

UNIVERSITY OF GHANA

CENTRE FOR SOCIAL POLICY STUDIES

SOCIAL SUPPORT FOR THE AGED: THE ROLE OF PRIVATE CARE HOMES

IN ACCRA

BY

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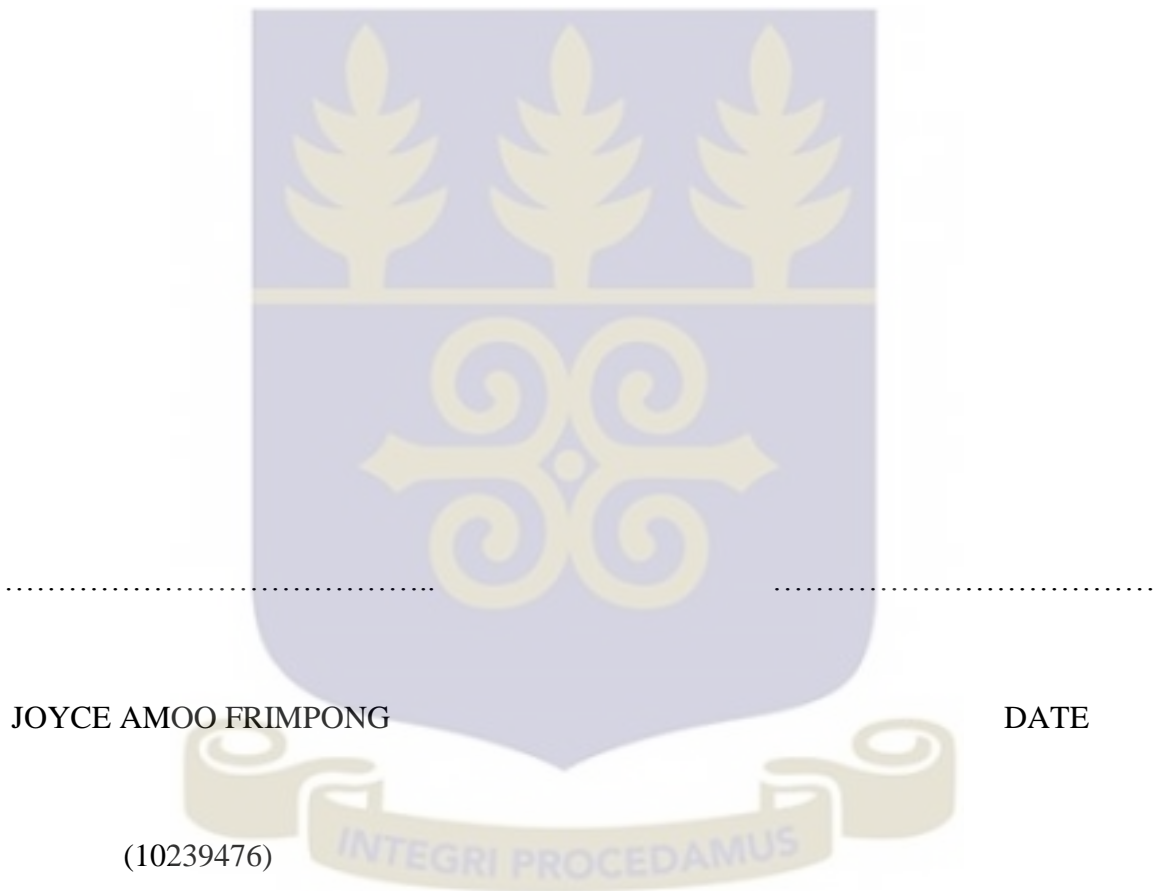
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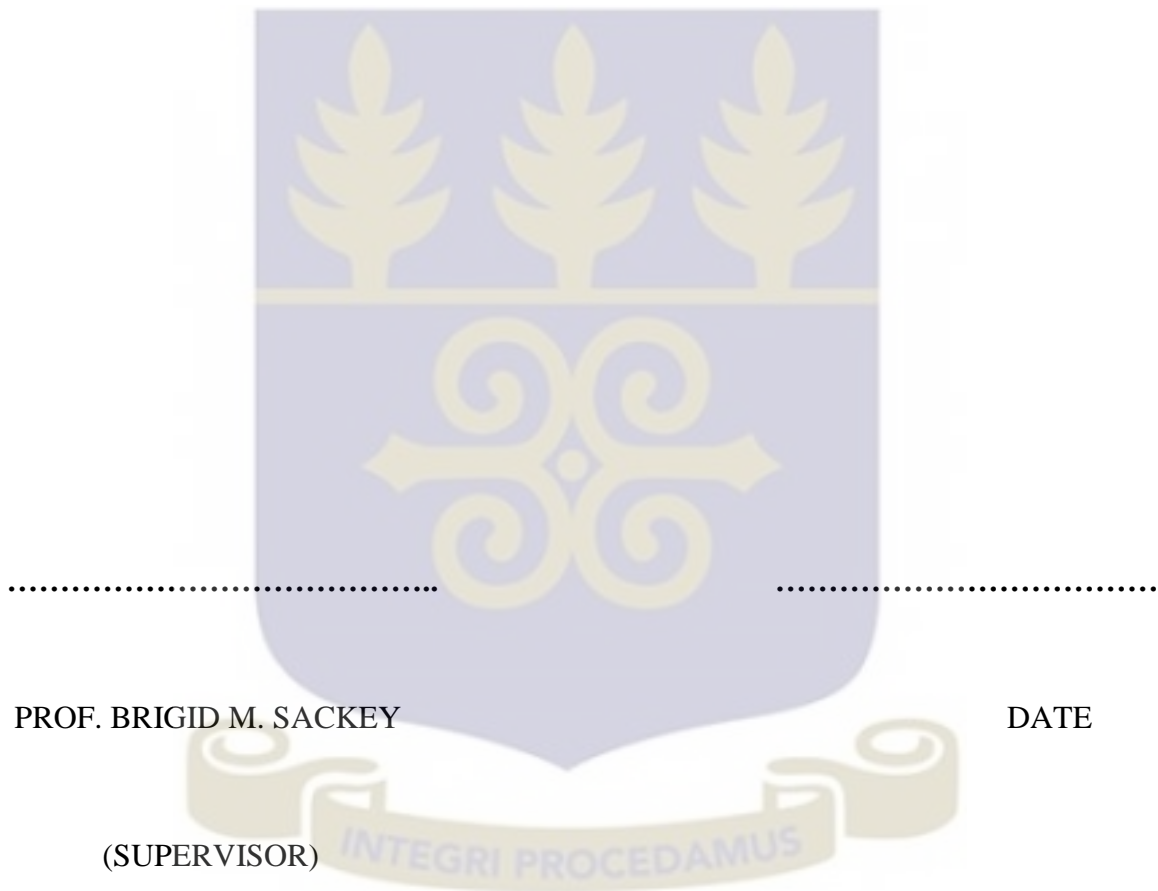
DECLARATION

I, JOYCE AMOO FRIMPONG, declare that this work is the result of my own research and has not been presented by anyone for any academic award in this or any other university. All references used in the work have been fully acknowledged.



CERTIFICATION

I hereby certify that this thesis was supervised in accordance with procedures laid down by the University.



PROF. BRIGID M. SACKEY

DATE

(SUPERVISOR)

INTEGRI PROCEDAMUS

DEDICATION

This work is dedicated to my husband, Mr. Bennet Frimpong, who provided me with all the support to come thus far. It is also dedicated to the memory of my late mother, Mrs. Gertrude Amoo, who until her death gave me all the encouragement to pursue higher academic achievements.

I will forever remain grateful.



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I thank God Almighty for His loving benevolence and mercy; God surrounded me with great people who supported me in many ways. My lips will not cease thanking you Lord; praise and honour be unto your name now and forevermore. Amen.

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Thank you all and God richly bless you!

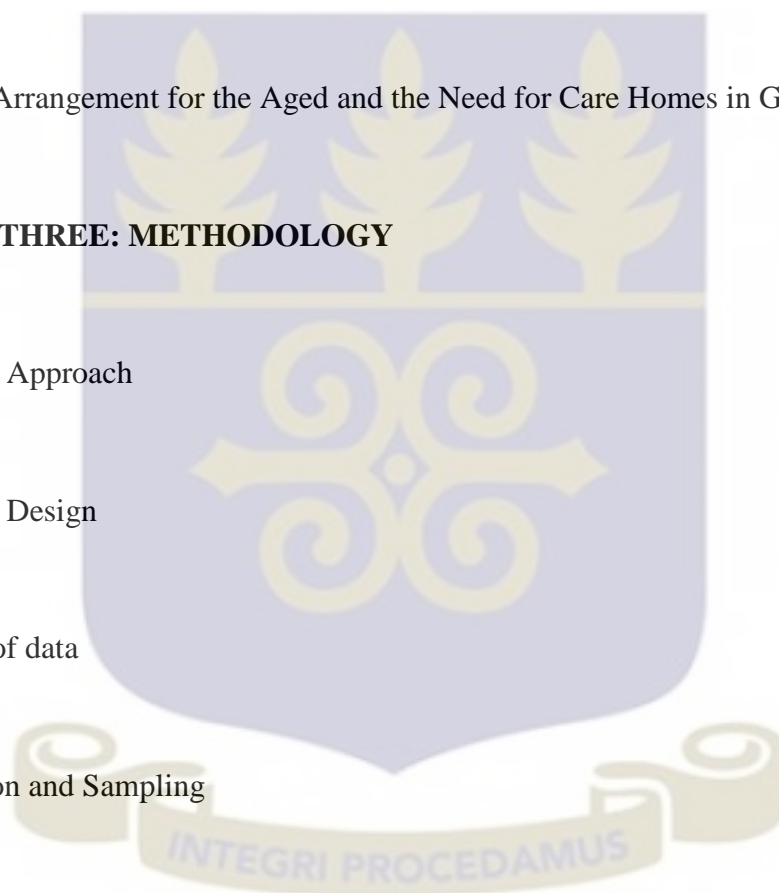
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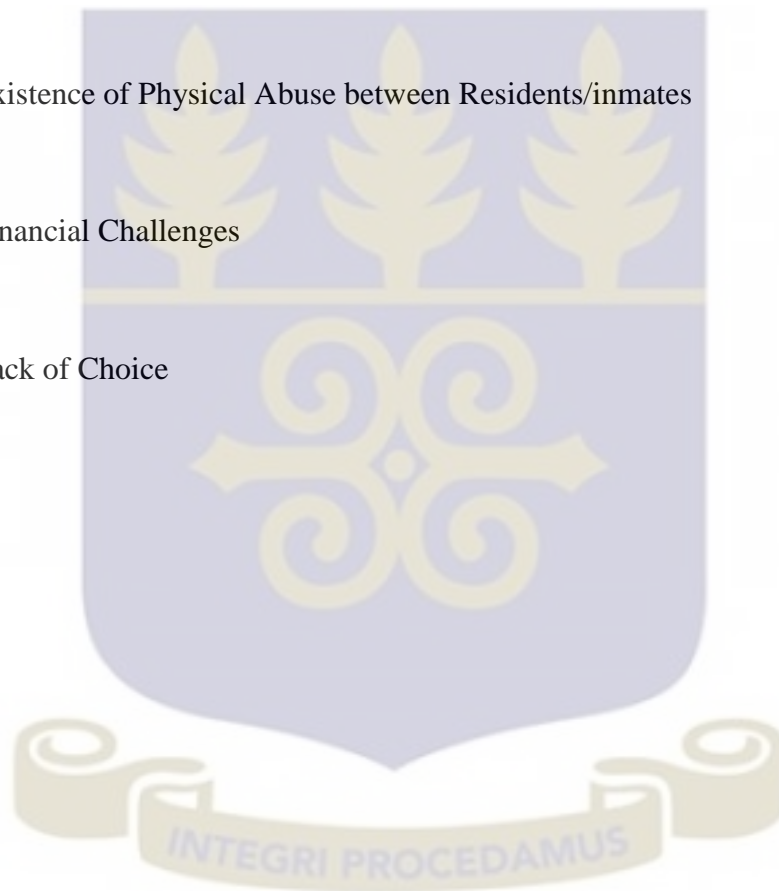
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LIST OF ABBREVIATIONS

CHC	-	Continuing Health Care
DNA	-	DeoxyriboNucleic Acid
JCCP	-	Joint Community Care Planning
NESF	-	National Economic and Social Forum
OECD	-	Organisations for Economic Co-operation and Development
SPSS	-	Statistical Package for Social Science
UK	-	United Kingdom
WHB	-	Western Health Board
WHO	-	World Health Organisation



ABSTRACT

This study sought to investigate the role of Private Care Homes in supporting the aged in Accra. The study adopted a mixed research technique in the data collection and analysis. It also used a cross sectional survey design. The data was collected from mainly primary sources using interview guide and questionnaire from Private Care Homes in Accra, Adenta, Osu and Dzorwulu. The data was analysed using descriptive statistics and thematic analysis. The findings of the study indicated that private Care Homes primarily provide their patrons services ranging from training in care for the elderly, medical services, social services and other home related services, as well as recreation. The study found that reasons why some aged people patronise services of private care homes are due to the busy schedule of their children, and neglect by their children, and modernisation. It also found that the challenges Private Care Homes face include (1) lack of or inadequate specialist staff, (2) committed or dedicated staff to provide services for aged people, (3) financial constraints, (4) lack of regulatory framework, among others. Lastly, it found that aged people in care homes are likely to face social inclusion problems, and institutional abuse in the form of being forced to eat or go to bed at a particular time, financial difficulties, as well as lack of choice and alternatives in service provision. It was however found that physical abuse between residents in private care homes will not exist and pose problem to the occupants. Consequently, services provided by private care homes suggestedly have affirmative impact on welfare of aged people. Based on these outcomes, the study made some recommendations which will significantly influence public policy in effective management of aged people and administration Care Homes in Ghana specially and Africa in general.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Ageing is inevitable and for as long as one does not die at a young age, he or she would definitely grow old. The concept 'elderly' refers to a category of adults who have attained advanced ages. The demographic understanding of the concept refers to persons aged 60 years and above. In the developed countries where life expectancy is high (more than 70 years) and the age of retirement from active public economic activity is 65 years, the elderly are defined as persons aged 65 years and above (Population Reference Bureau 2012). In developing countries on the other hand, since life expectancy at birth is lower, the age of retirement is 60 years and the elderly are considered as persons aged 60 years and above. At the international level, age 60 is now being used as the cut-off age for defining the elderly (United Nations Population Fund and Help Age, 2012).

The elderly are also referred to as the 'aged' or 'older people'. The concept of ageing is an associated word that refers to the process by which persons or adults are attaining chronological ages that are classified as old ages. Ageing also refers to a process by which the elderly or older persons constitute higher proportion of the total national population than at an initial period (Weeks, 2012). UN tabulations provided figures for both 60 and 65 years of age and older (United Nations, 1999), making possible more detailed estimates and projections for older people in most countries. The WHO uses categories starting at the age of 65 as elderly or older persons and 80 as oldest-old (WHO, 1999).

Globally, the population is ageing and the demand for health and home care services has become vital (Joint Community Care Planning Framework (JCCP), 2012). For instance, the average age of the United Kingdom (UK) population has increased. The proportion of people aged 65 and over in the UK population increased from 15% in 1985

to 17% in 2010, an increase of 1.7 million people. It is projected that by 2035 people aged 65 and over will account for 23% of the total population (Office for National Statistics, 2012). It is estimated that in England there are more than 400,000 older people living in care homes. This includes people receiving care in residential and nursing accommodation funded by Councils with Adult Social Services Responsibilities and people who either partially or fully fund their own care (Care Quality Commission, 2012).

Populations worldwide are ageing, leading to a dramatic increase in the numbers of people living into their seventies, eighties and nineties (World Health Organisation-WHO, 2011). According to the World Health Organisation (WHO), there are about 600 million people aged 60 years and above and this number is expected to double by the year 2025- the vast majority of them in developing countries like Ghana.

In Ghana, the 2010 Population and Housing Census estimated that the population of the aged has increased seven-and-half times from 1960 to 2010 namely from 213,477 and 1,643,381 respectively constituting 6.7 percent of the total national population in 2010 compared with 4.5 percent in 1960. Over two-thirds of all the elderly (68.2%) are aged 60-74 years, and approximately one tenth (9.6%) are very old (85 years and above) (Ghana Statistical Service, 2013). These increases in aged population are also likely to increase demand for care home services.

As demographic trends change, reflected in the growing proportion of the population in the older age categories, and in the rising proportion of women in paid employment, the need for publicly provided eldercare services has also grown. For example, women are no longer available, to the extent they have been in the past, to provide eldercare services. At the same time life expectancy levels have increased and as a consequence the

need and demand for public, voluntary and private market-based care services has grown (Barry, 2010).

Whilst the public sector has an important role to play in promoting health and well-being, supporting self-care and preventing ill-health, it is recognised that there are many other private organisations, particularly in the voluntary, community and independent sector, who may be better placed to provide these services (JCCP, 2012) as one of the most significant changes in care home in the last 30 years.

In UK for example therefore, there has been the extensive transfer of residential care places from public to private sector provision. Private residential home places increased rapidly in the 1980s from 39,253 in 1981 to 159,000 (Read & Worsfold, 1998). According to Victor, the proportion of long-term places in the independent sector rose from 18% in 1980 to 85% in 2001 (Victor, 2005). Residential and nursing homes in UK, for example provide support to about 410,000 people over the age of 65 years. Around 15,700 homes were in operation throughout the UK to deliver this service (Office of Fair Trading, 2005).

According to Van der Geest (2002), in Ghana however formally organized professional care for the elderly does not exist. The only facilities available in Accra – and perhaps a few other places – are day care centers where elderly people can meet each other, pass the time with games and other activities and receive a good.

A study by Barry (2010), found that most aged ones would prefer to stay in their own homes and to have support services provided in a way that would allow them remain in their own homes and communities for as long as possible. The provision of higher levels of care and support for older people, particularly the growing number of those living alone, becomes necessary as dependency increases with age. National Economic and Social Forum (NESF) (2009) in Ireland also highlight the strength of older people's

preference for home care. They conclude that older people are very positive about home care services because they allow them to remain in their homes for longer and their families to continue caring for them, reducing stress and increasing the quality of life.

This means that community care encompassing personal care services, nursing and certain health care services, as well as housing and transport services need to be provided in a manner that meets these needs through a combination of self-care, support for formal and informal carers in the family and at community level, as well as developing a parallel system of residential care. As a result, many countries are developing policies that encourage family or community-based care for aged people (Barry, 2010).

Similarly, in Ghana, the National Ageing Policy (2010) is set to achieve the overall social, economic and cultural re-integration of older persons into mainstream society. In the pursuit of this goal full recognition will be given to their fundamental human rights including the right to independence, active participation in society, benefit from community support and care, self-fulfillment in pursuit of educational and other opportunities and dignity, security and freedom from exploitation.

The policy aims at promoting and strengthening the role of family and the community in the care of its older members. It states that traditional support systems would be strengthened to enhance the ability of families and communities to care for older family members. The family would be encouraged to develop plans and incorporate in these plans strategies to support older people in the family (National Ageing Policy, 2010).

Based on this background, the current study sought to examine the role of private care homes in supporting the wellbeing of the aged in Accra.

1.2 Problem Statement

Private care homes are believed to play important role of promoting quality of life of the aged ones. In the view of Wistow et al. (2003), well-being is an important component of successful ageing and call for a greater focus on promoting older people's quality of life and their engagement in the community.

Unfortunately, it has also been noted that, the promotion of mental health and well-being in later life has been the least visible area of activity in older people's care services (Age Concern, 2006). Similarly, studies suggest that in Ghana the role and the well-being of older persons have long been ignored by social scientists (Ayisi, 2013).

Researchers, therefore, have made a call for the well-being of the aged participants to be considered paramount in future studies (Luff, Ferreira & Meye, 2011). Furthermore, in most developing countries like Ghana, the public had difficulty in finding out about private care home packages and how to access them. It was also observed that there was an absence of data to assess if the scheme was working well or not (National Economic and Social Forum (NESF, 2009).

Also, most care homes exist to provide a 24-hour service. However, many research projects have focused on the daytime care and services that residents receive in care homes. The review of the literature indicates that there is a need to better understand the totality of home cares services (Kerr, Wilkinson & Cunningham, 2008). Furthermore, despite a policy emphasis on providing good care options that promote choice for older people (Help the Aged, 2007) and the need to improve care standards in residential settings (Department of Health, 2001), much focus has not been directed in assessing the challenges private care homes face.

More so, services provided by private care homes have a beneficial impact on wellbeing, quality of life, morbidity and mortality (Age UK, 2011). However, very few studies have specifically evaluated the impact of private care homes on quality of life of aged people. Moreover, various studies on care for the aged have focused on developed world, for example Barry (2010) in UK, and Kerr et al. (2008) in Australia; with little or no focus on Ghana. The provision of higher levels of care and support for older people, particularly the growing number of those living alone, becomes necessary as dependency increases with age. This means that community care encompassing personal care services, nursing and certain health care services, as well as housing and transport services need to be provided in a manner that meets these needs through a combination of self-care, support for formal and informal carers in the family and at community level, as well as developing a parallel system of residential care (Barry, 2010). It is against this backdrop that this study seeks to examine the role of private care homes in promoting health and general wellbeing of the aged people using the experiences of some private care homes in Accra.

1.3 Research Objectives

1. To ascertain the services private care homes provide to support the aged people in Accra.
2. To determine the factors will account for the aged to demand home care services.
3. To explore the effect of private care home services on the quality of life or wellbeing of the older people.
4. To examine the challenges aged people who patronise the services of private care homes in Accra face.

5. To find out the challenges that private care homes face in providing quality services for the aged people and how they manage them.

1.4 Research Questions

1. What services do private care homes in Accra provide in support of aged people?
2. What factors will account for the aged demanding home care services?
3. What is the effect of private care homes services on the quality of life of older people?
4. What challenges do older people who patronage care homes services face?
5. How private care homes in Accra deal with challenges that they encounter in delivering quality support for older people?

1.5 Significance of the Study

This study seeks to investigate whether the role of private care homes in the support of aged people in Accra. The study's relevance is examined in the following areas: practice, policy and research. In terms of practice, the findings of the study would assist private care home operators to become aware of the contributions they are making in enhancing quality of life of aged people. Also, it would make them become aware of the challenges that face their beneficiaries as well as the institutions themselves. This will make them take appropriate remedial measures to overcome the challenges they face as institutions as well as the problems the aged people in their homes encounter. Consequently, they would assess their effectiveness and their overall contribution in the provision of care for the elderly.

With regards to policy, the findings of the study will guide policy makers in the relevant sectors such as Ministry of Gender and Social Protection, Social Welfare, among others, to

formulate appropriate policies to ensure that care homes receive necessary recognition and support to enable them work more effectively.

Finally, this study will serve as a contribution to knowledge in the area of care provision for the aged, in Accra specifically and Ghana generally.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the literature review and theoretical frameworks.

2.1 Theoretical Frameworks

2.1.1 Wear and Tear Theory

This theory is based on the idea that ageing is a ‘secondary effect’ of physiological work of cells (Weissman, 1891; Pearl, 1928). The wear and tear theory claims that with repeated use, parts in living organisms wear out and give rise to defects. These malfunctions provide the cellular substrate for the buildup of physiological deficits in aging. The premise of this theory is based on the observation that the lifespan of poikilotherms is shortened by increasing the environmental temperature and prolonged by decreasing it (Fanestil & Barrows, 1965; Strehler, 1962). Indeed, active tissues with high rates of cell turnover have been shown to contain more age-related lesions. For instance, more rapid telomere loss can be found in the endothelial lining of blood vessels that were exposed to high hemodynamic stress and underwent rapid turnover (Chang & Harley, 1965).

This theory is relevant to this current study because it will guide the researcher to ascertain from care givers at Care homes’ on whether ageing among their patrons is as result of a ‘secondary effect’ of physiological work of cells, and the extent to which wear and tear of cells in aged influenced the kind of services they offer to those who access their facilities. In addition, it will help the researcher to ascertain whether patrons of private care homes demand medical and psychological services as a result of defects in their systems created by of wear and tear leading to physiological deficits in their aging.

2.1.2 Modernisation Theory

Modernisation theory was formalised in social gerontology mainly through the work of sociologists. This general model of the relationship between modernisation and aging predicts a linear relationship between the status of older people and the degree of modernisation experienced in a given society. According to this theory, the more modernized a society becomes, the more the status of older people declines. Modernisation, thus inevitably affects the entire social structure of newly modernized societies, including the position customarily held by its elderly community, regardless of when or where it occurred (Cowgill, 1974; Cowgill & Holmes, 1972).

In 1972, Cowgill and Holmes developed a theory of modernisation as it related to aging and old age. Their position was that as societies modernise, undertaking the shift from farm and craft production within families to a dominantly industrial mode of production – repercussions of modernisation would diminish the status of older people. Cowgill's later theoretical refinements (1974) identified four key aspects of modernisation that undermined the status of older people: health technology; economic and industrial technology; urbanisation; and education.

According to Cowgill's theory, improved health technology, including advances in both medical practice and public health, has positive effects of improving health and increasing longevity, but it also has negative effects for older people. When people live longer, there is more competition in the labour market. Employers in industrialising societies prefer younger workers with new occupational skills to older workers, thereby forcing older workers out of the labor market into retirement. Once retired, according to modernisation theory, loss of income, prestige, and honour arising from labour market participation lead to a decline in the status of older people (Cowgill, 1974).

Modernising advances in economic and industrial technology create new occupations in factories located near transportation and services. Younger people acquire the skills for new occupational slots and join the industrial work force, relegating older people to less prestigious and increasingly obsolete jobs. This often leads to retirement, reversing the roles of old and young. In traditional societies, older family members control family production, and younger ones are dependent on the old. When older people are excluded from the industrial labour market, they become dependent on the young, losing social status (Cowgill, 1974).

Factory locations in urban areas are a magnet to young workers. The process of urbanisation leaves older family members behind in rural areas, undermining the traditional extended family and the prominent position of older members within them. The new family form in modernising societies is the nuclear family, and both social and spatial distance is increased between the young and the old, changing intergenerational relations. Modernisation theorists viewed upward mobility of the young as being accompanied by downward mobility among the elders in their families (Cowgill, 1974).

Increased literacy, emphasis on the superiority of scientific over traditional forms of knowledge, and education targeted toward children can all create inequalities in the knowledge base among family members of different generations, making the generation gaps between young and old even wider. Developments in science and technology render much of the traditional knowledge and many of the skills of older people that previously contributed to their high social status obsolete, since direct contribution to an industrialised economy becomes impossible (Cowgill, 1974).

Thus, modernisation and ageing theory have provided the main platform for the debate on changes in family support for older people in both the industrialised and the developing worlds. Although its well-known proposition of an ‘abandonment’ of older people in individualistic society has received much attention and been solidly refuted, the modernisation model continues to be the principal and most common framework for explaining the decline in familia material support for older people – both historically in the West, or at present in developing countries. The main rival explanation is provided by materialist accounts (Aboderin, 2004).

The wear and tear theory and modernisation theory provide a framework for explaining ageing and dependency. While, the wear and tear theories provide some theoretical causes of ageing, the modernisation theory explains how the aged become dependent in modern society. Modern jobs require current skills and knowledge which is the elderly mostly do not have. This increases demand for the services of young people thereby relegating older people to the background. This increases the dependency rate of older people in modern society in contrast to traditional societies, where older family members control family production, and younger ones are dependent on the old.

Also, the literature on informal support systems characteristic of the African model frequently forewarns of the weakening of African traditional family structures. Much of the literature cites the modern nuclear family’s inability to continue its care giving roles in the context of the current modernized urbanization life, as women increasingly join the labour force. The impact of world economic trends on family living standards is likewise projected as paving the way for extended family exclusivity (Mosamba, 1984; Shuman, 1991; Apt, 1992, 1996).

2.2 Ageing and the Aged

Old age in Africa and especially Ghana is considered desirable. It is viewed as ‘a blessing from God’ and a ‘reward for righteousness’ (HelpAge Ghana- Attitudes Survey 2002, cited in *Your Human Rights as an Elderly Person*, p.2). There is no consensus as to what constitutes old age, but largely the concept is defined as a stage in life beginning in the early sixties, in which retirement from work and many other social responsibilities is expected (Uhlenberg, 1992).

HAI (2004) posits that the definition of older persons by African countries differs from that in developed countries that have accepted the chronological age of 65 years and over as definition of older persons. In developed countries, this definition is linked with the age at which one begins to receive pension benefits. Like the developed countries, in many less developed countries, the definition of older persons corresponds to the retirement age which is often set by governments. This logic appears fairly illogical because in Sub-Saharan Africa and Ghana in particular, older persons live in rural areas and do not find themselves in the formal sector, and so expect no formal retirement benefits. This definition will also be inapplicable in countries where life expectancy is relatively lower. Moreover, this definition is also inappropriate because in Africa actual birthdates of many individuals are somewhat often unknown since an official record of their birth date is missing (HAI, 2004).

This increases the difficulty of developing a definition for older persons. Nevertheless, traditional means have been used in Africa to explain the concept of older person. According to HAI (2004), the colour of a person's hair, failing eyesight and diseases such as arthritis are features used to define an older person. In contrast to the chronological milestone which marks life stages in the developed world, old age in many developing countries seems to begin when active contribution is no more possible (Gorman, 2000).

Study results published in 1980 provide a basis for a definition of older persons in developing countries (Glascok, 1980). The definition was classified into three: chronological age (50 years and over); change in social role (change in work patterns, adult status of children and menopause); and change in capabilities (unsound status, senility and change in physical characteristics).

Though a number of definitions have been used to explain the concept of older persons, in many instances the age at which one qualifies for statutory and occupational retirement pensions has become the definition. The ages of 60 and 65 years are often used, despite its arbitrary nature, and debates about this have been prevalent from the end of the 1800's through the mid-1900's (Roebuck, 1979) and even to date.

Ageing is a progressive increase throughout life or after a given stage, in the likelihood that a given individual will die during the next succeeding unit of time (Comfort, 1979). In Comfort's view, aging happens as a result of a progressive loss of physiological functions that culminates in death. Indeed, the progressiveness of the aging process has brought about the idea of 'error accumulation' throughout the lifespan.

Harman has defined aging as: "The accumulation of changes responsible for the sequential alterations that accompany advancing age and the associated progressive increases in the chance of disease and death" (Harman, 1991, p. 5360). According to the National Ageing Policy (2010), an aged or elderly person is someone aged 60 and above. In some cases, it is from 65 years and over. This definition encompasses both the traditional and the legal definition of who an aged person is. Recent progress in aging research has led to frequent revisions of the definition of aging. For instance, Busse has divided the aging processes into primary and secondary aging (Busse, 1987). In his view, primary aging is intrinsic to the organism, and the detrimental factors are determined by inherent or

hereditary influences. On the other hand, secondary aging is caused by deleterious or hostile factors in the environment. In this study and aged person is defined or operationalized based on the National Ageing Policy's (2010) conceptualisation.

2.3 The Aged Population in Africa

At the same time as ageing has drawn considerable attention in developed societies for a very long time, in many African countries, it has thus far barely been perceived as a potential demographic change whose occurrence is only a matter of time. It goes beyond the small proportion of the older population currently projected in the population structure of African countries (Apt, n.d).

In Ghana and Africa as a whole, ageing is a phenomenon that has just begun; currently, it is a family crisis (Apt, 1995). The most rapid growth in the older population is expected in Western and Northern Africa, whose older populations are projected to increase by a factor of nearly five between 1980 and 2050. Of relative importance is the fact that the number of the very old in Africa is also expected to grow at a very fast rate. Between 1980 and 2025, the population aged 75 and over will increase by 434 per cent in Eastern Africa, 385 per cent in Middle Africa, 427 per cent in Northern Africa and 526 per cent in Western Africa (Apt, n.d). The southern Africa region has the continent's highest percentage of older inhabitants; in 1997 the 60+ age group constituted 6.2%, slightly more than in the northern African region (Kinsella & Ferreira, 1997). The United Nations (2006) forecasts that the percentage of the Nigerian population aged 60 years and above will increase by 26 percent by 2020 and 38 percent by 2050. This means that the number of aged people to be supported and cared for will grow significantly.

Like other countries in sub-Saharan Africa, Ghana is also experiencing considerable changes in the age structure of its population (Mba, 2010). The 1960 and 2000 Population

and Housing Census results of Ghana show that the proportion of older persons in Ghana increased from 5.2 per cent in 1960 to 7.2 per cent in 2000; while, estimates in the 2010 Population and Housing Census show that the population of the aged has increased seven-and-half times from 1960 to 2010 from 4.5 percent to 6.7 percent of the total national population.

Equally, recent studies have shown that Ghana has one of the highest proportions of age 60 and over population in Sub-Saharan Africa (Mba, 2010), which suggests large increases in the older population in the coming years. In fact, the population of older Ghanaians is expected to double between 2000 and 2030 (Smith & Mensah, 2003). The consistent rise in aged population suggests that it is also important to examine both chronic health conditions and the nature upon which these individuals receive care. Although Ghana's health policies have improved over recent years, issues such as limited access to primary care facilities have resulted in seeking assistance from orthodox to alternative forms of care, particularly in rural and less populated areas (Apt, 2013).

2.4 The Roles of the Aged in Ghana

Aged people are not excluded from the development of useful and collective participation in Ghana. In a classic Ghanaian family, the aged plays the role in societal upbringing of the young and thereby becomes the educator and the guiding spirit behind many initiatives of the young, psychologically a very important role. The elder is also entrusted with family lands, property and family wealth; consulted in administrative matters and important decisions (Apt, n.d).

The role for an elderly person has also changed in Ghana in the present day. Traditionally, the elderly person had the role as advisor in the family. It still works to some extent, however, not to the extent it used to. Nowadays, young people are not eager to learn from their elderly family members, since they can find what information they need on the

Internet. Even the adult family members do not value the knowledge and wisdom of the elderly anymore, since there is so much information elsewhere. This leads to marginalisation for the elderly person since the role as advisor is a major role for an elderly person (Karlberg, 2003).

2.5 Caring for the Aged in Africa

Traditionally, African communities had a well-articulated caring structure that preserved the quality of life of older persons, but this was linked to the low probability of survival of large numbers of older persons (Apt, 2000). The situation is changing, albeit, gradually; early mortality no longer limits the number of surviving elderly persons and traditional respect and caring structures are now facing substantial social challenge (Vatuk, 1996; Adamchak, 1995; AGES, 1995). Ageing has occupied the world's platform of popular concerns in the past century. Besides the demographic factors, there are economic and social factors that are bound to impact adversely on older persons during the current process of urbanisation and industrialisation occurring in the developing regions of the world, including Africa. That process gradually weakens traditional family patterns that provide centrality and social roles for older persons. There is no simple panacea for addressing the problem of meeting the social and economic needs of an ageing world. The orthodoxy of the industrialised world – the welfare state, old-style public pension schemes, and public-financed medical provision are all experiencing major difficulties. The crucial question is whether the cultural norms of African countries will remain strong enough for families to maintain their ties to older members as the dependency burden increases in the twenty-first century (Apt, n.d).

In a study on Ghanaian youth view on ageing (Apt, 1991), it was evident that young families would not be living with their elders much longer, as 81 per cent of the respondents were of the opinion that this arrangement was not feasible at the present time.

According to the researcher, it would, however, be a mistake to think that such separation is simply the outcome of the adoption of modern values and attitudes, as there are obvious infrastructural and structural factors involved in this change of practice. Urban housing conditions provide a good part of the explanation for these changes. According to Mba (2013), about 12 per cent of older persons live alone, while women are more likely to live alone than men (14% versus 9% respectively). Studies indicate that in Ghana, marital status and living arrangements of older persons differ greatly by localities (urban/rural) and by gender. Many older men remain married and in family settings as heads of households, whereas many women spend their later years as widows (Apt, 1994).

Apt (n.d) maintains that in the rural Ghanaian context, the provision of accommodation for all social categories is unproblematic; shortage of land is not a factor and simple additional dwellings are constructed of local materials as the need arises. Urban accommodation typically requires cash payment and is frequently subject to the landowners' limitation on the number of persons entitled to inhabit a property. When considered together, these factors place pressures on families, especially where family size is large to subdivide into component units (rural/urban). Such subdivision, in turn, adversely affects the internal budgeting arrangements of the conjugal family in respect of its ability to meet traditional welfare obligations.

On the other hand, in Sub-Saharan Africa, the living arrangements and the general welfare of older persons is yet to become a policy issue owing to the belief that families still remain as the strongholds of support (Kimuna, 2005 cited in Ayisi, 2013).

2.6 The Concept of Care Homes

Care Home has a different meaning and purpose across countries, varying from a safety net for those without relatives to a right for all citizens. Consequently, countries currently

show strong differences in features such as the role of professionals in home care; citizens' eligibility for services; financial conditions; and regulatory mechanisms that steer the sector (Burau, Theobald & Blank, 2007). Many studies on care home lack precision in defining the activities, goals and even the target groups of care home (Breedveld, 2004).

Defining exactly what is meant by a care home can be a complex task given that most countries use different terms for it. A "care home has been defined as a residential setting where older people live, usually in single rooms, and have access to on-site care services" (<http://www.firststopcareadvice.org.uk/jargon-care-home.aspx>) and where residents do not legally own or rent their home (Care Quality Commission, 2010). Home care refers primarily to services provided by professionals in the homes of adult recipients (Boerma & Genet, 2012). The EURHOMAP study has defined home care as care provided by professional carers within clients' own homes.

Care homes for older people are often categorised by the type of care they provide rather than the type of ownership (Help the Aged, 2007). In England, the Care Quality Commission defines both as residential social cares, referring to them as care homes with nursing services or those without (Care Quality Commission, 2010). In Northern Ireland, care homes were either referred to as nursing homes or residential homes.

In Scotland and Wales the term care home is used to include those with nursing care. Given a choice between care in an institution or at home, most people would prefer to stay in their own home (TNS Opinion & Social, 2007). This may be a major argument for the legitimacy of care provided at recipients' homes, but it is not the only one. The provision of services in patients' homes is typically more cost-effective than in institutions, particularly if available informal care is used effectively (Tarricone & Tsouros, 2008).

Expectations about the possibilities for home care have grown as new technology facilitates care coordination and enables distant monitoring and more complex treatments in the home situation (Tarricone & Tsouros, 2008). In many countries, the balance of long term care tends to shift towards home-based care, as many governments pursue the concept of ‘ageing in place’ (OECD, 2005).

2.7 Types of Care Homes

Broadly, there are two types of ownership for home care providers – publicly and privately owned organisations. Publicly owned providers fall under the direct control of government (at national, regional or local level) and thus can be directly influenced by it. Privately owned organisations cannot be influenced so directly and therefore other forms of steering are required, for example, to ensure quality and to determine the means of price setting (Genet, Hutchinson, Naiditch, Garms-Homolová, Fagerström, Melchiorre, Kroneman, & Greco, 2012).

For private providers, a distinction needs to be made between non-profit-making and profit-making providers. In some countries, the non-profit-making sector is extensive and comprises a mix of voluntary, charitable and professionally led organisations. This sector may involve many different organisations – for example, there are charitable organisations (e.g. in Bulgaria and England), some with church affiliations. Further examples include voluntary organisations (volunteers, sometimes mixed with professionals); small professional teams; or sometimes large professional non-profit-making organisations. Some of these large non-profit-making organisations were previously charitable organisations, e.g. in Luxembourg and the Netherlands (Genet et al., 2012).

There are care homes and care homes with nursing. Their distinctions are defined by Care Quality Commission (2010) as follows: A care home provides personal care (help with

washing, bathing and medications) and board and lodging. Some care homes are registered to meet a specific care need, such as dementia or terminal illness. In these homes, a district nurse or and specialist nurse would be invited to address the nursing needs. Care homes are, therefore, not required to employ a registered nurse in their homes. On the other hand, a care home with nursing will have a qualified registered nurse on duty 24 hours per day to administer nursing care.

The care home market for older people is now characterised by differing care packages. Residential homes support user needs with or without nursing, specialist homes cater for those with learning or physical disabilities and dementia while other organisations offer palliative care or dependency treatment for drugs. These services are supplied by a full range of providers: for profit firms (large and small); not-for-profit enterprises (voluntary organisations or charities); and the public sector (Laing & Buisson, 2002). This study applies the generic term care home to refer to both. This is because the researcher believes that care homes in Ghana may provide personal care as well as medical care services to its patrons.

2.8 Challenges of Private Care Homes

Several challenges bedevil private care homes generally. Critical among them is financial difficulties. Most care homes are faced with non-availability of sufficient funds to run and provide quality service to its inmates. These financial constraints also tend to make care home services inaccessible to those who need such services. Although some reimbursement for the provision of services or some cash benefits exist in most of the European countries, a number of economic factors restrict affordability and consequently access to home care in many countries (Garms-Homolov et al., 2012).

Using the framework of the Special Euro barometer survey, European citizens were asked their opinion on the affordability of services for themselves or for their relatives. About 30% considered home health care to be affordable, but another 30% thought that it would be too expensive. Expectations varied widely between countries (TNS Opinion, & Social, 2007). There were very high proportions of respondents who believed that care home was not affordable in Portugal, Croatia and Greece (ranging from 56% to 71%). The largest shares of respondents who thought that home care was affordable or that it was free of charge were found in Belgium, Denmark, France and the Netherlands (42% to 59%).

In a study of challenges faced by care homes, The RCN (2011) found that ten common challenges face care homes: Funding and admissions; staffing level; appropriate skill mix; recruitment and retention; low levels of moral and extreme pressure at work; lack of training; lack of equipment; inspections and bureaucracy; the ethic of the care home and concerns about the general management; and difficulties working with professionals from other sectors. The following present brief summary of these challenges.

In addition, care home is labour intensive and many of these institutions find it difficult to procure competent workers in sufficient numbers to match the growing demand for care home services, as the population structure changes. Scarcity also applies to informal carers, such as spouses, children, other relatives and volunteers. In many countries, informal care is becoming scarcer as a result of growing mobility, urbanisation and women's increasing participation in the labour market, the latter traditionally providing the lion's share of informal care (Mestheneos & Triantafillou, 2005; Gibson, Gregory & Pandya, 2003).

Home care is a labour-intensive sector. Although some initiatives use modern technology to replace some human labour, home care is mainly a hands-on activity. The provision of

home care that is quantitatively and qualitatively satisfactory requires workers who are available at the right time, the right place and with the right skills. Furthermore, quality and efficiency in home care may also be enhanced through effective human resource management methods (Genet et al., 2012).

In all Western countries, professionally trained nurses are responsible for medically oriented technical tasks, prevention and therapeutic care. Social services are provided by a wide range of professionals, ranging from well-trained social workers and personal social care workers to auxiliaries (domestic aid workers). Unfavourable working conditions (low wages, poor fringe benefits, and generally high workloads and migration are said to cause a shortage of well qualified home-care workers (Genet et al., 2012).

Care work is poorly paid, with many staff earning little over the minimum wage (Eborall et al., 2010; Low Pay Commission, 2009, Hussein, 2009). Pay and responsibility structures creating a clearly defined carer ladder for care staff are often absent, with little opportunity for individuals to progress either into training or managerial roles, or to specialise in specific aspects of care where both training and better remuneration are provided (Hussein & Manthorpe, 2011). There is arguably little opportunity or motivation for many care staff to progress in their careers. However, the type of ownership and management style varies, and some care homes do invest carefully in staff training and creating carer progression structures (Luff, Ferreira, & Meye, 2011).

The Care home sector is also complex because of its interdependency with other sectors that have a role in enabling people to stay at home. For instance, the hospital sector, primary health care, housing and the social welfare sector. Coordination is essential not just between professional care providers, but also between professionals and informal caregivers (Bonsang, 2009). Often, it is easy to get physical care and help, but difficult to

get psychological support and psychosocial care. The reason may be eligibility and financial coverage, but also differences in the availability of informal carers since poor countries have poor services. This is true in terms of the low density of (qualified) home-care services; limited information on how to access them; and limited choice between different providers and types of care (Garms-Homolová et al., 2012).

Additionally, Care home staff often receives only minimal training in line with statutory requirements. This is of course related to resources, but a lack of investment in staff is likely to be costly in the long run due to increased turnover and recruitment costs. It is also the case that when staff are trained individually by being sent on a course they find it hard to change their practice on returning to work because of the culture, environment and peer pressure. It is often wiser and more economical to provide training to the staff as a team so that they can support each other to implement changes (Cass, 2012).

Consistent with the above scholars, empirical findings in many Organisations for Economic Co-operation and Development (OECD) countries also found that there is a quality shortfall in care homes, ranging from inappropriate and sub-standard care to the more serious problem of neglect and abuse of residents (OECD, 2005). Problems contributing to unsatisfactory care in most care homes tend to be similar across OECD countries. These problems include insufficient numbers of trained staff, substandard buildings and facilities, inadequate quality assessment, and poor monitoring systems. Therefore, lack of consumer satisfaction with institutional care is often contrasted with the higher levels of satisfaction expressed by recipients of home care services.

2.9 Care home challenges in Africa

Studies on care homes in Africa are rare. A study by Muwaniki (2013) in South Africa found challenges facing Care Homes that are not different from those pertaining to care

homes in the West. The researcher found that Care Homes in South Africa are confronted with challenges such as (1) lack of practical skills required to provide effective home based care; (2) Care homes have limited finance therefore cannot offer its services adequately; and (3) Stigmatisation. Similarly, Evidence for Action (2011) found that Home-based care givers in Sub-Sahara Africa face challenges in carrying out their roles, including: lack of regular training and supervision, lack of recognition and compensation, and lack of psychosocial support.

2.10 Challenges Facing Residents in Care Homes

In other related studies, *malnutrition* was identified as one of the major challenges facing residents in care homes. According to the research finding, food is the 'highlight of the day' for many people in care homes and a measure of the overall quality of the service. Between 19 and 30 per cent of all people admitted to hospitals, care homes or mental health units are at risk of malnutrition (BAPEN, 2007).

Lack of social inclusion: People in residential care and their relatives often complain of lack of stimulation, activity, opportunities for social interaction, including sexual relationships, and community participation. The results of inactivity and social isolation could be experienced as harmful and abusive by individuals and could have a negative effect on mental health and general wellbeing (Cass, 2012).

Institutional abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfillment of adults at risk (SCIE, 2010). For example, people being forced to eat or go to bed at a particular time can be experienced as abuse. The culture of the organisation may promote

institutionalised care and may cause 'the practices of well-intentioned staff to deteriorate. It may also allow intentional abuse to go unreported (Marsland, Oakes & White, 2007).

Physical abuse between residents in care homes often have to deal with altercations and abuse between residents, some of which entail physical attacks. This could be the result of tensions between people living in close proximity and may also be caused or worsened by misunderstandings due to dementia, learning disability, or mental health problems. Some instances of challenging behaviour may be due to poor relationships with, and poor management of residents. Training in managing challenging behaviour, appropriate restraint and de-escalating situations is important (Cass, 2012).

Financial abuse: A study into the abuse of older people in the UK by O'Keeffe et al. (2007) found that financial abuse is the second most prevalent type of mistreatment after neglect. According to DH (2000), financial abuse includes theft, fraud, exploitation, pressure in connection with wills property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. Older people particularly, people with dementia are among those at greatest risk of financial abuse. Indications are that 60–80 per cent of financial abuse against older people takes place in the home and 15–20 per cent in residential care (Help the Aged, 2008).

People in care homes may be better protected than those who are isolated or living alone. For instance, they may be less likely to be targeted by rogue traders or telesales fraud, but there are different risks of financial abuse for this group. Some residents will have little or no control over their own money and are reliant on relatives or the home to safeguard their finances (Cass, 2012).

Choice of service: From the perspective of people using services, it is clear that as long as there is a lack of choice and alternatives in service provision, poor services will continue

to operate. There are many reasons why people may use services that are poor including lack of alternatives, affordability, location, choice and pressure from family members. With real choice, individuals would choose not to use poorer services and such services would consequently have to improve or go out of business. This is a key point for administrators as they must, where the market has failed, encourage variety and flexibility in provision to promote quality, choice and control for individuals. This in turn will reduce the risk of abuse, neglect, and harm (Cass, 2012).

Dehumanisation: People using care services often report the experience of being treated in a way that is 'less than human' or 'dehumanising'. Research has examined the way in which workers can distance themselves from, and fail to show empathy towards the people they support. 'The tendency to view a patient as less than human has been identified with a need to defend oneself against the anxiety that their condition provokes' (Menzies, 1977). Wardhaugh and Wilding (1993) referred to the concept as 'neutralisation of moral concerns'. This can 'place residents beyond the bounds of normal acceptable behaviour which allows abusive behaviours to be justified and perceived as legitimate' (Marsland et al., 2007). This issue has been closely related to the concept of 'burnout'. Workers who feel that they put more into the job than they get out are more likely to detach themselves emotionally from their work (Thomas & Rose, 2009). Other studies also found that appropriate staffing levels and skill mix in residential care homes are critical to the quality of life of residents (Murphy, O'Shea, & Cooney, 2006).

2.11 Concept of Quality of Life or Wellbeing

Care homes exist to facilitate the quality of life of the aged. Interest in quality of life has existed for centuries across different cultures. Early references can be traced back to Aristotle's writings on 'the good life' and the idea that this can be achieved by man leading a life of virtue and fulfilling his capacity for rational action (Smith, 2000). George

and Bearon (1980) deem quality of life to be the modern counterpart of ‘the good life’. A Scottish philosopher, John Seth, stressed the importance of considering the quality of the life as well as the quantity, and viewed this as a moral end towards which mankind could aim (Smith, 2000). The term ‘quality of life’ only came into popular usage in the 1950s and 60s following World War Two and the consequent post-war economic boom (Bond, & Corner, 2004; Smith, 2000).

The term ‘well-being’ is widely used in the research literature, often interchangeably with ‘quality of life’ and sometimes with ‘life satisfaction’, but often without any attempt at a definition. Where definitions are discussed, they tend to focus on four aspects of lifestyle: physical, emotional, social and financial. Discussions of social well-being in the literature tend to focus on factors such as social relations, social interaction, relationships, friendship networks and social support (Evans & Vallely, 2007)

In this study the researcher adopted World Health Organisation’s definition of quality of life:

as Individuals perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment (WHO, 1997, P.1).

While measurement initially focused on objective indicators such as material possessions, it was soon realised that these were inadequate for fully understanding and explaining the concept. Therefore, subjective measures such as the individual’s sense of well-being, happiness and satisfaction with life began to be taken into account (Smith, 2000; Farquhar, 1995). While health-related quality of life has been the most common measure of quality

of life in nursing homes, it is also important to take account of a wider concept of quality of life. Concepts such as self-esteem, sense of self and identity, sense of control and spiritual well-being have been largely ignored in the measurement of quality of life of older people in healthcare settings, which have tended to focus on narrow, medically orientated definitions of health (Bond & Corner, 2004).

2.12 Need for Care Homes

Age Concern (2006) identifies five key areas that influence the need of care homes for the aged. These include discrimination, participation in meaningful activity, physical health, poverty and relationships (family, friends, pets, spiritual faith and belief). In addition, social isolation (absence of meaningful relationships, lack of social contacts) is identified as a strong risk factor for poor mental health, which is experienced by a million older people in the UK. This study also intends to emphasise the importance of intergenerational contact in the Ghanaian context and identifies the need to encourage and support older people to take advantage of opportunities for meaningful activity, social interaction and physical activity.

In its analysis of the demand for home-based care services, the National Economic and Social Forum (NESF) highlight the strength of older people's preference for home care. They conclude that older people are very positive about home care services because it helps to reduce their stress and enhances their quality of life (NESF, 2009). NESF (2005)'s study found that quality of life in residential care home is enhanced if: residents are encouraged and facilitated to retain previous interests; residents are enabled to maintain contact links to the community; they have social networks and family; residents have meaningful relationships with those around them; and continuity of staff is developed and maintained.

The qualitative study by O'Connor & Thompstone (1986) in a representative random sample of twenty care homes that almost three quarters of residents were contented living in a care home while just over a quarter were unhappy or felt isolated. More women than men reported feelings of happiness or contentment. The residents reported that the best features of living in a home were the security and protection it provided and that the residents' day-to-day needs were looked after leaving residents free to enjoy their retirement. Negative aspects of living in a care home cited by residents included a lack of 'real home life', loss of friendships and loss of control over daily aspects of their lives.

The findings of these studies will guide the researcher to assess the factors that influence the wellbeing of the aged, the kind of services provided by care homes that make their patrons happy as well as the negative aspects of living in care homes in Ghana.

Studies in different dimensions have suggested that positive indicators of social relationship are more important to "older" than "younger" people. For instance, Matt and Dean (1993) found that more friend support leads to less psychological distress for old-old (71+ years) than young-old (50-70) community residents. Krause (2005) found that the stress-buffering effect of social support is more evident with advancing age, with the oldest-old benefiting the most from informal emotional support. Pinquart and Sorensen (2000) compared studies with a younger (55-70) versus an older (70+) mean age and found that both quality and quantity of social interactions become more important for subjective well-being with higher ages.

Furthermore, psychological and physical health has been widely studied in relation to social support (Cohen & Wills, 1985). Studies examining measures of well-being (e.g. depression, overall happiness, life satisfaction) have concluded that social support is emotionally beneficial. Further, a relationship between supportive social networks and

physical health is also well documented while the relationship between support and well-being is likely reciprocal, in that people who are healthy and happy may elicit positive social relations. A growing number of longitudinal studies support the concept that positive social networks lead to increased well-being and health (Seeman et al., 1995; Eaton, 1978).

Lydia and Liang (2012) examine social and subjective well-being among older Chinese. The sample consisted of 2,943 Chinese elders aged 60 to 94 years old. Structural equation modeling's results suggest that social support have significant contributions to life satisfaction of the aged. Another finding from the study is that it provides some evidence that social exchanges, both positive and negative, may take on greater meaning as older adults enter advanced old age. In the case of older Chinese, it has been shown that the old-old are more financially dependent, have fewer social ties, and are less likely to reciprocate support than the young-old (Liang et al., 1992).

Similarly, Garms-Homolová et al. (2012) found that social support has a strong impact on individuals, not only on older individuals with health problems. A lack of support network and poor family or social relations may be crucial in later life, and represent risk factors for elder abuse. Care homes based on the literature can play a significant role in improving the quality of life of the older people by offering them opportunity to belong to a social net and others with their peers. However, most of the above studies were conducted in foreign countries. Majority also focused on care homes provided by state institutions.

2.13 The State of Care Homes for the Elderly in Africa

According to Van der Geest (2002), in Ghana formally organized professional care for the elderly does not exist. The only facilities available in Accra and perhaps a few other

places, are day care centers where elderly people can meet each other, pass the time with games and other activities and receive a good meal.

In the views of Ajomale (2007), the lack of state provision of eldercare in Nigeria requires the family to provide the needs for the survival of the older people. Family members provide food, shelter, clothing, drugs and other basic necessities. The Nigerian government and political leaders believe that the provision of care is the responsibility of families. Policy emphasis is more on young people, women and children.

NGOs and faith-based organizations such as the African Gerontological Society, AGES Nigeria, the Catholic Church, and the Sorophormist Society are examples of organizations in Nigeria that make effective contributions to the service provision to older people through day-care centres, residential homes, libraries, regular medical check-up's, creating a forum for raising the awareness on older people's rights and avenues to seek redress when necessary (Ajomale, 2007). In Nigeria there are ten residential care homes facing an elderly population of over 5 million. The standard in these care homes is inadequate. Some of these homes are hospices where young people with terminal diseases or babies with life threatening diseases are also kept (Ajomale, 2007).

2.14 Living Arrangement for the Aged and the Need for Care Homes in Ghana

The process of ageing is taking place in an era in which the traditional systems that support elderly care have been transformed by the processes of modernization and globalization and in the absence of public welfare systems. Sub-Saharan African countries have not made enough economic progress before population ageing sets in (Ghana Statistical Service, 2013). Living arrangements are important to the health and well-being of the elderly. This is because the household is a major factor in determining social roles by providing support and interactions (or not) to older adults (Waite & Hughes, 1999).

In Japan, older adults with more children are less likely to live solely with their spouse but are more likely to live with an unmarried child. Japanese elderly with children nearby are less likely to live with a spouse only (Brown & Liang, 2002). In China, a study by Sereny (2009), it was shown that 60.42% of the elderly preferred to live with their children, 26.47% preferred to live alone (or with spouse) and children living nearby, 9.46% preferred to live alone (or with spouse), regardless of residential distance of children, and few (3.64%) preferred to live in institutions. The study further showed, 64.12% of the elderly actually live with their children, 21.62% actually live with alone (or with spouse) and children living nearby, 9.62% actually live alone (or with spouse), children are not nearby, 2.70% actually live in institutions and 1.94% indicated other living arrangements.

A study by Mba (2013) showed that about 12 per cent of the aged live alone, while women are more likely to live alone than men (14% versus 9%) in Ghana. Living alone among women is mainly due to widowhood as their husbands generally often die earlier than wives (Mba, 2009). This is consistent with the finding that women live longer than men globally (United Nations, 2011). However, this is not due to economic demand for privacy as is the case in the developed countries (United Nations, 1991).

The living arrangements of the elderly should therefore be examined within the context of changing traditional practices that may explain the tendency for old people to live on their own or in non-extended family units.

Generally, nucleation of the family may require that persons attaining older ages live with their children or spouse(s) but not with extended family members that they have not lived with before attaining older ages. Presently, the inability of many families to build their own house or purchase from an estate company means that renting of housing units has become a major characteristics of the life of older

people and their families. The problem of not saving towards acquiring houses for themselves mean that the elderly will also spend their old age with their children or other relatives (Ghana Statistical Service, 2013, p.73).

According to the 2010 Population and Housing Census Report, most of the elderly live in a dwelling owned by a household member (not necessarily the elderly) and almost a fifth resides in houses that are owned by a relative. Ownership of house is quite low among the elderly, considering that the elderly are expected to have their own houses and command some respect accordingly. The young old, especially have the lowest proportion that owns a house. A high “proportion of the elderly resides in dwellings, particularly compound houses, with limited access to sanitation facilities and amenities. As high as 22 percent of them have no access to a toilet facility and 34 percent use public toilet facility” (Ghana Statistical Service, 2013, p.vi).

Most elderly persons live with their extended family or their siblings. They are then part of the family of a relative (Dsane, 2010). By this type of living arrangements, the elderly receive support and care from their family members and others. Traditionally, it is expected that elderly people are cared for or reciprocated for all the care they gave to their children and others during earlier stages of their life. Consequently, public sector policies neglect the aged. Human development policies fail to address their needs adequately. Meanwhile, the support given to the elderly by their adult children and extended families has dwindled over the years (Dsane, 2010, Apt, 2002). The problems associated with the life of the elderly range from neglect to poverty and poor health as well as lack of or limited access to social infrastructure, housing and amenities (Obiri-Yeboah, 2000). Sackey’s (2009) study in Cape Coast and Dsane’s (2010) in Teshie, a suburb of Accra indicate that non-family sources of care for the elderly are emerging as a result of the

inability of children and extended family members to care for their elderly parents and relatives (Apt, 2000)

According to the above researchers, domestic care workers and nurses provide care for some elderly persons in Ghana. This is because family obligations and occupational demands do not permit the children and relatives of the elderly to meet the moral duty of caring for the aged. Migration, especially the children living outside Ghana, has also rendered co-residence of the elderly with their children impossible in some cases. Consequently, an industry of care with workers from the labour market has been gradually emerging in response to these dynamics of inter-generational relationship (GSS, 2013). This study, therefore, would examine how the services of private care homes influence the quality of life of the age people in Accra, the challenges the aged faced in private care homes in Accra as well as the challenges that private care homes face in providing support for the aged in Accra.



CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter details the method adopted to conduct the study. It consists of research approach, research design, population of the study, sampling technique and sample size, instrumentation, data collection procedure, data analyses, validity and reliability, and ethical considerations.

3.1 Research Approach

This study adopted the mixed research approach, thus, the qualitative and quantitative methods. Because quantitative data cannot provide in-depth analysis, qualitative research covers this weakness (Johnson, Onwuegbuzie & Turner, 2007). The two approaches when put together enabled the researcher to enhance the validity of the study's findings compared to one alone.

3.2 Research design

According to Creswell (2009, p. 3), research design is described as the “plans and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis”. This study sought to investigate the role of Private Care Homes in supporting the aged in Accra. In order to achieve the purpose of this research, the study used a cross sectional survey design. According to Boateng (2014, p.23), cross-sectional study is a study in which “a researcher collects information from a sample drawn from a population. The data the researcher obtains is derived from a cross-section of the population at one point in time”. The cross-sectional survey design helped the researcher to collect data from the research participants at one point in time.

3.3 Sources of data

The data were collected from mainly primary sources. Ahiawodzi (2011, p.2) describes primary data as a data that is “collected at firsthand in order to satisfy the purposes of a particular statistical enquiry”. According to him, primary data are collected by the researcher himself. He knows the conditions under which they were collected. Therefore, the researcher is aware of any limitations it may contain. The researcher used questionnaire and interview guide to collect firsthand information from the managers or workers and residents of care homes in Accra. The researcher did not conduct secondary research because Babbie (2008) maintained that the secondary research involves the recurrent question of validity. When one researcher collects data for one particular purpose, one has no assurance that those data will be appropriate for the new researcher’s interests.

3.4 Population and Sampling

The population of interest for this study is defined as all managers of Private Care Homes and the aged in Accra, specifically, Sakumono, Adenta, Osu and Dzorwulu. The sample size for this study was thirty-four (34). Thirty aged and four managers or workers were selected. They were conveniently and purposively selected for inclusion in the study. There were three private care homes and one non-governmental organisation that specialize in aged issues in the study area. These four organisations were interviewed and thirty aged people in these environs completed the research questionnaire. In Ghana, retirement age is 60 years although the retiree at such an age may be able to perform economic and other activities. Accordingly, in the present study, those aged 60years and above are included in the population classified as elderly. About 96.7 percent could also read and understand. Majority was mostly neat and calm but most of them were not quite

healthy. This issue of health of the aged really compelled the researcher to settle for a relatively smaller sample size.

Since each of the above towns has only one institution for the aged, all the directors for these aged institutions were selected by census sampling method. Census sampling method is where all the elements of a particular target group are selected to participate in the study, especially when their numbers is relatively small. Also, as already discussed, care home staff and managers often have a high workload; therefore, participating in research may not be prioritised. Hence, gaining a random or 'representative' sample of care homes for a survey or to precede more in-depth research could be challenging. Thus, it could be difficult to recruit care homes for research works. Consequently, the approach adopted is often to use a convenience sample set within a particular sampling frame (Kydd, 2008; Luff, 2008).

3.5 Instrumentation

The study employed a semi-structured questionnaire as the research instrument to collect the required data for the study. The questionnaire consisted of only closed ended questions in two sections. Section 'A' gathered data on participants' demographic variables such as age, gender, among others. Section 'B' collected data on the challenges residents face in private care homes. The instrument was developed by the researcher from the literature review with inputs from the study's supervisor. The research participants were required to indicate their level of agreement or disagreement with the statements that sought to ascertain challenges facing the aged in private care homes by ticking 1= Yes; 2 = No and 3 =Not sure. Sample items included: *Institutional abuse (eg. people being forced to eat or go to bed at a particular time); Lack of social inclusion, just to cite few.*

The study also employed interview in collection of the data. According to some researchers, the interview, whether structured or unstructured, locates a participant and

their divulged experience at centre stage (Bowling, 2009). An unquestionable strength of the interview as a research method is the mechanism it provides to hear the direct testimony of participants (Gubrium & Holstein, 2002). Sample interview questions included: *What major products or services do Private Care Homes offer in support of the aged people? In your opinion do these services have any impact on the general wellbeing of the aged people? What challenges do Private Care Homes face in their quest to provide services in support of the aged ones?*

3.6 Data Collection Procedure

The researcher sought permission from the directors of the homes to enable her use the homes for only data collection. The questionnaires were delivered by hand to the participants for self-administration. A follow-up call was made after five days of the distribution to remind the participants on the completion of the questionnaire. This was intended to facilitate the data collection process and to increase the response rate.

3.7 Data Analysis

The data collected were analysed in the light of the literature reviews and the objective of the study. With the aid of Statistical Package for Social Science (SPSS) software, descriptive statistics such as frequencies and percentages were employed to analyse the demographic data of the employees who were selected for inclusion in the study. The data collected using questionnaires were coded into the SPSS software to facilitate the analysis. The use of percentages and frequencies assisted the researcher to clearly represent true data characteristic and findings with a great deal of accuracy devoid of subjectivity.

The study also used thematic analysis to analyse the qualitative data collected using the interview guide. In its broadest form, thematic analysis is a categorizing strategy for qualitative data. Thematic analysis identifies, analyses, and reports patterns and themes within the research data with no set specific guidelines. Holloway and Todres (2003)

argue that thematic analysis should be viewed as a foundation method, and it should be the first qualitative analytical method that researchers learn when trying to tackle extremely diverse and complex qualitative research approaches and qualitative data for the first time. One of the primary benefits of thematic analysis is its flexibility, which comes from not being theoretically bound, limited, or constrained. Consequently, thematic analysis becomes a useful, flexible research tool that has the potential to provide ‘a rich and detailed, yet complex, account of data’ if undertaken properly (Braun & Clarke, 2006, p.78).

The researcher followed the six thematic analysis procedures described by Braun and Clark’s (2006) which are: 1) get familiar with the data, 2) generate initial codes, 3) search for themes, 4) review themes, 5) define and name themes, and 6) produce the results. The researcher read through the data several times to get familiar with the data, and to also assist in the definition and categorization of the themes that emerged from the data, as well as to presents the findings. The researcher identified various themes which have strong relationship to the study objectives or the research questions. These themes are presented under their relevant research objectives.

3.8 Ethical Considerations

The researcher encouraged voluntary participation of the respondents and also ensured that the respondents’ rights to be informed, right to privacy and right to choose was respected by maintaining confidentiality of all the information given to aid this study. This was done by ensuring that their names and other forms of identification were excluded from the data collection and the purpose of the study clearly explained to the participants.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the results of the study and also discusses the findings of the research.

4.2 Profile of the Research Participants

4.2.1 Demographic Analysis of the Aged in Care Homes

This section describes the demographic characteristics of the respondents who took part in the quantitative aspect of this study. Thirty (30) aged people completed the researcher questionnaire.

Gender Distribution of the Research Participants

To start with gender, Figure 4.1 illustrated the gender distribution of the research participants. From the figure, majority of the participants were females (63.3%) and some males (36.7%).

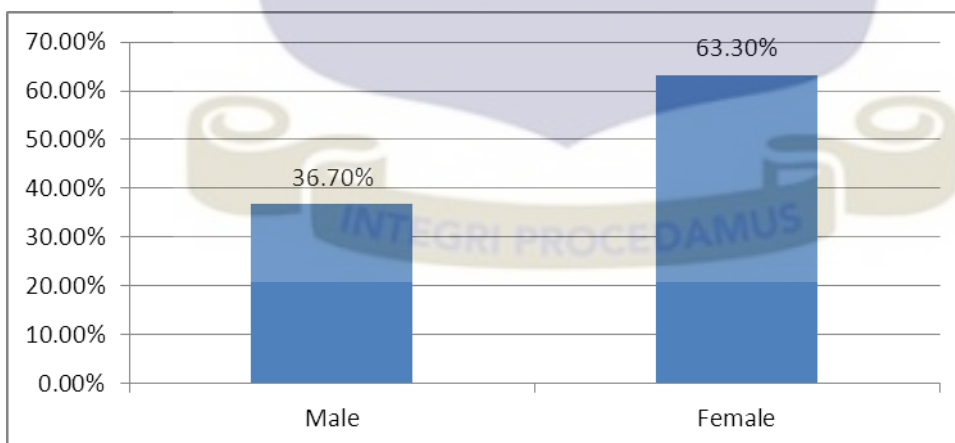


Figure 4.7 Gender Distributions of the Research Participants

Source: Field survey (2015)

Educational Levels of the Respondents

Figure 4.2 below shows the educational levels of the research respondents. As shown in the figure, more than half (66.7%) of the respondents had tertiary education, some (30%) had secondary education, but few (3.3%) did not indicate their levels of education.

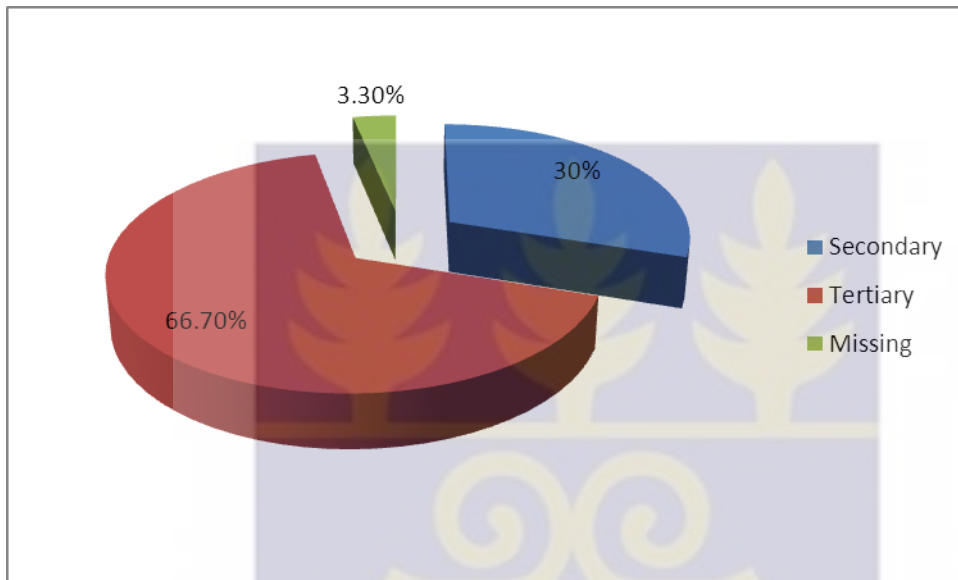


Figure 4.8: Educational Levels of the Respondents

Source: Field survey (2015)

Participants' Age Distribution

The Figure 4.3 below shows the age distribution of the research participants. As shown in the figure, most (70%) of the participants were within 60-69 years age category, some (26.7%) were within 70-79 years age group, and a few (3.3%) were within 80-89 years age category.

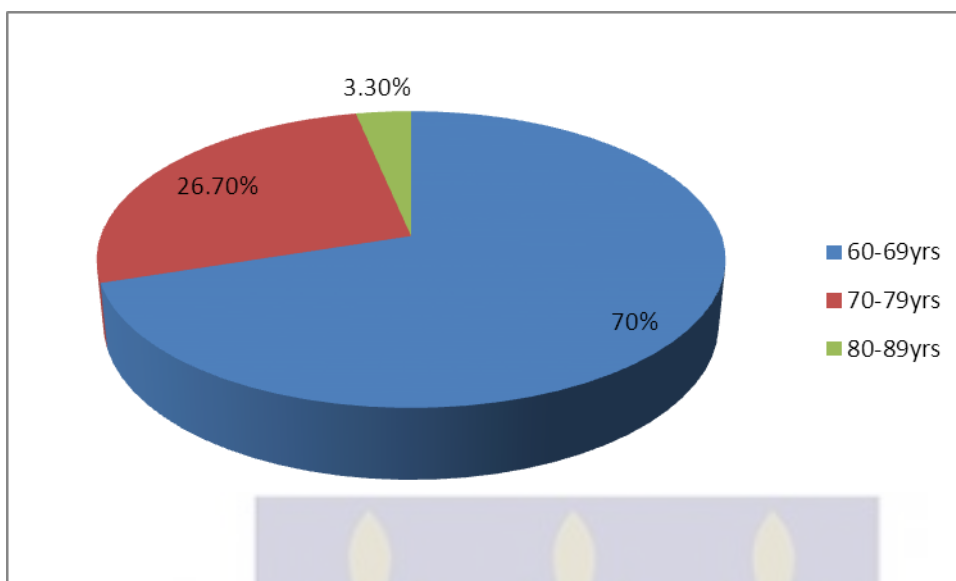


Figure 4.9: Participants' Age Distribution

Source: Field Survey (2015)

Marital Status of participants

The Figure 4.4 illustrates the marital status of the research participants. From the figure, more than half (53.3%) of the participants were married 16.7% were singles, 13.3% divorced, 3.3% were separated, and few (6.7%) did not indicate their marital status.

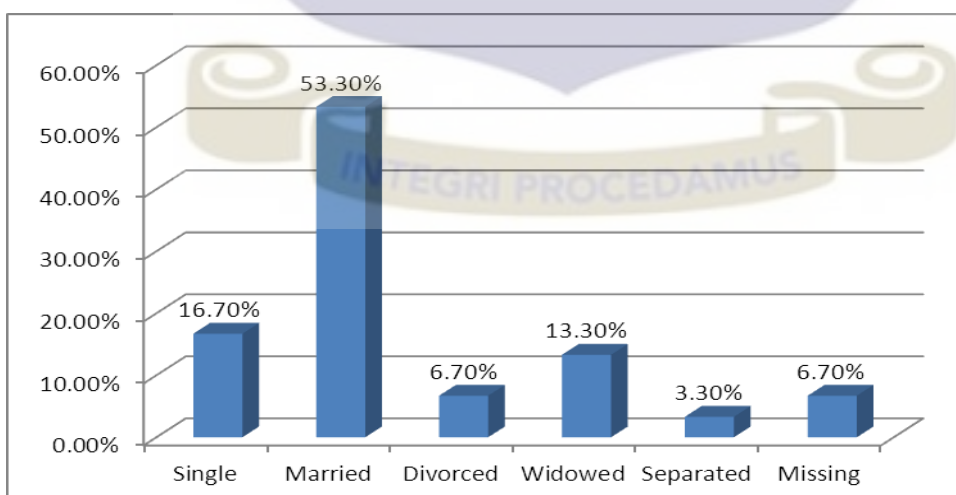


Figure 4.10: Marital Status of the Research Participants

Source: Field survey (2013)

Research Participants' Position

The position of the research participants were illustrated in Figure 4.5. From the figure below, more than half (56.7%) of the participants were senior officers, some (23.3%) were executive officers, and few (20%) were junior officers.

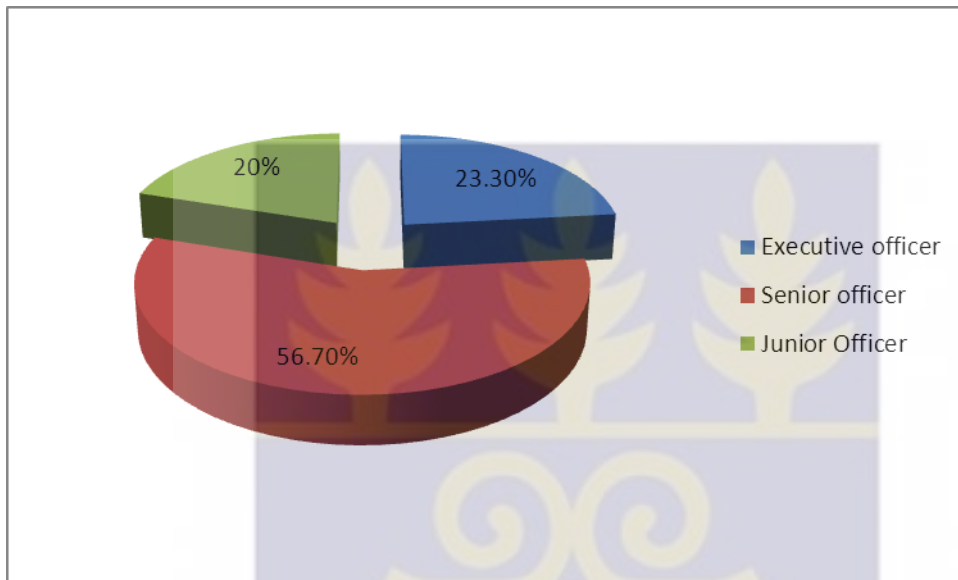


Figure 4.11: Research Participants' Position

Source: Field survey (2015)

Participants' Work Experience

In terms of work experience, more than half (53.3%) worked for about 21-30 years, some (43.3%) worked for about 31-40 years, and few (3.3%) worked for about 11-20 years.

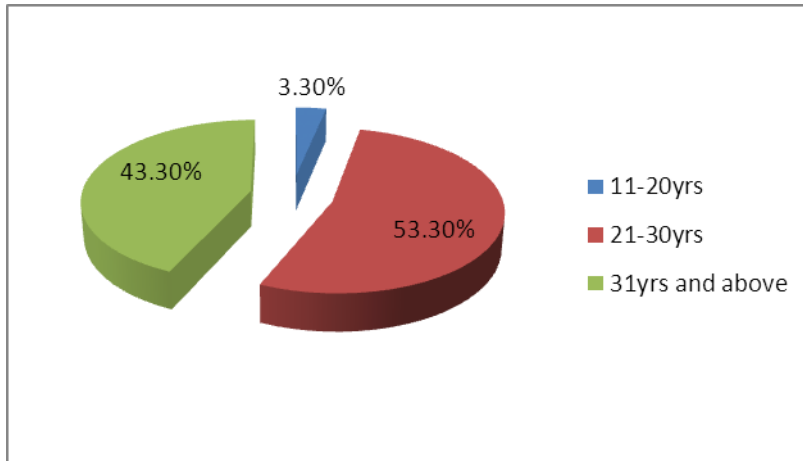


Figure 4.12: Research Participants' Work Experience

Source: Field survey (2015)

4.2.2 Profile Summary of Managers/Workers of Care Homes Interviewed

Table 4.1 below showed the demographic details of the managers or owners of Care Homes and Help Age Ghana. From the table, most (75%) of the respondents were females and a few (25%) were males. In terms of age distribution, half (50%) of the research participants were 40-50 years old and the rest (50%) were 60-70 years old. Also, all (100%) the participants had tertiary education. Finally, in terms of work experience, half (50%) had 1-10 years work experience, and 25% each had 21-30 and 31-40 years of work experience respectively.

Table 4.1: Demographic Analysis of the Aged in Care Homes

Demographic Detail	Frequency	Percentage (%)	N
Gender:			
Male	1	25	
Female	3	75	4
Age:			
40-50	2	50	
60-70	2	50	4
Educational Level:			
Tertiary Level	4	100	4
Work Experience:			
1-10	2	50	
21-30	1	25	
31 – 40	1	25	4

Source: Field survey (2015)

4.3 Services of Private Care Homes

The first objective sought to ascertain services private care homes provide to support the aged people in Accra. In order to achieve this, the interview responses from the managers or workers of the sampled Private Care Homes were analysed. From the results, Private Care Homes provide their patrons services ranging from training in care for the elderly, medical services for people with medical conditions like hypertension, diabetes and mild stroke, social services and other home related services for aged people who do not have anybody to cater for them. Private Care Homes especially, day care centres also provide recreational services and also afford the elderly the opportunity to change their environments.

Ma Mere Nursing Services, Adenta

Ma Mere Nursing Services at Adenta provide medical services, social care for the aged. The Home also trained people to cater for the aged. The officials visit some of the aged in their homes, some come to the home, and few reside in the Home.

According to a 64 year old retired Principal Nursing Officer who owns and manages Ma Mere Nursing Services at Adenta:

Initially the Home used to provide services in training people to cater for children with special need and also the elderly, but the child care services was not well patronized; so I decided to concentrate on the care for the aged since private care homes is not common in our society. My home gives training to Senior High School graduates to deliver physical healthcare services to the aged in their homes at a fee. Some of our clients have medical conditions and need special attention. Others also need just social care i.e. someone to be around them to give them some assistance as and when they need help. Also most aged people have health conditions which need special care; therefore there is the need for trained people to take care of them. The home, however, can take in only 4 aged persons at a time if they request to stay on our premises but basically we deliver home services to our clients (Interview, June 15 2015).

Mercy Care Home Centre, Sakumono

Mercy Care Home Centre at Sakumono provides 24 hours home care services to the aged as well as medical services to those with medical conditions. Some aged are housed in the Home and others come to the Centre daily to have access to the services that the Home provides.

Also 67 years old retired Senior Officer from the formal health sector of one the private care homes said:

We provide 24 hours home care to the aged whose family cannot give them the required care they need. We have nurses here who attend to their health needs since most of them have various health conditions like hypertension, diabetes and mild stroke, but then in critical situations we send them to the hospital for proper care and their families pay the bills (Interview, June 15 2015).

Ark Lifestyle Lounge, Dzorwulu

Unlike the above mentioned care homes, Ark Lifestyle Lounge at Dzorwulu provide its patron with only recreational services. Their services do not include medical and training services. They do not house their patrons. As a result, the aged commute daily to and from the Centre.

The Administrator of Ark Lifestyle Lounge remarked that:

We are a Social centre for the elderly and we take in elderly people from age 65 and above to come to this centre for recreation and for a change of environment (Interview, June 26 2015).

4.4 Factors Accounting for the Demand for Private Care Homes for the Aged

It was found at Mercy Care Home Centre at Sakumono that reasons why some aged people patronage services of private care homes are due to the busy schedule of their children and the realities associated with modernisation. Some elderly are also sent to private care homes because their children who are overseas and who feel their parents are not getting required support from family members.

A 67 year old retired Senior Officer from the formal health sector of Mercy Care Home Centre at Sakumono explained that:

Most of the residents here have their children living abroad and therefore no one to cater for them. Others also are here because their children feel they are not getting the required attention from family members. Therefore, they prefer their parents to be in our care rather than family members. Also some of our residents have their children living here in Ghana, but their busy schedules and lifestyle that come with modern living do not allow them to take care of their parents; thus, prefer them to be at a home like this (Interview, June 15 2015).

At Ark Lifestyle Lounge, it was found that the aged who like to have recreation but cannot cope with stress that comes with commuting to and fro the Centre rather prefers residential facilities. Thus, aged people also demand for Private Care Homes because of their need for recreation.

The Administrator explains that

People requesting for residential facility (in the homes) have their reason as finding it stressful coming through traffic every morning to the centre; therefore they prefer if they could stay at the centre, but then we don't have provision for a residential facility (Interview, June 26 2015)

4.5 Challenges Private Cares Homes Face: Interview Response Analysis

Private Care Homes face numerous challenges. These challenges include lack or inadequate specialist staff such as Geriatric doctor and/or nurse for providing specialist care to the aged, financial constraints, passion for caring for the aged as well as lack of policy or legal framework to access and run such private care homes in Ghana. It thus,

emerges that providing effective care for the aged required adequate financial support, workers who are well-trained and also have passion to provide care services to the aged.

Also, the absence of a policy or legal framework is a challenge with respect to the establishment, management, certification of aged caregivers, among others. In addition, another challenge facing the Private Care Homes is that patronage of their services is low since many Ghanaians are yet to embrace the concept of taking care of the elderly away from their homes.

At Ma Mere Nursing Services it was found that their major challenges were inadequate specialist staff such as Geriatric doctors and nurses and financial constraints.

In the views of a 64 year old retired Principal Nursing Officer of one of Ma Mere Nursing Services,

Ghana as a country does not have any Geriatric doctor and/or nurse who is/are specialist(s) in caring for aged people who are part of the vulnerable group in our society. Our society has not paid attention to institutionalised care for the aged like we have children's hospital for children and antenatal clinics for pregnant women. Aged people have to be attended to by general medical practitioners which should not have been the situation – they are therefore, put on adult medication, but that is wrong. Aged people are not everyday adults; they are a special group with special needs and must be treated as such. People like I am who is offering care services for the aged is doing it as a result of my passion toward the aged and not because I have a formalised training in caring for the aged. So with my experience as a nurse I am able to combine my passion and experience to provide the services (Interview, June 15 2015).

In terms of cost, the respondent disclosed that:

Financially, at the moment, the fee for 8hours care is between 500 and 600cedis and also between 800 and 900cedis for 10hours care services and theses charges could escalate depending on the number of hours that care is given (Interview, June 15 2015).

Challenges at Mercy Home Care Centre were not different from those that pertain at Ma Mere Nursing Services. They face financial challenges as well as recruiting staff who are committed, dictated and passionate about providing services to the aged in the home.

A 67 year old retired Senior Officer from the formal health sector of Mercy Home Care Centre had the following to say:

Well to me the main challenge is financial support for the home. It involves a lot of money and time to give these old men and women the support they need and if money is not forthcoming it is a problem to us. For now the proprietor of this Centre remits the Centre from time to time, but then we also charge the residents for their upkeep. One also needs a lot of passion for this kind of work since it requires a lot of patience to understand these old people. We charge 500 Ghana cedis per resident and this amount caters for their feeding and lodging. However, for those who use adult diapers, their families are required to provide their diapers; we do not provide the diapers since it is a bit expensive and looking at how much we charge it would be a big drain on our finances” (Interview, June 18 2015).

Also, Ark Lifestyle Lounge their concern was low patronage of the services that Home provides. This low demand is as a result of the fact the idea of caring for the aged by a private organisation away from home is new in Ghana, and many are yet to realise it values.

In the opinion of the Director of Ark Lifestyle Lounge:

The concept of housing the elderly is quite new to our society so the response to the centre is a bit slow since our society is now beginning to accept the idea of moving elderly people from their homes to a centre for care. Nevertheless, I believe society would gradually come to accept the idea just like we have now accepted the idea of taking babies to the crèche, which was not a part of us in the past (Interview, June 26 2015).

The challenges that confront Care Homes in Ghana from the perspective of HELPAGE are rather numerous. It goes beyond financial challenges to poor policy environment, absence of standards guiding, training, and administration and management of these homes for the aged. Absence of regulations has serious implications for the owners and administrators in respect of their liabilities.

According to the Director of HELPAGE:

Our policy environment is rather poor particularly, with reference to Private Care Homes like the ones you have visited. There are no standards and policies guiding the setting up of these Care Homes. They are using their own initiatives. There is no policy reference or even legal reference to access and run such Homes. There are absolutely no policies so there is that total gap which has led to people doing their own things. There are also no legal undertakings and this has serious implications. Nonetheless, we now have a few training centres, but who determines their syllabus. There are no set standards for even these training centres. Who trains who and what certificates are required for those who run these homes and those who take care of these older people? What qualifies who to run a home (Interview, June 18 2015).

4.6 Challenges the Aged face in Private Care Homes: Analysis of Responses from Questionnaires

The following shows the research findings regarding challenges the aged are confronted with in care homes.

Table 4.2 illustrates the research participants' view regarding whether social inclusion is a problem older people in care homes would face. As shown in the table, half (50%) are of the views that aged people in care homes face the problem of social inclusion, some (26.7%) said it is not a problem, and few (23.3%) were not sure whether social inclusion would be a problem to older people in care homes. From this result, it could be concluded that aged people in care homes face social inclusion problems.

Table 4.2: Challenges of Social Inclusion

Response	Frequency	Percentage
Yes	15	50
No	8	26.7
Not Sure	7	23.3
Total	30	100

Source: Field survey (2015)

Table 4.2 below, shows the research participants' opinion on whether aged ones face institutional abuses in Private Care Homes. More than half (60%) of the participants indicated 'yes', some (20%) said 'No' and others were unsure. It could therefore, be argued based on this finding that older people in care homes face institutional abuse in the form of being forced to eat or go to bed at a particular time.

Table 4.3: Institutional Abuse

Response	Frequency	Percentage
Yes	18	60
No	6	20
Not Sure	6	20
Total	30	100

Source: Field survey (2015)

The study also sought to determine whether physical abuse between residents in care homes exists. As shown in Table 4.3, majority (43.3%) of the research participants said such a problem does not exist, some (40%) were not sure, and few (16.7%) said it is a challenge. Inferring from the results, it was concluded that physical abuse between residents in private care homes does not exist or pose problem to the older people who patronise the services of private care homes.

Table 4.4: Existence of Physical Abuse between Residents/inmates

Response	Frequency	Percentage
Yes	5	16.7
No	13	43.3
Not Sure	12	40
Total	30	100

Source: Field survey (2015)

More so, the study sought to ascertain whether financial challenges is a problem that aged people face when patronising private care home services. The results as illustrated in Table 4.4 below show that majority (46.7%) were of the views that aged people who

patronise the services of private care homes face financial challenges; some (33.3%) said ‘No’, while few (20%) were not sure. Based on this, it is inferred that aged people who patronise the services of private care homes face financial challenges.

Table 4.5: Financial Challenges

Response	Frequency	Percentage
Yes	14	46.7
No	10	33.3
Not sure	6	20
Total	30	100

Source: Field survey (2015)

Interview Response Analysis

Also, it was gathered from the interviews that aged people who patronage services of private care homes usually face financial difficulties, as the services provided by care homes are often expensive to continually access it.

A 64 year old retired Principal Nursing Officer of Ma Mere Nursing Services at Adenta identifies some of the challenges clients face is primarily financial.

The challenges for clients is mainly financial since our services are quite expensive to the average person, and therefore if the aged do not have rich children who can give them financial support then it would be difficult for them to access a service like ours although they may need it (Interview, June 13 2015).

Furthermore, in the opinion of a 67 years old retirement Senior Officer from the formal health sector of Mercy Care Home Centre:

Sometimes financial support is a problem. Some of the people brought here find it difficult to pay for our services since they are not working and therefore needs financial support from their families (Interview, June 18 2015).

In another Home, the Manager said “we charge 100cedis a day per person and this covers their food i.e. breakfast, lunch, supper” (Interview, June 26 2015).

Finally, the study sought to investigate whether lack of choice and alternatives in service provision was a problem older people who access services of care homes face. The results are illustrated on Table 4.5 below. As shown in the Table, more than half (56.7%) of the research participants said lack of choice is a problem for older people in care homes, but some (43.3%) were unsure. It is therefore concluded from this findings that lack of choice and alternatives in service provision is a challenge to older people in care homes.

Table 4.6: Lack of Choice

Response	Frequency	Percentage
Yes	17	56.7
No	0	0
Not Sure	13	43.3
Total	30	100

Source: Field survey (2015)

It was also gathered from the interviews that, “most of them have to be convinced to use a care centre since they feel they should be in their own homes” (Interview, June 26 2015).

4.7 The impact of Private Home care services on the Aged

The researcher further learnt from the interviews that the services provided by private care homes make their beneficiary happy. It also provided them opportunity to interact with others through games and picnics among others. The services of the care homes thus, make the elderly enjoy social inclusion and greater acceptance.

The 67 year old retirement Senior Officer from the formal health sector of Mercy Home Care Centre expressed her satisfaction of the impact of the home's services on their clients as:

We give them the best of care here so to me they are happy. Also we have not received any form of complain from any of the inmates or their children so I know they are happy being here (Interview, June 13 2015).

The Manager of Ark Lifestyle Lounge said

I have observed that most of them are cheerful when there are here. They interact with each other and get along. So to me that kind of interaction is good for them. We also take them out sometimes out of Accra but not too far from Accra for picnics where they play games both like monopoly, scrabble, ludo and 'oware' (Interview, June 26 2015).

4.8 Discussion of Results

4.8.1 Services Provided by Private Care Homes in Supporting the Aged in Accra

The first objective of this study sought to ascertain the services private care homes provide to support the aged people in Accra. The study found that Private Care Homes provide their patrons services ranging from training in care for the elderly, medical services people with medical conditions like hypertension, diabetes and mild stroke, social services and other home related services for aged people who do not have any body to cater for them.

Private Care Homes, especially, day care centres also provide recreational services and also affords elderly people the opportunity to change their environments.

These diverse services provided by Private Care Homes appeared to be in response to problems associated with old age. For instance, it is a general knowledge that the aged are exposed to various medical conditions. So by making medical services available to the aged in Ghana could imply that Private Care Homes are showing strong commitment to supporting aged people by making specialized medical services that meet their unique health needs. Similarly, the provision of recreational services to support aged has theoretical implications which consistent with the modernization theory. Due to modernization, many people have abandoned their aged in search of jobs and other opportunities in cities and towns. Also, the breakdown of the extended family system in favour of nuclear family is due to modernization. This could means that increasingly, many aged people are left alone with no companions to keep their company. Thus, by providing recreational services, Private Care Homes are determined to support many older people overcome loneliness by providing them with opportunities to socialize and consequently improve their overall wellbeing.

Furthermore, the existence of these different service packages provided by private care homes is consistent with the assertion by Laing and Buisson ((2002) that the care home market for older people is now characterised by differing care packages. The existence of these differing service packages could be as a result of the fact that aged needs holistic care to enhance their welfare.

4.8.2 Factors that Account for the Aged to Demand Home Care Services

The second objective also sought to determine the factors that account for the aged demanding home care services. It was found that reasons why some aged people patronise services of private care homes are due to the busy schedule of their children and the

realities associated with modernisation and urbanisation. Some are also sent to private care homes because their children feel their parents are not getting required support from family members. Others were neglected by their children.

These reasons could explain why Adamchak (1995); AGES (1995); Vatuk (1996) stated that traditional respect and caring structures are now facing substantial social challenge. These findings also seem to be in line with the findings of previous researchers or writers. For example, Mosamba (1984); Shuman (1991); Apt, (1996; 1992) maintained that much of the literature cite the modern nuclear family's inability to continue its care giving roles in the context of the current modernised urbanisation life, as women increasingly join the labour force.

Besides, these findings also supported Apt (n.d) assertion that there are economic and social factors that are bound to impact adversely on older persons during the current process of urbanisation and industrialisation occurring in the developing regions of the world, including Africa. In addition, the finding is also supported Apt (1991)'s findings that young families would not be living with their elders much longer.

4.8.3 Challenges that Private Care Homes face in Providing Quality Services for the Aged People

The third research objective sought to ascertain challenges that private care homes face in providing quality services for the aged people. The study found that Private Care Homes face numerous challenges. These challenges include lack or inadequate specialist staff such as Geriatric doctor and/or nurse for providing specialist care to the aged as well as committed or dedicated staff to provide services for aged people. This finding supported the findings of RCN (2011). This finding could be further explained by the fact that Care home is mainly a hands-on activity (Genet et al., 2012) and labour intensive and many of these institutions find it difficult to procure competent workers in sufficient numbers to

match the growing demand for care home services, as the population structure changes (Mestheneos & Triantafillou, 2005; Gibson, Gregory & Pandya, 2003).

It was also found that financial constraint is a major challenge that faces Private Care Homes. This is in line with the findings of Garms-Homolov et al. (2012) and RCN (2011) that most care homes are faced with non-availability of sufficient fund to run and provide quality service to its inmates. These financial constraints also tend to make care home services inaccessible to those who need such services. Similarly, the findings is consistent with the findings of TNS Opinion & Social (2007) which found that very high proportions of respondents believe that care home was not affordable.

Also, absence a policy or legal framework is a challenge with respect to the establishment, management, certification aged caregivers, among others. In addition, another challenge facing the Private Care Homes is that patronage of their services is low since many Ghanaians are yet to embrace the concept of taking care of the elderly away from their homes. This attitude to home care services might suggests that most aged ones would prefer to stay in their own homes and to have support services provided in a way that would allow them remain in their own homes and communities for as long as possible (Barry, 2010; NESF, 2009).

4.8.4 Challenges Aged People who Patronise the Services of Private Care Homes in Accra Face

The fourth objective sought to ascertain people's perceptions regarding the challenges aged people who patronise the services of private care homes might face. The study found that aged people in care homes often experience social inclusion problems. This supported the findings of Cass (2012) that people in residential care and their relatives often complain of lack of stimulation, activity, opportunities for social interaction, including

sexual relationships, and community participation. Another challenge aged people in Private Care Homes face is institutional abuse in the form of being forced to eat or go to bed at a particular time. According to Marsland et al. (2007), the culture of the organisation may promote institutionalised care and may cause 'the practices of well-intentioned staff to deteriorate. It may also allow deliberate abuse to go unreported

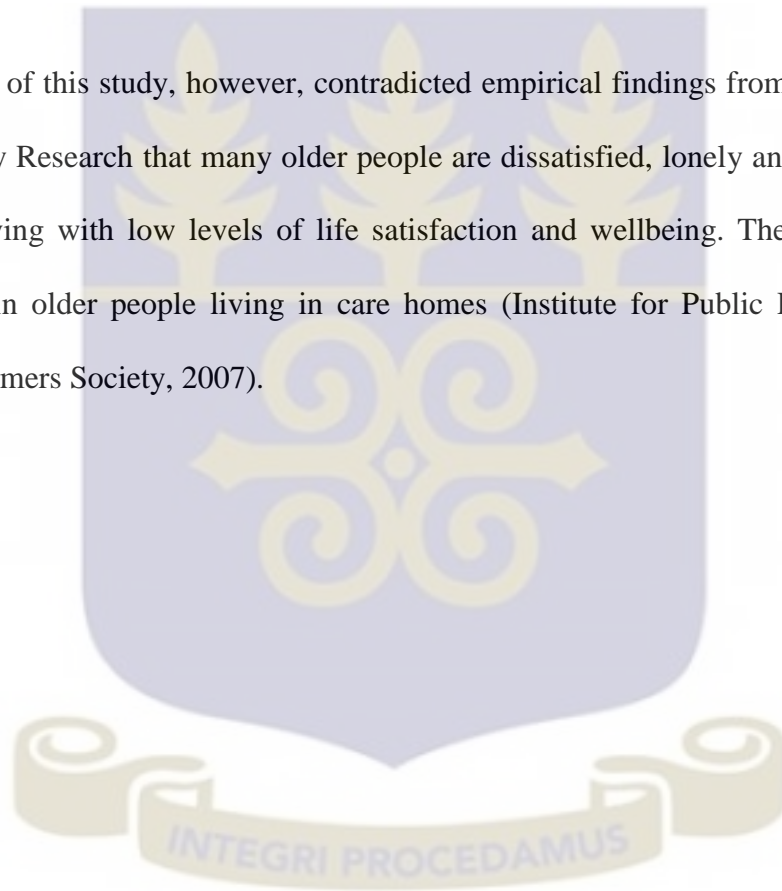
Also, a financial challenge was identified as a major challenge elderly people face in Private Care Homes. This could mean that some residents in care homes will have little or no control over their own money and are dependent on families or the home to safeguard their finances. The study further found that lack of choice and alternatives in service provision is challenge to older people in care homes. This result is consistent with the findings of Cass (2012). However, it was found that physical abuse among residents in private care homes would not exist does not pose problems to the older people who patronise the services of private care. This could be that the institutions have sufficient measures in place to prevent it from occurring.

4.8.5 Effect of Private Care Home Services on the Quality of Life or Wellbeing of Older People

The fifth objective of this study sought to assess the effect of private care home services on the quality of life or wellbeing of the older people. The study found that the services provided by private care homes make their beneficiary happy. It also provided them opportunity to interact with others in many ways. The services of the care homes thus, make the elderly enjoy social inclusion and greater acceptance. Thus, services of Private Care Homes impact on the wellbeing, especially, psychological or mental and health benefits of elder people.

This finding support earlier studies that services provided by private care homes have a beneficial impact on wellbeing, quality of life, morbidity and mortality (Age UK, 2011). Similarly, Garms-Homolová et al. (2012) found that social support has a strong impact on individuals, not only on older individuals with health problems. This impact on wellbeing could mean that Private Care Homes inspire and support older people by helping them take advantage of opportunities for meaningful activity, social interaction and physical activity (Age Concern, 2006).

The findings of this study, however, contradicted empirical findings from the Institute for Public Policy Research that many older people are dissatisfied, lonely and depressed, and many are living with low levels of life satisfaction and wellbeing. These problems are widespread in older people living in care homes (Institute for Public Policy Research, 2008; Alzheimers Society, 2007).



CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents summary of the research findings, conclusion and recommendations.

5.1 Summary

This study sought to investigate the role of Private Care Homes in supporting the aged in Accra. The study adopted a mixed research technique in the data collection and analysis. It also used a cross sectional survey design and largely gathered data from primary sources. The population of interest for this study was defined as all managers of Private Care Homes and the aged in Accra, specifically in Sakumono, Adenta, Osu and Dzorwulu. The sample size for this study was 34, and conveniently and purposively was selected for inclusion in the study. The data collected was analysed using thematic analysis, and descriptive statistics.

The following were the summary of the research findings:

First, Private Care Homes provide their patrons services extending from training in care for the elderly, medical services with people with medical conditions like hypertension, diabetes and mild stroke, social services and other home related services for aged people who need such services. There are also day care centers that provide recreational services, which also create opportunity for the elderly to change their environments.

Secondly, it was found that reasons why some aged people patronise services of private care homes are due to the busy schedule of their children and the variations associated with innovation or modernisation. Some are also sent to private care homes because their children believe their parents should have adequate care, while others were abandoned by their children.

Thirdly, Private Care Homes face numerous challenges. These challenges include lack or inadequate specialist staff such as Geriatric doctor and/or nurse for providing professional care to the aged, economic constraints, and devoted staff. It transpires that providing effective care for the aged required adequate financial support, as well as well-trained and passionate staff.

Again, seemingly nonexistence of a policy or legal structures is a challenge inter alia establishment, management, certification aged caregivers. Patronage of services is low since many Ghanaians are yet to grip the idea using care homes.

Fourthly, it can be established that aged people in care homes are likely to face social inclusion problems, and institutional abuse. Also, the aged people who benefit from services of private care homes are likely face financial difficulties, as the services provided by care homes are often expensive and may be deficient in choice and alternatives in service provision. Nonetheless, physical abuse will not exist and pose problem to residents who patronise the services of private care.

Finally, beneficiaries are pleased with the services provided by private care homes; they have the latitude to interact. Thus, services of the care homes create an avenue for social inclusion and greater acceptance of the elderly, hence, positively impacting on their welfare.

5.2 Conclusion

This study examines the role of Private Care Homes in providing support for elderly people in Accra. The study found that Private Care Homes support elderly patrons with medical services, social services and other home related services, recreational services. Also, it was found that reasons why some aged people patronise services of private care homes are due to the busy schedule of relations and desertion among other issues. In

addition, Private Care Homes face numerous challenges. These challenges include lack of expertise, financial constraints, and staff commitment, absence of a policy or legal framework, and low patronage of service. Finally, while the residents are likely to face social inclusion problems, institutional abuse, financial difficulties, as well as lack of choice and alternatives in service provision, it was, however, found that physical abuse between residents in private care homes will not exist and pose a problem to the older people who patronise the services of private care.

In conclusion, by these research findings, the researcher has contributed to knowledge by providing new empirical evidence in support for the aged and the role of Private Care Homes in Accra.

5.3 Recommendations

There is increasing support for a preventative approach to promoting well-being. Godfrey, Townsend and Denby (2004) suggest the need to focus on opportunities for personal development and growth, adjustment to the experience of loss, engagement in social life, involvement in activities, intimacy or companionship, stimulation and social and practical support. Wistow, Waddington and Godfrey (2003) argue that well-being is an important component of successful ageing and call for a greater focus on promoting older people's quality of life and their engagement in the community.

The study therefore made the following recommendations based on the findings of the study:

First, government and relevant stakeholders must formulate proper policies and regulations to regulate the management and administration of Private Care Homes in Ghana just like orphanages. Secondly, government should develop programmes to encourage the setting up of Private Care Homes as well as adequate funding support. The

state itself should be involved by setting up state Care Homes for our senior citizens as it pertains in some developed countries.

In addition, educational institutions should developed specialised programmes to develop key staff in the area of the provision of specialised care and support for the aged in society. There should be training for specialists in Geriatrics to give the aged the special physical care they need. Government should do more by committing more resources in the training of health care givers to give the aged the special care they need.

Furthermore, there should also be Geriatrics Hospital for the aged just as Children's hospital; Mental Hospital and Antenatal Clinics are available in the country. More so, people should encourage their aged parents to patronise institutions like private care homes that provide alternative care services for elderly people, since modernisation has weaken extended family support to the aged in society.

Moreover, the Livelihood Empowerment Against Poverty (LEAP) programme should be modified in such a way that it can benefit the aged in other ways other than giving out small amounts of money to them at given periods.

Finally, it is recommended that government should aim at improving the overall wellbeing of the elderly; not just care, but making them enjoy some subsidies on facilities like healthcare and transportation. For this reason the researcher recommend the currently introduced transportation package for the aged by Ministry of Gender and Social Protection. They Ministry and stakeholders should ensure that it is sustainable.

5.4 Limitations and Suggestion for Future Research

The researcher could not interviewed any of the aged who patrons the services of care homes. This is because most of them were not too well to participate in the study. Also, the study is limited to Accra and may not reflect the situation in other cities or regions.

Future studies are recommended to be conducted on the topic in other cities and regions. These studies should try to interview at least a resident of the homes or those who send them to the Centres. The sample size should also be larger.



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APPENDIX

Appendix A: Research Questionnaire

Dear Sir/Madam,

You are kindly invited to serve as a participant in this study which seeks to investigate social support for the aged; the role of private care homes in Accra. The researcher is a final year Masters student in Social Policy Studies at the University of Ghana, Legon. The study is purely academic. It is in partial fulfillment of the requirements for the award of Masters in Social Policy Studies. The questions will take about 15-20- minutes to complete. Participation is completely voluntary, and all information provided shall be treated with the strictest of confidentiality.

Thank you for participating.

SECTION A: DEMOGRAPHIC INFORMATION

Please kindly circle the response that most applies to you.

1. Gender

A. Male B. Female

2. Age range

A. 51- 60 yrs B. 61 - 70yrs C. 71 - 80yrs D. 81 – 90yrs E. 91yrs and above

3. Highest educational qualification

A. Primary B. Secondary C. Tertiary

4. Marital Status A. Single B. Married C. Divorced D. Widowed E. Separated

5. Position of last employment A. Executive Officer B. Senior Officer C. Junior Officer

6. Estimate work experience

A. 1-10yrs B. 11- 20yrs C. 21- 30yrs D. 31yrs and above

SECTION B: CHALLENGES FACING THE AGED IN PRIVATE CARE HOMES (PCH)

This section seeks to ascertain the challenges faced by the aged in PCH. You are required to indicate your level of agreement by ticking 1= Yes; 2; No and 3=Not sure to the following statements.

Lack of social inclusion	1	2	3
Institutional abuse, eg. people being forced to eat or go to bed at a particular time	1	2	3
Physical abuse between residents	1	2	3
Financial abuse eg. Theft, fraud, exploitations etc.	1	2	3
Lack of choice and alternatives in service provision	1	2	3

Appendix B: Interview Guide

Dear Sir/Madam,

You are kindly invited to serve as a participant in this study which seeks to investigate the support for the aged; the role of private care homes in Accra. The researcher is a final year Masters student in Social Policy Studies at the University of Ghana, Legon. The study is purely academic. It is in partial fulfillment of the requirements for the award of Masters in Social Policy Studies. The interview will take about 20-25- minutes to complete. Participation is completely voluntary, and all information provided shall be treated with the strictest of confidentiality.

1. **Gender**

A. Male B. Female

2. **Age**

A. 50-59yrs B.60 - 69yrs C. 70-79yrs D. 80yrs and above

3. **Highest educational qualification**

A. Primary B. Secondary C. Tertiary

4. **Marital status** A. Single B. Married C. Divorced D. Widowed E. Separated

5. **Position of last employment** A. Executive Officer B. Senior Officer C. Junior Officer

6. **Years of work experience**

A. 1-10yrs B. 11-20yrs C. 21-30yrs D. 31yrs and above

7. What **major products or services** do Private Care Homes offer in support of the aged people?

8. In your opinion do these **services have any impact on the general wellbeing** of the aged people?

9. What **challenges do Private Care Homes face** in their quest to provide services in support of the aged ones?

10. What **challenges do aged people in Private Care Homes face**?

11. Please provide any **further information** that may aid this study

Thank you very much for your time.