins & Apt, 2016).

Non-Residential Aged Care Facilities - Facilities for the supervised care of the elderly that specialises in providing activities such as meals and socialisation on one or more days a week during specified day time hours. The participants/informants are primarily persons with physical and or mental limitations who need socialisation, physical assistance, and or

psychological assistance, return to their homes each evening. In the high-income regions of the world, the programme is often used as respite by family members caring for an older person who cannot be left alone safely in the home (van der Geest, 2016a).

Residential Aged Care Facilities - A privately operated establishment or aged nursing homes that provide maintenance and nursing care for people who are old or aged and chronically ill, and who are unable to care for themselves properly. Aged nursing homes are places where the aged can live and receive appropriate care while they are being taken care of. They are also known as convalescent homes or long-term care facilities (van der Geest, 2016a).

1.4.2 Old Age

In defining “old age”, existing literature presents four main approaches: chronological age (numerical age), social roles and age (the set of expectations or guidelines for people who occupy certain positions in society), functional age (physical appearance or how people look and what they can do) and subjective age identity (a multidimensional construct that reflects how old a person feels and into which age group a person categorises himself/herself) (Quadagno, 1999; Rubin, & Berntsen, 2006). The choice of definition used in a particular research was influenced by the type of study conducted.

For the purposes of this study, the chronological age and the functional age were used in defining the category of aged people to be targeted for the study. The Chronological age was useful for making clear decisions about who to include as a subject in a study. It can also be an arbitrary marker despite the fact that it can be a poor indicator of old age because some people may look old at age 50 while others might seem young at age 70. As a result of the challenges associated with the chronological age, gerontologists often divide older

people into three subcategories; the young old (65 – 74 years), the old-old (75 – 84 years) and the oldest old (85 years and above) (Quadagno, 1999; Rubin, & Berntsen, 2006). Because civil servants go on retirement at age 60 in Ghana, the age range for the young old in Ghana will be presented as 60 years to 74 years.

The functional age is dependent on how people look and what they can do. A person becomes functionally old when he or she can no longer perform the major roles of adulthood. Social gerontologists have categorised old people into three subcategories: well (those who are healthy and active), somewhat impaired (those in the transitional stage – beginning to experience chronic ailments) and the frail (those who show some mental or physical deterioration and depend on others for carrying out their daily activities).

For the purposes of this study, the aged population was categorised and defined as follows;

1. Young old (the well) - This group of old people refers to those aged between 60 years and 74 years who are usually relatively well, physically active, relatively strong and can engage in some form of economic activities.
2. Old-old (the somewhat impaired) -This group of old people refers to older persons aged 75 years – 84 years, who are in the transitional stage – beginning to experience chronic ailments and therefore becoming weak and may need assistance with daily activities. They are beset by poor health conditions and suffer from non-communicable diseases.
3. Oldest old (the frail) - This group of old people refers to older persons aged 85 years and above who show some mental or physical deterioration and depend on others for carrying out their daily activities. This group of old people tends to need more care from family.

1.5 Significance of Study

There is extensive literature on caregiving for the elderly within the extended family system as well as the increasing neglect of the aged as a result of the nucleation of the family system. However, not much has been documented about the types of formal care facilities emerging within urban settings of the country and the evaluation process that the aged and their kin undergo in order to be able to switch from kin-based caregiving to the non-kin based caregiving that these facilities provide.

This present study provides insight into the processes leading to the elderly accessing long-term care from these residential aged care facilities, the perspective of the elderly and their relatives on fulfilling the traditional norms of reciprocity vis-a-vis accessing long-term care out of their usual places of dwelling at this phase of their lives. According to the statistics on ageing, the population of elderly people is likely to continue to grow globally especially that of the oldest old, it is therefore important that these facilities and the services offered be examined and analysed so as to contribute to knowledge that will enable society to adopt appropriate measures to regulate and support the formal care system to ensure the continued support for the elderly in times when care is needed most.

1.6 Structure of the Thesis

In addressing the objectives of the study, this study is organised into eight chapters. Chapter one discusses the background of the study, the statement of the problem, the objectives of the study, research questions, the definition of key concepts and the relevance of the study. Chapter two presents an overview of relevant literature and the theoretical framework for the study. Chapter three discusses the methodological approach for the study. This includes the study population, sampling procedure, methods of data collection, data management and the analysis of the data. Chapter four examines the antecedents to the elderly persons

requiring long-term care and the decision making processes for long-term care out of the usual dwelling of the elderly. Chapter five looks at the process of the elderly persons accessing residential non-domiciliary care in the urban centres of Greater Accra Region as well as the perceptions of the elderly about care received at the residential aged care facilities. Chapter six discusses how the elderly and their family members make sense of the whole process of accessing residential non-domiciliary aged care facilities for long-term care. Chapter seven discusses the perceptions of actors about the elderly accessing non-domiciliary care vis-à-vis the traditional norms of reciprocity. Chapter eight consist of the summary of the findings, conclusions and the necessary recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter is in two parts. The first part focuses on reviewing existing literature on the social support systems and caregiving for elderly persons globally and locally. The second part discusses the concept of reciprocity which forms an integral part of the research. The concept of reciprocity guided the explanation of the different aspects of the processes leading to the elderly persons losing domiciliary long-term care and accessing residential non-domiciliary care facilities in the urban centres of the Greater Accra Region of Ghana. The concept of reciprocity as defined by cultural anthropologists enabled me to develop a framework for the study to explain the processes leading to the elderly requiring care, the elderly accessing domiciliary care and losing it and the elderly finally accessing non-domiciliary care facilities to address their long term care needs. Additionally, it enabled me to appropriately comprehend the landscape and the activities of the residential non-domiciliary care facilities for the aged in the country.

2.2 Overview of Social Support and Caregiving for the Elderly

Since the mid-twentieth century, the world population has been experiencing increasing proportions of older people in the total population. The phenomenon of population ageing started much earlier in the high-income countries of the world but only began taking place in the low-income countries in the early 1990s (Sokolovsky, 2001). As the phenomenon gained global status and scale, the International Conference on Population and Development was held in 1994 in Egypt (United Nations, Department of Economic and Social Affairs, 2013). Subsequently, the cause of population ageing has been advanced at different regional

and global gatherings on the subject. Studies have shown that research on ageing in Africa began in the 1970s when the United Nations sponsored pilot surveys on ageing in nine low and middle-income countries, including Ghana and Uganda (de-Graft Aikins & Apt, 2016). After the first United Nations World Assembly on Ageing in Vienna (1982), the Government of Senegal in collaboration with United Nations Educational, Scientific and Cultural Organisation (UNESCO) and United Nations Population Fund (UNFPA), organised the first African conference on ageing in Dakar (1984) at which 29 African countries were represented. These gatherings led to a growing interest in the wellbeing of ageing populations in Africa, the conduct of research on ageing from the social sciences and humanities as well as the formation of networks such as the African Gerontological Society (AGES) and African Research on Ageing Network (AFRAN) for supporting and disseminating multidisciplinary research on ageing (de-Graft Aikins & Apt, 2016). In 2001, the African Regional Office of HelpAge International based in Nairobi, Kenya, achieved a major policy breakthrough by successfully including ageing issues on the agenda of an African Union (AU) meeting. The AU accepted in principle that ageing was an issue of concern for all member countries and endorsed the formulation of a Draft Policy Framework and Plan of Action on Ageing (de-Graft Aikins & Apt, 2016).

At the Second United Nations World Assembly on Ageing, in Spain (2002), the Madrid International Plan of Action (MIPAA) was developed and adopted by all countries present. MIPAA outlined three priority areas for research and intervention on ageing: (1) older persons and development; (2) advancing health and well-being into old age; and (3) ensuring enabling and supportive environments for the aged. The plan also emphasised the need for older persons to be able to participate in and benefit equitably from the fruits of development, to advance their health and well-being, and that societies should provide enabling environments for them to do so (de-Graft Aikins, 2016). The three priority areas

aforementioned formed the basis for the Global AgeWatch measurements conducted by HelpAge International of the social and economic well-being of older citizens in selected countries over the last decade (de-Graft Aikins & Apt 2016).

Over the years, it has become evident that the proportion of aged persons in the total global population will continue to increase with the intensity and depth of ageing varying considerably among countries and regions (United Nations, Department of Economic and Social Affairs, 2013). In some middle and low-income countries, the number of older adults 60 years and over will grow more rapidly than anywhere else in the world (United Nations, Department of Economic and Social Affairs, 2013). In these countries as well, population ageing is taking place at a time when these countries are experiencing rapid socioeconomic and demographic changes as industry replaces agriculture, literacy levels rise, rapid urbanisation, low fertility as a result of women having fewer children, and increased life expectancy as people live healthier lives (Bongaarts & Zimmer, 2002).

As life expectancy has increased in both the high-income and low-income regions of the world, a large number of studies have been conducted globally on the topic in both academic and policy circles (Beard, et al., 2012). Western scholars have tended to focus on a wide range of issues including ageing, poverty and financial security, gender and ageing, ageing social capital and intergenerational equity, ageing lifelong learning and social innovation, challenges of non-communicable diseases among the aged, geriatric conditions and disability, human rights and the social protection of older people, urbanisation, migration and population ageing, the role of the aged in society, ageing workforces, competitiveness and retirement, healthy ageing; the design and operation of health systems for the aged, ageing housing and the environment, ageing and technology as well as policy responses (Leone, et al., 2012; de Graft Aikins, et al., 2016).

The studies conducted in Ghana have focused on a much narrower range of issues: demographic profiles and patterns of ageing, the physical and mental health status of the elderly, roles and responsibilities of the elderly, social responses to the elderly and social protection and other forms of state support for the elderly and care and support for the elderly (de-Graft Aikins, et al., 2016). In the area of care and support for the elderly, research has focused on the living arrangements of the elderly as well as eldercare and the impact of caregiving on the caregivers and the range of care activities performed for the elderly (van der Geest, 2002a, 2002b).

2.2.1 Living Arrangements of the Elderly Persons

Throughout the history of mankind, the family has served as the locus where the elderly people in society live and are often supported by kin and kindred (Kimuna, 2013). It has been observed by researchers that the family has been the safest haven for the aged. The family ties have been the most intimate and long-lasting, and on them the aged have relied for greatest security (Sokolovsky, 2001; Ayernor, 2016). Kimuna (2013) pointed out that different types of living arrangements are shaped, sustained and transformed by both structural and cultural conditions that permeate different societies. Bongaarts and Zimmer (2002) noted that in largely rural traditional societies, residential families are more often extended, either horizontally or vertically, than in modern industrialised societies where the independent nuclear family predominates (Bongaarts & Zimmer, 2002, p.146). In China for example, the extended family household has formed the basis for the traditional family support system of the aged for centuries and it stood as a key manifestation of devotion to the family (Silverstein, et al., 2006).

Indeed, multigenerational households and co-residence of the elderly and the adult children was a common type of living arrangement globally until incomes began to increase in the

last century and trends of living arrangements began to shift towards independent living (Glaser & Grundy, 1998; Costa, 1999; Silverstein, et al., 2006; Wiemers, et al., 2015).

Over the years, there has been extensive changes in the living arrangements of elderly persons in most high-income countries resulting in more elderly people living alone as the proportion of those living with kin outside the nuclear family decreases (Gaymu, et al., 2006). The increase in elderly people residing independently is thought of as a reflection of both the ascendancy of cultural values that emphasise the desirability of living separately from kin and the increases in economic resources which enable older people and their kin to live independently (Glaser & Grundy, 1998). Family Sociologists generally hold the view that the size and complexity of households and residential families decrease as a society industrializes and urbanizes (Bongaarts & Zimmer, 2002; Silverstein, et al., 2006). Currently, the living arrangements of the elderly persons in society are quite dynamic and might change depending on the different phases of one's life course. Research has shown that the early life course of an elderly person strongly influences the decision making process about late life living arrangements. Hays (2002) shared the view that childhood co-residence with grandparents and midlife familial interactions are strongly related to a 'willingness to undertake intergenerational co-residence' (Hays, 2002, p.140).

Additionally, midlife experience of providing informal care to family members or formal health care to nonrelatives affects one's preferences about living arrangements (Hays, 2002, p.140). In using the data from the Panel Study of Income Dynamics to examine the living arrangements of older women and their adult children over the life course in the United States of America (USA), Wiemers et al., (2015), found out that over 50% of mothers who were observed living alone in their last years, had also lived with children since they were

58 years old. Similarly, 80% of those observed living with children who left home, had lived alone at some point since they were 58 years old. Indeed, women who lived with children had only spent 60% of the time since they were 58 years old living with children (Wiemers, et al., 2017, p.19).

A global study conducted by Bongaarts and Zimmer (2002) on intergenerational transfers and living arrangements of the elderly across 43 low-income countries provides more nuanced perspectives on the issue. They found that most older adults tend to live in large households, and they are likely to be living with an adult child, who is more likely to be male than female. They, however, argued that there is substantial variation in living arrangements by gender and education, and several regional patterns exist.

Nearly 1 in 10 older adults in the low-income regions of the world lives alone and the probability of living alone is greater for older women than men (Bongaarts & Zimmer, 2002). This contrasts sharply with the statistics from the high-income regions of the world. Drawing on USA census information from 1990, Palloni (2001) points out that roughly 65% of unmarried white women and men live alone. For African Americans, the figures are 51% and 48% respectively. In Western and Northern Europe, as in USA, the prevalence of the elderly population, regardless of marital status, living in a single-person household is between 15% and 40%.

In Asia more than elsewhere, multigenerational households are the norm. This residential arrangement fulfills the cultural ideal of devotion to the family. This arrangement according to Silverstein, et al. (2006), enhances the ability of children to deliver care, while allowing them to demonstrate deference, commitment, and sacrifice to the older generation as the

titular head of the family. The precepts of filial piety also encourage adult children to remain in the same local community as their parents (Silverstein, et al., 2006, p.256).

In the African setting, as in much of Asia, households were multigenerational in nature. The living arrangement that was common among the elderly was to live together with relatives - mostly their children, grandchildren and others such as siblings and cousins (Apt, 1996; Aboagye, et al., 2013). Over the years, socio-cultural transformations in the Ghanaian society resulting from modernisation, urbanisation, migration, education and wage labour have brought about changes in family formation, organisations and relations (Apt, 1996, 2002; Mba, 2001) which is gradually changing both the living arrangements of the elderly within society and the support system in place for them (Ghana Statistical Service, 2013).

Apt (2001) argues that there are three levels at which this is evident. First, migration leads to the departure of the able-bodied and the young, whose services are needed in the processing of daily needs. Secondly, the migration of caregivers, mostly women, through modern education and employment, limits their ability to act as providers of services within the household. Finally, the inability of the able-bodied to earn needed income as providers owing to increasing unemployment, underemployment and low salary levels even for the fully employed makes financial support for the aged more difficult (Apt, 2001, p.11). Additionally, migration leads to decreasing family solidarity, the widespread disruption of traditional gender roles and relations (Oppong, et al., 2009).

According to the 2013 Ghana Statistical Service Report, majority (62%) of the elderly are household heads or spouses of heads in the households in which they reside. Children, aged less than 15 years, form a third of the members of all the households in which the elderly live (Ghana Statistical Service, 2013, p.6). According to the report, some of the elderly are

residing with their spouses; the highest proportions of the elderly who live with their spouses are the young-old (12.7%) as compared with 7% and 6.1% of the old-old and the very old respectively. The young-old have lower prevalence rate of widowhood compared with the old-old and very old because of a relatively lower rate of mortality among the young-old. As a result, a higher proportion of the young-old would have their spouses still alive and reside with them (Ghana Statistical Service, 2013, p.73). These characteristics of the living arrangements of the elderly indicate that less than a tenth (8.3%) of the elderly receive care and support from an extended family member. The proportion of elderly persons who live alone increases with age. According to the 2013 Ghana Statistical Service Report, the proportion of elderly persons who stay alone ranges from 9.4% of the 65-69 year-olds to 11.4% of the 75-79 year-olds (Ghana Statistical Service, 2013).

In Ghana, on the average, 1 out of every 5 of the elderly persons resides as a parent or parent-in-law (11.1%) with their children or spouses of their children. While about the same proportions of all the categories of the elderly are living with their siblings and non-relatives. Higher proportions of the old-old and very old reside with those classified as other relatives as compared with that of the young old. Small proportions of elderly persons reside with non-relatives or in-group quarters or as outdoor sleepers. These last three types of living arrangements of the elderly are indications that family care is not available for some Ghanaian elderly people. Socio-cultural transformations account for such situations where the elderly are living in non-family situations (Ghana Statistical Service, 2013).

2.2.2 Determinants of the Living Arrangements of the Elderly

In their study on the perspectives on senior transitions in the living environment, Perry et al., (2013), commented that the experiences of ageing may necessitate transitions in living

environments, either through adaptations to current residences or relocations to more supportive environments (Perry, et al., 2013, p.75). Research has shown that a number of socio demographic characteristics of the elderly: such as age, sex, marital status, occupation/income, health, education, place of dwelling and number of children, play a decisive role and act as the important variables that shape the living arrangement of the elderly in society (Gaymu, et al., 2006; Panigrahi, 2009; Kimuna, 2013). A literature search shows that apart from the socio demographic characteristics of the elderly persons, a number of factors such as the migratory status and availability of children, as well as other characteristics of the children also play important roles in determining the living arrangement of the elderly (Kimuna, 2013).

Several factors therefore determine the living arrangements of an elderly person at any given time in their life course. Some researchers have categorised these determinants into push and pull factors. The most potent push factors resulting in change in living arrangements include the death of a spouse, changes in income or employment, hospitalisation, short term nursing home admissions, a sharp increase in outpatient visits to health care facilities, and changes in functional status (Hays, 2002, p.140). As the health needs of the elderly arise and adult children become involved in providing more support, an older person may be pulled nearer to or into co-residence with that child. Close ties to a previous dwelling place especially when siblings or children live there pull retirees toward return migration. Institutional pull factors, such as attractive characteristics of continuing care retirement communities, pull older persons to relocate the household to a specific facility (Hays, 2002, p.140).

Other scholars group the factors that determine the living arrangements of the elderly broadly into four categories as the resources available to the elderly persons, their needs,

availability of kin and their preferences (Gaymu et al., 2006; Panigrahi, 2009; Kimuna, 2013; Wiemers et al., 2017). The elderly are much more likely to live alone if they have the resources to do so. This is particularly true of older unmarried women whose improvements in economic circumstances have made it possible for them to opt for independent living (Wiemers et al., 2017).

In discussing the determinants of co-residence of the elderly and an adult child, Wiemers et al. (2017) argued that there is extensive evidence to show that the elderly person's needs arising from poor health, functional disabilities, and widowhood may be linked to the elderly co-residing with their adult children. They further pointed out that studies in the USA have shown that the characteristics of children of the elderly also influence their mothers' living arrangements. Having an unmarried child is strongly positively related to co-residence, though this could be an indicator of either having a child that can provide care or of having a child that requires support (Palloni, 2001; Wiemers et al., 2017). There is growing consensus that having a child with fewer economic resources increases the probability of co-residence. Conversely, the increases in children's income and more favourable economic conditions are associated with a higher probability of young adult children living independently of their parents, while unemployment for children predicts moving back in with parents (Barrow, 1986; Bongaarts & Zimmer, 2002; Novak, 2006; Silverstein, et al., 2006; Wiemers et al., 2017).

Apart from the above living arrangements, globally, some elderly persons live in special retirement communities or settings. Many of these communities in the high-income countries are built in resort areas where climates are warmer. Community living arrangements typically include recreational amenities for the elderly. Some retirement

communities provide supportive care to the elderly in the form of prepared meals, housekeeping services, transportation, planned events, and reminder services. Additionally, some elderly persons live in 'seniors only' apartments, which allow seniors to rent in a community with people their own age. Senior renters may be individuals who have owned a home or have been renting all of their life but desire to move to a community that support a senior lifestyle.

The structure of assisted living facilities can range from a dwelling that looks like a home in a residential area where the caregiver is the owner and single proprietor, to a large, apartment-style building staffed with many employees with the care style being different in these two types of properties. The board-and-care type of assisted living with three to eight beds usually provides a homelike environment and closer association with the other residents. Each resident has his or her own room and bathroom. The living room and dining areas are commonly shared with other residents. The support staff in such smaller-bed facilities are few. Elderly persons needs to be mobile to get around the facility by themselves. In contrast, large assisted living facilities may be staffed with 24 hour nursing care, have a help desk, provide activities staff, provide counseling, provide a memory care wing, provide education classes, group activity, entertainment and handicraft programs and provide large private apartments. Arrangements are sometimes made for home health agencies, therapists, or visiting doctors for residents' needs. Transportation, excursions and field trips are also available. No matter the size, assisted living facilities offer individual choices, independence, and the security of not being alone.

Nursing homes provide a cost-effective way to enable patients with injuries; acute illnesses or postoperative care needs to recover in an environment outside a hospital. Nursing homes

also serve chronically impaired individuals who are not expected to recover and who will typically die in the nursing home. Nursing homes serve two kinds of residents. The first are those who have been discharged from the hospital for rehabilitative care. Second are residents who may suffer from chronic physical or mental disorders or they may simply be feeble and unable to move about, bath themselves, or provide their own meals. In the USA, Medicare does not pay for their type of care, but Medicaid typically will pay. These people are often referred to as long-term care residents. Nursing homes fall into one of the five categories of facilities described as 'total institutions' by Goffman (1961) which he identified in human societies. A 'total institution' is 'a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (Goffman, 1961, p.13). Goffman's concept of the 'total institution' can be represented as follows: there is a continuum from open to closed institutions, but there is a break towards the closed end, separating off a group of closed, or nearly closed, institutions which can be described as 'total' (Jones & Fowles, 1984, p.104).

The first category of total institutions are those institutions established to care for persons thought to be both incapable and harmless; these are orphanages, poor houses and nursing homes for the aged. The second are places established to care for persons thought to be incapable of looking after themselves and a threat to the community, albeit an unintended one like mental homes, leprosarium and tuberculosis sanitariums. The third are institutions organized to protect the community against what are thought to be intentional dangers to it; here the welfare of the persons thus sequestered is not the immediate issue. Examples are jails, penitentiaries, and concentration camps. The fourth are institutions purportedly established the better to pursue some technical task and justifying themselves only on these instrumental grounds. Examples are Army barracks, ships, boarding schools, work camps,

colonial compounds, large mansions from the point of view of those who live in the servants' quarters, among others. The fifth are those establishments designed as retreats from the world or as training stations for the religious. Examples are monasteries, convents, abbeys, and other cloisters (Goffman, 1961; Jones & Fowles, 1984).

2.2.3 Effects of Elderly Persons Living Alone

Currently, the number of elderly persons living alone or independently across the globe is increasing (Michael, et al., 2001; Palloni, 2001). In the USA for example, Novak (2006) notes that nearly all (85%) older people live alone or with a spouse with the rest living with another relative or a nonrelative (Novak, 2006, p.283). Michael et al (2001) pointed out that women living alone in the USA were older than women living with a spouse or with people other than a spouse (Michael, et al., 2001, p.125). In contemporary Ghana, research has shown that the situation of living alone is entrenched among elderly men. Elderly women, who live alone more often than not, get support from their children. Moreover, it is more likely for elderly men with high social and economic protection to live alone (van der Geest, 2002; Mba, 2007; Aboagye, et al., 2013).

In a study conducted by Michael, et al., (2001) on living arrangements, social integration and change in function status among the elderly in the USA, they reported that women living alone were more likely to have comorbid conditions and more likely to be current smokers compared with those living with a spouse. They reported fewer social ties compared with women living with a spouse but were just as likely to report that they had a confidant. They also were similar to women living with a spouse in terms of the proportion who participated in three or more social engagement activities. They further pointed out that baseline physical function, vitality, and mental health were lowest among women living with a non-spouse,

highest among women living with a spouse except for vitality, and intermediate among women living alone.

Even though independent living arrangements for the elderly is usually perceived to be the most desirable for older adults in the USA because they offer more autonomy, these living arrangements have the likelihood of increasing their social isolation and reliance upon formal social support (Wilmoth, 2001). Studies have shown that those elderly people living in rented accommodation and those without children were less satisfied with life than those owning their homes and living with their children or other family member (Darkwa, 2000). According to Silverstein et al., (2006), living independently of children was detrimental to the emotional health of older parents, but the harm did not increase with greater distance from children (Silverstein, et al, 2006, p.263). Van der Geest (2002a) comments that a person's family size and the investment made in the care of that family largely determined the family relations that may be experienced in old age, including the living arrangement of the elderly.

2.2.4 Effects of Elderly Persons Co-residing with Kin

Co-residence of elderly persons with an adult child has over the years been considered to be a central feature of the familial support system in much of the low-income regions of the world (United Nations, 2012). Research has shown that the demand for co-residence of an elderly person with the children or other kin is much higher in societies with a hazardous institutionalisation of social transfers, with traditionally low levels of human capital investments, and where the health and disability of the elderly require large expenditures on care and health services (Palloni, 2001). The incidence of co-residence of elderly persons with an adult child is prevalent in low-income countries because there exists a negative

correlation between levels of kin co-residence and socio economic development (Mba, 2002). In reviewing studies conducted on the elderly persons household size and composition, as well as patterns of living arrangements and their socio-economic determinants in low-income countries, Mba (2002), concluded that elderly persons prefer to co-reside with their kin, especially with their spouse and children, and that elderly females are less likely than their male counterparts to live with a spouse. This is consistent with the findings of Bongaarts and Zimmer (2002) who argue that females are more likely than males to live alone and are less likely to live with a spouse or head of a household.

Additionally, the phenomenon of co-residence is higher among elderly persons with chronic disabilities. In the USA for example, nearly two-thirds of the 5.5 million elderly persons with chronic disabilities rely, often exclusively, on family members for help with basic activities of daily living (ADL). Much of the assistance provided by family members takes place in the context of co-residence of the disabled elderly person with adult children. Although evidence suggests a secular increase in living alone among the elderly persons, co-residence of disabled elderly parents with their adult children remains fairly common in the USA (Pezzin, et al., 2007).

In the process of parents and their adult children co-residing, both parties could derive mutual benefits depending on each person's resources, needs, availability of kin and preferences (Bongaarts & Zimmer, 2002; Mba, 2002; Kimuna, 2013). In the process of living together, even though the elderly persons may receive the social, financial, and health care support they require from the younger generation, reciprocal exchanges take place such that the elderly assist with taking care of their grandchildren. Additionally, the elderly look after the home when other adults are away (Bongaarts & Zimmer, 2002; Mba, 2002; Novak, 2006; Wiemers, et al., 2017). Some young adult children may benefit financially from living

with their parents (Wiemers, et al., 2017). Studies elsewhere bearing on this subject show that the gender of a co-residing child has implications for the level and nature of support provided to the elderly persons (Mba, 2002). Studies have shown that there are great variations in living arrangements by sex. Women are much more likely than men to live in extended households. Reasons being that women mostly tend to live longer than men, they may therefore have more grandchildren and children-in-law with whom to live and they may also need to move in with extended family for support upon demise of spouse. Additionally, grandmothers may be seen as the more natural choice of individuals to assist in caring for grandchildren (Mba, 2007). The study (Mba, 2007) further reveals that the older women of Lesotho are more likely to live with their young children than the older ones, although the difference is marginal. This presupposes that the elderly women have additional burden of fending for the children, most of whom are likely to be in school (Mba, 2002; de-Graft Aikins et al, 2016).

Overall, research in the West suggests that compared to living independently with one's spouse, elderly persons living with grown children are less happy, have less life satisfaction, and are more depressed, especially when the spouse is not sharing the household (Ren & Treiman, 2014). Living with children who were less supportive emotionally and financially detracted from the psychological well-being of older parents (Silverstein, et al., 2006). In contrast, living in a multigenerational household is very important to older adults in rural non-Western communities because beyond its functional benefits, it serves as a fulfillment of traditional or cultural ideals. In China for example, older people who are socially embedded within a traditional multigenerational household may have a greater sense of purpose by virtue of occupying a culturally sanctioned role within the family (Silverstein, et al., 2006).

2.2.5 Social Support and Caregiving for the Elderly Persons

In social gerontology, social support for the elderly person has been one of the focal points of research globally due to increasing ageing population and social change, which have undermined the traditional systems of caregiving across the globe. The tradition of family caregiving is fundamental to the human society (Grunfeld, et al., 1997). In every society across the globe, families and particularly women have always been critical in providing elder care, but the entry of so many women into the paid labour force has made eldercare increasingly difficult (Apt, 2002; Bookman & Kimbrel, 2011).

There have been systematic reviews of social support and caregiving for the aged as the world's population ages within different cultures. The studies have focused on activities of care performed for the elderly person, the composition of the caregivers, the experiences of the informal caregivers, the concept of caregiver's burden and the impact of caregiving, long-term care of the aged and end of life care, as well as parent-adult child relationships and grandparent-grandchild relationships.

Care and support for older adults in Ghana has been one of the six focal points for empirical studies among researchers (de-Graft Aikins, et al., 2016). Some of the topics researched into in this area are family support, filial obligations and the norms of reciprocity, caring for the elderly person within the family. Other areas researched into under care and social support are long distance eldercare, the composition of caregivers and the determinants of caregivers' burden, family relationships in long-term care of the elderly person as well as gender and intergenerational support.

On the issue of family support, filial obligations and the norms of reciprocity, research has shown that the practice of family members materially supporting the elderly persons which is an aspect of care in Ghana, as in other African countries, has declined over the course of time. Research has shown that the informal support systems in the form of the extended family has broken down which has shifted responsibility of the care of the elderly person to adult children who respondents felt had the moral obligation to take care of them (Adzakey, 2013). The reciprocal arrangements of care offered under the extended family system, however, face several threats, especially from the looming decline in the extended family system, rapid urbanization, mobility of labour and modernization (Domfe & Aryeetey, 2016). This has made taking care of the sick an increasingly challenging enterprise for the family concerned (Oppong, et al., 2009). It has exposed increasing numbers especially of urban elderly persons to destitution and poverty. The likely causes are the growing material constraints and the weakening traditional values (Aboderin, 2004, 2005).

Despite the above, some researchers argue that the traditional system of support for the elderly persons was still functional with families providing the aged with both material and instrumental support. However, the amount and quality of social support received by older adults may vary by their gender and ethnicity (Ayernor, 2016). Ayernor (2016) was of the view that this “occurs because older women tend to escape the phenomenon of retaliation of adult children that unduly affects older men because they, unlike men, do not neglect their responsibilities to their children, all things being equal” (Ayernor, 2016, p. 99).

He further notes that there is increasing evidence in both rural and urban Ghana that adult children resort to “retaliation” when they perceive that parents had neglected their responsibility. As a result, they tend to withhold some if not all support for older men disproportionately impacted by this action (Ayernor, 2016)

Females were reported to receive more material support than males; but males receive more instrumental support than females. Both males and females intimated that the support they received was inadequate (Darteh et al, 2014). Studies have shown that there is a mismatch between the number of people requiring care and the number of people providing care. In order to improve the health of caregivers and care recipients, there is a need to provide financial support for caregivers. In addition, pro-caregiving government programmes and policies should be established (Sanuade, & Boatemaa, 2015).

Studies have shown that the quality of relations between grandparents and grandchildren varies according to age and gender (Ayernor, 2016; de-Graft Aikins & Apt, 2016). Grandchildren of varying ages speak respectfully about their grandparents, but older people regret that their grandchildren do not come to them for advice once they have grown up. Older men seem more 'neglected' by their grandchildren than older women. Additionally, the performance of respect, affection and relatedness between grandparents and grandchildren are demonstrated in public even when their contents have dwindled over time (Apt and Katila, 1994; van der Geest, 2002, 2004c).

When it comes to studies on caring for the elderly person within the family, research has shown that technical, emotional and material activities of care are performed for the elderly person first and foremost by the female family members of the nuclear family before other female members of the extended family (van der Geest, 2002a, 2002b). Helping an elderly person in the performance of activities of care is based on their respect for the elderly person and fulfilment of the traditional norms of reciprocity. Some studies have discussed the meaning of respect and its linkage to reciprocity. It has been argued that 'respect' takes different meanings in different life situations, from outward deference to deep personal

affection. As such, the norm of reciprocity serves as the hidden principle that determines the type of respect given to an elderly person (van der Geest 2008). Reciprocity is considered to be conditional and dependent on the quality of relationships between young and old as well as the investments made by the elderly person in the kin while they were growing up. As such, parents who have done their part deserve support from kin (Mazzucato, 2008; van der Geest, 2008).

On the subject of long distance eldercare in Ghana, studies have shown that migrants make efforts at fulfilling the implicit contract to reciprocate their parents' care by remitting money to them back home (Mazzucato, 2008). Despite their efforts, remittances received by the aged were inadequate to take care of their needs. Majority of them spending a large proportion of the money they received on food rather than on investments or savings (Adzakey, 2013).

Caregiving was at the core of the Ghanaian extended family system (Apt, 1996; Tonah, 2009). Nukunya (2003) defines the extended family in two ways: first, as a group consisting of close relatives along either male or female line with the structure usually being defined by the descent system. Second, the extended family is defined as "a social arrangement in which an individual has extensive reciprocal duties, obligations and responsibilities to relations outside his immediate (nuclear) family" (Nukunya, 2003, p, 49). Households were multigenerational and consisted of members of the extended family (Apt, 1996; Mba 2002; Nukunya, 2003). In the extended family one was obligated to help a member in need, moneywise as well as concerning moral support and court cases. Thus, the extended family system served as a form of social security for Ghanaians who live in a country that does not have a well-developed social welfare system (Apt, 1996; Kumado & Gockel, 2003; Tonah, 2009; Ayernor, 2016). The socialisation and upbringing of the children was not only the

duty of the parents, all the adults in the family were expected to be involved. The elderly persons took part in the upbringing of their grandchildren. Thus, the elderly persons always had someone to help them in the running of errands. Filial responsibilities to parents included taking care of them when they are old and giving them a decent burial when they die just as the parents had taken care of the children when they were growing up. The main role, though, for the elderly person in the traditional system is to function as advisors on family matters.

In the Ghanaian society, some of the common activities for which elderly people needed the help of others to accomplish include getting food, taking a bath, washing clothes, and going to the toilet. Helping them financially and providing company are tokens of care, which are also indispensable. However, in the eyes of many, the most important type of 'care' is the organisation of a fitting funeral when the elderly person dies (van der Geest, 2002a, 2002b). Usually, the support given to an elderly person by the family and relatives is influenced by the needs and inabilities in the daily life of the elderly person. Support with food, clothing, and payment of medical bills, as well as housing and psychological support are the common forms of assistance and care accorded to the elderly persons by their primary carers (Aboagye, et al., 2013).

The care arrangements for elderly people in any given community in rural Ghana are complex. The quality of care given to old people varies. Factors such as the economic constraints pertaining and the belief systems can lead to the quality of care being compromised intentionally or unintentionally (Ayetey, 2009). As such, some old people are poor, neglected and miserable; while others are relatively well off in terms of care support from kin. For all, the care that they receive in the last years of their life may dwindle to very little, if seen in comparison to the attention, which they receive after death (van der

Geest, 1995). In a study conducted by Adzakey (2013), he notes that the formal support mechanisms available are inadequate to cater for the needs of the aged. The informal support systems in the form of the extended family has broken down which has shifted responsibility of the care of the elderly persons to adult children whom respondents felt had the moral obligation to take care of them.

The breakdown in informal support systems recorded for Ghana has also been noted in other societies, both high-income and low-income regions. Across the globe, massive social and economic change has resulted in declines in support for the elderly person. The elderly persons in these societies have thus, been exposed to increasing poverty and deprivation (HelpAge International, 2002; (Aboderin, 2004, 2005).

2.2.6 Health Conditions Leading to the Elderly Persons Requiring Care

Studies have shown that as societies modernize, they experience significant changes in their patterns of health and disease (Agyei-Mensah & de-Graft Aikins, 2010), from the dominance of communicable to non-communicable diseases. However, non-communicable diseases account for more than 50% of deaths in adults aged 15–59 years in most low-income countries (Leone, et al., 2012), this is even higher in older populations. De-Graft Aikins & Koram, (2017), have noted that Africa and Ghana for that matter faces a double burden of infectious and chronic diseases. Infectious diseases account for about 70% of deaths on the continent. Additionally, age specific mortality rates from chronic diseases in both men and women are higher in sub Saharan Africa than in all other regions of the world (de-Graft Aikins, et al., 2010b, 2014). With increasing life expectancy and prevalence of risk factors, NCDs like hypertension, diabetes and stroke are increasingly becoming common health problems globally (Addo, et al., 2012). Globally, the mortality burden of

diabetes for example is not evenly distributed. Low-income and middle-income countries carry a disproportionate burden. It is projected that by 2030 about 82.5% of people living with diabetes will live in low-income and middle-income countries (Leone, et al., 2012).

Ageing is associated with significant changes in the physiological, physical, psychological and immune function of the human body resulting in progressive generalized impairment that increases susceptibility to infectious diseases (Aganiba, et al., 2015). The process of ageing is characterised by the gradual reduction in reflexes, increase in chronic illnesses. The rate of chronic illnesses increases steadily with age, thus, poor health becomes associated with old age (Quadagno, 1999). Debpuur, et al (2010) notes that chronic diseases and disability are disproportionately high among older people thus, a growing elderly population will increase the demand for health care and other social services.

Studies have shown that chronic disease conditions lead to functional loss which in turn leads to disability and activity limitation in at least one ADL among older people globally and they account for a big chunk of deaths among the elderly persons (Novak, 2006). Most chronic diseases increase in occurrence and severity with ageing resulting in poor health in old age. Globally, chronic diseases are the leading causes of disability among elderly persons aged 60 years and above. For older women the causes of disability were unipolar depressive disorders, hearing loss, back and neck pain, Alzheimer's disease and other dementias, and osteoarthritis. Among older men, hearing loss, back and neck pain, falls, chronic obstructive pulmonary disease and diabetes mellitus were the leading causes of disability. Vision loss, caused by refractive errors or cataracts, is also an important cause of disability among older persons globally (World Health Organisation, 2012; United Nations, Department of Economic and Social Affairs, 2015). Research on the health of elderly

persons in sub Saharan Africa indicates high rates of hypertension, musculoskeletal disease, visual impairment, functional limitations and depression, many of these cases are usually undiagnosed or untreated (Aboderin, & Beard, 2015; United Nations, Department of Economic and Social Affairs, 2015). However, having a chronic disease does not necessarily mean being disabled as chronic conditions do not always turn into functional disability or the need for assistance with activities of daily living. Studies have shown that Africa faces an urgent but neglected epidemic of chronic disease. In many countries, disability and death rates due to chronic diseases such as diabetes, hypertension and stroke have accelerated over the last two decades (de-Graft Aikins, et al, 2010a).

Research in Ghana over the years has shown a high burden of chronic diseases in the older Ghanaian population, as well as high rates of modifiable health risk factors. Hypertension is a major public health problem in Ghana particularly in urban areas (Mensa-Wilmot, 2003; de-Graft Aikins, et al., 2012; Manu-Moshie, 2012; Minicuci, et al., 2014). Over the last fifty years, there has been a documented increase in prevalence rates of chronic diseases such as cardiovascular diseases, hypertension and diabetes in Ghana (de-Graft Aikins, 2007). The problems associated with the prevalence of chronic diseases is complicated by inadequate formal health care system in Ghana to meet the demands of chronic diseases burden. Additionally, the alternative health care system to formal health care provides unregulated chronic disease care (de-Graft Aikins, et al., 2012).

In a review of the burden of chronic disease in Ghana, research has shown that non-communicable diseases like hypertension, stroke, diabetes and cancers ‘causing high rates of disability and premature death’ among the adult populations (de-Graft Aikins, & Koram, 2017, p. 365). Studies have shown that people living with chronic diseases face a complex

set of challenges. Chronic disease conditions pose physical challenges, which range between minor physical ailments to severe physical disabilities, which have psychological implications as well as concrete impact on mobility and productivity. Additionally, managing these conditions poses many economic challenges, as treatment is expensive without health insurance. Some chronic disease conditions such as cancer and diabetes also appear to be stigmatised (de-Graft Aikins, 2007).

The prevalence rates of chronic non-communicable diseases (NCDs), neurodegenerative disorders and disability are expected to rise among the older populations in Ghana with implications for health systems, health and social care at the community and family levels (Addo, et al., 2012; de-Graft Aikins, & Apt, 2016). Without adequate detection and control, the increasing burden of hypertension will translate into a higher incidence of stroke and other adverse health outcomes for which hypertension is an established risk factor (Addo, et al., 2012).

2.2.7 Why Care for the Elderly Person

In most societies, adult children in families have had the moral responsibility for the support of elderly people who require support and care to sustain themselves. This responsibility has been encapsulated in norms of filial obligation, and enshrined in society's moral or religious codes (Aboderin, 2005). The adult children's filial obligation is typically based on the norm of reciprocity by which they have a responsibility to support their aged parents in return for or as repayment of the parental care and support they received from their parents in their childhood (Gouldner, 1960; Bongaarts & Zimmer, 2002; van der Geest, 2002a, 2002b; Aboderin, 2005). Aboderin (2005) notes that this reciprocal obligation does not

merely exist at ‘a normative level’; it is also applied and expressed in practices across societies, with the exception of some Scandinavian countries (Aboderin, 2015, p.3).

In Ghana, respect and the norms of reciprocity play a crucial role in the caregiving of children to their elderly parents and adults in society in general. According to van der Geest (2002), respect is no longer something that is automatically awarded to people just because they are older; respect is earned. To respect an older person is no longer a ‘natural’ thing to do. In his study among the Kwahu, he pointed out that both elderly and young people confirmed that respect and care depended on reciprocity. Those who are respected are assured of care. He argues that respect depends on what the elderly persons have achieved during their active life. Those who have worked very hard and have taken good care of others, their children, their partners and other relatives, will receive care, attention and financial help. The guarantee of care at old age is foremost a matter of reciprocity (van der Geest, et al., 2004). According to him, the giving of money is not a means to keep people at a distance and avoid getting involved in their lives, as it tends to be in industrialised societies.

Van der Geest et al., (2004) notes that the principle of reciprocity does not change with the departure of children from Kwahu-Tafo. On the contrary, working in the capital city or abroad is consistent with the reciprocity principle. Travelling to make a better living is expected to benefit the relatives who helped the migrant to reach his or her present position (van der Geest, et al., 2004). Research has shown that in instances where the arrangement of caregiving for the elderly persons may appear to be disorganised, the role of the traditional norms of reciprocity in the care arrangement remains strong. Even though there might be disagreements on the modalities of the care being provided, both caregivers and care receivers agree on this principle (van der Geest, et al., 2004).

In Kwahu-Tafo, where state provided material security for the elderly person is not available, material gifts and money are the most convincing proof of respect and affection (van der Geest, 2002a; van der Geest, et al., 2004). Those who worked hard for their children could be sure that they would receive respect and care from them. Whether they actually get that help in good quality and quantity depends very much on how they are regarded by others. In Mayerhoff's (1971) view of 'care' he argues that the concept of reciprocity becomes superfluous if an individual's caregiving is experienced as an extension of the individual's self then, the individual does not need any 'payback'. Therefore, caring in that sense is indirect self-fulfilment. That view fits the care given by parents to their children but much less the care of children for their parents. According to van der Geest (2002b), the Western notions of care should be handled with caution in a radically different social, cultural and economic environment. He pointed out that "the activity of caring is largely defined culturally, and will vary among different cultures" (van der Geest, 2002a, p.9).

In the traditional setting, members of the extended family are expected to care for each other in every aspect of life. Among the Akans for example, the burden of caring for the seriously ill primarily falls on the 'abusua' which is the localised segment of the matrilineal group that coordinates important institutionalised social interactions (Sackey, 2009). They are responsible for the nurture and care of a person from birth through socialisation, sickness and death as well as organizing a befitting funeral for the dead (Sackey, 2009). When a family gives good care to its elderly members, it yields praise and admiration for the family. At the same time, families who fail to look properly after their aged are criticised and insulted (van der Geest, 2002b).

Individual responsibilities to family members in the area of health care can be found in proverbs, adages and myths and the seriousness attached to these ensure the smooth running of social relations in the cultural setting (Sackey, 2009). The relevant proverbs that may be used to determine care giving arrangements in Akan culture are as follows; '*se obi hwewo ma wose fifir a, woso hwe no ma ne se etutu*' (if someone takes care of you to grow your teeth, you must also take care of that person to lose his teeth), and '*nsa benkum guare nyimfa na nyimfa so guare benkum*' (the left hand washes the right hand and the right hand washes the left hand) (Apt, 1996; van der Geest, 2002a; Sackey, 2009).

Caring for the seriously sick person irrespective of the person's age is a recognised responsibility of every family member irrespective of the person's prior relation or conduct. According to Manuh and Quashigah (2009), serious illnesses usually bring some family members living outside home back home to care for the sick depending on their personal ties with the sick person. It has been argued that generally, people see care for the seriously sick as a family responsibility that ought to be shouldered whether or not the person conducted himself well prior to sickness (Manuh & Quashigah, 2009). Sackey (2009) was of the view that illness is an important determinant of the type of family networking and relationships to which an individual belongs. On the contrary, a rural-urban study of diabetes experiences conducted by de-Graft Aikins (2005) showed that many poor rural people with diabetes often relied on financial support from their immediate and distant family members. However, the dependence on family members who themselves were financially insecure caused family tensions and frictions, which in some cases led to family abandonment and social isolation (de-Graft Aikins, 2007). Additionally, chronic conditions such as cancer and diabetes appear to be stigmatized as such some women living with both conditions are abandoned by their partners (de-Graft Aikins, 2006, 2007).

As such, the care of the seriously ill may either highlight family solidarity and integration or magnify existing dissensions and rancour within families, as the question of who takes care of the sick sometimes becomes extremely contentious. Manuh and Quashigah (2009) were of the view that the extent of care received depends on the ‘the kind of family’ to which one belongs. Thus, some families may abandon a seriously ill person if the illness is seen as a total disgrace to them or if the sickness is considered very serious but not based on the person’s conduct (Manuh & Quashigah, 2009). Manuh and Quashigah (2009) noted that sick persons receive care at various levels and places in the Ghanaian society depending on the severity of the sickness, as defined by the community and or professional health personal. Minor sicknesses are usually treated within households and are regarded as normal and part of the life cycle of changes and transitions. The sick person may be cared for in the family house or in the house or centre of a traditional medical practitioner especially where the sickness is perceived to result from a curse from the gods or ancestral spirits.

2.2.8 Who Cares for the Elderly Person

Generally, caregivers fall into two broad categories. There are those who are working for pay, who are usually part of the formal health care sector such as home care workers who could be nurses or health care assistants and unpaid “informal” caregivers, usually family members of the elderly person, who are motivated by a deeper commitment to the patient (Grunfeld, et al., 1997). Over the years, informal caregivers have mostly provided caregiving for elderly people within the traditional setting. The care of elderly people has traditionally been situated in the domain of partners, children, and the extended family or the lineage (Darkwa, 2000; Doh, et al., 2014). In times of ill health and or old age, a person requires assistance to live and die in dignity. Legal and moral norms are therefore devised within society to guarantee that an elderly person or sick person gets the needed care in times of such need. Family members, close relatives, friends and the community at large

have roles to play in the care of the sick, especially of seriously ill persons (Manuh & Quashigah, 2009).

Traditionally, there has been a sexual division of labour in providing aged parents with companionship and services. The major burden for physical care of the elderly persons in society as well as their social activity has traditionally fallen on the shoulders of the female relatives of the elderly person (Barrow, 1986; Quadagno, 1999; Pezzin, et al., 2007; Manuh & Quashigah, 2009; Sackey, 2009). Among children who care for their elderly parents, 70 to 80 percent are daughters (Quadagno, 1999). Studies have shown that the few male caregivers (i.e. husbands and sons) usually set limits on their caregiving activities or tend to avoid tasks that involve intimacy. They are more often likely to offer help with transportation, money or the management of services (Novak, 2006). Barrow (1986) also notes that the sons may take care of business matters, but the daughters keep the emotional bond strong by visiting and helping with daily chores. Friends and other community members may provide food, shelter and clothing or keep the sick person company and give them assurance (Quadagno, 1999; Novak, 2006).

Usually when an older couple is still together and the wife is healthy, she is the first to be tasked with looking after the sick husband (Barrow, 1986). If the man is alone, or if the wife is dependent herself, one of their children is likely to take care of them (van der Geest, 2004). The children are usually the secondary caregivers when the spouse is present and the primary caregiver when the spouse is not present or unable to assume the caregiver role (Durant & Christian, 2006). If there are no children around, another relative may take on the task. Nowadays, it is the children of the elderly person who are held responsible for the care of the elderly person first and foremost. The extended family may decide to help if the elderly person has helped members of the extended family during his active life (van der

Geest, 2002b). Some older parents are cared for almost exclusively by one adult child, while others are cared for by a network of adult children who share responsibilities (Durant & Christian, 2006, p.8).

Non-kin can also be co-opted to assist family with caregiving. This usually happens where all the children of the elderly are not available and the female spouse is old. In such cases, family members have made arrangements for people from other ethnic groups or neighbouring countries to assist the primary caregiver. The female spouse provided the intimate body care by bathing her husband and washing him after he used the toilet. The supporting caregiver on the other hand helped the elderly person get in and out of bed, helped him use a wheelchair, and carried him to the bathroom and the toilet (van der Geest, et al., 2004). In the absence of a spouse or her inability to care, the children assume that responsibility. Children, as discussed here, do not have to be biological. Van der Geest (2002b) pointed out that if someone takes care of relatives other than his children, those relatives will care for him in old age when his own children are not available. As a result, people are advised to care for both sides if they can afford it.

In his study of the Kwahu of southern Ghana, van der Geest (2002a, 2002b) sketches a nuanced picture of elderly care that gives some indication of contemporary caregiving in Ghanaian society. Among 27 older people for whom there was reliable information about their care, six were men with wives who looked after them, four said they could manage by themselves, eight received most help from a daughter, one was cared for by her son and his wife, and eight elderly people were helped by a more distant relative.

Increasingly, the decisive factor as to who should take care of the elderly person is not the exact relationship he or she has with the elderly person but who is staying in the house at a

given moment (van der Geest, 2004). Even though more often than not, the children of the elderly person are expected to take care of them, in actual life, things often turn out differently. In some cases where the children are largely absent from the household or community, it is the people who happen to stay in the same house with him/her, who take the main responsibility, albeit with mixed feelings. Opong, et al., (2009) argue that that ever escalating spatial separation of paid work and the home, the continuous drawing of women into impersonal formalised paid employment contracts drastically curtails the unpaid time individuals have available to spend on needed domestic activity with loved ones. Caregiving is in essence managed with considerable improvisation (van der Geest, 2004). Domestic workers can also be co-opted to take on the responsibility of care and support for the elderly (van der Geest, 2002a, 2002b; Aboderin, 2004).

Van der Geest, et al., (2004) point out that there is fragmentary evidence to suggest that during the last decade, the care of frail and sick older people by immigrants has become widespread, particularly in southern Europe. In recent times, Ghanaian families who can afford to access care from more distant relatives or non-relatives are now increasingly employing them to provide care for the elderly persons in their homes. There is ample evidence to show that in addition to the live in caregiver, some of these families also hire the services of medical personnel who usually visit periodically to assess the well-being of the elderly (Coe, 2016; van der Geest, 2016a). The emerging trend of hiring the services of non-relatives for home based care for the elderly seems to be in van der Geest's (2016a) view a development in the direction of formal professional care for the elderly in Ghana.

Despite the doubts expressed by some Ghanaians towards their elderly persons being intimately cared for by non-relatives or strangers, there is increasing evidence to show that such services are available. A number of initiatives by religious entities, non-governmental

organisations (NGOs) and individuals in the Greater Accra Region are available for addressing the care needs of the elderly. These services are offered by non-kin in and out of the homes of the elderly persons. These initiatives seem to have attracted the attention of some families that are unable to provide the quality of care that their older relatives need and deserve (van der Geest, et al., 2004; Dsane, 2013; van der Geest, 2016a). Some are recreational centres, home care services by professional caregivers (such as health care assistants and nurses) and a few are residential homes or facilities (van der Geest, 2016a).

2.2.9 Effects of Caring for the Aged on the Care Provider

Traditionally, women are expected to be the care providers for the elderly in society. Assuming that role makes caregiving demands on women particularly high. In caring for an elderly person, the primary caregiver may often have to provide assistance with ADL and IADLs (Elmore, 2014; Durant & Christian, 2006; Quadagno, 1999). Studies have found that providing care for a frail elderly person has an immense impact on the caregiver's lifestyle. Some caregivers experience increased stress as a result of their confinement to the living space of the elderly person being cared for (Durant & Christian, 2006). In instances where the women are formally employed, they tend to be confronted with the dilemma of choosing between the responsibilities of their jobs and their caregiving obligations. On the one hand, their need to work affects their ability and time to provide adequate care. On the other hand, if they withdraw from employment or opt for fewer hours of work, they will reduce lifetime earnings, pension and health-care coverage. Inevitably, these women will jeopardize their own future of financial security and well-being. Some women working in the formal sector of the economy have had to relinquish their jobs, change work schedule, reduce hours of work or take time off from work without pay in order to take care of an elderly family member (Durant & Christian, 2006).

In addition to the potential financial losses that Durant and Christian (2006) allude to, caregiving can put individuals at risk for other kinds of stressors, including physical and psychological hardship. Additionally, helping an elderly person to perform these caregiving tasks can put a lot of strain on a primary caregiver's physical and mental health. The strain of caregiving demands on the primary caregiver has been linked to poor health outcomes including depression, physical illness, anxiety, and poor sleep habits (Elmore, 2014). Research indicates that caregivers may put their own health and well-being at risk while assisting loved ones (Elmore, 2014). Research suggests that some caregivers may be at risk of negative physical and mental health effects, which may emerge over time as care demands increase. With regards to their physical health they may experience direct and indirect physical health consequences, including deficits in antibody responses to vaccination, higher levels of stress hormones, and poorer sleep quality (Elmore, 2014).

In comparison to non-caregivers, psychologically, they may report higher levels of stress or distress, depression, emotional problems, cognitive problems and lower levels of subjective well-being and self-efficacy (Elmore, 2014). Research in Ghana for example has shown that the high prevalence of stroke (a non-communicable disease) among Ghanaian adults and the health of the stroke survivors affected the health of their caregivers as well, with the impact being multifaceted (Sanuade, 2017). On the other hand, there is also evidence that suggests that caregiving, if not overly strenuous, can actually be associated with mental health benefits to the caregiver as they develop closeness to the loved one and a sense of satisfaction related to fulfilling this important duty (Wight, et al., 1998; Novak, 2006; Elmore, 2014). In addition, research indicates that caregivers who continue to fulfil social roles outside their duty as caregivers often report better health (Wight, et al., 1998).

2.3 The Concept of Reciprocity

The concept of reciprocity has played an important role in social science disciplines such as anthropology, ethnology, and sociology over the years. Some of the classical writings that contributed to the knowledge building on the concept are the works of Simmel (1950), Malinowski (1922), Mauss (1967), Gouldner (1960), Marshall Shalins (1972) and Karl Polanyi (1957/1977).

Polanyi (1977) argues that apart from the market, there are other ways of allocating resources in traditional societies and historically these other two types have been more important than the market exchanges (1957). Kirk (2007) argues that the genesis of Sahlin's reciprocity model of can be understood only in the context of Karl Polanyi's work, on the classification of the integrative forms of economic organisation in accordance with three major types: reciprocity, redistribution, and market exchange (Kirk, 2007, p. 184). According to Kirk, (2007), Polanyi (1977) uses the term "reciprocity" to designate the first of these three possible patterns of macroeconomic organisation, specifically, the institutionalised exchange of goods and services within a kin group, between separate kin groups, and among neighbours and friends; hence it is marked by symmetry among exchanging parties. "Redistribution" operates on the principles of centrality and asymmetry, that is, pooling under the auspices of a high-ranking authority (e.g., a chief, elites, a king), who then redistributes the goods. The third economic pattern is exchange of goods through the pricing mechanism of a market (Kirk, 2007, p. 184). Historically, the market played no vital role in human social life until recently. Because, the division of labour in society does not entail market exchange, it only entails the circulation of goods by either reciprocity, redistribution or exchange (Polanyi, 1957). The meaning of the concept of reciprocity varies in different disciplines and contexts. Thus, for the purposes of this work the cultural anthropological perspective of the concept of reciprocity will be used in interpreting the

interactions between the elderly and their family members in the process of the elderly requiring and accessing long-term care. Reciprocity is a continuous form of mutually giving and taking among peoples of equal status. This is a kind of exchange system which depicts primitive as well as modern types of exchange systems (Meera and Kumar, 2015).

Cultural anthropologists generally identify three different shades of reciprocity. These are generalised reciprocity, balanced reciprocity and negative reciprocity (Sahlins, 1972; Kirk, 2007; Meera and Kumar, 2015). In the work of anthropologist Marshall Sahlins (1972), he makes a connection between reciprocity and giving in family relationships and argues that generalised reciprocity, balanced reciprocity and negative reciprocity are distinct and different from each other on the ground of social distances among partners (Shalins, 1972; Kirk, 2005; Meera and Kumar, 2015).

Research on reciprocity suggests that among kin norms of reciprocity are grounded in open-ended exchanges that do not require "equal, direct, or contemporaneous transactions" as one finds in exchanges of an economic nature (Leblanc & Wight, 2000, p.632). This more "generalised reciprocity" among kin suffices because people tend to view their relationships with family as enduring, spanning the entirety of their lives. Therefore, family members both reciprocate past support, and anticipate future support from one another as they traverse the life course (Leblanc & Wight, 2000, p.632).

Sahlins considers giving to near kin and loved ones as mainly disinterested and not based on any definite expectations of returns, and he calls that "generalised reciprocity" (Komter & Schans, 2008). Kirk (2007) argues that general reciprocity is characteristic of the intimate relationships of kinship and friendship. Its emblematic feature is generous sharing, which generates gratitude and an open-ended, diffuse obligation to make a return (Kirk, 2007,

p.182). In generalised reciprocity, the exchange of goods takes place but there is no specific time limit and particular type of things to be returned (Meera & Kumar, 2015). Thus, those who give do not expect the recipient to make a return at any definite time in future. Generalised reciprocity occurs between individuals who are emotionally attached to one another and therefore have an obligation to help one another based on relative need (Bailey & Peoples, 2013, p.139). The relationship that is exhibited between a parent and a child is a typical example of generalised reciprocity. The parent takes care of the child for the long-term even though there is uncertainty that the child will fulfil the expectation of the parent (of a return care). With generalised reciprocity, the giver continues to provide material assistance even though the receiver is unable to return anything for a long time (Peoples & Bailey, 2014). As such, parents provide services, shelter, food, education for their children out of love or a sense of responsibility and adult children caring for their aged and infirm parents is a typical example of generalised reciprocity. Parents cannot expect the child to repay the amount for the gifted things (Meera and Kumar, 2015).

"Balanced reciprocity," is a form of direct and equivalent exchange and it is more likely to occur in relationships that are emotionally more distant (Komter & Schans, 2008). Balanced reciprocity features overt concern for equivalence and timeliness of exchange (Kirk, 2007, p.182). In balanced reciprocity, products are transferred to someone and the donor expects a return in products of roughly equal value. The return may be expected either immediately or whenever the donor demands it or by some specified time in the future (Bailey & Peoples, 2013, p.139; Meera & Kumar, 2015). While it frames such transactions as labour exchanges among kin and friends, it is also characteristic of more distant relationships in which self-interest and material concerns take priority over the human bond itself, as in market exchange (Kirk, 2007, p.182). With balanced reciprocity, the giver refuses to continue to transfer objects to the receiver if the latter does not reciprocate within the appropriate time

frame. Sahlin's (1965) analyzes Polanyi's "market exchange" as one possible manifestation of "balanced reciprocity" and asserts that "chiefly redistribution is not different in principle from kinship rank reciprocity. It is, rather, based upon the reciprocity principle, a highly organised form of that principle" (Sahlin, 1965 cited in Kirk, 2007, p. 185).

"Negative reciprocity" is unsociable and extreme; it is the "attempt by an individual to get something for nothing" (Komter, & Schans, 2008, p. 280). Negative reciprocity is the maximization of one's own benefit at the expense of another, in its pronounced forms amounting to exploitation (Kirk, 2007). Negative reciprocity is experienced when a trade is fixed which is of material advantage based on wishing to get something for nothing (gambling, theft, cheating) or better of a bargain. Negative reciprocity is the characteristic of both impersonal and unfriendly transactions. As such, it is generally carried out by those who stand as outsiders to one another in industrial, tribal and peasant societies. With regards to negative reciprocity, both parties attempt to gain all they can from the exchange while giving up as little as possible. It is usually motivated by the desire to obtain material goods at a minimal cost (Sahlins, 1972, p.188 - 195).

Even though social scientists agree on the specific nature of reciprocity within the context of family relationships (pure gift or generalised reciprocity), especially when caring for the needs of children or aged, Komter and Schans (2008) argue that this pattern may not be the only or the main reciprocity pattern existing within families. Factors like age, partner status, proximity, but also cultural norms and values are likely to affect the type of reciprocity (Komter & Schans, 2008). They argue that whereas the classical literature implies that exchange within the family is mainly characterised by generalised reciprocity, modern views tend to assume ethnic variation in the nature of reciprocity. Western culture is believed to be more 'individualistic' and put more emphasis on personal choice and

voluntary kin relations than do non-Western cultures, where 'collectivistic' values stressing familism and filial obligations would be more salient (Komter & Schans, 2008, p.280).

In that vein, it has been argued that balanced reciprocal exchanges are expected to be among ethnic minorities than among majority groups; cultural norms of obligation and loyalty are supposed to override self-interest implied by balanced reciprocity. However, contrary indications have been found (Komter & Schans, 2008). Exchange patterns in family relationships change over the life course, thus, both the very young and the very old people can receive the most depending on circumstances. Norms of reciprocity and exchange are integral components of social life, they however vary in form and function but observable in all societies.

Research has shown that giving and taking are the prescribed rhythms of life, both in the short and the long-term. The process of being cared for in old age is the direct result and an unflinching outcome of an industrious and caring life, which is an epitome of generalised reciprocity (van der Geest 2008). The care given to the elderly in society is increasingly a measure of the care that they gave to their children when they were young. That past determines their present status. According to van der Geest (2008), the care may be simple, if the children are poor, but some measure of care will be guaranteed.

Van der Geest (2008) discusses material and emotional reciprocity in his studies among the Kwahu. Material reciprocity has to do with the support received by the elderly in relation to food, shelter and health. Emotional reciprocity on the other hand refers to the social and moral support received from family. The material and emotional reciprocity are aspects generalised reciprocity discussed by Sahlin (1965). Each type of reciprocity tends to be

associated with certain kinds of social relationships. The kind of reciprocity that occurs between individuals or groups depends on the social distance (the degree to which cultural norms specify that they should be intimate with or emotionally attached to one another) between them. Van der Geest (2008) argued that material vulnerability may not be countered by reciprocity because those who are supposed to pay back also find themselves in precarious economic circumstances and are not able to provide sufficient food, shelter and other material livelihood essentials to the elderly.

One inherent 'injustice' of reciprocity is that those who have little, also have little to give to their children and may receive little or nothing back from them (van der Geest, 2008, p. 307). Reciprocity is considered by some to be conditional upon parents having done their part and thus, deserving support (Mazzuccato, 2008). Studies have shown that reciprocity does not always 'work' as society expects it will (van der Geest, 2008, p. 304). Thus, despite the moral obligation that many family members feel, some of them sometimes fail to carry the burden (Mazzuccato, 2008)

I therefore use the concept of reciprocity in all its forms (generalised, balanced and negative) to explain the nature of relationships that exist between the elderly persons accessing the residential non-domiciliary care facilities and the primary caregivers/family members whose assistance the elderly require to perform activities of daily living at their usual dwelling places. In addition, I discuss the conditions predisposing them to accessing care at the residential aged care facilities, and the attractive features and selling points of the facilities that appeal to the family members of the elderly in deciding to subvert the traditional norms regarding care for the aged, which are enshrined in the norms of reciprocity. I also use the norms of reciprocity to explain how the elderly lose power over

negotiations regarding how and where they access care owing to the impact of the complications associated with their chronic disease conditions and disability.

2.4 Summary

In this chapter, I have presented an overview of the history of living arrangements of the elderly, the determinants and the effects of the types of living arrangements, social support and caregiving for the elderly. I have also highlighted the different types of reciprocity as identified by cultural anthropologists focusing on generalised reciprocity, which serves as a folk belief and a moral norm informing who cares for the elderly and the activities of care performed for elderly persons in the Ghanaian society. I have also looked at the effects of eldercare on the caregiver. The rest of the work focuses on how the elderly come to require long-term care and access it from residential non-domiciliary care facilities because of failing domiciliary care, the search for alternative means of providing long-term care for the elderly and adopting the new perspective of care (residential non-domiciliary care). The next chapter discusses the research methodology, which encompasses the study sites, research design, sampling, data collection methods and instruments, ethical considerations and data management.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This study investigated the emergence of residential non-domiciliary care for the aged in the urban centres of the Greater Accra Region of Ghana, which is as a result of the gradual breakdown of the informal care systems that exist within the extended family. This study is informed by the growing literature on increasing neglect of the care needs of aged persons within the extended family (Aboderin, 2004). The study therefore sought to examine, the types of residential non-domiciliary aged care facilities emerging to fill this gap and manage the care needs of the aged in Accra. Additionally, the study investigated how the elderly and their family members deliberated on this new phenomenon of the aged accessing such facilities. The study first outlines the antecedents and trajectories leading to the elderly accessing residential non-domiciliary care. Second, it describes the operations of these residential non-domiciliary aged care facilities. The third focus is on the perceptions and feelings of the elderly about accessing care from these residential non-domiciliary care facilities. Finally, the study interrogates how the aged persons and their family members make sense of the decision to delegate the care of the aged to a formal institution vis-à-vis the traditional norms of reciprocity.

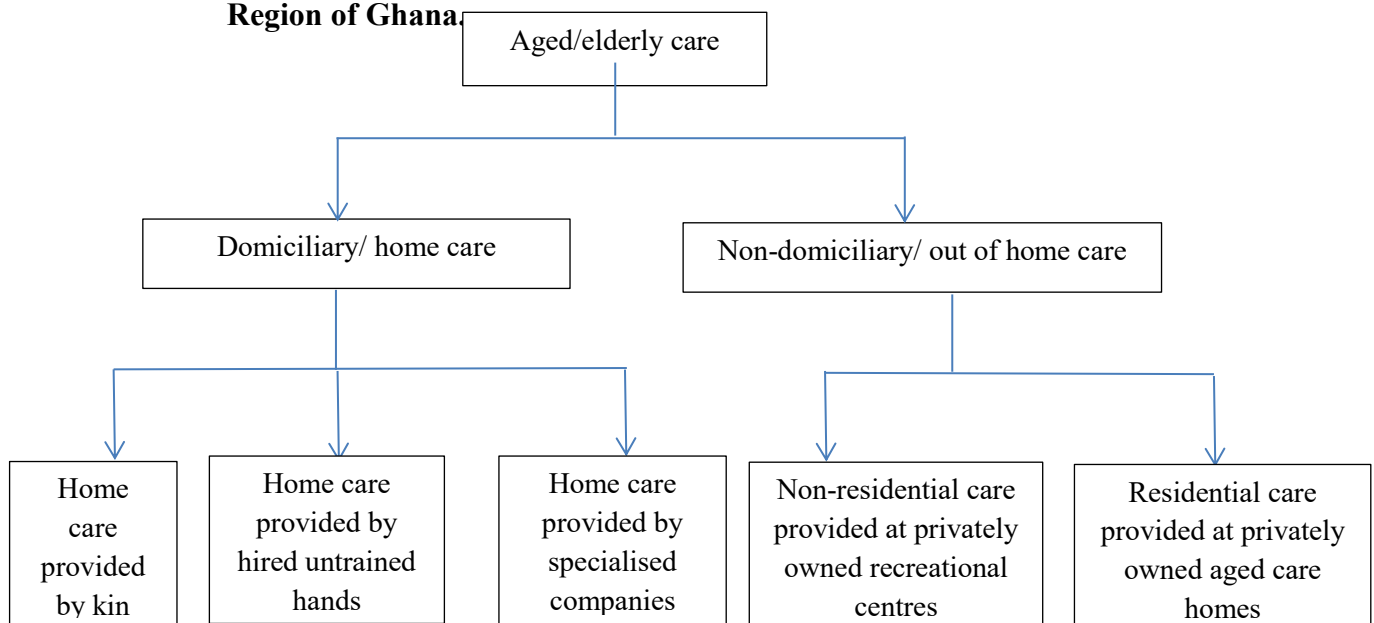
This chapter begins with a description of the landscape of aged care in the urban centres of the Greater Accra Region. This is followed by the brief discussion of the paradigm within which, the research is situated and examines the methodological choices made in this study. The chapter further discusses the research design, emphasising the assumptions underlying the various techniques used, the criteria used to decide which research methods to use and the justification for the use of those methods. It also presents a description of the sampling

unit, procedure and size. The data collection and analysis processes employed and utilised in the rest of the thesis. The chapter ends with a description of the Ethical consideration made for the study.

3.2 Types of Aged Care Systems in the Greater Accra Region of Ghana

As shown in Figure 3.1, two broad forms of aged care were available to the elderly within urban centres in the Greater Accra Region of Ghana. These were domiciliary and non-domiciliary aged care. All these forms of care for the aged listed in Figure 3.1 are prevalent and running concurrently in contemporary Ghanaian society.

Figure 3. 1: The landscape of aged care in the urban centres of the Greater Accra Region of Ghana



Source: Fieldwork, 2015 – 2016

There are three main types of domiciliary eldercare with their differences associated with the person performing the activities of care for the elderly. In the first type of domiciliary eldercare, the care activities are directly performed by the spouse (female), children, relatives and other members of the extended family where necessary. In the second type,

the activities of care are performed by non-relatives who have been hired through either individuals or outsourcing agencies for the purposes of assisting the elderly persons to perform ADL. Such individuals could be very young or old depending on the health status of the elderly person and the requirements of the key decision maker of the care needs of the elderly person. The third category refers to hiring the services of agencies that offer home care services by trained health care workers to elderly people. Some of the agencies currently providing home care services to elderly persons in their homes are Akrowa Aged Life Foundation, CarePlus Ghana, Health Concern Ghana, Healing Hands, and Ripples Health Care Ghana.

There are two main types of non-domiciliary eldercare facilities currently available in Ghana. These are: the residential, which is provided within the confines of an aged home facility; and the non-residential, which is provided at the recreational/day care facilities. The residential aged care facilities, which are popularly known as nursing homes or aged homes in the high-income countries of the world are privately operated facilities that provide live-in care services. Some of the residents need medical care in addition to personal care. Nursing aides and skilled nurses are usually available 24 hours a day. Residents usually include the elderly and young adults with physical or mental disabilities. The non-residential facilities or recreational/adult day care centres on the other hand, provide recreation, social stimulation and sometimes medical or rehabilitative care. They support the nutritional, social, health and daily living needs of elderly persons.

3.3 The Study Area

The Greater Accra Region is the smallest of the 10 administrative regions of Ghana in terms of area, occupying a total land surface of 3,245 square kilometres of the total land area of

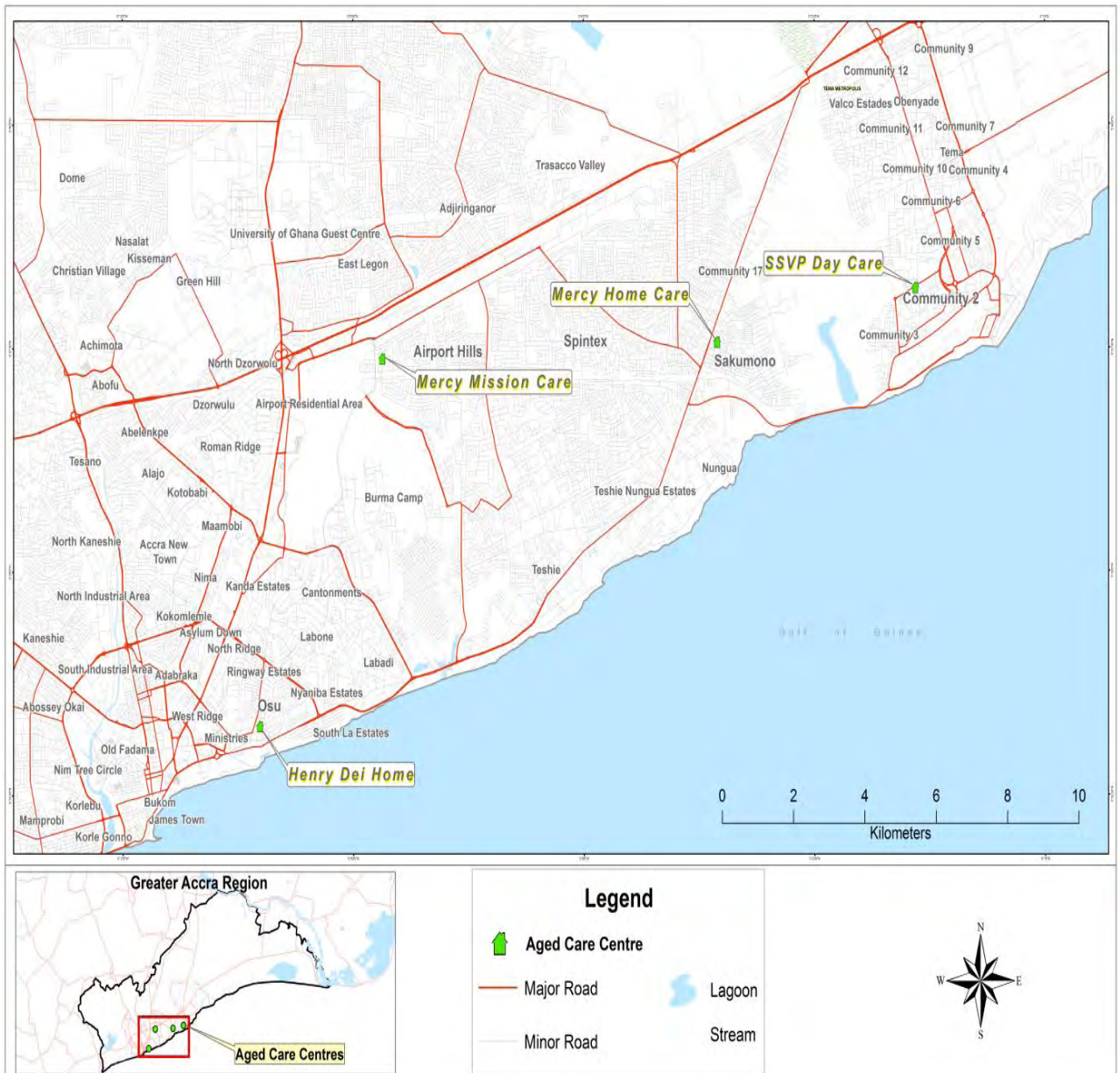
Ghana. It is the second most populous region in the country, with a population of 4,010,054 in 2010, accounting for 15.4 per cent of Ghana's total population. Greater Accra Region has remained the most densely populated region in the country since 1960 (ghana.gov.gh). Accra, the regional capital also serves as the national capital of Ghana. Accra is also the largest city of Ghana. It has an estimated urban population of 2.27 million as of 2012.

More than two-fifths (43%) of the elderly persons in Ghana reside in three regions namely; Greater Accra, Eastern and Ashanti Regions which are the most populous regions in Ghana. Greater Accra shelters 12.9% of elderly persons in Ghana with a higher proportion of them being females (Ghana Statistical Service, 2013). Slightly over 70 percent of the elderly persons in the Greater Accra Region are in the young-old age bracket (60 - 74 years) (Ghana Statistical Service, 2013). The Greater Accra Region is described as the gateway to the country and the entry point of every foreign or western ideology. It is the country's major industrial and commercial centres (ghanaexpeditions.com).

3.3.1 A Map of the Study Area

Figure 3.2 is a map of the study area showing the two residential non-domiciliary aged care facilities in relation to the location of two other recreational aged care facilities in the Greater Accra Region of Ghana. The two residential aged care facilities namely; Mercy Home Care Centre and Mercy Mission Nursing Care Home served as the study sites. They have been highlighted with big black circles.

Figure 3.2: Map of Study Area



3.3.2 Study Sites

The study was conducted at two residential non-domiciliary aged care facilities in the Greater Accra Region namely; Mercy Home Care Centre at Sakumono and Mercy Mission Nursing Care Home at Spintex road. The two residential aged care facilities were chosen because they are the only ones identified as residential aged care facilities so far within the largest city of Ghana; one of them is positioned as an upscale and elegant facility and the

other an averagely priced facility. In each of these two facilities, I interviewed the owners or operators/ administrators, caregivers/health care assistants, residents, and relatives of the residents. The two research sites are profiled below.

3.3.2.1 Mercy Home Care Centre

Mercy Home Care Centre was established as a residential aged care facility about 9 years ago by Mrs. Mercy Adarkwa, the President of the institution. The facility, however, became operational in 2010. Her aim for setting up the facility was to set up a social care organisation, which focuses on assisting people who require a certain degree of extra practical and physical help to live comfortably within Ghana. The facility is located at Sakumono in the same vicinity as the members of parliament (MP's) flat. The facility operates a 24-hour service seven days a week for the residents, however, for aged persons who would want to access the facility as non-residential patrons, they work from 8am to 5pm from Mondays to Fridays.

Mrs. Mercy Adarkwa is supported in her operations by her husband and children. The family lives in Switzerland but visits Ghana at least twice in a year. She is a matron by profession and operates a flagship radio counselling programme in Switzerland and Ghana. The programme is fashioned to serve as a platform on which Ghanaians in the Diaspora interact and share their thoughts and ideas with friends and loved ones' back home. Through the programme, she gained in-depth information about the challenges her listeners abroad faced concerning their aged parents in Ghana. She gathered that a lot of the elderly persons were not being given the needed care despite the periodic remittances sent for that purpose. Some of them were also vulnerable as a result of being wrongfully accused of witchcraft. Direct contact with the aged based on their children's requests also revealed that some were starved

and lonely for the greater part of the day. With her knowledge and consultations, she decided to establish an aged home care facility in Ghana. With the assistance of Stefan and Susan Hess, Dr. Rahel Rotlisberger of the Methodist Church in Burgdorf, Switzerland and Dr. Abena-Keller Agyepong, funds were solicited to furnish the facility for subsequent admission of the seniors.

Mercy Home is registered as a non-profit organisation, and a social welfare facility. The facility is housed in a two-storey building owned by the facility operator. The first floor of the building serves as bedrooms, bathrooms and toilet facilities for the residents who are fit enough to walk and climb the stairs. The ground floor houses a large furnished living room, the front desk, kitchen, dining area and a storeroom. A portion of the ground floor also serves as bedrooms for residents who are either bedridden or have disabilities that make mobility difficult. It also has washroom facilities. In front of the building is a summer hut, which serves as a place for sun bathing and recreation. At the back of the facility are a set of uncompleted buildings – more rooms being developed for the elderly.

The facility has ten rooms for housing. Four out of the ten are on the ground floor and the remaining six are on the first floor. At any point in time, all the rooms on the ground floor were occupied unlike those on the first floor. The resident population during the fieldwork period ranged between twelve and eighteen. The bed capacity of the facility was 21. The ground floor has nine beds in four rooms. The first floor has twelve beds in six rooms. The ventilation in the rooms was good. A few of the rooms had television sets. One of the rooms had a radio, which was personally owned by a resident. The rooms were, however, not decorated to give it a homely feel; they only contained the bare necessities (a bed, a chair, bed pans, chest of drawers for personal items, a walking aid and a small table for food where necessary). In the absence of the owner, apart from watching television and chatting,

recreational activities hardly go on in the living room. The facility has games such as Oware and Ludo for the elderly persons to play.

As at the time of the study, the facility had an administrator (a retired engineer) who is a family friend of the owner and had lived abroad for a greater part of his life. There was also a retired nurse who works there as the matron. The facility also had two state registered nurses and three health care assistants one of whom studied geriatrics at the National Vocational Training Institute. The nurses and health assistants are in charge of the operations of the facility most of the time. The caregivers run a duty roster that outlines their daily schedules. Apart from collectively helping the residents to perform ADL, they rotate weekly to cook and do their laundry. They also share the responsibility of bathing the residents who need assistance with maintaining personal hygiene. With the exception of the administrator, all the staff were females.

The facility operator and the spouse solicit for help through their religious affiliations abroad for the upkeep of the facility. They use proceeds for the day-to-day running of the facility. Proceeds, which are not required in the facility are either sold or donated to health care facilities, institutions and boarding schools. Proceeds from the items sold are used to purchase necessities for the aged. In the words of one of the caregivers:

The money we get from the sale of the items is used in buying fruits and any other things that might be needed for the elderly people. We are an NGO so people give her things to bring to the aged when she comes, she has to distribute some of the things. If she does not sell some, the duty she has to pay for bringing the items and others will be her debt so she has to sell some and give some too out. She sells them to support the work at the home.

To supplement the resources gained from these sales, the facility charges GH500.00 per head per month for the upkeep of the residents.

At the initial stages of the facility's operations, the residents were recruited through radio advertisements. Over time, residents are recruited through referrals and recommendations from people who have accessed the facility in the past or are currently doing so. Additionally, people are increasingly getting to know about the facility through the internet.

Keeping the elderly persons engaged to meet their emotional needs is not top priority. The health assistants usually chat among themselves when they are free or play games on their phones. Residents who find themselves in the dining area stand the chance of chatting with the health assistants who might be seated close to the kitchen, resting or chatting.

3.3.2.2 Mercy Mission Nursing Care Home for the Aged

Mercy Mission Nursing Care Home for the Aged is an upscale residential aged care facility in Accra. It is located off the Spintex road and adjacent to the Pentecost Church at East Airport Residential Area and close to the Palace Shopping Mall. The facility offers a 24 hour residential skilled nursing care to the aged. However, for non-residential residents, they work from 8am to 5pm from Mondays to Fridays. Mercy Mission which was first commissioned in 2011 is owned and operated by Mrs Mercy Makafui Attor with support from her husband. She is a seamstress by profession. She has a Bachelor of Arts degree in Psychology from Central University College. The facility is committed to providing the highest quality nursing care for the aged, and helping families eliminate worry, reduce stress and re-establish the personal freedoms of their loved ones. The facility organizes entertainment and fun packed events for the residents. They also organize excursions to places of interest.

The facility is housed in a walled and gated residential building rented by the operator. It has an unmanned security post by the gate and a doorbell. The gate is usually locked such

that one can only access the facility if admitted from within. The facility has an average sized generator on the compound, which is switched on during the day when the lights go off.

The facility has six rooms, one of which one is used by the staff, and the other four are occupied by residents of the facility. The resident population during the fieldwork period ranged from five to thirteen. In all, the facility had 15 beds as at the time of the fieldwork. The rooms are well ventilated. None of the rooms had gadgets. The rooms were bare; only one of them, which was occupied by a foreigner, was decorated in a homely manner.

As at the time of the fieldwork, the facility had an administrator who is a retired nurse, two nursing officers, one registered nurse, a cook, a cleaner and two orderlies who assisted with work in the facility. The administrator partly assists the nurses in performing the ADL and assisting the medical doctor to assess the health status of the residents whenever he visited. The nurses shared the work of caring for the residents. The facility charges GH1,500.00 Cedis per head per month for the upkeep of the residents.

The daily routine of Mercy Missions changed during the course of the study largely because of the onset of the hot weather at the beginning of the year, which induced profuse sweating and discomfort among the elderly persons because of the heat indoors. A shed was constructed by the wall in addition to the canopy for the use of the elderly persons as the weather became very hot and staying indoors became increasingly costly due to the high cost of electricity. The residents now had their breakfast and lunch under the canopy and the shed. They also spent the time between breakfast and lunch outside the building. With the changes in the routine came the issue of the aged persons sitting from morning till after

lunch at one place for a long time. In the past, the process of being moved to the living room served as an opportunity for some of them to move around. Those who could move to the washroom on their own did so while others lay down in the sofa to watch television. Watching television, which was done between 10:30am and lunchtime, was no longer available.

At the initial stages of the facility's operations, the residents were recruited through radio advertisements. Over time, residents are mostly recruited through the internet and recommendations from people who have accessed the facility. The health assistants mostly pay attention to the personal grooming and hygiene of the residents as well as providing them with food. The caregivers also make the effort of keeping the elderly persons engaged through conversations and discussions based on the news on the radio.

3.4 Qualitative Research

All research is based on some underlying philosophical assumptions about what constitutes 'valid' research and which research methods are appropriate for the development of knowledge in a given study. In order to conduct and evaluate any research, it is therefore important to understand these assumptions.

In Ghana, the care for an elderly person is considered to be a private and personal issue since people would not want to wash their dirty linen in public (Apt 1996; van der Geest, 2002a). The conduct of research on the subject of caregiving is therefore delicate and necessitates the adoption of a methodology that is especially sensitive to the circumstances surrounding the study and to the participation of potential participants/informants. The choices of methods employed in this research were mainly driven by the paradigms and philosophical

assumptions, which allow for research of sensitive material. Qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem (Creswell, 2009). It is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world into a series of representations (Denzin and Lincoln, 2000). Savin-Baden and Major (2013) simply define it as social research that is aimed at investigating the way in which people make sense of their ideas and experiences.

Qualitative methods were used in gathering the relevant data for the study because the terrain of non-domiciliary aged care in Ghana is relatively new and an uncharted territory. The organisations operating these facilities are new and are not open to public scrutiny. As such, I started the pilot phase of the fieldwork not knowing a priori what I would find on the ground. Nevertheless, I set out with the intent of generating data that is rich in detail, encompassing the views and opinions of all the key players involved in the processes leading to accessing residential non-domiciliary aged care. For that purpose, methodologically, qualitative methods were deemed the most appropriate for this study. Additionally, qualitative methods were adopted for the following reasons: 1) To ensure that the study incorporates and reflects the views of the “actors” in the study which can better be captured through face-to-face interactions, 2) To generate a more descriptive details and explanations for the activities of the non-domiciliary aged care facilities engaged in the business of providing care to the elderly in urban Greater Accra Region and 3) To give a contextual understanding of the social phenomenon under study. Research has shown that it is difficult to identify the behaviour of members of a social group other than in the specific environment in which they operate (Bryman, 2001). The qualitative research method allows this to be achieved.

Furthermore, qualitative methods offer diverse ways for uncovering and understanding the processes or circumstances surrounding the aged persons' access to non-domiciliary care facilities and the activities of care received from the different facilities; how they manage their stay at the facilities and adjust to the cultural contexts; and they enable the researcher to collect extensive and rich data that provide invaluable insights. Moreover, qualitative methods also permit crucial avenues for securing access to prospective research participants/informants from closed and private groups, and for establishing credibility and trust with them. Thus, I situate my research within the broad qualitative research paradigm.

Qualitative research is situated within a given world view or philosophy; it has a more or less subjective and personal orientation and it occurs in natural settings of people whose experiences are the object of exploration, the researcher attempt to make sense of or interpret phenomena in terms of the meanings people bring to them (Savin-Baden & Major, 2013). In conducting qualitative research, the process changes both the investigator and the subject; the location of the research philosophy and justification of the strategy demonstrates congruence between the philosophical and methodological stance; data comes from multiple sources; data has primacy; analysis and interpretation occur from the beginning of the study and are inductive processes; there is an acknowledged pursuit of quality, which may differ according to beliefs and research strategy (Savin-Baden & Major, 2013).

In doing qualitative research, the researcher is immersed in the setting and becomes the primary instrument of data collection so the research is necessarily value laden. The researcher focuses on an emic perspective or the views of the people and their perceptions, meanings and interpretations. Qualitative research involves the studied use and collection of a variety of empirical materials that describe routine and problematic moments and

meanings in individuals' lives. They acknowledge a multiple constructed realities and they must show respect for the participants/informants, acting ethically toward them and where appropriate engage them as co-researchers. Accordingly, qualitative researchers deploy a wide-range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter at hand. It is understood, however, that each practice makes the world visible in a different way. Hence, there is frequently a commitment to using more than one interpretive practice in any study.

Qualitative methods are the most appropriate and relevant techniques for this study because qualitative methods presented me with the opportunity to explore and understand the issue of emerging non-domiciliary aged care facilities in Ghana and how the elderly persons and their families make sense of it. This exploration was required, in turn, because of a need to study how the aged in the urban centres are being cared for in the face of increasing neglect of their care needs by their families as a result of social change (Aboderin, 2004; Creswell, 2007). It offered varied ways of uncovering and understanding the processes leading to the elderly accessing a particular type of facility as I observed the daily activities of the elderly in the facilities. This detail can be established by talking directly with aged people at the facilities and their family members, and allowing them to tell the stories unencumbered by what we expect to find or what we have read in the literature (Creswell, 2007).

The qualitative research methods used were in-depth interviews and observations/ethnography. The combination of these qualitative research methods was used to gather information on the perceptions about and receptiveness of the aged and their relatives to the emerging forms of residential non-domiciliary care services designed to meet the care needs of the aged in the urban centres of Accra.

I adopted qualitative mixed methods approach in this study to examine closely the personal lives of the elderly persons who patronize the emerging forms of non-domiciliary aged facilities in the urban centres of Accra, and how they and their family members make sense of the process of accessing non-domiciliary care facilities. This was done with the aim of discovering the basic social processes that is the theoretical reflections and summarisations of patterned systematic uniformity flows of social life, which people go through and which can be conceptually captured and further understood through the construction of thematic networks. In doing the analysis, I conceptualised and classified events, acts and outcomes that were sifted from the interviews and observational notes. The categories that emerged, along with their relationships served as the foundations for developing a framework for the study (Patton, 2002). I have developed a framework on reciprocity and access of care within domiciliary and non-domiciliary context for the study findings that explain and interpret the presence of the phenomenon of non-domiciliary care for the aged that is emerging in the urban centres of the Greater Accra Region of Ghana. Working from a pragmatist perspective, I drew from the concept of reciprocity as defined by cultural anthropologists to build the theoretical framework.

3.5 Sampling

My choice of using qualitative approach in this study to understand the emerging phenomenon of residential aged care facilities was confronted with the issue of the adequacy of sample size. Although there is no indication as to what size is adequate, there is the position that a qualitative research sample must be large enough to ensure that most or all of the varying perceptions that might be important in the study are uncovered. I therefore sought to achieve a large sample devoid of repetitive and eventually excessiveness (Mason, 2010). I was additionally influenced by the worldview of qualitative research, which supports multiple sources of information towards unravelling a subject under study. As

such, key persons whose activities were connected to the process of the elderly accessing aged care at the facilities, as well as, individuals who ensured that the elderly were able to achieve activities of daily living out of their usual dwelling places were purposively selected and interviewed.

The sampling units for this study comprised five groups of people: facility owners, facility administrators, caregivers of the residential aged care facilities, residents of the residential aged care facilities, and the family members of the residents at the residential aged care facilities. The inclusion criteria for the sampling of the aged persons were: adult population of Ghana who were 60 years and above, who were on admission at elderly care facilities and who could talk, and freely consent to participating in a research project about caregiving among the aged. The exclusion criteria for the sample selection were persons below 60 years of age who were accessing such facilities, elderly persons who were cognitively impaired, non-autonomous, or not able to talk or give free and informed consent. I began by listing and ruling out all the aged persons in the facilities who could not talk or were cognitively impaired. I then approached those elderly persons who could talk one after the other about the nature and objectives of the study and requested their participation to talk about their care needs and how those needs were being addressed within the facilities.

Recruiting the participants/informants for the interviews was not complicated after I had spent a couple of weeks partially participating in the routine activities of the facilities. Just a few of the residents (two elites) refused to participate in the study on account of perpetually not feeling well and lack of interest respectively. One of the elderly women who had previously worked in the education sector took interest in me and also helped in dispelling any doubts potential participants/informants had about my research project and my

intentions by assuring them that it was a requirement for completing my academic career at the university and therefore it was for academic purposes only.

Purposive sampling was appropriate for the study in three instances; first, it is used in selecting unique cases that are especially informative, second it is used to select members of a difficult to reach specialised population and third, it is used to identify particular types of cases for in-depth investigation (Neuman, 2007). The logic and power of purposive sampling lies in selecting information rich cases from which one can learn a great deal about issues of central importance to the purpose of the research (Patton, 1990). There are different strategies for purposefully selecting information-rich cases with the logic of each strategy serving a particular evaluation purpose. I used the maximum variation sampling technique which is purposive in nature in selecting the different categories of participants/informants for the study. The maximum variation (heterogeneity) sampling aims at capturing and describing the central themes that cut across a great deal of participant variation. For small samples, a great deal of heterogeneity can be a problem because individual cases are so different from each other (Patton, 2002). Patton (2002) argues that the strategy turns that apparent weakness into strength by applying the following logic: any common patterns that emerge from great variations are of particular interest and value in capturing the core experiences and central, shared dimensions of a setting or phenomenon (Patton, 2002).

In maximizing the variation in the small sample, I began by identifying the diverse characteristics or criteria for constructing the sample such as, the types of facilities, type of services provided and the location of facilities. In addition, the type of participants/informants which consists of owners, operators or administrators, caregivers, residents and the family members of facility users. The data collection and analysis yielded two kinds of findings (1) high quality, detailed descriptions of each case, which was useful

for documenting uniqueness, and (2) important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity (Patton, 2002). In this regard, I did not seek to generalize findings to all aged persons or all aged care facilities but looked for information that elucidates institutional variations and significant common patterns within that variation.

3.5.1 Chronic Diseases Presented at the Study Sites for Care

The two residential non-domiciliary care facilities provide care for elderly persons with a variety of chronic diseases and their associated health complications developed as a result of suffering from those chronic diseases. Thus, the residents interviewed for the study had varied chronic diseases with associated complications. From the beginning of 2013 to the middle of 2016, Mercy Home had admitted and cared for 51 aged persons with chronic diseases. Over half (30) of them presented one chronic medical condition each. A fifth (10) of them presented multiple conditions (2 conditions each) and another fifth of them (11) were admitted without their medical conditions being stated on the forms (this could be as a result of poor documentation on the part of the staff who admitted the residents). Within that same period, Mercy Missions admitted 30 elderly persons at the residential aged care facility. Out of this number, 9 of them presented multiple chronic medical conditions (5 of them presented 2 conditions, 3 presented 3 conditions and 1 presented 4 conditions) and 6 had been admitted on account of old age with no chronic medical condition. The rest (21) presented a chronic condition each.

The four common chronic diseases presented at the two residential aged care facilities were Hypertension, Stroke, Diabetes, and Dementia, with hypertension being the most prevalent. Some of the other chronic diseases presented at the facilities were blindness (4.0%),

swellings and bodily pains (2.4%), depression (1.6%), amputations and sores (1.6%) and deafness (1.6%). Table 3.1 shows a breakdown of the chronic medical conditions presented by the aged persons on their admission at Mercy Home and Mercy Mission.

Table 3. 1: Chronic diseases of residents presented by their relatives during the admission of the elderly persons at the two residential aged care facilities.

Ages of residents who accessed the residential aged care facilities between 2013 and mid 2016																		
Medical conditions presented	Mercy Home								Mercy Mission								Grand Total	
	60 -74 Years		75-84 Years		85 Years+		Total		60 -74 Years		75-84 Years		85 Years+		Total			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Hyper tension	8	11.0	11	15.1	7	9.6	26	35.6	7	13.5	6	11.5	-	-	13	9.6	39	31.2
Stroke	3	4.1	4	5.5	1	1.4	8	11.0	5	9.6	5	9.6	1	1.9	11	21.2	19	15.2
Diabetes	3	4.1	5	6.8	-	-	8	11.0	4	7.7	4	7.7	-	-	8	15.4	16	12.8
Dementia	4	5.5	2	2.7	1	1.4	7	9.6	1	1.9	-	-	1	1.9	2	3.8	9	7.2
Blindness	3	4.1	1	1.4	-	-	4	5.5	-	-	-	-	1	1.9	1	1.9	5	4.0
Others	4	5.5	2	2.7	3	4.1	9	12.4	7	13.5	2	3.8	2	3.8	11	21.2	20	16.0
Not specified	3	4.1	4	5.5	4	5.5	11	15.1	3	5.8	2	3.8	1	1.9	6	11.5	17	13.6
Total	28	38.4	29	39.7	16	21.9	73	100	27	51.9	19	36.5	6	11.5	52	100	125	100

Source: Field Data 2015 - 2016

Hypertension was the most frequently presented chronic disease at the facilities. A total of 31.2% of the chronic diseases presented at both residential aged care facilities were hypertension cases with 20.8% of it presented at Mercy Home and 10.4% presented at Mercy Missions. Slightly more than one out of every three (35.6%) of the residents at Mercy Home was a hypertensive patient. Less than a tenth (9.6%) of those at Mercy Missions had presented hypertension.

The second most frequently presented chronic disease was stroke. 15.2% of the chronic disease conditions presented at both residential aged care facilities were stroke cases. Of

this figure, 6.4% were admitted at Mercy Home and 8.8% at Mercy Missions. Over the period under review, one out of every ten (11%) of the residents at Mercy Home had been admitted with stroke without the stroke type being documented. One out of every five (21.2%) elderly persons admitted at Mercy Missions had stroke. The incidence of stroke was slightly higher among the old-old as compared to the young-old.

Diabetes was the third most frequently presented chronic disease. Over the period under review, 12.8% of all chronic disease conditions presented at the two facilities were diabetic cases with equal presentation at both facilities of 8 cases each. About one out of every ten (11%) of the residents at Mercy Home had been admitted to a residential aged care facility with diabetes and its associated long-term complications requiring care with a lot more of the diabetics being in the old-old age category. At Mercy Missions, 15.4% of the residents were diabetic. A few of the residents have had one or both limbs amputated as a result of suffering from diabetic neuropathy which is a nerve disease that damages the nerve fibres primarily affecting the legs and feet resulting in foot ulcers.

Brain disorders were the fourth most frequently presented chronic conditions. About a tenth (8.8%) of total chronic disease conditions admitted over the period under review were cases of brain disorders with 7.2% of it being dementias and the remaining 1.6% being as a result of vehicular accident and alcoholic psychosis. About a tenth (9.6%) of the residents at Mercy Home and 1.6% of those at Mercy Mission had been admitted on account of dementia between 2013 and mid-2016. The types of dementia presented included Alzheimer's disease, vascular dementia and Parkinson's disease.

With regards to the recruitment of the aged persons, the sample for the study was elderly males and females who were accessing non-domiciliary care facilities to meet their activities of daily living (ADL) and instrumental activities of daily living (IADL). The primary research units consisted of fifteen elderly persons who are users of residential aged care facilities and six relatives of the residents of the two residential aged care facilities. Out of the fifteen residents interviewed, twelve were females and three were males.

During the fieldwork, a total of thirteen elderly males were observed in the facilities, one had dementia and was talking incoherently, six could talk coherently but with much effort and the remaining six were not talking (aphasic) due to their medical condition (suffering from full or partial stroke). Out of the six who could talk coherently, three of them refused participation in the study. Twenty-three elderly females were observed in the facilities, two of them had dementia and were talking incomprehensibly, two were critically ill, the remaining nineteen could talk coherently but seven of them refused participation in the study because of tiredness and not feeling well.

3.5.2 Demographic Characteristics of the Elderly Persons Sampled

Table 3.5.2: The demographic characteristics of the elderly persons interviewed.

Demographic Characteristics of the residents interviewed							
Name*	Age	Sex**	Marital status***	Surviving children	Ethnicity/home town****	Former Occupation	Chronic Disease (s)
Emmalyne	70	F	W	3	Larteh	Headmistress	BP, partial Stroke
Edwina	82	F	W	3	Kukurantumi	Farmer	Diabetes, both limbs amputated
Elsie	80	F	W	11	Adukrom	Food vendor	Dementia, mild stroke
Evelyn	80	F	W	5	Akyem	Secretary/Seamstress	BP, Urine incontinence,
Edna	76	F	D	1	James town	Nurse/Midwife	Diabetes, full stroke
Esther	93	F	W	1	Tutu	House mistress/Baker	Frailty
Doris	70	F	W	2	Ho	Farmer	BP, Mild stroke
Dorcas	99	F	S	1	Ho	Farmer/Trader	Frailty
Deborah	74	F	W	3	Cape Coast	Headmistress	BP, spine problem, partial stroke
Alberta	86	F	W	7	Ga	Health worker	Deafness, BP, frailty
Karen	73	F	D	3	Swedru	Petty Trader/traditional birth attendant	Diabetes, Amputee
Maud	78	F	M	2		Petty Trader	Diabetes, BP
Edmund	70	M	M	3	Ho	Civil Servant	Dementia, BP, partial stroke
Henry	72	M	D	6	Hohoe	Technician	BP, glaucoma, mild stroke
Emmanuel	75	M	W	4	Mampong	Business man	BP, full stroke

* These are pseudonyms,

** F = Female; M = Male,

*** W = Widow/Widower; M = Married; D = Divorced; S = Single

**** Home town but not necessarily their place of birth

Table 3.5.2 summarizes the demographic characteristics of the sample of elderly persons I interviewed at the facilities. The elderly comprised of three males and twelve females.

Majority of them were within the young-old (7) and old-old (5) categories. Only a few of

them (3) were in the oldest-old age range. The distribution of the elderly population at the facility shows a concentration of the elderly in the age groups 60 to 74 years and 75 to 84 years. Over half (9) of the residents were widowed with most (8) of them being women who had helped care for their spouses before they died. In Ghana, husbands do not usually offer care to wives. When wives die, other women are found to care for husbands. When husbands die, the reverse is not done. Two of them were married as at the time they were brought to the facility. Another three of them had been divorced.

Majority (11) of the participants/informants have had some form of formal education in the past. The highest level of education attained by five of them was post-secondary education as they had attended training colleges to become professional teachers, nurses and or midwives and technicians. Two of them had completed secondary education. Four of them had completed basic education (middle school leaving certificate). Four of them did not have any formal education. The majority of the residents could be described as part of the elite elderly population and therefore more likely to have invested in the education of their children.

Of the six family members interviewed, four were biological children of the elderly. One was a lawyer/legal practitioner, two were entrepreneurs/business women, and one was a critical care nurse. Apart from the children, one son in-law and one pastor/priest were interviewed as filial kin because they were the people consistently observed to be visiting the aged persons and providing the necessary material care for the upkeep of the elderly persons at the facilities. The son-in law of the elderly person was married to a PhD holder who works with an INGO in the United States of America.

Eight of them had worked in the formal sector of the economy as, civil servants (4), teachers/educationists (2), nurse/midwife (1), and technician (1). Over a third (7) of the participants/informants worked in the informal sector as petty traders and businessmen (4) and farmers (3). Five of the participants/informants were Ewes, four of them were Akans, and another four were Guans. The rest were Ga-Dangme (2).

Prior to accessing the facilities, six of the participants/informants were living with a daughter, four of them were living alone either in an extended family property or rented space. Two of them were living with a spouse and another two were living with a sister. Three were living with people other than their family members. All the participants/informants had surviving biological children who were responsible for their care. Ten of them had one to four surviving children while five of them had five or more surviving children.

3.5.3 Demographic Characteristics of the Family Members of the Elderly

Additionally, I interviewed six relatives of the residents of the two residential aged care facilities.

Table 3.5.3 summarizes the demographic characteristics of the sample of family members of the residents I interviewed at the facilities. They consist of three (3) males and three (3) females. Four (4) of them were married as at the time of the interview. Of the remaining 2, one was a single parent and the other was separated from the spouse. Three of them were below the age of 50 years (40-49 years), another two (2) of them were between 50 and 59 years. Only one of them was above 60 years of age.

Table 3.5.3: The demographic characteristics of the family members of the residents interviewed.

Demographic Characteristics of the family members and relative of residents interviewed						
Name*	Age range	Sex**	Marital status***	Surviving children	Relationship with elderly****	Occupation
Claudia	50-54 years	F	Separated	3	1 st of 4 children of the elderly and his only daughter	Lawyer / Legal practitioner
Catherine	55-59 years	F	Married	3	1 st of 3 children of the elderly, and her eldest daughter	Entrepreneur/ Business woman/ spare parts dealer
Clara	40-44 years	F	Single parent	1	5 th of 7 children of the elderly, but her eldest daughter	Entrepreneur/ Business woman/ imported clothes dealer
James	45-49 years	M	Married	2	The last of 8 children of his mother	Critical care nurse
Jason	40-44 years	M	Married	2	Church leader of the elderly and family friend	Full time minister of a Christian denomination
Jeremy	60-44 years	M	Married	4	Husband of the 1 st of 4 children, elderly's son in law	Retiree

* These are pseudonyms,

** F = Female; M = Male,

*** S = Separated; M = Married; SP = Single Parent;

**** Participants/informants relationship to the resident

All the family members had dependent children, with the majority (5) of them supporting between 2 and 4 children. All the three females were kin/daughters of the elderly; two of them were living with the elderly prior to accessing non-domiciliary care.

Only one of the males was kin/son of the elderly but was not living with the mother prior to the access of non-domiciliary care.

Majority of the females (2 out of 3) who are supposed to be the primary caregivers, were entrepreneurs/business women.

3.5.4 Demographic Characteristics of the Service Providers at the Facilities

Table 3.5.4: The demographic characteristics of the service providers interviewed at the facilities.

Demographic Characteristics of the service providers interviewed						
Name*	Age range	Sex**	Marital status***	Duration of work at facility	Qualification	Highest education attained
Jemima	55 - 59 years	F	M	Since inception		Vocational School
Jacklyne	50 - 54 years	F	M	Since inception	BA degree	Tertiary
Magdaline	25 - 29 years	F	S	7 months	Trained Nurse	Training College
Beatrice	20 - 24 years	F	S	15 months	Health care assistant	NVTI
Ransford	25 - 29 years	M	M	10 months	Trained Nurse	University
Kinsley	60 - 64 years	M	M	4 months	Retired nurse	Training college
Obed	20 - 24 years	M	S	5 months	Trained nurse	University
Charity	25 - 29 years	F	S	3 months	Health care assistant	Training institute

* These are pseudonyms,

** F = Female; M = Male,

*** S = Single; M = Married,

Table 3.5.4 summarizes the demographic characteristics of the sample of non-domiciliary aged care facilities owners and staff interviewed for the study. Both owners are females, below 60 years of age, and married. The caregivers consist of three (3) males and three (3) females. Four (4) of them were single as at the time of the interview. With the exception of the retired male nurse who was above 60 years of age, all the rest were between 20 and 30 years of age.

3.6 Data Collection Methods and Instruments

I sought to collect rich sufficient data and that consisted of collecting background data about the persons, processes, and settings, including a full range of contexts, and detailed

descriptions of the participants/informants views and actions. The data collection was therefore done in all the two non-domiciliary aged care facilities with owners or administrators of the facilities, service providers, residents, and the relatives of the residents. For the purposes of this study, I adopted a qualitative mixed methods research approach in gathering the required data. Additionally, but to a lesser degree, I used admission forms, facilities leaflets/handouts, webpage information and existing literature.

Three different data collection instruments were used to gather all the relevant and rich data for this study. This is because rich data reveals what lies beneath the surface, incorporates multiple views, and comparisons across and between the data. Each of the instruments was used to elicit specific sets of information from the participants/informants. They consisted of demographic forms (for the elderly persons and their relatives), semi-structured interview guide (for the service providers, elderly persons, family members of the elderly persons), and a list of pointers/checklist for the field research or participant observation (refer to Appendices B, C, D). I discuss below the use of the instruments; the rationale and the processes for their use.

3.6.1 Participant Observations

Participant observation is an ethnographic technique for data collection which is appropriately used in research work when the research question involves learning about, understanding, or describing a group of interacting people (Neuman, 2007) and how they construct their social realities (Savin-Baden & Major, 2013). It is a way for the researcher to document everyday practices of participants/informants and better understand their experiences (Savin-Baden & Major, 2013). The technique of field research, which is based on naturalism requires that the researcher directly talks with and observes the people being

studied while participating in a small-scale social settings in the present time and in the researcher's home culture with the aim of examining the social meanings and grasp the multiple perspectives in the natural social settings of the aged facilities for the purposes of learning about, understanding, and describing the types of elderly people accessing the different types of aged facilities and services accessed.

At the initial stages of the fieldwork, I assumed a no base knowledge stance and therefore made the observations as exhaustive as possible, with me observing everything and anything that happened in the facilities. My observations, however became more focused and selective as I began interviewing the participants/informants of the study because their responses then guided me in making decisions about future observations of various types of activities to seek out the differences among them (Savin-Baden & Major, 2013). The observations I did were structured because I used a predetermined protocol (see Appendix E). The observations were relatively long-term spanning over a period of 8 months. At the initial stages of my visits to the facilities, I took the stance of doing the observations at a level of passive participation with minimal involvement in the activities of the facilities. I mostly functioned as a bystander and did not interact directly with the residents of the facilities. I sought to be detached, observing rather than engaging in the day-to-day activities at the facility. I also tried to be as unobtrusive as possible to avoid potentially biasing the observations (Savin-Baden & Major, 2013).

I, however, realised with time that to gather detailed information about the social context I was studying I had to get involved and increase my participation in the activities of the facilities. Therefore, I balanced participation by participating occasionally but not fully in the activities of the facilities thereby striking a balance between my role as an insider and outsider. I increased my participation in the day-to-day activities at the facility. At each of

the facilities I joined in some of the activities that the health assistants were doing (like setting of table and serving of food, feeding residents, picking items for residents, participating in devotion and reading scriptures to residents) but not in all of the caregiving activities. I combined the participation in the activities of the residents with the maintenance of a professional distance which allowed me to adequately observe and record data. Whenever I was tempted to get too involved in the setting, I immediately found reasons to withdraw from the site to retain my outsider role (Savin-Baden & Major, 2013).

In managing the balance between the observations, participation and keeping a professional distance, I learnt that qualitative research is an iterative approach to gathering data whereby the methodology, content of the discussion and stimulus are adapted over the course of the research programme. The learnings from the initial sessions of the data collection is used to influence the inputs for subsequent phases of the fieldwork. As such, predetermined procedures of fieldwork or research protocol might not be the same as what actually happens in the fieldwork and therefore there is the need for a qualitative researcher to keep a notebook documenting all the steps taken on the field to ensure that the needed data was gathered.

During the fieldwork, I sought to get inside the meaning system of residents in the non-domiciliary facilities by switching perspectives and looking at the setting from multiple points of view simultaneously (Neuman, 2007). During the participant observations, I talked with and observed the participants/informants as their worlds naturally unfolded at the various facilities. This includes those times when the different parties in the field come together to spontaneously have a conversation, discussion, or argument (Berg, 2001, 2004; Bobbio, 2010). Through the balanced participation and interaction over the months, I learnt about them, their life histories, their interests, hopes, fears, and dreams (Neuman, 2007). In

doing the participant observations, I focused on the physical settings of the different types of the facilities, the participants/informants, and the activities of care provided to whom and by whom. I also observed the interactions that took place at the facilities, how information is delivered within the facilities and subtle factors like non-verbal cues (Creswell, 1998). All these helped me to provide the contextual information about the research environment in the subsequent chapters on the work.

The participant observation approach of data collection provided me with a nuanced contextual information about non-domiciliary aged care facilities and the residents of the facilities within a natural environment, which could not be derived from another fieldwork approach. This helped me develop a holistic understanding of the phenomenon of non-domiciliary aged care as objective and accurate as possible given the limitations of the method. The approach allowed me to access the ‘back stage culture’ and gain information that people may not be willing to share in interviews (Savin-Baden & Major, 2013). In addition, the approach helped me to improve the validity of the study in that the observations provided me with information about the physical environment and their influence on the residents of the facilities. The observations helped me to examine the non-verbal expressions or cues, to determine who interacts with whom and how, to evaluate how the participants/informants interact with each other and to gauge the degree to which they do certain things. To also find out whether the self-reported information of the caregivers and facility operators is likely to be different from actual information. Although the observations were extensive, those excluded from the study were not observed. The general data presented in the findings section of the work does not include any information on the elderly persons excluded from the study owing to cognitive impairment, inability to talk or give free and informed consent as determined by the researcher and refusal to participate in the study.

3.6.2 Demographic Forms for Residents and their Relatives

Two demographic forms, found in Appendix B, of the document were designed and used to gather information on the socio-demographic characteristics of the elderly persons accessing the facilities and that of their family members. The socio-demographic characteristics of the participants/informants gathered include: information about age, education, occupation, socio-economic factors, living arrangements, physical health, and use of the health care system. The use of the demographic forms made available useful background data about the participants/informants, which enabled me to fully describe the research sample, provide a guide for the maximum heterogeneity sampling. The maximum variation (heterogeneity) sampling aims at capturing and describing the central themes that cut across a great deal of participant variation. For small samples, a great deal of heterogeneity can be a problem because individual cases are so different from each other (Patton, 2002).

3.6.3 Semi Structured Interview Guides and Interview Processes

The semi-structured interview guide was the main instrument used for the fieldwork. In all, five different semi-structured interview guides were developed for this study. These instruments were administered to the two owners of the facilities, two administrators/operators, six caregivers, fifteen residents and the six family members of the residents who were the key decision makers about the care of the elderly persons. I discuss below the features and the processes involved in constructing the guides, which were used to interview the different target groups sampled for the study.

During the pilot phase, four unstructured interviews were conducted with the owners and administrators of the facilities in order to have an orientation into the activities of these

service providers. This initial interaction with the service providers offered me the opportunity to gain insight into the kinds of services offered, mode of advertisement and recruitment of elderly persons into the facility, the type of elderly persons admitted, operations and motivations for operating such facilities.

The initial information from the two facilities formed the basis for designing the semi-structured interview guides which were used for the main fieldwork after they had been approved by the Ethics Committee for the College of Humanities at the University of Ghana.

The instrument contained open and extensive questions that encouraged the participants/informants to talk more freely and at length about the issues raised to help me elicit individual stories, thoughts and feelings about the target phenomenon. This is because it offered the participants/informants the opportunity to tell their stories, to speak freely and reflectively developing their ideas and expressing their concerns. The development of the instruments was guided by the main objectives underpinning the study. The initial set of open-ended questions focused on the circumstances leading to the elderly persons accessing the facilities, individuals who influenced the actions of the aged persons, the living conditions of the elderly persons and the person who was responsible for ensuring that the care needs of the elderly persons were being met and how were they being addressed.

The intermediate questions focused on the awareness and knowledge about the facilities before they accessed it, their thoughts and feelings about accessing the facility/service before and after, persons involved in the decision making process, activities of care accessed from the facility on daily basis. The next set of questions sought to find out the changes that have occurred in the lives of the elderly persons since they began accessing the facility, how

they perceive themselves now, what helps them to manage their presence in the facility, the problems they are encountering in this facility, who has been most helpful to them during this time of their life. The ending questions focused on finding out how their views about themselves may have changed since they started accessing the facility, how they have grown as a person since they started accessing the facility, the strengths that they discovered or developed through this experience, what they value most about themselves now and what advice they would give to someone who had just discovered that he or she needed care.

The interviews were conducted after informed consent had been obtained from the participants/informants and the demographic form completed. The different interview guides were used appropriately depending on participant/informant type. In-depth interviews were conducted with the participants/informants. The questions were formulated to give the participants/informants an opportunity to provide the researcher with their own thoughts about the emerging forms of residential non-domiciliary care for the elderly, and not to just answer the researcher's questions. I listened carefully to the participants/informants genuine concerns, perspectives, and meanings, in order to determine what was important for these elderly persons in their own context.

The context of each interview was different, and the interviews varied by the type of participants/informants. I started each interview session with an interview guide, which contained a list of issues I was interested in exploring with the participants/informants type. For the first few interviews, I closely followed the order of the questions as I had outlined in my interview guide. The different topics of conversation and issues that emerged in the initial interviews which I deemed relevant to the study were included in the subsequent interviews. The interview questions were therefore expanded based on the emerging

relevant issues. The subsequent interviews were, less formal, more relaxed, and more open-ended.

3.6.3.1 Languages Used in Interviews

The interviews were conducted in four languages. These were Twi (the native language of the Akans and the most widely spoken language in Ghana), English (the official language of Ghana), Ga (the native language of the Ga people of the Greater Accra Region of Ghana) and Ewe (one of the native languages of the people from the Volta Region of Ghana). Twi was the dominant language spoken by the residents and the service providers in one of the two facilities, so the bulk of the interviews in that facility was conducted in Twi. Ewe and Ga speaking elderly dominated the other facility. Three of the languages (English, Twi and Ga) were spoken and written by the researcher and the last (Ewe) was spoken by the research assistant who accompanied the researcher in a few of the trips to the facilities. Even though I had studied Ewe at the undergraduate level (language proficiency course) of my tertiary education, my command of the language was not sufficient to decipher most of the conversations going on among the participants/informants at one of the facilities where Ewe was the dominant language spoken. I therefore had to rely on a research assistant who was fluent in Ewe. My reliance on the research assistant who served as a translator and an interpreter in conducting the interviews under my supervision added much more meaning to the interviews. Seventy-five percent of the interviews were conducted in Twi, ten percent in Ga and fifteen percent in Ewe which were sometimes interspersed with phrases in the English language to convey a particular meaning easily as the native language equivalent was too complex. These were to ensure that the participants/informants spoke freely and were able to communicate their views and thoughts on the subject with ease.

3.6.3.2 Duration of Interviews

The initial set of interviews that were conducted during the fieldwork phase of the study generally lasted much longer because those were interviews conducted with the owners and facility operators or administrators as well as the staff of the facilities. These interviews lasted more than an hour. However, those conducted subsequently with the residents of the facilities were generally less than an hour long. Interviews with the relatives of the residents during the second phase of the fieldwork were also long, on average lasting over an hour. This was because for the initial set of interviews conducted, the views and opinions expressed were new to me. I therefore had to probe into detail on almost all issues and steps to understand the operations of the facilities. As the interviews progressed I became familiar and more informed about the operations of the facilities, therefore there were fewer instances where further clarification and probing were required from my participant. Thus, I spent lesser time in doing the interviews than I had done at the beginning of the study.

3.6.3.3 Venue for the Interviews

Regarding the venue for the interviews, after getting the consent of the participants/informants to interview them, they were given the opportunity to choose where they would like the interviews to be conducted. Generally, the interviews were mostly conducted at the facilities. The owners and the staff of the facilities were interviewed in their working spaces. These interviews were interrupted a couple of times because they had to attend to other people, making those interviews comparatively lengthier than those held with the residents. Only a few of the residents were interviewed in their rooms. Most of them were interviewed in the living room space where a number of them were present at any given time. I had less control of the interview settings with some of the residents who were interviewed in the living room or common sitting places of the facilities.

During the initial interviews with the residents, some residents and caregivers were curious about my presence in the facility for that period of time despite all that they had been told by the operators of the facilities. Anytime I started interacting with the residents a staff or another resident would get closer to listen in on the conversation. When they became satisfied that the resident was talking about his/her socio-demographic background, they would retreat and give me the opportunity to ask the sensitive questions. On some of those occasions, the interviews were more like focus group discussions as multiple viewers (caregivers, facility operators and residents) were all anxious to listen and contribute to what was being said. On countless occasions I was offered food items and beverages by the facility operators and some residents of the facilities. My acceptance and willingness to consume these items created a very conducive atmosphere for me to interact with them.

The settings for the interview of the family members varied and required different levels of negotiation. I conducted all the interviews with the family members of the residents on a one-to-one basis and most of them took place in the workplaces of the informants (hospital, market/business place, corporate offices) and lasted between one to two hours because of interferences. Three interviews took place at the aged care home on a weekend afternoon because the interviewees could only find time when they visited their relatives at the facility. The interviewing procedures with the family members of the elderly in the facilities were different from that of the residents. I had to overcome suspicions of the owners of the facilities and the relatives of the residents. After assuring the participants/informants of the confidentiality and anonymity of the research which was crucial in securing their consent, some of the family members were reluctant to talk because they were afraid that they would be identified with the recordings of the interview. I therefore decided not to audio tape/record the voices of those family members because of their fear of identification.

I presented myself to the relatives of the residents in ways that reduced my position as an ‘outsider’ by relating my own experiences with caring for my aged parents even though it might not be the same as theirs. Some of the relatives and the facility operators were curious about my background and my desire to spend so much time studying aged care. I therefore had to speak frankly about my family, my personal beliefs, and myself. In all, I made a total of 57 visits to the facilities between September 2015 and October 2016. The initial set of 35 visits were made to observe the morning and afternoon routines at the facilities and to interview residents. The remaining 22 visits were made to observe late afternoon and evening routines. The morning visits were made between 7:30am and 1pm. The afternoon visits were made between 1:30pm and 8pm. A few additional visits were made to the facilities purposely to interview relatives who were paying visits to their elderly persons. On each of the visits, field notes were recorded of the setting of the interviews, important nonverbal cues or communication, and general observations of sights, sounds, and feelings about what was going in the setting. The field notes were transcribed verbatim for data analysis purposes.

3.7 Data Management

Prior to analyzing the qualitative data gathered there is the need to manage the raw data (Boeije, 2010). Data management in qualitative research involves three aspects; data storage, transcribing audio sources and cleaning the data. Upon my return from the field each day, I transferred the saved audio recordings on the recorders into a folder designed on my computer and then in my virtual folder for storage purposes because a good storage of audio recordings and other materials will enable me to easily retrieve them as and when they are needed (Boeije, 2010) and also ensure that the data I gathered were not lost. Because of the ethical requirements for conducting the fieldwork, the hard copies of data collected in the form of completed demographic forms, long hand notes gathered during the participant

observation and the in-depth interviews were typed out and electronically stored on my laptop which is a password protected computer and the hard copies which consisted of five notebooks were stored in a locked filing cabinet. As part of the storage process, I categorised them based on; first by the type of facility, name of facility, the type of participant and their relevant uses in the analysis steps. For example all interviews with residents of the facility were stored separately from interviews with their family members.

The notebooks used during the fieldwork of the study served two purposes. First, they were the main data recording instrument for the long hand notes that were made of my participant observations at the facilities, which could not be tape-recorded, such as the nonverbal cues, the mood of the facility, and other happenings in the environment. I wrote down my observations meticulously by writing down incidents and happenings that were relevant to the study. The note taking of my observations were done without attracting attention to myself so that the residents will not change their behaviour to suit what they thought I expected to see. I only wrote down my observations after I had excused myself to use the washroom or under the pretense of making a phone call or picking a call. They also served as a back-up for the audio tape recording of the residents who were the main actors in the study.

I then proceeded to transcribe the recorded audio interviews one after the other into text and gave them out for typing. For the interviews that were conducted in Twi, Ga, and Ewe, my research assistant and I translated and transcribed them into English concurrently.

All the interviews audio taped were transcribed verbatim. Most of the tape-recording of the interviews was transcribed shortly after each field visit. As advocated by Lofland and Lofland (1995), transcribing data, as and when a set of data is available, allows the

researcher to be more aware of emerging themes. After I had received the typed transcript of each participants/informants, I cross checked it against the voice recording to ensure that all the transcribed interviews had been typed correctly. Prior to coding the transcripts, because of the ethics regarding confidentiality and anonymity, all information gathered that could be used in identifying the actual participants/informants of the study were omitted, the data was thereafter identified by specific codes, which were selected by me.

3.7.1 Data Analysis

Data analysis involves the drawing of inferences from the raw data gathered be it secondary or primary. The process of data analysis can involve multi-methods that are applied sequentially known as methodological triangulation (Patton, 2002). Conducting data analysis in qualitative research involves dismantling, segmentation and reassembling of data to form meaningful findings in order to draw inferences from the data (Boeije, 2010). I used thematic network to analysis the data with the aim of exploring the understanding of the issue of emerging forms of care for the elderly and the significance of this relatively new phenomenon. I used the thematic network analysis approach for the purposes of breaking up the text and finding within the text the explicit explanations and their implicit meanings as well as the implications. The process of doing thematic network analysis can be differentiated into three broad stages: (a) the reduction or breakdown of the text; (b) the exploration of the text; and (c) the integration of the exploration (Attride-Stirling, 2001).

In breaking down the text as suggested by Attride-Stirling (2001), I first of all put together a coding framework based on the salient and recurrent issues that arose in the text, the theoretical interests guiding the research questions as well as a set of constructs that were explored systematically during the fieldwork. The codes devised in the coding framework

were applied to the data in the transcript to dissect it into text segments: meaningful and manageable chunks of text such as passages, quotations, single words, or other criteria judged necessary for the analysis (Corbin & Strauss, 1990; Miles & Huberman, 1994). I ensured that the codes in the coding framework were defined so as to limit their scope such that they all had explicit boundaries in order not to use them interchangeably.

After all the text had been coded, I went through the text and listed the important and common significant themes in the coded text segments in order to identify the emerging themes, and the underlying patterns and structures. These were then refined to ensure that they were non-repetitive and broad enough to encapsulate a set of ideas contained in numerous text segments. Thus, reducing the data into a more manageable set of significant themes that summarizes the text. The themes derived from the text were grouped based on similarities. I systematically extracted the basic themes in the text which are the lowest premise evident in the text. I then grouped the basic themes into different categories according to the underlying story they are telling and these became the organizing themes. From the organizing themes I identified the global theme which is a metaphor that encapsulates the set of organizing themes. These were then represented as a web-like map that depicts the salient themes at each of the three levels and illustrating the relationships among them.

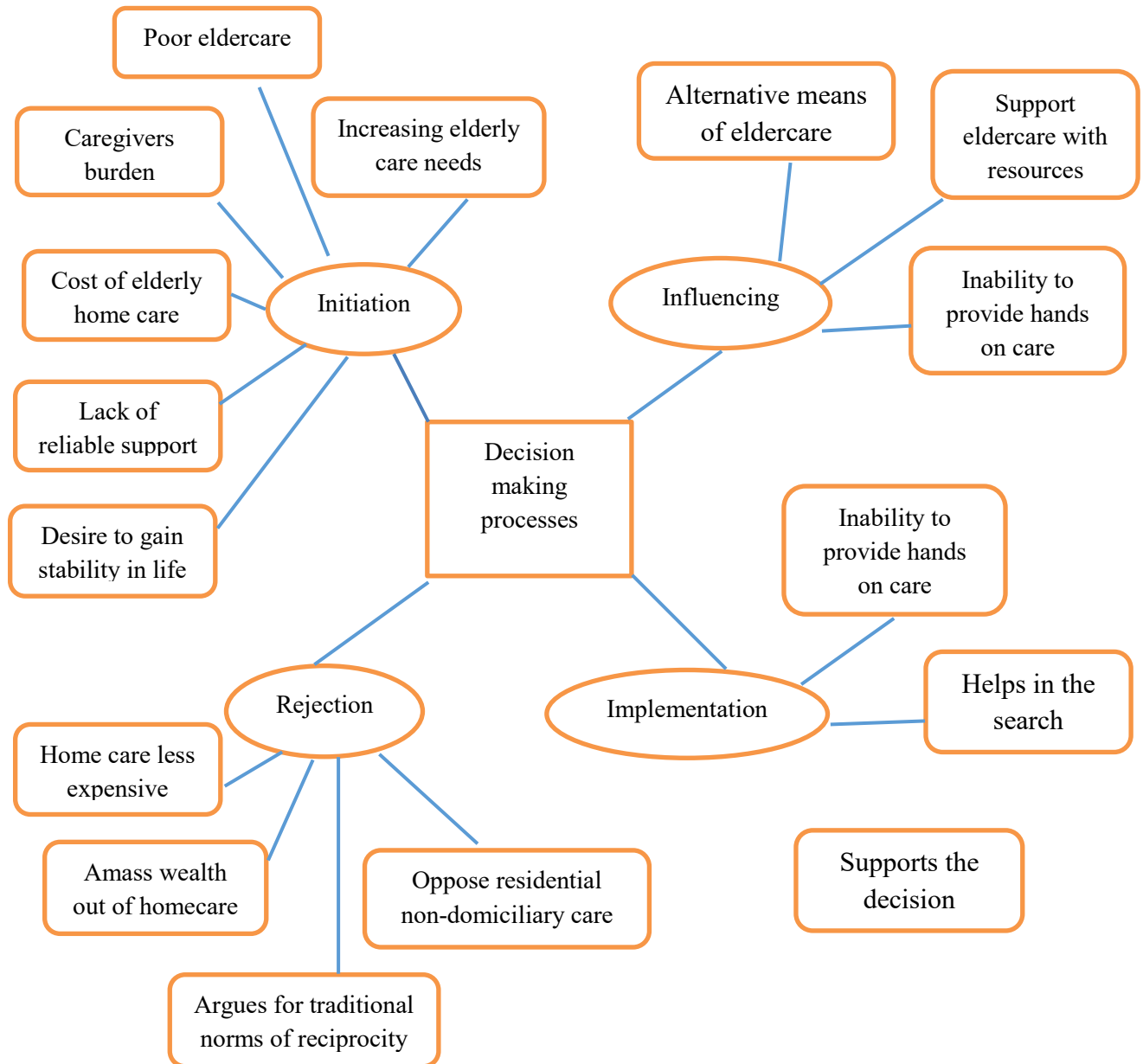
Based on their content and theoretical groundings, the groupings then became the thematic networks. Each group had its deduced distinct global theme, which was supported by discrete organizing theme and its set of basic themes, which had been derived from the texts and assembled into groups. The basic themes, organizing theme and global theme were then used to illustrate a nonhierarchical web-like representations with each distinct global theme

and supported organizing and basic themes producing a thematic network. Each aspect of the thematic network was cross-checked with data to ensure consistency.

I then set out to explore themes identifying the patterns underlying each of them and described the thematic networks. Taking each network in turn, I described its contents and supported the descriptions with text segments from the data. After summarizing the thematic networks, the patterns were interpreted to address the research questions and the theoretical interests underpinning them and address these with arguments grounded on the patterns that emerged in the exploration of the text (Attride-Stirling, 2001).

Figure 3.3 represents the analysis of the decision-making processes leading to the elderly accessing residential non-domiciliary facilities.

Figure 3.3: Thematic network analysis of the decision-making processes leading to the elderly accessing residential non-domiciliary facilities in the Greater Accra Region.



Source: Fieldwork, 2015 - 2016

The global theme derived from figure 3.3 thematic network analysis was the decision-making processes leading to the elderly accessing residential non-domiciliary aged care facilities. The organizing themes are initiation, influencing, implementation and rejection of the decision-making processes. For the initiation organizing theme, the basic themes were:

caregivers burden, lack of reliable and dependable support, increasing elderly care needs, cost of home care and desire to gain stability in life. For the influencing organizing theme, the basic themes were: inability to provide hands-on care to elderly, suggests alternative means of eldercare, and supports eldercare with resources. The basic themes for the implementation organizing theme were; inability to provide hands-on care, supports non-domiciliary care access, helps in the search. The basic themes for the rejection organising them were: opposition of non-domiciliary aged care, arguments in favour of traditional norms of reciprocity, home care less expensive than out of home care, amassing of wealth through home care.

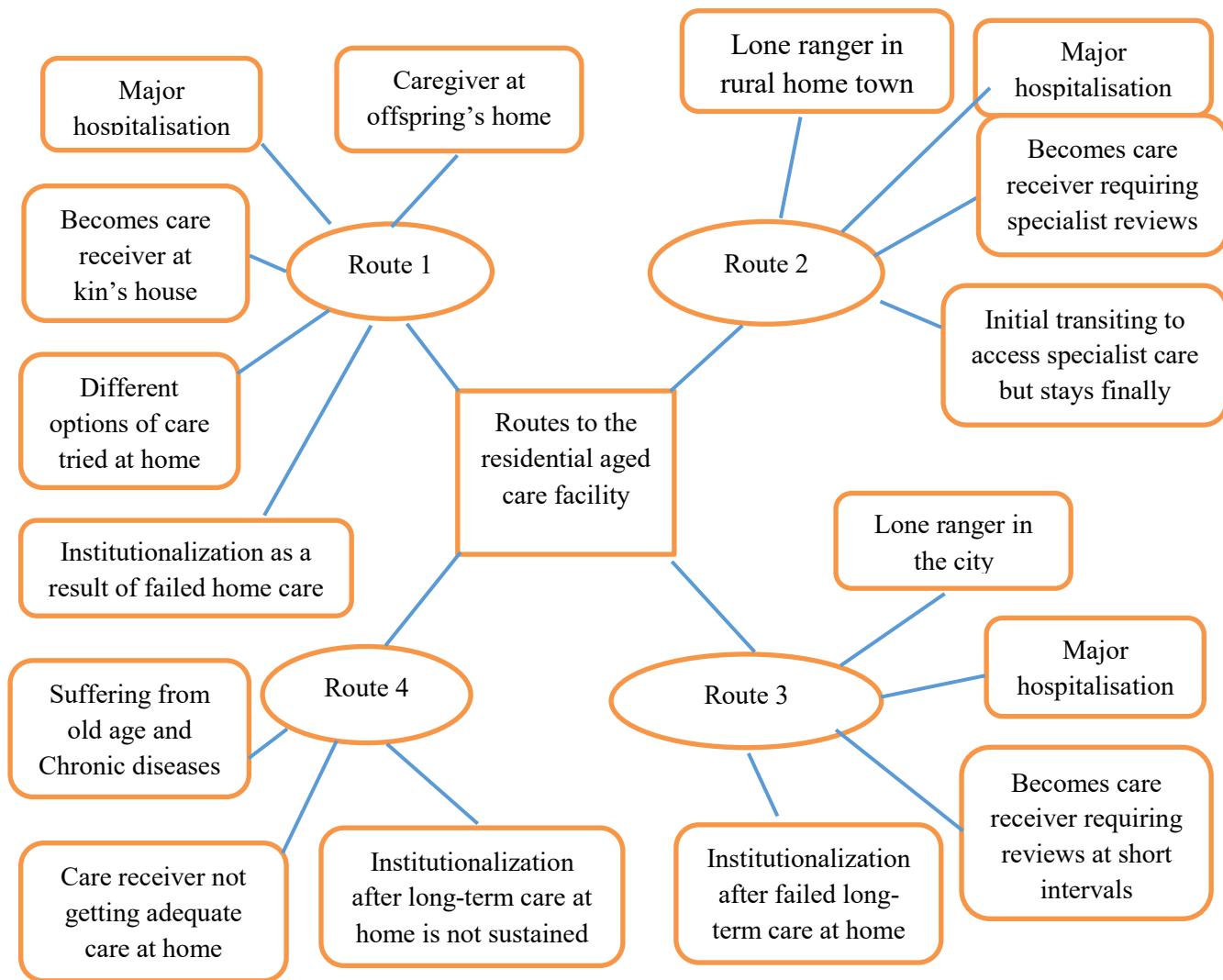
The global theme derived from figure 3.4 thematic network analysis was the routes followed by the elderly persons to the residential non-domiciliary aged care facilities to access long-term care. The organizing themes are the four route followed by the elderly to the residential aged care facilities, which are route 1, route 2, route 3 and route 4.

For the route 1 organizing theme, the basic themes were: elderly as caregiver in offspring's home, major hospitalisation, elderly becomes care receiver at offspring's home, different options of care tried at home and institutionalization as a result of failed home care. For the route 2 organizing theme, the basic themes are: elderly lives as a lone ranger in rural home town, Major hospitalisation, elderly becomes care receiver requiring specialist reviews. Initial transiting at facility to access specialist care but stays there finally. The basic themes for the route 3 organizing theme were; elderly lives as a lone ranger in the city, major hospitalisation, elderly becomes a care receiver requiring reviews at short intervals, institutionalization after failed long-term care at home. The basic themes for the route 4 organizing theme were: elderly suffering from old age and Chronic diseases, care receiver

not getting adequate care at home, Institutionalization after long-term care at home is not sustained.

Figure 3.4 represents the analysis of the routes leading to the elderly accessing residential non-domiciliary facilities.

Figure 3.4: Thematic network analysis of the routes leading to the elderly persons accessing residential non-domiciliary facilities in the urban areas of the Greater Accra Region.



Source: Fieldwork, 2015 – 2016

3.7.2 Scientific Rigour

Specific strategies are used by qualitative researchers throughout the research process to increase the worth of qualitative projects (Krefting, 1991; Shenton, 2004). To ensure the trustworthiness of the study, the following strategies: credibility, transferability, dependability and confirmability (Shenton, 2004) were adopted at different stages of the research process. Some of the strategies need to be addressed in the study design stage, while others are applied during data collection and after data are interpreted (Krefting, 1991).

Credibility and quality in research recognizes subjectivity as an essential aspect, trustworthiness of the researcher and the findings, triangulating the results, paying attention to reflexivity, praxis, and particularity, seeking enhanced and deeper understandings, and contributing to an on-going dialogue (Patton, 2002). I sought to enhance credibility by gathering rich data from the multiple sources, and seeking depth and variation in the data. To ensure credibility of the research, I spent an extended period of time with the residents at the facilities. This prolonged engagement allowed me to check the different perspectives and allowed the residents to become accustomed to my presence at the facilities. The extended time or period increased the rapport between the researcher and the researched. As such, the residents usually volunteer different and more detailed information than they had done at the initial stages of the fieldwork (Kielhofner, 1982; Lincoln & Guba 1985; Leininger, 1985). The prolonged engagement with the research sites enabled me to identify response sets where informants' consistencies agreed or disagreed with the questions asked for further probing and clarification. Additionally, the long period of observations and interviewing allowed me the opportunity to identify this problem as they occurred. The use of hypothetical cases in some instances and the rephrasing of the questions helped in eliciting more personal responses.

The observations were done under various natural situations. I ensured that the number of visits were equally split between the facilities to ensure that I was sampling all possible situations including different social settings, times of day, days of the week and seasons. I also observed interactions among different social groupings for example interaction between residents and peers, caregivers, family members, and other visitors to the facilities. I also observed interactions in different contexts at different times of the day and on weekdays and weekends.

I kept notebooks which served as field journal throughout the research process. I had information on my daily schedule, logistics of the study and the methods used at each visit. I also used it to document questions, problems, thoughts, feelings and ideas generated (Lincoln & Guba, 1985; Shenton, 2004). Additionally, I have included in the audit; raw data (a sample of field notes and a transcript of an interview), data reduction and analysis products (quantitative summaries of the demographic analysis, flow chart of the landscape of aged care in Urban Greater Accra), data reconstruction and synthesis products (web-like thematic network analysis), instrument development information (pilot forms, semi structured interview guides) (Lincoln & Guba, 1985; Shenton, 2004).

In enhancing the quality of the research, I did triangulation to ensure that convergence of the multiple perspectives for mutual confirmation of data to ensure that all aspects of the phenomenon of residential aged care facilities have been investigated (Kreftling, 1991; Shenton, 2004). Patton (1999) defines triangulation with reference to the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena. Additionally, triangulation is a qualitative research strategy used in ensuring validity through the convergence of information from different sources. Over the years, four

types of triangulation have been identified by researchers i.e. method triangulation, investigator triangulation, theory triangulation, and data source triangulation (Patton, 1999; Denzin, 1978). I used method triangulation and data source triangulation to ensure the trustworthiness of the research.

I triangulated data methods by comparing the data I had gathered through the participant observations with that from the in-depth interviews. I also triangulated the data sources by comparing the information I had gathered from the elderly persons and their kin with information provided by the facility operators and caregivers. This was done in order to maximize the range of data that contributes to completing the understanding of the concept of residential aged care facilities in Ghana. I achieve that I interviewed all the stakeholders in the business. This enabled me to verify the viewpoints and experiences of individuals against that of others creating a rich picture of the attitudes, behaviour and needs of the participants/informants (Lincoln & Guba, 1985; Shenton, 2004).

Member checking was done by checking the information from one interview with responses from another informant before a subsequent interview with another was done (Lincoln & Guba, 1985). To ensure peer scrutiny of the research project, the research proposal was presented to faculty members at the department of Sociology prior to the commencement of fieldwork. This enabled the researcher to refine the methods of data collection and develop an improved explanation of the research design strengthening the arguments of the study. The findings of the research were also presented to faculty members to check the categories that have developed out of the data and refine them before the dissertation was submitted to the graduate school for assessment (Lincoln & Guba, 1985; Krefling, 1991; Shenton, 2004).

I transcribed all the interviews, field notes, and memos verbatim and stayed close to the data by doing initial, line by line, and in vivo coding which, will facilitate the construction of a thematic network analysis that reflects the participants/informants experiences of care in a residential non-domiciliary care setting. Keeping raw data, field notes, and memos, provided an audit trail of the various steps, from the raw data to analysis and interpretation.

At different sections of this chapter, I have extensively described the exact methods of data gathering, data analysis and interpretation used in this research. The extensive description of the methodologies therefore provides information as to how repeatable and unique the study is. Throughout every stage of the research process, I was constantly communicating with the thesis committee members about the sites and the emerging thoughts to ensure the dependability and transferability criteria were achieved in the data collection. I sought to enhance dependability and transferability of the research by triangulating the data collection methods used so that the weaknesses of one method of data collection is compensated for by the use of alternative data gathering method (Lincoln & Guba, 1985; Krefting, 1991, Shenton, 2004).

3.8 Ethical Considerations

Qualitative researchers place a high importance on ethics and consider it from design to treatment of individuals, to processes, to presentation of products (Savin-Baden & Major, 2013). Efforts were therefore made to ensure that ethical concerns were addressed at every stage of the life cycle of this study. Silverman (2000) cautions researchers to always remember that while they are doing their research, they are in actual fact entering the private spaces of their participants/informants which understandably raises several ethical issues that should be addressed during, and after the research had been conducted. Israel and Hay (2006) also point out that researchers need to protect their research participants/informants;

develop trust with them; promote the integrity of research; guard against misconduct and impropriety that might reflect on their institutions and cope with new challenging problems. For them, ethical questions are apparent in such issues as personal disclosure, authenticity and credibility of the research report, the role of the researchers in cross-cultural context and issues of personal privacy through forms of internet data collection (Israel and Hay, 2006 cited in Creswell, 2008).

Ethical practices involve much more than merely following a set of static guidelines, such as those provided by professional associations. Researchers need to anticipate and address any ethical dilemmas that may arise in their research (Berg, 2001, 2004; Punch, 2005). One of the normally unexpected concerns relating to ethical issues is cultural sensitivity. Silverman (2000) argues that the relationship between the researcher and the subject during an interview needs to be considered in terms of the values of the researcher and cultural aspects. Therefore, appropriate steps should be taken to adhere to strict ethical guidelines in order to uphold participants/informants privacy, confidentiality, dignity, rights, and anonymity. In view of the forgoing discussions, the following section describes how ethical issues in the conduct of the research were addressed.

First and foremost, I sought ethical clearance from the Ethics Committee for Humanities of the University of Ghana (see Appendix A) before embarking upon the fieldwork. The ethical considerations made and followed in the course of the study were at three levels. At the first level were the facilities, which served as the research sites, the second were the participants/informants who were the residents of the facilities and the third were the family members of the aged persons at the facilities, who take decisions about their care needs.

3.8.1 Residential Aged Care Facilities

One crucial ethical procedure that was required for and during the fieldwork had to do with the researcher gaining the permission of the owners and operators/administrators who control access to the facilities in order for the researcher to conduct the study at research sites. To do this I hand delivered letters of introduction to the owners and operators/administrators of the facilities and sought their permission. The letters stipulated the objectives of the study, the length of time for the study, the potential impact and the outcomes of the research. The representatives of the two facilities told me to go and wait for their call but I did not hear from them for about a month. I therefore made follow up calls to the two facilities upon which they granted me the permission to commence the fieldwork. After granting permission for the data collection, the owners and operators/administrators did not withhold information from me or prevent the staff and residents from expressing their views on issues raised by me throughout the period of data collection. The owners and operators/ administrators were most of the time not available at the facilities. The caregivers were mostly in charge of the day-to-day activities at the facilities.

Additionally, effort was made at respecting the research sites so that they are left undisturbed after the study by virtually saying nothing about the other places I had been to and what I had seen there even in instances where I had been interrogated by the owners and operators/ administrators of the facilities. Being cognizant of the fact that the observations and interviews might be prolonged at each site, I made efforts to minimize the disruption of the physical settings. My visits to the facilities were timed such that my intrusion on the flow of activities of participants/informants was very minimal.

Some of the owners and operators/administrators also expected me to contribute in kind to addressing the care needs of the residents whenever I was there. I therefore fed some of the residents, read the bible to them, run errands for some of them (getting them water, calling a caregiver for them, picking one item or another for them), supported others to move about, helped the assistants to set the dining table and serving of food, clearing of the dining table.

3.8.2 Participants/informants of the Study

Creswell (2003) states that the researcher has an obligation to respect the rights, needs, values and desires of the informants. The dictum to 'Respect your subjects' urges researchers to preserve their participants/informants human dignity even if they question the participants/informants perspectives on issues or their practices (Blumer, 1969; Resnik, 2011). One way of respecting research participants/informants is by establishing rapport with them. Establishing rapport will enhance the researcher's access to conduct subsequent interviews or observations.

After I had been given permission to start the fieldwork, the administrators/operators of each of the facilities introduced me to the staff and residents of the facilities informing them about the purpose of my visit to the place and the duration of my stay at the research sites. Thereafter, I had to start negotiating and forming my social relations at each of the facilities as I commenced my participant observations. The negotiation of the social relationships occurred on each of my visits as I came across new faces at the facilities until I developed a stable relationship with them, gained access, developed trust, obtained information and reduced hostile reactions to my presence at the facility (Neuman, 2008).

All the stakeholders (the owners and operators/administrators, participants/informants and their relatives) in this study were made aware that the research was for academic purposes

only and that their participation in it was absolutely voluntary. No facility or individual was coerced/forced to participate in this study.

As and when I had the opportunity to interview a resident of the facilities, I re-informed them about the overall purpose of the investigations and the main components of the research. I informed them about the nature, data collection methods, and extent of the research prior to commencement of the interviews. Further, I explained to them their typical roles in the face-to-face interaction. As part of the process, the researcher obtained their informed consent in writing with the help of a form developed for that purpose.

On each occasion, I read out and explained the possible risks (physical, psychological, and legal) and benefits they might incur from participating in the study and requested them to sign the written form after they had agreed to participate in the study. Efforts were made in ensuring that none of the elderly persons interviewed was stressed with too much talking by asking them at short intervals whether they would want to pause the interview and continue at another time. The researcher ensured that no participant was put in a situation where they might be harmed physical or psychological as a result of their participation in the study.

I also informed them about the need for me to use an audio recorder during the interviews for accuracy and the speeding up of the interview process and assured them that they had the right to grant me permission or otherwise. A few (3) of the residents of the facilities declined the use of the tape recorder so I conducted the interviews without their voices being taped. All the participants/informants were assured of privacy, anonymity and confidentiality. The researcher ensured that the confidentiality and anonymity of the participants/informants were maintained through the removal of any identifying characteristics before widespread dissemination of information. The researcher made it clear

to the parties involved that their details would not be used for any other purposes, nor will information be shared that would reveal their identity in anyway. I also sought permission from the owners and operators/administrators before taking pictures of the facilities.

3.9 Summary

In this chapter, I have presented the methodological choices I made regarding the study. I have highlighted some of the issues and principles of doing qualitative research focusing on how my subjective position is an integral part of the data collection, the research analysis and the dissemination of the research findings. My discussion of the experiences at the facilities by no means claims universality because it is grounded in a specific time-space context. The next chapter discusses the antecedents leading to the elderly persons requiring care and accessing care within the domiciliary context and losing it. It also looks at the decision making processes leading to the elderly accessing residential non-domiciliary care facilities.

CHAPTER FOUR

HOW IT ALL STARTED: THE JOURNEY TO THE RESIDENTIAL AGED CARE FACILITIES IN URBAN ACCRA

4.1 Introduction

As Ghanaians, the general perception evident in our beliefs, practices and adages is that children ought to look after their parents in old age as the elderly had done when the children were growing up (Domfe, & Aryeetey, 2016; Alidu, et al., 2016), the elderly persons accessing care at the residential aged care facilities and their kin represent an anomaly within the Ghanaian society. In this chapter, I am interested in the processes by which the elderly persons and their kin come to the decision to subvert the traditional norms regarding care for the aged, which are enshrined in the norms of reciprocity. The chapter begins with a look at the trajectories leading to the elderly persons accessing the residential aged care facilities in urban Accra. It further examines the decision-making processes leading to the elderly accessing the residential non-domiciliary aged care. It further looks at the family members' thoughts about the decision they have taken and their perceptions and attitudes towards reactions from relatives and friends about their elderly accessing eldercare from non-domiciliary facilities.

4.2 The Trajectories Leading to the Elderly Persons Accessing the Residential Aged Care Facilities

Demographers have found out that migration patterns follow the life course peaking mainly around ages 20 to 24 (when young people leave school, search for jobs and marry to start their own families) and between ages 60 to 70 (after people retire from active work) (Longino, 2004). According to Novak (2006), an increase in migration occurs again at the

end of life due to decline in health. In analysing the demographic patterns of migration over the past few decades, demographers have documented three distinct movement patterns and functions in old age. An important stream of research on the geographic mobility of older adults has revealed that it occurs in three distinct phases (Heisler, et al., 2004).

Research has shown that elderly people tend to move from their usual places of dwelling for three reasons in old age; retirement, moderate disability and major chronic disability (Longino, 2001 cited in Novak, 2006). The first phase of the movement occurs at retirement, the second phase occurs when minor disabilities arise and the third phase of the movement mostly follows the onset of major disabilities (Litwak & Longino, 1990, Longino, 2001, Heisler, et al., 2004).

According to Heisler, et al., (2004), the first move around the retirement transition is made by individuals between the ages of 60 and 70 years seeking lifestyle amenities, such as nice weather and opportunities to pursue hobbies such as boating and golfing. This is, however, not relevant to the Ghanaian situation. Longino (1992) calls the first type of movement at retirement among the aged 'amenity migration'. Amenity migration occurs when elderly people move to either enjoy a new life style, to be with friends who have moved, to establish a new identity as a retiree or to move back to a person's childhood home state (Heisler, et al., 2004; Novak, 2006).

The second type of movement in old age is known as 'kinship migration' or 'assistance moves'. This type of migration takes place after retirement and it is more often precipitated by health events, most commonly occurring when disabilities make living in one's usual dwelling place difficult. Frequently, retirees who had moved further away from their

children in their “amenity” move will return to live closer to their adult children as they begin to experience serious health problems, disability or widowhood (Heisler, et al., 2004; Novak, 2006). Elderly people who live in rural areas will move to more urban centres at this period in their lives so that they can access health care and support from their children and from social services (Heisler, et al., 2004; Novak, 2006). On the contrary, Apt (2001) argues that most of old persons in Ghana tend to remain where they have spent most of their adult lives as the ability of families to care for their elderly in the urban context is seriously impaired by limited financial resources.

Novak (2006) contends that the third move comes near the end of life. This move is known as a move in ‘preparation for ageing’. This move constitutes an elderly person moving from a community setting be it from their homes, a rented space or living with their children to an institution. The third move is typically made by those with intensive illnesses or those who do not have an available caregiver (Heisler, et al., 2004). This move mostly coincides with increased disability and the need for long-term institutional care (Novak, 2006, p.88). According to Heisler et al., (2004), the frequency of this third move is statistically underrepresented because they are commonly local and hence are not included in migration rates as migration rates do not reflect local mobility (Heisler, et al., 2004, p.7).

In comparing the three moves identified above with the findings of the study it can be argued that the majority of elderly persons at the residential aged care facilities had performed or made two out of the three moves. Some of those who had worked in the urban centres have made ‘amenity migration’ by returning to their roots or rural hometowns after their retirement and then subsequently made ‘preparation for ageing’ move by being sent to the aged home facility after hospitalisation on account of complications related to chronic

diseases they were suffering from. Others made ‘kinship migration’ or ‘assistance moves’ by going to live with their children and their families after hospitalisation. They then make ‘preparation for ageing’ movement after long-term care within the domiciliary context fails or not sustained. Another group of elderly persons made only one of the three moves in that they made the ‘preparation for ageing’ move by accessing the aged care facilities after they were unable to access adequate care or were abused within the domiciliary context. In all these instances, family members discussed the likelihood of the elderly persons being moved out of home to access care before the decision was taken. Some elderly persons agreed to the decision other elderly persons did not agree but were moved despite their disagreement.

Contrary to what pertains in literature, findings from the study show that some of the elderly persons are withdrawn from the facilities back home after they had made the ‘preparation for ageing’ move. Such a move is usually due to ill health requiring thorough medical investigation and care. Other reasons were dissatisfaction with care received at the facility, inability to sustain the payment of bills for the long-term care, as well as complaints and threats from members of the extended family directed at the offspring of the elderly person for non-domiciliary care for their parent. The findings from this study show that the processes leading to the elderly persons accessing the residential aged care facilities in Ghana and their stay there is diverse and in most cases not planned or thought through over a long period of time. Only one of the elderly persons at Eastwoods Home was psychologically prepared over a period spanning 2 years before accessing the facility.

Findings from this study show that the very first movement of the residents after retirement from active work were originally engineered or necessitated by two main reasons; the need

for a female elderly person to give care to the grandchildren and the need for an elderly person (both males and females) to seek care from kin. Those who initially moved to give care to their grandchildren were women who were largely healthy and well at the time of the movement, while those who moved to seek care from kin were both men and women who were unwell. In a typical Ghanaian society, the elderly women take care of the children (Tonah, 2009; Atobrah, 2016; Alidu, et al., 2016). Findings from this study show that customarily, the female parent intermittently moves to support the adult daughter and in some cases the daughter-in-law whenever they give birth to a child. Some of the elderly women stay on to care for the infant until the child starts going to school. With time, they move to stay with the child's family to care for the grandchildren in order to free their adult child to fulfil their career demands and goals. This is what Evelyn said:

I was in a bungalow with my daughter and her family before I came here. I was living with them and taking care of my grandchildren. Before I went to live with my daughter, I was in a rented house, a compound house and I was living with someone who was running my errands and taking care of my place.

Even though the care given to older people within society has been extensively documented, it can be argued that far from being the passive recipients of their adult children's bounty, reciprocal help is given by the elderly persons to their children. Some of the help given is in the form of home services, monetary assistance, assistance in time of illness and other crisis situations. Older parents often provide childcare services (Novak, 2006, 2015). Quadagno (1999) argues that the 'exchange of services between generations also varies over the life course', with a gradual shift from parents as givers to parents as receivers (Quadagno, 1999, p.199). For most of their lives, parents give substantially more help to their children than they do receive from them. Research has shown that over a lifetime, parents customarily tend to give more support to younger people than they receive and they provide support to their children throughout their later years (Novak, 2006, 2015). Elderly

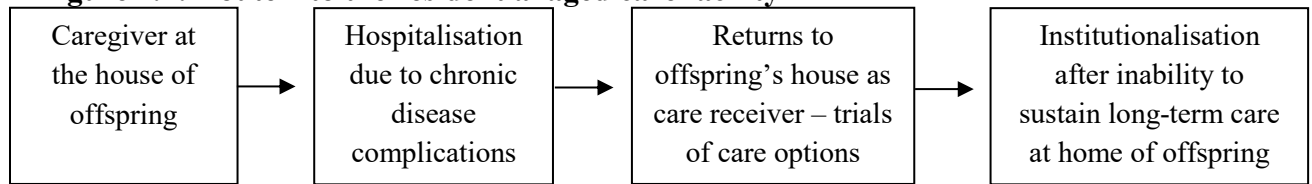
people commonly help their children with health care, daily chores and personal care. Some elderly people provide daily and lifelong care for children with disabilities (Novak, 2006, 2015). Studies have shown that younger families benefit from the care that grandparents give to grandchildren. Many elderly people look after their grandchildren while their middle-aged adult children work (Novak, 2006, p.364).

In an attempt to identify the antecedents to the aged persons making the ‘preparation for ageing’ move and how the aged persons ended up accessing care from the residential aged care facilities, two main routes to the residential aged care facilities were identified during the study.

4.2.1 Route 1 to the Residential Aged Care Facility

The cultural role of being a grandmother entails the female elderly ensuring the survival and wellbeing of their grandchildren (Badasu, 2004). As such, the elderly usually felt a sense of traditional responsibility and obligation to exhibit virtues of care and devotion to their families (Atobrah, 2016) and therefore supported their children in the care of their grandchildren as much as they can especially when they are on retirement. They showed resilience in providing care despite their weaknesses and care needs. As more and more young and middle-aged women obtain formal education and increasingly engage in rigid formal work, much of their care burden is shifted to elderly women because care work remains feminized (Atobrah, 2016).

Figure 4.1 depicts the route of the elderly persons who entered their children’s homes as caregivers and later on developed complications related to the chronic diseases they were suffering from.

Figure 4.1: Route 1 to the residential aged care facility

Source: Fieldwork, 2015 - 2016

In the first instance, the elderly person at the residential aged care facility had initially moved from their usual places of dwelling be it an extended family property, owned or rented house to a female child's house more often than not as a caregiver to their grandchildren. With time, the elderly person develops a health complication requiring medical care and therefore is sent to a hospital or a health centre. After the hospital stay, the elderly person is typically sent back to the female child's house for continued care until the care of the elderly person cannot be sustained at the daughter's home. The elderly are then sent to the residential aged care facility for care.

Six of the residents interviewed were living with the family of one of their children (mostly female child) prior to accessing the facility. Four of the elderly women had gone to their children's house as caregivers for their grandchildren and followed this route to the residential aged care facilities. The remaining two elderly persons had made 'kinship migration' or 'assistance moves' by going to live with them after hospitalisation.

Evelyn's case lends credence to the scenario above. Evelyn is an 80-year-old widow suffering from urinary incontinence, hypertension and mild stroke. She has five children. All of them were born while she was living and working in Accra. One of her children works abroad and the others work in Accra. On retirement, she lived in a rented space and had someone who was being paid to run her errands and take care of her. She moved in with her

daughter and her family to help take care of the grandchildren because of the daughter's busy schedule. She had a road traffic accident, broke her leg, and could not do anything for herself. She was admitted at the hospital. She was on admission for a long while. She moved in to stay with her daughter after her discharge from the hospital. Because of her daughter's busy schedule, a nurse was hired to take care of her at home. The outcome was not as desired because the daughter was not available to supervise the care being given to the mother. As a result, she was brought to the facility. The daughter she was staying with before the accident was the one who decided that she should be brought to the facility to get the needed care and attention. She has been at the facility for over two years. Before the accident, the daughter used to help assist her take care of herself but she was doing most of the things for herself. According to her, it was because she needed care that was why she was brought to the facility.

In comparing the first route with the moves identified in Longino (1987) and Heisler, et al's (2004) work, it can be argued that some of the residents who used this route made one major move, which was 'preparation for ageing', after having moved into the daughter's homes as caregivers for the grandchildren. Other elderly persons who were living with their children because of ill health made 'assistance move' and 'preparation for ageing' move.

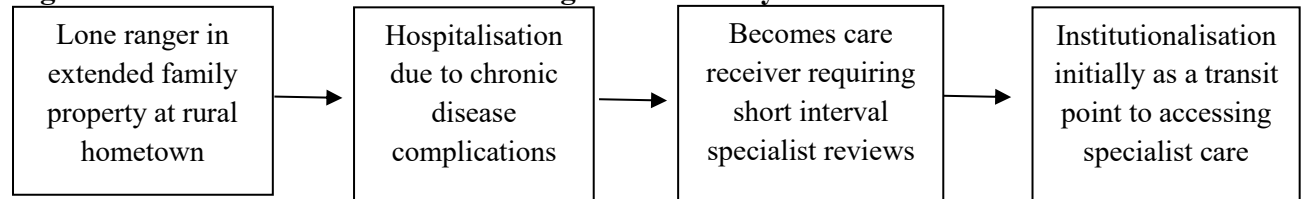
4.2.2 Route 2 to the Residential Aged Care Facility

Three groups of elderly persons followed route 2 to the residential aged care facilities. They were elderly persons who were living on their own and had developed complications associated with the chronic diseases they were suffering from and therefore required long-term care to perform activities of daily living.

4.2.2.1 Route 2.1 to the Residential Aged Care Facility

Figure 4.2. depicts the route of the elderly persons who were living on their own in extended family property at their rural hometown. These elderly persons had developed complications associated with the chronic diseases they were having over time and required long-term care.

Figure 4.2: Route 2.1 to the residential aged care facility



Source: Fieldwork, 2015 - 2016

In the second instance, some of the elderly persons were living alone in extended family property in their rural hometowns or outside the national capital prior to developing medical complications, which required extensive medical care in specialist healthcare facilities. A total of four of the participants/informants were in this situation.

Brief Transit at Offspring's House

Two (2) out of the four (4) were moved from their usual place of dwelling to the hospital first. They briefly transited at the female adult child's house before being sent to their usual place of dwelling in their rural hometowns. After recovery, the elderly persons were usually left with irreversible disabilities requiring long-term care. Arrangements were then made for relatives to care for the elderly person with the adult children paying the bills associated with the care.

Majority of the primary caregivers who had relied on extended family members in their rural hometowns to take care of their elderly persons prior to accessing the residential aged care facilities did not have pleasant stories to tell about the kind of care their aged persons received in the rural settings. The parties involved usually come to a consensus about the care arrangements. The children reported remitting the caregivers and providing all that is required for the treatment and care or upkeep of the elderly persons in the rural setting. When the care arrangements agreed upon by both parties are not followed and the elderly is neglected, tensions arise between the family members of the aged persons and the extended family over the elderly person's care. Some of the children therefore look for an alternative means of care for their aged persons and resort to the residential aged care facilities. Some of these elderly persons are brought in weak and disoriented because of the improper feeding or starvation, which has compromised their health and disease condition.

Some of the primary caregivers at the rural hometowns of the elderly go to the extent of justifying the kind of care given to the elderly by attaching spiritual interpretations to the behaviour of the elderly and their subsequent response, which leads to their lack of care for the elderly to achieve the performance of ADL. In narrating the story of one of the male residents at Westwoods Home, Ransford said:

She (the daughter of the resident) decided to bring the man from Lome to this place. When they were in Lome ...the extended family there used to lock the man indoors in a small cubicle which was not cemented, there was sand in there, they used to lock him in there, they used to starve him so the daughter questioned them about them starving the father and they told her that he is always calling for food around 12:00am and 2:00am and at odd times and they think he is eating with the gods at night at those odd times so instead of giving him food they would rather starve the gods, so that is why they were starving the man.

Edwina's case is a good example of the scenario painted above. Edwina was brought to the facility on 13th July 2013. She is an 82-year-old widow suffering from diabetes with both of

her legs amputated. Edwina has three surviving children who work in Accra and Kumasi. She lived and worked as a farmer in a rural community in the Eastern Region. In narrating her story she mentioned that the space in between her toes started itching so she scratched, then a strange sickness affected her leg. It started like *apɔɔɔ* (footrot), with time she took it to see the doctor. There was a scar on one of her legs so the *apɔɔɔ* (footrot) entered the scar and it spread. It became a sore. Her children took her to the hospital but the sore was not healing, so the doctor amputated one of her legs. Later on, the same sickness affected her other leg, which was also amputated. After amputation, the wound was not healing so she was sent to stay with a nurse in Tafo who finally succeeded in making the wounds heal. She was brought to the daughter's home after the wounds had healed to stay for a while and later went back to the village. She was alone in the village for about 6 months, but her children were not getting anyone to take good care of her in the village. Her family provided for the caregivers but because they were working elsewhere, they did not take good care of her. The eldest of her children, a daughter who works in Accra came to look for a place at the facility for her when she got to know that they accept people who need to be cared for. She has been there for three years.

In comparing the second route that Edwina's life represent with the three elderly moves after retirement (Longino, 1987; Heisler, et al., 2004), it can be argued that Edwina made two moves that is 'kinship migration' or 'assistance move' and 'preparation for ageing move' after care in the rural setting away from her children became difficult. She was, however, withdrawn from the residential aged care facility by her children at the beginning of this year after her three-year stay owing to constant quarrels with a relatively new female resident who was picking on her.

Transit at Residential Aged Care Facility Turns Permanent

For yet another group living alone in extended family property, their conditions were such that after the long hospital stay, they required short interval medical reviews at the hospital over a long period of time, which necessitated that the elderly persons be accommodated in the city. The case below is an example of how an elderly person started accessing the residential aged care facility as a transit point to accessing specialist medical care and ended up staying there for over two years. Thus, what began as a temporary measure became permanent in nature as it became convenient to the family members and gave them easy access to the elderly person reducing the journey they had to embark on anytime they had to visit him at the rural hometown. Such was the fate of Henry. He was brought to the facility on 19th June 2013. A 72-year-old divorcee, he was suffering from blindness, hypertension and mild stroke. Henry had lived and worked in the Greater Accra Region until retirement. He has six children, four of whom lived in Accra and the remaining two in other parts of the country. On retirement, he went back to his rural hometown to live in his father's house. After a while, he became sick; he had glaucoma, which affected his sight and then hypertension. At one point, he had complications of high blood pressure and things became bad so he called his eldest daughter, who sent a car to the rural hometown to bring him to Accra, specifically the SSNIT hospital. He was admitted for a while, when he was discharged, the eldest daughter who was in charge of all the arrangements sent him to the facility. He attended weekly reviews at the hospital for a while. Now, he awaits a scheduled review. In the meantime, at the facility, they are getting his high blood pressure under control.

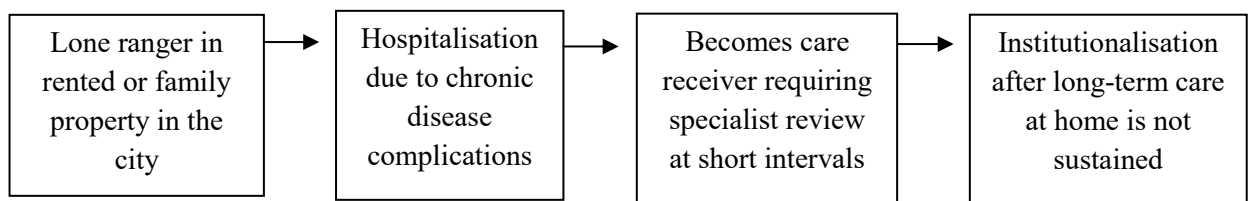
In comparing the second route that Henry's life represents with the three elderly moves after retirement (Longino, 1987; Heisler, et al., 2004), it can be argued that Henry made two

moves, ‘amenity migration’ by returning to his rural home town after retirement and then ‘preparation for ageing’ after hospitalisation over a long period of time.

4.2.2.2 Route 2.2 to the Residential Aged Care Facility

Figure 4.3 depicts the route of the elderly persons who were living on their own in rented property or extended family property in the cities. These elderly persons had developed complications associated with the chronic diseases they were having and required long-term care therefore moved to the daughter’s house to access care.

Figure 4. 3: Route 2.2 to the residential aged care facility



Source: Fieldwork, 2015 - 2016

In this instance, some elderly persons were moved by the children from their own dwelling places in the cities to the eldest and or available daughter’s family house in the bid to be cared for after they have developed chronic disease conditions without getting the needed care from extended family members. They usually stay in the daughter’s house for a year or more and are finally moved to the residential aged care facility by the children in order to access proper care. Three of the elderly persons interviewed followed this pathway to the residential aged care facility. Emmalyne is a good example of someone whose trajectory reflects this path. Emmalyne was brought to the facility on the 2nd of February 2014. A 70-year-old retired educationist. She suffered a stroke, which has slightly affected her speech and the left side of her body. Even though Emmalyne hails from the Akwapim ridge, she did not migrate to her rural hometown after retirement but chose to remain in the city where

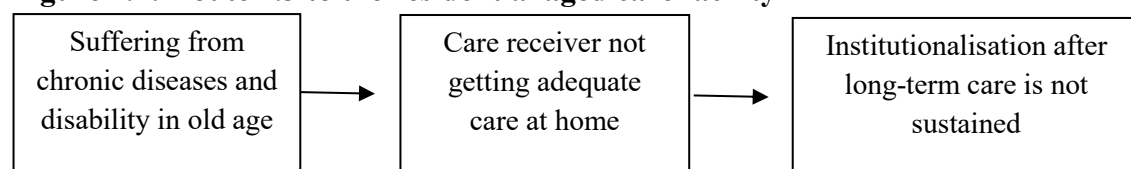
she has built a network of social relations and friends. Arrangements were therefore made for a househelp to live with her to run errands and to keep her company where necessary. She had the stroke not long after the demise of her spouse and was taken to the hospital. After the hospital stay, she moved in to stay with one of her daughters, but the daughter could not take care of her alone; her care required the support of her son-in-law. With time, the daughter's husband had to go on transfer so she was brought to the residential aged care facility. In the absence of her son-in-law, her daughter could not take care of her in emergency situations.

Elderly persons who accessed the third route to the facility made two moves after retirement. The first move was 'kinship migration' after their long stay at the hospital due to complications associated with the chronic diseases they were suffering from. They then made 'preparation for ageing' move after long-term care within the domiciliary at the daughter's house was not sustained.

4.2.2.3 Route 2.3 to the Residential Aged Care Facility

Figure 4.4 depicts the route of the elderly persons who were living on their own and were moved by their children to the residential aged care facilities owing to lack of proper care or abuse from caregivers.

Figure 4.4: Route 2.3 to the residential aged care facility



Source: Fieldwork, 2015 - 2016

In the fourth variation of the trajectory to a residential aged care facility, the elderly persons were moved from their usual places of dwelling to the aged care facilities after family members were unable to sustain the long-term care requirements of the chronic disease condition of the elderly person within their own homes. Three of the participants/informants went through this pathway and ended up at the facility. Two of the elderly persons (females) lacked intimate care and the third elderly person was being abused.

Elsie's story buttresses the point above. She was living in the city with three of her biological children in a house built for her by a child abroad before she was brought to the facility. She was in a locked room but not supported in the performance of intimate ADL. She was being provided with some amount of food. Even though the children and their offspring moved to the city to join her and take care of her, they failed.

She had been locked up in a room for about one year before she was brought to the facility. Her food was given to her by passing it under the door of the room she was in. Meanwhile, she has eleven children. The child who brought her here is in London. He got to know through a friend that the condition the mother was in was not good. He bought a ticket and came down without informing anyone about his visit and came to see the condition of the mother. He immediately brought the mother here and since then he has not permitted any of the siblings or family members to come and visit her here.

Elsie was brought into the facility dirty and had an offensive smell. Her personal grooming was poor because she had not had adequately intimate technical care. Below is an extraction of a case shared by Jemima, a residential aged care facility operator:

... They were not taking good care of the woman. Sometimes it takes long before they bath her, at times it takes a month or more before she gets a bath. Sometimes when someone is brought, the filth on the person eh? ... the state of the person, the pants they wear for example is so dirty and filthy and the aged person requires total shaving and cleaning at once, excuse me to say, sometimes the least said...the better, sometimes they say the elderly persons are witches so they will not ensure her personal hygiene, they will not do anything for them.

Similarly, Jacklyne, another residential aged care facility operator purported that she had encountered such situations. She narrated one of the instances with reference to a female resident I had interviewed earlier on in the process of data collection at her facility:

This woman that you are seeing like this (referring to Doris)... When they brought her it was something else, what was on her, excuse me to say the smell on her was something.., one of the girls ran to me and said eh, mummy, look the woman is smelling and we need Rexona Lime Fresh soap... I told her I don't like such things.... I told her that is not the solution to the problem and how can you describe a human being as smelling. She continued by saying that "but I even washed my hands with soap after helping her and it is even still smelling. I was very angry with her. I sent her to go and buy lime... and I took Mary to the bathroom. It was true, what she was saying was true but the way she was saying it was not right so I asked Mary whether she knows what the lime was used for. I told her when we do fatigue, we have scent on our body some sometimes when I do fatigue I put it on my armpit, everywhere, anytime I bath with it. We convinced her to not feel what the girl was trying to portray so I smeared the lime on her whole body and I bathed her nicely and changed her clothes nicely.

A few of the elderly persons have been brought to the aged care facility on account of being abused (physically and verbally) by the family members. The narration below is what Obed shared about the condition of one of the elderly persons who had several scars on the skin at the residential aged care facility:

When the man was brought he had bruises all over his body. When we asked the daughter she said they use to drag him on the floor. He does not like bathing. He can even beg you with everything. If you want to bath him, he will keep making certain demands – "please make it tomorrow and heat the water more. I do not want water on my body, I will fall sick if I bath". So when the daughter said that they used to drag him on the ground to give him a bath we understood because at times two men have to raise him and take him to the bathroom and he will be begging but when you pour the water on him then he keeps quiet because he begged you and you did not mind him so he keeps quiet. At times he himself will take the sponge from you and bath himself but if you want to start he will never go so we realised that might be the problem because if you do not have the heart, you will drag him if you are alone taking care of that old man who is very energetic, he is very strong so if you try he will resist and then the family will drag him to where ever they want to take him, even if you want to sweep the room and he doesn't allow it, so the person will drag him so that explains the bruises on the skin.

Esther is a good example of someone who was abused and followed this trajectory. Esther was brought to the facility in June 2016. She is a 93-year-old trader who is a widow and has lost all of her children except for one male. When she was brought to the facility, she was suffering from general bodily weakness and slurred speech. Prior to that, she lived in an extended family property in her rural hometown with a granddaughter who is a single parent to two children. She had a caregiver who cleaned her room, washed her clothes and prepared her meals. Her granddaughter, however, treated her poorly. She had taken to drinking and would verbally abuse all the elderly people in the house including her grandmother when drunk. She was also in the habit of abusing the grandmother economically. She would take money that belonged to her and would leave the upkeep of her children to her grandmother. She was also physically abusive to her children. On one occasion, in her bid to save her great grandchildren from their mother's physical abuse, she got her share of the beating. The surviving son got wind of it and therefore arranged for her to be brought to the facility so that she would be saved from the abuses being meted out to her.

In comparing the fourth route that Elsie and Esther's stories represent to the elderly moves after retirement discussed by Longino (1987) and Heisler, et al., (2004), it can be argued that Elsie and Esther made only one move that is 'preparation for ageing' after accessing care in their home setting became difficult as a result of poor treatment meted out to them by their family members.

4.3 The Decision Making Processes

In the literature, several factors have been identified to contribute to the relatives of an aged person selecting institutional care for the elderly person. These include; the age of the supporter (young people were less willing to go on caring), satisfaction with the help

received from relatives or extended family (those dissatisfied with the amount of help given by other relatives were more willing), whether the carer was in a paid employment (with those employed full time most likely to favour institutional care jobs) and whether or not the carer had another dependent to look after (as one would expect those with more than one dependents were more likely to advocate institutional care) (Askham, 1989). This study is no different.

The decision making process is usually triggered by factors which increasingly become glaring and daunting to the primary caregiver. The four major triggers that led to the initiation of the decision making process in this study were; the increasingly demanding work schedule of the primary caregiver, the poor physical and psychological health of the primary caregiver, the lack of having a caregiver or hired hand who is reliable and dependable to address the care needs of the elderly, and the elderly person increasingly requiring care and support in the performance of ADL due to the deteriorating condition.

More often than not, the decision to send an elderly person to a residential aged care facility is commonly taken after three different options of domiciliary care (i.e. care by kin, by untrained hired hands and by trained hired hands) have been accessed and the attempts at providing domiciliary care for the aged person over a long period of time has failed. Studies have shown that giving long-term care to a physically disabled or a cognitively impaired older person leads to a caregiver burden (Novak, 2006, 2015). Owing to longer life expectancy now, increasing number of elderly people suffer debilitating illnesses and survive as frail elderly with greater need for support in the performance of ADL for more years, thus, placing an increasing demand on more family caregivers (Novak, 2006; Oppong, et al., 2009). Even though those family members who provide care to the elderly

have been shown to do it willingly and lovingly, there are limits to willingness and some constraints which make it harder to provide care, however, willing people may be (Askham, 1989).

Research has shown that the willingness to continue caring for a dependent relative within the domiciliary setting is influenced by dynamics such as the nature and symptoms of the illness or the disability, the nature of the relationship with kin before frailty or illness began, the age of the primary caregiver, primary caregiver's contact with friends, satisfaction with the help received from relatives or extended family, whether the caregiver was in a paid employment or not and whether the caregiver had another dependent to look after (Askham, 1989). Thus, the need for an elderly person to access a nursing home facility for care can often be anticipated by the family members or close relatives some months before they actually enter into the residential aged care facility, as the progressive limitations in behaviour and function of the elderly person associated with the chronic diseases or age becomes irreversible (Barrow, 1986). In the high-income regions of the world, family members of the elderly person usually have sufficient time to prepare themselves and the elderly person by making a thoughtful and careful selection of the homes and easing the transition from one living arrangement to the other (Barrow, 1986). This is because there is the accepted culture care of social care and homes for the elderly.

Findings from this study show however, that this is not the case in Ghana where the residential aged care facilities are very few (2) and the awareness of them is very low. Even though the caregivers might begin to get tired of directly caring for the aged person, the first line of action is to try different forms of domiciliary care; that is home care by kin, home care by untrained hired hands and home care by trained hired hands. Accessing non-

domiciliary care is neither the norm nor the first line of action. People therefore do not process that as an option until they chance upon the availability of such services through their associations with others who might have heard of one, knows someone who has used one or used one themselves.

In a few (2) of the cases however, the decision to send an elderly person to a residential aged care facility is taken at the hospital. The decision is taken when the family members of the elderly person take into consideration the health condition of the elderly, the amount of care required for him/her to achieve ADL, his/her usual living arrangements, proximity of the living arrangements to the location of family members and the infrastructure of the available accommodation of family members as well as the preferences of the elderly. Clara's mother's case gives credence to the points mentioned above. Karen was a trader selling cloth and materials at Makola in Accra until it became necessary for her to relocate to Swedru (Central Region) to take care of her ailing mother. She left her business and joined her mother until the mother went on pension and later passed away. Being the eldest child, she decided to stay at her mother's place with the relatives at Swedru to build a shop and do business by selling provisions. With time, she decided not to come back to Accra because she had been divorced from the husband. She did not marry again but the husband did. She started suffering from Diabetes and it was not diagnosed early. It was realized after she had seriously fallen sick and been admitted at Korle-bu when she was 70 years old. When she recovered, she went back to Swedru and later on, she fell down and hurt one of her toes, which later became worse because she kept it to herself thinking that it will heal. She felt she would be worrying the children by telling them. On one of her reviews at Korle-bu, they examined it and realized it had gone bad and was moving up her leg. Within a short while, they had to amputate her leg. The reason why she was sent to the aged care facility was that, the surgery was done on a Friday at Korle-bu and by the next Tuesday she had been

discharged and the family did not know how to handle the whole situation. The daughter who could have taken care of her in Accra to recuperate lives with the father and step mother. Clara intimated that;

Well, my mother was told to come and live with me but I am living with my father and stepmother and she thinks that she cannot come and live in the same living space with my father and his wife.... Recently we went to take her to my father's place but she said no and that we should rather take her to Swedru where she was living because she would be more comfortable there. She feels that she would be living with her rival in my father's house and she does not want that even though she will be with me and I will be the one taking care of her, she says no. One of my aunties wanted her to come and live with her because whenever she comes to Accra, that is where she stays, she was sick for about a year and was accessing health care in Accra, all that while she was living with my auntie but my auntie lives in a storey building, using a wheelchair there will be difficult.

In the other instance, the elderly person was sent to the facility directly from the hospital because she was living alone prior to the hospitalisation. She is a single mother who was living abroad with one of her two daughters until 2001 when she moved to Ghana to do ministerial work at the Accra temple of her church. The other daughter who does not have any close relationship with the mother lives and works in a rural setting in Ghana. The elderly person had built stronger ties with the members of her church and was therefore closer to them. As such, the church leadership was the first to be informed about her ill health and subsequent hospitalisation. The church leadership then informed her relatives (sister who is in Accra and her daughters) about her condition. The daughter abroad whom she was close to came down while the mother was in the hospital and they collectively decided to send her to the residential aged care facility. In recounting the events preceding the access, Jason, the filial kin (pastor) of the elderly mentioned;

I was in Tamale and she called to say that she is not feeling too well but because I was not in Accra I could not immediately go and see her. All I could do was to tell her that she will be fine so she did understand. Finally, when I got to her place she had become severely sick and my understanding of things is that she had emphatic stroke so we took her to the clinic near our house. The doctor referred her to Korle-

Bu. At Korle-bu, she was attended to and after keeping her there for a while they thought that she should go home but the house was not prepared for her and considering that, she was living alone and that moment everybody we were talking to was looking at a full time nurse coming to stay with her and the charges associated with it. We asked for an extension of time at the hospital and they gave us two more weeks and after the two (2) weeks we did not have a place so we took her to the hospital where she was initially taken to and she nearly died there. We brought her back to Korle-bu and we were searching on the internet... then her sister found this place.... so we finally came here when she was discharged from the Korle-Bu we drove her straight to this place.

There are three players or actors in the decision-making processes regarding an elderly person accessing non-domiciliary care. They are the initiators, the influencers, and the rejecters.

4.3.1 The Initiators and the Role they Play in the Decision Making Process

The initiator is usually the child or family member who is living with the elderly person (like the eldest or the available daughter) or the one who is responsible for taking decisions about the care of the elderly person (like the first-born child or the eldest female child). Findings from this study show that in the majority of the cases, the decision making process regarding the elderly person accessing residential aged care facilities is started by the child or family member who is living with the elderly person or who is responsible for taking decisions about the care arrangements of the elderly person. As primary caregivers, they discuss the failed or not sustained long-term domiciliary care for the elderly with the influencers and ask for suggestions. Through conversations, the initiators get to know about the existence of facilities for the aged from influencers who had either heard about them (through word of mouth, advertisements on the radio) or accessed them.

Some of the initiators also search on the internet or listen to advertisements on electronic media for information on aged care in Ghana. When they come across the web pages of the

facilities, they contact the facilities to make enquires before communicating with their siblings on the subject. Jacklyne, one of the facilities operators' recounts:

I was there, then somebody called me from Holland that her mother needed care and that she was looking for a place for her mother and that she was on the internet and saw us and wanted to bring her, I said okay if she could get a family member to bring the person here because she wanted me to go for her but you know as for family issues and eh there might be some issues behind it, I cannot just go in there and say that I have surfaced to come and take somebody so if she can involve some family members, so she talked to her brother to do so. So they brought the woman here and she also had dementia, yes, Alzheimer's dementia, As soon as she got here that day, the woman called.

After equipping themselves with the requisite information, those initiators who can, first pay a courtesy call at the facilities to acquaint themselves with what the facility operators have to offer as well as their charges before raising the issue for discussion with their siblings. In some cases, the challenges associated with the care of the elderly person might have been discussed a couple of times prior to this. More often than not, the Ghanaian traditional beliefs regarding care of the elderly and the norms of reciprocity leads to primary caregivers delaying the decision to remove an elderly person from the extended family to an institution until all options of domiciliary care have been exhausted. The primary caregiver, her/his siblings and close relations come to a consensus giving their moral support to the decision to move the elderly person to the residential aged care facility before the step is taken. Claudia, a daughter of one of the residents recounts her decision-making process in this manner:

I thought through it, I discussed it with very close people,... I spoke to friends, relatives, church members and all of them knew what I was going through because I did not have any social life and there were instances where I did not go out for training, I mean work related training and I needed to let it go because of caring for him...we all agreed that it was the best decision to take so I did not just bundle him and take him to the residential facility, I worked on him for close to 2 years because I knew that this sort of thing is alien to us. It is not something that we would do, it is not traditional or cultural you see.

Catherine, a daughter of one of the residents likewise said:

When the caregiver left, we looked for someone to no avail, so I had a chat with a friend that I needed help with the care of my ageing mother and the person said, ah this whole issue of help with its accompanying problems, why don't I take her to a new place/home ... that she has heard about so that I can get my peace of mind, also all the help she needs she can get it there, so I should take her, so I went to ask and then I sent her.

Findings from this study show that as the elderly persons begin to require long-term care, they gradually lose control and power over their performance of activities of daily living and care arrangements that ensures the performance of such activities. As the elderly persons go through this phase of their lives, the primary caregivers control and power over the caregiving arrangements of the elderly gradually increases. Weber (1922) defines power as the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests (Hurst, 2007, p.152). Power can take a variety of forms. A person's power can be shown in the social order through their status, in the economic order through their class, and in the political order through their party. Thus, class, status and party are each aspects of the distribution of power within a community (Hurst, 2007, p. 152).

The study findings show that with the exception of a few of the elderly persons who were being sustained at the residential aged care facilities from either their monthly pensions or proceeds from the rental of their properties, the rest of the elderly persons were being sustained from the resources of their nuclear family members i.e. the primary caregivers and their siblings. According to Weber (1922), the ability to possess power derives from the individual's ability to control various "social resources". In this regard, the primary caregivers possess power over the care arrangements of the elderly persons because they control the various social resources needed to ensure that the elderly person achieves the

activities of daily living. Lemert (2004) was of the view that the mode of distribution gives to the propertied a monopoly on the possibility of transferring property from the sphere of use as 'wealth' to the sphere of 'capital,' that is, it gives them the entrepreneurial function and all chances to share directly or indirectly in returns on capital (Lemert, 2004. P. 116). These resources Lemert (2004) talks about can be anything and everything: they might include land, capital, social respect, physical strength, and intellectual knowledge.

In the case of primary caregivers and the care arrangements of the elderly, reference can be made to the caregivers' ability to convince the elderly persons to make kinship assistance move (Litwak & Longino, 1987; Heisler, et al., 2004) from their usual places of dwelling to caregivers' residence. This move is necessitated by the primary caregivers' sense of responsibility towards their elderly persons and the physical strength to support the elderly in that regard. Additionally, the kin/primary caregivers' ability to foot the elderly person's medical bills and pay for care provided by persons other than themselves.

The primary caregivers begin to exercise their power over the elderly persons long-term care arrangements when they begin to experience caregivers burden and start discussing their challenges with friends and acquaintances. In doing so, they discover alternative means of ensuring that the elderly persons perform activities of daily living without the primary caregivers being directly involved. Studies have shown that the ability of a primary caregiver to exercise power takes a number of different forms, but all involve the idea that it means the ability of the primary caregiver to get their own way with the elderly persons, regardless of the ability of the elderly person to resist them (Hurst, 2007).

The nucleation of the family as a result of factors of social change minimizes the role, power and influence of the extended family in the decision making processes relating to eldercare. As such, the adult biological children of the elderly assume the major role of discussing the utilization of residential aged care facilities when they begin to have challenges with sustaining long-term domiciliary care for the elderly. Additionally, factors of social change contributes to the desensitization of primary caregivers towards fulfilling the traditional norms of reciprocity, which has been at the core of eldercare in Ghana.

4.3.2 The Influencers and the Role they Play in the Decision Making Process

Three groups of people usually influence the decision making process either positively or negatively. The first group of people who usually influence the decision making process are friends and acquaintances at the work places and churches with whom the primary caregiver has been discussing their problems in relation to eldercare. They usually point the primary caregivers in the direction of accessing residential aged care facilities mostly because they are aware of the availability of such facilities and might have accessed them or know people who have accessed them in the past. Research has shown that primary caregivers contact with friends influences their willingness to continue domiciliary care for an elderly person. Primary caregivers with more contacts were less willing to continue long-term care within the domiciliary context as they were usually provided with options of caring for the elderly person through interactions with their contacts (Askham, 1989). In a few of the cases, the close friends of the elderly persons have also played a role in approving of the intended decisions the family members want to take. In narrating the steps, they took in the decision making process, Jeremy a filial kin/son in-law brings to the fore how classmates and friends influenced the process:

When the decision making became critical we called the closest friend, the lady who came here to visit her earlier on and we told her ‘look, this is what we want to do for

grandma because she has been your friend all this while, tell us what you think, give us some advice and let's see how it goes....She told me, Jeremy just go ahead and do it, just get her children involved. We just did not come and dump her here. When we came to Ghana to be honest with you, she was so fearful and we were afraid when I saw her. When I came in to the country and from sources, it is either the people were beating her at home or they were shouting at her. You could not have wheeled her without her wanting to grab hold of anything she can lay her hands on.

The second group of people who usually influence the decision making process are the siblings of the primary caregiver and their spouses (in a few cases) who are normally not in a position to take up the responsibility of being the care providers or delivering hands-on care to the aged persons and therefore encourage the primary caregiver to find whatever solution they can get.

More often than not, the decision making process is made easier when some of the children of the elderly person are already aware of the concept of aged homes as a result of them living abroad or having travelled abroad. Such individuals tend to influence the siblings positively towards accessing the residential aged care facilities by emphasizing the selling points of aged homes and the fact that it is the best option among the options available. The following is what transpired in Catherine's decision-making process:

We did not get anyone to take care of her. I was asking everyone everywhere...so I went to ask someone and the person said there is a home at a place, one of my friend's mother is there...So I told my sister who is outside the country about it, then she said thank God if the home business has gotten to Ghana then it's a good thing, she said I should check and get back to her on that so that we can take her there because the home care facility is the best in this instance. That is what my sister said. She said the home is the best, as for my brother, the whole thing was worrying him a bit because we did not know what to expect, so even when someone is complaining about it he would say that the people are villagers they are ignorant, they do not know anything and yet they will not keep quiet, They do not know about the home system they think the person has been neglected but that is not it, people will even talk at length about it but my sister said, we should not listen to anybody but go ahead with the decision to take her to the facility. She said we should do what we think will suit us and will favour us because if I were to be well, I should have taken care of our mother but I have no strength, you see.

The third group of influencers in the decision making process were the extended family members, especially the siblings of the elderly. Typically, the extended family members of the elderly person are not consulted or involved in the decision making process or made aware of this decision once it is made. Catherine, (a daughter of one of the residents) commented:

Yes, she (mother) has two siblings who are alive but they themselves do not visit her often so that is the problem, they do not even know what is happening, if they were to be visiting her then they would know. It was yesterday that I got to know that they said one of her sisters has heard of it that she is in a home and the sister's daughter called to check on her so she (my mother) told her niece that she has been taken to a home by her children so the sister called to ask why we have taken her to the home and she also called her siblings to tell her that their sister has been taken to a home.

Only three of the elderly persons were brought to the facility with the knowledge and support of their relatives. In two out of the three cases, the search for the residential aged care facilities was partly conducted by the elderly person's younger sister who was not in a position to support the elderly because of her own challenges. The younger sisters of the elderly were the ones that discovered the residential aged care facilities and encouraged the elderly person's children to send them there. Jason, the filial kin of one of these women reported,

It was her sister who lives on the Spintex road who influenced it,...she kept asking people in the vicinity and they directed her here, she came and inspected the place and she liked it so that was it.

Similarly, Clara recounts

My siblings abroad and my auntie decided to send her to the facility so that she could be closely monitored and given the best care possible. Well I searched on the internet for aged care places and I informed my auntie about it. So my auntie took the initiative and went there to make the necessary research before a decision was taken.

4.3.3 The Rejecters of the Intended Decisions to be Taken

The study findings show that even though the family members of the elderly justified their act of sending their elderly persons to residential aged care facilities to access care in the performance of ADL, majority of them (4 out of 6) faced opposition from extended family members and friends and subsequently found ways of dealing with them.

Even though the primary caregivers necessarily have to inform their family members, especially their siblings and come to a consensus regarding the decision making process, because of the proverbial Akan saying “*tikoro enkɔ egyina*” (meaning two heads are better than one), extended family members who are usually living outside of Accra more often than not are not made aware or involved in the decision making process. Findings from this study show that some of the extended family members in the rural settings are willing to support their aged relatives to age gracefully but at a cost. They will therefore not agree to the new concept of the elderly accessing care from aged homes in the performance of ADL, if they were made aware of the health condition of the aged person in the city.

Some of the family members complained of the extended family members amassing wealth through them as a result of them caring for their elderly person. Others actually maligned their extended family members and equated their attitude towards caring for the aged and their services to that of the home care agencies offering domiciliary care. Reasons for making such accusations were the numerous financial demands the extended family caregivers make all in the name of providing the elderly persons with needed resources, which do not translate into the care of the elderly person. In some cases, when the children withdraw the elderly persons from the rural setting to the residential aged care facilities for quality or adequate care, the extended family members usually react negatively by complaining about the behaviour of the children of the elderly. Some of them even go to the

extent of threatening the children should the elderly person pass on at the residential aged care facility. The extended family members were purported to have reacted that way because the withdrawal of the elderly person meant they would not receive the financial contributions they otherwise would have received.

Apart from the extended family members that some of the primary caregivers have to contend with on the issue of the elderly person accessing non-domiciliary care, close friends of the elderly persons could also oppose the idea and confront the primary caregivers on the decisions they have taken. In a few of the cases, close friends of the elderly persons who had been informed about the movement of the elderly person to the residential aged care facilities owing to deteriorating health despite domiciliary care opposed it. They were displeased and complained about the decision until they had each been taken to the residential aged care facility to visit their friend. From observations, these friends of the elderly person changed their negative attitude towards the primary caregivers and commended them because the condition of their friend had changed for the better. Jeremy, a filial kin recounts:

... When you tell people that there is a home like this in Ghana they do not want to believe it. That is her classmate visiting her. When we told the classmates and friends that we were taking grandma to a nursing home in Ghana, they said ah, is there a nursing home in Ghana and we said yes... Some few friends of hers when they got to know about we and especially me spearheading her coming here they were not too happy about it and they thought we were trying to abandon her... So I came here with them one after the other, there are three of them who attended Wesley Girls with her, I brought them on three different occasions to come and look at the place and the lady who is operating the facility happened to be around so she took them around [and] they were all really impressed.

Not all family members deplored the decision to send a family member to a residential aged care facility. Depending on the strength of the family ties, relatives of the elderly person especially their siblings who are close to them and are living in Accra are more often than

not informed of the elderly person's condition and are supportive of the decision. In three of the cases, the sisters of the elderly persons played a crucial role in the identification of the facilities as well as the initial contacting and evaluation of the residential aged care facilities. Knowing the challenging conditions of eldercare in the city and the busy lifestyle of their nieces and nephews as well as their inability to offer any assistance owing to their own challenges associated with ageing, these siblings of the elderly persons supported the idea of them being sent to the residential aged care facilities to access care. Jason, a filial kin, describes the role the elderly person's sister played in her accessing the residential aged care facility as follows:

Because the care at the clinic was bad, ...she deteriorated and we returned her to Korle – Bu, when she came back around luckily the sister had found this place and so she was brought here...her sister lives on the Spintex road so she kept asking people in the vicinity and they directed her here. She came and inspected the place and she liked it so that was it. Infact, I drove her here with the daughter but like I said the place was identified by the sister and then she verified and approved it...We were searching on the internet but it was something that you could not easily find on the internet...The sister did a good job by finding this place.

A second group of supporters are those extended family members who get tired of caring for the elderly person without seeing any improvement in their health condition and are happy to relinquish their support of the elderly person to others, residential aged care facility or not. Claudia notes:

Em, when he came down with the full stroke, the extended family members said they were going to take him down to Kumasi and try some herbal approach for him so reluctantly I agreed. They came for him and kept him for close to nine months and then I think that they felt that caring for him was too much for them so I had even travelled at that time and they were calling me morning, noon and night to come for him. So I told them that I am not in Ghana and that immediately I come back I will come and get him so they should hold on with him while I am away...So immediately I got to the country I called them and I think I came on Wednesday and by Saturday they had sent him back to me.

Usually, the children reacted in two ways to the threats of the extended family members. They either succumbed to the pressure and threats of the extended family members or stood their ground. Three groups of family members and relatives are likely to succumb to the pressures of the extended family members. The first group are those whose financial basis for supporting the elderly person at the residential aged care facility are weak and therefore need the siblings or other influential family members to contribute to the payment of the bills. The second group are those who are afraid of being left alone to bury the elderly parent without the support of the extended family. The third group are those who are afraid of their own safety or the safety of other family members as a result of incurring the wrath of the extended family members and the spiritual implications of this wrath.

Those who do not succumb to the pressure and threats of the extended family usually defend their stance and keep the elderly persons at the residential aged care facility regardless of what the extended family members would say or do. Two groups of family members fall into this category. The first group are usually the ones who are financially stable and the breadwinners of the family who are prepared to bear the cost of keeping the elderly person at the facility. The second group are those who are not afraid of the comments from the extended family members and are even prepared to go to the extent of proving to them that the elderly person is getting better care than what they had offered him/her at home. Jemima, one of the officials at Eastwoods Home provides a perfect description of a member of the second group in this manner:

Sometime ago someone who was outside the country made her friend bring her mother to this place. The mother stayed here for almost three years. When the friend brought her mother, the extended family members complained bitterly about it, so she came to Ghana about two years ago...she hired two buses, loaded it with the extended family members and brought them here. She was a no nonsense person; she was just angry with the extended family's behaviour. When they came, we thought they were some church people who had come to visit the aged. They came in a convoy, ... she is a very difficult person and wanted to prove a point. When they got here, we also took

our time to take them around for them to see the facility and what it had to offer. The person who had been receiving the money from abroad for the upkeep of the mother got some money for himself from the family, so by bringing her here that source of income for that guy was halted so he would not agree to that. He instigated the whole extended family against the lady...Meanwhile they were also not taking good care of the woman, ...some of them were saying that as for this one it is a hotel oh, she has been brought to a hotel, we did not know, that is why we were complaining...They looked surprised, the young man who was the cause of all the troubles could not even speak again [anymore]. They had a lengthy interaction with their relative before leaving, they were very impressed.

4.3.4 The Implementation of the Decisions Taken

The decision for an elderly person to access the residential aged care facility is usually taken by the biological children of the elderly person usually as a group in collaboration with the spouse (where applicable) after thorough discussions amongst themselves. Only one of the elderly persons was said to have been taken to the facility based on the sole decision of a child who lived abroad after having quarrelled with the siblings who were supposed to be taking care of the elderly person. He accused his siblings of neglecting the care needs of their mother.

In situations where a consensus is not reached on the matter because of the needed financial commitment or entrenched beliefs about norms of caring for the aged, the idea is pursued by the few who see the need to do so. In instances where the children disagree on the matter, the decision is more often than not taken by the child who is living with the elderly person and bearing the brunt of the care (typically the eldest female child or the daughter who is available in the country) or the child who is prepared to foot the bills associated with accessing the facility. The following narrative was given by Newman the spouse of Jemima who is a joint operator of the residential aged care facility:

Before the person will bring the elderly one here, he has to discuss with the other siblings. They have to sit down and come to an agreement before they decide that they should bring him, that is what sometimes is a problem. For some of them when they

hear the adverts they come and make enquiries and what they end up saying is that they will have to go and discuss with the others, but the person who feels he is responsible for the elderly person and has his own money to foot the bill just takes the decision and brings the person after coming to look at the place and make enquiries.

More often than not, the initiator, his/her siblings (and their spouses) as well as the siblings of the elderly persons (in a few cases) implement the decisions that have been taken regarding the elderly accessing domiciliary care. This is done after they have agreed on the modalities for the payment of the bills. All of them accompany the elderly to the facility on the day the elderly is moved to the residential aged care facility.

4.4 Making Sense of the use of Residential Facilities for Aged Care

The practice of family members sending their aged people to residential aged care facilities for care is a new phenomenon to many Ghanaians. It is therefore important to identify how these family members justify their behaviour. In sharing their thoughts about the decision they have taken for their elderly persons to access care from the residential aged care facilities, all the family members and relatives shared the view that they felt the elderly persons needed special attention because of the complications that had arisen as a result of their medical condition. This special attention could easily be provided at the residential aged care facilities because they had been purposefully set up to provide such services. Apart from the technical or physical care, the facilities also provided medical care based on economies of scale and since their elderly persons needed such services at short intervals, accessing the facilities was the way to go to reduce challenges associated with domiciliary care. Some of them were of the view that recruiting nurses and physiotherapists to provide the needed care within the domiciliary context in addition to other support services they might require was going to cost them a lot more than accessing these services from the common pool of the residential aged care facilities. Jason remarked as follows:

What they do here is not just for the aged, say if you have a young man sick, ...you know that cardio vascular illnesses are on the rise and people can recover from some of them with the needed care, if you do not have a facility like this to help people with such problems, you will have a situation where the whole thing is done from the home which is very expensive. I know a senior nursing sister from Korle-Bu who had a stroke and this is a nurse and because her children and her family helped her to hire two nurses who work on her for 24 hours she got better but just you look at it you pay these 2 nurses, you administer medication all that and you look at the cost and you come, here and you look at the cost, you reckon they are using economies of scale to care for the people who need it if will help everybody.

Some of the family members and relatives clearly stated that they did not have the know-how required to handle the situation they found their elderly persons in which is why they made that decision. Such families after sending the elderly to the facility subsequently make the necessary arrangements for the elderly to return home when the critical stage of their health complications has abated. Elderly persons who were suffering from diabetes and have had a limb amputated for example needed a nurse to care for the wound to ensure that it heals completely because any infection as a result of improper care of the wound could aggravate the situation. Such elderly persons also require the daily testing of the blood sugar levels and diet control by eating in small portions at certain times of the day to prolong the life of the elderly person. Clara, a daughter of a female amputee who was operated upon in Accra but lived alone in an extended family property in the rural hometown, recounts that:

Korle-bu did the surgery on Friday and by Tuesday they said they had discharged her, we saw the amputation as a major surgery, we the relatives too we did not know how to handle it all so one of my brothers who is abroad and my auntie, a retired nurse decided that we could get a special place to take her so that they take care of her...She wanted to go back to Swedru but we cannot assure ourselves that she will get the needed care with the wound.

From the above case, keeping the elderly persons who were initially in the rural hometown at the residential aged care facility afforded the family members who are in Accra the opportunity to be closer to the elderly person and visit her periodically. It also provided

them the opportunity to somewhat supervise the type of care being accessed toward her recuperation.

The family members and relatives of the elderly persons accessing the facilities acknowledge that caregiving is a major responsibility that is time consuming and stressful. Care provision is often burdensome thus, choosing to be an informal caregiver or to source for care from formal service providers always involves trade-offs for the family members and relatives because they have other obligations within their own households and they face higher opportunity costs. This is similar to Bauer and Sousa-Poza (2015) findings on the burdensomeness of caregiving on the primary caregiver and the trade-offs associated with sourcing for care from non-kin.

In conclusion, the trial and failure of the elderly accessing long-term domiciliary care from kin and kindred owing to caregiver's burden and challenges associated with accessing domiciliary care lead to the search for alternative means of addressing the care needs of the elderly outside the domiciliary context and the associated decision making processes. The outcome is the identification and selection of residential non-domiciliary care facilities as the alternative means of care that will enable the elderly achieve the performance of ADL long-term and additionally enable the primary caregivers gain control of their lives.

4.5 Summary

In this chapter, I have presented the decision making processes leading to the elderly accessing residential non-domiciliary care, the trajectories leading to the elderly persons and their family members accessing residential non-domiciliary care. Additionally, I have also discussed how the family members of the elderly made sense of the whole process of accessing residential aged care facilities to address the care needs of the aged. The next

chapter discusses the residential non-domiciliary aged care facilities identified, the kinds of services these facilities provided to the elderly as well as the perceptions of the elderly regarding the types of care accessed from these facilities.

CHAPTER FIVE

REQUIRING ELDERCARE OUT OF HOME IN URBAN ACCRA: A DAY IN A RESIDENTIAL AGED CARE FACILITY

5.1 Introduction

In this chapter, I discuss the nature of residential aged care facilities available in the urban parts of the Greater Accra Region to address the care needs of the elderly, aside the traditional forms of care which is situated within the extended family system and outlined by researchers (Apt, 1996; van der Geest, 2002b). I also examine the different kinds of care activities offered by the residential aged care facilities to the elderly who access them as well as the elderly persons' perceptions of the care received at the facilities. This is followed by a look at a typical day at the residential aged care facilities.

5.2 Residential Aged Care Facilities or Nursing Homes

Formal institutions for eldercare are a relatively new phenomenon in Ghana. Until 2007, Ghana did not have public or private institutions for the care of elderly people (van der Geest, 2002; Tonah, 2009). Van der Geest (2002b) noted in his work among the people of Kwahu that, not a single residential institution for eldercare existed in the country at the time of his study. The only facilities that were available in Accra and perhaps a few other places were day care centres where elderly people could meet each other, pass the time with games and other activities and eat a good meal. By 2007, a long-term eldercare facility had been created in Koforidua in the Eastern Region and was being run by the Department of Social Welfare. Agbenyiga and Huang (2012) in assessing the nature of residential non-domiciliary care provided for aged persons in Ghana noted that governmental social services have failed to recognise and address the eldercare issues appropriately. Results from their study show that government social welfare workers were not trained to serve the ageing

population; they were not well informed about ageing and the needs of elderly people and were therefore not providing ageing services (Agbényiga & Huang, 2012). Unsurprisingly, loneliness, malnutrition and a lack of appropriate eldercare resources were key themes that repeatedly emerged from their participatory observations at the facility. The majority of the elderly in the residential non-domiciliary facilities reported no experience or contact with social work professionals. Between 2007 when the first eldercare facility was established and 2016 when this study was undertaken, a number of privately owned non-domiciliary care facilities for the aged had been established in Accra and its environs. These were two residential aged care facilities and a number of recreational centres.

Residential Non-domiciliary eldercare relates to all the types of care that are provided to the elderly outside their usual dwelling places. Residential aged care facilities or institutions are popularly known as nursing homes, convalescent homes, skilled nursing facilities, care homes, rest homes or intermediate care in the high-income regions of the world. In Ghana, nursing homes, are privately operated residential aged care facilities that provide live-in care services. Some of the residents need medical care in addition to personal care. Nursing aides and skilled nurses are usually available 24 hours a day. Residents usually include the elderly and younger adults with physical or mental disabilities.

In his work on ‘total institutions’ Goffman (1961) defines the concept of ‘total institution’ as ‘a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life’ (Goffman, 1961, p.13). Goffman (1961) further argues that not all institutions are total institutions, though ‘every institution has encompassing tendencies’; but some institutions, such as homes for the blind or the aged, mental hospitals, prisons, concentration camps, army barracks, among others are encompassing to a degree

discontinuously greater than the ones next in line. The 'encompassing tendencies' refers to these institutions capturing something of the time and interest of its members and providing the members with something of a world for them. The encompassing or total character of the institutions is symbolized by the barrier to social intercourse with the outside that is often built right into the physical plant: locked doors, high walls, barbed wire, cliffs and water, open terrain, and so forth (Goffman, 1961).

A basic social arrangement in modern society is that human beings tend to sleep, play and work in different places at different times. In each of these instances, the activities are performed with a different set of people or co-participants, under a different authority, and without an overall rational plan (Goffman, 1961; Jones & Fowles, 1984). However, the central features of 'total institutions' can be described as a breakdown of the kinds of barriers that ordinarily separates the three spheres of life mentioned above. In a total institution, firstly, all aspects of life are conducted in the same place and under the same single authority. Secondly, each phase of the member's daily activity will be carried out in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Thirdly, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole circle of activities being imposed from above through a system of explicit formal rulings and a body of officials. Finally, the contents of the various enforced activities are brought together as parts of a single overall rational plan purportedly designed to fulfil the official aims of the institution (Goffman, 1961; Jones & Fowles, 1984). The features of 'total institutions' are also found in other places such as large commercial, industrial and educational establishments which provide cafeterias, minor services and off-hour recreation for their members.

Total institutions have four main characteristics which Goffman (1961) calls: batch living, binary management, the inmate role, and the institutional perspective. 'Batch living' describes a situation where 'each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike, and required to do the same thing together.

The 'binary management' characteristic of the total institutions refers to the two different social and cultural worlds that develop, jogging alongside each other with points of official contact, but little mutual penetration (Goffman, 1961, p.9). Total institutions typically consist of these two groups of people, the managers and the managed. The managers have power and use social distance as their weapon. They exercise this most tellingly in withholding information, so that the managed exist in 'blind dependency', unable to control their own destinies. The very fact of being an inmate is degrading: 'Staff tend to feel superior, and righteous. Inmates tend ... to feel inferior, weak, unworthy and guilty' (Goffman, 1961, p.7). Because the two groups do not and cannot know each other as individuals, they set up antagonistic stereotypes. Staff tend to see all patients as being alike – 'bitter, secretive and untrustworthy'. The managed draw similar hostile pictures of the managers. The two groups may use a special tone of voice in talking to each other.

The two residential aged care facilities identified in the study serve largely as a place of dwelling for elderly people who require continual nursing care and have significant difficulty coping with the required activities of daily living (ADL). Unlike Western facilities that have been designed to take care of elderly persons based on their special needs and therefore separating elderly persons who are able to perform ADL from those who were unable to do so (Quadagno, 1999; Novak, 2006), both facilities in Ghana admit all types of elderly persons irrespective of their health conditions and the kinds of help they need. Given

the novelty of these operations in Ghana, if the facilities operated by categorisation of the elderly persons based on their care needs, the patronage of their facilities would be very low and it would be difficult for them to break even in their operations. Currently, the likelihood of any of the two residential aged care facilities being filled to capacity is relatively low even though the bed capacity of the two facilities is between 15 and 21. On average, Eastwoods Home accommodates between 12 and 15 and Westwoods Home accommodates 9 to 12 residents. People might be turned down at Eastwoods Home not because it is full but because of the state in which the elderly person is and whether he or she can climb a flight of stairs without assistance.

5.3 Morning Activities of Care at the Residential Aged Care Facilities

Care, according to van der Geest (2002a) has various shades of meaning with its two basic constituents being technical/practical and emotional care. Depending on the context, technical care may dominate emotional care or vice versa (van der Geest, 2002a). Technical care comprises support with food, clothing, housing and the payment of medical bills while emotional care refers to psychological support (Aboagye, et al., 2013). When a family gives good care (both technical and emotional) to its elderly members, it receives praise and admiration from people outside the family. At the same time, families who fail to look after their aged properly are criticised and insulted (van der Geest, 2002a). In van der Geest (2002a) study among the Kwahu, he notes that some of the most common activities for which elderly people need the help of others include: getting food, taking a bath, washing clothes, and going to the toilet. Additionally, helping the aged financially and providing company are tokens of care, which are also indispensable. Finally, and, in the eyes of many, the most important type of 'care' is the organisation of a fitting funeral when the elderly person dies (van der Geest, 2002a).

In comparing the findings of this research with the activities of care listed above, it can be mentioned that the activities of care performed for the elderly persons accessing the residential non-domiciliary systems of care are a lot more than the traditional systems of mostly technical care because these facilities incorporate medical or health care. Spiritual care and end-of-life care are also provided to the elderly as and when the need arises.

A typical day starts at about 5:30 am at both residential aged care facilities when the caregivers wake the elderly persons up one after the other to commence the performance of intimate and non-intimate technical/practical ADL. Caregiving takes place throughout the day, peaking early in the morning and at meal times. During weekdays, some of the family members visit the facilities either early in the morning on their way to work or after close of work. Visits of residents are usually done on weekends and usually at the end of the month, mostly to restock medications and to pay bills.

Eight activities of care are performed for the residents in a typical morning. These are mostly non-intimate and intimate physical or technical care and medical care. The morning activities of care at the residential aged care facilities entails the caregivers taking the elderly persons through the early morning rituals of using the toilet - assisting the residents to sit on the toilet bowl and cleaning them afterwards, provision of water for bathing, brushing of teeth, bathing, dressing up of the elderly (including diaper usage), serving of breakfast, medication and massaging, movements to different locations and weekly personal grooming.

5.3.1 Intimate Technical Care: Toilet

Toilet use is the first activity of care the elderly are usually assisted to perform at the facilities after waking up in the morning. Elderly persons who are assisted to the washroom

are left there by caregivers for a while on account of the need for them to completely empty their bowels so that they do not soil themselves later on. They are then cleaned and sent to the bathroom for bathing. Those who might have soiled themselves in the middle of the night are cleaned by the caregivers before bathing takes place.

The toilet as a topic is very crucial in any discussions related to the care and well-being of elderly people and could serve as a major source of worry for the elderly on a daily basis. This is because for an elderly person to have easy access to a toilet facility constitutes a *sine qua non* for well-being according to van der Geest (2002b). He was of the view that one cannot feel at ease, if one cannot comfortably ease oneself. Additionally, easing oneself comfortably for the elderly persons is closely linked to feelings of being respected. An elderly person's honour and respect are jeopardised when the old person's intimate world is invaded (van der Geest, 2002a, 2002b). For van der Geest (2002a, 2002b) the first 'care' in toilet use for the elderly has to do with finding a suitable private toilet facility, which is a privilege (van der Geest, 2002a, 2002b). The residents of the non-domiciliary care facilities are privileged in the sense that they all have easy access to a private toilet facility at the premises of the facilities. The lack of privilege, however, was evident in having to access other people's help while using the toilet. This causes unease and embarrassment for the elderly person receiving the help (van der Geest, 2002a, 2002b) because what one used to do all by oneself, now needs to be done in the presence of a second person. It disturbs the old routine and causes an infringement on one's privacy.

This study confirms van der Geest's views in that some of the residents who are able to perform some ADL on their own proudly talk about their achievements when you interact with them but when it comes to discussions surrounding care activities that have to be

performed for them like lifting someone from a wheel chair onto a toilet seat they are too embarrassed to talk. Among the residents who are solely dependent on the caregivers to access the toilet or to take their bath, they have no choice but to get used to it or forever feel uneasy. Edmond discusses his unease with this process in the following words:

When I wake up, she (the caregiver) will come, she will wake me up and then they will take me to another room where I will use the toilet to ease myself, then after pupuing then they will say eh have you finished? or something then I will say okay I have done whatever I have to do and then before I realize this woman is on me, she is removing my clothes and then starts bathing me.

Poor communication while assisting the elderly to perform ADL invades the elderly's sense of privacy. This unease is complicated by the fact that residents who need help to get to the toilet facility often need assistance urgently. In some instances, residents get the urge in the middle of the night or when they are seated in the living room while caregivers are busy cleaning their rooms or attending to other residents. In such instances, residents who are not able to control their bowels soil themselves and cause much embarrassment. In some instances too, those who are assisted to the washroom are left there by caregivers for a long while on account of the need for them to completely empty their bowels so that they do not soil themselves later on. The control of residents by caregivers may be kept by means of a system of rewards and punishments which might be petty by outside standards (Goffman, 1961; Jones & Fowles, 1984). In some of these instances, the caregivers choose to openly complain about such residents misbehaviour to shame them so that they would desist from such deeds. Such behaviour is not unique to Ghanaian caregivers. Research has shown that nurses exhibit negative attitudes towards elderly persons with clinical conditions such as incontinence (Redfern, 1989). The attitude of caregivers towards elderly persons who they perceive to have deliberately soiled themselves with human waste is usually negative. Some caregivers adopt a name and shame poster with the aim of embarrassing the elderly to stop such practices. This influences the elderly person's perceptions about accessing care with

toileting for example as ‘bothering the caregivers’. As such, some of the elderly persons sometimes adopt measures such as not feeding or drinking much in order not to bother the caregivers with their human waste.

Incontinence is the most painful and humiliating consequence of ageing. The embarrassment is made more unbearable when non-kin have to care for the elderly during this period (van der Geest, 2002a). Participants/informants suggest that the issues of incontinence are a bit more bearable for the elderly person suffering from it when it occurs in the safety of the elderly person’s home and away from public view. The issue of incontinence sometimes contributes to elderly persons refusing to eat or not wanting to consume as much food or water as they require in order to avoid defecating on themselves. Some of the residents in the residential aged care facilities view the whole idea of soiling themselves with their waste matter as “worrying the caregivers”. They would therefore do all they can to avoid such situations. Catherine, Deborah’s daughter describes her mother’s behavior as follows:

The last time I went there she did not want to eat or to drink so I wanted to find out why. Then she said that she does not want to disturb the caregivers with her toilet so she does not want to eat for her to be defecating and she does not want to drink the water too to be urinating. You see she does not walk by herself, if she were to be walking, she would get up and urinate or attend to nature’s call you see so honestly I got very disturbed about that, I got worried.

Although the residents were quite unhappy with having to need help with going to the toilet, the caregivers were of the view that being cared for at old age is part of life and that elderly people have to learn to receive help whenever necessary. Catherine continues to describe her mother’s behavior as follows:

I should have been able to tell them all that she has said or even say it, but it will be like I have gone to report her to the workers, but on the day we went for her for the function in her hometown, I got a fine chance to tell them that the last time I was

there, she refused to eat because if she eats she will defecate and worry the young ladies with her feaces and then the Madam told her that she should not do that, she should eat Then I told the madam that she was also refusing to drink water because she said she will urinate a lot, so the woman told her that she has to overlook that because all the aged persons here once in a while defecate on themselves and they are cleaned so she should feel free to do it.

The poor care experiences of some of the elderly, inhibits their desire to perform ADL which could in turn compromise their health status.

5.3.2 Intimate Technical Care: Bathing of Residents

Bathing is a daily routine and it is usually the second activity of care that takes place at the residential aged care facilities. Residents in both residential aged care facilities have a bath once a day in the morning. Maintaining oral hygiene is incorporated into the bathing process. Elderly persons who can have a bath by themselves do so while those who cannot bath themselves are assisted or taken to the bathroom and given a bath by the caregivers. Water is usually available in the bathroom via the tap. However, caregivers have to carry hot water to the bathroom to mix with the tap water before the residents take their bath. Making bath water available to each elderly person is part of the responsibilities of the caregivers and not a characteristic gesture of respect as noted by van der Geest (2002b) in the traditional setting. Elderly people who are critically ill and may not be able to get out of bed are usually given a bed bath.

Bathing is another important aspect of intimate technical care. Uncleanliness and a bad smell on the body of an elderly person are unmistakable signs of neglect and loss of respect. Daily baths curb such situations.

Bathing a resident was no easy task. First, residents had to be lifted from the bed into a wheel chair, from the wheel chair onto the bath seat or chair for the bath to take place and

the reverse after the bath was over. This is necessary in order to send the resident to the bathroom and back. Some of the caregivers mentioned that the male residents are usually heavier than the average sized female resident or caregiver thus, making this task nearly impossible. Others were of the view that apart from the size of the resident, the height also matters. Assisting tall, obese residents was therefore particularly challenging. Stronger and able bodied males ought to be employed to purposely move them where necessary so as to reduce the toll of it on the female caregivers.

In both facilities, any caregiver can bath any resident on any day. As at the time of the fieldwork in Eastwoods Home, all the caregivers were females and they rotated and bathed residents both male and female. In Westwoods Home, the caregivers were both males and females with the males being in the majority. They, however, shared and bathed residents irrespective of the sex of the residents. Bathing of the residents was therefore not gender specific. In comparing the care received at home with regards to bathing to that of the facility, Elsie, was of the view that:

They (caregivers) give me a bath, they bath me every day, I cannot bath by myself so they bath me. At home my children were there, they were not taking care of me, oh, they did not take good care of me at all, they did not, this is difficult for me, in bathing they did not take care of me at all.

Accessing the facilities enables the elderly to achieve ADL where family members had failed to assist them do so.

Whether a resident was assisted in the bathroom or given a bed bath, being bathed by an unfamiliar face for the very first time created unique challenges of its own. Establishing a rapport before bathing the elderly is crucial in the whole process of bathing. It takes between two weeks and a month for a new resident to adjust to the whole idea of being bathed by the

caregivers. Because they rotate the bathing of residents, it is not every day that a particular caregiver goes to a resident to bathe him or her. Over time the residents become familiar with the caregivers and allow them to bath them. New caregivers also face the problem or challenge of being pushed aside or avoided by residents when it comes to bathing them as the residents usually prefer to be bathed by the old caregivers with whom they have developed a relationship. In instances where residents refuse to be attended to by a new caregiver, the matron or administrator assigns that responsibility to another caregiver with whom the resident is comfortable. In such instances the caregiver who has been rejected by the elderly person swaps activity with the re-assigned caregivers.

Being bathed by a caregiver of the opposite sex was a major source of worry for a few of the female residents one of whom was a Jehovah's Witness and insisted that such practices are against her religion. She, however, complained infrequently about it because if she refused such an offer on religious grounds, she might end up not getting anyone to help her maintain the personal hygiene she needed. In her words:

Oh I was bathing myself and all that because I do not want somebody to see my nakedness. As for this place, there is nothing I can do about it, they have shared the responsibilities and they call us to give us baths so when it is your turn they will help you to bath and when they finish they will dress you up. They see my nakedness all the time and it is not good because my church and religious beliefs is against such things. In my church, a man and a woman do not have to do such things. I am not too particular about a lot of things anymore because if you complain who will do things for you? The way things have changed if you insist that what you want is what you should be given or what should be done for you then there will be a problem but, I ask myself, if the kind of living you want, you do not get it, should you not demand for it or worry someone to do it for you?

The clash of beliefs and behaviour of the elderly in receiving support to achieve ADL can impact negatively on care received. Adhering strictly to one's religious beliefs when one does not have power over the care arrangements might jeopardize the quality and quantity of care received from the caregivers at the residential aged care facilities.

Others decide to overlook the phenomenon of being bathed by a caregiver of the opposite sex and convince themselves that if they were in the hospital, a nurse of the opposite sex could be assigned to them so they are in a similar situation. Others are not able to get over the whole idea but cannot do much about it. Such residents make the effort to cover their nakedness as often as they can irrespective of who is taking care of them or where they are. Some residents are also unhappy with the way they are handled by the caregivers in the bathing process. For some of them, their body parts are handled with disregard as if the caregivers were attending to children. Others also dislike the scrubbing that is done in the process of being bathed because the caregivers scrub them too hard. Edmond describes the manner in which he is handled during bath times as follows:

Well we are woken up around 5am, then they bring you out and then depending on the state in which you are they take care of you, they bath me, they wash me down. As for this place, they wash every part of you, they do not care, they will be scrubbing me hard like that, they wash your testes everywhere oh, neat and smelling good, yes oh the people wash the thing well, they wash it properly, they should come and confess, they bath you very well if you do not take care your testes will break or something I swear, they clean you oh, I do not know whether it is because they are soldiers or something. They will raise your legs and clean you well, but once they are not killing you, it's okay.

Because the residents wake up relatively early at the facilities to perform their daily morning rituals of using the toilet and bathing before breakfast, majority of them feel sleepy and doze off after they have had breakfast. When compared to the daily routines of elderly people discussed in the traditional setting by van der Geest (2002a, 2002b) even though visiting the toilet early in the morning is a daily practice, bathing does not usually take place afterwards. Bathing usually occurs when a bucket of water has been heated by the sun. This could be in the middle of the day. Elderly people therefore were not required to wake up that early each day to bath as it is being done at the facilities.

5.3.3 Intimate Technical Care: Dressing and Clothing of Residents

Dressing up is the third activity of care the elderly are usually assisted to perform at the facilities after waking up in the morning. Dressing is an important aspect of physical care needed daily by an elderly person. The appearance and dressing of an elderly person speaks volumes about the kind of care being given to him or her. Wearing torn and dirty clothes affects the esteem which should be accorded to them (van der Geest, 2002b). The elderly are worn fresh clothing each day after bathing. These are usually changed when it becomes necessary for them to change their clothes because of soiling themselves with urine, excreta or vomit. As part of the dressing, most of the elderly are worn disposable diapers. Van der Geest (2002b) noted that when an elderly person goes about shabbily dressed, the old person does not only present their own degradation but are in a literal sense as well as the proverbial sense presenting the 'dirty linen' of the extended family they belong to which can be seen by everyone in the street (van der Geest, 2002b). The relatives of the elderly person are the ones required to take care of the washing of the old person's clothes and also provide him or her with new clothes. Most of the elderly are also conscious of their status as elder; which require of them to dress properly.

In Eastwoods Home, residents are provided with different coloured uniforms (loose dresses), imported by the operator for them to wear for easy identification outside the premises by people in the neighbourhood should a resident step out of the facility unnoticed. The wearing of uniforms by the elderly bears semblance with one of the features of total institutions identified by Goffman (1961). When an elderly person is admitted to the facility, the caregivers look through the items brought for the person's use at the facility. The caregivers take out the things the elderly patients might need and give the family members the rest to be taken away. These items are labelled for easy identification. This admission process is somewhat similar to what Goffman (1961) calls 'disculturation' or 'roles

tripping'. By this process, the individual is reduced from a person with many roles to a cipher with one that of the resident role. The residents are usually required to bring two dresses for use whenever they have to be taken to church on Sundays. On special occasions like Mother's day, Father's day, Easter and Christmas, the elderly persons are required to wear their own dresses because they might be receiving visitors.

Residents of Westwoods Home wear their own clothing, however, the operator sometimes gives some of them her used clothing when it becomes necessary. Residents of all the other facilities wear their own clothes.

5.3.4 Non-Intimate Technical Care: Feeding

Breakfast is served between 8am and 8:30 at both facilities. Residents who are not able to feed themselves are fed by caregivers with a spoon. In instances where the caregivers feeding them are few, such elderly persons would have to await their turn. Caregivers ensure that residents are fed especially those who are frail and critically ill. In a few instances, those who are well and refuse to eat because they do not like what they have been served are not forced but provided with other alternatives where necessary. Dishes served for breakfast are porridges (made from corn or maize, millet, oats, *Tom brown* – dry roasted corn flour) and beverages (tea, cocoa); and these are eaten mostly with bread.

Nutrition is a very important element of health in the older population and it affects the ageing process. The nutritional status of an individual is an important component of his or her physical and mental well-being irrespective of age (World Health Organisation, 2000). Obtaining adequate and good nutrition is a major problem for many elderly persons (Barrow, 1986) as good nutrition can support health of the aged and limit the progress of

disease (Novak, 2006). Chronic and acute diseases have been associated with poor nutritional status in the elderly (Aganiba, et al., 2015). Research has shown that an adequate consumption of food ingredients rich in vitamins and minerals can have a good effect on the body of elderly persons. Vitamin C may reduce the risk of heart disease by blocking the formation of fatty proteins; increased intake of vitamin E may reduce the risk of Alzheimer's disease. Calcium and vitamins D in the diet of elderly persons increases bone density and prevent osteoporosis in elderly women (Novak, 2006).

As the human body gets older, its nutritional needs and health concerns change due to an increasing susceptibility to degenerative diseases (Aganiba, et al., 2015). The nutritional difficulties of elderly persons are compounded by the physiological and socio-psychological factors associated with ageing as digestive processes slow down with the process of ageing (Barrow, 1986). Dental problems can limit the choice of foods to those that are easily chewed. Reduction in the keenness of taste, sight and smell can diminish the enjoyment of food and dampen the appetite of elderly persons. This can lead to vitamin and mineral deficiency (Novak, 2006). Social and psychological factors such as loneliness, death of a close relative, and the environment they find themselves in can affect their feeding habits (Barrow, 1986). Additionally, physical handicaps experienced by an elderly person such as arthritis often complicate the consumption of food.

In conversations with the elderly persons at the different facilities about the activities of care performed for them at the facilities, timely provision of warm food was the topic they were quick and excited to talk about. This confirms van der Geest's (2002b) findings that getting something to eat is the most concrete aspect of daily survival for them. For those who provide care, it is the most regularly returning type of care that is expected from them. What

to eat, when, who will bring it, filled a great deal of van der Geest's conversations with the elderly as in my case. The study shows that timely provision of food at meal times is part of the services provided by the facilities; therefore, residents do not have to worry about when their next meal will be served and who will bring it. Edwina, a resident at Eastwoods Home highlights the difference between kin and non-kin care with respect to this particular aspect of technical care when she notes:

They [Eastwoods Home] take good care of me. At first when I was in the village even food, what to eat was a problem, the person who was asked to take care of me did not do much, my children gave her everything including food but for her to cook and give me some was something else, it was not good, even if she gave me food, it was in the evening and even that, she gave me very little food. In the morning if she gave me food, something very small is what she gave to me. Because of that, my children were worried. Since I came here, they have been taking good care of me, they do not make me starve, I do not get hungry, left for me alone, they take good care of me.

5.3.5 Non-Intimate Technical Care: Movement of Residents

Usually, after breakfast, the residents at Eastwoods Home relocate to the living room to watch television. Those at Westwoods Home usually stay on the compound listening to radio. With the exception of a few residents who either move from one place to the other walking without support, majority of the residents at the non-domiciliary facilities move about with the aid of assorted walking frames, others are pushed around in wheel chairs and those who have strong arms move about in wheel chairs by themselves. Yet a few others who have weak arms and feeble legs are also assisted to move about by the holding of their hands. Findings from this study show that the movement or pushing of residents in wheel chairs requires a lot of effort and energy from the caregivers if done slowly. Therefore, some amount of speed is required and used in the process. This confirms Redfern's (1989) findings that the style of nursing in the traditional wards was highly routinised and put priority on getting through the work. Speed and convenience took precedence over

individual needs (Redfern, 1989, p.147). Some residents irrespective of the type of facility were, however, unhappy with the way and manner in which they were pushed about in wheel chairs; the speed with which such an activity is performed creates fear and panic in most of the residents in wheel chairs. There were reports of some of them having fallen in the past. Some of them express the fear by shouting when the ride becomes too fast, others become very tense and sit on edge holding the handles very tight till they are brought to a stop.

5.3.6 Medical Care

Medical care is incorporated into the activities of care performed for the aged persons who access residential aged care facilities. Under the national health insurance scheme (NHIS), the government provides free health care for elderly persons who are above 70 years of age as well as elderly persons on the Social Security and National Insurance Trust pension scheme (Tonah, 2009; Doh, et al., 2014). In 2015, the Ministry of Gender, Children and Social Protection (MGCSP) began the free registration of the elderly under the NHIS initiative to ensure that they are taken care of properly. This initiative forms part of the nationwide implementation of the EBAN Elderly Welfare Card project that was launched in January 2015. So far, over 10,000 free health insurance cards have been given to elderly persons in the country. Overall, having access to the NHIS has been a big relief to many individuals and households who otherwise would have had to bear the huge cost of medical care of their elderly parents and relatives. Elderly persons who could not afford the user fees being charged for medical care and treatment are now being catered for under the NHIS (Tonah, 2009; Doh, et al., 2014). For some of the elderly persons, the national health insurance brings their families closer to them and also reduces the economic burden on family members who support them (Aboagye, et al., 2013). With all these developments in the country, even though medical care continues to be expensive and the outcome somewhat uncertain, people are a lot more willing nowadays than in the past to spend money on a sick

person who is going to die as part of the cost is born by the NHIS (van der Geest, 1995, 2002a, 2004).

At both residential aged care facilities, whenever the caregivers sense that an elderly person is not well, they quickly take the resident to the nearest health facility for treatment. While doing that, they contact the elderly person's children or relatives to inform them and request their presence at the health facility. While waiting for the family members or relatives, the facility operators or their representatives ensure that the elderly person gets all the needed care by making the necessary financial commitment at the hospital. In instances where the children or family members are unable to be present until a later date, the caregivers take care of the elderly persons at the health care facilities until they are discharged and sent back to the home. Family members or relatives who are able to be present sometimes take their elderly persons' home for a change of environment and for them to recuperate. Residents who have routine doctor's appointments are usually taken to the hospitals on the appointed day by their relatives. In instances where the relatives are unable to do so, the caregivers at the facilities take up the responsibility and inform the relatives afterwards. Jemima, one of the facility operators noted:

Sometimes someone has a doctor's appointment so we take him or her to see the doctor, and...we normally just talk to the family members over the phone. If they cannot go with you they will tell you to take a car and go they will reimburse you later. The family of the person pays for the hospital bills, we normally use the health insurance to take care of some of the things. Those who do not have the insurance, their families bear the cost.

This additional responsibility assumed by the facility operators further reduces the activities of care the family members perform for the elderly to solely financial transactions. Caregivers at the residential aged care facilities ensure that residents who are on medication at any given period take their drugs at the prescribed times. Residents who have high blood

pressure and are on treatments are given their medications alongside their breakfast at Eastwoods Home each morning and this is judiciously performed by the caregivers responsible for ensuring that they have their meals. Usually, after breakfast, the residents at Eastwoods Home relocate to the living room to watch television, where their vitals (blood pressure, body temperature) are checked one after the other and documented in their books. This is done about four to five times in a week. For residents who require a massage, caregivers at the facility who are not on duty at the laundry or kitchen give them the needed massage. At Westwoods Home, however, a physiotherapist visits the facility twice a week to give the elderly the needed therapy at a cost of GHS 50.00 per session.

At Westwoods Home, the operator has made arrangements with a medical doctor from a nearby clinic to visit the facility and assess the residents once every two weeks. Files for medical records have been created and kept at the facility so on each visit, the medical doctor with the help of the caregivers checks the blood pressure of residents, takes their temperature, and assesses them. He also takes their blood and urine samples to the health facility for assessment and charges the facility for the services rendered. A few of the residents in Westwoods Home who are very old (above 90 years) think the routine visits and the checking of vitals is not necessary and an inconvenience since they are old and are on their way out of this world. They have therefore refused to be assessed on those routine visits. This is not out of place since really they would not be going through such routine checks if they were in their usual dwelling places.

In his study among the people of Kwahu, van der Geest (2004) notes that in narrations of the death of elderly persons there is an account of the worsening condition of the person, but it is rare that a long series of medical interventions play a role in the report which people

give about the last days or weeks of their relative. However, findings from this study show that medical interventions are increasingly becoming a part of the narratives of the stories of death of former residents with emphasis placed on the role of the aged homes in prolonging the lives (for a few months to about a year or more) of the elderly people who were brought in very sick. Jemima, one of the residential aged care facility operators said:

He was brought here sick, he had prostate cancer... he was being taken care of by the sister, so when we started advertising the sister heard about the place and brought him. When she brought him she said that the doctor said he had only two weeks to live, the maximum period for him will be one month, but he stayed here for about six months before he fell sick and was taken to a hospital nearby ...and he died there.

5.3.7 Emotional Care

Providing companionship to elderly people in society, especially to those who are confined to the house, constitutes an important aspect of emotional care, which may have a profound effect on the well-being of the elderly (van der Geest, 2002b, 2004). Over the years, gerontologists and researchers have differentiated between objective and subjective features of loneliness. The elderly have been noted to suffer from social isolation as their social contacts decrease with ageing. They also experience emotional isolation or loneliness as they become dissatisfied with the quantity or the quality of social relationships (Hall & Havens, 2002). Studies have shown that older people who are in institutional facilities with few family contact and support feel lonely (Novak, 2006). However, it has been argued that being alone and having few social contacts does not necessarily mean that a person feels this as an unpleasant or unacceptable discrepancy between the amount and quality of their actual social relationships compared with their desired ones (van der Geest, 2004).

Even though the facilities are expected by kin to provide emotional care through association and companionship with other elderly persons in similar conditions, this study indicates that

elderly persons at the residential aged care facilities tend to be left unattended to either in the living room (Eastwoods Home) or on the compound (Westwoods Home) for a greater part of the late morning when some of the caregivers are either cleaning the rooms of the elderly persons or attending to their own personal hygiene. During such periods, the elderly persons tend to doze off even though the television is usually on therefore creating the impression that they are lonely and bored. However, when residents pay attention to what is aired on television, it serves as infotainment. It creates the opportunity for residents to discuss issues of common concern like road accidents, robbery, thereby generating lengthy discussions among them. Sometimes, programmes being aired like local movies and religious or denominational preaching sessions generates arguments between residents and especially when the caregivers are around resulting in both parties making sarcastic comments depending on the topic.

Personal grooming such as cutting or trimming of hair and nails are routine or periodic physical activity performed for the residents at the residential aged care facilities. Such activities usually take place during mid-morning hours when the elderly persons are resting. For the men, their hair and beard are shaved once a week with the aid of electrical gadgets. Most of the women also have their hair cut low for ease of cleaning when bathing; theirs is usually trimmed. That of the men is maintained low. Residents' nails are also cut with nail cutters. There have been instances when some of the male residents had refused to be groomed at the appointed time resulting in the assigned caregiver exhibiting a negative attitude towards the elderly person. On some occasions, some of the residents show signs of stubbornness, anger, aggression, and uncooperativeness when it comes to personal grooming and this evokes negative attitudes in the caregivers.

After personal grooming, the elderly persons tend to be left unattended to either in the living room (Eastwoods Home) or on the compound (Westwoods Home) for a greater part of the late morning when some of the caregivers are either cleaning the rooms of the elderly persons or attending to their own personal hygiene. During such periods, the elderly persons tend to doze off even though the television is usually on therefore creating the impression that they are lonely and bored. They stay in the living room till lunch when everyone moves to the dining room again for lunch. On a number of occasions, fruits (pineapples and water melon) and snacks (biscuits and fizzy drinks) have been served before lunch at Eastwoods Home.

The rooms of the residents are usually cleaned and the beds made when they come out of the rooms for breakfast. Their dirty clothes are also washed after cleaning the rooms. At both facilities, the caregivers after having their breakfast either rest or spend time with the residents chatting, those of them who have not taken care of their own personal hygiene do so during the time the elderly persons are in the living room or under the canopy.

After breakfast, caregiving plateaus. At Eastwoods Home, caregivers who are not on duty move to the rooms to clean them. Those at Westwoods, ensure their personal hygiene and have breakfast before joining the elderly under the shed to chat.

5.4 Afternoon Activities of Care at the Residential Aged Care Facilities

In the afternoon three activities of care are performed for the elderly. These are serving of lunch and feeding, movements to different locations as well as occasional playing of games. Lunch is usually served an hour earlier at Westwoods Home than at Eastwoods Home. While lunch is served at Westwoods Home between 12 noon and 12:15pm, Eastwoods

Home serves lunch around 1pm. The main dishes served for lunch or supper are *Banku* – balls made from a mixture of cooked fermented corn and cassava dough (mostly served with okro or leafy green stew or soup), *Konkonte* – thick pap made from cassava flour (served with palm nut soup or ground nut soup), *Rice balls* – cooked rice moulded into ball (served with palm nut soup or ground nut soup), *Kenkey* – balls made from fermented soaked grounded corn (served with grounded pepper and flaked tinned fish), *Jollof rice* – rice cooked in spicy tomato stew (served with vegetables and chicken or fish), plain rice (served with gravy or palm nut soup or ground nut soup), *Fufu* – moulds of pounded, cooked cassava and green plantain (served with light soup, palm nut soup or ground nut soup) and *Gari* – roasted cassava grits/flour (served with beans stew). Any of these dishes could be served on each day as the menu at both facilities is not rigidly followed.

After lunch, residents at Westwoods are sent to their rooms for siesta and to rest their backs from the long hours of sitting, while majority of the residents at Eastwoods Home return to the living room until about 5:30pm. Caregiving then plateaus afterwards until the evening as the caregivers take the opportunity to rest. Caregiving activities peak again at other meal occasions of the day and then at night when the residents are being prepared for bed.

Even though both residential aged care facilities have pasted menus at vantage points for use at the facilities, my observations showed that these menus are not strictly followed. Dishes prepared are based on ingredients available at the facility at any given time which is likely to be influenced by the availability of food ingredients on the market as well as what the administrator had planned to be eaten. The staff partook in the consumption of food prepared. This could limit the variety of dishes prepared but ensure that quality dishes served.

Residents at the residential aged care facilities are provided with three meals a day. Eastwoods Home serves two main meals that is breakfast, lunch, and a beverage or fruits for supper. The residents are, however, provided with fruits and snacks (biscuits) in the course of the day. Westwoods Home serves the residents with three meals and hardly serves fruits or snacks. Eastwoods Home pays a lot more attention to the dietary needs, quality and quantity of food served to the elderly persons by serving fruits and snacks in addition to the two square meals, thereby ensuring that they have free bowels each day, as constipation is unhealthy for them.

In addition to the differences in frequency of meals served, the facilities offered different types of food. Whereas Eastwoods Home prepares a lot more of soups and dishes that can easily be swallowed (which is often limited in options), Westwoods Home prepares more stews and chewy dishes and are therefore more likely to present residents with a wider variety. The serving per plate at Eastwoods Home is usually a lot more in quantity than that of Westwoods Home. However, how much a resident can eat is dependent not on the quantity of food presented to them but the type and texture of food offered to them as well as whether or not they have to be spoon-fed. Swallowed foods are easily eaten and within a shorter period of time than chewy foods which take longer time to consume. Elderly persons who have difficulty in chewing consume more food when it is of the swallow variety boosting their nutritional levels. Elderly persons who have to be spoon-fed also tend to consume less. This is because the process of being spoon-fed can be time consuming and daunting as the caregivers have to wait patiently for the resident to complete each masticating or chewing process before the caregiver serves him or her with another spoonful of food. A lot of emotional care goes into ensuring that those spoon-fed eat adequately to boost their nutritional levels and caregivers are sometimes frustrated by the slow process.

On one of my visits, I had to help feed a resident because the caregivers for the day were few and the one who was supposed to feed her complained of tiredness. I went and sat by her and told her what I was going to do. I put an apron on her chest and she prayed, after which I started feeding her. The process took over an hour. She chewed slowly and it took a while for her to finish chewing a morsel of food. I had to play a game on my phone to while away the time as I fed her. She asked if she was worrying me or wasting my time and I said no and that she should not worry. She asked that question about three times before the whole process ended. She ate about half of the food she had been served largely because she was tired of the process. She mentioned that the food - jollof rice with vegetables and grilled chicken - was too dry. The patients who had to be spoon-fed were conscious of the amount of work it took and were uncomfortable with the idea of giving the caregivers too much trouble. She did not want gravy on her jollof, which would have made it easier to chew. In her words, "I do not want to trouble any one, different people cook rice differently so I will just cope with it like that".

In some cases, the variety of food served at the facility was perceived to be too limited. Some of them would want to be served with a lot more dishes than what was available to them. In some instances, some of the residents actually refused to eat the food they were served if they did not like it. They would in turn complain to their relatives. A few of the residents who had been in the facility for over a year also suggested that meals had gotten more basic over time. As Edna puts it:

Yes but things have changed and the kind of living we have here, it is not what you want, it is not like that at all, they are helping me so I do not want to worry them, when it comes to feeding, oh it is what their money can reach that we will eat and that is okay, we all eat the same food, everybody has her own cup and plate for eating, they arrange things nicely, they dish out and serve each and every one of us.

With respect to taste, some of the residents commended or praised the cooks for knowing how to cook and prepare tasty dishes for them. Some also mentioned that the food eaten at the facilities tasted much better than what they had been served by their caregivers at home prior to coming to the facilities. Esther at Eastwoods Home notes:

As for my food I did not have a problem at home, the caregiver always brought it on time. She cooked it at her place and brought it, I did not get hungry, just as I felt hungry, she brought the food. She did well in taking good care of me, it is just that her food was not tasty. If I did not eat it, she would even report it to my son who was paying her, I would not bother myself teaching a grown up like that how to cook, I just kept quiet and ate what I could. Her food was generally not nice, since I came here I have been observing things I generally do not like soup but here, since I came they have prepared soup two times or three times, I cap my ears and I listen to all that is going on, and how they prepare meals, I can confidently say that the way they prepare and serve the food here I do not have any bad comments about it. Their food is on point; they do it exactly as it is expected.

A final component of the technical care of food provision was related to food preferences. On applying to access the facility, relatives of the potential resident, as part of the form completion process are supposed to list the dishes that the elderly person does not like or eat at home. Some of the residents state what they do not eat so that at mealtimes when dishes they do not eat are prepared, other meals are provided for them. However, because some relatives want their elderly persons to be admitted at the facilities at all cost, they fail to list their dietary preferences. Caregivers only discover the true state of affairs when the residents refuse dishes offered them at mealtimes. Lack of disclosure of elderly person's dietary preferences can lead to poor feeding and compromise their health.

In cases where the dietary needs of the resident could not be accommodated by the facility, alternative arrangements were made. Relatives of one of the residents who is a Nigerian with dementia hired a cook to prepare Nigerian dishes for him. His meals are prepared outside the facility and brought for refrigeration twice a week. This ensures that he gets what

he wants to eat at any mealtime. The family's effort at ensuring that this resident ate adequately came at an extra cost to them.

When those on the first floor of the Eastwoods Home come downstairs in the morning after freshening up, they first stay at the dining area until they have eaten their breakfast and then they move to the living room. They stay in the living room till lunch when everyone moves to the dining room again for lunch. After lunch, some of the residents on the ground floor go to their rooms to rest for a while. Those on the first floor move back to the living room and stay there watching television or sleeping till they are served with snack in the late afternoon after which they start leaving the living room one after the other on account of tiredness from the long hours of sitting.

5.5 Evening Activities of Care at the Residential Aged Care Facilities

Four activities of care are performed for the elderly in the evening and they are serving of supper and feeding, movements to different locations, changing of diaper and putting them to bed. Supper is served outside at about 5:30pm at Westwoods Home. After supper residents are moved from the compound to the living room to watch television until about 8pm when they are sent to their bed rooms for the night. Those who prefer to go to their rooms after supper are assisted to do so. At Eastwoods, residents are served with fruits or a light meal between 4:30pm and 5:30pm after which they are moved to their rooms. By 6pm the Eastwoods Home living room which is usually the hub of activity is usually bare as most of the residents have retired to their rooms after which majority of the caregivers prepare to close from work and leave the facility. At both facilities, residents who require a cup of beverage or water are served by the caregivers before the lights are turned off.

Their diapers are changed before they are put to bed for a good night sleep. Diaper use by the elderly persons is a common feature in all the different types of non-domiciliary aged care facilities. With the exception of elderly persons who can access the washrooms easily and without any incontinence issues (and they are quite few), almost all the other residents (about 95%) wear diapers. Under normal circumstances, an elderly person uses two diapers within 24 hours, one during the daytime and the other at night if the elderly person does not have incontinence issues related to defecation. Eastwoods Home usually sells diapers at subsidised prices to residents. In instances where the facility runs out of diapers, the relatives of the elderly persons are required to bring diapers for the use of the elderly person. Residents who have urine incontinence and have run out of diapers or cannot afford to buy some at any given time are provided with catheters. The wearing of diapers is a major source of discomfort for the residents especially at the initial stages of use. The idea took a while for some to accept. Catherine describes the process by which her mother came to accept the need for diapers in the following words:

Well as for my mother, the whole thing really disturbed her a lot; wearing the diaper was a source of worry for her. As for that I will not lie to you, she even weeps about that, it really pains her. We really struggled and went through a lot before she even agreed to start wearing it. In the beginning she said no way to the idea, she will never use a diaper, but gradually she realised that when she gets the urge to urinate and she is not able to walk fast to the washroom then she starts soiling herself and that started worrying her so she had to gradually accept to use it.

Even after accepting the idea of using diapers, some would wear the diapers and yet call for assistance to the washroom anytime they had the urge to visit the washroom until they gradually got used to having to ease themselves in it. Again, Catherine's words are instructive:

My mother will wear the diaper and not urinate in it but rather call you to take her to the washroom to urinate. It is unless the urge is so strong and she cannot control it any longer that is when she will do it into the diaper, it is difficult. Sometimes it's like children when you dress them in diapers at a certain age, they will remove it

themselves and rather urinate on themselves and all that. They will insist that you remove it for them before they will urinate.

5.6 Additional Activities of Care at the Residential Aged Care Facilities

Spiritual care and end-of-life care also take place at the residential aged care facilities periodically but not on daily basis as those discussed as routine activities of care at the facilities.

5.6.1 Spiritual Care

Throughout the ages, religion has been for the African, the normal way of looking at the world and experiencing life itself. Mbiti (1991, p.14) writes that we cannot “understand the African heritage without understanding its religious parts”. According to him, religion is part of the cultural heritage and it is by far the richest part of the African heritage. Religion is found in all areas of human life. It has dominated the thinking of African peoples to such an extent that it has shaped their cultures, their social life, their political organisations and economic activities. Religion, can therefore be said to be closely bound up with the traditional way of African life, while at the same time, this way of life has shaped religion as well (Mbiti, 1991, p.10). Africans find comfort and hope through religion. Over the years, the Pentecostal churches more than the orthodox churches have found ways of addressing the challenges associated with the social, economic and political facets of countries (Gifford, 2004). Globally, Christianity has witnessed a tremendous growth since the turn of the twentieth century but more so in Africa where the number of churches and evangelists has increased at a tremendous rate (Gifford, 2004).

Religious affiliation and the presence of religious bodies and activities contribute to the mental well-being of the adherents (Ghana Statistical Service, 2013). Religious bodies and

the social networks within them serve as sources of social capital for those who belong to them. They also serve as an informal source of social protection for the elderly and their families. Some of the elderly may join some such churches for some of such benefits apart from spiritual purposes (Ghana Statistical Service, 2013). Meeting the spiritual needs of the elderly persons at the different non-domiciliary aged care facilities is paramount in the scheme of affairs of the facility operators. In a country where 71.2% of the population professes the Christian faith and more than 90% of the elderly adhere to a religion (Ghana Statistical Service, 2013), it is not surprising that Christian religious activities are incorporated into the activities of care performed for the elderly; the residential aged care facilities provide weekly or periodic church services and give Holy Communion.

At both residential aged care facilities, morning devotions are not a routine as much of the morning is used by the caregivers in helping the elderly persons perform technical/practical activities of care. Spiritual or religious activities are limited to the visits of pastors and others who visit the facility and would want to pray with them or encourage them with spiritual messages. Occasionally, when the facility operator of Eastwoods Home is available, she encourages the residents after breakfast when the residents are seated in the living room watching television to tune into religious programmes. At Eastwoods Home, representatives from churches in the nearby communities of the facility visit periodically to encourage residents and to pray with them. At Christian celebrations, representatives of the churches make donations of food and confectionary to residents. The reverend ministers of the Presbyterian Church of Ghana visit the facility once a month to give residents of the facility Holy Communion after preaching to them. Once in a while and during Christian festivities, residents are taken to a selected church in the community for them to join church services. On the other hand, in Westwoods Home, church service is usually organised each Sunday

by visiting pastors who are usually compensated for their work by the operator of the facility.

5.6.2 End-Of-Life Care

This study shows that the two residential aged care facilities provide some form of end-of-life care to the elderly people who access the facilities. Elderly persons who are critically ill and at the verge of dying are usually sent to the nearest healthcare facilities for assessment and then the family members of the elderly person are informed about the condition of the elderly person. In some cases, the elderly person dies at the health care facilities and the facility operators hand over the responsibility of caring for the corpse to the family should they arrive on time. Family members who are abroad or outside Accra and cannot be immediately present usually hand over the care for the corpse to the facility operators who then ensure that the corpse is sent to an appropriate morgue for preservation. In such instances, the facility operators hold the fort till the family members of the deceased make themselves available and take up the responsibility for the corpse. The two facilities also offer other services that the family might require in planning for the funeral. Jacklyne, a caregiver at one of the residential aged care facilities remarked:

She did not die here, we took her to the hospital before she died, she died there, the whole process was about three to five minutes because in the morning she bathed, walked around. Normally while waiting for breakfast, she sat on her bed, but [that day] she went to lie down. Normally she does not lie down. When we went to the room to take her roommate for a bath, she was lying down. They had not even taken breakfast. When they went, they called her “Auntie Mary get up” but there was no response, so we took her to the nearest hospital. When we got there, there was no doctor and she died about three minutes after she had been attended to.

Similarly, Jemima notes:

When we got there she was unconscious but not dead, we took her to the hospital before she died so there were no issues, at her age too, old age comes with that so...when it happened like that we had to contact the person who is the key contact

so that we know the way to proceed, when we contacted the child he asked if we could take the body to any closest or immediate home so we did the necessary arrangement and took her to Lashibi funeral home.

In comparing the end-of-life care in Ghana and the Netherlands, van der Geest (2004) writes that the only positive thing he discovered was that old people in Ghana are allowed to die. Unlike in the Netherlands where life is unduly prolonged by medical intervention and, occasionally, enforced artificial feeding, the wish of Ghanaian elders to die was respected. In comparing this with what is happening in the residential aged care facilities, it can be argued that the life of elderly persons are increasingly being prolonged by medical intervention, provision of ADL and in some cases artificial feeding. Residents who were not able to feed themselves were fed by caregivers either with a spoon or through the tube. Caregivers ensure that residents were fed especially those who were frail and critically ill. In a few instances, those who were well and refused to eat because they do not like what they have been served were not forced but provided with other alternatives where necessary. Lack of good medical facilities and poverty, particularly in the rural areas, were blessings in disguise as they saved the elderly from the torture of forcibly extended lives, which their peers in Europe and North America suffered (van der Geest, 2004). This, however, cannot be said of the elderly persons accessing the non-domiciliary facilities.

It can, however, be argued that even though there is financial hardship generally, accessing the increasing medical facilities in the urban centres is becoming much easier because of the relatively free NHIS for the aged (70 years+). Prolongation of life is therefore creeping slowly into Ghanaian society as well. The fact that people are increasingly living longer with chronic diseases that require long-term care beyond what families have provided in the past has also necessitated the need for residential non-domiciliary care facilities.

In instances where the elderly person is discharged by the medical facility to go and die at home, both residential aged care facilities provide shelter for those residents or elderly persons who need to be kept somewhere or offered a place to stay and pass on. Eastwoods Home has a special place for that purpose. This is usually accessed by the children of the elderly persons who had been hitherto providing shelter for them in the urban centres and are not emotionally prepared to see the elderly person die on their hands at home. They also have shrouds, bags for carrying the body and other items required for performing the last offices before sending the corpse to the morgue. Both residential non-domiciliary facilities give the bereaved or deceased family the needed help throughout the time of bereavement if required. They make all the necessary payments at every stage of the process – at the hospital and at the morgue. The family members usually refund all such expenses before the documents covering the corpse is handed over to them. As Jacklyne put it:

Two came and eh, they were all at terminal points. You know some people fear to see their old folks die. Actually that was what one daughter of an old lady said. She said she was afraid to see the mother die but eh, she was here for a few weeks and they came to say that the Abusuapanyin who is eh the elder brother of the woman said that, to hell with them, they cannot take his Odeshie or something to a home, so they should come for her but she was at the terminal point anyway so they carried her away.

Similarly, Jemina notes:

For some of them when you take them to the hospital the doctor will say that because of the age it is not necessary to keep them there so the elderly person has to be sent home, so we ask if the person can do that, if the person is not able to take the aged person home because maybe he is renting a place somewhere and cannot take the old person there to die, we bring the aged back to the facility and give him a different room, so when the person is about to die, we then inform the relative that the end is coming. When the person dies we give you a car, a dress for the corpse to wear and something to cover the body with.

To conclude, the aged persons were moved to the residential aged care facilities requiring care in different forms and magnitude depending on the level of functional loss and the state

of health of the elderly. The residential aged care facilities admit them and assist them perform ADL. They are given technical/physical, medical, emotional, spiritual, and end-of life care depending on the care needs of the elderly. As such, the elderly end up achieving technical/physical, medical and spiritual care and they begin to improve based on the high levels of attention paid to the provision of care in these facilities.

5.7 Summary

In this chapter, I have presented a day in the life of an elderly requiring care at the residential aged care facilities. I have also looked at the residential non-domiciliary systems of care available in the urban centres of the Greater Accra Region as well as the services these residential aged care facilities provide to the elderly persons who access them. The next chapter discusses how the elderly persons and their family members make sense of the new phenomenon of the elderly accessing long-term care from residential non-domiciliary care facilities.

CHAPTER SIX

MAKING SENSE OF THE NEW PHENOMENON OF ACCESSING CARE FROM RESIDENTIAL AGED CARE FACILITIES

6.1 Introduction

With the gradual breakdown of the extended family system and the nucleation of families, some elderly persons have found themselves at residential aged care facilities based on decisions taken by their family members. It is therefore crucial to understand how the elderly and their family members perceive the notion of accessing residential non-domiciliary care for the elderly within the Ghanaian context. I commence this chapter by looking at the representations of ageing. I discuss the perceptions and feelings of the aged persons about the shift of their care from the domiciliary context to the residential aged care facilities. Additionally, I examine the opinions and views of the family members about their elderly persons accessing non-domiciliary care at the aged home care facilities.

6.2 Representations of Ageing

According to van der Geest, et al., (2010), in the Netherlands and other high-income regions of the world, reaching old age is usually not perceived positively or enviably despite the fact that the positive image of the “young-old” gives a picture of older people as active, financially well-off and having enough free time to enjoy life. Generally, the image of the oldest-old is mainly negative. Attaining a high chronological age is generally associated with loss and decline in body functioning and well-being resulting in dependency, loneliness, depression and cognitive decline.

The Ghanaian elderly seemed to share similar perspectives with Westerners on ageing. Four (4) of them chose to express their views on ageing by either singing or referring to the chorus of Ray Williams' all-time favourite song with the lyrics "*Growing old, growing old, I wish I never grow old*". For them, the lyrics of the song adequately captures the process of ageing.

Doreen shares her perspective on the appropriateness of this song when she notes:

The song is true [she started singing the chorus "growing old song"] When you are old, you suffer a lot and you also get tired but when you are young, you do not have any care in the world and you do things with ease, in other words you struggle in life (*Wo bre*) you suffer, when you are young you can walk faster but when you are old, you need the help of people and other things to be able to walk, you cannot have what you want. Just look at me I have to come here with a walker, all my movement is dependent on that, when I was young I was walking with ease (*pim pim pim*), The song we sung is very true. You cannot go wherever you want to go or do what you want to do; you are restricted, by your body's strength and abilities. The person who sung that song did well.

Although at first glance the above suggests that the residents at the residential aged care facilities are like Westerners in being negative about ageing, the perspectives of the Ghanaian elderly at the residential aged care facilities are more nuanced than that. Although the majority (10 out of 15) of them pointed to the difficulties and sufferings the elderly person experiences in life, they nonetheless indicated that they were thankful to be alive. They view this phase of their lives in a positive light because, given the relatively low life expectancy rate in Ghana, attaining old age is a gift and a blessing from God. Catherine was of the view that;

Growing old is a good thing. It is a blessing, it is full of blessings if you have good health, you can only enjoy it if you are well. If you have people to take care of you and be at your beck and call then it is a pleasant experience, if even it is the home you have your peace of mind all that it is okay, growing old is a blessing that a lot of people do not get. If the person is not sick and is healthy it is full of joy, it is not something bad.

Henry shares his thoughts as follows;

We have to prepare for that time of our life, you see the whites they have gone through all of these stages already, they are educated and they know much about all

these kinds of situations with growing old. In their schooling they are made aware of all these things so they get prepared, we are not used to such things, we just come and join inside we find ourselves in the situation, like me, if it were not that my children are there, and they are not educated like that, I will be like some others and I will die early, that is why people die early.

Doreen was also of the view that:

Old age is thought of as a gift from God which comes any way even though not all experience it, we all long to grow old, anyway it sometimes the way of life that shall determine their life in old age, it comes with its challenges, like sickness but not everybody has it so those of them who are old should be thankful to God all the time despite the difficulties they face.

In sharing their thoughts about ageing, the majority of the elderly persons described the process of ageing as a two-part progression with the first part perceived to be positive and the second as negative. The first or the positive part is characterised by the elderly person being largely healthy, strong and independent and therefore able to perform all the activities of daily living (ADL) on their own. During the first phase of ageing, the elderly person pursues activities of interest like attending social gatherings and playing a key role in social organisations. They can also continue to pursue economic activities and support members of their family in diverse ways.

On the other hand, the second phase is characterised by a period of ill health (when chronic diseases set in), increasing disability and limitations that require long-term care. The second phase is characterised by increasing dependence on others for the performance of the ADL, limited mobility as well as restriction to limited space or confinement. Additionally, they are unable to pursue economic activities or to support family members; they rather require financial support for daily living and medical care when they have ill health. It is during the

second phase that challenges associated with caring (technical/physical, material, emotional and medical) for the aged persons begin to surface. Edna shares her thought as follows;

If you become old and you are healthy it is a blessing, growing old is full of difficulties, Life is full of troubles, growing old is difficult, in the past there were so many things I could do without any body's help but, if you are old and cannot do anything for yourself and you have things to do but there is no one to do them for you it is difficult.

A theme in participants/informants perceptions of ageing is the idea of ageing as a cyclical process, one where in van der Geest's (2012, p.228) words "the dependence and helplessness of new born babies and small children returns to many people at the end of their life" rings true. For some of the residents, ageing is a process which is associated with one becoming like a child because of the increasing disability associated with the chronic diseases they suffer and the need for them to depend on others to achieve ADL. Just as a child has to be nurtured until it gains the required skills to perform ADL on their own, the elderly person becomes increasingly dependent on others to achieve ADL. Between the two scenarios, however, whereas the child learns to perform ADL within a few years, the elderly person's degeneration can last much longer. Elsie shares her thoughts about ageing as follows:

Oh I will say that when you growing old you increasingly become like a child... you become a child in every way, that is what I know,...you become a child when you grow old because they have to do everything for you as they did when you were a child...becoming like the child is not good for me, I wish I could do everything by myself.

The residents were of the view that ageing becomes much more pleasurable and satisfactory if the health challenges are minimal. This confirms van der Geest's (2012) view that many elderly people expressed satisfaction about being old, in spite of possible limitations, poverty and poor health that they might be experiencing. As Evelyn noted:

As for ageing it is a good thing if you have the strength and the health to do the things you have to do then it is a good thing, sometimes in ageing it gets to a point when one experiences a lot of difficulty like falling sick. For some old people they are even restricted in what they have to eat, some of these old people are for example suffering as a result of the amputations.

Some of the residents were of the view that the experiences of old age are individualistic, because an individual's life course and body frame largely determine the onset of life's challenges the person might experience in old age. Others were also of the view that experiences of old age are situational and that an individual's perceptions about ageing are dependent on the conditions in which the individual finds him or herself. Experiences of old age are influenced by the social support systems of the elderly person, the health status as well as the financial status of the individual and the family. Henry notes that:

My impressions about ageing is that it is based on the situation in which you are in that influences whether it is seen as negative or positive, you may be a very poor man, with a poor family and all that you will see is negative but if you are rich and you have people to care for you, then you will be okay.

Findings from this study show that having a good and active ageing experience requires that one would have spousal and/or children's support as well as family members who would be willing and able to take care of the aged person, and the financial resources for the provision of all the needs of the aged persons. Financial wherewithal is a crucial component of active ageing as it cushions the individual and reduces the stress associated with accessing necessities of life. This supports the findings of Sackey (2009), who argues that money is a necessary determinant of good care.

The availability of money within a family is very significant in accessing care for the aged person. In many cases, the availability of money can enhance access to the best hospitals, doctors or other care providers and medicine. Money is used to establish and maintain social

bonds, and to secure care in old age as it also engenders respect while lack of it discloses failure and shame (van der Geest, 1997).

There are many songs and sayings within the Ghanaian setting that stresses the importance of money in life. For example some of the highlife songs are “*sika ye mogya*” (money is blood), “*ohia ye adanbo, sika fre mogya*” (poverty is madness, money calls/invites blood). Some sayings are also as follow; “*ade a eyefe no sika na yede ye*” (any good or nice thing requires money), “*sika ye abrantee*” (money makes one a gentleman/young). To buttress this point, Henry mentioned that:

If you are a poor man and you do not have energy you will sit there and die, ...If you have the money but no one to care for you, they will bring you here, if you are strong you can go out to anywhere around and come back later and your food will be assured...If you are poor man how are you going to meet your needs and your children will still be depending on you.

Similarly, Evelyn was of the view that,

Yes, money matters in old age, if you do not have children who can take care of you and if you do not have a husband who has left you with a house and property and others which is used in caring for you, life becomes difficult.

Money is but one component of good care for the aged. Other crucial forms of support are physical and emotional care from family members. Without these, the health and physical conditions of the elderly will be poor. Ageing is much more pleasurable and satisfactory when all these facets of good care are available to the elderly within the domiciliary context. However, sustaining domiciliary care is increasingly becoming difficult for family members.

The findings of the study show that an individual's perception about old age is influenced by the different facets of the person's life and the social and economic support or capital that the individual has access to as they journey through this phase of their of lives.

6.3 The Elderly Person's Perspectives on being sent to Residential Aged Care

Facilities to receive Care in the Performance of ADLs

Even though the majority of the residents had learnt to receive support from the caregivers in their performance of ADL, they were unhappy that they could not perform such activities on their own. Some of them even described the whole idea of calling for help as bothering the caregivers. This sense of discomfort with receiving care was heightened when caregivers were non-kin. Indeed, the increasing need to resort to residential aged care facilities was creating tension in some cases between the elderly person's nuclear family and the extended family. With increasing social change and external influences, the question of hiring outsiders in the absence of kin seems to be the answer (Sackey, 2009) although it was clear that not all the individuals involved in such decisions accepted it. The majority were quite comfortable with the decision, attributing it to the changing times. Edwina, for example, notes:

It is okay for the caregivers to take care of me. The older people have a saying that when you give birth to children and you take care of them for them to grow their teeth, they will also take care of you for yours at or you for example if I take care of you for you to grow you will also take care of me at a time that my teeth is coming off and I am old. I think it is all part of it because the children do not have the time to take care of me so my children are paying for me to be taken care of so it is like they are taking care of me, it is part of ensuring that I am supported and cared for my teeth to come off.

Indeed, contrary to traditional norms of appropriate caregiving, nine (9) out of thirteen (13) of the elderly persons at the residential aged care facilities accepted to be moved to the

facilities after they had been informed about the availability of such a place for the aged and the need for them to be sent there. Elsie revealed that:

It was my daughter-in-law who told me that there is a good place for the care of the elderly, which is very good so they will bring me here and I said okay. Oh I liked the idea and I agreed that I should be brought so they brought me here even though I was being taken to a place I did not know, because I was told they will take care of me I was okay. This place is good, I have my peace of mind and I am comfortable here.

Of the nine (9) residents who accepted to be sent to the facilities, seven (7) of them accepted to go there based on the explanations they were given and the remaining two claimed they were misinformed or given limited information about their destination. The two who felt they were misinformed were of the view that they would have protested if they had known that they were being sent there to receive care for such a long period. The challenge, however, for them is that they were brought in at a point when they had no control over the happenings around them and really needed the help and care of their caregivers in accessing health care and other needs. Henry indicated that:

When I was discharged, my daughter told me *I was going to a similar place so I thought I was going to be admitted at another hospital*. Then they brought me here I said okay, because they told me I will be attending SSNIT for treatment so I said okay.... *They did not tell me, they should have told me you know, that I was coming to an aged home* though at that time I did not have the energy to resist I would not have come. If they had told me that they were bringing me here to stay for more than 6 months I would not have liked it [the idea] and I would not have agreed, but being here now it is okay, it is not that bad [emphasis mine].

Similarly, Edna mentioned that:

It was my son who brought me to this place, one of my sisters, the one after me heard about this place so she told my children about it and they brought me here. When they were bringing me *they did not explain into detail to me, they only told me that there is a place they are taking me to so that I can go and rest and get better* [emphasis mine].

In both instances, the primary caregivers were reported to have withheld some information about the destination of the elderly persons from them. They were perceived to have failed to fully disclose important information about the residential aged care facilities. The elderly on the other hand were powerless under the circumstances they found themselves in to refuse their movement to the residential aged care facilities. Powerlessness, according to Wilkinson (2005), is “the perception that one’s own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening” (Wilkinson, 2005, p. 386). Kubsch and Wichowski (1997), were of the view that “the perception of powerlessness is a condition that can affect all humans at times throughout life” (Kubsch & Wichowski, 1997, p. 7) and that chronically ill patients are extremely vulnerable to developing feelings of powerlessness “because of unrelenting exposure to intrusive procedures, side effects of drugs, and the continual downward disease trajectory” (Kubsch & Wichowski, 1997, p. 7).

The basis for the elderly accepting to be moved to the residential aged care facilities was largely related to how these facilities were presented by the family members to them; as a solution to the challenges all and sundry were facing regarding the difficulties associated with getting adequate and appropriate care for them. The three attractions of the residential aged care facilities used by the family members in persuading the elderly persons to accept to access the aged home facilities were: ‘change of environment’, ‘a source of recuperation’ and ‘a source of peace of mind to all and sundry’. Because the concept of ‘aged homes’ is new to most people in Ghana, the picture painted of them by the family members went a long way to influence the elderly person’s perceptions and attitude towards their move and stay at the residential aged care facilities.

Some of the residents were told that they were being taken to a place for a change of environment; which could help them recuperate from their medical conditions so that they could return to their normal activities. Others were told that they were being taken somewhere conducive for them to rest and recuperate. Edna revealed that, “They told me that there is a place they are taking me to so that I can go and rest and get better.”

For those living alone and not getting care in the achievement of ADL, the bait used by the family members, were the thoughts of the elderly being ‘comfortable’ as well as the whole family ‘having their peace of mind’ about the kind of care the elderly person will subsequently be accessing from the residential aged care facility. These attractions were usually presented together as in the cases of Esther and Edwina. Esther specified that:

It is my son who brought me here and I do not know how he got to know of such a place, or how he got to know, he was the one who called me and said that *he wants to take me to a place for a change of environment, a place where I will have my peace of mind* as for that place nobody will worry me and that will I go? I said yes why not, there is no one to take care of me except him so whatever he says, I do not have anything to say, you are the one who is taking care of me so what can I say, if you say I should go and I do not go and you decide not to take care of me again what will I do? [Emphasis is mine]

Additionally, Edwina also mentioned:

Yes some people if they are taken out of their home it does worry them, for some people it does, but as for me it did not worry me at all, eh sister, if your child tells you that where you are, you are not being cared for well and it is worrying us, so they have heard that *there is a place that if they bring you, they will take good care of you so that they will have their peace of mind, and me too I will be comfortable*, why should I complain? What will I say? [Emphasis is mine]

In the case of Esther, the process of her being transferred to a nursing home was a source of fear and anxiety to her in the last years of her life. She was afraid of losing the financial

support and care of the only surviving offspring, should she refuse to agree to the demands of her son. This generated a sense of powerlessness within her.

The traditional norms of reciprocity are such that care is given to children when they are young and adults when they are old. Both the child and the elderly receive care when they do not have the power to perform the activities of daily living they require by themselves. Whereas the child increasingly gains power with time and finally reduces dependence on others, the reverse is the case for the elderly. The elderly person's dependence on others to perform activities of daily living increases with time. The elderly lose power over negotiations as to how and where to receive care in the context of the ill health condition when they are not in the position to make the care arrangements themselves or foot the bills that comes with achieving ADL.

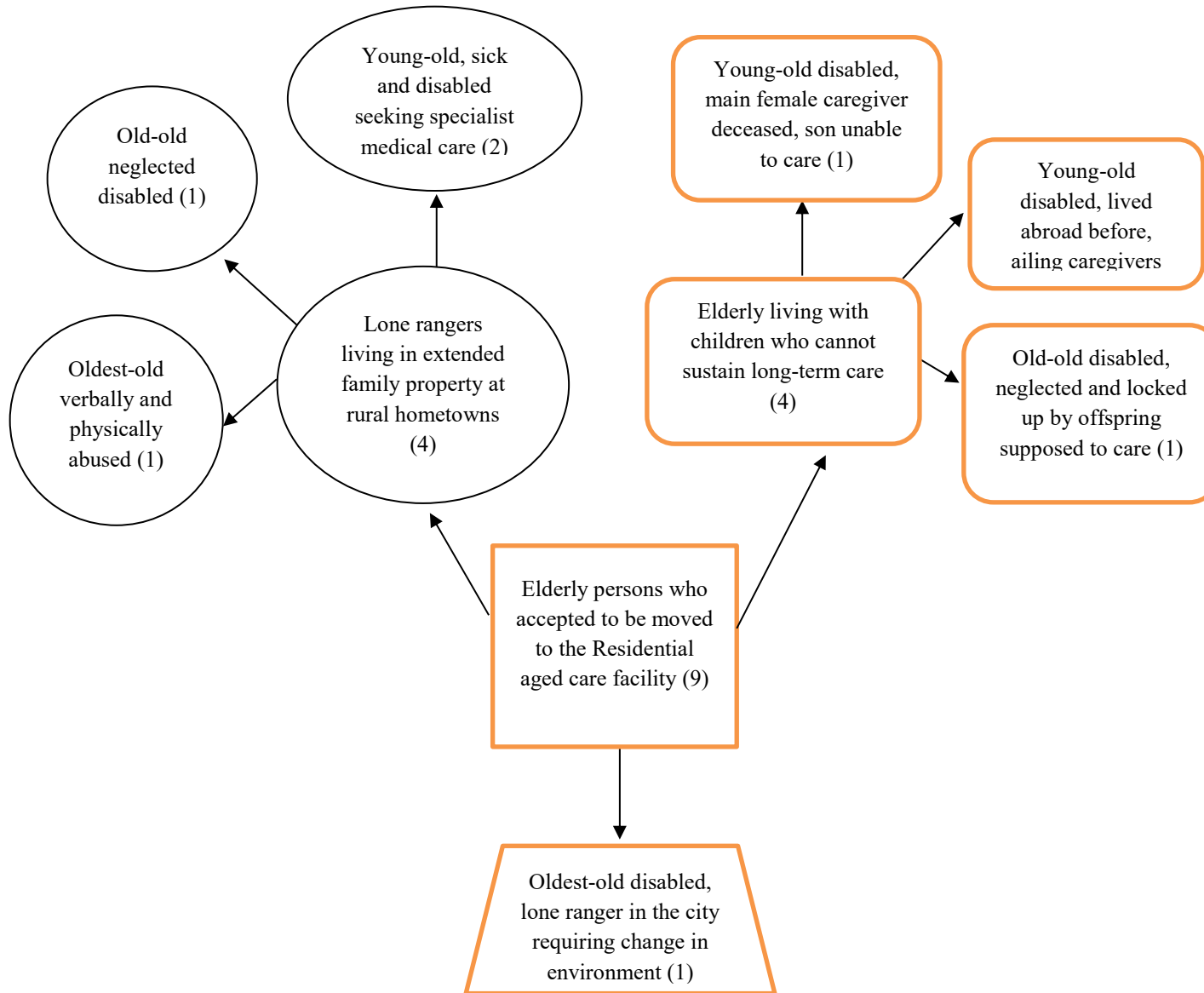
The elderly persons who accepted to be moved to the residential aged care facilities can be categorised into three broad groups. The first group of accepters were elderly persons who were living alone in extended family property in their rural hometowns. This group consisted of disabled elderly persons who were sick and required specialist medical care; those who were being verbally and physically abused and those whose care needs were being neglected by those supposed to be taking care of them.

The second group of accepters consisted of elderly persons who prior to accessing residential aged care facilities were living with their family members or children who could not sustain long-term care. This group comprised of disabled elderly persons who had lived abroad before and were aware of the concept of aged homes and were being cared for by daughters who were themselves on the threshold of being considered as old with multiple

health conditions; those whose care needs were being neglected; and those whose main caregiver (daughter) had died and the surviving offspring (son) was unable to sustain long-term care.

The third group of acceptors were elderly persons who were living alone in the city and had accessed the facility with the aim of spending time in a new and peaceful environment (see Figure 7.1). Accepting to be moved to the residential aged care facility did not mean that the elderly were happy about the decision taken by their primary caregivers.

Figure 7.1: The characteristics of the 3 different groups of accepters of the residential aged care facilities.



- All Accepters of residential non-domiciliary care
- Accepters living alone in rural hometowns
- Accepters living with children in urban centre
- Accepters living alone in urban centres

Source: Fieldwork, 2015 - 2016

Four (4) of the thirteen (13) participants/informants did not wholly accept the idea of being moved to the residential aged care facility to access care when told about the need for that. They were however, moved despite their displeasure. Those who did not accept to be moved were female elderly persons who had been caregivers of their grandchildren and were living with the families of their daughters in the urban centres prior to their hospitalisation.

The rejecters had cared for both their children and grandchildren. They would have continued their caregiving activities but for ill health. They had actually entered their offspring's homes as caregivers to ensure that their children's homes would run smoothly. They had become care receivers due to health complications. After hospitalisation, their offspring usually initiate domiciliary care by doing so themselves. They gradually shift the actual activities of care to hired hands. Thus, the offspring graduate from care providers to care managers. Such elderly persons experience the kin delivering a combination of technical and emotional care to support them in achieving ADL. They therefore feel a sense of rejection and abandonment when the long-term care within the home is not sustained and terminated abruptly at a point when they are supposed to be reaping the benefits of the care they have given twice over since they cared for their children and grandchildren.

Even though such elderly persons may initially not accept the idea of accessing care from the residential aged care facilities, with time they begin to rationalise all that they have gone through and they come to accept their stay based on the realities facing them. Some of the residents survive their stay at the facilities by making 'secondary adjustments' as they may become converted, genuinely accepting the institution's view of themselves and what is acceptable behaviour (Goffman, 1961; Jones & Fowles, 1984). Evelyn pointed out:

Things have changed but people are living in their homes with the old mind set, they will say that as for them they will never take their mothers to such a place but when you look at things critically, what Auntie Mercy has done, she has done very well...As for the death it will come but if you get someone to pamper you a little (*like it is being done at the facility*) before you die it is very good...Today there is no one at home to care for an elderly person, if you do not take care you will be locked inside the house, if you are in an estate building and the door is not locked, the gate will be locked so that you stay indoors.

Rationalising the move to residential aged care facilities and coming to terms with it is crucial to the quality of life lived at the residential aged care facilities.

6.4 Sense of Abandonment

Whether the elderly accepted the non-domiciliary care or not, most of them felt a sense of abandonment at three different stages of the process of accessing the residential aged care facilities. The first is when they are told about being sent to the facility, the second is when they are moved to the facility and left there and the third is when the elderly persons do not hear from family members through telephone calls or visits while they are at the residential aged care facilities.

The first stage at which the elderly persons feel a sense of abandonment is when they are told about being sent to the facility. Whether they are told early or not, the elderly persons reported that they start feeling a sense of abandonment immediately they are made aware and they may adopt a solemn demeanor henceforth. Catherine professed that:

I told her about it and she accepted it whole heartedly because she has also lived abroad before so she was familiar with the whole idea so when I told her she said of the facility is now available here?She was not sad per say, she willingly accepted it, because she realised I was not that strong and I did not have the strength to be taking care of her she knew we were always looking for people and we were not getting them but she became very quiet, she was not herself.

The second stage at which they feel a sense of abandonment is when they are moved to the facility and left behind by the family members who accompanied the elderly person. Barrow (1986) contends that forced relocation is more difficult than a voluntary move and it can bring trauma, confusion, grief and a heightened sense of aloneness. According to him, voluntary movement to improved living environments have been shown not to adversely affect the aged (Barrow, 1986, p.222-223). Findings from this study confirm Barrows findings. Some of the residents survive their stay at the residential aged care facilities by making 'secondary adjustments' by withdrawing or cutting themselves off from contact and interaction with others (Goffman, 1961; Jones & Fowles, 1984). At the initial stages, some of them become very sorrowful and moody and as part of the procedures, such elderly people are observed by the facility operators for a period of two weeks after which a decision is taken as to whether the resident should be retained or sent home. Edna shared the following, "When we got to the facility initially I felt sad that they had changed my living environment, I said oh is this my end, I was very sad to think that now such a decision had been taken about me."

Observations of some of the residents indicated that they were confused and restless at the initial stages of the move to the residential aged care facilities with some of them refusing to be cared for by the caregivers. Those who were confused kept asking repeated questions and were sometimes ignored by the caregivers and other residents. Some of those who were restless were strapped to their seats. Those who attempted leaving the Eastwoods Home were restrained by some residents who could talk or make audible sounds by calling the attention of the caregivers. At Westwoods Home, the gate to the facility is usually locked so even though they might try to leave the premises they are unable to unlock and open it. Four residents were observed behaving in this manner and all of them were described by the caregivers as suffering from dementia.

According to Sackey (2009), in many African societies, the sick are never left alone. They are usually surrounded by relatives (Sackey, 2009, p.202). Traditionally, when a sick person has to be sent to the shrine for treatment, relatives accompany them and they remain with the sick person at the shrine and return home with them. Sackey (2009), notes that this practice to a great extent has been transferred to healing churches and state hospitals. The presence of family members at the bedside of a sick person is important in fulfilling the cultural practice of giving water to the dying person to drink before death occurs. In comparing this practice to what pertains to aged persons accessing the residential aged care facilities for care, it can be argued that unlike the healing churches or the state hospital settings even though the elderly are admitted at the facilities when they are critically ill requiring long-term care, all the relatives who accompanied the elderly person leave the facility after the elderly have been admitted and assigned space. The elderly persons are left behind to share the living space with strangers and be cared for by unfamiliar faces thereby heightening the emotional state of the elderly person. Family members or relatives may only visit for a short period of time in a day and at least once a week. Majority of the elderly persons were reported being sad and sorrowful upon admission.

The first two stages of the feeling of abandonment is experienced by the majority of residents as they are brought and left to stay at the residential aged care facilities. Those who are not informed prior to access do not usually experience the first sense of abandonment but rather a greater magnitude of the second phase when they are left behind at the facility. Usually at the initial stages of accessing the facilities, the family members call and visit the facility often to ensure that the elderly has settled in and to reassure him or her of the love and care for them. Observations are that for some of them, the longer the stay of the aged person at the facility, the wider the interval of visits of the family members.

The third stage of abandonment experienced by some of the elderly persons is when they do not hear from family members through telephone calls or get visits from them. This level of abandonment is usually heightened and residents experiencing it are often perceived to be very sad and tearful. For such individuals, anytime one draws them into a conversation, their family's behaviour is all they talk about in the midst of tears. This is what one of the female residents who was not getting visits from family members but yearned for the affection of her parents stated:

But right now that my parents are not alive, so it has made my case pitiful, here I am alone and my family is somewhere (*ini efee mɔbɔ*). My daughter used to come but these days she is busy so she does not come, she is also a [Jehova's] Witness and plays an important role in the church so she is very busy with church activities too. My son does not go to Jehovah's witnesses, he used to come here a lot but he has stopped so I do not see him now, he has stopped coming.¹

Generally, the sense of abandonment felt by the elderly persons reduces when they get telephone calls, visits, or both from their relatives and family members at short intervals. This then reassures them, making them feel that their stay at the facility is a temporary phenomenon, which will change with time. They therefore begin to understand and accept their condition. Apart from feeling abandoned, whenever residents do not hear from their family members, they become anxious until they hear from them. The following is Esther's remarks about the frequency of visits from her grandchildren. Her only surviving child lives abroad.

My grandchildren, they come and visit often, those of them who know that I have come to Accra, they come and visit me. Yesterday I looked forward to seeing any of them but none of them came, one of them is a teacher ...the one who brought me to this place in a car promised to come and visit but I have not seen her. She has not been here for about a week but she called that she has not been well that is why she has not come... when she called I told her not to worry herself and rather get better, because I am better here and I am fine.

¹ The daughter she was referring to had actually died.

Only a few of them did not feel a sense of abandonment at the initial stage of the process as they were brought to the residential aged care facility. Some of such people are those who lived in towns and villages outside the Greater Accra Region and had been brought to Accra on referral from a health facility for specialist care. Such people initially go on admission at the hospital and after they have been discharged look for accommodation within the city in order to visit the hospital for subsequent reviews. A few of such people access the facility until they have been totally discharged from the health care institution. Such people usually see the residential aged care facility as a health care institution and a mid-point to accessing health care for their medical condition therefore accept it whole-heartedly.

Other elderly persons who have been verbally and physically abused by relatives, who were supposed to be caring for them, are usually relieved to find themselves in an environment that is different from what they were used to. Those who have also been neglected are also happy to find themselves in an environment where people who are not relatives are willing to care for them and ensure that they perform ADL.

None of the family members were of the opinion that they had abandoned their elderly persons just because they had taken them to the residential aged care facilities to access care. For them, the elderly persons required specialist and dedicated care outside the domain of the hospitals or clinic, thus, the residential aged care facilities. Findings from this study show that owing to the transition the elderly persons go through, some of the family members do not deem the elderly persons fit to make appropriate decisions regarding how and where they should access care. Therefore, even though moving them to the residential aged care facilities might not be what the elderly persons want, that might in actual fact be

a transit point in order to achieve the goal of better care to enable them regain the use of some of their body parts affected by their chronic diseases. Jeremy was of the view that:

....We are trying, we want her to live,...some few friends of hers when they got to know about it and especially me spearheading her coming here they were not too happy about it and they thought we were trying to abandon her. I have been in the country for about 7 to 8 weeks and I pay her a visit every other day on behalf of my wife and eh I will not call that abandonment....I think we have moved further in the right direction for her to get better treatment, I wish you had seen her when we brought her. She was so fragile and now she can sit in the wheel chair balancing herself. At first when she sits, she just goes like this (slanting sideways) she cannot come back unless you push her.... You see my wife wants to come down soon to visit her and when she comes she will spend only 3 days, when she is coming she spends about US\$1500 to come and stay for 3 days, will you call that abandonment?

Whereas the elderly feel a sense of abandonment but rationalize their experiences with time, the family members on the other hand initially feel excited at identifying the facilities but become anxious and distressed about the decisions they have made and how it will be interpreted by society. They also worry about the adaptation of the elderly to the new environment. With time, the family members convince themselves and feel relieved that they had found a solution to the challenges associated with addressing the care needs of their elderly. Thus, accessing domiciliary care is not abandonment.

6.5 Family Members Rationalisation of the Shift from Domiciliary Caregiving to Accessing Care from Residential Aged Care Facilities

In rationalising the whole process of their elderly accessing non-domiciliary care, the primary caregivers intimated that most of the elderly persons become disoriented and disillusioned during and after their hospitalisation experience. After they have suffered major medical complications associated with their chronic diseases, they go through a transitional period from a phase of performing all ADL by themselves to a phase that they have to accept care in the performance of the ADL and depend on others to achieve such

tasks. For the majority of the family members and relatives, that period is a very difficult transition for their elderly persons. This transition usually affects the psychological and emotional state of the elderly persons and as a result, some of them may refuse to be assisted in performing ADL. Catherine shared her thoughts about the state of mind of her mother as follows:

The major changes and adapting to all that is not an easy thing for them, my mother for example, I can see that all that has happened to her is really worrying her and eating her up, it has been about 4 to 6 months now so maybe it will take a while before she gets used to everything and accept that the condition has become part of her some people easily move on or are forgetful but as for my mother things worry her a lot and she does not forget things that easily so she is still holding on to all that, we try to encourage her to be patient and that she will feel better with time, things will get better with time but still... She keeps asking oh so when will I walk again and then we tell her not to worry and that she will be better with time.

In sharing their thoughts and feelings about providing support to their elderly persons to achieve ADL during that phase of their lives, some of the family members and relatives were of the view that the elderly become more demanding of their offspring. At the initial stages, some of the elderly persons may be difficult to handle and may demand that the activities of care be performed on their own terms; that is, as and how things had been done in the past and when they decide to have it done. Jason was of the view that:

Those transitional periods are not easy ones for them, this is somebody who was working and doing everything for herself and at her will, she was, doing her own laundry, her own ironing and her cooking, she drives to town, to the market and do her shopping and all that living the European style of an organized person's life and then within a short while she has become a dependant someone has to lift her up, wearing her things and all that, the transition is huge, so initially, she did not believe that was her, it had to take some time....so she has to be helped to understand the condition in which she is in and how she ought to act and all that.

Some of the family members and relatives were of the view that in trying to help the elderly settle into their new role as sick people and ease the stress associated with the transition, the elderly persons get used to the attention and care shown them after their discharge from the

hospitals. They would want their children to be at their 'beck and call' all the time, helping them in performing all the activities of care. At the initial stages, this leads to them becoming the care providers as society expects of them. Findings from this study show that the elderly demand the presence of their children at their bedside and they would not allow others to help them perform intimate technical activities of care when the need arises. Catherine professed:

This is interesting because my mother..., she likes to be pampered, (eyitso mli ngole tso) at every time she wants someone to be by her side pampering her, at every time she wishes that you are there by her, when you answer the call and you go and see her too you realize there is nothing wrong with her you have to be bossing her and all that, she needs pampering and nothing more.

Similarly, Claudia also mentioned that:

...Initially I was doing all of the work and it was affecting me emotionally, and physical because I have to get up early in the morning, bath him, make sure his food is ready.... Well my father did not have any problem with me bathing him, infact, when I was not around he would not allow anyone else to do it for him, he just didn't want that so I had to do it myself all the time.

Findings from this study show that being present at home to answer to every call of the elderly person as the norms of reciprocity demands, does not become realistic with time. This is because, if the caregiver had taken time off work to care for the elderly person, he or she has to resume work and would therefore not be present at home to answer to the elderly person's calls. In cases where a business operator had left the business in the care of another person, the operator had to return to ensure that her business is not being run down. As the baton of care is given to hired hands to assist with the care of the elderly in the absence of the primary caregiver, issues begin to rear their ugly heads as some elderly persons even refuse to accept care from the hired hands until the return of the primary caregiver each day. In instances where the health condition of the elderly person does not improve and caring becomes a lifetime career for the primary caregivers, looking for

alternative means of care for the elderly outside the home is the next option they consider.

The following are excerpts from my conversations with Claudia to shed light on the above.

....It has been like 9 years since he fell ill in 2007 and we are in 2016 you see, ... he has been here for 3 to 4 years... initially I was doing all of the work of caregiving.... Infact when I was not around he would not allow anyone else to do it for him, he just did not want that so I had to do it myself all the time....em there was a time that my father soiled himself and I was at work, he would not allow anybody to touch him until I returned from work. I came home at 9pm and I was tired and stressed out all that yet I had to bath him after having cleaned the faeces you see, then I said enough of that.

Almost all the offspring who were living with the elderly persons prior to them accessing the aged home facilities were first and foremost care providers who delivered hands-on care before they assumed the role of care managers having oversight responsibility for the care provided to the elderly. This switch is usually done because of the energy sapping nature of physically caring for the aged especially when it comes to lifting the aged person from one place to the other. In sharing her thoughts about changing her role from a care provider to a care manager, Catherine recounts that:

She was living with me and my family, she has her own place where she was living but when she fell sick she came to live with us so that she could be cared for. She was with me for about a year. You see we are all growing old... my strength is not much and since infancy I have not been that strong so I do not do much hard work, I can't do that so when it became necessary for me to care for her I tried but it was not something I could do for long so we decided to employ somebody to take up that responsibility so that we pay her, we got somebody who started but it got to a time when that person's child who was about two years had to start schooling and she was not living in our area, she was a married woman too so it became necessary for her to leave us to take care of her family.

Becoming a care manager while the elderly person lives at the usual dwelling place is not usually associated with ill feelings for the primary caregiver because this phenomenon is hidden and out of public view or critique. It is the act of moving the elderly person out of home to access care at the residential aged care facility that is associated with feelings of guilt and remorse for some. One (1) out of the three (3) daughters of residents mentioned

feeling remorseful after the mother had been admitted to the facility and she had to leave her. The other two women rather heaved a sigh of relieve after their elderly persons had been admitted to the facilities.

Although feelings of guilt, duty, loyalty and even shame are often associated with any attempt to consider nursing home care prior to the critical need for it (Barrow, 1986), findings from this study show that over time, the family members and relatives of the elderly rationalize the decisions they have taken regarding the termination of domiciliary care for their elderly persons. Some of them see the support given to elderly in the performance of the ADL in accordance with the traditional norms of reciprocity as old fashioned and outmoded. Such people usually refer to the impact of social change and modernity, which calls for Ghanaians for that matter to adapt to new ways of doing things where necessary so as to achieve the needed results. Jeremy, a filial kin of an elderly person who lives in the USA with the family pointed out that:

People have different perceptions about these things and we need to come out of our old shells and just know that times have changed so we need to move with the new times and we will be happy, us, the children and all aged will be happy.... You see about the abandonment, we are Ghanaians and we have different perceptions about things and people hold on to or value thing which excuse me to say are archaic you see, we need to just come out of our shell and mentality and look a little bit at the outside and look forward. If we look at it as an European way of doing things, then there is a problem. They would say she has a house, why take her out of it elsewhere. Why take her to a home and that sort of thing but look, apart from this woman who came visiting her she was a leader of a church, they had more than 100 people nobody had visited apart from this lady, meanwhile they will sit somewhere and say they are not seeing her and then they will come and say all sorts of things that is why when we were bringing her I wanted the daughter to be here for her to be the one who signs the document to say that I brought my mother here, not the in-law.

In Ghanaian society, female offspring or relatives and in some cases daughters in-law have the responsibility of helping the aged persons address their ADL needs. Currently some

female offspring and relatives are educated and working out of home. Therefore, they are usually not available to perform the traditional societal expectations of being physically present to care for the young, sick and elderly in the family. Caring for the aged after close of work for them to achieve ADL becomes a difficult task, which is usually performed with some amount of frustration. This could antagonise the relationship between parent and child if the elderly person is perceived to be making seemingly unreasonable demands.

The revolution in women's traditional roles as caregivers because of social change and higher educational attainment makes the traditional notion that women are more available to provide care progressively outmoded. However, studies have shown that women's engagement in fulltime employment did not prevent a woman from becoming a caregiver as many of them simply add the unpaid work of caregiving to their other responsibilities (Quadagno, 1999).

The primary caregivers or decision makers who choose care at the facilities for their elderly persons are mostly women who are the first born or first female child of the elderly person who are highly educated and are career oriented. Some of them are in high positions at their work places or operating their own businesses or shops. These women usually went to work early but closed late. They embarked on business trips within and outside the country for varying periods of time. Some of them also attended training programmes, which sometimes took them out of home even on weekends. They therefore required care services needing minimal or no supervision for their elderly persons. Others have been living and working abroad and therefore unable to be present to supervise the kind of care being provided to the elderly by those who have been assigned and are being compensated to do so. Yet others

were the only surviving children (usually male) and could not adequately provide the hand-on care for the aged person who is usually of the opposite sex.

The family members usually commence their role as parent caregivers to severely disabled older parents when they are in their middle age or early old age. Three (3) out of the six (6) primary caregivers were above 50 years of age and were experiencing some amount of health challenges themselves. Unlike caregiving for children who become more independent with age, caregiving for the severely impaired elderly person requires more assistance with time. These female caregivers also had dependent children at home and were manning their homes as single parents or married women.

Studies have shown that care provision by informal caregivers invariably comes at a cost to the care providers, as it is time consuming, mentally stressful, and physically exhausting. These costs can negatively impact on the career and health of the caregiver (Bauer and Sousa-Poza, 2015). The degree of stress experienced by a caregiver depends partly on the coping mechanisms they have adopted or developed to deal with other life events and partly on the kind of social support available to them (Quadagno, 1999).

Knowing that the Ghanaian society will question their behaviour and in some cases verbally abuse them for their actions regarding their aged parents accessing the residential aged care facilities, most of the family members and relatives seemingly over emphasized the negative aspects of their caregiving experience. The negative effects of caregiving on the caregiver includes emotional strain, loss of a familiar lifestyle that comes with greater confinement, disruption in plans, financial worry associated with having to pay for unbudgeted bills related to home care services.

Findings from this study show that the initial effort at providing hands-on care for their elderly within the domiciliary context had varied effects on the primary caregivers because they were combining the provision of care with their paid work. They suffered physical, emotional and psychological stress irrespective of the duration of providing eldercare within the home. Studies have shown that caring for older persons with many chronic conditions can stretch the limits of caregivers' energy, health and emotions. This study finding shows that informal caregiving can be a daunting task, which can have varied effects. Caregivers often feel mental and emotional strain. This can lead to depression, anxiety and emotional exhaustion (Novak, 2006). This is how Claudia describes the burden of being a care provider to her father:

...Initially I was doing all of the work of caregiving and it was affecting me emotionally, and physical because I have to get up early in the morning, bath him, make sure his food is ready before going to work. As I said it was affecting me mentally, physically and all that, so that was when I started looking for help so that was when somebody pointed me to that place at Madina, but it was not residential but at least it was going to solve the problem somehow. So they will come in the morning bath him and all that.

Findings from this study show that by providing hand-on care for the elderly person, the caregivers curtailed their social life as the frequency and contacts as well as the quality of social life reduced. The act of hand-on caregiving often restricts the social contacts of the caregiver outside the domiciliary environment. According to Novak (2006), this can lead to caregivers feeling trapped and at a dead end in life. The greater the impairment of the elderly person, the higher the feelings of depression experienced by the caregiver (Novak, 2006. p. 359). Bauer and Sousa-Poza (2015), note that informal caregiving affects the caregivers' family dynamics and living arrangements because caregiving is constantly present within the household and therefore affects the family's daily living. Claudia revealed the following:

...I thought through my situation, I discussed it with very close people and all of them knew what I was going through because I did not have any social life...

In most OECD countries, caregivers are entitled to leave work for a limited amount of time. The absence granted from work varies and only some countries provide paid leave. Even when paid leave is provided, it tends to be short, usually less than a month and rarely as long as the 12 months allowed in Belgium. This, however, is not available in Ghana, a lower middle-income country. Another incentive used to promote care in the home to avoid hospitalization is financial transfers made either to the care receivers themselves or to the informal caregivers because informal caregiving is often a full-time job. According to Bauer and Sousa-Poza (2015), over the years, studies have shown that caregiving of the elderly usually affects the job performance of caregivers. Some of the work related problems encountered by employers are often caused by employees' caregiving responsibilities such as employees stress, fatigue, absenteeism, late arrival at work and early departures, and above average telephone use. Additionally, the caregivers experienced a lot more of conflict between family demands and job demands in the process of providing domiciliary care for their aged (Quadagno, 1999).

Findings from this study show that there were instances where one of the caregivers was torn between travelling outside the country for a scheduled work training and forfeiting it in order to care for the aged parent. Even though she discussed her challenges with the employer, she suffered setbacks in her career progression. Below is how Claudia narrates how being a care provider affected her career as a legal practitioner:

... There were instance where I did not to go out for training, I mean work related training and I needed to let it go. I discussed my current situation with my bosses and I told them that I will not able to go for that reason. Yes, I did you see, it affected my career progression so those where some of the difficulties I was going through I talked to people close to us. It was the best decision to take under the circumstances.

Operators of own businesses also face the challenge of choosing to either hand over the running of their businesses to third parties (and operate at a loss) in order to care for their elderly persons or continue the management of the businesses themselves and sublet the care of the elderly person to hired hands. In choosing to stop running their business operations in favour of caring for the aged, one should be physically positioned to assist the elderly and there should be financial reserves to fall on to address all the necessary financial needs. In such instances, most elderly persons would not encourage their offspring to choose them over their businesses knowing that it is the main source of income in addressing the family's financial needs. Catherine explains the dilemma she found herself in and the decision she was willing to take regarding her mother's care arrangements:

On one of the occasions that she was crying at the home, I asked her whether she would like me to close the shop and come and stay at home and care for her? I will not be worried I can do that but will I be able to lift her up from one place to the other? no I cannot do that because I am not that strong and what will we eat at home? If I am not able to lift her I will need someone to do that for pay, how will I pay that person and what will we be eating, daddy is there but he is also a pensioner.

6.6 Family members Perceptions about the Care Received by the Elderly

Contrary to the views of the elderly, most of the family members were quick to give positive feedback regarding the services being provided by the residential aged care facilities. Some of them even mentioned that they would recommend the facilities to other people who are in need of such support services to care for their aged persons provided they could afford it. In evaluating the care their elderly persons were receiving at the residential aged care facilities, some of the family members described it as a relief. Family members can now attend to the different facets of their lives and go about their busy schedules with some peace of mind.

This study finding shows that the elderly people's patronage of the residential aged care facilities brings the family members some relief and the assurance that the elderly are being assisted to perform ADL. However, this does not give the family members the absolute peace of mind and desired satisfaction they would require to go about their daily activities. Some of them wonder about the kind of care and treatment meted out to their elderly persons when they the family members are not at the facility. They were very much aware that the elderly persons were demanding and difficult to handle and therefore wondered how long the pleasant attitude the caregivers expressed in their presence could be sustained. For some of them, the probability of the caregivers ignoring the elderly persons because of their numerous calls and attitudes was a source of worry to them. Some were happy that their elderly persons could talk and communicate any maltreatment that would be meted out to them. Some of them were however, worried about elderly persons who had lost the power of speech and therefore could not complain when the need arose. Clara, a daughter of a female resident shared the following;

I was saying sometimes her demands became too much for me to handle and therefore I do not mind her how much more them the caregivers, so I think about all that and I became worried/troubled, ...So when I am here and she calls then I quickly pick a car to go and visit her and chat and encourage her.

Catherine was of the view that:

I want to say that the care is okay, it is fine, personally I would say that human nature, sometimes it comes to those of us who are even related to the elderly persons, when we are at home with them once in a while you can be fed up with them, the elderly person will do certain things that will make you frustrated with them and sometimes fed up with their demands. In one minute she wants to get up, in a second she wants to sit down, do this, do that, I will watch television, take me to that place, all sorts of demands. We are human beings may be you might get fed up and say that why don't you just make up your mind regarding what you want? So you can imagine at the facility she is not the only one there making demands, there are others there too like that, they are many, so those taking care of them too once in a while, something like that can happen.

Through the interviews, it came to the fore that because most of the elderly persons suffered one or multiple disabilities, most of them became attention seekers wanting their caregivers to perform one task or the other at very short intervals. When that happened over time and the elderly persons were perceived not to be making any effort to recover the use of their limbs, the caregivers began to ignore their demands. That did not usually go down well with the elderly and they put all sorts of interpretations to the actions of the caregivers. It was observed that such elderly persons complained, asking questions such as “*meyɛ wo busua ni a anka wobɛ yɛ me saa?* (If I were your relative is that how you would treat me).

A few of the family members were worried about how the elderly persons felt. For them, if family members ignore their elderly within the domiciliary context, the elderly glosses over it and life continues but they were not sure of how an outsider’s reaction would be interpreted. They were therefore worried that such actions would cause the elderly persons sorrow and they would be blamed for such treatment by outsiders. Catherine was of the view:

Those people working there are humans and elderly people can be difficult to handle and troublesome. My mother for example she is very heavy, it is not easy to do things for her so if every minute they have to care for them then.... My mother for example every other minute she wants to either get up or lie down so you can imagine at home, we will be patient to do it and even if I grumble or murmur for a while you do not have a choice so you will do it but the moment she does that at the home care facility and the people complain or ignore her she will be hurt and keep it inside. If we were to be complaining at home she will be hurt but not that much you see, even if it hurts her she will not take it serious but the moment she goes to do that at [the] home and maybe she calls and nobody minds her, she will say that “Look at where my children have come to throw me away at and see how these people are also treating me.”

Despite their level of satisfaction with the type of care the elderly received at the residential aged care facilities, majority of them agreed with the point stressed in the Ga and Twi languages saying that “*kwɛmɔ oha miɛ, etamɔɔ bo diɛntsɛ/whɛ ma me entese woankasa*”

(asking someone to take care of something for you is not the same as you doing it). They acknowledge that taking care of an elderly person is a difficult task; therefore, the elderly persons might end up not having the type and quality of care the family members might have provided them if they had the time to do so.

When it comes to feeding, majority of the family members were satisfied with the quantity and quality of food provided to the aged persons at the facilities, which contributed to their recuperation. Based on the complaints of their elderly persons, a few of them felt that the quantity of food served to the elderly at meal times was not sufficient. Some of the family members would have preferred to cook in bulk and send the food to the facilities for storage and serve to their elderly persons at meal times. But they were not allowed to do so. Some family members had to console their elderly persons that what they were being provided was commensurate with the dietary demands of their medical conditions. Clara, a daughter of a resident complained that:

They do not allow us to take food to them and that is what worries me because she is my mother and sometimes I feel that when I am eating something nice I should go and give her some. She is my mother and I know the things she likes, but they say that that is not how things are done, we cannot take food to them, all we can take when we are visiting them is maybe fruits, bread and the like, but you see some times she complains that she gets hungry. Those who suffer from diabetes usually eat in bits you see, so I look for sugar free biscuits and buy it for her....That is what worries me about the place.

On the issue of spiritual care, a few of the family members were of the view that the residential aged care facilities ought to offer the aged persons a lot more spiritual care than they were currently doing so as to comfort them at this phase of their lives. For them, increased spiritual activity would help the aged because it would increase their faith in God a little more and help some of them be healed quicker. For others increased spiritual activity is better than non-existence of the same because the elderly need spiritual things in order to

prepare them for their journey into eternity. It was also suggested that they be made to fast once in a long while despite the fact that they were on medications and required to eat. Jason, a filial kin of a resident who is a priest shared the following views:

I think they should add a little more spiritual dimension to the care. They should bring them together in the morning and share scriptures and help them sing some hymns not ordinary apostolic songs. They should sing hymns, teach them a hymn or two, teach them scriptures. Hymns help us to reflect a lot more than the other songs, apostolic songs are kind of like danceable tunes. The hymns help us to tune into God, the words in the hymns, the words brings comfort....They will not die if they fast, in any case if they die, it's only this body that is separating itself, they are spirits they would have gone but leaving her to meet higher spirits to obtain strength, so that is it.

The medical care provided by the facilities was rated high by the majority of family members. Most of them were appreciative of the routine medical checks provided at the facility and the first aid provided as well as the prompt action taken when an elderly person had to be sent to the health care facility as and when the need arose. Contrary to the expectation of some of them, however, their elderly persons had not had adequate physiotherapy to have them recuperate and regain the use of their limbs as they had anticipated. Claudia was of the view that:

I don't think that my father's condition has gotten worse or better; he has just been okay... I think if they were doing the physiotherapy for him he would get around by himself sometimes and without assistance he cannot get around all by himself. But now you have to put him in a wheel chair. If a physiotherapist was around, it would have been good.

Similarly, Catherine was of the view "that place there is small, small, massaging and all, but I also got to know that the physiotherapist who was supposed to come does not go to the facility any more. Once in a while they get someone to come and offer that service." Instead of physiotherapy being part of the package, some of them had to pay additional monies to access physiotherapy. At Westwoods Home currently, a physiotherapist visits the facility

twice in a week and elderly persons who require that care have to pay GH50 out of pocket per session to the service provider.

The quality of equipment at the facilities were rated low by the family members. Even though the facilities were deemed to be putting in their best to ensure maximum care of the elderly, some of the family members complained that the facilities did not have adequate and state of the art equipment necessary for caring for the aged. Complaints were made about the quality of wheelchairs used at the facility to transport the elderly from one place to the other. Complaints were also made about the lack of equipment for exercising and doing physiotherapy.

With the amount of money paid at Westwoods Home for example, it was expected that the family members would complain about their elderly persons sharing their living space with others but they did not. Majority of the elderly persons had not been sharing their bedrooms with others prior to accessing the facility. However, they had to share rooms at the residential aged care facility, except for a few foreigners who were willing to pay for single room occupancy. Yet most of the family members did not complain about the issues of their elderly persons having to share their living space at the facility with one or two other elderly people who they did not know and who had varied health conditions. This is because their stay at the facility is seen as a temporary measure necessitated by the need for them to access maximum care. Some even preferred that arrangement so that their elderly person would see others around them. Apart from companionship, it served as a way of someone raising an alarm whenever the need arose for the caregivers to offer prompt attention. At Westwoods Home, an elderly person could be given a whole room to him/herself provided the family can afford it. A filial kin mentioned:

Yes, she had her own room and living space, she used to be alone in her room but here they are two in a room but looking at the circumstances, sometimes you need to bend the rule a little bit, you can't always get what you want if you are in such a situation. So we accepted it when we came and they told us she has to share a room we did not have any objection to it. She has a whole house to herself but then the situation would not permit her to be in her own home... the rules have to be bent a bit for her to get the maximum care

For some of them, the elderly persons continue to be difficult and demanding even at the residential aged care facilities, creating a lot of stress for both the family members and the caregivers. Some of the elderly were reported to have physically abused the caregivers and had confronted family members whenever they visited. The confrontational attitude did not encourage family members to visit, if all they got were complaints and tears. Jason, one of the filial kin, however, recounted how his elderly relative had transitioned from a state of being difficult and demanding to that of sobriety and appreciation.

... because of the transition she was going through, today she has become a lot more patient. Initially it was like "do this for me but I want you to do it the way I want it," well it is not always [on] your terms, so for example today I noticed that she has changed remarkably, she is now learning to be more patient and appreciative, previously when I come and visit she is like "you have not visited me, I am not happy with you, I am going to do this." Now she understands. Today, I was looking at the excitement in her eyes and I was excited myself. Then she said, "I know your work does not give you time but I am happy you have come.

Even though some elements of care received from kin might be perceived to be much better than that of the non-domiciliary facilities, the unavailability of kin to provide hands-on care made the family members appreciate care from the non-domiciliary facilities to that of unsupervised hired hands within the domiciliary context.

To conclude, failed domiciliary eldercare results in families accessing residential aged care facilities to address the care needs of the elderly. Even though the elderly might not be happy with it, they rationalized their situation and accepted to access care from the residential aged

care facilities. As the care needs of the elderly were being met, the relatives of the elderly became satisfied. The whole process of accessing non-domiciliary care is characterized by a sense of abandonment experienced by the elderly. Some of the elderly became dissatisfied with their stay at the facility when upon improving, the children did not take them back home. Some of them also began to deteriorate as they refused to perform some ADL. In a few cases, the inability of family members to continuously pay for long-term care resulted in the withdrawal of the elderly from the residential aged care facility.

6.7 Summary

In this chapter, I have looked at representations of ageing and how the residents and their family members make sense of the whole notion of the elderly persons accessing care from the residential non-domiciliary care facilities available in the urban centres of the Greater Accra Region. I have also discussed the perceptions and thoughts of the elderly and their family members regarding the services they access from the non-domiciliary systems of care as well as how they rationalise the whole process. Additionally, I have discussed the sense of abandonment felt by the elderly in accessing long-term care from the residential aged care facilities. The next chapter discusses the traditional norms of reciprocity vis-à-vis the phenomenon of the elderly accessing non-domiciliary care.

CHAPTER SEVEN

TRADITIONAL NORMS OF RECIPROCITY REDEFINED: MAKING SENSE OF THE ACCEPTABILITY OF RESIDENTIAL AGED CARE FACILITIES FOR THE ELDERLY

7.1 Introduction

Traditionally, per the norms of reciprocity, the responsibility of caring for elderly persons within the Ghanaian society to age in place, lies first and foremost with the spouse and offspring of the aged persons and then with members of the extended family. However, in this study, when the elderly persons requires long-term care as a result of complications related to their chronic diseases, they begin to access domiciliary care but lose it with time. The search for alternatives means of eldercare because of kin's inability to continue providing hands-on care or supervise care provided by untrained and trained hired hands results in the elderly persons accessing non-domiciliary to address their care need.

The concept of reciprocity, as has been severally discussed by cultural anthropologists over the years generally, identifies three different types or shades of reciprocity that are embedded in human relations which establishes and maintains social relationships in human communities across the world. They are generalised, balanced, and negative reciprocity (Sahlins, 1971; Meera, & Kumar, 2015). In this chapter, I discuss how the three forms of reciprocity relate to the traditional norms of reciprocity and how they come into play in the process of the elderly persons requiring care, accessing domiciliary care and losing it, the search for alternatives means of eldercare and finally accessing residential non-domiciliary care.

7.2 The Traditional Norm of Reciprocity and Caring for the Aged in Ghana

Generally, there are pleasures and pains associated with ageing in a middle-income country such as Ghana and these are directly linked with the concept of reciprocity, which largely determines the type of respect an elderly person gets within a society. Van der Geest (2008), notes that respect takes on different meanings in different life situations, from outward deference to deep personal affection and that the hidden principle that determines the type of respect is reciprocity (van der Geest, 2008, p.297). In Ghana, an array of traditional customs and culturally moulded expectations define the ways and locations in which the terminally ill are likely to be treated in addition to modern medical practices and religious beliefs and behaviour (Oppong, et al., 2009). In the Ghanaian traditions generally, there is an unwritten moral code of conduct that regulates behaviour of citizens in the traditional society. There also exists a network of social obligations which must be adhered to (Sackey, 2009). Tonah (2009) argues that in a typical Ghanaian household, all the members have important and complementary roles to play. The elderly will take care of the children and they in turn can expect the youth to reciprocate by caring for them in their old age (Tonah, 2009, p.131). Responsibilities assigned to individuals within the traditional setting concerning health care can be found in proverbs, adages, and myths.

Some of the proverbs used in determining reciprocity and caregiving arrangement in the Akan cultural setting for example are as follows: “*woye ma obi a na obi nso ye ma wo*” (if you do something for someone, that person will also do something for you), “*nsa benkum guare nifa na nifa enso eguare benkum*” (the left hand washes the right hand and the right hand washes the left hand) “*sɛ obi whɛ wo ma wo sɛ fifri a, wo so hwɛ no ma ne sɛ ntutu*” (if someone takes care of you to grow your teeth, you must also take care of that person to lose his teeth). Sackey (2009) argues that even though these proverbs do not explicitly mention the mother, most invariably, it is a mother who nurses a child to become an adult

and self-sufficient. That child must in turn reciprocate by caring for the mother in her old age (Sackey, 2009, p.202).

The traditional norms of reciprocity, which has been at the core of the system of care within the extended family, ensuring the security of an elderly person within the extended family is increasingly becoming difficult to sustain. The gradual breakdown of the extended family system because of factors of social change has led to the lax in the application of traditional norms that bind society together. As such, the traditional norms of reciprocity are not being applied by kin and kindred of the elderly as society demands. The extended family cannot do much about the situation because they are not in a position to take full responsibility for the care of the elderly. Thus, some elderly persons enjoy their old age while others are miserable, lonely, poor and hungry (van der Geest, 2008). Findings from the present study show that some elderly people at the residential aged care facility enjoyed their stay there a lot more than others. Those elderly persons who had frequent visits and gifts from their family members seemed to enjoy a lot more than those who did not. Similarly, elderly persons whose family members came for them to participate in family functions were observed to be in a better mood than those who hardly stepped out of the facility. Studies have shown that aged persons in towns and urban centres are often socially isolated with few opportunities to interact with their children, relatives and friends on a daily basis (Tonah, 2009). Additionally, the elderly cannot be assured of the family members support and care largely as a result of the unstable economic conditions they might find themselves in and are not able to provide sufficient food, shelter and other material livelihood essentials for the elderly (van der Geest, 2008; Tonah, 2009). Contrary to the expectations of the elderly, the majority of their family members might not practice the traditional norms of reciprocity fully. However, the family members do not shirk their responsibilities towards them but identify other means of achieving the goal of eldercare at a cost to both parties.

A thorough analysis of the narratives and the study findings show that all the three forms of reciprocity as identified by cultural anthropologists feature in this study and were exhibited by the three different players (initiators, influencers, and the rejecters), in the decision making process regarding the elderly accessing non-domiciliary care.

7.3 Generalised Reciprocity

The study findings show that the Ghanaian traditional norms of reciprocity touted in literature is the same as generalized reciprocity, which is characteristic of the intimate relationships of kinship and friendship. Its emblematic feature is generous sharing, which generates gratitude and an open-ended, diffuse obligation to make a return. In Generalized reciprocity, exchange of goods takes place but there is no specific time limit and particular type of things to be returned (Sahlins, 1971; Kirk, 2007; Meera & Kumar, 2015). The basic elements of generalized reciprocity are that there is no expectation of exact or prompt repayment; the exchange is just a small part of the social relationship between the individuals, as between parents and their children. As such, parents continuously provide for their children out of love and a sense of responsibility but cannot expect the children to repay but hope that they would also be loved and cared for by the children someday. As to whether that will be fulfilled to the expectation of the parent and society at large is another thing.

Throughout the history of humankind, all the three forms of reciprocity as identified by cultural anthropologists has existed in varying shades with generalised reciprocity being the more dominant (Sahlins, 1971; Kirk, 2007; Meera & Kumar, 2015). Among the Akans of Ghana for example, a person who does not reciprocate the kind gesture of others is referred to as ‘*òyèmònyonfoò*’ (someone who accepts other people’s food but does not want to give some of his own). Other words reflecting the act of withdrawing from the rule of reciprocity

are '*boniayèni*' (ungrateful person), '*mankomeyèm*' (only my own stomach), '*adifudepè*' (someone who wants to eat but does not want others to eat) or a '*pèsèmenkomenya*' ('I want it for myself alone'). All these terms depict selfish behaviour (van der Geest, 2008).

All the family members of the elderly persons accessing the residential aged care facilities were well aware of the traditional norms of reciprocity that has governed social interactions within the Ghanaian society over the years. All of them acknowledged the roles the elderly persons played in their lives in becoming who they are presently. They were also well aware of the fact that they have the responsibility to ensure that their aged parents are adequately cared for and supported to perform all the activities of daily living (ADLs) and to age gracefully.

For most of them (5 out of 6), caring for the elderly persons as prescribed by the traditional norms of reciprocity when the need arose is the ideal way of supporting the aged as they aged in place. When an individual child is able to perform the task of caring for the aged, that individual has really made a mark and ought to be commended. Clara, the daughter of a female amputee shared the following view on it:

If someone is able to do that then she has done very well, it is a good idea if after you have completed your education you are able to be available to take care of her...your mother has been able to take care of you, maybe during that time she could have used all her resources to build a house but because of your school fees and others as a student you have to do this and that, the money is not there like that anymore, maybe even her clothes she has sold all of them to take care of you, because of you now she is a paupershe has not said that you should refund all the money she has spent on you but at least giving her the support and the care is important because most of them do not demand much from us. My mother was still buying things for us just before she fell sick.

Despite the above, all of the family members were of the view that because of modernity and factors of social change, practicing the norms of reciprocity, as done traditionally by

our ancestors, is neither feasible nor realistic in modern-day Ghana. It is unattainable especially when family members are not available to provide hands-on care for the elderly the way the elderly persons know how and are used to 24 hours a day, and seven days a week if the offspring is working. In evaluating the current situation, Jeremy, a filial kin of a female elderly resident, indicated:

With what is happening, it looks like reciprocity has somewhat failed.., I will say the living standards have changed from that of our parents' time, our time is quite different so you can't go back to the village and say that you are going to live there and be taking care of your granny or mother you know because the situation you are in wouldn't permit that, the pros and cons of the whole issue; it will either be that you have to sacrifice money and pay for the care so that you come and visit her but you can't just leave your job, go and sit with an old lady in the village and take care of her.

7.3.1 Contemporary Reciprocity: Partial or Failed Generalised Reciprocity?

Oppong, et al., (2009), argue that the ever escalating spatial separation of paid work and the home, the continuous drawing of women into impersonal formalised paid employment contracts drastically curtails the unpaid time individuals have available to spend on needed domestic activity with loved ones. For the primary caregivers who acted as initiators and implementers in the scheme of things, challenges related to health, occupation, family and time constraints inhibited them from providing the hands-on care required of them by the elderly. Additionally, getting reliable and dependable hired hands to provide the needed care for the elderly within the domiciliary context without their supervision is very difficult to achieve. The aforementioned constraints were the reasons why they chose the option of sending their elderly persons to the residential aged care facilities (with their permission) to access care rather than neglecting the care needs of the elderly when long-term domiciliary care could not be sustained.

Even though the family members of the elderly persons acknowledged that they were not following the traditional norms of reciprocity to the letter as society might expect, they, however, did not see themselves as violating the traditional norms. In their view, even though they were not available to provide hands-on care as required, they had not neglected the care needs of their elderly persons as some have done but have put in measures to ensure that the ultimate aim of the elderly persons receiving care or support in the achievement of the ADL was met. Some of them went to the extent of referring to the Scriptures to emphasize their point. James said:

Ha! You do not order that woman about even at her age, no! This is someone who cared for you when you were nobody so if today you have reached somewhere in life it's just a matter of paying back. As the Bible says, it is our responsibility you know to make sure that she is comfortable because with my experience as a parent, I think that whatever I enjoyed as a kid was a result of my parents' sacrifices. Our daddy is no more and if she is alive, we have to give her the needed comfort, okay. That is how we see life after she has worked that hard for us.

Findings from this study show that generalised reciprocity is no more practised to the letter by the primary caregivers as tradition demands. In the place of generalised reciprocity (traditional norms of reciprocity) has emerged what the researcher calls *partial generalised reciprocity*.

7.3.1.1 Partial Generalised Reciprocity

Five (5) out of the six (6) primary caregivers interviewed accepted that per the traditional norms of reciprocity, they were providing their elderly persons with partial generalised reciprocity because even though they were managing the care arrangements of the elderly and paying the bills for their care, they were not available to provide the required hands-on care. For them, providing the partial generalised reciprocity is the best they could do under the circumstances in which they found themselves. With this kind of arrangement, every

party involved in the care of the elderly had the peace of mind to pursue their busy schedule while the elderly accessed care to achieve ADL.

This study further shows that the sense of partial generalised reciprocity dished out to the elderly was the same regardless of the nature of relationship the primary caregivers might have had with their parents. Most of the family members of the elderly persons described having a positive relationship with their elderly persons at the residential aged care facilities. Some of them used words such as 'very close' to describe the bond that existed between them and their parents when they were growing up and could attest to the unique roles their parents played in their upbringing. Claudia narrates that:

I have been very close to my father right from infancy, and a number of my friends know that and they know him so even whenever I travelled they would just ask so how is your father? Some of my friends who have been out of the jurisdiction for a long while, whenever they see me the first question they ask is how is your father doing?

Likewise, James recounts:

Well I used to be the hot type, I do not offend people but if you offend me I will make you pay back; the Torah law type of thing. She was the calm, cool person so she would encourage me to let it go and to forgive the other person. Take it easy and I always thank God and thank her because, all that has given me some level of maturity okay.

A few (2) of them, however, acknowledged that they did not have any close relationship with their parents when they were growing up because their parents were not living with them at one point in time or the other. One of them lived with the father and stepmother after the divorce of the parents. The other lived with the grandmother while the parent travelled abroad. This, however, did not make them renege on their responsibility in paying for the elderly persons to access care from the residential aged care facilities. As indicated by the findings, the relationship or bond between the elderly persons and their children went

a long way in influencing the way and manner in which the elderly persons were moved to the residential aged care facilities after hospitalisation. This study indicates that, family members who have strong bonds with their elderly person usually take the elderly persons to an adult child's home after major hospitalisation to access long-term domiciliary care first. Accessing long-term domiciliary care could span a period of between six months to two years before the elderly person is moved to the aged care facility as a result of difficulty in sustaining long-term care.

Personalised care is more often than not reserved for those with whom the primary caregivers have a close relationship. It is when the circumstances of caring for the elderly within the home gets beyond control that the primary caregivers usually opt for care out of home for them. However, when the relationship between the parent and the offspring is poor, personalised care within the domiciliary context is skipped altogether. Traditionally, elderly persons who had worked hard during their active life and helped their children and others could be sure that those they have helped would in return help them during their old age (van der Geest, 2008). Conversely, it is implied that an elderly person who does not get proper care, failed to provide care for the children and others during his active life.

Elderly persons who did not have strong bonds with their family members were usually moved straight to the residential aged care facilities from the hospitals upon being discharged after a long stay there. Jason, a filial kin (the church leader and family friend) of an elderly lady who lived and worked abroad for 40 years, sheds light on the reasons why he is the one who frequently visits the elderly woman at the facility instead of her two daughters. Residential non-domiciliary care facilities allow children to pay for the care of parents in the situation where they cannot physically provide hands-on care themselves.

So the daughter in Ghana...I should say that she also visits I don't know how often though and she takes care of the background stuff, like paying of the bills and getting the necessary items,...the daughter in the UK, came with us when we brought her to this place, so I can say that they are doing their bit, ...the mother understands that the daughter in the UK for example cannot be here forever. She is a citizen of [the] UK and she has a young daughter, and a husband to take care of. The other one here in Ghana does not have that closeness with her because she was abroad for a long time. She lives outside Accra, she is married and has her own family so it will be difficult for her to come and stay with the mother otherwise she would have to leave her three children, leave her husband and go, and take care of her mother. That is the issue.

Accessing the residential aged care facilities serves as a form of respite for the family members as well as the elderly persons. This is, however, different from the respite care provided for the elderly in the high-income regions of the world, as the stay of the elderly at these facilities is usually long. Non-domiciliary respite care in the high-income countries refers to a short-term stay at a senior community, usually an assisted living or memory care community. It gives the family members of an elderly person the opportunity to attend to everyday activities or to go on holidays while ensuring that the elderly persons are supported to perform ADL. Claudia was of the view that:

The home takes some pressure off you, because society is dynamic. Previously if a family member was in a condition like this, you get one family member who would offer to come and assist you to take care of the aged person but we do not have that anymore. The extended family support is not there anymore. Now, everything boils down to you as an individual so once we don't have that kind of thing you have to find social interventions by way of such facilities coming in to support people who are in need, your only choice then if you want some form of support I think the only choice is to bring the elderly person to such a facility subject to the funds [being] available.

None of the family members saw their decision to send the aged persons to the residential aged care facilities as having failed to fulfil the traditional norms of reciprocity. This is because, even though they had terminated domiciliary care, their actions were in the interest of sustaining quality and adequate care for the elderly persons, which was the ultimate goal. Therefore, however this aim can be fully achieved, that is the route they would pursue. For

some of them, their elderly persons accessing the residential aged care facilities was their way of ensuring that the wishes of the elderly were adhered to before they died. Paying for the elderly person to have a change of environment to revitalise herself spiritually and access care in the performance of ADL at the residential aged care facilities was their way of contributing to their elderly person ageing comfortably. James recounts that:

She likes very quiet environments where she can meditate and pray and all that. Just home away from home. Life can be stressful okay, she believes in that kind of thing you know. I mean, going away for a while and getting refreshed and coming back, you know...She always tell us that charley if there is something you people want to give me give it to me now not when I am dead and laid in state. Let me enjoy it now.

From the above discussions, it can be argued that the Ghanaian traditional norms are failing because of factors of social change. Probably, it is high time Ghanaians revisited the norms that have regulated social behaviour so that expectations of relatives and extended family members can also be regulated to suit the demands of time. When it comes to care of elderly persons among Ghanaians, the most popular proverb commanding long-term care for the elderly as a moral duty for those who enjoyed care at a young age, states that: “*sɛ obi whɛ wo ma wo sɛ fifri a, wo so hwɛ no ma ne sɛ ntutu*” (if someone takes care of you to grow your teeth, you must also take care of that person to lose his teeth). In the current scheme of things, the aforementioned proverb, has to be rephrased to read as follows; *Sɛ obi whɛ wo ma wo se fifri a, wo so wo bɛ hwɛ atua ama ya hwɛ no ama ne se Etutu*” (if someone takes care of you to grow your teeth, you must also ensure payment for the person’s care for the person to lose his/her teeth).

7.3.1.2 *Feelings Associated with Partial Generalised Reciprocity*

The process of dishing out partial generalised reciprocity to the elderly is associated with a number of emotional swings spanning from a phase of excitement to a phase of

psychological distress. When the primary caregivers get to know about the existence and availability of residential aged care facilities in the city, most of them become both surprised and excited at the same time at the thought of having such a solution to the challenges associated with caring for their aged persons. Owing to the existence of very few facilities and the low awareness creation of the facilities, most people do not believe that such facilities are available in the country for eldercare. They are usually held in suspense until they visit the premises. Clara shares her discovery as follows:

....So here I was trying to look for a place and in speaking to friends about whether they knew of such facilities, one of them said that 'there is one such facility right within your community'. I said are you serious? she said yes, just drive there and check it out, but because I was busy I couldn't do that so I asked one of his grandchildren to do it. He did a little bit of searching and he found the location so the next morning before I left for work I came here and spoke with the lady who was in charge at the time.

Likewise, Jason recounts how they felt on the day of arrival at the facility as follows:

When we got there, we were all at a loss that a place like this was available here in Ghana, we did not believe that there is a place like this, that such a place exists, we loved the place, the place is really, really good...with regards to the services being offered here...I mean you cannot find this anywhere and the fact that this is the first place I am seeing this happen, so in my view they are pioneering it and I think that they really should have support, to make it work.

This initial phase of excitement, however, turns into a phase of anxiety and psychological distress as the primary caregivers become unsure of how their decision to terminate domiciliary care for the elderly would be interpreted first and foremost by the elderly person and the other family members. At the initial stages of contemplating on making such a move, most of the primary caregivers become anxious and feel a sense of guilt as they try to convince themselves about their intended actions bearing in mind the norms of reciprocity which is so entrenched in the Ghanaian culture and the reactions they are likely to get from members of the society if they hear of the decisions they have taken about the care

arrangements for their elderly. The family members usually juggle the thought of whether they were abandoning their elderly persons or not and finally convince themselves and take the decision depending on the responses of family and friends on the matter. This is how Claudia the daughter of a full stroke elderly and Jeremy the filial kin revealed about the whole process. First Claudia:

This sort of thing is difficult, this is not our culture, no matter how a parent is sick he is usually kept at home and he is given the necessary care at home and I knew that taking him out of the home environment to a facility like this for some people would be inappropriate....

Similarly, Jeremy answers the same question as follows:

Even in bringing her here, it was difficult because it might be seen as if I have taken her from her home. She is not my mother, she is my mother-in-law and I do not have too much right over her being here and all that.

From observations, on the day of arrival at the residential aged care facility, all those who accompanied the elderly person are usually in a pensive mood largely because of the mood of the elderly person. Some of the caregivers and their siblings even shed tears silently as they go through the process of filling the admission forms and answering the necessary questions prior to admission. The most difficult part of the process is when the family members have to leave the elderly at the facility after the paper work has been done and the elderly is ushered into their living space: below is Catherine's narration:

On the first day when we were leaving her hmm, oh I felt so sad, I did, I even wept but I did not let her see it ...Oh it hurts that she was with me and I have sent her to that place just like that because I could not care for her as it is expected, but she was okay but quiet

Similarly, this is what Jeremy the filial kin shared:

Yeah on her part I could not really say much, it is because she can not talk but on my part, I was so sad within me because my wife was also here when we brought her, when we sat in the car and we were going, both of us were very sad knowing that this is somebody who has stayed on her own and lived a very good life, all of a

sudden all these things really happens to her, it so devastating to us who are close to her.... that is why I told you from the beginning that we brought her here and I was leaving I was sad. Here is a woman I had known for the past 30 years living on her own, doing things for herself and now virtually everything needs to be done for her so it is a little bit difficult.

Contrary to the general emotions expressed or felt by the family members as they left the elderly person at the residential aged care facility, a few of them mentioned feeling relieved that they had found a solution to the challenges associated with addressing the care needs of the elderly persons. In describing how she felt when they took the amputee mother to the facility below is what Clara shared.

I did not feel bad that we had taken her to the facility because at the beginning I was like “as for this case where will we pass with it, handling a wound like this” we have to lift her from one place to the other and all that what if we hurt her in the process, if it were a normal sickness with both legs intact then it would have been easier to handle, it was the handling of the amputation that made us take her there... The people there claim they are nurses so we felt that will help with her sugar control and all that, since they have the nursing ideas, as for me I do not know anything about diabetes, even if I stay with her I will not know whether her sugar has gone up or not so to me I felt it was good in that way and I was okay.

Generally, anxiety then sets in for the majority of the family members after they have left the elderly person at the residential aged care facility because of their guilty conscience and feelings. Additionally, they become anxious because they are not sure of how the elderly person will interpret the decision they have taken. Some of them also become worried about how the elderly person would adjust to the new environment and the new care arrangements.

The first few weeks of the elderly person’s stay at the residential aged care facility are tense moments for the family members as they wonder about how they are adjusting to their new environment. At Eastwoods Home for example, the conduct of the elderly person during that period would determine whether they would be kept there or dispatched home. Elderly

persons who continuously weep and refuse food are likely to be sent home in order not to aggravate their problems. Some of the family members mentioned having sleepless nights for a while after having left their elderly persons at the residential aged care facility. Claudia describes the turmoil that she went through after leaving her father at the care facility as follows:

..., normally you are not sure how things would turn out even though he had agreed to be moved to a residential facility, you are not sure of what to expect, how he will relate to or react to the people there. I think that he will find any familiar face and that was also going to be a problem in a way for them. Sometimes the thought is that I have been abandoned, you understand... So I was also anxious as all those thoughts run through my mind.

Similarly, Catherine reports that:

I must say that the whole thing worried me a lot because of the human nature I talked to you about how I wonder a lot about how she would cope knowing very well how it is difficult to handle and be with and how demanding she can be sometimes, if she behaves like that there and she is looking for something they will not mind her as for that I can be sure of it.

In order to appease their conscience that the elderly are in safe hands, and to reassure the elderly that they have not been abandoned and to give the elderly their continued support, the family members make phone calls to talk to the elderly persons to assure them of their love and care. They also visit the elderly at the residential aged care facility at short intervals, with those of them living close to the residential aged care facilities doing about three visits in a week. This is contrary to Goffman (1961) assertion that in the total institutions, many channels of communication between the residents and the outside world are restricted or closed off completely. Claudia for example was of the view that:

.... I did not want him to feel that way so I called the facility often and they would let me speak to him, I tried as much as possible to keep in touch with him. Fortunately, wherever I have taken him has been close to where I live. Both places in that sense proximity was okay. I could go through the facility early in the morning before I go to work so he was seeing me like thrice a week. I do maybe Monday and

then another day, then Saturday if am not able to call then I added Sunday after church so I think he was assured that he had not been abandoned.

Even though the mother is at the residential aged care facility, Catherine still sees herself as being at the beck and call of the mother because of the frequency of her visits to the facility.

She was of the view that:

I often go there, I go there a lot, I am at her 'beck and call', I go there on weekends too, in the course of the week too I go there once if there is no problem with her. ...So when I am here and she calls then I quickly pick a car to go and visit her and chat and encourage her..... Just for her to be at peace and for her heart to be at peace when she calls and complains about something, I usually go there that same day, so that she will not think that she has been abandoned or neglected.

This study finding shows that with time the primary caregivers manage to convince themselves that their aged persons are being well catered for at the residential aged care facilities because of the initial experiences they and their elderly persons have at the facilities. The initial experiences such as the elderly person being given a good and thorough bath by the facility operators themselves, being provided with a tasty and good meal as well as providing other services with utmost care reassures them that they have made a good decision. However, the phenomenon of the facility operators giving some of the elderly persons an initial bath can be viewed through the lenses of Goffman (1961) when he writes that the bath, in particular, is a highly symbolic ritual, involving physical nakedness as the midpoint of a process of abandoning one life for another. 'The new arrival allows himself to be shaped and coded into an object that can be fed into the administrative machinery of the establishment, to be worked on smoothly by routine operation' (Goffman, 1961, p.16). Additionally, within a few weeks, family members see remarkable improvement in the physical appearance of their elderly persons. They therefore end up convincing themselves that they have made a good decision and that they do not need to worry about how the elderly persons are coping at the residential aged care facility. Catherine notes:

I think that at the home she is in 'good hands' so I decided not to worry too much but initially I did.

In looking back on the decisions taken regarding their elderly persons, a few of them were actually proud to have taken such a decision. For some of them, sending the aged person to the residential aged care facility was the best decision they could have taken for the elderly person. Claudia says:

I do not have any regrets at all. I mean I am a friend of this facility and I come here quite often and when I see something I am not happy with, I tell them and sometimes I tell them that I would speak to their madam about it and things get done.

Some of the family members equated sending their elderly parents to the residential aged care facility with sending a child to the boarding house. For them, the initial stages of taking such a decision are fraught with all sorts of issues which when heeded to can lead to a parent withdrawing the child from the school. For them, at the initial stages of accessing the residential aged care facilities, there might be several complaints from the elderly person but just as the child at the boarding school adjusts to the school environment in the long run, so does the elderly person to the new care arrangement. Therefore, to ensure continued care at the residential aged care facility the primary caregiver would have to be strong willed and not budge when he or she hears complaints from the elderly person about care received. Catherine offers the following piece of advice regarding the possibility of sending my aged mother to a residential aged care facility:

...if you send your mother there and once in a while your mother complains, you should not let it work you up too much because it is a change of environment and the way things are done there is different so things will not be the same as what she is used to. It is like going to the boarding school for the very first time. You will miss home and the things you are used to for some time before you get used to your new environment and its routine activities...So at that point you the parent of the child have to do (*di wo tirimu*) (*Obaa tse otui ofo omli*) be strong willed, not act based on the comments, not get carried away by emotions and act in response to the complaints not act immediately you hear something. If you do not act bravely, (*ke ohie ya waa, ebaa fee bo ahontow*) you will be overwhelmed by events and go for

your mother. But within that period we were not planning to work with her complaints because we knew she would definitely complain about almost everything because even when she was at home she did that just because she is not happy with herself.

7.3.1.3 *Failed Generalised Reciprocity*

The system of reciprocity may fail materially when those supposed to pay back are not positioned to do so. Findings from this study show that sometimes the elderly males end up having several children from polygamous marriages even when they are old and their adult children end up assuming responsibility of care for the young children. In such instances, resources, which could have been used in caring for the elderly, are redirected towards the care of the young ones to their detriment, therefore creating the impression of neglect. In sharing his views, Nicholas, a father of thirteen children, some of whom are below 10 years commented that:

It is difficult to get money, any time I ask for money from my children who are well to do, they ask me that what would I use the money for because they are taking care of my younger children for me and footing the children's bills so I shouldn't ask for money. The young people of today are senseless but people of my generation are very sensible that is why we saw that education was good so we would use all our resources to educate the children even to the extent of denying ourselves of the pleasures of life. We used all the casual work money on them with the hope that when the children become well off, they would care for us but alas, that is not guaranteed, but we will console ourselves that at least they did not turn out as bad as some other people despite their efforts. As a casual worker, I do not have pension or any savings to cater for my own needs.

Additionally, the system of reciprocity may fail if the children are unwilling or unable to care for the elderly (van der Geest, 2008). Esther, a resident buttresses the point above when she notes:

If you have someone who takes care of you and gives you good food to eat that is good living, when you are dirty they make sure you go and bath, so you are not dirty, this dress you are wearing is not good change it, you go and sit outside for fresh air

and all that and then they chat with you, but if you do not get it like that and you are troubled, you are more likely to beckon death (*wosefre owu a wobekɔ*).

Based on their experiences regarding life and ageing, a few (3) of the residents noted that individuals should plan for their old age even as they care for their offspring during their active life to ensure successful ageing so that their lives will not be terminated as a result of the worries associated with ageing. Additionally, planning for ones future reduces the material or physical burden of caring for the aged on the children because they only have to supplement and not totally pay the bills associated with the care. Even though this might not be full reciprocity, as one would expect, assisting the children halfway serves a dual purpose for the aged as it goes a long way to ensure that the elderly person's life is not shortened for want of necessities and also to ensure a pleasurable ageing experience. The children also benefit in that they are not unduly stressed with financial demands therefore, it ensures a cordial relationship between both parties. Henry stated the following:

You have to prepare for that time of your life, you see the Whites they have gone through all of these stages already, they are educated and they know much about all these of situations so in their schooling they are made aware of all these things so they get prepared. We are not used to such things and such living, we have just come and joined inside we find ourselves in the situation. Like me, if my children, are not educated like that, I will be like some others and I will die early, that is why people die early, yes that is it, because they do not plan for their old age.

In a bid to advise the researcher on the subject of planning for the future, Evelyn stated that:

When you work you should put some money aside, make it a point to save some money for the future, so that when it happens like that, when you grow old you can fall on it and take care of yourself. When it happens like that you do not need much from your children but you also have to try very hard to take good care of your husband and your children so that in the future when you grow old they will also take care of you. Remember whatever you do now will wait for you in the future so do well to take care of all of them. If you are there, and you say you will not take care of your children, and you will not take them to school, and your children are like this and they are like that, you will see in the long run.

The above comment from Evelyn confirms van der Geest's (2008) findings on reciprocity when he writes that early suffering serves a purpose: you suffer for the well-being of your children who will help you when you grow old, late hardship is senseless (van der Geest, 2008, p.306).

Some of the residents, however, felt they themselves had not planned well for their future and therefore they were not in any position to caution the future generations about planning for retirement and old age. This is because if they had planned well, their children would not have to bear the cost of their care at the aged home in addition to caring for their own children. In responding to the question of whether he was advising his children to plan for their future, Henry remarked:

Ehm, they are saying it themselves, I don't have to tell them. I will not even say it because if I do they will ask me that did you plan yourself for your future before we brought you here, they will tell me that. When I came here there were two soldiers, two ex-service old men they were paying their own bills here but now they have gone.

Practicing the traditional norms of reciprocity for elderly persons with multiple chronic diseases and associated functional limitations amidst factors of social change is perceived as a daunting task, which is unattainable presently. As such practicing partial generalised reciprocity whereby adequate eldercare is achieved irrespective of who provides the hand-on care and the location where the adequate care is received is the last resort in ensuring that they reciprocate the gesture of the elderly person so that their care needs are not neglected. Reciprocity fails only when the elderly are neglected entirely. Practicing partial generalised reciprocity is therefore equal to managing the care arrangements of the elderly out of their usual dwelling places. The effects of factors of social change and market forces has led to the increasing difficulties in the performance of the traditional norms of reciprocity as has been known and practiced by kin and kindred over the years. Studies have shown that kin

and kindred who were working outside the country or in urban centres and away from their elderly persons have been sending remittances to the elderly persons or their caregivers for the upkeep of the elderly (van der Geest, 2002, 2004, 2008).

This study shows that the initiators and influencers have access to the resources of the elderly and have the mandate to manage the resources, use the resources of the elderly to pay for the upkeep and sustenance of the elderly at the residential aged care facilities. The resources include monthly pensions, proceeds from the rental of property and the sale of property or farm produce. Both Deborah and Emma are retired educationists and for that matter receive monthly pensions for their upkeep. Deborah and Emma's children therefore receive the monthly pensions of their mothers and use the money to meet the needs of the elderly at the residential aged care facility. In Emma's instance, apart from her monthly pension, her house has been rented out as well. In discussing her upkeep at the residential aged care facility, she said that:

My second daughter, the one I was living with before coming here pays the bills. They have rented out part of my house, my second daughter collects the money and uses it to care for me in this facility.

In the case of Edwina, her children have rented out her farmland to tenants and they manage the resources.

Right now, because I am here at the facility, I have given the 6 acres farmland to one of my children to take care of it, he is the one who has rented it to someone to work on it, that twins son works here in Accra, because he will not get the time to go and farm himself that is why he has given it out, He has found someone who takes care of it. He goes there to check on what is going on there. At first I was using the money from the farm to take care of myself there, right now it is my son who collects the money. Since I have been here, it's my children who have been paying for me.

In all these cases, the initiators who also implemented the move of the elderly persons to the facilities used what they had been given control of by their elderly persons to ensure the

elderly access eldercare from the residential aged care facilities and to sustain their upkeep there.

Partial generalised reciprocity is not the only pattern of reciprocity existing within these families. The other two types of reciprocity exhibited by the family members were balanced and negative reciprocity.

7.4 Balanced Reciprocity

Balanced reciprocity features overt concern for equivalence and timeliness of exchange. Kirk (2007), was of the view that while such transactions are framed as labour exchanges among kin and friends, balanced reciprocity is also characteristic of more distant relationships in which self-interest and material concerns take priority over the human bond itself, as in market exchange (Kirk, 2007; Meera & Kumar, 2015). The basic elements of balanced reciprocity are that the giver expects something equivalent in return; the repayment is often delayed thus, establishing a relationship between the giver and the receiver. Balanced reciprocity is the most common form of reciprocity that people usually think of when they hear the term reciprocity.

All the initiators who also acted as implementers expected the extended family members who had been assigned the responsibility of taking care of the elderly in the rural hometowns to exhibit balanced reciprocity as they were being remitted for the services they were rendering to the elderly. This, however, did not materialise to the expectation of the elderly person and the family members resulting in the termination of their services to the elderly within the domiciliary context to access non-domiciliary care. This can be inferred from the narrations of Edwina, who shared the following;

The relatives, we do everything for them but because they are also working elsewhere, they do not take care of me well, so the care was not any good, my children buy everything but still, the care was not good and it was worrying my children so, the eldest of my children, my daughter the one that I said works in Accra came to look for a place here for me so she heard that they accept people who need to be cared for and she came to get a place here for me, then they brought me here

Additionally, the residents who initially rejected their movement to the residential aged care facilities took that stance because they expected the initiators and influencers of the decision to exhibit balanced reciprocity in the caregiving experience. This is because, they the elderly persons had cared for them as children and had actually moved into the homes of the initiators and influencers as caregivers for their grandchildren prior to their hospitalisation and their need for care.

7.5 Negative Reciprocity

Negative reciprocity is the maximization of one's own benefit at the expense of another. In its pronounced form, negative reciprocity amounts to exploitation (Kirk, 2007). Negative reciprocity involves unsocial extreme of exchanges. It is experienced when a trade is fixed which is of material advantage based on an individual or a group wishing to get something for nothing or the better of a bargain (Meera & Kumar, 2015). The basic elements of negative reciprocity are that; the giver expects something of greater value in return by profiting from the transaction, often times, payment has to be immediate, because the parties do not really trust each other; each is trying to get the better of the other. Negative reciprocity occurs when there is an attempt to get someone to exchange something he or she may not want to give up or when there is an attempt to get a more valued thing than you give in return. This may involve trickery, cohesion or hard bargaining.

Findings of the study show that negative reciprocity was exhibited by the members of the extended family who were assigned the direct responsibility of ensuring that the elderly achieve activities of daily living in their rural hometowns away from their children when they continuously demand and receive remittances from the children of the elderly for their upkeep but fail to ensure that the elderly is well cared for. Such individuals are noted to make frequent financial demands in the name of ensuring the needed care for the elderly but fail to do so. They were purported to be in the habit of amassing wealth at the expense of the elderly person's nuclear family anytime they found the opportunity to do so. Thus, the extended family members were generally perceived as people who would want to continue benefitting from the elderly accessing care in the rural hometowns.

As rejecters, they would disagree with any effort at terminating the poor domiciliary care offered to the elderly in exchange for non-domiciliary care. These are suggested in the stories of Jeremy about the care of his mother in-law and the story of Edwina. Jeremy talked about how the extended family members created the impression that their care for the elderly within the domiciliary context in the rural setting would be less expensive than accessing residential non-domiciliary care in the city but in the end succeeded in amassing wealth at the expense of the elderly people's nuclear family. In sharing his experiences with the extended family members, Jeremy, a filial kin, shared the following:

The relatives, let me be honest and truthful to you the relatives just like in our case with grandma, they will amass wealth through us, they will first of all talk you out of accessing care out of the home and tell you with that kind of money you are spending at the place, why don't you give us half of that money and we will take care of her. When she dies, they don't lose anything and they might have made their money just like we were paying those people from the agency who were taking care of her in the house. We were paying them and I was managing all those monies, I know exactly what I am talking about.

With regards to Edwina, she was supposed to have been cared for by a relative in her rural hometown but the individual was often not available to feed her adequately. In the case of Elsie, three of her children had moved from their rural hometown to stay with her in the city, in a house provided by an offspring abroad for the purpose of supporting their elderly person to perform the activities of daily living. They were remitted by the offspring abroad to care for their mother but did not live up to the task.

Negative reciprocity was also exhibited by the extended family members who were not willing to continue to take on the responsibility of providing hands-on care for the elderly as in the case of Emmanuel. In his instance, even though he had financially supported the extended family a lot more than his nuclear family, they decided to terminate his care when they were not seeing any improvement in his condition after caring for him over a period of time. Claudia notes:

Em, when he came down with the full stroke, the extended family members said they were going to take him down to Kumasi and try some herbal approach for him so reluctantly I agreed. They came for him and kept him for close to nine months and then I think that they felt that caring for him was too much for them so I had even travelled at that time and they were calling me morning, noon and night to come for him. So I told them that I am not in Ghana and that immediately I come back I will come and get him so they should hold on with him while I am away...So immediately I got to the country I called them and I think I came on Wednesday and by Saturday they had sent him back to me.

Additionally, although Emmanuel's sons influenced the decision making process and helped in its implementation, none of them supported their sister Claudia by contributing towards the payment of bills at the facility despite the fact that they were in a position to do so. Findings from this study show that some of the offspring of elderly persons fail to reciprocate the support and care they had received from their parents when they were growing up at the time the elderly need care most. Kin exhibit negative reciprocity when

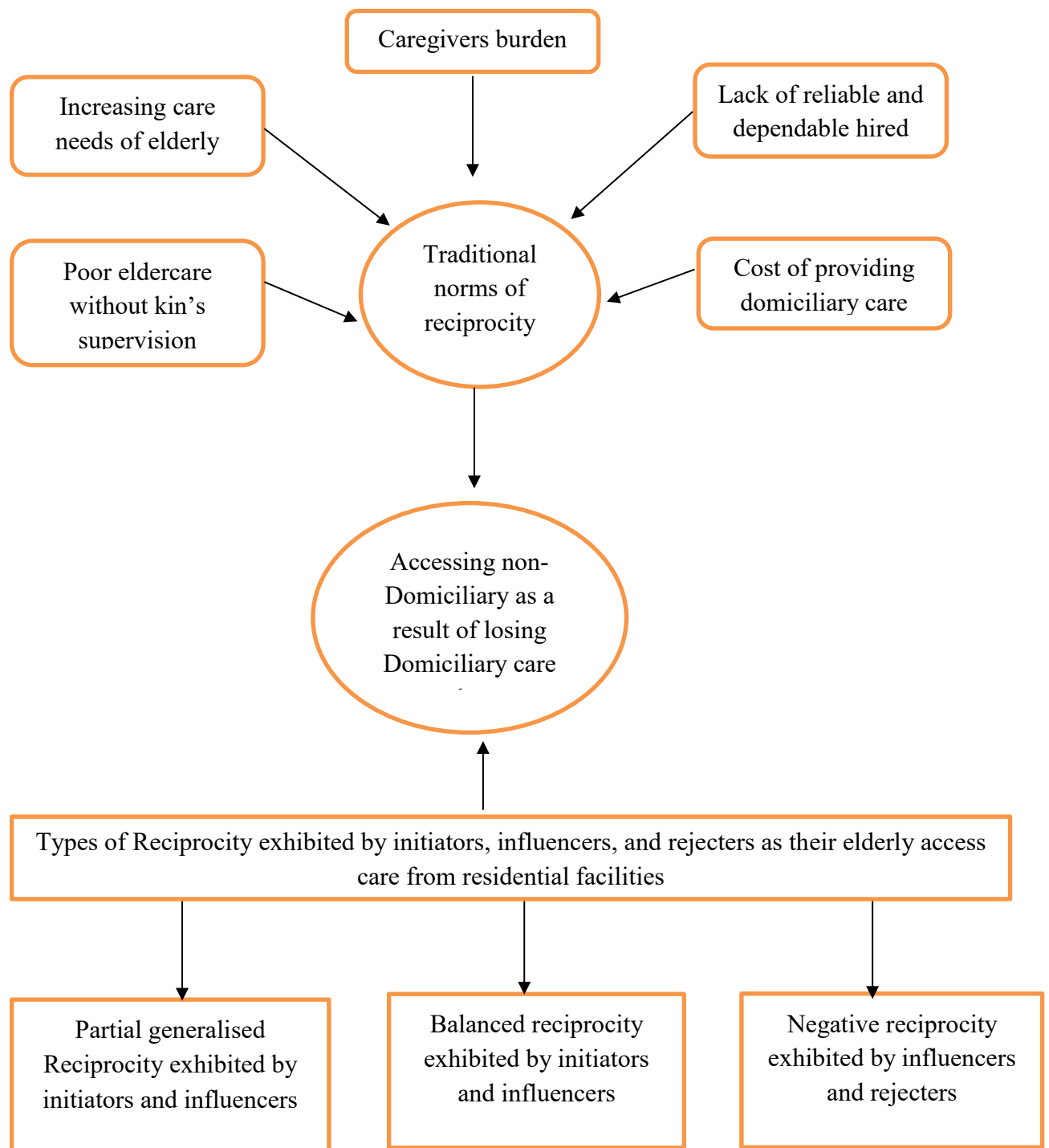
they refuse to support the elderly financially in accessing long-term care in the performance of activities of daily living.

... I took a form and I filled it out by then my brother who lives in the UK was coming down so I took him there to also access the facility. He came to look around and he was okay with the facility so we moved in here.... I have come to the point of accepting that this is my cross and I need to bear it alone because it has become quite clear to me that they don't really care, they don't even call, they don't call to find out how he is doing. I have not asked them for anything. It is just one time that a friend was just pushing to ask them how much they will be able to contribute towards the taking care of their father because doing all this by yourself is not good...It's not too much for me but like I said I have come to realize that may be I should do it all by myself. I do not want to keep asking if they really wanted to do it, I do not have to be asking them, really because he is a father to all of them.

7.6 Framework on the Shades of Reciprocity and their interplay with Domiciliary and Non-Domiciliary eldercare

In searching for long-term eldercare, the elderly access domiciliary systems of care per the traditional norms of reciprocity. This however is not sustained for long resulting in them losing domiciliary care. The search for alternative means of eldercare after the inability to sustain long-term care within the domiciliary context entails; finding new perspectives of eldercare, desensitisation of traditional norms of reciprocity, trials of the new perspectives, decision making on the options to adopt, and finding stability in eldercare as well as the caregiver's life. The framework of factors affecting the performance of the traditional norms of reciprocity and the different shades of reciprocity exhibited by family members as the elderly access the emerging forms of care encapsulates study findings presented in previous sections of this work (see Figure 7.2).

Figure 7.2: The factors affecting the performance of the traditional norms of reciprocity and the different shades of reciprocity exhibited by family members.



Source: Fieldwork, 2015 - 2016

The framework, as shown by figure 7.2 presents the nuances associated with the caregiving experiences of primary caregivers as the power of the traditional norms of reciprocity over

primary caregivers wane in the process of providing hands-on care to the elderly. This is as a result of the negative effects of the caregivers providing the elderly with hands-on care daily to the detriment of the other facets of their life as against the increasing choices they had to make to ensure a fair balance and stability in their lives while their elderly persons access the needed and adequate care.

The framework developed is based on the experiences of the elderly and their family members, which commences after the major hospitalisation of the elderly due to complications associated with their chronic diseases. After the major hospitalisation, the elderly begins to require care, which is readily provided within the domiciliary context. Accessing domiciliary care starts with the initiator providing hands-on care resulting in the elderly achieving satisfactory care. With time, the initiator experiences caregiver's burden because of directly helping the elderly to achieve ADL. Hands-on care provision is shifted from the primary caregiver to hired hands and kin supervises care resulting in the elderly losing satisfaction in the care provided.

The initiator then begins searching for alternative means of care. In the process, the initiator finds new perspectives of care and becomes desensitized about the traditional norms of reciprocity. In the quest to finding relative stability in care provision and care access for the caregiver and elderly person respectively, non-domiciliary care is accessed while the primary caregiver manages the care provided. Thus, even though the initiators set out to fulfil the traditional norms of reciprocity when the elderly require long-term care, factors such as caregivers' burden, increasing care needs of the elderly, lack of reliable and dependable hired hands, poor eldercare without kin's supervision and cost of maintaining domiciliary care leads to the initiator failing to sustain long-term care within the domiciliary context and therefore terminates it in favour of non-domiciliary care for the elderly.

In the cases of the influencers (other children of the elderly), even though they are aware of the traditional norms of reciprocity, because they are not willing or unable to take full responsibility for the hands-on care for the elderly, they tend to suggest alternative ways of eldercare. In the process, desensitize the initiators towards fulfilling the traditional norms of reciprocity although the influencers might have benefited from the elderly in one way or the other.

In a few of the cases, the three groups of people in the decision making process planned from the onset to dish out partial generalised reciprocity to the elderly right from the onset of the elderly requiring long-term care as a result of prevailing circumstances and their inability to handle the health condition of the elderly after the major hospitalisation.

While at the residential aged care facility, different shades of reciprocity are exhibited by kin and kindred in ensuring that care for the elderly is sustained. Majority of the initiators and influencers exhibit partial generalised reciprocity as they continuously ensure the care of the elderly at the residential aged care facilities from their own resources. In this type of reciprocity, the three parties periodically contribute financial resources and time to support the upkeep and care of the elderly at the residential aged care facility. For them, even though they are not providing hands-on care for the elderly to achieve ADL and care is being sourced out of home, that option is the best way of fulfilling their responsibilities towards caring for their elderly to age gracefully.

Some of the initiators and influencers exhibit balanced reciprocity as they use the elderly person's resources they were controlling to ensure the continued care for the elderly at the residential aged care facilities.

Some of the influencers also exhibit negative reciprocity in the course of the elderly person's stay at the residential aged care facilities. This happens when they terminate their financial support toward the payment of the bills of the elderly person at the residential aged care facilities to ensure their continued upkeep.

In exhibiting negative reciprocity, the rejecters do not ensure care of the elderly within the domiciliary context but expect continuous compensation for intended care and will do all it takes to fight against the elderly accessing non-domiciliary since that will terminate the benefits they would have accrued from the eldercare. While the elderly accessing care at the residential aged care facilities, the rejecters continuously complain about the cost of non-domiciliary care. They argue in favour of a less expensive domiciliary care for the elderly.

To conclude, as people age and become disabled owing to their chronic disease conditions, they experience a phase in their lives where their dependence on others, especially family members, to achieve ADL continuously increase. This phase of life ushers in the period where the elderly is expected to reap the fruits of the labour invested in caring for their family members during their active years. Owing to the demands of the times, family members who are unable to be physically present to provide hands-on care or supervise the care provided by hired hands in the fulfilment of the traditional norm of reciprocity, seek for alternative means of providing their elderly persons with the requisite care. This leads to the elderly accessing non-domiciliary care systems to address their care needs. The inability of kin to totally fulfil the traditional norms of reciprocity leads to kin and kindred exhibiting either partial generalised, balanced or negative reciprocity while the elderly accesses long-term care at the residential aged care facilities.

7.7 Summary

In this chapter, I have presented the traditional norms of reciprocity practised by Ghanaians vis-à-vis the different shades of reciprocity as defined by cultural anthropologists. I have also discussed the contemporary reciprocity practiced by the family members of the elderly persons at the residential aged care facilities to ensure that the elderly accesses long-term care. Additionally, I have discussed the perceptions and feelings of the family members and relatives about dishing out the contemporary form of reciprocity in their bid to fulfil their responsibilities towards their elderly persons. Lastly, I have presented a framework that depicts the factors that inhibits the performance of the traditional norms of reciprocity for elderly persons requiring long-term care. Additionally, I have shown the different shades of reciprocity and their interplay with the elderly accessing domiciliary and non-domiciliary systems of care to address their care needs. The next chapter presents the summary of findings, conclusions and recommendations of this study.

CHAPTER EIGHT

SUMMARY, CONCLUSION AND RECOMMENDATIONS

8.1 Introduction and Purpose of the Study

Studies focusing on the care of the aged within the extended family system or the traditional context has a long history. The discourse on population ageing within an era when the traditional systems of caring for the elderly is failing and their care needs being neglected is not complete without acknowledging the role of the emerging forms of non-domiciliary care for the aged within the urban centres of the Greater Accra Region. The phenomenon of out of home care for the elderly by non-kin in a social context where eldercare has been situated within the confines of the extended family system and out of public view is perceived as an anomaly and foreign to the Ghanaian culture. The Ghanaian society is yet to come to terms with it.

This study focuses on how an anomaly such as the out of home residential care of the elderly which is perceived as foreign is gradually gaining grounds within the Ghanaian socio cultural context and how the phenomenon is being rationalized. This study draws on participant observations and in-depth interviews with fifteen elderly residents of such facilities, six family members of these residents, two administrators of the residential aged care facilities, two facility owners, and six health care assistants. The study has five goals. These are: to identify the different forms or types of systems of care currently available in the urban centres established to meet the care needs of the elderly people; to explore the kinds of activities of care provided by these systems of care to the elderly who access them; to describe the circumstances under which the aged are admitted into residential aged care facilities; to find out how the elderly accessing these facilities make sense of the decisions

made to delegate their care to non-domiciliary aged care facilities; and to examine how the family members of the elderly accessing the non-domiciliary systems of care evaluate the decision they have made to delegate the care of their aged persons to a formal institution.

8.2 The Landscape of Caregiving and Caregiving Services

The landscape of caregiving for the aged in the urban centres of the Greater Accra Region is characterised by two broad systems of care i.e. domiciliary and non-domiciliary care. Domiciliary systems of eldercare refer to all the different kinds of care provided for the elderly persons within their homes and these consist of three forms i.e. care provided by primary caregiver, untrained hired hands and trained or professional hired hands. Currently there are about six health care agencies offering professional home care services within the capital city to the elderly within their homes (Coe, 2016). Non-domiciliary systems of eldercare relates to all the types of care that is provided for the elderly persons outside their homes. There are two main types of non-domiciliary eldercare currently available. These are residential which occur within the confines of an aged home facility and non-residential which occurs at recreational or day care centres.

The residential non-domiciliary facilities are privately owned and operated mostly by individuals who have lived and worked abroad. The residential aged care facilities are run on a sole proprietorship basis employing not more than six people at any given time. There are two types of caregivers at the facilities; trained caregivers who deliver the direct acts of caring, and untrained caregivers who act as support staff. The facility operates a 24-hour service seven days a week for the residents. The rooms are shared between two to four elderly people depending on the size.

8.2.1 Activities of Care Performed for the Elderly at the Non-Domiciliary Care

Facilities

Within the traditional setting, four facets of activities of care are performed for the elderly by their caregivers. They are technical care (feeding, bathing, toileting, and clothing), emotional care (companionship), material care (remittances) and funerals (van der Geest, 2002a, 2002b). In comparing the above with the activities of care performed for the elderly at the residential aged care facilities, one can easily identify the technical care which has been grouped as intimate and non-intimate technical care and a minimal quantity of emotional material care. Material care in terms of the payment of bills and provision of other requirements is largely provided by the family of the elderly persons in order to ensure continued care at the facility. In addition, the residential aged care facilities offer their patrons medical care, spiritual care, and end of life care. The intimate technical care includes toileting, bathing, dressing and clothing of residents, cleaning a person who has soiled himself or herself, assisting the person to use the toilet and diaper. The non-intimate technical care includes: feeding, movement of residents around the facility, aspects of personal grooming, and maintaining oral hygiene.

The medical care offered to the elderly are in accordance with the medical complications presented at the facilities and those that they may suffer subsequently. The four common chronic diseases or medical conditions presented on admission at the residential aged care facilities were hypertension, stroke, diabetes and dementia, with hypertension being the most prevalent. The medical care includes administration of routine medications, routine checks of blood pressure, body temperature, and blood sugar levels, routine medical appointments, emergency visits to the hospital, and physiotherapy where appropriate.

Spiritual care offered includes daily morning devotions, weekly church services and monthly administration of the Holy Communion to the elderly. Out of the five different facets of caregiving to the elderly, the emotional care is the most lacking at the residential aged care facilities. Technical/physical and medical care are the two most adhered to by the caregivers.

8.3 Choosing Non-Domiciliary Care: The Conditions under which Non-Domiciliary Care is Chosen for the Elderly

The motivation leading to people choosing non-domiciliary care for their elderly persons within the urban centres of the Greater Accra Region are losing domiciliary care as a result of the elderly not getting the needed long-term care within the domiciliary context, the search for alternative means of providing long-term care for the elderly and adopting the new perspective of care which is the non-domiciliary care.

8.3.1 Losing or Failing Domiciliary Care

The major challenge that faced the family members as well as their elderly persons in the caregiving experience at the time of accessing care at the facilities was the nuances associated with accessing long-term care within the domiciliary context. Whereas the family members were concerned about how to sustain hands-on long-term care for the elderly within the domiciliary context, the elderly on the other hand were worried about how to continually get the needed care to perform activities of daily living (ADL) after developing health complications from chronic diseases.

Although the care experience usually commences on a good and warm note, the situation changes as caregiver's burden and stress begin to set in and the family members begin to worry about their ability to sustain care provision over a long period of time within the

domiciliary context. In the process of losing care the elderly persons still have some amount of care but not adequate in the desired quantity and quality. In some cases, the caregiving arrangements became shaky and at low levels resulting in the uncertainties associated with the quality and frequency of care. Losing care was as a result of the unavailability of the children of the elderly persons to provide hands-on care or to supervise the arrangements made for the care provision by a third party.

In the process of losing care in the domiciliary context, the elderly are confronted with uncertainties about their future as they live with multiple disabilities and transitioning from taking care of one's self to being taken care of by others. A phase in life when decisions are made for the elderly with or without their consent. It also comes with losing one's privacy and in some cases one's home and the things they hold so dear to them. As the challenges associated with caring for the elderly mounts, and the prospects of sustaining domiciliary care wanes with time, the process of searching for alternative means of caring for the multiple disabled elderly starts and the primary caregiver begins the search for a way out.

8.3.2 Searching for Alternative/New Ways of Meeting the Care Needs of the Elderly

As it becomes increasingly evident that the sustainability of domiciliary care for the elderly to perform ADL over the long haul becomes challenging and less feasible, the primary caregivers begin to re-examine the roles they have assumed in the bid to fulfill the traditional norms of reciprocity as against the choices they would want to make looking at the myriad of responsibilities they have to shoulder. Not getting the requisite care within the domiciliary context became increasingly certain with time. To reduce the physical, emotional and psychological effect of providing hands-on care for their elderly, the family members began to search for alternative means of addressing the care needs of their elderly persons.

The search usually began with consultations which took different forms like talking to acquaintances, friends and family members about the challenges the primary caregivers were having, following up on advertisements aired on the radio, searching on the internet for information on aged care facilities and calling agencies. Consulting acquaintances, friends and family was a requisite to the whole process of identifying the different options of care that they could sample from and access to address the care needs of the elderly. In consulting these different groups of people about the difficulties they are going through and their inability to sustain long-term domiciliary care, the primary caregivers are given the needed support and impetus to access the type of care that will enable all and sundry to get the needed peace of mind to pursue their normal duties. The search for alternative ways of caring for the elderly usually leads the family members to re-orient their perspectives on care for the aged in three fundamental ways.

First, finding new points of views about caring for their elderly which hitherto is unknown to the primary caregivers or negatively perceived by them. In empathizing with the primary caregivers, those consulted usually redirected their attention towards both in home and out of home systems of care for the elderly which they had hitherto not accessed. In consonance with fulfilling the traditional norms of reciprocity, majority of them opt for domiciliary systems of care for the elderly until they begin to encounter challenges. In battling with the notion of continued domiciliary care with its associated challenges, the primary caregivers rationally choose to access non-domiciliary systems of care for their elderly persons. This is as a result of the quest to find some form of stability between caring for themselves, their family and career as well as caring for the elderly.

Second, in the search, the primary caregivers begin to get desensitized about practicing and fulfilling the traditional norms of reciprocity as it used to be done. They also get desensitized about the negative perceptions they hold about the concept of aged homes in the Western world. As accessing domiciliary care becomes increasingly difficult, aged home facilities are presented as places where their elderly could get all the needed technical care, emotional care as well as medical care and all parties involved will get their piece of mind.

Third, the search gives the primary caregivers the hope and assurance of regaining their lives and going about their normal activities, thereby getting the relative sense of stability they so much desire in their lives. The initial experience of caregiving is characterised by the family members providing hands-on care for the elderly around the clock to the detriment of other facets of the lives leading to caregivers' burden and strain.

In the midst of searching for an alternative means of addressing the care needs of the elderly, available options are evaluated and decisions are taken mostly in consultation with other family members. All these are done with the aim of the elderly persons regaining adequate and quality care while the primary caregivers achieve a fair stability in the process of performing multitasks. Regaining one's life by prioritizing roles and responsibilities and finding stability between the myriad of responsibilities of the primary caregivers was very crucial at a point in time when providing domiciliary care for the elderly has become a daunting and burdening task.

After deciding on the new perspective of addressing the care needs of the elderly, the primary caregiver delegates the daily activities of care to the third party recruited for that purpose. This is done with the hope that adequate and quality care would be provided.

Inability to achieve the said results leads to disappointments and a quest for a permanent solution to the problem. Finding stability was crucial in the quest to reduce the impact of the challenges associated with caring for the elderly person within the domiciliary context. The primary caregivers begin to look at options of care, which is likely to give them relative stability in the care arrangements for the elderly. This is usually found in the out of the home facilities available.

8.3.3 Trajectories of the Search for Alternative Means of Meeting the Care Needs of the Elderly

The search for alternative ways of addressing the care needs of the elderly is characterised by different trajectories depending on the living arrangements of the elderly, their needs, resources, kin availability and preferences (Kimuna, 2013). Some of those living alone in their rural home towns are moved straight to the residential aged care facilities, others are moved first to the adult child's house prior to the institutionalisation. Those already co-residing with the family of their offspring were moved directly to the residential aged care facilities. Majority of elderly persons at the residential aged care facilities had made two out of the three moves usually made by elderly people after retirement from active work (Litwak & Longino, 1987; Heisler, et al., 2004).

Some of those who had worked in the urban centres have made 'amenity migration' after their retirement and then subsequently made 'preparation for ageing' move by being sent to the aged home facility after hospitalisation. Others made 'kinship or 'assistance moves' after hospitalisation and then make 'preparation for ageing' movement after long-term care within the domiciliary context fails. Another group of elderly persons made only 'preparation for ageing' move by accessing the aged care facilities after they are unable to access adequate care within the domiciliary context. Contrary to what pertains in the

literature, some of the elderly persons are withdrawn from the facilities back home after they had made the 'preparation for ageing' move due to ill-health requiring thorough medical care, dissatisfaction with care received at the facility, inability to sustain the payment of bills for the long-term care, as well as complaints and threats from members of the extended family directed at the offspring of the elderly person.

8.3.4. Making Sense of the New Forms of Caregiving as a Care Recipient

The Ghanaian elderly at the non-domiciliary care residential facilities hold both positive and negative perceptions and feelings about having to access the facilities. Although they would have preferred to age in place, the ability to access non-domiciliary care ensures that they get the needed care around the clock to perform ADL.

Despite the fact that majority of them accepted to be moved to such facilities, only a few of them were happy about the decision. They, however, did not want their care needs to be a source of worry to their kin and kindred. The basis for them accepting to be moved to the residential aged care facilities was largely related to how these facilities were presented by the family members; as a solution to the challenges all and sundry were facing regarding the difficulties associated with getting adequate and appropriate care for them and the peace of mind they would all enjoy as the by-product of the elderly accessing the facilities. The accepters of accessing the aged care facilities comprised of elderly persons who were (1) living alone in extended family property in their rural hometowns requiring care, (2) living with their family members who could not sustain long-term care, (3) had lived abroad before and were aware of the concept of aged homes and the role they play and (4) living alone in the city needing care.

In spite of accepting the new terms of caregiving, most of the elderly felt a sense of abandonment at three different stages of the process of them accessing the non-domiciliary aged care facilities. The first is when they are told about the need for them to be sent to the facility, the second is when they are moved to the facility and left there and the third is when the elderly persons do not hear from family members through telephone calls or get visits from them. The elderly come to terms with reality over time and accept their stay at the facility.

Those who had moved into their children's homes as caregivers prior to the major hospitalisation rejected the decision for them to access care from the residential aged care facilities. They however had to rationalise the move with time.

8.3.5 Making Sense of the New Forms of Caregiving as a Primary Caregiver

The primary caregivers of the elderly persons were very much aware of the traditional norms of reciprocity that has governed social interactions over the years and they deem that as the ideal way of caring for and supporting the aged to age in place. However, even though all of them know that the onus lies on them to ensure that their aged persons are adequately cared for and supported in their old age, the majority of them were of the view that owing social change, practicing the norms of reciprocity as it has been done traditionally by their forefathers is currently not feasible.

Even though most of them are not proud about the decisions they have taken, they deem it as out of necessity owing to the challenges related to health, occupation, family and time constraints which inhibit them from providing the hands-on care required of them by their elderly persons. Getting reliable and dependable hired hands to provide the needed care for

the elderly within the domiciliary context without their supervision is very difficult to achieve necessitating the option of sending the elderly to the residential aged care facilities to access care instead of neglecting their care needs when domiciliary care failed. For them, ultimately, the aim of the traditional norms of reciprocity which is ensuring that the elderly person receives care and support in the achievement of the ADL has been met through the process of accessing the non-domiciliary aged care. Therefore, practicing partial generalised reciprocity via the residential aged care facilities ensures that the care needs of the elderly are not neglected as some have done.

The inability of kin to totally fulfil the traditional norms of reciprocity leads to kin and kindred exhibiting either partial generalised, balanced or negative reciprocity while the elderly accesses long-term care at the residential aged care facilities. Majority of the initiators, and influencers of the decision exhibit partial reciprocity by paying for the care of the elderly from their own resources. Some of them also exhibit balance reciprocity towards the elderly as they use part of the resources of the elderly to pay for their care. Some of the influencers also exhibit negative reciprocity as they terminate their financial support towards the upkeep of the elderly. The rejecters exhibit negative reciprocity as they oppose the decisions made for the elderly to access non-domiciliary eldercare.

8.4 Conclusions

This study contributes to the growing literature on emerging trends of care and support of the elderly in an increasingly changing social context with the dwindling fortunes of the traditional informal caregiving system. The difficulties associated with the elderly accessing hands-on informal care from kin (and untrained hands) is gradually giving way to two forms of caregiving. The first is a growing market of agencies and individuals (professionals)

offering the elderly persons the opportunity to access home care services from trained hands to enable them achieve the ADL and age in place. The second is the growing market of home residential aged care facilities that serves as an option for clients who prefer that form of care for their elderly. This option has provided long-term care for about 100 elderly persons in Ghana since 2013.

Traditionally, Ghanaians have provided long-term care for their elderly within the domiciliary context with the traditional norms of reciprocity guiding the quality and quantity of care received by the elderly. The generalised norms of reciprocity regarding caregiving are such that the parents provide care for the child within a relatively short period until the child assumes full responsibility for those activities of care themselves. With regards to the adults, care is provided by the children when the elderly are old, frail and sick. Among the primary caregivers, care for the elderly is initially provided hands-on and subsequently outsourced and managed when adults are old and sick, not simply old. Thus, caregiving for a sick adult is long-term in a way while care of children is not.

The nature of the rule of reciprocity Ghanaians have adhered to over the years is reciprocity as a transactional pattern of interdependent exchanges, a folk belief and moral norm. Different rules of reciprocity are invoked depending on the type of actors in a given interaction. When it comes to parent and child relationship, the concept of generalised reciprocity is invoked.

The norm of generalised reciprocity assumes that the social context within which the terms of reciprocity are given/received are similar across time and space but this is not the case. Even though the elderly had played their part in given hands-on care to their children, there

is no guarantee that the offspring would also provide hands-on care over the long haul because the social context has changed over time. Owing to factors of social change, the children of the elderly persons have assumed career related responsibilities within and outside the country making it increasingly challenging to supervise hands-on care provided by others within the domiciliary context.

Secondly, caring for an infant is a lot more interesting than caring for a sick disabled elderly person who is largely depressed because of the transition they have to go through especially after a major hospitalisation. Even though the caregiving experience commences with the children providing hands-on care as the parents had done per the norms of reciprocity, they begin to feel the burden of the care and realise that the care required of them by the elderly is demanding and long-term with no end in sight. Rational choices are therefore made in the search for alternative means of addressing the care needs of the elderly.

The increasing number of elderly persons at the residential aged care facilities gives a vivid expression to the failing traditional norms of reciprocity, which has been the guiding principle for eldercare within the extended family system over the years. Although an anomie, the gradual emergence of non-domiciliary care facilities in the Greater Accra Region of Ghana as a result of private initiatives is as a result of social change and the rationalisation of the phenomenon at a time when the kin cannot sustain long-term domiciliary care. It also gives those who would normally not provide the care the opportunity to pay for care for their elderly persons. Non-domiciliary care facilities are a clear example of social change and adaptability.

Primary caregivers would prefer to delegate the responsibility of providing hands-on care of their elderly to non-familial relations on business basis and pay for the care received. Primary caregivers are increasingly becoming suspicious of the intentions of the extended family whenever a helping hand is extended because caring for the elderly serves as a route to the extended family amassing wealth from the family of the elderly person requiring care without them providing the requisite care.

The non-domiciliary care facilities, especially the residential aged care facilities serve as a one-stop shop in addressing the multiple care needs of the chronically ill and disabled elderly persons who access them. They provide the elderly with a lot more services within the confines of the facility than the elderly could easily access from their homes. The residential aged care facilities provide technical, medical, spiritual, emotional and end of life care to the elderly depending on their care needs.

The circumstances under which the elderly are admitted at the residential aged care facilities are varied but largely boil down to their need for long-term care to perform ADL. Most of them had one or more disabilities associated with the chronic diseases they were suffering from. They had been brought to the facilities at a time when their chronic diseases had developed complications that required that their primary caregivers offer a lot more support and or care in the performance of or achievement of ADL than they would typically do.

Majority of the elderly persons who could talk as at the time they were being admitted to the residential aged care facilities accepted the idea of them accessing non-domiciliary care. Accessing the residential aged care facilities are associated with the elderly experiencing a sense of abandonment which some of them imbibe. Others get over the feelings of

abandonment and adjust to their new environment. Most of the elderly persons felt a sense of abandonment at three different stages of the process of accessing the residential aged care facilities. The three stages were when they were initially informed about accessing the non-domiciliary care, arrival at the residential aged care facility and being left there and lastly when the elderly persons were not visited or contacted through telephone calls.

The presence and sustenance of residential aged care facilities and their mode of operations in the urban centres of the Greater Accra Region favour the career oriented middle aged adults who are responsible for addressing the care needs of their elderly persons. The primary caregivers enjoy a balanced life and the peace of mind needed, knowing that their elderly person's achievement of ADL is not dependent on their availability to supervise the care provided or physical presence to provide hands-on care for them. The benefits derived from accessing the residential aged care facilities, comes at a cost to the primary caregivers which some are not able to sustain over a very long period.

8.5 Recommendations

The recommendations based on the study are in two parts, the first part focuses on areas where further studies could be made towards enhancing the implementation of the new phenomenon of non-domiciliary care of the disabled, frail elderly. The second part addresses issues related to policy formulation in the country.

More research is needed to find out how the extended family members feel about their relatives accessing such facilities and intergenerational views about the elderly persons accessing non-domiciliary care facilities to address their care needs. Additionally, further research is needed to develop the concepts and processes described in the study findings.

There is the need for research into the nature and content of care provided by the home care service agencies and ways of ensuring that appropriate care is provided by the professionals in the absence of primary caregivers of the elderly. This is to improve upon the delivery of such services as an efficient option to residential non-domiciliary care with the aim of promoting ageing in place for those who can afford it.

Additionally, there is the need for further research to be conducted into issues of relations and powerlessness of the elderly in the processes leading the elderly accessing non-domiciliary care in the urban centres of the Greater Accra Region.

The research findings serve as a unique insight into the practicality and outcomes of hired hands caring for elderly persons out of their homes. These experiences of accessing non-domiciliary care serves as a basis for future research to develop private initiative support programmes, interventions and policies for non-domiciliary care to promote healthy and safe outcomes for the disabled, frail elderly as they access long-term care out of their homes.

Most of the residents of the non-domiciliary care facilities are elderly persons suffering from chronic diseases with multiple disabilities, some of whom might have lost their speech but requiring technical/ physical, medical, spiritual, emotional and in some cases end of life care. They require care from people who understand their condition and have the necessary skills to care for them appropriately. There is the need for a state institution such as the Department of Social Welfare to assume responsibilities for these facilities and periodically visit them, assess their operations to ensure that they are operating per the stipulated rules of engagement, which warranted their certification to operate as such. This will go a long

way in ensuring that the quality of services offered to the elderly are high and adequate so as to prevent eldercare abuse.

Additionally, studies have shown that improvement in technology, the environment, self-care and lifestyle changes, can lead to better functioning in later life. There is the need for the elderly to be introduced to assistive devices so that they can learn to change their habits in order to function independently.

There is the need for a draft document to be prepared by the state regarding the nature and basic tenets of an eldercare institution so that private initiatives can follow it in the design of theirs.

There is the need for government to set up public residential aged care facilities for families who require out of home care for their elderly persons but cannot afford cost of private residential aged care facilities or nursing homes currently available in urban Accra.

REFERENCES

- Aboagye, E., Agyemang, O. S., & Tjerbo, T.** (2013). Elderly demand for Family-Based Care and Support: Evidence from a Social Intervention Strategy. *Global Journal Of Health Science*, 6 (2), 94–104.
- Aboderin, I.** (2004). Decline in Material Family Support for Older People in Urban Ghana, Africa: Understanding Processes and Causes of Change. *The Journals of Gerontology: Social Sciences*, 59 (3), 128–137.
- Aboderin, I.** (2004). Intergenerational Family Support and Old Age Economic Security in Ghana. In P Lloyd-Sherlock, (Ed.), *Living longer: Ageing, Development and Social Protection* (210–229). London: Zedbooks.
- Aboderin, I.** (2005). “Conditionality” and “limits” of filial obligation: conceptual levers for developing a better understanding of the motivational basis and societal shifts or patterns in old age family support. *Oxford Institute of Ageing Working Paper* No. 205, Institute of Ageing, Oxford.
- Addo, J., Agyemang, C., Smeeth, L., de-Graft Aikins, A., Edusei, A. K., & Ogedegbe, O.** (2012). A Review of Population-Based Studies on Hypertension in Ghana. *Ghana Medical Journal*, Volume 46 Number 2 Supplement.
- Adler, R. G. & Constantinou, C.** (2008). Knowing - or not knowing - when to stop: cognitive decline in ageing doctors. *The Medical Journal of Australia*. 189 (11/12) 1/15, 622 – 624.
- Adzakey, G.Y.** (2013). Contribution of Remittances to the Care of the Elderly in Ablekuma South. An Unpublished M.A. Thesis. University of Ghana (Center for Social Policy Studies).
- Aganiba, B.A., Owusu, W.B., Steiner-Aseidu, M., & Dittoh, S.** (2015). Association between lifestyle and health variables with nutritional status of the elderly in the Northern region of Ghana. *African Journal of Food, Agriculture, Nutrition and Development*, 15 (4), 10198–10216.
- Agbényiga, D. L., & Huang, L.** (2012). Impact of the Organizational Networks on the Roles of NGOs in Eldercare: Perspectives from HelpAge Ghana Day Centres. *Ageing International*, 37 (3), 338–355.
- Agyei-Mensah, S., & de-Graft Aikins, A.** (2010) Epidemiological Transition and the Double Burden of Disease in Accra, *Ghana Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 87, No. 5.
- Agyemang, F.A.** (2014). Survival Strategies of the elderly in rural Ghana. Unpublished PhD Thesis, University of Ghana (Department of Social Work).
- Agyemang, C., Buene, E.A., Meeks, K., Owusu-Dabo, E., & de-Graft Aikins, A.,** (2014). Research on Obesity and Type 2 Diabetes among African Migrants: The RODAM study. *BMJ Open*.4:e004877.
- Alidu, S., Dankyi, E., & Tsiboe-Darko, A.** (2016) Aging Policies in Ghana: A Review of the Livelihood Empowerment Against Poverty and The National Health Insurance Scheme. *Ghana Studies Journal*, 19, 154-172.

- Apt, N.A.** (2002). Ageing and the Changing Role of the Family and the Community: an Africa perspective. *International Social Security Review*, 55 (1), 39–47.
- Apt, N. A.** (2001). Rapid Urbanisation and Living Arrangements of Older Persons in Africa. *United Nations Population Bulletin, Special Issue*, (Special Issue Nos. 42/43), 1–30.
- Apt, N. A.** (1996). *Coping with Old age in a changing Africa*. Aveburg: Aldershot.
- Apt, N.A. and Katila.** (1994). Gender and intergenerational support: the case of Ghanaian women. *Southern African Journal of Gerontology*, 3 (2), 23–29.
- Ardayfio-Schandorf, E.** (1995). *The Changing Family in Ghana*. Proceedings of the National Conference, Accra, Ghana, Ghana Universities Press.
- Askham, J.** (1989). The Need for Support. In A. M. Warnes (Ed.), *Human Ageing and Later life: Multidisciplinary Perspectives* (107–117).
- Attride-Stirling, J.** (2001). Thematic Networks: An Analytical Tool for Qualitative Research. *Qualitative Research*, 1 (3), 385–405.
- Atobrah, D.** (2016). Elderly Women, Community Participation and Family Care in Ghana: Lessons from HIV Response and AIDS Orphan Care in Many Krobo. *Ghana Studies Journal*, 19, 73–94.
- Ayernor, P.K.** (2012). Diseases of ageing in Ghana. *Ghana Medical Journal*, 46(2), 18–22.
- Ayernor, P.K.** (2016). Health and Well-Being of Older Adults in Ghana: Social Support, Gender, And Ethnicity. *Ghana Studies Journal*, 19, 95–129.
- Ayettey, S.** (2009). Prologue. In C. Oppong P. Antwi and K. Waerness (Ed.), *Care of the Seriously Sick and Dying. Perspectives from Ghana* (51–91).
- Badasu, D. M.** (2004). Child Care among Ewe Migrants in the City of Accra: Cases of Crisis. *Research Review*, 16, 17–37.
- Bailey, G. & Peoples, J.** (2013). *Essentials of Cultural Anthropology*. 3rd Edition. Wadsworth Publishing.
- Barrow, G. M.** (1986). *Aging, the Individual, and Society*. West Publishing Company.
- Bauer, J. M. & Sousa-Poza, A.** (2015). Impacts of Informal Caregiving on Caregiver Employment, Health, and Family. IZA Discussion Paper No. 8851.
- Beard, J. R., Biggs, S., Bloom, D. E., Fried, L. P., Hogan, P., Kalache, A., & Olshansky, S. J.,** (2012) *Global Population Ageing: Peril or Promise*, Geneva: World Economic Forum.
- Boeije, H.** (2010). *Analysis in Qualitative Research*. Sage Publications Ltd.
- Berg, B. L.** (2007). *Qualitative Research Methods for the Social Sciences*. 6th Edition. San Francisco: Pearson Education, Inc.
- Berg, B. L.** (2004). *Qualitative Research Methods for the Social Sciences*. (J. Lasser, Ed.) (Fifth Edition). Pearson Education, Inc.

- Berg, B. L.** (2001). *Qualitative Research Methods for the Social Sciences*. (J. Lasser, Ed.) (Fourth Edition). Pearson Education, Inc.
- Blumer, H.** (1969). *Symbolic Interactionism*, Englewood Cliffs, NJ: Prentice Hall.
- Bobbio, L.** (2010) Types of Deliberations. *Journal of Public Deliberation*, 6 (2), 1
- Bookman, A. & Kimbrel, D.** (2011). Families and Elder Care in the Twenty-First Century, 21 (2), 117–140.
- Bongaarts, J. & Zimmer, Z.** (2002). Living Arrangements of Older Adults in the Developing World : An Analysis of Demographic and Health Survey Household Surveys, *Journal of Gerontology: Social Sciences*, 57 (3), 145–157.
- Brown, C.K.** (1992). Family care of the Elderly in Ghana. In J.I. Kosberg (Ed.), *Family Care for the Elderly: Social and Cultural Changes* (17–30), Newbury Park: Sage.
- Brown, C.K.** (1991). Caring for the Elderly in Ghana: Present and future Policy challenges. *Bold*, 1(3), 15–17.
- Bryman, A.** (2001). *Social Research Methods*. Oxford: Oxford University Press.
- Chattopadhyay, A.** (2004). Population Policy for the Aged in India. *Economic and Political Weekly*, 39, 43.
- Corbin, J. & Strauss, A.** (1990). "Grounded theory research: procedures, canons, and evaluative criteria". *Qualitative Sociology* [Online], 13(1), 3-21.
- Coe, C.** (2016). Not a Nurse, Not a Househelp: The New Occupation of Elder Carer in Urban Ghana. *Ghana Studies Journal*, 19, 46–72.
- Cornwell, E. Y., & Waite, L. J.** (2009). Social Disconnectedness, Perceived Isolation, and Health among Older Adults. *Journal of Health and Social Behavior*, 50, 31–48.
- Costa, D. L.** (1999). A house of her own: old age assistance and the living arrangements of older nonmarried women, *Journal of Public Economics*, 72, 39–59.
- Creswell, J. W.** (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Sage Publications, Inc.
- Creswell, J. W.** (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 3rd Edition. Los Angeles: Sage Publications, Inc.
- Creswell, J.W.** (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J.W.** (2003). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 2nd Edition. Los Angeles: Sage Publications, Inc.
- Creswell, J.W.** (1998). *Qualitative inquiry and research design: Choosing among five approaches*. Sage Publications, Inc.
- Darkwa, O.K.** (2000). Toward a comprehensive understanding of the needs of elderly Ghanaians. *Ageing International*, 25 (4), 65–79.
- Darteh, E.K.M., Nantogmah, B., & Kumi-Kyereme, K.** (2014). If your parents help you

grow your teeth: You help them loose theirs: Family support for the aged in Yamoransa, Ghana. *Journal of Social Sciences*, 7 (2), 38–50.

Debpuur, C., Welaga, P., Wak, G., & Hodgson, A. (2010). Self-reported health and functional limitations among older people in the Kassena-Nankana District, Ghana. *Global Health Action*, 3, 54–63.

de-Graft Aikins, A. & Koram, K. (2017). Health and Healthcare in Ghana, 1957 – 2017. In Aryeetey, E. and Kanbur, R. (ed.) *The Economy of Ghana Sixty Years after Independence* (p. 365 - 384).

de-Graft Aikins, A. & Apt, N. A. (2016). Ageing in Ghana: Setting Priorities for Research, Intervention and Policy, *Ghana Studies Journal*, 19, 35–45.

de-Graft Aikins, A., Kushitor, M., Sanuade, O., Dakey, S., Dovie, D., & Kwabena-Adade, J. (2016). Research on Ageing in Ghana from the 1950s to 2016, *Ghana Studies Journal*, 19, 173–189.

de-Graft Aikins, A., Awuah, B. R., Pera, T. A., Mendez, M. & Ogedegbe, G., (2014). Explanatory models of diabetes in urban poor communities in Accra, Ghana. Routledge. *Ethnicity & Health*, 1-18.

de-Graft Aikins, A., Pitchforth, E., Allotey, P., Ogedegbe, G., & Agyemang, C. (2012). Culture, ethnicity and chronic conditions: reframing concepts and methods for research, intervention and policy in low and middle-income countries. Editorial. *Ethnicity & Health*, 17 (6), 551–561.

de-Graft Aikins, A., Addo, J., Ofei, F., Bosu, W. K., & Agyemang, C. (2012). Ghana's Burden of Chronic Non-Communicable Diseases: Future Directions in Research, Practice and Policy. *Ghana Medical Journal*, Vol. 46, No. 2 Supplement.

de-Graft Aikins, A., Boynton, P. & Atanga, L. L. (2010a) Developing effective chronic disease interventions in Africa: insights from Ghana and Cameroon. *Globalization and Health Journal*, 6:6.

de-Graft Aikins, A., Unwin, N., Agyemang, C., Allotey, P., Campbell, C., & Arhinful, D. (2010b). Tackling Africa's Chronic Disease Burden: from the Local to the Global. *Globalization and Health Journal*, 6:5.

de-Graft Aikins, A. (2007). Ghana's neglected chronic disease epidemic: a developmental challenge. *Ghana Medical Journal*; 41 (4), 154-159.

de-Graft Aikins A. (2006). Reframing applied disease stigma research: a multilevel analysis of diabetes stigma in Ghana. *Journal of Community and Applied Social Psychology*. 2006;16 (6), 426–441.

de-Graft Aikins A. (2005). Healer-shopping in Africa: new evidence from a rural-urban qualitative study of Ghanaian diabetes experiences. *British Medical Journal*. 331:737.

de-Graft Aikins A. (2003). Living with Diabetes in Rural and Urban Ghana: a Critical Social Psychological Examination of Illness Action and Scope for Intervention. *Journal of Health Psychology*. 8(5), 557–572.

- Denzin, N. K., & Lincoln, Y. S.** (2000). *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications, Inc.
- Doh, D., Afranie, S., & Aryeetey, E.B-D** (2014). Expanding social protection delivery opportunities for older people: a case for strengthening traditional family systems and community structures. *Ghana Social Science Journal*, 11(1), 26-52.
- Domfe, G. & Aryeetey, B-D. E.** (2016), Household Composition and Well-Being of Older Persons in Ghana. *Ghana Studies Journal*, 19, 130–153.
- Dsane, S.** (2010). Care of the Elderly: A case study of grandmothers and childless elderly women in Teshie. Unpublished PhD Thesis, University of Ghana (Institute of African Studies).
- Durant, T. J. & Christian, O. G.** (2006). Caregiving To Aging Parents. *The Forum on Public Policy*, 1–24.
- Elmore, D. L.** (2014). The Impact of Caregiving on Physical and Mental Health : Implications for Research , Practice , Education , and Policy, 15–32.
- Gaymu, J., Delbès, C., Springer, S., Binet, A., Kalogirou, S., & Ziegler, U.** (2006). Determinants of the Living Arrangements of Older People in Europe. *European Journal of Population*, 22 (3), 241–262.
- Gifford, P.** (2004). Persistence and Change in Contemporary African Religion. *Social Compass Journals*. 51(2), 169–176.
- Ghana Statistical Service,** (2013). 2010 Population and Housing Census, Accra: Ghana.
- Glaser, K. & Grundy, E.,** (1998). Migration and Household Change in the Population Aged 65 and Over, 1971-1991, *International Journal of Population Geography*, 4, 323-339.
- Goffman, E.** (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. London, Penguin
- Gouldner, A. W.** (1960). The norm of reciprocity: A preliminary statement. *American Sociological Review* 25: 161–178.
- Grunfeld, E., Glossop, R., Mcdowell, I., & Danbrook, C.** (1997). Caring for Elderly People at Home: the consequences to caregivers, *Canadian Medical Association Journal*, 157 (8), 1101–1105.
- Guba, E.G.** (1981). Criteria for assessing the trustworthiness of naturalistic inquiries, *Educational Communication and Technology Journal* 29 (1981), 75–91.
- Guba, E. G. & Lincoln, Y. S.** (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.
- Guba, E. G. & Lincoln, Y. S.** (1989). *Fourth Generation Evaluation*. Newbury Park, CA: Sage Publications Inc.
- Hays, J. C.** (2002). Living Arrangements and Health Status in Later Life : A Review of Recent Literature. *Public Health Nursing*, 19 (2), 136–151.

- Heisler, E., Evans, G. W. & Moen, P.** (2004). Health and Social Outcomes of Moving to a Continuing Care Retirement Community. *Journal of Housing for the Elderly*, 18(1) 5-23.
- Helpage International (HAI)** (2002). The state of the world's older people, 2002. Aging and development report: Poverty, independence and world's older people. London. Earthscan Publications.
- Hurst, C. E.** (2007). *Social Inequality: Forms, Causes, and Consequences*. Boston MA, Allyn and Bacon, 6th edition, ISBN 0-205-48436-0.
- International Labour Organisation** (2009). Conditions of Work and Employment Programme: *Domestic work and domestic workers in Ghana : An overview of the legal regime and practice*. Series No. 23. Geneva.
- Jones, K. & Fowles, A. J.** (1984). 'Goffman: the radical', in *Ideas on Institutions*. London: Routledge & Kegan Paul, pp. 12–16. In Johnson, J. and DeSouza, C., (2008) *Understanding Health and Social Care: An Introductory Reader*, by Sage
- Karlberg, T.** (2003). Elderly People in Ghana - About Roles and Life Situation from their own Perspective. *Örebro Theological Seminary*, 4–38.
- Kielhofner, G.** (1982). Qualitative research: Part one. Paradigmatic grounds and issues of reliability and validity. *Occupational Therapy journal of Research*, 2, 67-79.
- Kimuna, S. R.** (2013). Living Arrangements and Conditions of Older People in Zimbabwe Theoretical Explanations : Rational Arrangements of Older People Choice. *African Population Studies*, 20 (2), 143–163.
- Kirk, A.** (2007), Karl Polanyi, Marshall Sahlins, and the Study of Ancient Social Relations. *Journal of Biblical Literature*, 126, (1), 182-191.
- Kodwo, S.** (2009). Determinants of international long-distance eldercare: Evidence from Ghanaian immigrants in the United States (Unpublished Thesis).
- Kodwo-Nyameazea, Y., & Nguyen, P.V.** (2008). Immigrants and long-distance elder care: An exploratory study. *Ageing International*, 32 (4), 279–297.
- Komter, A. E. & Schans, D.** (2008). Reciprocity Revisited: Give and Take in Dutch and Immigrant Families. *Journal of Comparative Family Studies*, 39, (2), 279-298.
- Krefting, L.** (1991). Rigour in Qualitative Research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy*, 45, 3.
- Kubsch, S. & Wichowski, C. H.** (1997). Restoring power through nursing intervention. *Nursing Diagnosis*, 8(1), 7-15.
- Leblanc, A. J. & Wight, R. G.** (2000). Reciprocity and Depression in AIDS Caregiving. *Sociological Perspectives*, 43, (4), 631-649.
- Leininger, M. M.** (1985). Nature, rationale and importance of qualitative research methods in nursing. In M. M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 1-28). New York: Grune & Stratton.
- Lemert, C.** (2004). *Social Theory: The Multicultural and Classic Readings*. Boulder CO, Westview P., 3rd edition ISBN 0-8133-4217-1 and 978-0-8133-4217-7.

- Leone, T., Coast, E., Narayanan, S., & de Graft Aikins, A.** (2012) Diabetes and Depression Comorbidity and Socioeconomic Status in Low and Middle Income Countries (LMICs): A Mapping of the Evidence. *Globalization and Health* 2012, 8:39.
- Lincoln, Y. S., & Guba, E. A.** (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Litwak, E. & Longino, C. F.** (1987). Migration Patterns Among the Elderly: A Developmental Perspective. *The Gerontological Society of America*. 27 (3), 266-272.
- Lofland, J., & Lofland, L. H.** (1995). *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont, CA:Wadsworth.
- Malinowski, B.** (1922). *Argonauts of the Western Pacific: An Account of Native Enterprise and Adventure in the Archipelagoes of Melanesian New Guinea*. London: Routledge.
- Manuh, T. & Quashigah, K.** (2009). Legal and Ethical Issues in the Care of the Seriously Ill in Ghana. In C. Opong, P. Antwi and Waerness, K. (Ed.), *Care of the Seriously Sick and Dying. Perspectives from Ghana* (51–91).
- Manu-Moshie, A.** (2012). Ageing lifestyles behaviour and chronic degenerative diseases in Ghana. An unpublished M.A. Thesis. University of Ghana (Population Studies)
- Mauss, M.** (1967). *The Gift: Forms and functions of exchange in archaic societies*. New York: Norton.
- Mason, M.** (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research*, 11(3), Article 8.,
- Mazzucato, V.** (2008). Transnational reciprocity: Ghanaian migrants and the care of their parents back home. In E. Alber, S. van der Geest and S.R. Whyte (Eds), *Generations in Africa: Connections and Conflicts*. Munster:LIT Verlag. (111–133).
- Mba, C. J.** (2002). Determinants of Living Arrangements of Lesotho's Elderly Female Population. *Journal of International Women's Studies*, 3 (2), 1–22.
- Mba, C. J.** (2007). Gender Disparities in Living Arrangements of Older People in Ghana: Evidence from the 2003 Ghana Demographic and Health Survey, 9 (1), 153–166.
- Mba, C. J.** (2010). Population Ageing in Ghana: Research, Gaps and the way forward. *Journal of Aging Research*, 27 (7), 1147–1169.
- Mbiti, J. S.** (1991). *Introduction to African Religion*, second Ed., Oxford, Heinemann Educational Publishers.
- McPherson, C. J., Wilson, K. G., & Murray, M. A.** (2007). Feeling like a burden: Exploring the perspectives of patients at the end of life. *Social Science and Medicine*, 64 (2), 417–427.
- Meera, S. & Kumar, D. C.** (2015). Reciprocity, Exchange and Social Solidarity. *International Research Journal of Social Sciences*, 4 (5), 84-88.
- Mensa-Wilmot, Y.M.** (2003). Risk Factors for Non-Communicable Disease among the Adult Population in the Kassena-Nankana District. A Community-Based Survey. An

unpublished M.A. Thesis. University of Ghana. (School of Public Health).

- Michael, Y. L., Berkman, L. F., Colditz, G. A., & Kawachi, I.** (2001). Living Arrangements , Social Integration , and Change in Functional Health Status. *American Journal of Epidemiology*, 153 (2), 123–131.
- Miles, M. & Huberman, M.** (1994) *Qualitative Data Analysis: An Expanded Sourcebook*. London: Sage.
- Nakua, E. K., Otupiri, E., Dzomeku, V. M., Owusu-Dabo, E., Agyei-Baffour, P., Yawson, A. E., & Hewlett, S.** (2015). Gender disparities of chronic musculoskeletal disorder burden in the elderly Ghanaian population: study on global ageing and adult health (SAGE WAVE 1). *BMC Musculoskeletal Disorders*, 16 (1), 204.
- Neuman, W. L.** (2007) *The Basics of Social Research: Qualitative and Quantitative Approaches*, 2nd edition Pearson Education, Inc.
- Neuman, W. L.** (2004) *The Basics of Social Research; Qualitative and Quantitative approaches*, Pearson Education Inc.
- Novak, M.** (2006). *Issues in Aging: An Introduction to Gerontology*. United States of America Pearson Education Inc.
- Nukunya, G.K.** (2014). *Tradition and Change in Ghana. An Introduction to Sociology*. Accra: Ghana Woeli Press.
- Nukunya, G.K.** (2003). *Tradition and Change in Ghana. An Introduction to Sociology*. Accra: Ghana University Press.
- Ofori-Dua, K.** (2014). *Extended family support and elderly care in Bomang, Ashanti Region, Ghana. Unpublished PhD Thesis, University of Ghana (Department of Social Work)*.
- Opong, C., Antwi, P., & Waerness, K.,** (2009). Care of the Seriously Sick and Dying: Perspectives from Ghana, *BRIC* (17 - 26).
- Palloni, A.** (2001). Living Arrangements of Older Persons. *United Nations Population Bulletin, Special Issue*, (Special Issue Nos. 42/43), 1–13.
- Panigrahi, A. K.** (2009). Determinants of Living Arrangements of Elderly in Orissa : An Analysis, (Working Paper 228), 25.
- Patton, M. Q.** (2002), *Qualitative Research and Evaluation Methods*. Third Edition, Thousand Oaks, CA Sage Publications, Inc.
- Patton, M. Q.** (1990). *Qualitative Evaluation and Research Methods* (169-186), Beverly Hills, CA: Sage.
- Perry, T. E., Andersen, T. C., & Kaplan, D. B.** (2013). Special Issue : Remembering Our Roots Relocation Remembered : Perspectives on Senior Transitions in the Living Environment. *The Gerontologist*, 54 (1), 75–81.
- Pezzin, L.E., Pollak, R. A., & Schone, B. S.** (2007). Efficiency in Family Bargaining: Living Arrangements and Caregiving Decisions of Adult Children and Disabled Elderly Parents*CESifo Economic Studies, 53, (1), 69–96.

- Peoples, J. & Bailey, G.** (2014). *Humanity: An Introduction to Cultural Anthropology*. 10th Edition, Published by Cengage Learning.
- Polanyi, K.** (1957). *The Great Transformation. The Political and Economic Origins of our time*. Boston: Beacon Press.
- Polanyi, K.** (1977). *The Livelihood of Man*. New York: Academic Press.
- Punch, K. F.** (2005). *Introduction to Social Research: Quantitative & Qualitative Approaches*. London: Sage.
- Quadagno, J.** (1999). *Aging and the Life Course: An Introduction to Social Gerontology*. United States of America: McGraw-Hill Companies Inc.
- Ren, Q., & Treiman, D. J.** (2014). *Living Arrangements of the Elderly in China and Consequences for their Emotional Well-being Population Studies Center Research Report 14-814*.
- Rubin, D. C. & Berntsen, D.** (2006). People over forty feel 20% younger than their age: Subjective age across the lifespan. *Psychonomic Bulletin & Review*, 13 (5), 776 - 780.
- Sackey, B.M.** (2009). Family networking and relationship in the care of the seriously ill: perspectives from Ghana. In C. Opong, P. Antwi and K. Waerness (Eds.), *Care of the seriously ill and dying* (188–210). Bergen: Allkopi.
- Sahlins, M.** (1972). *Stone Age Economics*. New York: Aldine de Gruyter.
- Sanuade, O.A.**, (2017). *Burden of Stroke in Ghana: Prevalence, Experience and Caregiving*. Unpublished PhD Thesis, University of Ghana (Regional Institute of Population Studies).
- Sanuade, O.A., & Boatemaa, S.** (2015). Caregiver profiles and determinants of caregiving burden in Ghana. *Public Health*, 129, 941–947.
- Savin-Baden, M. & Major, C. H.** (2013). *Qualitative Research: The Essential Guide to Theory and Practice*. New York: Routledge.
- Shenton, A.K.** (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 22, 63–75.
- Silverman, D.** (2000) 'Analysing Talk and Text' *Handbook of Qualitative Research*, 2nd Edition, Thousand Oaks, CA: Sage.
- Silverstein, M. & Giarrusso, R.** (2010) Aging and Family Life: A Decade Review. *Journal of Marriage and Family* 72: 1039 – 1058.
- Silverstein, M., Cong, Z., & Li, S.** (2006). Intergenerational Transfers and Living Arrangements of Older People in Rural China: Consequences for Psychological Well-Being. *Journal of Gerontology: Social Sciences*, 61, (5), 256–266.
- Sokolovsky, J.** (2001). Living Arrangements of Older Persons and Family Support in Less Developed Countries. *United Nations Population Bulletin*, (Special Issue Nos. 42/43), 1–38.

- Strauss, A. L. & Corbin, J.** (1990) Basics of qualitative research: Grounded theory procedures and techniques, Newbury Park, CA, Sage.
- Tawiah, E.O.** (2011) Population ageing in Ghana: a profile and emerging issues. *African Population Studies*, 25, (2), 623-645.
- Tonah, S.** (2009). The Challenge of Ageing in Rural and Urban Ghana. In S. Tonah (Ed.), *Contemporary Social Problems in Ghana* (125–146). Accra: Research and Publication Unit, Department of Sociology, University of Ghana.
- United Nations**, Department of Economic and Social Affairs, Population Division (2015). *World Population Ageing 2015*.
- United Nations**, Department of Economic and Social Affairs, Population Division (2013). *World Population Ageing 2013*.
- United Nations**, Department of Economic and Social Affairs, Population Division (2005). *World Population Prospects The 2004 Revision*.
- Van der Geest, S.** (2016a). Will families in Ghana continue to care for older people? Logic and contradiction in policy. In: J. Hoffman & K. Pype (eds) *Ageing in Sub-Saharan Africa: Spaces and Practices of Care*. London: Policy Press, pp. 21-41.
- Van der Geest, S.** (2016b). Studying Older People in Ghana: Closing Reflections. *Ghana Studies Journal*, 19, 190-201.
- Van der Geest, S.** (2012). Graceful and successful ageing: Observations from Ghana and the Netherlands. In B. Röder, W. de Jong and K.W. Alt (Eds.), *Alter(n) anders denken: Kulturelle und biologische Perspektiven* (227–238). Wien, Köln, Weimar: Böhlau Verlag GMBH & Cie.
- Van der Geest, S.** (2011). Loneliness and distress in old age: A note from Ghana. In: M. Tankink and M. Vysma (Eds), *Roads and boundaries: Travels in search of (re)connection* (67–74). Diemen: AMB Publishers.
- Van der Geest, S.** (2009). End-of-life care in Ghana and the Netherlands: Good death, bad death and euthanasia. In: C. Oppong, Antwi, P and Waerness, K (Eds.), *Care of the seriously sick and dying: Perspectives of Ghana* (265–289). Bergen: BRIC, Unifob Global.
- Van der Geest, S.** (2008). Resilience and the whims of reciprocity in old age: An example from Ghana. *Medische Antropologie*, 20 (2), 297–311.
- Van der Geest, S.** (2004). They don't come to listen": The experience of loneliness among older people in Kwahu, Ghana. *Journal of Cross-Cultural Gerontology*, 19, 77–96.
- Van der Geest, S., Mul, A., & Vermeulen, H.** (2004). Linkages between migration and the care of frail older people: observations from Greece, Ghana and The Netherlands. *Ageing and Society*, 24 (3), 431–450.
- Van der Geest, S.** (2002a). Respect and Reciprocity: Care of Elderly People in Rural Ghana. *Journal of Cross-Cultural Gerontology*, 17, 3–31.
- Van der Geest, S.** (2002b). The Toilet: Dignity, Privacy and Care of Elderly People in Kwahu, Ghana. *Ageing in Africa. Sociolinguistic and Anthropological Approaches*,

227–244.

- Van der Geest, S.** (1997a). Between respect and reciprocity: Managing old age in rural Ghana. *Southern African Journal of Gerontology*, 6 (2), 20–25.
- Van der Geest, S.** (1997b). Money and respect: The changing value of old age in rural Ghana. *Africa*, 67 (4), 534–559.
- Van der Geest, S.** (1995). Old people and funerals in a rural Ghanaian community: Ambiguities in family care. *Southern African Journal of Gerontology*, 4 (2), 33–40.
- Wiemers, E. E., McGarry, K., & Hotz, V. J.** (2015). Living Arrangements of Mothers and Their Adult Children over the Life Course. *Forthcoming in Research on Ageing*, 1–33.
- Wight, R. G., LeBlanc, A. J., & Aneshensel, C. S.** (1998). AIDS caregiving and health among midlife and older women. *Health Psychology*, 17(2), 130–137.
- Wilkinson, J. M.** (2005). *Prentice Hall nursing diagnosis handbook with NIC interventions and NOC outcomes*. (8th edition). Upper Saddle River, New Jersey: Pearson Education.
- Wilmoth, J.M.**, (2001). Living Arrangements Among Older Immigrants in the United States. *The Gerontologist*, 41, (2), 228–238.
- Wolff, J. L., & Kasper, J. D.** (2006). Caregivers of Frail Elders: Updating a National Profile. *The Gerontologist*, 46 (3), 344–356.
- Wolff, J. L., Dy, S. M., Frick, K. D., & Kasper, J. D.** (2007). End-of-life Care, Findings from a National Survey of Informal Caregivers, *American Medical Association*, 167, (6), 40-46.

APPENDICES

ETHICAL CLEARANCE LETTERS

APPENDIX A1

APPENDIX A2

APPENDIX B1

INSTRUMENT FOR USERS OF THE FACILITIES/SERVICES

INTRODUCTION

Good morning/afternoon/evening. My name is.....I am from the Sociology Department of the University of Ghana, Legon. As part of my academic work, I am conducting a research on “the management of the care needs of elderly persons in the urban centres of the Greater Accra Region of Ghana as well as the role the emerging aged care facilities play in the society”. As an elderly person accessing one of these facilities, it would be interesting to hear your views on the emergence of such facilities and the role they play in the care of the elderly in society.

This project work is for academic purposes only. Your name is not required for the study. There are no right or wrong answers to the questions that would be asked therefore kindly feel free and share your views with me. Your responses and that of others from the other research sites will be put together and analysed. If need be, I am willing to share the summary of the findings of the study with you at the end of the project. If you have any questions concerning the study, please feel free to ask for clarification at any point of the interview. You are also free to contact any of the supervisors on this research work at the numbers provided below if you have questions at a later time.

Phone numbers.....

With your permission, I would like to ask you a few questions if you could spare a few moments.

SECTION A: SOCIO- DEMOGRAPHICS

1. Observe and record sex of **participant**

Male	1
Female	2

2. Can you kindly tell me how old you are?.....

Below 60 years	1	85 - 89 years	7
60 - 64 years	2	90 - 94 years	8
65 - 69 years	3	95 - 99 years	9
70 - 74 years	4	100 - 104 years	10
75 - 79 years	5	105 - 109 years	11
80 - 84 years	6	Above 110 years	12

3. What is your marital status?.....

Single	1
Living with partner	2
Married	3
Widowed	4

Divorced	5
Other (Specify)	6

4. What is the highest level of education you have attained?

No formal education	1	Post Secondary (ACCA etc.)	6
Some Primary	2	Tertiary (university completed)	7
Completed Primary	3	Tertiary (HND/Diploma)	8
Some Secondary	4	Other (specify)	9
Completed Secondary	5	Other (specify)	10

5. What was your occupation when you were younger?

Unemployed	1	Engineer	9
Civil servant	2	Farmer	10
Artisan	3	Driver	11
Teacher/Educationist	4	Trader/Businessman or woman	12
Lecturer	5	Caterer/Chef	13
Nurse/Midwife	6	Seamstress/Dressmaker/Tailor	14
Lawyer	7	Hairdresser/Barber	15
Medical Doctor	8	Other (specify)	16

6. Ethnicity: which part of the country do you come from?

Akan	1	Dagarti	5
Ga	2	Hausa	6
Guan	3	Ewe	7
Dagomba	4	Other (specify)	

7a. How many children (living) do you have?.....

7b. What is the occupation of your children?.....

7c. Where are all the children currently?.....

8a. Living arrangement: Who do you live with? how many people are in your household?

.....

8b. How are you related to the members of your household?.....

8c. Ownership of residential aged care facility: who owns the facility you live in with your household members?.....

Thank you

APPENDIX B2

INSTRUMENT FOR THE RELATIVES OF THE USERS OF THE FACILITIES/SERVICES

INTRODUCTION

Good morning/afternoon/evening. My name is.....I am from the Sociology Department of the University of Ghana, Legon. As part of my academic work, I am conducting a research on “the management of the care needs of elderly persons in the urban centres of the Greater Accra Region of Ghana as well as the role the emerging aged care facilities play in the society. As a relative of an elderly person accessing one of these facilities, it would be interesting to hear your views on the emergence of such facilities and the role they play in the care of the elderly in society.

This project work is for academic purposes only. Your name is not required for the study. There are no right or wrong answers to the questions that would be asked therefore kindly feel free and share your views with me. Your responses and that of others from the other research sites will be put together and analysed. If need be, I am willing to share the summary of the findings of the study with you at the end of the project. If you have any questions concerning the study, please feel free to ask for clarification at any point of the interview. You are also free to contact any of the supervisors on this research work at the numbers provided below if you have questions at a later time.

Phone numbers.....

With your permission, I would like to ask you a few questions if you could spare a few moments.

SECTION A: SOCIO- DEMOGRAPHICS

1. Observe and record sex of **participant**

Male	1
Female	2

2. How are you related to the elderly person you visit?.....

Mother (biological)	1	Grandfather	6
Father (biological)	2	Other relative	7
Uncle	3	Neighbour	8
Aunt	4	Church member	9
Grandmother	5	Other (Specify)	10

IF THE PERSON IS A RELATIVE OF THE ELDERLY IN QUESTION, ASK SUBSEQUENT QUESTIONS, IF NOT TERMINATE THE INTERVIEW

3. Can you kindly tell me how old you are?.....

Below 20 years	1	40	-	44 years	6
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20 - 24 years	2	45 - 49 years	7
25 - 29 years	3	50 - 54 years	8
30 - 34 years	4	55 - 59 years	9
35 - 39 years	5	Above 60 years	10

4. What is your marital status?.....

Single	1
Living with partner	2
Married	3
Widowed	4
Divorced	5
Other (specify)	6

5. What is the highest level of education you have attained?

No formal education	1	Post Secondary (ACCA etc.)	6
Some Primary	2	Tertiary (still in university)	7
Completed Primary	3	Tertiary (university completed)	8
Some Secondary	4	Tertiary (HND/Diploma)	9
Completed Secondary	5	Other (specify)	10

6. What is your religious affiliation?

Christianity	1
Islam	2
Traditional Religion	3
Other (specify)	4
Other (specify)	5

7. What is your occupation?.....

Unemployed	1	Engineer	9
Civil Servant	2	Farmer	10
Artisan	3	Driver	11
Teacher/Educationist	4	Trader/businessman or woman	12
Lecturer	5	Caterer/Chef	13
Nurse/Midwife	6	Seamstress/Dressmaker/Tailor	14
Lawyer	7	Hairdresser/Barber	15
Medical Doctor	8	Other (specify)	16

8. Can you kindly tell me how old your elderly relative is?.....

Below 60 years	1	85 - 89 years	7
60 - 64 years	2	90 - 94 years	8
65 - 69 years	3	95 - 99 years	9
70 - 74 years	4	100 - 104 years	10

75 - 79 years	5	105 - 109 years	11
80 - 84 years	6	Above 110 years	12

9. Who is the main person responsible for taking decisions about the care for the elderly relative?

Self	1
Elderly person's children	2
Elderly person's siblings	3
Elderly person's relatives	4
Other (specify)	5
Other (specify)	6

10. What are the care needs of the elderly in question?

.....

Thank you

APPENDIX C1

INTERVIEW GUIDE FOR USERS OF THE AGED CARE FACILITIES OR SERVICES

INTRODUCTION

Good morning/afternoon/evening. My name is.....I am from the Sociology Department of the University of Ghana, Legon. As part of my academic work, I am conducting a research on “the management of the care needs of elderly persons in the urban centres of the Greater Accra Region of Ghana as well as the role the emerging aged care facilities play in the society. As an elderly person accessing one of these facilities, it would be interesting to hear your views on the emergence of such facilities and the role they play in the care of the elderly in society.

This project work is for academic purposes only. Your name is not required for the study. There are no right or wrong answers to the questions that would be asked therefore kindly feel free and share your views with me. Your responses and that of others from the other research sites will be put together and analysed. If need be, I am willing to share the summary of the findings of the study with you at the end of the project. If you have any questions concerning the study, please feel free to ask for clarification at any point of the interview. You are also free to contact any of the supervisors on this research work at the numbers provided below if you have questions at a later time. Phone numbers.....

With your permission, I would like to ask you a few questions if you could spare a few moments.

Warm up questions

- How has your day been so far?
- What is the interesting thing you saw on television or heard on the radio today?
 - Why was it interesting? What do you like to watch on TV or listen to on radio?

Initial Open-ended Questions

- Tell me about how you came to be at this facility or access this service?
- When, if at all, did you first experience or notice the need for you to access this facility /service?
 - (If so,) what was it like? What did you think then? How did you happen to be at this facility (repetition)? Who, if anyone, influenced your actions? Tell me about how he/she or they influenced you.
- What was going on in your life then? How would you describe how you viewed your life before you came here? How. If at all, has your view of your life changed?
- How would you describe the person/persons who were living with you then?

Intermediate Questions

- What, if anything, did you know about this facility or service before accessing it?
- Tell me about your thoughts and feelings when you learned about the need for you to access this facility/service?

- Who, if anyone, was involved? When was that? How were they involved?
- Tell me about how you learned to handle the idea or thought of you accessing the facility/service?
- How, if at all, have your thoughts and feelings about the facility/service changed since you first accessed it?
- What positive changes have occurred in your life since you accessed this facility/service?
- What negative changes, if any, have occurred in your life since you accessed this facility/service?
- Could you describe a typical day for you when you are at this facility/or accessing this service? (Will probe for different times of the day)
 - Now tell me about a typical day when you are at home with your household members.
- Tell me how you would describe the person you are now. What most contributed to this change in your life?
- Could you describe the most important lessons you learned through experiencing the need to access this facility/service?
- What helps you to manage your presence in this facility or you accessing this service?
 - What problems are you encountering or are likely to encounter in this facility or accessing this service? Tell me the sources of these problems.
- Who has been the most helpful to you during this time of your life?
 - How has he/she been helpful?
- Has any organisation been helpful? What did the organisation do to help you? How has it been helpful?

Ending Questions

- Tell me about how your views and/or actions may have changed since you started accessing this facility/service?
- How have you grown as a person since you started accessing this facility?
 - Tell me about your strengths that you discovered or developed through this experience.
 - What do you most value about yourself now? What do others most value in you?
- After having these experiences, what advice would you give to someone who has just discovered that he or she needs to be cared for as a result of the situation he or she finds himself/herself in?
- Is there anything that you might not have thought about before that occurred to you during this interview?
- Is there anything else you think I should know to help me understand your situation better?
- Is there anything you would like to ask me?

Thank you

APPENDIX C2

IDI GUIDE FOR FACILITY/SERVICE OPERATOR

INTRODUCTION

Good morning/afternoon/evening. My name is.....I am from the Sociology Department of the University of Ghana, Legon. As part of my academic work, I am conducting a research on “the management of the care needs of elderly persons in the urban centres of the Greater Accra Region of Ghana as well as the role the emerging aged care facilities play in the society”. As an operator of an aged care facility, it would be interesting to hear your views on the emergence of aged care facilities in the urban centres of the Greater Accra Region and the role these facilities play in the care of the elderly in society.

This project work is for academic purposes only. Your name is not required for the study. There are no right or wrong answers to the questions that would be asked therefore kindly feel free and share your views with me. Your responses and that of others from the other research sites will be put together and analysed. If need be, I am willing to share the summary of the findings of the study with you at the end of the project. If you have any questions concerning the study, please feel free to ask for clarification at any point of the interview. You are also free to contact any of the supervisors on this research work at the numbers provided below if you have questions at a later time.

Phone numbers.....

With your permission, I would like to ask you a few questions if you could spare a few moments.

WARM UP QUESTIONS

Please tell me about the genesis/history or circumstances surrounding the startup/beginning of this facility/service provision?

- How business was started/commenced?
 - Source of capital etc.
 - How big was the facility they started business with?
 - How many rooms, beds, services offered, etc.
- Size of business when started?
- Location of business when started?
- Professional background of the person who started the business?
- Reasons for starting the business of caring for the aged?
- Number of employees, type/profession of employees commenced with?
- Current number of employees, type/profession of employees?
- Years of operation of business?
- Any affiliation to other facilities or organisations within or outside the country etc.?
- What is the source of the clientele base of this facility?
- What are the services offered to the elderly in this facility?
 - How much do you charge for each type of service?

- What training do the employees of the facility have with regards to the operations of the facility?
- Are you aware of other caregiving facilities offering similar services to the public in the city?
 - Where is competition located/address?
- In your view, what are some of the factors that have led to the emergence of aged care facilities in the urban centres of the Greater Accra Region?
- What are some of the factors contributing to the patronage of your facility?
- Can you tell me about the challenges you and your facility faces in the bid to meet the care needs of the aged in the urban centres?
- Looking at its journey in the business of caring for the aged how would you describe the performance of the facility?
- How do you measure your performance as far as your business activities are concerned?
 - What accounts for your success or lack of success in the business?
- IF THE BUSINESS IS NOT PERFORMING WELL ASK: What would have to happen for them to see themselves as successful in their business?
- Is there anything else you think I should know to help me understand your business operations better?
- Is there anything you would like to ask me?

Thank you

APPENDIX D

IDI GUIDE FOR THE RELATIVES OF THE ELDERLY PERSONS ACCESSING FACILITIES OR SERVICES

INTRODUCTION

Good morning/afternoon/evening. My name is.....I am from the Sociology Department of the University of Ghana, Legon. As part of my academic work, I am conducting a research on “the management of the care needs of elderly persons in the urban centres of the Greater Accra Region of Ghana as well as the role the emerging aged care facilities play in the society”.

This project work is for academic purposes only. Your name is not required for the study. Your responses to the questions raised and that of others from the other research sites will be put together and analysed. If need be, I am willing to share the summary of the findings of the study with you at the end of the project. If you have any questions concerning the study, please feel free to ask for clarification at any point of the interview. You are also free to contact any of the supervisors on this research work at the numbers provided below if you have questions at a later time.

Phone numbers.....

ESTABLISHING THE RULES FOR THE SESSION

I am interested in all of your views, ideas, comments and suggestions. Please note that I am interested in how you feel, what you think and what you as an individual want. All comments, both positive and negative, are welcome.

With your permission, I would like to start T introduction of himself/herself.

I would like you to introduce yourself to me just as I have done by telling us your first name, family status or the composition of your household, number and ages of your children or the people you live with, main activities (whether professional or not)

Warm up questions

Initial Open-ended Questions

- Could you describe the events that led up to or preceded the elderly relative coming to this facility or accessing this service?
- When, if at all, did you first experience or notice the need for the elderly relative to access this facility /service?
 - How did you feel? Who, if anyone, influenced the decision for the action to be taken? Tell me about how you or any other person influenced the process.
- Who were those responsible for meeting the care needs of the elderly relative before he/she started accessing the facility/service? Probe if paid/unpaid

Intermediate Questions

- What, if anything, did you know about this facility or service before accessing it?

- How did you feel when you became aware of the existence/availability of such a facility?
 - What were your expectations of the facility/service before accessing it?
- What are the services being provided to your elderly relative at the facility?
 - Probe for ADL
 - What are your thoughts about the services offered by the facility?
- How did the elderly relative feel when he/she was told about the need to him/her to access the facility/service? What did he/she do next?
- How did you feel when the decision was taken for your elderly relative to access the facility/service?
- Tell me, on the day of arrival at the facility (first occasion), how did you and your elderly relative feel?
 - What emotions did you and the elderly relative experience?
- How did you feel when you took leave of the elderly relative?
- How, if at all, have your thoughts and feelings about the facility/service changed since you first accessed it?
 - What has led to the changes in thoughts and in feelings?
- What changes (positive/negative) have occurred in your life and that of your elderly relative since he/she started accessing this facility/service?
- When you have to visit your elderly relative at this facility? How do you usually feel when you pay them the visit? What about the elderly person?

Ending Questions

- After having these experiences, what advice would you give to someone who has just discovered that he or she has to care for an elderly relative as a result of the situation he or she finds himself/herself in?
- In your view, how does your elderly relative feel about accessing the facility/service at this phase of his/her life?
- Is there anything else you think I should know to help me understand your situation better?
- Is there anything you would like to ask me?

Thank you

APPENDIX E

POINTERS FOR THE OBSERVATION OF FACILITIES

BACKGROUND

- Type of facility
- Location of facility
- Number of people working in the facility and their positions /roles/ responsibilities
- Working hours/periods
- Ownership of the facility
- Internal/external description of facility where necessary
 - Number of rooms
 - Number of beds in each room
 - Facilities in each room (Television sets, radio, refrigerator, ventilation, light etc, Artifacts? Types of artifacts)
 - Area for recreation?
 - Availability and types of facilities for recreation (games – what type of games)
 - Accessibility recreational facilities (who uses what?)

MAIN OBSERVATION

- What is the setting of care/caregiving like?
 - Initial impressions about the setting?
 - When and how does care/caregiving take place?
- What is going on?
- What specific acts comprise the activity of care/caregiving?
- What is the distribution of participants/informants over space and time in these facilities?
- How are the elderly persons or research participants/informants organised?
 - Who oversees, regulate or promote care/caregiving in the facility?
- How are members/research participants/informants stratified in the facility?
- Who is visibly in charge? Does being in charge vary by activity?
- How are participants/informants recruited/admitted/membership achieved and maintained?
- What do actors (staff of facility and the elderly) pay attention to? What is important, preoccupying, critical?
- What do the actors (staff of facility and the elderly) pointedly ignore that other persons might pay attention to?

ADDITIONAL NOTES

APPENDIX F

UNIVERSITY OF GHANA



Official Use only
Protocol number

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study:	‘HOME AWAY FROM HOME?’: THE EMERGING FORMS OF AGED CARE IN THE URBAN CENTRES OF THE GREATER ACCRA REGION
Student Investigator:	JOANA KWABENA – ADADE
Certified Protocol Number	ECH 096/14 – 15

Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The purpose of this study is to explore the nature of the formal systems of care that are emerging to manage and address the care needs of the increasing aged population/elderly persons within the urban centres of the Greater Accra Region in light of the increasing neglect of the care needs by informal support systems.

The whole process of talking to you about the study will take between 50 minutes and 60 minutes (one hour.)

If you agree to participate in the study I am conducting as part of my academic work at the University, I will spend some time with you in this facility at your convenience. In order for me to understand you better, you will be asked to answer some questions about yourself (age, highest education attained, occupation, religion etc.) and your immediate relatives (such as number of children, household members, the person who brought you here etc.) Then you will be asked about your care needs and how they are being met in this facility. Your answers to these questions will be audio taped with your permission. The form and

questions will take about 50 minutes to an hour. I would like to visit you again at a time that is best suited to you, if I have additional questions to ask you, or if there is the need for some clarification to be made about what you said previously.

Benefits/Risk of the study

The study will not pose any physical, social or psychological risk to you. Answering the questions may be somewhat tiring. You do not have to answer any questions you do not want to. You can stop being in the study any time you want. If you get tired, do not feel well or become upset, you can take a break at any time or end the interview.

Taking part in this study will not benefit you directly, although some people have benefited from talking about their situation to researchers. However, what you say may help others and the nation as a whole in the long run. The information will contribute to knowledge that will enable society to come up with firm measures to regulate and support the formal care system to ensure the continued support of the elderly in times when care is needed most.

Benefits/Risk of the study

The responsibility of the ethical researcher is to consider the consequences of his or her research for those being studied. The general goal of the researcher is not to cause any harm simply because someone volunteers to be a research participant. The anticipated risk might be minimal. The possible risk associated with the study is similar to that which is encountered in daily life or during the performance of routine physical or psychological examinations or tests.

Risks of the study

Physical Risk/Harm

The study does not anticipate causing any physical harm or risk to you. Even though physical harm is usually rare in social research (Neuman, 2007), efforts will be made to ensure that no physical harm ever comes to any of the study participants/informants. At each research site, potential risks including basic safety concerns (e.g., safe buildings, furniture, and equipment) as well as exposure to pain, injury or side effects will be anticipated before beginning a study. The researcher will screen-out high-risk participants/informants (those with heart conditions, mental breakdown, seizures, etc.) should there be great stress involved.

The researcher accepts moral and legal responsibility for any injury that might be caused to participants/informants due to participation in research and will terminate the project immediately if she can no longer fully guarantee the physical safety of the people involved.

Psychological Risk/Harm

The study does not envisage causing any psychological risk or harm (such as depression, guilt, embarrassment and loss of self-esteem whether brief, recurrent or permanent) to you. Answering the questions may be somewhat tiring for some participants/informants. You do not have to answer any questions you do not want to. You can stop being in the study any time you want. If you get tired, do not feel well or become upset, you can take a break at any time or end the interview.

The researcher would consult with other researchers who have conducted similar studies and mental health professionals as part of the planning process of the study. The researcher would screen out high-risk populations (e.g. those with emotional problems or weak hearts), and terminate the research if dangerous situations arise. The researcher will always obtain written informed consent before the research and debrief the people immediately afterward.

The researcher will ensure that she never creates unnecessary stress (i.e., beyond the minimal amount needed to create the desired effect) or stress that lacks a very clear, legitimate research purpose. The researcher will always work closely with her supervisors at every stage of the data collection period, because the involvement of several ethically sensitive researchers reduces the chances of making an ethical misjudgment.

Social Risk/Harm

The study does not envisage causing any social harm or risk (such as breach of confidentiality resulting in embarrassment, or criminal charges) to you. Your participation in the study will be kept confidential and private. The information gathered through the interviews will not be disclosed under any circumstance to the facility operators/care givers or your family members to affect your relationship/standing with them.

Economic Risk/Harm

The study does not anticipate causing any economic risk or harm to you. The researcher will ensure that you do not lose any economic resources in the process (if they are able to render certain services for a fee). She will schedule interviews at times that will be convenient for the participants/informants (e.g. those on medication who are supposed to eat, rest etc. at certain times). Participants/informants time for basic routines will be respected accordingly. The researcher would ensure that participation in the study does not jeopardize the remittances received by the elderly. Participants/informants will not be rewarded financially to jeopardize subsequent research. Participants/informants will be made aware of the amount of time it will take to participate in a study.

Legal Risk/Harm

The study does not anticipate causing any legal harm or risk to you. In my estimation, the issue under investigation will not pose any legal risk to you. As part of the study, researcher will be responsible for protecting the research participants/informants. Should the researcher learn of any illegal activity at any of the research sites when collecting data, the researcher would weigh the value of protecting the researcher-subject relationship and the benefits to

future researchers against potential serious harm to innocent people. The researcher would bear the cost of his or her judgment.

Benefits of the study

Taking part in this study will not benefit you directly, although some people have benefited from talking about their situation to researchers. You will not be paid for the study, and the only cost to you is the cost of your time for participating. However, the information you provide may prove beneficial to others and the nation as a whole in the run. The information will contribute to knowledge that will enable society to come up with firm measures to regulate and support the services of non-domiciliary care system to ensure the continued support of the elderly in times when care is needed most.

Confidentiality

Your answers will be written down on a form, it will not have your name on it. The tape recording will be transcribed, but your name will not be on any of the information. The consent forms will be stored separately from your answers. Your name will not appear in any report. All information from this study will be reported in a group format for academic work purposes, conferences, and publications so no one can identify you. Although direct quotations will be used in reporting the results of this study, they will be presented in such a way that no one can identify you. Your name will not be used and all identifying information will be removed from our report.

Your answers to the questions will be stored in a locked drawer at the researcher's personal library for at least five years. Only the research team (i.e. researcher, and her three supervisors) will be able to look at the information.

Compensation

This study is solely for academic purposes only. There is will be no compensation package either in cash or in kind for participants/informants who participate in the study.

However, a basic need at the facilities which will not be too expensive to address will be identified during the period of observation and addressed by the end of the data collection period. The amount to be spent per facility will not exceed GH100.00 since the research is self-financed by the student investigator. In instances where addressing the need becomes costly, toiletries worth the said amount will be purchased and donated to the facility.

Withdrawal from Study

Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort by telling me. You may refuse to answer any individual question if you wish. You may withdraw your responses from the study after the interview

by notifying me at any time, and your responses will be withdrawn, if possible. If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request.

Your withdrawal from the study for any reason, at any time, will not affect your care in any way at this facility.

Please be assured that you or your legal representative will be informed in a timely manner if information becomes available that may be relevant to your willingness to continue participation or withdraw from the study.

Should a participant be taken suddenly ill or incapacitated and therefore unable to take part in the study, his/her interview will be terminated.

Contact for Additional Information

This study has been approved on ethical grounds by the University of Ghana Ethics Committee for Humanities Ethics Board on 13th July, 2015.

If you have any questions concerning the study, please feel free to ask at any point: you are also free to contact the supervisors of the study on the phone number provided below if you have questions at a later time. Tel: 0302-21-500312/500300 Ext:6154/6084

If you would like to find out about the results of the study, please contact the researcher on Mobile Phone 0244 385566.

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@isser.edu.gh / dopai-tetteh@ug.edu.gh or 00233- 303-933-866.

Section C- VOLUNTEER
AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

Name of Volunteer

Signature or mark of volunteer

Date

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Name of witness

Signature of witness

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

Date

APPENDIX G

PICTURES FROM MERCY HOME CARE



PICTURES FROM MERCY MISSION HOME

