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CHALLENGES OF CAREGIVERS STAYING AT HOSPITAL PREMISES:

THE CASE OF KORLE – BU TEACHING HOSPITAL

BY

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DECLARATION

With the exception of the duly acknowledged references, I, EFUA ACQUAH, hereby declare that this research is the result of my own original work at the Department of Social and Behavioral Science in the School of Public Health of the Collage of Health Science in the University of Ghana under the supervision of Dr. Phyllis Dako-Gyeke, and hence has not been presented for any other degree in the University or elsewhere either in whole or part. I am responsible for the views expressed and the factual accuracy of its content.

Signed……………………………….. Date……………………

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Signed……………………………… Date……………………..

DR. PHILLIS DAKO-GYEKE

(Supervisor)

DEDICATION

I dedicate this project to my lovely children for their love, understanding and support.

ACKNOWLEDGEMENT

I give thanks to God Almighty for his loving kindness, mercies His grace and protection upon my life.

I give my heartfelt gratitude and thanks to my loving husband Mr. Michael Majeed Adams, my Uncle Dr. Nana Enyimayew and to my siblings for their support, encouragement and prayers.

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ABSTRACT

Background: Caring for a loved one with a chronic disease can results in physical, emotional and economic stressors for those in the caregiving role. Therefore, burden on the caregiver for those who are chronically ill is a probable outcome and substantial challenge of the experiences of the caregiver. Caregiving takes a physical, social and mental toll on caregivers, resultant in additional stress and increased additional medical bills for the person rendering care.

General Aim: This study sought to explore the challenges of caregivers staying at facility premises using Korle-bu Teaching Hospital (KBTH) as a case study.

Methodology: This study employed a qualitative design using an in-depth interview among patient care givers staying at the premises of the KBTH. Data from interviews will be transcribed, coded and then analyzed using thematic analysis in Nvivo Software.

Findings: The study provided baseline information on the difficulties encountered by caregivers of the chronically ill staying in facility premises, identified physical, psychological, sociocultural, social and economic experiences of these caregivers. The study also determines the coping strategies used by caregivers.Information obtained can serve as literature for other researchers and can be used to formulate policies that can be used to improve caregiving processes in health facilities

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CHAPTER ONE

INTRODUCTION

1.1 Background

A caregiver is someone who offers support to another person who is, to some extent, helpless (Alliance, 2001). Informal caregiver or family caregiver, are terminologies which are used to refer to unpaid individuals such as family members, friends and neighbors who provide care. These persons can be primary or secondary caregivers, full time or part time, and can live with the person being cared for at the hospital or live separately (Alliance, 2001).

Human recourse remains one of the most imperative assets in any healthcare system (Sadigh, Nawagi & Sadigh, 2016). However, some hospitals in various low-to-middle income countries are deficit in hospital staff who are supposed to care for patients (Sadigh, Nawagi & Sadigh, 2016). This situation has led to a common practice in African countries, including Ghana, where hospitalized patients are cared for by relatives or friends who act as patient's informal caregiver either in the hospital premises or within the home settings (Vernice, 2002). Hence, caregivers turn to execute wide range of responsibilities caring for their sick fellows.

Research has identified that the presence of an informal caregivers account for an important source of psychological stability for the patient, as well as a source of support for better recovery, since it helps patients to maintain contact with their house and friends (Smitka, 2012). Caregivers of the chronically ill provide the basic needs of the patient in the hospital

(Piercy & Chapman, 2001). Additionally, caregivers of such patients can help patients decrease stress, encouraging patients to respond effectively in the therapeutic form he or she follows (Shim, Barroso, & Davis, 2012). At the same time, caregivers of the chronically ill can direct the patient to participate in self-care activities and effectively face any complications of his or her illness. Sadigh et al. (2016) discovered in their survey on economic and social impact of informal caregivers at Mulago that caregiver's duties include being present for doctor visits and feeding, cleaning, administering medication to patient, keeping patient company, providing counseling, physical therapy, massage and sometimes, turning patients to avoid bedsores.

In as much as caregivers try to keep their sick relatives emotionally and psychological relaxed, to some extent, it burden to the informal care giver. A qualitative study done in a rural area of Ghana revealed that the consequences of care giving to patients on the part of the informal care giver includes: poverty, discrimination and stigma, lack of support from others, diminished social relationships, depression, emotional trauma, and poor or interrupted sleep (Ae-Ngibise, Doku, Asante & Owusu-Agyei, 2015). Oliver et al. (2017) noted informal caregivers undergo frustrations with patient care, emotional challenges, and frustrations with various health care systems, financial problems and personal health concerns. In addition, some caregivers face social exclusion and not having adequate time for other social responsibilities (Ae-Ngibise, et al, 2015).

The demands of caregiving can challenge the health of caregivers and aggravate their existing chronic health conditions, particularly for highly strained older adult caregivers. Such caregivers may incur injuries ranging from mild to serious falls, injured muscles, and skin abrasions while providing care (Rosenberg, 2006). Sleep deprivation is also an important issue. Due to the demands on their time, caregivers are more likely than non-caregivers to neglect their own health and less likely to practice preventive health behaviors. The social support networks of caregivers may dwindle over time resulting in real or perceived social isolation (Vernich, 2002). Caregivers often sacrifice their own physical and emotional needs, resulting in feelings of exhaustion, isolation, anger, and sadness. The constant demands of caregiving can result in mild to severe symptoms of depression. Caregivers of the chronically ill who are younger are at higher risk of depression. They often experience a greater effect on their non-caregiving activities, and report less social support, sense of control over their life, and personal growth (Cohen, 2001).

In light of these challenges however, caregivers still are able to withstand the stress till the end of the caring process. In some instances, people who live in large households, distribute care among individuals, resulting in the main caregiver feeling less stressed (Prince, 2004). With patients whose sickness are getting more chronic and never healing, care givers resort to religious prayers and the anticipation of cure were the main coping strategies adopted by caregivers, with expectation of new treatments being discovered (Ae-Ngibise et al., 2015). Nevertheless, it has become a necessity to care until sickness normalizes. Patients, visitors, nurses and doctors have expressed common opinions concerning the positive contribution of family on the care of patient in the hospital. As iterated, caregivers of the chronically ill constitute an important source of psychological and emotional support for hospitalized patients however, the burden and risk faced by caregivers is often underestimated (Rapp & Chao, 2000).

The role of caregivers in patient management is well documented for most chronic infections. Nevertheless, there is paucity of studies that investigate the challenges faced by caregivers of hospitalized patients. It is of essence that the challenges faced by caregivers be investigated as well as the coping mechanisms they adopt.

1.2 Problem Statement

The presence of caregivers to cater for patients in the hospital premises is an essential part of effective health care delivery. Evidence has indicated deficit in hospital staff in various hospitals across nations hence patients who are chronically ill need extra support and company of informal caregivers to feel mentally strong (Oliver et al., 2017). Caregivers of the chronically ill provide the basic needs of the patient in the hospital while at the same time, providing critical information about patients to health practitioners, which aids in diagnosis.

Whiles caregivers evidently play a crucial role in the recovery process of patients both at home and in the hospital, their presence in the hospital can be injurious to their own health. Caregivers are mostly without protective clothing, gloves and usually sleep very close to their patients. Most caregivers lack basic knowledge on the chronic diseases of their patients, which exposes them to all forms of health risks and infections (Bevans & Sternberf, 2012). By way of reducing some of these health risks, caregivers may adopt coping strategies (Cagle & Kovacs, 2011).

Korle-Bu Teaching Hospital (KBTH) is the largest hospital in Ghana, which provides care to people all over the country, as well as those from neighboring countries. Observations indicate caregivers of the chronically ill either sleep close to their relatives or are found sleeping on the corridors of the hospital. This can be with associated health risks of overcrowding including adverse prognosis of diseases and poor clinical outcomes such as mortality. This situation often increases the health burdens in most families with a hospitalized relative.

Many studies have been conducted that document the role of caregivers in caring for sick patients. However, studies that seek to explore the experiences of caregivers, documenting their daily challenges as well as coping strategies is limited. In addition, the few studies done on coping mechanism used retrospective approaches (Cagle & Kovacs, 2011). This study, therefore seeks to explore challenges and various coping strategies adopted by caregivers of hospitalized patients at Korle Bu Teaching Hospital.

1.3 Justification

The role of caregivers in patient management is well documented for chronic illnesses such as cancers and physical disability in developed countries (Ae-Ngibise et al., 2015). Caregivers however face challenges such as emotional challenges, frustrations with health systems, getting nosocomial infections, and having no social life (Oliver et al., 2016). In Ghana and some other African countries, most caregivers have no choice than to stay with their hospitalized patient's until recovered. Unfortunately, studies conducted to evaluate coping strategies adopted by caregivers in overcoming such challenges are limited. KBTH happens to be the largest hospital in the country has only one place for caregivers to stay leading to nosocomial infections. As a result, this study was conducted to identify challenges faced by caregivers and the coping mechanisms they adopt. Result of this study is most likely to influence planning and implementation of policies regarding care givers health in the KBTH.

1.4 Conceptual framework

Several theories have been used to explain the experiences and challenges of caregivers and their care recipients. These theories include;

Stress process model

Stress process model helps to explain the stress associated with caregiving (Carretero et al., 2009). Pearlin's stress process involves four components, namely the background and context of caregiving, the stressors, the mediators of stress, and the outcomes of stress (Pearlin et al., 1990). Stress process model emphasizes the relationships between these components. Stress process is influenced by background and context of caregiving such as caregiver's characteristics and caregiving history (Bastawrous, 2013; Carretero et al., 2009; Pearlin, 1989).

The background and context of caregiving determine the stressors that caregivers are exposed to, the mediators they are able to organize and the stress they may experience (Pearlin, 1989). A stressor refers to the condition, experience and activity that give rise to stress. The stressors can be classified as primary and secondary. Primary stressors are the needs and demands of the care recipients such as cognitive status, problematic behavior, and daily dependencies (Pearlin et al., 1990). These needs and demands of the care recipients lead to other problems and challenges referred to as secondary stressors such as family conflicts, difficulties at work (occupational strain) and financial difficulties (economic strain). Thus, secondary stressors are regarded as the consequences of primary stressors (Pearlin, 1989).

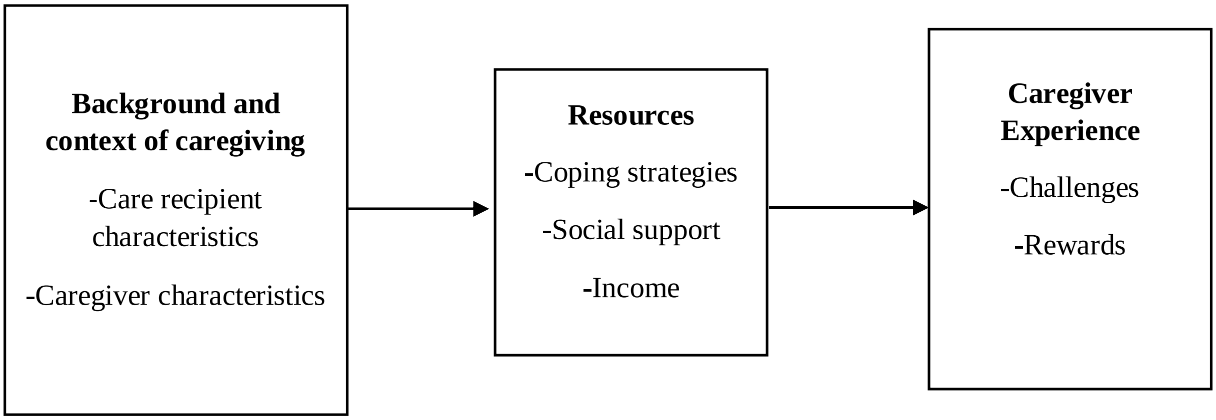
Stress process model can be applied to the study of the experiences of caregivers and their care recipients. The characteristics of caregivers (such as their sex, marital status, and employment status) and the needs and demands of the care recipients can lead to negative caregiving experiences such as burden and depression. In addition, the social support family caregivers receive from their relatives and non-relatives, and their coping strategies can mitigate their negative experiences.

The conceptual framework for the present study is a modified version of the caregiver adaptation model proposed by Kramer (1997) which is based on the stress process model. The caregiver adaptation model proposed by Kramer (1997) postulate that the adaption process consists of three components, namely background and context of caregiving, intervening processes and well-being outcomes. The caregiver adaptation model is an integrated framework which synthesize different theoretical and conceptual frameworks such as stress process model.

The conceptual framework shows that the outcomes of caregiving are directly influenced by the background and context of caregiving and indirectly influenced through resources (intervening processes). The background and context of caregiving are made up of three components, namely care receiver characteristics, caregiver motivations for providing care, and caregiver characteristics. Care recipient characteristics include sex, age, ethnicity, and needs (assistance they receive from their caregivers), among others while caregivers characteristics also include age, sex, employment status, and duration of caregiving, among others.

In this study, the background and context of caregiving indirectly influenced the caregiver and care recipient experiences through resources. Resources can influence the experiences of caregivers and their elderly care recipients. Resources was conceptualized as coping strategies, social support, and income in this study. The types of coping strategies employed and social support received by caregivers can influence their caregiving challenges. A caregiver can also conceptualize the social support he/she receives as a reward. In addition, the social support elderly care recipients receive from their caregivers and significant others can influence their satisfaction with the care they receive from their caregivers. The monthly income elderly care recipient receive can also influence their satisfaction with the care they receive from their caregivers, especially material care. Research has identified coping strategies and social support as important resources that can help mitigate the negative impacts of family caregiving to the elderly (Carretero et al., 2009).

Figure 1.1 Conceptual framework showing the relationship between background and context of caregiving, intervening process and outcomes of caregiving



Source: Adapted from Kramer, 1997

1.5 Research questions

1. What are the health challenges faced by family caregivers staying in the KBTH premises?
2. What are the physical, economic and social challenges faced by caregivers staying at the KBTH premises?
3. How do caregivers cope with challenges they face at KBTH premises?

1.5 Study Objectives

1.5.1 Main objective

To determine challenges faced by caregivers of chronically ill patients at the Korle-bu Teaching Hospital (KBTH).

1.5.2 Specific Objectives

1. To explore the psychological and emotional health challenges faced by caregivers who stay with their sick relatives at the KBTH premises.
2. To examine the physical, economic and social challenges faced by caregivers staying at the KBTH premises.
3. To identify the coping strategies adopted by caregivers staying at KBTH premises.

1.6 Expected Outcome

At the end of the study, challenges faced by caregivers of hospitalized patients will be determined. The study will also determine the various coping strategies adopted by caregivers in overcoming such challenges. Information obtained can serve as literature for other researchers and can be used to formulate policies that can be used to improve caregiving processes in health facilities.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Familial caregivers contribute and play a crucial role in the management of disease conditions. This chapter discusses relevant work on challenges faced by caregivers of those chronically ill and staying at the facility premises. This section seeks to present relevant information under the following headings:

2.2 Familial Caregivers

There are different forms of caregiving rendered by different types of people who could either be professional (doctors, nurses, and other healthcare professionals) or non-professional (siblings, adult children, and spouses). Whiles the former get some sort of financial reward for their care giving roles the latter are not. Non-Professional caregivers despite not being rewarded willingly take up the task of care giving. Amid caregivers, literature suggests that spouses and matured children mostly take up the family care giving responsibilities. According to Hooley and Mast (2009) bulk of works done on care giving concentrated on these forms of familial caregivers.

Kuhn (1990) as cited in Mohahan (1995) reiterates the idea that caring for a family member puts stress on the family in the home and this stress is carried on even when the sick person has been hospitalized. Limited studies done showed a breakdown of the number of familial caregivers; but other researchers did make available precise fractions of those taking the task of family caregiving responsibilities. Literature reviewed gave a range of 38% to 50%

in relation to the terms of the numeral figure of partners caring for a loved one with chronic diseases, studies ranged from 38 to 50% (Regehr, & Sussman 2009; Lockenhoff et al., 2011).

2.3 Challenges faced by Caregivers

The research indicated several undesirable effects as the consequence of taking on the role of care giving. These undesirable consequences comprised of financial, psychological, and physical stressors that start with the identification of disease condition and often worsens as the disease advances. As many as 50% of people rendering some kind of care believe that their responsibility for the client is a round-the-clock job, a clue of the challenges tied to this role (Schulz, et.al 2003). Kim and Schulz (2008) in their study conducted on people rendering care for four different types of ailments, discovered that people caring for loved ones with chronic diseases and cancer were more likely to experience psychological concerns than those caring for people with other types of disease conditions. This is consistent with other findings in literature which suggests that psychological difficulties are the major headaches of persons rendering care.

2.3.1 Psychological effects

Some expressive problems when taking care of a close person diagnosed with Alzheimer's disease included sadness or depression, grief, anger towards the sick person, and then a feeling of regret for expressing such emotions. There was a link between emotional problems in the caregivers and the intensity of the chronic disease in their loved ones as documented in a study done by Brodaty and Luscombe (1998), using 193 pairs of people rendering care and their sick counterparts with chronic disease. Battista, et.al.,(2004) point out that behavioral and cognitive problems in loved persons with chronic disease were related with feelings of burden in their caregivers. In an enhanced care givers intervention group, care givers requested information mostly on on grief and depression management, living a healthy lifestyle and lastly relaxation. (Nichols, et.al, 2009). These issues were aimed at alleviating stress intensities and to aid them deal with the emotional outcome of their responsibility. A descriptive cross sectional study conducted in Uganda to explore the challenges caregivers who reside in the hospital setting face indicated emotional burdens as one of the challenges (Sadigh, Nawagi, & Sadigh, 2016)

Increased stress levels was one emotional effect of rendering care as documented in literature. Findings in a study by Bertrand, Fredman, and Saczynski (2006) conducted on 349 persons caring for sick persons found that stress was greater among caregivers caring for sick people with chronic disease as compared to those caring for sick people without a chronic disease diagnosis. Respondents in Burns,et al., (2003) study, were put into two major groups, with the intervention group receiving information on enhanced care to be able to decrease emotional problems and handle stress. Results point to that the fact that the group that received information had lowered levels of stress and improved general wellbeing as compared to the other group.

Rudd, Vines, and Preston (1999) found undulate outcome in that female partners who rendered care with high level of stress also were anxious in their care giving responsibilities. This was as a result of the fact that these female spouses had to take up in addition to their responsibilities, other responsibilities which was formerly done by their sick partners (Rudd et al., 1999). In spousal caregivers, Sussman and Regehr (2009) found fairly high levels of "service-related stress," implying that in adding to the stress produced by the caregiving role, communal facilities that were invented to support them in their role instigated extra stress. As revealed in the literature, stress infuses the lives of persons rendering care and much provision is needed in releasing this consequence of caregiving. Depression was also very widespread in the collected works on caregivers.

Cohen and Eisdorfer (1986) found that half of people rendering care and living with a relative with chronic disease experienced clinical depression, similar findings in Nichols et al. (2009) coping with grief and depression were part of the top most educational materials requested for by persons rendering care. Grief was found to be a dominant theme in the literature, which directs that dealing with loss is an essential part of the caregiving experience. Rudd et al. (1999) described the process of grieving a person goes through as a result of losing a loved one with chronic disease.

The initial stage of grieving is refusing to accept that the love one had died, this stage may be followed by a feeling of guilt as a result of the anger experienced in the preceding stage. After these stages, the person also experiences the sadness and loneliness. In a qualitative study by Rudd et al. (1999), sadness was found to be the most collective sentiment that emerged. Loss and grief was more for partners once rendered care for their dead loved ones. A lot of investigators incorporated explicit vocabulary to define the type of grief that people rendering care for loved ones with chronic diseases go through.

As cited in Sanders et al, (2008) Martinson and Jones specified that as the disease condition progresses, grief of the caregiver also increases and contained within this is the concept of “dual dying,” indicating that care givers usually go through two main forms of grief. This is what he termed as the “pre-death grief” and then “additional grief” once the loved one is physically gone. Similar to the “pre-death grief” is “anticipatory grief,” which denotes grieving in expectation of the imminent loss of the sick loved one. (Holley & Mast, 2009). Marwit and Meuser (2001) also point to that fact that grief in expectation of a loss is comparable and real as the grief from the physical loss of a loved one.

They established that although grief is often ignored in caregivers, it is a weighty part of the caregiving experience (Meuser & Marwit, 2001). Holley and Mast (2009) show how prevalent grief is in the life of familial care givers, and they are of the view that it acts as an important role in appreciating caregiver burden. Regardless of the fact that physical lost is not experienced, once a diagnoses of chronic illness is made, it is important that all forms of support are provided to the people rendering the care because the general public does not identify the diagnosis as a loss of their loved ones (Rudd, Viney, & Preston, 1999). Doka (1989) finds “disenfranchised grief” particularly worrying because intimate associates of a loved one with chronic disease have grief, yet the general public does not recognize the grief or offer the same amount of care and luxury as when an actual death occurs. Likewise, Boss (2011) defines the idea of “ambiguous loss” as having a loved one who is bodily present, but emotionally absent. Abstruse loss does not provide authentication of moods of grief and loss or care for caregivers because the person with chronic disease is still alive. In addition to grief over the progressive loss of their loved ones, there is also the idea that there is a sense of a personal loss to freedom for people caring for loved ones in addition to grieving over a loss which is progressive was also predominant through the writings as well. The theme of grief and loss was obvious through the literature, which demonstrated a necessity for providing continuing provision for caregivers as they grieve the progressive loss of their loved ones. In addition to undesirable emotional effects such as grief, stress, sadness and depression. Anger and guilt were among the consequences of rendering care to someone. They established that nursing home caregivers to harbor more guilt as compared to home caregivers, while home caregivers were found to have more anger, especially partners of men with chronic disease (Rudd et al., 1999).

The partners' anger was naturally found to be the result of violent and damaging behavior in their sick partners which, previous to the diagnosis was not apparent (Rudd et al., 1999). Rage in women also stemmed from the awareness that they had been disadvantaged of independence in their old age due to taking on the caregiving role (Rudd et al., 1999). In Meuser and Marwit's (2001) study of 42 spousal caregivers and 45 adult-child caregivers, they found the adult children to be angrier than the spousal caregivers. Connell and Gallant (1998) indicated there is a cause and effect relationship between mental and physical health. Caregivers who feel depressed, sad, or angry are less likely to take care of themselves, leading to physical health problems, another negative effect of caregiving.

2.3.2 Physical effects

Caregivers who took care of their loved ones were generally found to neglect their own health and physical well-being. Conwell and Gallant (1998) found that health is adversely affected for both genders as the result of taking on the role of caregiver. Due to the demands of caregiving, healthy activities are compromised, such as exercising, sleeping, and eating nutritiously (Conwell & Gallant, 1998). Increased alcohol consumption and cigarette smoking were also associated with caregiving, which consequently caused poorer health outcomes (Conwell & Gallant, 1998). Specifically, Conwell and Gallant found that high levels of depression in the caregivers were correlated with an increase in changes to the caregivers' health.

Son, Erno, Shea, Femia, Zarit, and Stephens (2007) found associations between high levels of burden in caregivers and three different measures of health. Caregivers reported poorer health, had more unhealthy behaviors, and used health care services more often (Son et al., 2007). Similarly, in their study of 90 spousal caregivers and 111 adult-child caregivers, Ott, Sanders, and Kelber (2007) found significant health changes in spousal caregivers after their loved ones were diagnosed with Alzheimer's disease. Overall, 57.7% of the total sample experienced health changes, with 65.6% of the 90 spousal caregivers and 51.4% of the 111 adult-child caregivers experiencing health changes (Ott et al., 2007).

2.3.3 Economic Burden

In addition to physical and emotional difficulties allied with rendering care, monetary drain is also classic effect of this practice. Amenities outside and within the confines of where one lives comes with extra financial difficulties and close relatives are often the most likely ones to assist in monetary terms when long-term care is not available. Regardless of the significance of the economic aspect and subject, inadequate information was part of literature. Consequently, studies on the undesirable economic effects of caregiving is essential to study. A descriptive cross sectional study conducted by Sadigh and colleagues in Uganda to explore the challenges caregivers who reside in the hospital setting face indicated financial burdens as one of the challenges they face as caregivers (Sadigh et al., 2016).

2.3.4 Characterizing Caregivers

While taking notice of the fact that there exist undesirable effects rendering care, studies showed differences between female and male family caregivers. The influence of the sexes on rendering care has been examined in present literature. Majority of these looked at the variations between the sexes with a few however established matches between genders. Two of such studies fixated on definite beliefs that are perceived by others about males rendering care. It is not unexpected that that differences exist between the sexes in literature in relation to their know-hows, considering the wide spread beliefs in the United States about what each sex is allowed or not allowed to do. Collins, et.al. (1994) established that feminine caregivers have a tendency to experience more depressing feelings and symptoms of affliction than masculine caregivers.

Likewise, Sanders et al. (2008) point to the fact that females rendering care are most likely to experience grief than their counterparts. Due to the fact that wives of husbands with chronic illness are more likely to experience higher levels of stress which is indicative of the multiple roles they have and trying to manage all these diverse aspects of their lives. (Chadiha, Rafferty, and Pickard, 2003) Female that cared for their partners were more found to be more angry, anxious, depressed and sad in a study by Rudd et al. (1999) as compared to males that cared for their partners. Males rendering care pursued their hobbies and kept living their lives, but their counterparts did otherwise. The latter felt that their lives had been "robbed of all their retirement plans" with their husbands (Rudd et al., 1999)

Regardless of what studies revealed that females experience feelings of sadness and grief, other studies have also shown that they are better at grief and depressive symptoms, some researchers found women to be better at dealing with their grief than males (O'Rourke & Wenaus, 1998). In disparity to studies that focused on gender dissimilarities, Conwell and Gallant (1998) indicated that the process one goes through when under stress does not differ by sex and that the undesirable effects on health affects both sexes equally and this is no different than what was found by Fitzpatrick and Vacha-Haase (2010) in that burden on caregivers and marital fulfillment were not dissimilar for both male and female partners when caring for a partner with chronic disease.

Literature incorporated material on residents that are at a higher risk or more susceptible to bodily or emotional challenges as a result of caregiving. Literature is inconclusive about the type of caregivers are most susceptible and the populace that are at risk for challenges linked to rendering care to a loved one. Caregivers with less formal learning and lower socioeconomic status have been documented to be undesirably affected. This was also supported by other works done by Sun, Kosberg, Kauf, and Leeper (2010), Connell and Gallant (1998) and Sorensen and Conwell (2011), which also indicated that residents at more risk are those with lower socio-economic status. Precisely, those with lower level of formal learning were found to be more susceptible to the undesirable effects of rendering care, and to have more subjective burden overall (Connell & Gallant, 1998). Sun et al. (2010) found that socioeconomic issues of people living in rural areas also had a bearing on how challenges that arose in regard to their responsibilities were dealt with.

One more population that was found to be exposed to the effects of rendering care were people living in rural communities with fewer amenities. In a study of 141 persons who rendered care in caregivers in rural Alabama, Sun et al. (2010) found that this population of caregivers is “understudied and unseen”. There is still a debate existing in the literature with regards which group of people are mostly at risk of the undesired effects of rendering care; either older or younger persons. Age was found to be a “protective buffer” when older persons are rendering care for a person with chronic illness in a study done by Fitzpatrick and Vacha-Haase (2010). Caregivers that were younger needed more resources and thus were more at risk, but it’s in contrast to another study carried out by Monahan (1995). He concluded that male care givers who are older are likely to experience more drain in respect to their responsibilities but suggested that more research needs to be done.

CHAPTER THREE

3.0 METHODS

3.1 Introduction

This section provides a thorough explanation of the study design and site, sampling procedures, data collection and data quality, data analysis and ethical consideration.

3.2 Study Design

This research was a qualitative study that utilized individual face to face in-depth interviews to explore experience and difficulties encountered by personal caregivers staying on the facility premises of Korle-Bu teaching hospital of Ghana as well as identify the psychological, emotional, physical, economic and social experiences of caregivers staying at the facility premises. Interviews were conducted using an interview guide. Each conversation was audio-recorded whiles notes were taken alongside. Each participant's name was replaced by codes during the audio recordings for confidentiality purpose. Both English and local language was used in conducting the study as some participant had formal education and others not.

3.3 Study Area.

The study was conducted in the Korle-Bu Teaching Hospital. The hospital is located in the Greater Accra Region of Ghana.

It was established in 1923 and situated in the Ablekuma district in Accra West. It is the first largest teaching hospital in Ghana and the second largest in West Africa. The hospital serves as one of the biggest health delivery facility in the country. It covers a total land space of approximately 441 acres and hemmed in by the Korle Lagoon, Korle-Gonnor, Lartebiorkorshie and Mamprobi to the east, south, north and west respectively. The hospital serves as a referral point for neighboring towns and cities across the country and also a referral point for private and public health facilities in the country. The hospital do serve as a referral hospital for neighboring countries such as Togo, Burkina Faso among others. Currently, the medical and surgical department of the KBTH has about 500-beds with 12 clinical and surgical units. Averagely, both departments attend to about 200 patients daily with 50 admissions (KBTH.Gov.Gh, 2019).

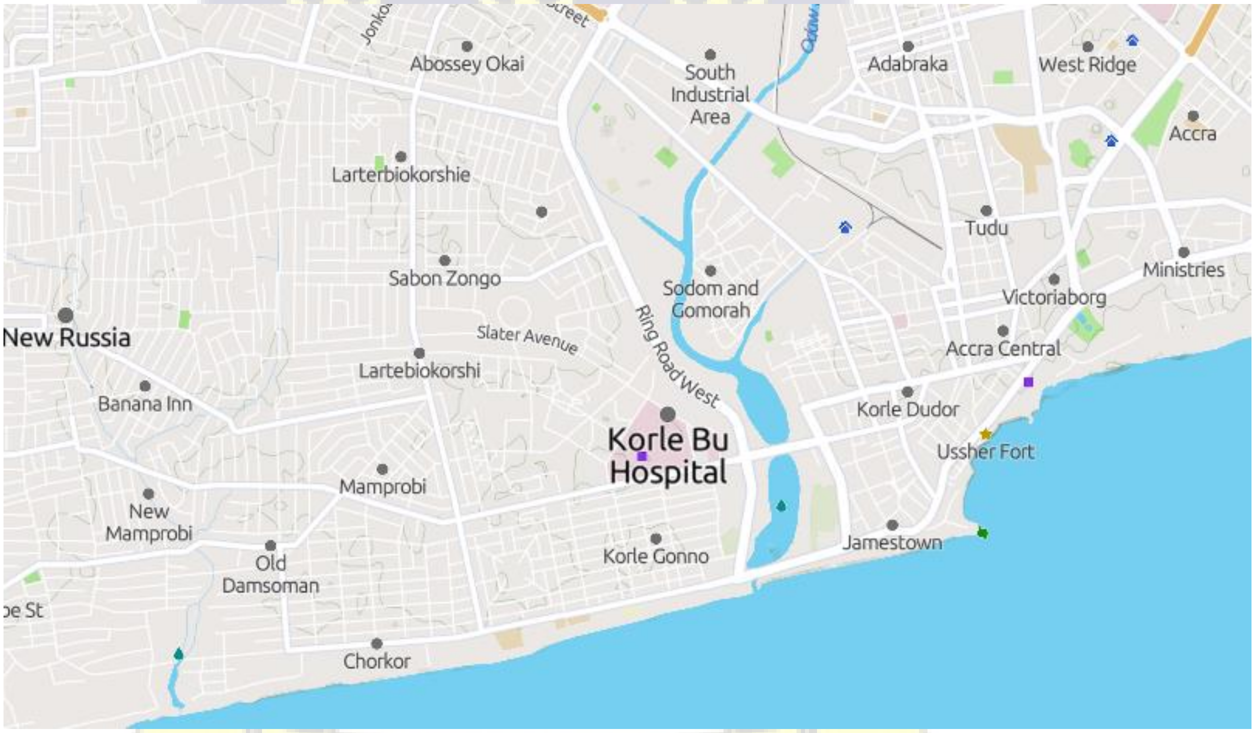


Figure 1: Map of Korle-Bu Teaching Hospital
Source: https://mapcarta.com/29259730

3.4 Study Population

The study population was family caregivers of patients who were admitted and had been diagnosed with chronic disease at the Korle-Bu teaching hospital.

3.5. Inclusion and exclusion criteria

3.5.1 Inclusion criteria

The study included the main caregivers of patients with chronic disease staying on KBTH premises, who were above 18 years, who stayed and slept around the hospital and consented to the study.

3.5.2 Exclusion criteria

Caregivers of patients at the Out-Patient-Department were excluded from the study. Caregivers who were below 18years, and those who refused consent were also excluded from the study.

3.6 Sample Size

In this study, the sample size determination was in line with the sample size limit of at least 12 participants required for IDIs in qualitative research for homogeneous groups (Adler & Adler, 1987). Quite recently, another research has also reported a sample size of 10-15participants as sufficient for qualitative design to elicit adequate information (Monette, Sullivan, & DeJong, 2011). Based on data saturation a total of 19 participants were interviewed in this study. Data saturation is reached when the researcher no longer gets new insights from the data (Creswell, 2014).

3.7 Sampling Technique

Purposive sampling technique was used in selecting caregivers for In-depth Interviews (IDI). Eligible participants were recruited using convenient sampling at the study sites following approval from the head of the various departments. The matron in charge of the ward mentioned the names of the caregivers, after which each name was mentioned out of a group of caregivers sitting along the corridor. In-depth interviews were then scheduled to explore the challenges of care givers.

3.8 Data Collection Instrument

An interview guide was used in the collection of data from caregivers. The interview guide had two sections, the first section centered on the socio demographic characteristics of research participant, the second section focused on challenges of care givers staying at facility premises. The psychological, emotional, physical, economic and social experiences of caregivers staying at the facility premises and coping strategies adopted by care givers were explored. Audio recorders were used for recording interviews and notebooks for taking field notes.

3.9 Data collection procedure

Approval for this study was sought from the Korle-Bu Teaching Hospital ethical review committee. Also the researcher sought permission from the various heads of department of the medical and surgical units before conducting the research. The research assistants were taken through training which included going through the interview guide to enable them become familiar with the questions. They were also taken though process of avoiding any influence on the participant's responses, how to take note, establish good rapport, how to probe and assure participants of confidentiality.

At the various departments the participants who fell within the inclusion criteria were recruited. They were briefed on the study and approach for verbal consent to participate. Written informed consent was sought prior to each participant being interviewed. An interview was conducted for each participant in an enclosed office at the department. The principal investigator conducted the interviews whiles the research assistant took the notes. The researcher established good rapport and assured participant of confidentiality of any information provided. For confidentiality, participant were also give pseudonyms. Participants were also informed that 'participation was voluntary and without .penalty or loss of benefits to which they were otherwise entitled, they were free to refuse participation or even if they changed their mind after agreeing to participate they may discontinue the interview at any time.

Recruitment continued until determined theoretical saturation occurred where they were no new information given. The interviews were conducted in both English and local dilate, and all participants' interviews were audio recording. Without any hesitation and participants' willingness to talk, each interview lasted approximately 25 minute with adequate information attained.

3.10 Data Handling

The voice recordings was protected by a password, the transcribed scripts were kept by the researcher and accessible to the principle supervisor only. Eligible caregivers were given pseudonyms to promote easy identification and confidentiality. Transcripts are made available for at least three years after the study was completed.

3.11 Data analysis

In this study, content analysis was used to analyze the data.The recorded interviews were transcribed verbatim and themes were generated based on study objectives, the data was then compared between researcher and another transcriber for similarities to determine differences in the coding.

Data reduction was done by loading portions of the transcribed data unto the Nvivo version 12 on the computer, codes and groupings were compiled as nodes, the loaded software also helped for easy access to quotations needed to support the findings.

A table was generated to display the codes after which the codes were sorted according to the groupings. In the final step, interpretation of findings was done and conclusion were drawn based on the frame 3211of reference defined by the research questions to categorize the data identified to enable description of the experiences of the caregivers.

3.12 Dissemination of results

Findings of the study was presented at the VIVA of SPH, University of Ghana. A copy of the thesis will be made available to the school's library and the hospital authorities. The findings will be published in a high impact factor peer reviewed journal.

3.13 Ethical Issues

The researcher had an obligation of safeguarding that benefits and risks of the study was well clarified to participants. Before data collection, clearance was first sought from the Korle-bu Teaching Hospital Ethics and Protocol Review Board. An introductory letter was obtained from the School of Public Health and administration to the Hospital to seek permission to gain entrance into the research setting. The letter indicated the purpose and nature of the study and a copy forwarded to the Deputy Director of Nursing Services and appropriate authorities, informing them of the research. Issues regarding anonymity, informed consent, risks or benefits freedom to participate and withdraw and confidentiality were clarified.

The nature and purpose of the research were explained to every partaker and queries raised were answered appropriately, after which the "written informed consent form" was signed. To ensure that the participants have understood the information, they were given another form “Volunteer Agreement form to fill. Respondents were informed that they had the right to withdraw from the study at any point of the study without giving reasons. Since the researcher anticipates the risk of psychological discomfort associated with some of the questions a detailed explanation concerning the nature of the research was given and efforts made to reduce the level of psychological effect. Individual respondents were given mock titles to ensure anonymity.

Information solicited from participants was stored under security device and key and PINs are used for softcopies to ensure confidentiality. The data was made available only to supervisors and possibly authorities from the Institutional Review Board (IRB) if required.

3.14 Quality Control

There was pilot of the study in Ridge Hospital, Accra which is a similar facility to the study area to ensure that the questions on the interview guide were well framed and easily understood. The study guide was revised based on the outcome of the pretest. It was found that the number of questions on the interview guide were too many and apparently repeating themselves whiles some were not easy to understand. Therefore the interview guide was reviewed for accuracy, and understanding. In addition research assistants were trained on the appropriate data collection skills and data entry to ensure uniformity and accuracy of the data collected.

3.15 Summary

The study is a purely qualitative study that will employ in depth interviews of care givers of chronically ill patients at the korle-bu teaching hospital. Nineteen (19) care givers of chronically ill patients were purposely selected and interviewed using an interview guide. All ethical issues were adhered to and due process followed in the data collection and analysis of the data. Interviews were transcribed and analyzed using the thematic approach with the help of the Nvivo software. The outcome of the analyses is presented in the next chapter.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

This chapter presents qualitative outcomes of themes generated. Themes were generated built on the objectives of the study. The section is sub divided into four main components. First component presents background characteristics of caregivers' interviewed. The second component is made of health challenges faced by caregivers' at the teaching hospital whiles taking care of their patients. The third component is made of psychological, emotional, physical, economic and social difficulties faced by persons rendering care whiles taking care of their patients. The final component deals with the various coping strategies of caregivers' adopted at the health facility.

4.2 Findings

The table below presents the background characteristics of caregivers'. In all sixteen (16) females and three (3) males were interviewed. Among interviewed female caregivers, ten (10) were between 20-39 and nine (9) were >40. Among the males, two (2) caregivers' were between 20-39 years' whiles one (1) was 41 years. At the time of the study, six (6) women were married and ten (10) were single. One (1) male was married and the rest were single. Among the sixteen (16) females, one (1) was a student, thirteen (13) were self-employed and two (2) were unemployed. For the males one (1) was a farmer and two (2) were unemployed. In addition, eight (8) of the females attained primary level of education whiles three (3) had no formal education. Only one (1) of the males had tertiary level of education. Fourteen (14) and three (3) of the females and males were Christians respectively

TABLE 1.0 Socio-Demographics of Respondents (N=19)

CHARACTERISTICS	MEDICAL	SURGICAL	TOTAL
Age group (years)			
20 - 29	3	1	4
30 - 39	5	1	6
40 - >	7	2	9
Sex			
Male	2	1	3
Female	10	6	16
Marital status			
Single	6	1	7
Married	8	4	12
Profession			
Trader	10	2	12
Farmer	4	1	5
Student	1	1	2
Work Duration(as a caregiver)			
Below 5years	2	3	5
Above 5years	12	4	14
TOTAL			19

4.3 Health Challenges

These challenges focus on the health of the caregivers who stayed at the hospital premises.

Their challenges were expressed in two forms, psychological effect and emotional effect.

4.3.1. Psychological and Emotional Burdens

Psychological Challenges

P*sychological* is used to describe things that are primarily mental or emotional

Psychological challenge therefore is the excessive mental discomfort faced by the caregivers.

Emotions can be defined as a positive or negative experience that is associated with a particular pattern of physiological activity. It produces different behavioral, cognitive and emotional changes. Emotional challenge therefore is as a result of feeling alone in a situation that one would have loved to shear with another. In this regard, Caregivers' mentioned that they were faced with psychological as well as emotional challenges whiles giving care. Examples included being faced with sadness, lack of emotional support, depression and loneness. Some of the care givers also tend to be the only ones taking care of their patients eventually making them feel depressed. For instance some caregivers mentioned that;

"I used to think a lot and always feel sad about my mothers' condition. It made me not to do anything. Sometimes I feel some heaviness within myself and cry about everything that is happening now" ***(Female, 40y/o, no education)***

"Sometimes, I think too much. I feel am the only one suffering. In fact my family members have neglected my husband and I. Things are difficult for me" ***(Female, 30y/o, Tertiary education)***

4.4. Health Facility challenges

This challenges focus on unavailability of adequate infrastructure to accommodate and provide comfort to both the sick patient and caregiver. The managerial difficulties faced by caregivers' whiles taking or giving care to the patients at the hospital. It span from inadequate infrastructural challenges to caregiver-to-health care provider relationship challenges. As discussed below.

4.4.1. Inadequate Infrastructures

The major challenges faced by these caregivers' were mostly infrastructural. Lack of place to sleep, inadequate washrooms, and inadequate assistive devices e.g. wheelchairs. Among these challenges, the most pressing concern of all respondents was lack of place to sleep. Caregivers' indicate this in the following quotes;

"The problem is that the building where we sleep is small and cannot accommodate all of us (caregivers), making some of us to sleep in open places which is not good for us".. (Female, 34y/o, Secondary Education).

4.4.2. Caregiver-to-health care provider relationship

Concerns and challenges were not only infrastructural based but patient-to-caregiver related. Some caregivers amidst the challenge of taking care of their patient had to endure negative attitudes from health care providers, such as shouting when talking to them, and being rude that made the caregivers uncomfortable. A 34 year old caregiver said;

"The last time there was one nurse and I didn't like her attitude when she was trying to administer drugs she shouted at the patient and I was there looking at her quietly and thinking so I said she should take her time because if not for his illness he won't be here. She fled up asking me why I am saying so and continued talking to me harshly so since then I hardly interacted with her" ***(Female, 51, No Education).***

4.5. Personal Challenges

Personal health challenges were related to situations that affect the caregiver directly, this fall into three (a) Physical categories of challenges, these are challenges that affect the caregiver directly in tangible ways. (b) Social challenges are those challenges that affect the social lives of the caregiver. It span from relationship with others and inability to take part in social activities. (d) Economical challenges are those challenges that affects the economic development of the caregiver in relation to work.

4.5.1. Social challenges

These were challenges that affect the social lives of the caregiver. It span from relationship with others and inability to take part in social activities. Socially, caregiving has an effect on caregivers'. According to the caregivers' giving care has crippled their routine ways of doing things from attending social programs to partaking in church activities. However whiles care giving has negatively affected the lives of caregivers, some found it beneficial in a way of adding to their knowledge base and also inform friends and family members. Some caregivers' mentioned the following;

"Hmm, since I've been here taking care of him I don't find anything else to do and there's no work for me here" (***Female, 51y/o, No Education***).

"Yes because I can't go to some of the programs that I used to go because of her and I have to stay home and take care of her". ***(Female, 31y/o, Tertiary)***

4.5.2 Economic challenges

These are challenges that affect the economic development of the caregiver in relation to work activities. Economic challenges were viewed from two dimensions. Firstly, caregivers' inability to finance hospital bills and secondly, how caregiving has affected the ability of the caregiver to work and generate income. Most of the caregivers made mention of facing financial challenges and inability to go to work to be due to the caregiver roles. Challenges that they face economically. Some of them mentioned the following;

*"for me where I sleep now does not bother me like my financial issue because for me I have lost my husband and I have no one so it's my finances and that is my greatest problem"....(****Female, 49y/o Vocational Education***).

"yes because now I can't work and if I come in the morning around 5 a.m. by the time I get home it is already 8 p.m. so I'm not able to do anything anymore"....(***Female, 30y/o, Tertiary Education***).

4.6. Coping strategies

In this study, coping mechanism is defined as methods adopted by caregivers' to deal or contend with above challenges. Amidst all the challenges, caregivers' are adopted to cope and carry out activities demanded. Coping strategies employed by caregivers span from the religious perspective to social perspective.

4.6.1 Religious Perspective

In this coping strategy caregivers' engage in spiritual activities by going to church to pray to God, believing that by praying the situation improves faster and they tend to get an inner assurance that God hears and watches over them. Some of them said;

*"And sometimes I also talk to my friends at the market place which also helps to comfort me and there's nothing God cannot do so in anything we give praise to God"..... (**Female, 37y/o, JHS Education**)*

*"And sometimes I also talk to my friends at the markets place which also helps to comfort me and she tells me there's nothing God cannot do so in anything we give praise to God and believe" (**Female, 37y/o, JHS Education**).*

4.6.2. Creating Bond of Friendship

Some caregivers also relate with friends to temporarily take their mind off things happening around them. Some said;

*“Yes I talk to my in-charge and my colleagues when they come to visit and I also hang around with other caregivers which makes me feel relieved”.. (**Female, 31y/o, Tertiary**).*

*“I call my friends I stay with at home and I talk to them to divert my thought from the hospital, sometime too I walk around and make friends with other caregivers”..(**Male, 34y/o, JHS Education**).*

4.6.3. Positive Attitude;

Some caregivers develop a positive mind set about their sick relative, which makes them feel happy within. Some said; *“I believe that my patient will get better from the way she is responding to treatment”.* ***(Female 37y/o, JHS Education)***, and another said *“Caring for my patient and staying at the hospital has helped me to understand some behaviors of sick people on admission. I believe they will improve and be discharged home”. (**Female, 31y/o, Tertiary**).*

4.7 Summary

The respondents were made up of 16 females and 3 males, majority being above 40 years, married, traders and being in the care giving role for more than 5 years. The responses were analysed into various thematic themes as follows, health challenges, health facility challenges, personal challenges and coping strategies. Each of these themes had subthemes to capture all difficulties faced by the respondents. It also captures some of the statements verbatim by the respondents. The next chapter discusses these findings.

CHAPTER FIVE

DISCUSSION

5.1. Introduction

This chapter presents the discussions of the findings of this study

Discussion

The results of this study showed that in the study sample, more females than males tend to stay with relatives at the health facility until total recovery before leaving to their houses. Nineteen caregivers were interviewed, comprising sixteen females and three males. Out of eight women who were aged between 20-39 years, six were married, and this did not deter them from providing care for their admitted relatives. This is consistent with findings by Sharma, Chakrabarti and Grover (2016) who identified that women are the predominant caregivers for family members with chronic medical conditions and disabilities (Sharma, Chakrabarti, & Grover, 2016). Swinkels and colleagues also documented that women experience greater caregiver burden than men, resulting in they experiencing more secondary stressors including financial and multi-tasking problems (Swinkels, Tilburg, Verbakel, & Broese van Groenou, 2017). On the other hand, men have been identified to be assuming the caregiver role as well (Baker, Robertson, & Health, 2008) as was the case in this study.

Some of the challenges faced by caregivers, as observed by the results of this study included health facility challenges, comprising of infrastructural challenges and patient-to-healthcare provider relationship, among others, and personal challenges, comprising of physical, social, emotional and economical challenges, among others. According to Lavarone and colleagues, the challenges that caregivers face contribute immensely to their psychological, physical and financial burdens (Lavarone, Ziello, Pastore, Fasanaro, & Poderico, 2014). The results of their study indicated an increased risk of cardiovascular disease and high prevalence of hypertension among caregivers (Lavarone et al., 2014).

5.2. Health Facility challenges

Pertaining to health challenges, caregivers involved in this study presented complaints about lack of a place to sleep and inadequate washrooms. Accordingly, Bevans and Sternberg (2012) commented that caregiver stress resulting from prolonged hospital admission of patients with chronic diseases may result in sleep disturbances, excessive fatigue, and unhealthy behaviours (Bevans & Sternberg, 2012). They further recounted that, disturbances in sleep patterns of caregivers may result in changes in stress response, glucose regulation and immune function (Bevans & Sternberg, 2012). This is further evinced by findings from a study conducted by Wells-Di Gregorio and colleagues. They identified that sleep irregularities results in immune system dysfunction (Wells-Di Gregorio et al., 2012).

5.3. Health Challenges

Pertaining to psychological/emotional challenges, caregivers at KBTH involved in this study were identified with sadness, lack of emotional support, depression and loneliness. It has been documented that there are both positive and negative psychological effects on caregivers of patients with chronic diseases (Ekwall & Hallberg, 2007). Consistent with this study, Fujinami et al (2013) documented that both caregiver and patient experience uncertainties and fears associated with treatment choices and decisions (Fujinami, Otis-Green, Klein, Sidhu, & Ferrell, 2012). Cooper and colleagues in a study identified a clinically significant anxiety among 10%-35% of caregivers, and depression among 10%-34% of caregivers (Cooper, Balamurali, & Livingston, 2007). On the other hand, caregivers who are in strong relationships with patients tend to foster better care, improving the prognosis of the patient's condition (Chen et al., 2009). As stated in the attachment theory, patients feels psychological satisfied having in mind that the family is supportive and caring. Patient also feel more secured and loved when the care provided is from a blood relation (Anderson, 2007). Others also observe that, adult care or attachment to patients brings improved healing.

5.4. Personal challenges

On economic challenges, this study sought to identify how caregivers are able to finance hospital bills, and how caregiving has influenced their economic activities. Most of them complained of inability to attend to their work schedules as expected, and drastic financial loss because of heavy hospital bills. In their study, Fujinami et al (2013) documented that financial burden on caregivers increases with increased demands of care of patients (Fujinami et al., 2012). Accordingly, Mazanec and colleagues identified that increasing demands of care may lead to missed time from work, decreased productivity and job resignation (Mazanec, Daly, Douglas, & Lipson, 2011).

Several of the caregivers raised concerns about experiencing excruciating bodily pains pertaining to some physical challenges they faced. Fujinami and colleagues have documented that tolls on the physical health of the caregiver is predominant among caregivers of patients with chronic diseases (Fujinami et al., 2012). It has been identified that most family caregivers are more likely to take sick leave permits from work after the daunting task of caring for family members with chronic conditions in the hospital (Sjovall et al., 2010). A study conducted in Mexico identified that women caregivers usually face challenges in their reproductive health, nutrition and mental health (DiGirolamo & Salgado de Snyder, 2008).

Caregivers also raised concerns about how their social lives have been impacted negatively because they agreed to stay over to cater for their relatives. Some are unable to attend church any longer. Others complain of leaving their families back at home to cater for the one person in the hospital. This is consistent with findings by Fujinami et al (2013). They identified that worsening illnesses in patients increase the burden on caregivers, who become fatigued and unable to continue normal social activities (Fujinami et al., 2012). On the brighter side, one caregiver disclosed how they are learning much and are able to discuss their newly acquired knowledge on disease conditions with others who are not privy to such information.

5 .5 Coping Strategies

The results of this study revealed several coping strategies adopted by caregivers at Korle-Bu Teaching Hospital to deal with the challenges they faced at the facility. Identifiable coping strategies included religious caregivers who go to church to pray to God for healing for their relatives. Other caregivers resorted to relating with friends to take their minds of the conditions of their relatives on admission. One particular caregiver recounted that she is occasionally given money for her upkeep and to reduce the hospital bills of her relative on admission, and she had resorted to this for comfort. Coping has been defined as “a process of adaptation to stressful situations, which includes the allocation of cognitive and behavioral resources in response to specific internal and/or external demands that are deemed to exceed the subject’s normal requests” **(Lavarone).** In accordance to the results of this study, coping has been classified into three broad main types, namely task-focused, emotion-focused and avoidance-focused strategies (Baker et al., 2008).

According to Kramer (1997). The caregiver adaptation model, postulate that the adaption process consists of three components, namely background and context of caregiving, intervening processes and well-being outcomes. The caregiver adaptation model is an integrated framework which synthesizes different theoretical and conceptual frameworks such as stress process model, appraisal theory, attachment theory and social exchange theory all geared at making caregiving a better experience on the part of the caregiver and having a positive impact on the part of the patient being cared for, to attain maximum health care delivery in both formal (qualified health personals) and informal (unqualified personals, in this case the non-medically trained caregiver).

Research has identified coping strategies and social support as important resource that is helping mitigate the negative impacts of family caregiving services rendered family members as well as non-family members. (Carretero et al., 2009).

5.6 Limitations of the study

Although there are several departments in the Korle-Bu Teaching Hospital, only two department were involved in the study. This does not provide a fair idea of which department caregivers face the most challenges. Further studies should take into consideration the various department for the study, and also include other teaching hospitals or health facilities.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Nineteen caregivers at Korle-Bu Teaching Hospital (KBTH) were interviewed in this study, comprising sixteen females and three males. Most (52.6%) of these were aged between 15-39 years, with the rest aged 40 years and above. Most (63.2%) were single, and not married. There was one student among the females, with majority (68.4%) were self-employed. Several challenges were identified among those interviewed, including physical, social, emotional, economical and psychological challenges. Other identified challenges were health-facility challenges, which included inadequate sleeping spaces and washrooms for caregivers. Caregivers were identified to have adopted create strategies that helps them deal with the tasks they faced with. Some, being Christians, resorted to prayer and belief in God for a positive prognosis, while others would usually relate with friends to take their minds off happenstances around them in the hospital.

The conclusion presents a collection of result attained in the study. The recommendations suggest further areas needed to be considered to improve upon this study, and feasible adoptions to be made in respect to the outcomes of this study.

6.2 Recommendations

1. Research: Rodriguez-Perez has identified that the quality of life of caregivers is influenced by their coping strategies. Further studies into coping strategies of caregivers should focus on how these coping strategies affect the quality of life of caregiver.

2. Institutional: Hospital management should have a continuous educational program for health care providers on good interpersonal relationship with patient and their caregivers. As part of the orientation given to the patient on the ward, orientation should also be given to caregivers on how to take care of their self to prevent infection.

   Caregivers should be educated on the importance of enrolling on the National health insurance policy to reduce financial burden when the need arises.

3. Government and Non-Governmental Organizations (NGOs): The results of this study identified health-facility challenges, including inadequate sleeping spaces and washrooms for caregivers at the hospital's premises. Thus, it is recommended that structures are put in place to house the increasing large number of caregivers, in accordance with the about 250 daily admissions at the Korle-Bu Teaching Hospital.

REFERENCES

Adler, P. A., & Adler, P. (1987). *Membership roles in field research* (Vol. 6). Sage.

Baker, K. L., & Robertson, N. (2008). Coping with caring for someone with dementia: Reviewing the literature about men. *Aging and Mental Health*, *12*(4), 413-422.

Bastawrous, M. (2013). Caregiver burden—A critical discussion. *International journal of nursing studies*, *50*(3), 431-441.

Battista, M. A., Pate, D. S., Hierholzer, R., Howsepian, A. A., & Mogelof, J. (2004). Caregiver reports: A systematic method of comparison with clinical impressions. *Clinical gerontologist*, *27*(4), 53-70.

Bernstein, S. L., Aronsky, D., Duseja, R., Epstein, S., Handel, D., Hwang, U., & Schafermeyer, R. (2009). The effect of emergency department crowding on clinically oriented outcomes. *Academic Emergency Medicine*, *16*(1), 1-10.Blau, P. M. (1994). Structural contexts of opportunities. Chicago: University of Chicago Press.

Boss, P. (2011). *Loving someone who has dementia: How to find hope while coping with stress and grief*. John Wiley & Sons.

Brodaty, H., & Luscombe, G. (1998). Psychological morbidity in caregivers is associated with depression in patients with dementia. *Alzheimer disease and associated disorders*.

Burns, R., Nichols, L. O., Martindale-Adams, J., Graney, M. J., & Lummus, A. (2003). Primary care interventions for dementia caregivers: 2-year outcomes from the REACH study. *The Gerontologist*, *43*(4), 547-555.

Carretero, S., Garce´s, J., Ro´denas, F., & Sanjose, V. (2009). The informal caregiver.s burden of dependent people: Theory and empirical review. *Archives of Gerontology and Geriatrics*, 49, 74–79

Chadiha, L. A., Rafferty, J., & Pickard, J. (2003). The influence of caregiving stressors, social support, and caregiving appraisal on marital functioning among African American wife caregivers. *Journal of marital and family therapy*, *29*(4), 479-490.

Chen, S. C., Tsai, M. C., Liu, C. L., Yu, W. P., Liao, C. T., & Chang, J. T. C. (2009). Support needs of patients with oral cancer and burden to their family caregivers. *Cancer nursing*, *32*(6), 473-481.

Cohen, Carole A., Angela Colantonio, and Lee Vernich. "Positive aspects of caregiving: rounding out the caregiver experience." *International journal of geriatric psychiatry* 17, no. 2 (2002): 184-188.

Cook, K. S., & Rice, E. (2003). Social exchange theory. In J. Delamater (Ed.), *Handbook of social psychology* (pp. 53-76). New York: Kluwer Academic/Plenum Publishers.

Cooper, C., Balamurali, T. B. S., & Livingston, G. (2007). A systematic review of the prevalence and covariates of anxiety in caregivers of people with dementia. *International Psychogeriatrics*, *19*(2), 175-195.

DiGirolamo, A. M., & Salgado de Snyder, N. (2008). Women as primary caregivers in Mexico: challenges to well-being. *salud pública de méxico*, *50*, 516-522.

Ekwall, A. K., & Hallberg, I. R. (2007). The association between caregiving satisfaction, difficulties and coping among older family caregivers. *Journal of Clinical Nursing*, *16*(5), 832-844.

Fitzpatrick, K. E., & Vacha-Haase, T. (2010). Marital satisfaction and resilience in caregivers of spouses with dementia. *Clinical gerontologist*, *33*(3), 165-180.

Fujinami, R., Otis-Green, S., Klein, L., Sidhu, R., & Ferrell, B. (2012). Quality of life of family caregivers: challenges faced in care of the lung cancer patient. *Clinical journal of oncology nursing*, *16*(6), E210

Gallant, M. P., & Connell, C. M. (1998). The stress process among dementia spouse caregivers: Are caregivers at risk for negative health behavior change?. *Research on aging*, *20*(3), 267-297.

David Gefen, C. M. R. (2002). Implementation team responsiveness and user evaluation of customer relationship management: A quasi-experimental design study of social exchange theory. *Journal of management information systems*, *19*(1), 47-69.

Holley, C. K., & Mast, B. T. (2009). The impact of anticipatory grief on caregiver burden in dementia caregivers. *The Gerontologist*, *49*(3), 388-396.

Homans, G. C. (1961). Social Behavior: Its Elementary Forms Harcourt. *Brace & World, New York*.

Kramer, B. J. (1997). Gain in the caregiving experience: Where are we? What next?. *The Gerontologist*, *37*(2), 218-232.

Kuhn, D. R. (1990). The normative crises of families confronting dementia. *Families in Society*, *71*(8), 451-460.

Iavarone, A., Ziello, A. R., Pastore, F., Fasanaro, A. M., & Poderico, C. (2014). Caregiver burden and coping strategies in caregivers of patients with Alzheimer's disease. *Neuropsychiatric disease and treatment*, *10*, 1407.

Liao, L. F. (2008). Knowledge-sharing in R&D departments: A social power and social exchange theory perspective. *The International Journal of Human Resource Management*, *19*(10), 1881-1895.

Löckenhoff, C. E., Duberstein, P. R., Friedman, B., & Costa Jr, P. T. (2011). Five-factor personality traits and subjective health among caregivers: The role of caregiver strain and self-efficacy. *Psychology and aging*, *26*(3), 592.

Mazanec, S. R., Daly, B. J., Douglas, S. L., & Lipson, A. R. (2011). Work productivity and health of informal caregivers of persons with advanced cancer. *Research in nursing & health*, *34*(6), 483-495.

Meuser, T. M., & Marwit, S. J. (2001). A comprehensive, stage-sensitive model of grief in dementia caregiving. *The Gerontologist*, *41*(5), 658-670.

Navaie-Waliser, M., Feldman, P. H., Gould, D. A., Levine, C., Kuerbis, A. N., & Donelan, K. (2001). The experiences and challenges of informal caregivers: Common themes and differences among Whites, Blacks, and Hispanics. *The Gerontologist*, *41*(6), 733-741.

Nichols, L. O., Martindale-Adams, J., Greene, W. A., Burns, R., Graney, M. J., & Lummus, A. (2008). Dementia caregivers' most pressing concerns. *Clinical Gerontologist*, *32*(1), 1-14.

Northouse, L. L. (2005, July). Helping families of patients with cancer. In *Oncology nursing forum* (Vol. 32, No. 4, p. 743). Oncology Nursing Society.

Ott, C. H., Sanders, S., & Kelber, S. T. (2007). Grief and personal growth experience of spouses and adult-child caregivers of individuals with Alzheimer's disease and related dementias. *The Gerontologist*, *47*(6), 798-809.

Pearlin, L. I. (1989). The sociological study of stress. *Journal of health and social behavior*, 241-256.

Pearlin, L. I., Mullan, J. T., Semple, S. J., & Skaff, M. M. (1990). Caregiving and the stress process: An overview of concepts and their measures. *The gerontologist*, *30*(5), 583-594.

Piercy, K. W., & Chapman, J. G. (2001). Adopting the caregiver role: A family legacy. *Family Relations*, *50*(4), 386-393.

Rapp, S. R., & Chao, D. (2000). Appraisals of strain and of gain: Effects on psychological wellbeing of caregivers of dementia patients. *Aging & Mental Health*, *4*(2), 142-147.

Raschick, M., & Ingersoll-Dayton, B. (2004). The costs and rewards of caregiving among aging spouses and adult children. *Family relations*, *53*(3), 317-325.

Rudd, M. G., Viney, L. L., & Preston, C. A. (1999). The grief experienced by spousal caregivers of dementia patients: The role of place of care of patient and gender of caregiver. *The International Journal of Aging and Human Development*, *48*(3), 217-240.

Rodríguez-Pérez, M., Abreu-Sánchez, A., Rojas-Ocaña, M. J., & Del-Pino-Casado, R. (2017). Coping strategies and quality of life in caregivers of dependent elderly relatives. *Health and quality of life outcomes*, *15*(1), 71-71. doi:10.1186/s12955-017-0634-8

Sadigh, M., Nawagi, F., & Sadigh, M. (2016). The Economic and Social Impact of Informal Caregivers at Mulago National Referral Hospital, Kampala, Uganda. *Annals of global health*, *82*(5), 866-874.

Sadigh, M., Nawagi, F., & Sadigh, M. (2016). The Economic and Social Impact of Informal Caregivers at Mulago National Referral Hospital, Kampala, Uganda. *Annals of global health*, *82*(5), 866-874.

Schulz, R., Mendelsohn, A. B., Haley, W. E., Mahoney, D., Allen, R. S., Zhang, S., & Belle, S. H. (2003). End-of-life care and the effects of bereavement on family caregivers of persons with dementia. *New England Journal of Medicine*, *349*(20), 1936-1942.

Sharma, N., Chakrabarti, S., & Grover, S. (2016). Gender differences in caregiving among family-caregivers of people with mental illnesses. *World journal of psychiatry*, *6*(1), 7.

Shim, B., Barroso, J., & Davis, L. L. (2012). A comparative qualitative analysis of stories of spousal caregivers of people with dementia: Negative, ambivalent, and positive experiences. *International journal of nursing studies*, *49*(2), 220-229.

Sjövall, K., Attner, B., Lithman, T., Noreen, D., Gunnars, B., Thomé, B., & Englund, M. (2010). Sick leave of spouses to cancer patients before and after diagnosis. *Acta Oncologica*, *49*(4), 467-473.

Smitka, M., Loll, J., NolteBuchholtz, S., & von der Hagen, M. (2012). Measuring quality of life in patients with life-limiting neuromuscular disorders: a pilot study using the Kidscreen-27- and KINDL-R-questionnaire. *Neuropediatrics*, *43*(02), PS15_10.

Son, J., Erno, A., Shea, D.G., Femia, E.E., Zarit, S.H. and Parris Stephens, M.A., 2007. The caregiver stress process and health outcomes. *Journal of aging and health*, *19*(6), pp.871-887.

Sussman, T., & Regehr, C. (2009). The influence of community-based services on the burden of spouses caring for their partners with dementia. *Health & Social Work*, *34*(1), 29-39.

Swinkels, J., Tilburg, T. V., Verbakel, E., & Broese van Groenou, M. (2017). Explaining the gender gap in the caregiving burden of partner caregivers. *The Journals of Gerontology: Series B*, *74*(2), 309-317.

Wells-Di Gregorio, S., Carpenter, K. M., Dorfman, C. S., Yang, H. C., Simonelli, L. E., & Carson III, W. E. (2012). Impact of breast cancer recurrence and cancer-specific stress on spouse health and immune function. *Brain, behavior, and immunity*, *26*(2), 228-233.

https://www.vocabulary.com/dictionary/psychological

https://www.en.wikipedia.org/wiki/Emotion

APPENDICES

APPENDIX 1: INFORMATION SHEET

INFORMATION SHEET

Dear Participant,

Introduction

I am a Master of Public Health student from the School of Public Health, University of Ghana conducting research that seeks to explore the **challenges of caregivers staying at facility premises the case of Korle – Bu Teaching Hospital.** An information will be given to you and you will be invited you to be part of this research. Please ask me questions if not clearified about the information given and it will be properly explained to you, and late questions would be clearified by the researcher. Participating in this research is voluntary and a choice of yours whether to participant or not. A change your mind to stop participating even if you agreed earlier is acceptable. Confidentiality is assured. Before the interview kindly read the inform consent and willingly sign.

Purpose of the research

This study was to explore the psychological and emotional health challenges faced by caregivers who stay with their sick relatives at the KBTH premises with their sick relatives, to examine the physical, economic and social challenges faced by caregivers staying at the KBTH premise, and to identify the coping strategies adopted by caregivers staying at KBTH premises. We want to know your challenges for the pass years. Knowing this information might help us to know how to support and reduce caregiver burden.

Procedures

Once you have agreed to be involved in this study, an interview will be conducted. With the interview, i will sit down with you at the medical block in an enclosed room. During the interview, if you feel uncomfortable about a question, you may say it and the interviewer will move on to the next question. Be informed that the recorded information is confidential and no one else except the researcher will have access to the information documented during your interview. Interview will be audio-recorded, and no identity will be mentioned by name on the tape. Data will be kept in a secured cabinet. Research will take place within 3-4 weeks in total. Each interview will take about25- 30 minutes.

Risks

I don’t for see any negative consequences for you in taking part. It is possible that talking about your challenges in this way may cause some distress. The information we seek are personal and confidential, and you may feel uncomfortable answering some of the questions. It is not so mandatory if You do not want to answer any question or take part in the interview if you do not wish to.

Benefits

There are no benefits to you and you will not bear any cost associated with the study. Korle-Bu Teaching is the major referral center for most medical conditions in Ghana and we hope to learn about this common problem and provide information for policy makers to make future decisions.

Compensation:

No incentives are given to voluntary participants to be part of the research.

Confidentiality

Data collected from this research will be privately kept, for any data we make public, we will ensure that your identity is protected. Data is placed in a confidential file and privately kept save such that only the researcher can retrieve it.

Right to Refuse / Withdraw

Being part in this study is completely voluntary. One may skip any questions that one does not feel comfortable with. In case you decide not to take part or to skip some of the questions, it will not affect your current or future relationship with Korle-Bu Teaching Hospital. If you decide to take part, you will be asked to sign a consent form.

Contact

For clarification on any unclear question, you can ask about them now or later. If you wish to ask later, you may contact any of the following:

Efua Acquah, School of Public Health, University of Ghana; Tel: + 233-244485476

E-mail: efuatirzah1@gmail.com or Dr. Phyllis Dako-Gyeke (Research Supervisor) University of Ghana; Tel: +233-207970370

If you want to speak with someone not directly involved as far as research study is concerned, please contact the Research Ethics Committee Administrator at Korle Bu Teaching Hospital

Korle Bu Teaching Hospital IRB contact: 0302666766

A copy of this form will be given to you for your records.

We highly appreciate the participation. Thank you for taking part in this study.

APPENDIX II: INFORM CONSENT

Title: Challenges of caregivers staying at facility premises the case of Korle – Bu Teaching Hospital.

Consent Statement: Having read the above statement, with the chance to ask question and satisfactory answers received, do accept to be a partaker of this research. I am with the understanding of withdrawal from the study and it would have no effect on me in any way.

Interviewee pseudonym ________________________

Participants Name ____

Signature /Thumb Print…………………….………….

Date……………………………………

The nature and purpose of this research have been explained and questions answered to the satisfaction of the interviewee.

I testify to the fact that consent by participant was voluntarily and not pressured.

Researchers signature / Person taking the consent………………………………..

Date…………………………..

APPENDIX III: INTERVIEW GUIDE

Challenges of caregivers staying at facility premises the case of Korle – Bu Teaching Hospital.

SECTION A

SOCIO-DEMOGRAPHIC DATA

Department………………

Fill / tick the appropriate answer

Age (years)	**Sex:** Male Female	**Educational Level:** No education Primary Secondary/Vocational Tertiary	**Marital status** Single Married Divorced Widowed Co-habiting	**Religion:** Christians Muslims Traditionalist	**Employment** Farmer Student Salaried worker Unemployed Self-employed Retired	**Residence:** Urban Sub-urban Rural

SECTION B

INTERVIEW GUIDE

Physical, economic, social, psychological and emotional challenges

1. Please could you give me a brief of yourself?

   (Probe: Your lifestyle before a caregiver-social dynamics, thus social activities, work, friendship etc.)

2. Since when have you been responsible for your loved one?

   (Probe: To you what does it mean to provide care?)

APPENDIX II: INFORM CONSENT

Title: Challenges of caregivers staying at facility premises the case of Korle – Bu Teaching Hospital.

Consent Statement: Having read the above statement, with the chance to ask question and satisfactory answers received, do accept to be a partaker of this research. I am with the understanding of redrawal withdrawal from the study and it would have no effect on me in any way.

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Participants name ____

Sign /Thumb Print………………………………..

Date ………………………………..

The nature and purpose of this research have been explained and questions answered to the satisfaction of the interviewee.

I testify to the fact that consent by participant was voluntarily and not pressured.

Researchers signature / Person taking the consent………………………………..

Date :…………………………...

APPENDIX III: INTERVIEW GUIDE

Challenges of caregivers staying at facility premises the case of Korle – Bu Teaching Hospital.

SECTION A

SOCIO-DEMOGRAPHIC DATA

Department………………

Fill / tick the appropriate answer

Age (years)	**Sex:**	**Educational Level:**	**Marital status**	**Religion:**	**Employment**	**Residence:**
	Male Female	No education Primary Secondary/Vocational Tertiary	Single Married Divorced Widowed Co-habiting	Christians Muslims Traditionalist	Farmer Student Salaried worker Unemployed Self-employed Retired	Urban Sub-urban Rural

SECTION B

INTERVIEW GUIDE

Physical, economic, social, psychological and emotional challenges

1. Please could you give me a brief of yourself?

   (Probe: Your life before a caregiver-social dynamic, thus social activities, work, friendship etc.)

1. Since when have you been responsible for your loved one?

   (Probe: To you what does it mean to provide care?)

3. For the duration stated, is it all in the hospital or care started elsewhere (home)
4. If care elsewhere how long were you, caring for the person before you were admitted?
5. Is the duration of care the same as the length of illness? If no who was rendering care before you?

6. Currently, are you the only caregiver to your loved one?

(Probe: if no, who are the rest?)

7. What is been different about you the condition of your loved one was discovered with this condition?

8. What is the duration of time spent caring for your ill person at the hospital?

9. What is the relationship between you and the sick person?
10. How What has been different about you and your relative since he/she was discovered with the current condition?

11. Please tell me the type of care you provide to your patient in the hospital

    (Probe: Ask of eating, bathing, dressing, toileting, paying of bills, medicine, social support or emotional support, counselling (praying) etc.)

12. On a typical day, narrate what you do for your patient

13. Personally, how do you feel providing care to your patient?

    (Hint: relate this to the type of care provided and ask why)

14. How did you become a caregiver to your patient?

    (Probe: What happened before you became a caregiver, who decided that you should be the caregiver and do you like the idea? Why?)

15. What are your experience in taking care of the sick specifically, your patient?

16. Do you think being a family caregiver has affected your life?

    (Probe: If yes, how?-relate to social, family, religious, economic/financial, lifestyle emotional life)

17. Have you benefited from your caregiving duty?

(Probe: If yes, how? Relate with, material gifts, appreciation, self-esteem, inheritance, maturity, self-development)

18. Are you rewarded in any way for providing care?

(Probes)

- ***a. Do you think your reward matches your duties as a caregiver?***
- ***b. How has it been gainful to you since you started caring for the sick?***
- ***c. Do you feel satisfied taking care of the patient? In what way do you feel satisfied?***

19. For number of days you have been here, what are some of the challenges in your line of duty as a caregiver?

(Probes)

- ***a) Are these challenges personal or challenges associated with rendering care to the patients?***
- ***b) Can you elaborate on the challenges? (Probe: Are these financial, Physical, Psychological, social etc.).***
- ***c) In which ways does the hospital contribute to the challenges you face?***
- ***d) What is the most challenging? (Rank in tope 5)***
- ***e) As a caregiver, how do you deal with these challenges?***
- ***f) Do you feel this challenge(s) is/are good or bad/ positive or negative***
- ***g) If yes, are they affecting your relationship with your loved ones? If yes can you explain how it is affecting others***

20. Do other family member or relative support you?

(Probe: If yes, in what way? Was it helpful?)

21. Have you ever provided care to any other person in the past?

(Probe: If yes, who and why did you provide care)

Coping Strategies

22. What strategies do adopt to taking care of your ill person every day and generally?

(Probes)

a. ***Do you get help from other people when caring for the patient?***
b. ***What activities do you engaging yourself in more often than previous (prayer, singing, conversation either on phone or face to face chat etc)***

23. Are you able to shear you challenges with others other than the ill loved person?

(Probes)

a. ***How is the person related to you?***
b. ***Is the person also related to the sick person?***
c. ***Do you feel relieved after you talk to the person?***

24. Are there any community resources available to you apart from family and close friends?

(Probes)

a. ***What kind of support exist? (spiritual support? Physical support through visitation? Emotional support through advice and counselling? Financial support?)***
b. ***How often do you receive such help?***
c. ***What community resource has benefited you the most?***

25. Outline which of these from the most stressful to the least stressful, Emotional or psychological stress, financial stress or physical (health related)? ***(Probes)***

a. Why do you think that event is the most stressful?

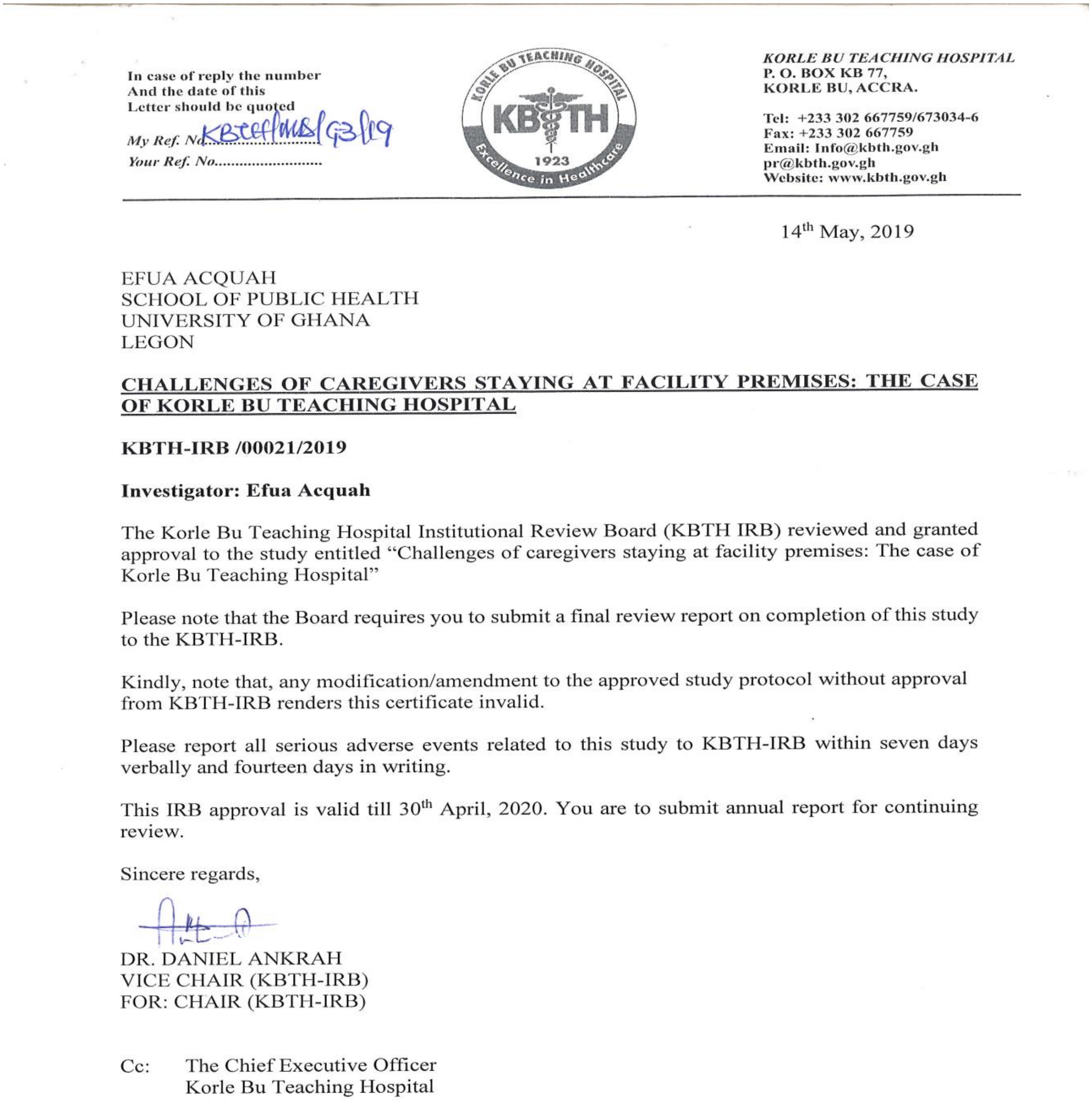
26. To give it your all, what type of support would you need to help you right now, today, in caring for your loved one?

THANK YOU

<u>COMMENTS ABOUT RESPONDENT</u>

…………………………..……………………………………………………………………………

APPENDIX IV: ETHICAL CLEARANCE



In case of reply the number
And the date of this
Letter should be quoted

My Ref. No. KBTH/MS/93/19
Your Ref. No..........................

KORLE BU TEACHING HOSPITAL
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Tel: +233 302 667759/673034-6
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Email: Info@kbth.gov.gh
pr@kbth.gov.gh
Website: www.kbth.gov.gh

14th May, 2019

EFUA ACQUAH
SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF GHANA
LEGON

CHALLENGES OF CAREGIVERS STAYING AT FACILITY PREMISES: THE CASE OF KORLE BU TEACHING HOSPITAL

KBTH-IRB /00021/2019

Investigator: Efua Acquah

The Korle Bu Teaching Hospital Institutional Review Board (KBTH IRB) reviewed and granted approval to the study entitled "Challenges of caregivers staying at facility premises: The case of Korle Bu Teaching Hospital"

Please note that the Board requires you to submit a final review report on completion of this study to the KBTH-IRB.

Kindly, note that, any modification/amendment to the approved study protocol without approval from KBTH-IRB renders this certificate invalid.

Please report all serious adverse events related to this study to KBTH-IRB within seven days verbally and fourteen days in writing.

This IRB approval is valid till 30th April, 2020. You are to submit annual report for continuing review.

Sincere regards,

DR. DANIEL ANKRAH
VICE CHAIR (KBTH-IRB)
FOR: CHAIR (KBTH-IRB)

Cc: The Chief Executive Officer
Korle Bu Teaching Hospital

MEDICAL DIRECTORATE
KORLE BU TEACHING HOSPITAL

22nd May, 2019

THE HEADS OF DEPARTMENTS
KORLE BU TEACHING HOSPITAL
KORLE BU

LETTER OF INTRODUCTION – EFUA ACQUAH
"CHALLENGES OF CAREGIVERS STAYING AT FACILITY PREMISES: THE CASE OF KORLE BU TEACHING HOSPITAL"

I have the pleasure to introduce to you the above named Investigator from School of Public Health, University of Ghana, Legon. Efua Acquah sought and has been granted approval to conduct a study entitled "Challenges of caregivers staying at facility premises: The case of Korle Bu Teaching Hospital" in your Department.

She is to contact you to discuss the commencement date of the study.

Please verify her identity with a Government issued National ID card and accord her the needed assistance.

Attached is the Scientific and Technical Committee and Institutional Review Board approval, which specifies the terms.

Sincere regards,

Dr. Ali Samba
Director of Medical Affairs
For: Chief Executive

Cc: The Chief Executive
Korle Bu

In case of reply the number
And the date of this
Letter should be quoted

My Ref. No. KBTH/MD/03/19
Your Ref. No...........................

KORLE BU TEACHING HOSPITAL
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Excellence in Healthcare

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pr@kbth.gov.gh
Website: www.kbth.gov.gh

3rd April, 2019

EFUA ACQUAH
SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF GHANA
LEGON

SCIENTIFIC AND TECHNICAL COMMITTEE APPROVAL
PROTOCOL IDENTIFICATION NUMBER: KBTH-STC 00021/2019

The Korle Bu Teaching Hospital Scientific and Technical Committee (KBTH-STC), on 3rd April, 2019 approved your submitted study protocol.

TITLE OF PROTOCOL: "Challenges of caregivers staying at facility premises: The case of Korle Bu Teaching Hospital"

PRINCIPAL INVESTIGATOR: Efua Acquah

This approval requires that you **forward your approved document to Korle Bu Teaching Hospital – Institutional Review Board (KBTH-IRB) for the ethical aspect of the proposal to be assessed before the project can be initiated.**

This STC approval is valid till 30th October, 2019
You may, however, request extension of the approval period, or renewal as the case may be, should the study extend beyond the stated period.

Upon completion, you are required to submit a final report on the study to the STC. This is to enable the STC ensure among others that, the project has been implemented as per the approved protocol. You are also required to inform the KBTH-STC and Research Directorate of any publications that may emanate from the research findings.

Kindly note that, should the need arise, the KBTH-STC or IRB may institute appropriate measures to satisfy itself that study is being conducted according to the highest scientific and ethical standards.

Please note that any modification to the study protocol without Scientific Technical Committee (STC) approval renders this approval invalid.

Sincere regards,

Prof. G. Obeng Adjei
Chairman, KBTH-STC

Cc: The Chairman, KBTH-IRB