UNIVERSITY OF CAPE COAST

INSTITUTIONALISED CARE AND CAREGIVING SERVICES FOR THE ELDERLY IN THE PADRE PIO REHABILITATION CENTRE, AHOTOKUROM

VIDA BOAKYE OPOKU

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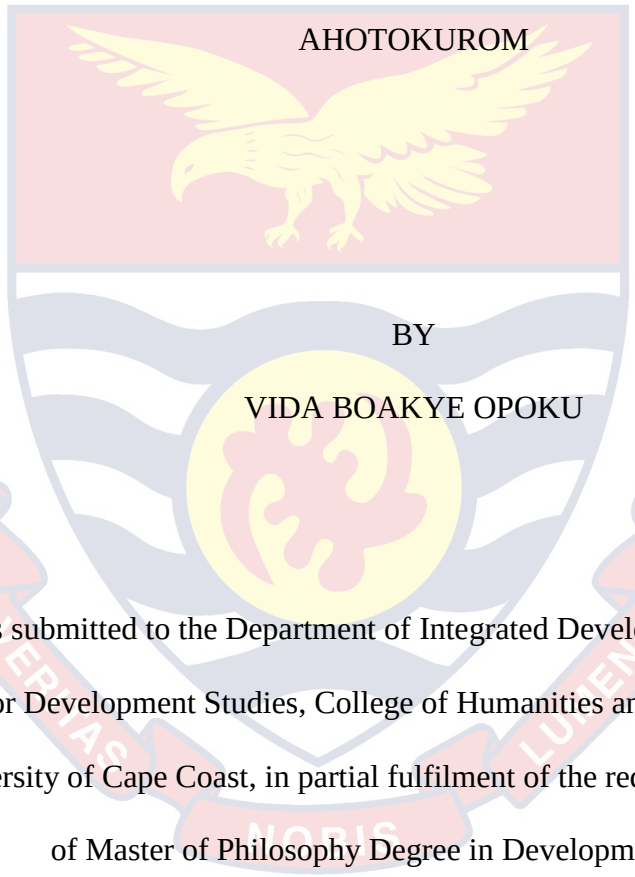

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Name: Vida Boakye Opoku

Candidate's Signature ……..... Date ….....

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised following the guidelines of supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Name: Prof Akua O. Britwum

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ABSTRACT

The concept of institutionalised care is gradually being accepted as an alternative source of care for the elderly in Ghana. Institutionalised homes exist to provide care for the elderly, yet many studies on care homes in Africa, including Ghana have neglected the needs of the elderly and the adequacy of care given by care homes. This is a study exploring the adequacy of the caregiving services provided by the Padre Pio Rehabilitation Centre (PPRC) in the Central region of Ghana, in addressing the medical, economic, psychological, and physiological needs of its elderly residents. An explorative research design was employed for the study. Evidence was gathered through participant observation and semi-structured interviews with residents, caregivers and family members over two weeks. The narratives from the data were organised into three central themes: the needs of the elderly (medical, economic, psychological and physiological), the kinds of services provided by the PPRC and the adequacy of care services offered by the PPRC. The study found that medical needs are the most occurring need, followed by psychological and economic, physiological being the least among the needs of the elderly in the PPRC. The findings revealed that the physiological and medical needs of the elderly residents were adequately provided by the PPRC. However, there was a limit to the ability of PPRC to provide all the economic needs of the elderly residents. The study concludes that the PPRC serves as the primary provider of adequate care for the elderly residents amidst its economic challenges. The study recommends the PPRC be supported by state institutions and other organisations, including NGOs.

KEYWORDS

Elderly

Care Homes

Caregiving Services

Institutionalised care

Social Exchange

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DEDICATION

To my lovely parents, Chief Inspector (Rtd) Michael Nana Opoku-Boakye and Mrs. Comfort Opoku for their endless support and inspiration throughout my academic journey.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

ADL	Activities of Daily Living
CCM	Cape Coast Metropolis
GSS	Ghana Statistical Service
HAI	Help Age International
IADL	Instrumental Activities of Daily Living
KEEA	Komenda- Edina- Eguafo- Abrem
MIPAA	Madrid International Plan of Action on Ageing
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
PPRC	Padre Pio Rehabilitation Centre
SDGs	Sustainable Development Goals
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNPF	United Nations Population Fund
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background of the Study

The elderly population is increasing rapidly across all countries. This demographic transition places new demands on governments to seek necessary ways to provide comprehensive long-term care systems for the elderly in their homes, at institutions such as hospitals and in various communities (World Health Organisation (WHO), 2017). The 2030 Agenda for sustainable development outlines a universal plan of action to achieve sustainable growth in a balanced manner that seeks to realise human rights for all. It agitates for leaving no one behind and to ensure that the Sustainable Development Goals (SDGs) are achieved for all parts of society, across all ages, mainly focusing on the most vulnerable, which includes the elderly (Westerhof &Tulle, 2007).

Following Ghana's international commitments, the Ministry of Employment and Social Welfare (MESW) developed the National Ageing Policy in 2010 which sets out to achieve the overall social, economic and cultural re-integration of the elderly into mainstream society. In pursuing this goal, full recognition is given to the elderly's fundamental human rights (MESW), 2010). The National Ageing Policy also aims to promote and strengthen the family and community's role in the care of its elderly members. Its objective is to support traditional systems and to enhance the ability of families and communities to care for the family members who are elderly. The policy aims at encouraging the family to develop various strategies and plans and incorporate them in providing support for the elderly members in the family (National Ageing Policy, 2010).

The term elderly is a social construction as it is defined either based on chronology, biology, social and psychological explanations. The chronological definition of ageing is based on one's birthdate usually tied to the age at which one is eligible for retirement and/or state pensions. The biological definition of ageing is related to a person's physical features, such as greying hair and limited mobility. In contrast, the psychological meaning of ageing depends on psycho-emotional functioning. Social roles such as grandparenting, among others is also used to classify individuals as elderly irrespective of their age (Westerhof &Tulle, 2007).

In many developing countries including Ghana, the elderly themselves use social roles, declining functional, mental or physical capacity to define the concept of being aged (GSS, 2013). This study adopts the Ghana Statistical Service's (GSS), definition which states that the elderly is anyone above 60 (GSS, 2013).

Mackenzie (2012) distinguishes the elderly into three categories. They include entering old age, the transitional phase, and the frail elderly. According to Mackenzie (2012), the first phase is the immediate phase upon retirement (60 to 70 years). This stage is characterized by good health, and providing care at this stage should be channelled towards reducing illness risks and promoting healthy lifestyle choices. The period between 70 and 85 years constitutes the transition stage which is usually characterized by a decline in functions as comorbidities develop among the elderly. The frail stage, beyond 85 years is defined by Buchner and Wagner (1992) cited in Markle-Reid, Browne Henderson, Roberts and Gafni (2003) as a stage where the elderly

cannot perform Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and social roles.

Care may be discussed as a specific type of working activity. Indeed, care may encompass a highly differentiated and diverse activity that may be paid or unpaid, depending on the party that renders the service (Duffy, 2011; Gottfried, 2013). Services such as housekeeping, and attention given to infants may all be seen as care. However, the elderly is one main category of people who need care to keep up with daily life. In view of this, the elderly within our society needs adequate care to enhance the general human experience (Brown 2012). Levinson (2008) explains the elderly situation as associated with the regeneration of health, coupled with the incapacity of self-care and disability, rendering them dependent on others for care. This, however, implies that the elderly needs care in the form of assistance to perform certain activities such as ADL, which include cooking and washing among others; and IADL, which consist of running errands and many more. Within the family, an individual, usually a woman, preferably the eldest daughter, is chosen to live with the elderly and provide care (Stack & Burton, 1994). Papalia, Olds, and Feldman (2004) observed that the decision made on where and with whom the elderly stay is influenced by cultural and traditional values. Jamuna and Ramamurti (1990) further outline some circumstances that affect the family's decision on the living arrangement of the elderly as: migration, availability of children and spouses, sex of the elderly, family size, health, and financial status of the elderly and their kin as well as past and current emotional bonds and past experiences.

The term care home may be described as all residential long-term care settings (outside the home) which provide maintenance and nursing care for the elderly who are chronically ill and/ or are unable to perform ADL and IADL. Care home has been used synonymously with institutional care for the elderly in this study. Institutionalisation of care may also be seen as being placed or kept in a residential institution outside the natural home (Ausserhofer, Deschodt, De Geest, van Achterberg, Meyer, Verbeek, & Ellen, 2016). Institutionalised care has become necessary across all countries due to two significant societal developments: population ageing and the increasing number of the elderly seeking alternative care arrangements in the absence of home-based care (Menezes, 2013).

The family has always been recognised as an important institution in providing care and advancing the elderly's health and wellbeing. However, there is increasing evidence of many other institutions and organisations, particularly community-based networks, voluntary institutions, and private-owned facilities that provide care services for the elderly (Fry, 2000). The significance of these care institutions for the elderly across the world is realised at the juncture of two significant societal developments: first, the growing population of the aged and second, an aggregate number of older people in need of alternative care arrangements (Kumar, 1997). However, Novak (2006) argued that it was not until the 1950s that the institutionalised care system for the elderly was popularised and gained relevance in the intellectual debate in the international sphere.

As indicated by Martinson, Widmer and Portill (2002), institutionalised care homes play an important role in the elderly's lives. The

functions are not limited to providing accommodation and physical care, but includes psychological and medical services where minor ailments are managed and treated. Another study by Park-Lee, Moss, Rosenolf, Caffrey, Sengupta, Harris and Kojetin (2012) showed that institutionalised care involves supporting early intervention and intermediate care, promoting independence as well as meeting the needs of those elderly who require specialist care services.

There exist two significant kinds of institutionalised homes. They include private and publicly owned elderly homes. Privately owned institutionalised care homes comes in two forms; for profit and non-profit such as the ones managed by Non-Governmental Organisations (NGOs). The sort of elderly home care accessed by one is mainly dependent on the physical and psychological health and the financial situation of the individual. The private institutional homes may be for those who can afford to pay for the services provided and the public ones are free and mostly accessed by those who cannot afford the care services provided (Feng, Liu, Guan& Mor, 2012).

Dhemba and Dhemba (2015) concluded that generally, the idea of the elderly assessing institutionalised care homes in African communities is a new phenomenon shunned by many and is only adopted as the last resort of care. Ideally, being elderly is accompanied by a period where the individual remains in the community, lives in the home, and plays an advisory role to family members. In exchange, the elderly also receive care from family members (Hungwe, 2011). Providing care and support for the elderly, who are living alone becomes necessary as dependency increases with age. Argyle, Downs and Tasker (2010) also highlighted the strength of the elderly's home care

preference. Argyle, Downs and Tasker (2010) concluded that the elderly may prefer home care services because home care services allow them to stay in their homes for longer and with their families as they continue caring for them. This helps reduce stress and increase their quality of life.

The ageing of the world's population is reflected in population statistics. According to the United Nations (2009), the number of aged people worldwide will increase from about 737 million in 2010 to about 2 billion in 2050. In 2015, over 901 million people were recorded to be 60 years and above, representing about 12.3 percent of the global population (United Nations Department of Economic and Social Affairs (UNDESA), 2015). Even though Africa is home to a relatively small number of older people, it is projected to increase from 64 million to 105 million by 2030 (UNDESA, 2015).

WHO (2017) indicates that a greater number of elderly in sub-Saharan Africa are in situations where they cannot perform essential tasks of daily life without being assisted by others. Again, the WHO revealed that most elderly, 65 years and older, living in sub-Saharan Africa, require higher care needs than people of similar ages in more advanced settings. The WHO further estimated that in Ghana, more than 50 percent of persons between the ages of 65 and 75 require some assistance in performing daily activities. Also, for those 75 years and older, the percentage jumps to more than 65 percent (WHO, 2017). In Ghana, the 2010 Population and Housing Census showed that the aged population has increased seven-and-half folds from 1960 to 2010. The entire elderly population has increased from 213,477 (4.5 per cent) in 1960 to 1,643,381 (6.7 per cent) in 2010. These statistics show a significant

increase in the elderly population over the years (Ghana Statistical Service, GSS, 2013). Mba (2010) highlighting the increasing elderly population in Ghana projects that the elderly persons between the ages of 60 and 80 will increase from 6.1 percent in 2010, to 14.1 percent in 2050 (Mba, 2010).

The increase in the elderly population is accompanied by socio-economic developments such as globalisation, liberalisation, urbanisation and migration. These changes are undermining the capacity of families to provide care for the elderly as well as the traditional norms underlying such care (Kumar, 1997). Aboderin (2004) reiterated that the support system by the family in recent times can no longer be relied on to provide sufficient economic protection for the elderly (Aboderin, 2004). This development has resulted in the elderly looking for alternative sources of care. The result is that the majority of the elderly who require such alternative care arrangements may turn to non-profit institutional care because either they cannot afford commercialised care within their own homes or there is a lack of these alternatives in their locality (Dosu, 2014). Traditionally, the extended family's multi-generational household has always been the single most important source of care in Sub-Saharan Africa (Haregu, Beguy & Ezeh, 2015). Boggatz and Dassen (2011) add that Africans have always depended on the strength of traditional family solidarity. However, as demographic trends continue to change, which is notable in the growing proportion of the elderly population, and the increasing number of women in paid employment, the need for institutionalised homes to perform eldercare services is also in high demand. For example, women are no longer available, as the case in the past, to provide eldercare service (Barry, 2010). This development has resulted in older people

looking for alternative care arrangements. The result is that the majority of the elderly who need alternative care arrangements turn to institutionalised care (Bhat & Dhruvarajan, 2001).

There exist several theories that explain the challenges of the elderly. These theories support the relationship between societal institutions and care for the elderly. Prominent among these theories are the Social Change Theory, Buffering Theory and Social Exchange Theory. The position of the social change theory is that changes occur in society as a result of several factors which could be economic, financial, and social. These changes affect social ties that bind people together. According to Darkwa and Mazibuko (2002), migration, urbanisation and industrialisation, resulting from changes in the society has led to the gradual breakdown of the family system that provided care for the elderly.

As the theory of social exchange argues, in the traditional setting, the elderly give wisdom to the family and expects that at old age, such service is reciprocated through caregiving. Ideally, the elderly is seen as a repertoire of wisdom to the family. The main argument in the social exchange theory is that interactions among individuals are because of an exchange process. The theory proposes that the relationship between individuals is generated by the pursuit of rewards and benefits and the avoidance of costs and punishment (Sabatelli & Shehan, 2004). Reciprocity, as a concept, is an important component of the social exchange relationship. This is because the relationship between individuals is strengthened by the notion that a kind gesture would be reciprocated.

Buffering theory, on the other hand, provides a link between the nature of care and the wellbeing of the elderly (Cohen & McKay, 1984). According to the theory, when an elderly person is aware of the presence of adequate care services, it helps buffer or shield them from the negative impact of stressful events. The theory further explains that human beings are social creatures, and strong social support systems such as institutionalised care would have a positive impact on their mental and physical health (Cohen & Pressman, 2004).

Bhattacharyya and Shibusawa (2009) outline several challenges associated with being elderly including financial, safety and security, health, loneliness and physical and sexual abuse among others. The old-age diseases like failing eyesight and hearing capacity, slow and faltering steps, declining energy, forgetfulness among others make their lives all the more difficult. Deteriorating health conditions and sickness, nutritional deficiencies and poor housing facilities tend to affect the physiological and economic conditions of the elderly. The physio-social and environmental problems create a feeling of neglect, loss of importance in the family and inadequacy among others. The elderly become intolerant, short-tempered, sentimental, rigid and suspicious when they lose friends, spouse, power, influence, income, and health (Bhattacharyya & Shibusawa, 2009). Thus, their psychological makeup makes their living and adjustment in society more problematic. Poor health, economic dependence and non-working status tend to create among them a feeling of dependency and powerlessness.

Economic growth, migration, urbanisation and the resulting changing family structures, has affected initial home-based care for older people in

Ghana. As such, there is the flooding of several institutions providing care for the elderly. In the early 2000s, Van der Geest recognised some formally organised professional care for the elderly in Ghana (Van der Geest, 2002). These facilities operated as recreational centres where elderly people meet up with each other, pass the time with games and other activities and receive a good meal. These institutions amongst others have emerged to respond to some of the challenges of the elderly. They work to promote the prospects of elderly persons in the Ghanaian society (Agbényiga & Huang, 2012; de-Graft Aikins & Apt, 2016).

The population of the Cape Coast Metropolis in 2010 was about 169,894 with the aged population of 10,881, representing about 6.4 percent of the entire population. The dependency ratio of the metropolis is 49.1 which is 4 percentage (GSS, 2014). Thus, the increasing number of aged in the Metropolis will mean that more elderly persons will depend on caregivers for their survival. This is because ageing and dependency are linked by the fact that as individuals grow older; they become increasingly susceptible to a loss of independence. The Padre Pio Rehabilitation Centre (PPRC) is the only identified centre in Komenda- Edina- Eguafo- Abrem (KEEA) Municipality. It is located in Ahotokurom near, Cape Coast. The PPRC provides care services for the elderly. The PPRC is privately-owned, not-for-profit institution which is noted for its support services within the Municipality a reason for selecting it as a case in this study. This study explores the caregiving services of the PPRC to its elderly residents and the extent to which the care services meet the needs of these elderly residents.

Statement of the Problem

The elderly population has witnessed a steady increase in Ghana since the 1960s (GSS, 2013). Consisting of about 3.2 percent of the population in Ghana in 1960, the elderly population rose to 4.0 percent in 1980 and 5.3 percent in 2000 (Tonah, 2009). Even as the elderly percentage decreased to 4.7% in 2010 (Ghana Statistical Service 2012), it is argued that the percentage of the elderly population in relation to the total population of Ghana will increase rapidly than those in developed countries of Western Europe and North America (Mba, 2013)

Recognising this development in the population of the elderly, the 1992 Constitution of Ghana and the National Ageing Policy acknowledged the need to provide care for the elderly and ensuring that formal institutions promote the wellbeing of the elderly in Ghana (MESW, 2010). The National Ageing Policy also seeks to achieve the overall social, economic and cultural reintegration of older persons into mainstream society and to enable them participate fully in the national development process.

Providing care for the elderly in Ghana falls mostly on the immediate and or the extended family. The elderly in Ghana most often than not, reside with and depend on family members, particularly their children, for care (Mba, 2004; Nukunya, 2003). However, the role of the family in elderly care is dwindling in the face of social change, due to migration, urbanisation and the gradual breakdown of the traditional or cultural systems and the family structure. Despite these changes, De-Graft and Apt (2016) reported that poverty rates tend to be higher in the households with elderly persons as heads than the national average in several countries. Their report further projected

that poverty rates are likely to increase among the elderly population especially in countries that have limited coverage of social security systems. Aboderin (2004) revealed that the need for more institutionalised care increases as poverty rates among the elderly increases.

The concept of institutionalised care, as an emerging phenomenon, providing alternative care to the elderly has attracted different perspectives among researchers. Many writers have expressed both positive and negative views on the institutionalization of elderly care. According to Wistow, Waddington and Godfrey (2003), institutionalised care systems provide adequate care services by playing an important role of promoting the wellbeing of the elderly. Whereas Tran (2012), presented a different result that institutionalization invokes negative feelings of regret, neglect, powerlessness and guilt in the elderly when the services given are inadequate.

For most developing countries like Ghana, there is a general difficulty in assessing institutionalised homes for the elderly. Despite the increasing number of institutionalised homes that provide a 24-hour service, many types of research have focused on private care homes and the extended family systems of care without focusing on the specific needs of the elderly within public institutionalised homes. The review of the literature indicates that there is a need to better understand the totality of institutionalised care 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 (Mba, 2013), much focus has not been directed in assessing the needs of the elderly in institutionalised homes. The PPRC is a long-term residential

home that primarily provides support service for the elderly who are unable to live independently. The institution strives to ensure that the displaced, disadvantaged and marginalized have a safe, clean and secure place to live. As an institutionalised home for the elderly, the PPRC performs caregiving services for its residents. It is against this background that this study seeks to explore the extent to which the caregiving services provided by the PPRC meet the needs of the elderly residents.

Objectives of the Study

The main objective of this study is to explore the extent to which the caregiving services provided by the PPRC meet the needs of the elderly residents. Specifically, this study seeks to:

1. Examine the kinds of services provided by the PPRC.
2. Examine the needs of residents at PPRC.
3. Analyse the gap between the stated needs of the elderly residents and the available services at the PPRC.

Research Questions

1. What are the caregiving services that the PPRC provides?
2. What are the needs of the elderly in the PPRC?
3. How do the services provided by the PPRC meet the stated needs of the elderly in the residential facility?

Significance of the Study

This study contributes to knowledge on the role of institutionalised care in the wellbeing of the elderly. The elderly persons are important in every country's demographic strata; therefore, they deserve to be cared for. This study also provides an insight into the extent to which the needs of the elderly

are catered for in institutionalised care system in the PPRC. In furtherance, the study suggests measures that can be adopted by the PPRC together with the family to strengthen institutionalised care services particularly for residents in the PPRC. This knowledge should help institutionalised home managers to redefine care services and activities to ensure adequate services that address the needs of the elderly.

Organisation of the Study

The study is organised into five chapters. The first chapter presents the background to the study, problem statement, and objectives of the study. It also contains the research questions, the significance of the study, as well as the delimitations and limitations of the study. The second chapter reviews relevant literature on the theories, concepts and core issues of the study. The third chapter captures explanations of how the study was conducted. It consists of the study design, study population, sample size and sampling procedure, sources of data, and procedure for data analysis and presentation. The fourth chapter is made up of the analysis and discussions of the results and the fifth chapter presents the summary, conclusions for the study and recommendations.

Delimitation of the Study

The study was conducted within the framework of exploring how the PPRC as an institution, provides care for the elderly. It was a study including a single Care home and therefore, it would not permit its results to be generalised but rather its findings to be placed in the relevant context of the PPRC.

Definition of Terms

i. Activities of Daily Living (ADL): activities including bathing, eating, dressing up and personal care among others that an individual performs for themselves.

ii. Caregiver: an individual who supports the elderly with one or more of the Activities of Daily Living and Instrumental Activities of Daily Living.

iii. Elderly: older people, the aged and elderly persons are all used interchangeably in this study to refer to persons who are 60 years old and above (Ghana Statistical Service, 2010).

iv. Elderly care: a wide range of services (including physical assistance, social support, financial and material assistance, emotional support and companionship) that are provided to old people who need help to perform their normal activities of daily living over an extended period.

v. Extended Family: in this study, the extended family refers to close relatives or social arrangement in which the individual has extensive reciprocal duties, responsibilities and obligations to relatives outside their immediate nuclear family. It includes members of one's nuclear family, in-laws, siblings and members of a household.

vi. Household: for this study, refers to a group of persons living together in the same compound and shares housekeeping arrangements (Ghana Statistical Service, 2010).

vii. Instrumental Activities of Daily Living (IADL): include skilled activities such as grocery shopping, cooking and driving among others.

viii. Institutionalised homes: a place where the elderly can live together and receive care.

ix. Wellbeing: Wellbeing adopted in this study means the extent to which the individual meets the necessities of life such as shelter, clothing, healthcare, companionship and economic.

Chapter Summary

This chapter presented the introduction and background to the study. In the background of the study were issues that motivated the study. This was followed by the problem statement, research objectives and questions for the study. The rationale for the study and an overview of the structure of the study concluded the chapter.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The information for this chapter was fully researched using relevant books and journals from previous studies. The first section focuses on the theories underlining the study; the Buffering and Social Exchange theories. The second discussion focuses on conceptualisation of the terms; elderly care and institutionalised care. The chapter again discusses empirical literature from other studies related to the care for the elderly. The last discussion introduces the conceptual framework for the study, which draws on the theoretical and conceptual underpinnings that helped inform how institutionalised care for the elderly affects their wellbeing.

Theoretical Perspectives

Several theoretical explanations have been used by researchers to account for the provision of care by various institutions such as the family to the elderly. These theories include social exchange theory and the concept of reciprocity among family members. This study examining institutionalised caregiving services for the elderly relies on the Social Exchange theory as the main underlying theoretical framework while considering the Buffering theory to support in defining the concepts. These theories are adopted in the thesis to examine the adequacy of caregiving services by institutionalised homes.

Social Exchange Theory

The social exchange theory was developed by Homans in 1961. The theory is grounded on the notion that social interaction or human behaviour is an exchange activity (Homans, 1961) involving the exchange of goods and

services. It is a commonly used theoretical base for explaining the behaviour of individuals concerning the exchange of goods and services involving costs and rewards (Blau, 1964). The exchange of costs and rewards have been recognized by Coleman (1993) as a phenomenon that permeates all social life. The basic assumption of the exchange theory, according to Blau (1964), is that individuals engage and continue to establish social relations on the basis that their actions will be reciprocated in a manner that will be mutually advantageous. According to the social exchange theory, interactions among individuals is regulated based on a self-interest analysis of the cost and benefits of such interaction. That is people most often than not, pursue to maximize their benefits and minimize their cost when engaged in the exchange process (Molm, 2000). The benefits or rewards that one receives in a social exchange may either be intrinsic (love) or extrinsic (assistance with chores). In an exchange situation, at least one of the parties may be dependent on the other, and mostly the dependency is what prompts the social exchange. This implies that, a person's personal goal may only be met through interaction with another person (Blau, 1964).

According to the social exchange theory, elderly people tend to become more dependent on others with assistance in activities of daily living or health maintenance functions (Dowd, 1975). After a lifetime of typically giving more to younger persons than they received from them, elders must increasingly come to accept beneficence; for parents, this kindness most often comes from children (Dowd, 1984). Exchanges can either be reciprocal or negotiated (Molm, 2000). Reciprocal exchanges occur in situations when people encounter a cost in the process of providing a reward for their partners

without specifying the exact nature of repayment but usually with an expectation that some form of repayment will occur in the future. Such exchanges are voluntary and typically occur as a result of relationships established by prior successful exchanges (Mitchell, Cropanzano, & Quisenberry, 2012).

In summary, the discussion above on social exchange theory makes a case for the need for providing care for the elderly. It indicates that the elderly has made contributions to the lives of the younger generation and in reciprocity, they should be given adequate care in their old age. It further explains that, even though at an old age, the elderly does not have the resources to engage in an exchange interaction as in the case of the PPRC, the PPRC may gain satisfaction in observing improvements in the wellbeing of the elderly residents. However, the social exchange theory does not define the concept of care, and the outcome or consequences of adequate care or otherwise, making it necessary to adopt another theory, hence the buffering theory.

The Buffering Theory

The buffering theory emerged in 1976, developed by John Cassel and Sidney Cobb and links directly care to people's wellbeing (Cohen & Pressman, 2004). The theory conceptualized care as an external source of emotional, informational, and instrumental aid (Auslander & Litwin, 1987). Instrumental aid involves the provision of tangible goods and services such as financial, medical care, clothing and food items among others, which directly support a person in need. Instrumental aid is usually provided by one's household, friends, colleagues and neighbours (Barrientos & Lloyd-Sherlock, 2002).

Additionally, emotional aid involves sharing life experiences. It includes the provision of empathy, love, trust and other forms of care which enhance the feelings of comfort. Informational aid also constitutes providing knowledge, advice, suggestions, and information that a person can use to address their problems (Gottlieb, 1983; Gooding & Marriot, 2007).

The buffering theory explains the linkage between adequate care giving services and the wellbeing of individuals. The buffering theory posits that the presence of care helps shield or serve as a buffer against limitations posed by circumstances such as ageing, among others. Cohen and McKay (1984) revealed that ageing presents challenges which may have adverse effects on the health and wellbeing of individuals. Individuals who receive little or no care would experience deteriorating health conditions while these effects will be lessened or eliminated for those individuals with stronger support systems providing them with adequate care (Cohen & Wills, 1985; Thoits, 1986).

Care is considered fundamental in helping the elderly cope with challenges associated with ageing such as assistance in ADL and IADL. The buffering theory also indicates that care is a tool that protects people against the generally deleterious and sometimes life-threatening effects of stressors. Hence, it maintains that care is beneficial in ensuring wholesome life experiences (Mezuk, Diez Roux & Seeman, 2010).

The buffering theory conceptualizes care and its possible impact on the physical and emotional health of the elderly. However, it is unable to ascertain who should provide care and the reasons why an institution should

provide care thus, making the synergy between the social exchange theory and the buffering theory necessary.

Antonucci (2001) contended that in order for care to serve as a buffer to an individual, there is the need for adequate social networks, proper relational ties and the right social climate that promotes the provision of care. Care is always not automatically available to all elderly persons. It depends on the adequacy of the social network of institution that the elderly find themselves, the degree of their connectedness to that social network and a conducive environment. The synergy between the social exchange and buffering theories is achieved as social exchange theory explains the adequacy of the services provided by the social network. The next section focuses on discussing the conceptual issues in this study.

Conceptual Review

Concept of Elderly

The term elderly is a biological process, however, what constitutes old or young is socially constructed, that means a single definition of elderly is not used by all societies. From the biological perspective of ageing, physical characteristics such as grey and bald hair is associated with ageing. The social roles played by individuals are also used as a benchmark for being elderly in some instances. For instance, people who assume the role as a head of family, grandparent at the age of 50 or less are addressed as elderly (Devi & Bagga, 2006). In general, the concept ageing is defined as a stage in life beginning in the early sixties, in which retirement from work and many other social responsibilities like grandparenting is expected (Uhlenberg, 1992)

Like other countries in sub-Saharan Africa, Ghana is also experiencing considerable changes in the age structure of its population (Mba, 2010). The findings from the 2010 Population and Housing Census in Ghana showed that the proportion of older persons in Ghana increased seven and half times, that is, from 213,477 (6.7 percent) in 1960 to 1,643,381 (7.2 per cent) in 2010. The census also revealed that two-thirds of the elderly population in Ghana as at 2010, were between the ages of 60 and 74 years, and approximately one-tenth, constituting 9.6 percent were 85 years and above (Ghana Statistical Service, 2013).

The population of older Ghanaians are expected to double between 2000 and 2030 (Smith & Mensah, 2003). The consistent rise in the aged population suggests that it is also important to examine both chronic health conditions and nature upon which these individuals receive care (Agyei-Mensah & de-Graft Aikins, 2010). De-Graft Aikins and Koram, (2017) noted that in Ghana and for most developing countries infectious and chronic diseases are more prevalent among the elderly population. Novak (2006) also revealed that chronic disease conditions lead to functional loss which in turn leads to disability and activity limitation in at least one ADL among older people and these diseases also account for a majority of deaths among the elderly persons (Novak, 2006).

Although Ghana's health policies have improved over recent years, issues such as limited access to primary care facilities have resulted in the elderly seeking assistance from orthodox to alternative forms of care, particularly in rural and less populated areas (Apt, 2013). In Ghana, the elderly in rural areas is more disadvantaged than those in urban areas (Apt, 2013).

According to the Ghana Statistical Service (GSS) (2013), an aged or elderly is someone aged 60 and above. This definition encompasses both the traditional and the legal definition of who an aged person is. In this study an elderly person is defined or operationalized based on the Ghana Statistical Service (2013) conceptualization as 60 years and over. A point where the individual is eligible for the state pension (Ghana Statistical Service 2013). Though many definitions have been used to explain the concept of the elderly, 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 1800s through the mid-1900s and even to date.

Recent progress in ageing research has led to frequent revisions of the definition of ageing. For instance, Mackenzie (2012), puts the elderly into three categories. They include entering old age, the transitional phase and the frail elderly. The first stage, according to Mackenzie (2012), is the immediate stage upon retirement (60 to 70 years). It is characterized by good health, and providing care at this stage should be channelled towards reducing risks of illness and promoting healthy lifestyle choices. The period between 70 and 85 years constitute the transition stage which is usually characterized by a decline in functions as co-morbidities develop. At this stage, it is essential that these co-morbidities are identified quickly and managed whiles focusing on reducing the risk of further health deterioration (Mackenzie, 2012). A subsequent time eventually arises when the individual becomes frail at the point where it becomes impossible to be independent. This usually happens as a result of diseases such as stroke and dementia, among others (Mackenzie,

2012). Anstey, Stankov and Lord (1993) divides the ageing processes into primary and secondary ageing. In his view, primary ageing is intrinsic to the organism, and inherent or hereditary influences determine the detrimental factors. Secondary ageing is caused by harmful or hostile elements in the environment.

From the discussions on the conceptualization of the term elderly, being elderly is certainly socially constructed. Aside from broad definitions associated with chronological, social, and cultural factors, the age at which the elderly begins is unique to every institution. Whereas some countries and organisations agree on the age 60 as elderly, others begin at 65 and in some cases 55. For this study, the definition of elderly is adopted from the Ghana statistical service as 60 years and over.

Elderly Care in Africa

Ethnographic studies propose that care is generated through negotiated commitments (Finch & Mason, 2013). Care, according to Bailey (2009) is a universal term. The perspective on care originates from humanity but also encompasses practical accommodation of basic human needs. The actions that determine care are those performed together with another person, either healthy or ill, to achieve optimal health or quality of life (Adei, Anning & Mireku 2015). This section discusses the issues such as the traditional system of elderly care in Ghana, the political economy of elderly care in contemporary Ghana, community-based care for the elderly, and quality of care for the elderly. This will help to provide an understanding of the primary care of the aged.

In traditional African societies, it is believed that adults rely on children as security against old age. (Dosu, 2014). In the agrarian societies and traditional African societies, children were necessary for farm labour and other domestic tasks (GSS, 2013). The desire for large family size was attributed to these reasons and has then persisted to contemporary times.

The traditional family system, just as in other countries, was the very first provider of care and support for its members (Dosu, 2014). As such, one could feel a sense of belonging since, everyone was being responsible for each other. Also, the family provided social support, both physically and mentally. Today, urbanization has declined the family ties, which have put more pressure on the alternative sources of social protection, particularly elderly care institutions (Dosu, 2014).

Some transformations in the economies and societies of African countries have been witnessed over the years. Nevertheless, children continue to be desired as security against old age by some parents. People who have no biological children would typically foster children of their kin or non-kin to be assured of security when they become elderly (Palloni, 2000). As explained in the social exchange theory, the elderly in sub-Saharan Africa, therefore, enjoy both biological and social support and care from their children. The parent-child contract (the cultural value of reciprocity) ensured that children, having received care from both their biological and social parents would in turn provide all their parents' needs during their old age.

In their study of elderly expectation and perception of their needs, Yiranbon, Lulin, Antwi, Marfo, Amoako and Offin (2014) found that care for the elderly was the traditional practice in rural Africa; support to the elderly in

the form of economic gains is increasingly becoming a requirement of urban life in Africa. However, employment insecurity, coupled with lower wages may work against the ability of the African children to provide the economic needs of their parents (Heslop & Gorman, 2002).

In his work, Adepoju, (2005) describes how families in western Kenya and Ghana overcome challenging times by organising family meetings, either regularly or after a crisis such as a demise of a family member. During these meetings, families will decide on who will take care of their orphans, the elderly and other vulnerable members of the family. This activity is said to create a sense of unity among the family. Nyambedha, Wandibba and Aagaard-Hansen (2003) revealed how the elderly in western Kenya lament the lack of adequate care, not because they are not provided with support, but to ensure that those around them live up to their commitments. As Van der Geest (2002) has discussed that eldercare in Kwahu, Ghana puts pressure on particular people to provide care. Still, responsibilities and commitments are always negotiated among family members and can change through those negotiations. In addition to paying attention to the negotiated process of care, Coe (2017) focuses on a second aspect hidden by the kin-script that emphasizes the role of adult children.

Stack and Burton (1994) introduced the concept of kin-work, as all the labour that is required to sustain that family from generation to generation. This labour ranges from paid employment to childcare, eldercare and household chores. The concept of kin-scripts is labelled in a manner in which categories of kin are recruited into kin-work based on age, gender, and social position (Stack & Burton, 1994). In the kin-scripts of contemporary Ghana,

older children are kin-scripted to be responsible for eldercare. More particularly, the successful children provide financial support, and one of the daughters, ideally the eldest, lives with the elderly person and performs kin work activities such as washing, bathing, house cleaning, grocery shopping, and cooking.

In southern Ghana, non-kin have comprised domestic house help, and fostered children and nieces and nephews, extended kin, or non-kin (Coe, 2017). Coe (2017) further revealed that in Ghana while kin, often male and sometimes family heads take up the role of managing care by recruiting daily caregivers, extended kin and non-kin can become care providers in helping older adults with the tasks of everyday life.

In the late twentieth century, the eldest daughter was chosen as the ideal, normative caregiver of an elderly person in care-scripts (Coe, 2017). Towards the late twentieth century in Ghana, usually an older woman provided support, by providing daily care and household labour both to the elderly and to grandchildren left behind by migrant parents in the hometown. As the older woman herself became too frail and weak to do care work, the care slot was passed from one woman to another. Usually, the oldest daughter was recruited by others to live with her mother or her mother's siblings, in part because she was most likely to have grandchildren who also required her care. However, if other daughters or granddaughters were better positioned because of their unemployment or marital instability, then they might be asked in the first daughter's stead.

Aside the physical and emotional activities of care, another activity which is carried out in support of the elderly is the need for organizing a

fitting funeral for the elderly in their demise. Organizing a befitting funeral for an elderly person was described by van der Geest (2002), as the most decisive form of care which the extended family is supposed to perform for the elderly members.

Elderly care varies widely across societies. The family has long been the primary provider of care for the elderly. In more advanced states, unlike developing countries where family ties are weak, the responsibility of elderly care falls on the government and charitable organisations. It can be concluded that the beginning of old age (60 years and over) is accompanied by various physical, health, financial, and psychological challenges, among others. Even though ageing is experienced differently among individuals, at the point when the individual becomes frail, they will need the assistance of another person in their daily activities. The family has long been the foremost provider of this support to the elderly. The capacity of the family to provide the needs of the elderly is highly dependent on its social and economic situation. Poverty and changes in the family system as a result of urbanization and modernization have placed enormous pressure on the family in proving adequate care for the elderly. The unavailability of family members to care for its elderly has necessitated the mushrooming of institutionalised care, affording institutionalised care for the elderly a significant area for consideration.

Even though doubts have been expressed by some Ghanaians towards their elderly persons being intimately cared for by non-relatives or strangers, there is increasing evidence to show that such services are available. A number of initiatives by religious entities, non-governmental organisations (NGOs) and individuals in Ghana, particularly in the Central, Greater Accra

and Eastern Regions are available for addressing the care needs of the elderly. These services are offered by non-kin in and out of the homes of the elderly persons. These initiatives seem to have attracted the attention of some families that are unable to provide the care needs that their older relatives need and deserve (van der Geest, et al., 2004; Dsane, 2013;). Some of these institutions are recreational centres, home care services by professional caregivers (such as health care assistants and nurses) and a few are residential homes or facilities Kwabena–Adade, 2018).

Challenges of the Elderly

There are challenges associated with being elderly and they exist in the areas of finance, health, social and physical and sexual abuse (Mba, 2002; van der Geest, 2002; Mba, 2007). According to Hal and Larry (1992), ageing could be seen as a continuous process of change, and that change comes with many problems and challenges. It exposes a person to an increased risk of diseases and disability, as the body becomes weak, frail, and not able to perform its tasks as it once did. Old age is feared in recent times; however, this was not always the case. Agyeman (2014) reiterated that, the older generations used to hold a critical position in the family tree and society. They were the epitome of wisdom. Younger family members benefitted from the profound knowledge and experiences of their elders. The youth was thus, allowed to be seen in public gatherings but were not to be heard. The scenario is changing, with senior citizens being considered as non-productive and a social and economic burden (Myers, 1992). For instance, in urban areas in India, the entire responsibility falls on the male child with whom the ageing parent resides.

In the traditional Ghanaian setting, being elderly is recognized as a transition from a youthful stage. It is seen as part of life, a blessing from God, and the point of departure to join the ancestors (Van der Geest, 2002). With the advent of the nuclear family system, the elderly tend to feel neglected when the others remain busy with their schedules (Agyemang, 2014). The experiences of the old are considered inappropriate in this advanced technology-driven world and no one wants to pay attention to what they have to say (Quashigah & Lucy 2016). The challenges of the elderly which include economic, physiological, psychological and physical and sexual abuse are discussed in the following paragraphs:

Economic Challenges Faced by the Elderly

Old age is associated with retirement period and it includes a stage where individuals are expected to enjoy the lifetime savings of their youthful days (Myers, 1992). However, in some cases, elderly persons face grave economic challenges (Agyemang, 2014). Agyemang (2014) revealed that, when economic challenges befall the elderly, some are forced to engage in active economic activity to feed themselves while others may have to sell off their property for their upkeep or to support their children who may still be schooling or under vocational training (Agyemang, 2014). Many elderly persons live in poverty (Mba, 2007). A fair number lack adequate food, essential clothes and medicines. This is because one of every six of the elderly in Ghana has incomes close to or below the poverty line (GSS, 2013; Agyemang, 2014).

Suppose elderly persons have the financial resources to remain financially independent in that case, they are going to feel a great deal better

about themselves, than if they are deprived of their former lifestyle (Johnson & Mommaerts, 2011). According to Agyemang (2014), the economic challenges of the elderly may be linked to early or forced retirements, which often create a financial and psychological burden that retirees usually face without much assistance or preparation. Ghana's Social Security programme supports early retirement, which can come as early as age 55 years for men and 50 years for women (Holmes, Powell-Griner, Lethbridge-Cejku, & Heyman, 2009). Many workers who retire early supplement their pension by taking other jobs, usually of lower status (Agyemang, 2014). The more a person's life revolves around work, the more difficult retirement is likely to be (Johnson & Mommaerts, 2011).

Health Challenges of the Elderly

The World Health Organisation (WHO) explains health as a state of complete physical, mental and social well being, and not merely the absence of diseases or infirmity (World Health Organisation, 2010). Therefore, good health is very important in every individual's life. Health is an element of human capital in carrying out survival strategies or activities. Most elderly people who face deteriorating conditions struggle, as they cannot engage in many activities. According to Kimmel (1974), in general, it is challenging to separate the physiological, social and psychological effect of ageing from the effects of a disease, since ageing and disease highly go together. Kimmel (1974) reiterated that most elderly people become more troubled by chronic diseases such as arthritis, heart conditions or high blood pressure. Studies from most developing countries show that when elderly people are in good health, they continue to work while those who are ill end up in poverty when support

from household members is insufficient (Help Age International) (Hai), 2004; Muruviwa, 2011).

Typically, lack of access to healthcare in most developing countries has left the elderly vulnerable to sicknesses and diseases as they lack the means to pay for treatment that they need (Agyemang, 2014). Most countries have a pluralistic medical system, with traditional and orthodox and alternative medicines operating side by side. Since most elderly persons reside in rural areas, they tend to rely on traditional medicine to meet their health care needs (Agyemang, 2014).

Physical and Sexual Abuse of the Elderly

Elderly persons suffer from sexual and physical abuse which has continued to increase among countries. Elder abuse refers to the maltreatment of the elderly by those in a position of trust, power or responsibility for their care (Fallon, 2006). There is a considerable evidence of older women having been accused of witchcraft and lynched, raped and molested (Miguel, 2005; Acierno, Hernandex-Tejada, Muzzy & Steve, 2010).

Wilson (2020) revealed that two out of three elderly people in the United Kingdom faced abuse in the form of insults both from the public and their own families (Wilson, 2020). Trauma and shame associated with rape and elder abuse make it difficult for most of these cases to be reported. These humiliating actions are done by either the family members or people who are close to them (Andersen & Taylor, 2001). For instance, the findings by Aboderin (2004) showed that, in Accra, when financial difficulties set in a family, adult children might accuse their mothers of witchcraft, and for having brought misfortune to the family. In the end, they deny the elderly of care

regardless of the nurturing their mothers gave them through their childhood. This creates fear of reporting these cases with the view that the support and care will be withdrawn and also they will be isolated from the community.

Evidence shows that even in 2020, elderly women are accused of witchcraft, beaten, abolished from their communities and sometimes murdered. An example is the news of the brutal murder of Maame Akua Denteh, a 90-year- old woman who was accused of witchcraft in Kafaba, East Gonja in the Savanna Region of Ghana which shocked Ghanaians in the 2020. The short video record showed community people gathered and watched as some women hit Akua Denteh with objects and eventually set her ablaze until her final demise (Mahama, 2020).

There have been systematic reviews of institutional care and caregiving services for the elderly as the world's population ages within different cultures. Studies have focused on the economic, health, physical and emotional needs of the elderly. As the elderly has cared and provided support for younger persons in the family, it is expected that the younger generation would provide care for the elderly. However, it is established from the literature that, some elderly are neglected by their families and hence fall prey to challenges which are economic, physical and sexual abuse especially among women. It is also seen that in most cases the family, which is supposed to be a safe haven for the elderly has become the source of abuse to the elderly.

Institutionalised care for the Elderly

The general increase in life expectancy, coupled with improved medical care, has caused a drastic change in the living patterns among the

elderly (Rajan, 2006). These trends elicit concerns about housing, care and support for the elderly. Institutional care has, to some extent, bridged this gap as elderly people seek institutional care in the absence of home-based care.

There are various ways in which old age services can be given to those who need them. There are care homes that specialise in caring for the aged. Those who can afford may make use of caregivers by employing them. Institutionalised care allows the elderly to maintain some level of independence with assistance for daily living activities like cooking and cleaning (Hoi, Thang & Lindholm, 2011).

There are undoubtedly positive results that come from living in a care home for the elderly. For instance, living together in a specialized old age facility promotes social cohesion and the feeling of belonging to one family among the elderly. Residents perceive the environment differently depending on their cultural background and want different things from it. The condition and health of some elderly persons with functional disabilities due to wounds and chronic diseases improve as a result of the restorative and rehabilitation programmes which are offered at care homes (Z1obicki & Kumarasuriyar, 1997).

On the negative side, some elderly people have fears and concerns about nursing homes. Residents may feel abandoned by their families and friends and may fear depending on strangers (caregivers). Anger is a typical response from those who need nursing care. Their unmet needs may result in apathy, submissiveness and boredom. The lack of free choice and lack of variation in the daily routine may result in lethargy and resultant psychological problems (Eliopoulos, 1993).

Empirical Review of Care for the Elderly

The empirical studies presented are studies conducted that focus on care for the elderly. The literature on the more specific issues of institutionalised care exist and present a strong case for recognition of their impact on the elderly. For most countries, care for the elderly has always been the responsibility of the family. A range of research studies has demonstrated the fact that the extended family continues to be the foremost provider of care to the elderly, regardless of the nature of theoretical approach adopted (Aboderin, 2004; Darteh, Nantogmah, & Kumi-Kyereme, 2014; Frimpong, 2015; Coe, 2017). This section of the review will tease out critical issues which relate elderly care and institutionalised care services as described by various researchers.

Coe (2017) examined how elder care is negotiated and the role of non-kin in Akuapem, Ghana. Data were analysed in three historical periods - the 1860s, the 1990s, and the 2000s. For the 1860s, the researcher relied on record of the Basel Mission from the Ga, Akuapem and Akyem-Abuakwa presbyteries. Data from the 1990s was collected through life history interviews conducted in Akropong. This was followed by a household survey, conducted in 2008 to provide information on eldercare in the 2000s. Finally, the researcher conducted ethnographic research extending over three years (2013-2015) on home nursing agencies in Accra and the activities of churches and other NGOs to help support the elderly. The study found that taking care of the elderly is not done solely by kin, but non-kin can also be substituted in the Ghanaian family. For instance, records provided by the Basel Mission showed that domestic slaves were quite common in Akuapem, as they were captives

from the Ewe wars. These slaves played an essential role in the care for the elderly in the past by assisting in ADL and IADL.

Darteh, Nantogmah and Kumi-Kyereme (2014) examined family support for the aged in Yamoransa, Ghana. The study assessed the material and instrumental backing provided by the family to the elderly. The study employed a cross-sectional survey design to collect data from 153 respondents who were 60 years and above by using the simple random sampling technique. It was revealed from the study that the elderly is still being provided with material and instrumental support by their families. The results indicated that females received more care on material support whiles men received more on instrumental support. However, both males and females indicated that they were satisfied with the support they received.

Kodzi, Gyimah, Emina, and Ezeh, (2011) examined the relationship between religious identity, religiosity, and secular social engagement on the wellbeing of the elderly in Nairobi, Kenya. They used survey data of 2,624 participants, aged 50 years or older to analyse the wellbeing of the elderly people. Based on current trends in Sub-Saharan Africa, rapid urbanization is believed to weaken the social safety net of the past. Kodzi et al. (2011) indicated that apart from financial wellbeing and health status, religious and secular forms of social involvement of the elderly is vital predictors of subjective wellbeing. The findings showed that instrumental and material support had a positive impact on emotional and physical wellbeing of the elderly. The number of close friends, family support and the intensity of social participation had a strong positive effect on general life satisfaction. They further discovered that health status and the social involvement of the elderly

people were vital to their life satisfaction; for example, in Sub-Saharan Africa, Evangelical and Pentecostal worship experiences are associated with messages of hope, divine healing, and material provisions for adherents.

Aboderin (2004) studied material family support for older people in urban Ghana. The study adopted a qualitative research approach and a case study design. The study's focus was on Accra, Ghana. She interviewed 51 persons, comprising 23 elderly persons stratified by gender, income group (high, middle and low) and ethnic group (Akan or Ga). The remaining 28 respondents consisted of four older people who had been abandoned by their families in hospital and 24 adult children and grandchildren chosen from among the potentially available adult children. The full sample thus consists of three generations of respondents who were blood related.

Aboderin (2004) found that the family support system, as it has developed and operates today, can no longer be counted upon to provide sufficient economic needs for the elderly. In contrast, the care given by the family to the elderly in the past was primarily adequate to meet their material needs and even to provide many with a surplus. Aboderin (2004) explained that issues of non-support for the elderly were allegedly rare in the past. However, they are common today because parents' entitlement to care which was based on the principle of reciprocity is no longer unconditional as it used to be. The study noted that it is the children themselves who rate the conduct of their parents and decide if they will provide them with care or not. It was also found that when economic times are hard, adult children accuse their mothers of witchcraft, of having brought misfortune on them and,

consequently, deny them care, despite the nurturing their mothers gave them through childhood.

Similar observations were made by Van der Geest (1997) in his study of elderly people in Ghana. The study examined issues around the social and cultural bases of care, the concept of elderly, role of money and respect in the life of the elderly, older people's wisdom and witchcraft, the meaning attached to building a house and the meaning of death and funeral. The area of focus was Kwahu-Tafo. The sample size was 35 elderly people, supplemented by observations of other people living in the same house and discussions with younger men and women in the community.

The study concluded that the position of the elderly in the average Akan community is exceptionally varied and ambiguous. Some of the elderly are better off in terms of health, social, psychological and economic wellbeing; whiles others are simply miserable. The principle of reciprocity partly explains these differences. The elderly who took good care of their children are sure to receive good care from their children in return and those who did not face serious problems in their old age. Van der Geest further observed that the disgrace of insufficient care for the elderly was kept in-doors and was washed away after the old person's death. The hidden shame, which is shared by the young and the old, is definitively undone by the public performance of a successful funeral. A proper burial demonstrated how much the family loved the deceased and what excellent person they were.

Frimpong (2015) researched the role of Private Care Homes in supporting the elderly in Accra. The study focused on services provided, factors that account for the aged to demand care homes, the effects of private

care home services on the quality of life of the aged and the challenges the aged who patronize the private care homes in Accra face. The data was solicited from mainly primary sources using an interview guide and questionnaire from selected Private Care Homes in Accra: Adenta, Osu and Dzorwulu. The data was analysed using descriptive statistics and thematic analysis. The study discovered that private Care Homes primarily provide their patrons' services including training in care for the elderly, medical services, social services, recreation and other home-related services. The study found that some significant reasons why some elderly people patronise services of private care homes are due to the busy schedule of their children, and neglect by their children, and migration. It also concluded that the challenges faced by Private Care Homes include: lack of inadequate specialist staff, committed or dedicated staff to provide services for aged people, financial constraints and lack of regulatory framework.

Lessons from empirical Review

The empirical review discussed so far supports the conclusion that the elderly population is increasing and changes in the family support system poses a challenge in meeting the needs of the elderly. These changes may be attributed to rapid urbanization and economic hardship, among others. From the various empirical studies, it emerged that the qualitative research approach was the most used in studying care for the elderly. However, most of the studies focused on home-based elderly care (Aboderin, 2004; Darteh, Nantogmah & Kumi-Kyereme, 2014; Coe, 2017). Frimpong (2015) studied elderly care and challenges in profit institutionalised care homes in Accra. The context of elderly care among non-profit institutional care homes is therefore

not clear. This study sets out to address the knowledge gap in understanding the elderly caregiving services by non-profit institutional homes by focusing on the PPRC in the Cape Coast metropolis.

Conceptual Framework for Institutionalised Care for the Elderly

The conceptual framework creates a synergy among the theories which are: the social exchange theory and the buffering theory as well as the key concepts that underpin the study, namely institutionalised care and the elderly.

The nexuses suggest that the elderly are expected to be taken care of by the family, which primarily is to offer economical, medical, physiological and psychological assistance to the elderly. In the process of providing this assistance, the implementers (family) of this support may encounter some initial challenges. These challenges can limit the effectiveness of the institution (family) in achieving its established objectives.

The conceptual framework, using the buffering theory as a guide, identifies four categories of needs of the elderly, namely; economic, medical, physiological and psychological. These categories include tangible and intangible contributions, ADL and IADL. The physiological needs include food, clothing and shelter, which are substantial contributions. Health care, cash remittances, emotional support, visits by family and many more form the intangible contributions.

Institutionalised homes, in this case, the PPRC is the source of care for its elderly residents, providing the economic, medical, physiological and psychological needs of the elderly. It is expected that the care provided by the PPRC would show love and respect, create a sense of belongingness companionship and improve health and dieting among the elderly residents.

However, these institutions (specifically the care home facility) may encounter some economic and administrative challenges that might also affect the quality of care. Thus, all these put together would contribute either positively or negatively to the living conditions of the elderly.

The social exchange theory was adopted to inform the conceptual framework of this study. According to the theory, interactions between individuals is an exchange of goods and services. The resources exchanged here include activities of daily living and instrumental activities of daily living which are beneficial to the wellbeing of the elderly. The conceptual framework further explains the needs of the elderly and the kinds of caregiving services provided by the PPRC.

The buffering theory also explains that adequate caregiving services provided for the elderly lead to improved outcomes. Hence the conceptual framework would further be used to assess the adequacy of the caregiving services of the PPRC. Analysing the adequacy of caregiving services centred on how the elderly and their family appreciated the services that is provided by the PPRC. The underlying assumption of the conceptual framework is that the elderly in the PPRC, as a result of their medical condition and old age, among others, tend to rely on the PPRC for care. Using the concept of reciprocity under the social exchange theory, the framework assumes that, as the elderly in the PPRC receive economic, medical, physiological and psychological care from the PPRC, in exchange, the PPRC gains satisfaction in the improvement in the wellbeing of the elderly residents. An improvement in living conditions occurs, as explained by the buffering theory, when there is improved health, improved food consumption, feeling of belongingness. These

may happen because the support from the institution was able to meet the needs of the elderly.

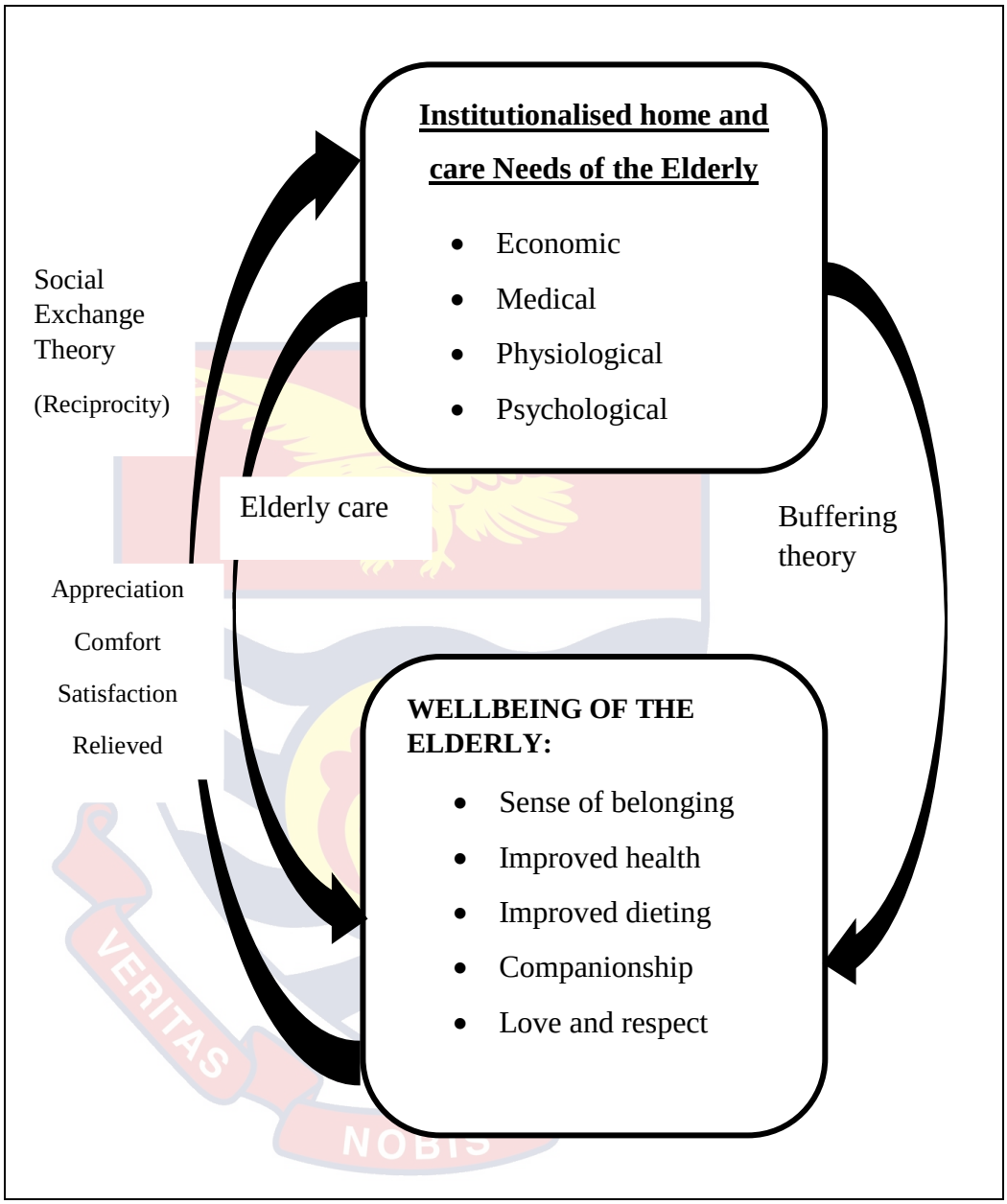

Figure 1: Conceptual Framework for Institutionalised Care for the Elderly
Source: (Homans, (1961); Blau, (1964); Sabatelli & Shehan, (2004) and Cohen & Pressman (2004)

Summary

The purpose of this chapter was to present in detail the theories underpinning this research and empirical review of related research. There are several theories such as social exchange theory and buffering theory which

explain the interactions between the elderly and their family members in the process of the elderly requiring and accessing institutionalised care. This study, however, employs the social exchange theory as the main underlining theory, which best explains the elderly and how their care is negotiated among family members and other institutions. The theory argues that, as people age, the ratio of rewards to costs associated with social interactions might shift based on social status (e.g. being elderly) and personal resources (e.g., money, power, the ability to work and provide care to others). The empirical literature also points out some methodological issues and findings of other works related to this work. Finally, the conceptual framework depicts the relationship, which exists between the key concepts of the study, which are the elderly and institutionalised care.

Desirable as it may, being elderly comes with its new challenges and demands that the individual has to deal with daily. The ageing process exposes individuals to increasing needs, which aim at sustaining their lives. These needs include health, economic, psychological, and physiological, among others (Mba, 2010; Genet, Hutchinson, Naiditch, Garms-Homolovà, Fagerström, Melchiorre, Kroneman, & Greco, 2012). Providing the needs of the elderly is a collective responsibility among the family, community and the state. The family is seen as the fundamental institution to provide the needs of the elderly. However, largely, other institutions like NGOs, the state among others sometimes come in to support these elderly when the family fails to provide these needs adequately.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter discusses the research procedures adopted for the study. It begins with a review of the competing research paradigms, followed by a description of the research design. The chapter also captures the target populations and sampling procedures. The last section deals with data sources, instruments for data collection, fieldwork, data processing and analysis, as well as ethical considerations of the study.

Research Design

Sarantakos (2005) explains research methodology as steps, strategies and procedures that are employed by a researcher to gather and analyse data in research investigation. Research methodology entails two broad paradigms, namely, qualitative and quantitative methods and the combination of the two is referred to as the mixed method. The quantitative approach employs statistical methods such as descriptive statistics and the parametric and non-parametric methods in analysing data (Bhattacherjee, 2012; Neuman, 2011). The advantages associated with the quantitative approach include generalisation of results, replicability of studies and the presentation of value free results (Sarantakos, 2005; Neuman, 2011). The weakness associated with the quantitative approach is that it fails to distinguish between appearance and essence of social events (Sarantakos, 2005).

The research questions signify that the intention of this study is not the quantification of social phenomena (Creswell, 2007). It was explorative, being particularly interested in capturing the respondents' everyday interactions and

understanding how they construct meaning out of their life experiences in the care home. This could only be achieved by immersing into their daily lives, talking to them and observing their interactions along with those who are a part of their lives and are responsible for their care and support.

The research paradigm that informed the design of this study was the phenomenological approach. This paradigm which is also known as the interpretative approach aims at understanding (De Vos, Strydom, Founche, Poggenpoel, & Schurink, 2011). As explained by De Vos et al. (2011), in this paradigm, the researcher spends hours and days in direct contact with participants observing them and making field notes relevant to the study. Central to this approach is the researcher's detailed study of transcripts, conversations and audiotapes to make sense of subtle non-verbal communication or to understand the interaction in its real context (De Vos et al., 2011).

Yin (2003) explains research design as the logical sequence that connects a study's initial research questions to the empirical data and ultimately, its conclusion. That plan of action serves as a bridge between research questions and the conditions required for collecting and analysing data in a way that aims to combine relevance to the research purpose.

The strengths of qualitative approach include; achieving a deeper understanding of the respondent's world, allowing higher flexibility, humanizing the research process by raising the role of the researched, researching people in a natural setting and presenting a more realistic view of the world. (Chadwick, Bahr & Albrecht, 1984). Qualitative research is often criticized on the basis of the following: it is time-consuming; small sample

size and minimal generalizability of findings; problems of objectivity; and risk of collecting meaningless and useless information (Chadwick, Bahr, & Albrecht, 1984).

There are two main rationales for adopting qualitative research design for this study. First, the assumption that the subjective experience of elderly needs differs among different ages and background. Secondly, the study aims at gaining in-depth insight into what happens in the study area (Nyenase & Benpogya). The focus is not on generalization but at best, on transferability in a similar context. The findings of the study are context specific.

Study Case

The study was conducted at the PPRC (Ahotokurom) in the Central Region. PPRC is located at Ahotokurom, near Elmina in the KEEA Municipality. The PPRC was established as a partnership between the Daughters of Mary and Joseph (DMJ), and the Franciscan Friars and the local community in the early 1980s. The PPRC is mainly engaged in the rehabilitation and reintegration of former sufferers of leprosy and Buruli ulcer into their communities. It is the vision of the PPRC to provide unique Christian Caring Services which are sustainable in the long term and to build self-reliance in clients. The centre operates a childcare and family support centre, day-care for children and young adults with special needs and care home for those who are unable to live independently as well as providing support services for the village of Ennyindakurom, a former army camp.

The service to the people at Ennyindakurom is at the core of the PPRC's work. This small settlement, Enyindakurom started as a military camp in the early 1950's until the late 1970's. After the military left the settlement,

Enyindakurom became a place where people who were seeking treatment for leprosy at the Ankaful Leprosy Hospital came to stay. Even after they had been cured, many could not return to their various communities because of the stigma associated with the disease and were forced to squat in this former army camp. The conditions at the camp at the time were dismal and unhygienic, especially during the rainy season. Suffering and misery were a key feature for many people who were living at the Camp. To alleviate some of the woes, it became a dream for the PPRC to work towards the provision of residential housing. A significant step forward was taken with the construction of houses. Today, the PPRC strives to ensure that residents can reintegrate into their former communities and that the children of leprosy sufferers do not get caught in a cycle of intergenerational poverty.

The centre provides integrated social care to hundreds of people from socially and economically disadvantaged backgrounds through its four centres. The four centres include St. Joseph's Childcare and Family Support Centre, which is a residential and part-time respite care home for up to about 20 children and young adults. St. Clare's Residential Home provides long-term care for the elderly and St. Elizabeth's Childcare and Family Support Centre is a multi-faceted special needs daycare centre that focuses on children and young adults with special needs. This study focused on the St. Clare's Residential Home, the care home for the elderly.

St. Clare’s is a long-term residential home for up to 20 people, primarily elderly and physically disabled former leprosy sufferers. Many of the elderly people in St. Clare’s have been struggling with leprosy for many years and suffer from deformities associated with the disease, such as chronic

ulcers. Many of the residents of St. Clare's have also lost their sight due to nerve damage. The facility has a 20-bed capacity home with an average of 17 residents at any given time. It also offers a rehabilitation programme for Buruli ulcer sufferers. St. Clare's also provides outreach and day-care programmes for the elderly in Ennyindakurom and other surrounding villages who need assistance in their day to day lives.

Population

A population is a complete set of persons or objects, which possesses some common characteristics that are of interest to the researcher (Brink, 2001). In this study, the population consisted of PPRC (St Clare) residents. All the residents are Ghanaians and hail from different communities and regions. The facility accommodates both male and female elderly persons aged 60 years and above. In all, there is a total of 15 residents at St Clare's home, of which all have intact cognitive and functional disabilities ranging from total dependency to needing care.

The PPRC was chosen because it is the only institutionalised home for the elderly near the Cape Coast Metropolis, which provides care services. The elderly residents and the caregivers were chosen because they have either experienced or provided assistance to meet the needs of the elderly. The population also included family members of the elderly residents. In this study, the total number (population) of residents and caregivers in the PPRC is 22. The PPRC consists of 15 elderly residents and seven caregivers. The management team of the PPRC consists of one Executive Administrator and two deputy Administrative Assistants, a trained nurse, a cook and two care assistants.

Sampling Technique

The study covered the entire population of the St Claire's home in the PPRC. This approach is essential where every member of the population is selected for data collection. Accidental sampling was used to choose elderly family members who came to visit.

Sources of Data

For this study, the main data was primary, which was solicited from a section of the PPRC, which included the elderly residents, caregivers (including management) and family members of the elderly.

Data Collection Instruments

To collect empirical data on the phenomenon being studied, an interview guide was the instrument used. These interviews were structured under various themes in correspondence with the research objectives (except for the background characteristics which does not have any link with the research objectives but essential to the conceptual framing) which directed the researcher to ask questions that were relevant to the study. The themes include the needs of the elderly, services provided by PPRC, adequacy of care rendered by the PPRC and measures to improve elderly care at the Centre (see Appendices B, C and D).

Open-ended questions were asked to allow freedom of expression, feelings and thoughts on the issues under study. This also helped to solicit views from respondents independently without any influence. Since some of the respondents could not express themselves in the English language, some sessions of the interviews were conducted in the Akan and Ewe languages.

Observation guide was adopted to ensure the systematic recording of events. The observation guide was structured around the concept of the study and caregiving activities at the PPRC (see Appendix E). The non-participant observation presented an opportunity to validate some of the responses given by the respondents, such as the kinds of services provided by the PPRC and the care needs of elderly residents.

Fieldwork

Data collection refers to pieces of information gathered during a research study (Brink, 2001). In discussing data gathering, Polit and Beck (2008) explained that it is a systematic and precise way of information gathering, relevant to the research purpose, or specific objectives, questions, or hypothesis of a study. For this study, face-to-face, in-depth interviews were used as a tool for gathering such information as required in this project. The benefit associated with this technique, however, is that it does not disadvantage people who cannot read and write, and secondly, it is very useful in exploring people's attitudes. The data was collected during the day; between the hours of 6:00 am and 5:30 pm. The data was gathered by the researcher and assisted by two field assistants. Discussions during the interview sessions were recorded using an audio recorder and later transcribed. The actual data gathering was carried out between December 2nd and 17th, 2019. An initial visit was made to the institution in November 2019 to book appointments for the interviews. Two research assistants; graduate students of the University of Cape Coast, were employed to aid in the data-gathering exercise. Between three to four interviews were conducted a day.

Interviews of the elderly residents and caregivers of the PPRC as well as some family members were carried out to provide a detailed understanding of the needs of the elderly and the caregiving services provided by the PPRC. Each interview lasted for an average of 10 minutes. This was to avoid overburdening the elderly residents with too many questions. A few questions were asked for a day, and the same process was repeated the following day until all items on the instrument were covered for each aged resident. In all about 45 minutes was spent on each elderly respondent as they were interviewed on three or four different sessions on different days.

Finally, observations were useful supplements to the interviews. The non-participant observation was employed to study the daily routine of the elderly and the structures the PPRC has in place for providing care for its elderly residents. The observation allowed for a more direct experience than an interview does, and also helped to clarify the context in which the study is conducted.

Data Processing and Analysis

The data gathered was purely qualitative data and therefore required qualitative analysis. Thematic network approach was used to analyse the data to explore the understanding the issue of institutionalised care for the elderly and the gap between the needs of the elderly residents and the caregiving services provided by the PPRC. This method involves examining, analysing and reporting themes within data. The thematic analysis method was used due to its suitability for data sets which makes it possible for the researcher to support themes with data (Anderson, Lees & Avery, 2015).

All the interviews with the residents, caregivers and family members were translated into English and transcribed fully. The categories in the conceptual framework (economic, medical, physiological and psychological needs) were used to guide the coding process. Trends were identified from the data using the open coding method. The prevalent trends defined from the coding were organised into the following thematic areas; needs of the elderly, kinds of caregiving services provided by the PPRC and adequacy of care services provided by the PPRC. Quotations derived from the coded data were used in the text for the analysis to support the emerging trends.

Specifically, the analysis of the support services provided by PPRC focused on their institutional capacity to provide the needs of the elderly residents. The conceptual framework was used to explain how the family and the roles of the PPRC interplay in the care for the elderly. The analysis of the adequacy of care centred on how the elderly and their family appreciated the services they were receiving as well as the institutional capacity.

Ethical Issues

The ethical issue of informed consent was overcome with a formal request to the head of the institution outlining the nature of the research, the intention, the methods used and the time. All participants and relatives also received an oral explanation about the aim, nature, and significance of the study and informed consent was obtained in written form or orally. Hence, participation was purely voluntary and any participant could withdraw their consent at any time of the interview. Participants were also assured that their names would not be mentioned in any report and that their confidentiality would be maintained. The identities of persons and events, as well as their

actions and comments, were altered with pseudonyms to preserve the anonymity and confidentiality of participants in the data. These were emphasized before commencing interviews with participants.

Even though anonymity was assured, it became quite a challenge during analysis stage. This is due to the relatively small number of elderly respondents; hence making it difficult to hide the identity of respondents. Finally, protecting the PPRC from negative and injurious information was a challenge that confronted the study. The remedy therefore was for the researcher to go back to the PPRC to confirm and/or verify all the data gathered during the fieldwork. This was done to ensure the authenticity of the data acquired.

Validity and Reliability

According to Creswell and Miller (2000), validity is achieved when the researcher systematically explores the linkages among different sources of information to inform the themes in a study. Validity of the study was enhanced by employing multiple sources of data within the organisation (the elderly, caregivers and family members) and different methods of data gathering (interviews and non-participant observation). This implies triangulation within the qualitative methods of data collection. Validity was achieved because by relying on several forms of evidence rather than a single data point in the study. Observing the lived experiences of the elderly in addition to the interviews with different respondents increased the trustworthiness of the results.

Conclusion

This chapter sought to provide in detail the methodology of the research. There exist several designs that underpin research. However, this study employed the explorative study design to inquire in-depth information on the subject matter and offered a detailed profile of it. The study was purely qualitative and used qualitative tools in its data collection, processing, presentations and analysis.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results and discussion of the study. The findings are presented under four broad sections following the specific objectives of the study. The chapter begins with the background characteristics of the respondents. The first section deals with the investigation of the needs of the elderly in the study organisation. The kinds of services provided by the PPRC were examined under the second section. The third section represents the analysis of the adequacy of the care rendered by the PPRC to the elderly. Finally, the fourth presents the recommendations made by the respondents for the improvement of elderly care at PPRC.

Background Characteristics of the Elderly Respondents

The purpose of this section is to provide an account of the general characteristics of the elderly in the institution, their family members and the caregivers in the PPRC that provided information for the study. The background information of respondents in this study includes the length of stay and age range of the elderly. All elderly residents have stayed at the Ahotokurom for at least three years, and one resident has stayed there for 20 years (Table 1).

Table 1: Demographic Characteristics of the Elderly Residents of PPRC

Years of stay at PPRC	Age	Sex	Marital Status	Surviving Children
20	86	M	W	6
15	78	M	S	1
12	79	M	Md	5
9	69	M	Md	4
9	70	M	Md	4
8	70	F	W	1
7	65	F	Md	6
6	75	M	D	3
5	68	F	W	5
4	77	F	W	2
4	66	M	D	4
3	69	F	D	2
3	74	F	W	4
3	65	M	W	7
3	72	M	W	6

Source: Field survey (2019)
F= Female; M= Male
W = Widower/widow, Md= Married, D= Divorced; S= Separated

Table 1 shows the tabulation of the demographic characteristics of the elderly in the PPRC. The research participants consisted of 15 elderly residents: 9 men (60%) and six women (40%). They ranged in age from 60 years to 86 years.

The elderly in the PPRC can be said to be in the 'entering old age' and 'transitional phase' of ageing, as categorised by Mackenzie (2012). Some elderly are in good health, whereas for others, it constitutes the stage where there is decline in functions as comorbidities begin to evolve. All residents had been in the organisation for a minimum of three years. Most of the elderly

(52%) were widowed. Many of the elderly residents as well had no form of contact with their families since they were admitted in the PPRC.

Table 2: Background Characteristics of the Elderly Residents of PPRC

Characteristics	Number of elderly	Percentage (%)
Reason for accessing the PPRC		
Medical	15	100
Financial	12	80
Physiological (food, shelter, Clothing, ADL/IADL)	8	53
Medical Condition		
On daily medication	12	80
With a wheelchair	7	46
Use artificial legs	4	27

Source: Field survey (2019)

The field data showed that all elderly residents came to the PPRC for medical reasons. All residents were affected by at least one medical condition which caused them to be unable to perform ADL and IADL. Twelve elderly (80%) were faced with financial challenges that made it difficult for them to either provide their basic needs or access private care homes. It is also clear that more than half of the elderly residents accessed the PPRC due to the physiological challenges like food, clothing and shelter that they faced (see Table 2). The medical conditions of the elderly residents as shown in Table 2, reveal that 80 percent are on daily medication, 33 percent use wheelchairs to aid them in their movements and 27 percent have artificial legs.

Kinds of care services provided by the PPRC.

The PPRC is a long-term residential home providing care for up to 20 people primarily elderly and physically disabled former leprosy sufferers. The work of PPRC can be best described as offering a peaceful and serene

environment for people who have suffered much during their lives. The centre provides medical supports to their clients. Caregiving services offered by the PPRC for the elderly is in two folds: residential and outreach services. The outreach services, on the other hand, relates to all the types of care that are provided for the elderly persons in their homes.

The kinds of caregiving services of the PPRC were analysed in terms of physiological, economic, medical and psychological. Physiological needs centred on food, clothing and shelter. Economic care giving services was measured not by the cash remittances handed to the elderly, but items procured for the elderly residents. Medical care encapsulated health care, medication and medical aids that the PPRC provides for its residents. Finally, Psychological care was discussed based on emotional support, social or recreational activities and visits from family.

With respect to shelter, the interviews and observations revealed that there are rooms allocated for the elderly residents. The Saint Clare's home consists of three cottages and each cottage has five (5) rooms. The elderly residents share the rooms, two per room. The rooms are warm and have an in-built toilet and bathroom. The rooms were fully furnished with one bed each for a resident, a wardrobe and a table and two chairs. It was also observed that each bed had a mosquito net mounted on it to prevent mosquito bites at night. The floor of the rooms was not slippery as it was concrete floor and the elderly expressed that it was suitable for their wheelchairs. However, there is no provision for alarm buttons accessible to residents in case of an emergency. Shower and bathrooms are conveniently located in each room. There is one

lounge for the residents, and the buildings are close to one another for convenience of care.

There were seven caregivers who include a trained nurse and a health assistant, one cook, one care assistant and three administrators. The nurse is responsible for scheduled drugs, medication and supervision of care, and the health assistant was responsible for the dressing of wounds. This was done every two days. The cook was assisted by the assistant caregiver to prepare breakfast, lunch and supper. The administrators saw to the day-to-day running of the organisation. The head administrator mainly managed the financial resources of the PPRC. The remaining two are responsible for (IADL) such as procurement of goods and services and also made sure that the facilities, including water and electricity, are adequately managed. They also performed ADL for the elderly in case the elderly is sick or in a position that they cannot perform ADL on their own. During the early morning routine, the nurse spends about three to five minutes with each resident. The caregivers are not always present in the resident's room even though they are all within the same arena. They come there intermittently to check up on how the residents are doing and go back to their office.

Food and clothing are also another basic need provided by the PPRC. The field data showed that the, PPRC has no dietician, but one cook is an experienced chef. All residents (100%) admitted that they rely on the PPRC for their breakfast, lunch and supper. Meals are served three times a day. However, the most common dish was rice with beef or fish stew, which was served four times within a week. Other dishes served at the PPRC include yam and plantain with leafy greens like cocoyam leaves or garden eggs stew. The

interview sessions and observations revealed that the foods are nutritious and consist of fluid, soft and high protein. Porridges like Koko (porridge made with fermented corn dough), white oats, Tom Brown (porridge made with roasted corn meal), whole wheat and rice porridge are served with milk for breakfast. Yam and plantain with egg stews are made for lunch and rice and vegetable stew for supper. All the elderly sat at the dining hall to have their meals served. Cultural meals like fufu and banku are prepared on some days. Breakfast (usually beverages like cocoa tea or porridge and bread) is served at 7:00 am; lunch and supper are served at 1:30 and 6:00 pm respectively. It was also observed that there is no strict menu for food that is served within a week.

What emerged during the conversations with the elderly residents and caregivers was that some individuals, religious groups and Civil Society organisations mostly from Cape Coast and its environs come to donate clothing which is given to the elderly. The PPRC also ensure that the residents have adequate clothing such as pullovers and jackets during the rainy season.

Among the caregiving services provided by the PPRC is economic or financial. The caregivers indicated that all the elderly who patronize the facility are from poor backgrounds, and hence, it behoves on them to provide all the financial needs of the elderly. In discussing the provision of financial needs, the elderly explained that they were not given physical cash to spend. Nevertheless, they were allowed to request for items that they would like to buy and the PPRC purchases it for them. Such items purchased for the residents include two mobile phones, one radio set, one television and mobile airtime.

Another service the PPRC provides is medical care. This includes regular visits to the hospital for routine check-ups, dressing of wounds, physical therapy, medical aid and medication. As indicated, all the residents of PPRC have at least one medical condition that requires regular visits to the hospital and routine checks. From the observations, every morning, as the residents are getting up from bed, one manager, who is a trained nurse, together with at least one caregiver goes to the beds of each resident to find out how they are feeling and whether they had a good night sleep. In this case, if any of the residents are found to be unwell, they are given first aid or sent to the hospital immediately.

It was also revealed by the elderly respondents that the PPRC provided for the medical needs, including payment of surgeries, procurement of artificial or prosthetic legs and payment of medication not covered by the National Health Insurance Scheme (NHIS), among others. The PPRC covered the surgeries of all seven (47%) of leprosy patients. In addition, 4 (26 %) who needed prosthetic legs were given. Seven (66%) who used wheelchairs, had it provided by the PPRC. One family member of one of the elderly residents sorrowfully said this,

> *I do not know what my mum would have done without this institution. She lost sight in both eyes, and we were kicked out of our place of residence as well. My senior brother could afford neither our rent nor her medical bills. This institution took her in and got her eye surgery done. Now she can see with one eye and the other surgery would be done in a few months to come.* (*A family member, 11th Dec 2019).*

> *The institution provides me with what I need, so I do not bother my family. When it comes to food, clothes, accommodation, drugs, in fact, anything that we need which they can afford, they give to us. (An elderly resident, PPRC, 14th Dec. 2019).*

Another elderly at the PPRC speaks of the kind of services they receive from the institution,

> *In fact, we do not pay for anything here. Food, rent, everything is free. They cater for everything that we need which they can afford. Moreover, if they cannot, they let us know. Life would have been really difficult if not for this place. (An elderly resident, PPRC, 13th Dec. 2019).*

It is worthy of mentioning that the elderly expressed the psychological support provided by the PPRC. Considering regular visits from the family, the PPRC ensures to get in touch with family to pay visits. The discussion revealed that nine (60%) of the elderly had not been visited since their admission. The PPRC has tried on several occasions to reach out to the family members but to no avail. The management reiterated that some family members had blocked the lines of the PPRC, so they are unable to reach them by phone. Three (20%) had their families visiting them and sometimes were allowed to spend the weekend with their families.

A family member gave accounts on the impact of their visits on the elderly residents in the following manner,

> *I know that my father becomes very happy and energetic when we come to visit. Sometimes, during the weekends, we take him home and it makes him very happy. I have observed that some of the elderly*

residents who are not visited by their families look a bit sad. Mostly, when I come around on my visits, I try to talk to all of them. They like to share their experiences and we crack jokes and laugh. (A family member, 11th Dec 2019).

Table 3: Contact with Family

Contact with Family	Number of Elderly	Percentage
Never	9	60
At least once a week	3	20
At least once in a year	2	13
At least once in a month	1	7
Total	15	100

Source: Field Survey (2019)

As indicated in Table 2, majority (nine) of the elderly residents had no form of contact with their families since they were admitted in the PPRC, 20 percent are visited by their family members on a weekly basis whereas the remaining 20 percent are not visited regularly.

Support and Challenges of the PPRC

To obtain information on the ability of the PPRC to meet the needs of the residents, the management and caregivers were asked during the interview sessions of their source of finance, their significant stakeholders and how they are able to manage the facility. It was revealed that the core funding currently required for the day-to-day running of the centre is approximately Four Hundred and Eighty Ghana Cedis (480,000 GH¢) that is (USD 87,272.73) per year. (I USD =GH¢ 5.51) The main benefactors have been the New York Province of the Franciscan Friars, the Friends of Ahotokurom in England,

Ireland and the Netherlands as well as the many individual friends and benefactors from around the world. In more recent times, the PPRC has seen strong and growing support from local benefactors. *'Unfortunately, the financial backing of some of our significant benefactors who have helped the PPRC with the day to day running of our centre has diminished over the years, even as some expenses have increased. This is partly due to the worsening economic situation in Ghana. This is of great concern as it affects the long-term sustainability of the Centre's work'* (Executive Manager, PPRC).

The findings also showed that the PPRC face numerous challenges. These challenges include lack or inadequate specialist staff such as doctors and/or nurses for providing expert care to the aged. In the views of the administrator at the PPRC, Ghana as a country does not have many Geriatric doctors and/or nurses who are specialist(s) in caring for elderly who are part of the vulnerable group in our society.

> *As a country, we do not have many doctors who specialized in this area. Those who are specialized are mostly in high demand. The situation is such that, we depend on doctors from the Ankaful Leprosarium who give us such services only on the basis that we send our clients to them for treatments. (Caregiver, PPRC, Dec. 15th 2019)*

It was also found that their significant challenges were financial constraints and passion for caring for the elderly, among others. It thus emerges that providing effective care for the elderly required adequate financial support, workers who are well-trained and have the passion for providing care services to them. It was clear that the institution does not

receive any source of funding from the government. Most of the development partners that supported them with grants do not do so regularly as they did in the past. This has become an enormous challenge for the institution in both providing for the residents and keeping up the place. Some of their remarks included:

> *We need money to cater for our residents. Most of them demand a lot, especially when it comes to health. We know, when the doctor prescribes a medication, we must get it for them, but sometimes we don't have enough money to buy the drugs because they are costly. Besides, some get frustrated when we are unable to meet their demands. Most of the organisations that used to support us financially do not provide funds anymore. (A caregiver, PPRC, 16th Dec. 2019).*

In the case of the PPRC and the aged relationship, the social exchange theory plays out that the aged tend to receive much attention in terms of medical, emotional and physiological supports voluntarily from the PPRC. The PPRC, in this case, does not specify any exact reward to be received from the aged. However, the PPRC sees that such services that they render to the aged would be rewarded in terms that the aged would feel comforted and that aligns with the vision of the PPRC. As the theory argues, for every service rendered, there should be a reciprocal effect. However, in this case, the aged does not have the exact reward to exchange for the services they receive from the PPRC. What they can give back is appreciation and the evidence that they are satisfied with the kinds of services they receive from the PPRC. The PPRC sees that as a social responsibility cost without expecting any immediate

returns but hopes that the impact of their services on the aged pays them off in the end in the view that the aged feel comforted and relieved.

Needs of the Elderly in the PPRC

The study's second objective was to investigate the needs of the elderly in the PPRC. To achieve this objective, the analysis focused on the medical, economic, psychological and physiological needs of the elderly as presented in Table 4. In the individual interviews, residents were asked to describe their personal needs and the caregivers and management were asked to outline needs of all the elderly in the PPRC. It was gathered that all the 15 elderly residents in the PPRC have vital needs which included ADL and IADL. These needs were grouped under four major categories: Economic, medical, physiological and psychological. The table shows that, out of the responses, medical needs was the most occurring need (100%) among the elderly residents of PPRC. Some of the needs that fell under the medical category as explained by the respondents included: Routine medical checks, drugs not covered by NHIS, Medical aid (such as prosthetics, wheelchair, etc.), and dressing of wounds. Psychological was the second most mentioned need (87%) revealed by the residents, with physiological needs being the least occurring need of the elderly.

Table 4: Needs of the Elderly Residents of PPRC

Needs category	Needs of the elderly	Frequency
Medical	Drugs not covered by NHIS, Medical aids Surgery, Routine check-ups Dressing of wounds	15 (100%)
Psychological	Emotional care, Family visits Recreational activities. Church service	13 (87%)
Economic	Money	12 (80%)
Physiological	Clothing, Food, Shelter, ADL/IADL	8 (53%)

Source: Field survey (2019)

To understand the needs of the elderly at the PPRC, the residents were asked what led them to the facility. The finding from the interview revealed that all 15 residents moved to the PPRC based on both minor and major disabilities. For five of them, (33%), they were living with relatives who later asked them to move out or left them to live alone which necessitated them to look out for an alternative living arrangement. However, the most common reason that led them to Ahotokurom was as a result of contracting the leprosy disease (53%) and other forms of accidents (13%) which led to the amputation of one or both legs and arms. As a result, they could not work to provide for themselves; neither could they afford rent and other expenses, hence their reason for coming to the PPRC. One elderly resident gave his reason for moving in as:

I had a car accident, and my leg was amputated at the leprosarium. The doctor told me that if I come to this place 'Ahotokurom', they could assist me in getting an 'artificial leg' so that I can move quickly. Therefore, I agreed and was brought here from the leprosarium. I only called my family to inform them of my decision to come here (An elderly resident, PPRC, 8th Dec. 2019)

Another resident also had this to say:

I was working as a security man at Abura. I had wounds and the sore was infectious. I later found out at the leprosarium that I was infected with leprosy. I spent a couple of weeks at the leprosarium where my leg was later amputated. The doctor advised I come to stay at Ahotokurom because the PPRC can take care of me. The people here also promised to give me 'artificial leg'. So I had to come here since I can't afford to buy the artificial leg (An elderly resident, PPRC, 10th Dec. 2019)

I went blind and I was sacked from where I was staying. I didn't have anywhere to go, so I decided to come here. I used to work here, so I already knew they could provide me with accommodation and health care. (An elderly resident, PPRC, 11th Dec. 2019)

A 66-year-old man revealed that he was a merchant seaman from Takoradi in the Western Region. He started having infectious wounds, which he did not know what it was. It took a long time before he came to the Ankaful leprosarium upon the recommendation of a friend. It was at the Leprosarium he was diagnosed with leprosy and the only way to stop the wounds from spreading was to amputate his left leg. The doctor further advised he comes to

stay at Ahotokurom where the doctor believes he would be taken good care off. So he informed his family and was brought to the PPRC

Table 5: Health Conditions Associated with Elderly Residents of the PPRC

Disease	No. of Elderly	Percentage
Blindness	5	33
Diabetes	5	33
Leprosy associated ulcer and Injuries	6	40

Source: Field survey (2019)

In the PPRC, all the 15 elderly have medical conditions of various kinds which include blindness, diabetes, ulcer and wounds associated with leprosy. Six (40%) male elderly suffered from leprosy and as a result, had either legs or hands amputated. Also, five (33%) of the elderly at the PPRC had diabetes and high blood pressure, two (13%) were totally blind (both eyes blinded) and the remaining three (20%) were partially blind (blind in one eye). The finding also showed that the health of the elderly was deteriorating as a result of ageing in itself and the deformities that were associated with diabetes and leprosy. For instance, one male elderly resident had total blindness as a result of his diabetic condition. Again, all 15 elderly residents mentioned that they suffer from general body weakness such as waist and body pains. In view of this, it was found that the elderly needed medical attention to be able to meet up with their daily life activities. These medical needs include medical equipment such as prosthesis (artificial legs) and wheelchairs. Their health needs also included daily medication, dressing of wounds, routine check-ups by health officials and eye surgeries for those who had lost their vision.

The above findings made from the data gathered around the needs of the elderly showed that medical needs consisting of the need for artificial legs, wheelchairs, expensive drugs or medication and surgeries among others ranked as the most occurring needs of the elderly. These needs were essential to their survival and as such, was the most prioritized.

Concerning the economic needs, it was found that the elderly require some financial support to meet specific daily expenditures such as personal belongings in the form of mobile phones to contact friends and family members. It was found that the elderly wished to have access to certain meals of their choice and do some personal shopping. The absence of financial means to meet such needs was a worry to them. About six of the elderly complained about finances to mean that they wish to get certain personal things for themselves.

The interview sessions and observations revealed that the elderly needed support with respect to a variety of food, shelter and clothing of their choice. These needs form part of the physiological needs of the elderly. Out of the total number of 15 residents, four of the elderly wished they could have their private rooms so they could enjoy their privacy. All the elderly mentioned that they would have been happy if they had more and better clothes to wear.

From the interviews made during the fieldwork, the family members of the residents did not have financial resources to meet the expenditure of the elderly. Eight, (54%) revealed that their children were not engaged in any economic activity that is able to cater substantially for their household and them as elderly.

Another physiological need revealed from the interviews was ADL and IADL. ADL involved assisting the elderly in bathing, washing and cleaning, among others. The results from the interviews indicated that the PPRC assisted the elderly with ADL when the elderly is weak to perform these functions by themselves. According to the caregivers, the residents need this assistance usually during their first few weeks of admittance in the PPRC. It was revealed that 89 percent of the elderly could not perform ADL when they were admitted. According to the caregivers and the elderly because they had undergone surgeries that led to the amputation of either their legs or arms, they had to rely on the caregivers of the PPRC for ADL. Other residents came in blind in both eyes, so they also needed assistance. The discussions showed that the PPRC trained these elderly to perform ADL. It was observed that most of the elderly residents cleaned their room and washed their clothes without assistance. The elderly residents who had lost part of their bodies such as arms and/or legs also indicated that they are able to bath and use the toilet without any difficulty.

The discussions revealed that there is a visiting Catholic priest who serves as a psychologist. He takes turns talking to the elderly residents about their emotional needs and comforts them when necessary.

> *Because we do not have permanent medical staff, we, on most occasions, perform specific essential health responsibilities like temperature checks and the rest. We mostly send them to the Ankaful General Hospital when we realize it is beyond the stage that we can manage. (Caregiver, PPRC, 13th Dec. 2019)*

The findings further showed that there are some recreational and leisure activities available for the elderly. Listening to the radio and watching television are two main leisure activities that the elderly is exposed to within the facility. To a more considerable extent, the elderly is taken to funfair centres on special occasions. Arrangements are made for residents to participate in religious services such as church. Special days like Christmas and Easter are celebrated, and residents are given gifts such as watches, bracelets and cakes. Donations of blankets, radio sets, slippers, shoes and sweets are received from the mainstream community.

As the discussions unfolded with the respondents, it was found that the elderly had psychological needs. The finding showed that affection, care, attention and visits from family are the psychological needs of the residents. It was shown that 12 (80%) of the elderly were not visited by their family members. Out of the twelve, seven had neither seen nor heard from their family members ever since they were admitted in the PPRC. Two out of the remaining five were found loitering around Ahotokurom as they had been ejected from their place of residence and did not have any relative to support them. The remaining three, had their relatives visiting them during the first year of their stay and since then, did not come to visit anymore. Hence, the elderly expressed a feeling of neglect and abandonment.

Psychological needs were not only limited to attention from family members but also, who to talk to and with whom to share their most profound sentiments. Six elderly residents, representing 40 percent revealed that the fear of death and other dreadful events, such as the death of close relatives, kept recurring in their memories. According to a 62-year-old man, he was once

involved in a fatal accident and anytime he sleeps, he feels the incident recurring.

From the data, it came out that all the elderly respondents are registered members of the National Health Insurance Scheme (NHIS) in Ghana and therefore, do not have a problem with hospital attendance. However, it is worthy of mentioning that the NHIS covers only basic and common diseases. The NHIS does not cover prescriptions for some chronic and terminal diseases. As such, the patients have to bear the cost themselves. As the findings of the study revealed, the elderly need money to keep up with some medical demands they need, such as expensive drugs. This means that elderly persons without financial support may not be able to access medical services or buy the needed drugs.

> *I wish I could buy certain things for myself, but I cannot because of lack of money. Sometimes certain drugs that I need are costly, but I cannot afford them because there is no money. (An elderly resident, PPRC, 8th Dec. 2019)*

A caregiver at the institutionalised home also added her voice regarding the economic needs of the elderly,

> *You know, money says it all. When you have money, most of the time, it helps you recover quickly when sick. These residents we have here, most of them have impoverished backgrounds. The institution takes care of their needs. Sometimes they need certain personal things which the institution does not provide, but because they do not have the means, they cannot get such things. (Caregiver, PPRC, 16th Dec. 2019)*

The wellbeing of the elderly in contemporary societies is very much associated with their financial resources. Most straightforwardly, it allows them to purchase whatever is lacking for the fulfilment of that wellbeing. Even though the economic need is an extremely complex entity, in basic terms, it has a diverse impact on the living standards of the elderly. The elderly being no exception are among the most vulnerable who need substantial economic assistance to survive. Their situation is exacerbated by their poor health and deteriorated physical condition and as a result, cannot generate economic power for their livelihood.

While elderly people vary significantly in their health status and ability to adapt, the health problems to the elderly remain significant. Health need is a considerable concern for the elderly at PPRC. All the elderly respondents revealed that the primary reason for coming to the institutionalised home was for health reasons. These health needs are expected to be provided to them by their families; however, the case is different. The absence of this gesture toward the elderly from their family members calls for an alternative which is expected to fill the gap of providing the health needs of these elderly. However, due to factors such as poverty, such demands are not provided to the elderly and hence the alternative to get such from the institutionalised homes.

> *Every elderly person needs medical assistance. When you become old, your body does not function as it used to be. Therefore, you get sick very often. Now and then, we need doctors to run a routine check-up. Aside from that, many of us have underlying conditions. Almost all have suffered from leprosy, some of us have not healed completely, and*

therefore we need the help of medical practitioners to be dressing our wounds and all that. (An elderly resident, PPRC, 2nd Dec. 2019)

From the findings under this section, it can be concluded that the nature of the care home (PPRC) brings together persons with health problems.

In analysing the basic needs, the finding showed that food, shelter and clothing were the needs of the elderly. The absence of physiological needs to be provided to the elderly will result in health deterioration. Physiological needs of the elderly aim at improving the wellbeing of the elderly.

Access to food, clothing and shelter is something that has been overlooked by many for a long time when you are young, your parents provide you with these things, when you are working, and you can offer them for yourself and your family. However, when you grow and you do not have money and a house on your own, it's very frustrating. I am here because I cannot provide food for myself. As for a home, I was living in a rented apartment and when I could not pay for the rent due to my illness, I was sacked. (A 78-year-old elderly resident, PPRC, Dec7, 2019)

A caregiver also expressed her view in this manner,

The elderly who come here or are brought here require food, clothing and shelter. Some of them were picked up from the street with no trace to their families. If not for this place, they were sleeping outside and begging for food and clothes from strangers. (PPRC, Dec 11, 2019)

Most of my relatives, including three of my children, are dead. I live here with strangers. I feel that I am going to die soon and I do not like the feeling that it brings. My body is becoming weaker by the day. I

used to live with my niece and her husband, but her husband told me I could no longer live with them, so I left. I feel rejected ever since that day. I have no one to talk to, and it is tough to live like this. (An 85-year-old elderly resident, PPRC, 17th Dec. 2019).

My wife and children do not even pick up my calls. I do not know what I have done to them. Ever since I told them I had been admitted, that was the end of the story. They did not even come to look for me or even to see where I am staying and have refused to talk to me. (An elderly resident, PPRC, 11th Dec. 2019)

In general, the psychological and or emotional needs of the elderly in PPRC are also worth considering. Due to the reduced social networks and physical mobility and ill health of the elderly, they feel a great deal of loneliness and depression. This finding concurs with the conclusion of Hall and Havens (2001), which revealed that the elderly suffers from social isolation as their social network decreases with ageing. As a result of the loneliness felt, psychological needs of the elderly become very prime to them. In most cases, the majority of the elderly are not visited by their family members. Some (60%) have neither seen nor heard from their wives, children or other relatives since they were admitted into the institution. It should be understood that visits from family members of the elderly at the PPRC are a need for survival. This need creates a sense of belongingness and affection between the elderly and their family. As often as the elderly receive such visits, the healing process that comes with their age quickens. Those elderly people who receive visits from their families (children) have somehow maintained their social networks, which have contributed to their wellbeing.

Adequacy of Care Rendered at the PPRC

The third objective of the study sought to analyse the adequacy of caregiving services rendered to the elderly at the PPRC. This was to ascertain the extent to which the elderly residents found caregiving services provided by the PPRC satisfactory. In analysing the adequacy of caregiving services by the PPRC, the study compared the needs of the elderly against the caregiving services provided by the PPRC. The study also inquired on the health, economic, psychological and social wellbeing of the elderly residents and made comparison as against the services provided by the PPRC. Out of the identified needs, residents were asked to indicate which of them are met by the PPRC.

All, 15 residents indicated all their physiological needs are being met by the PPRC. Eight (53%) residents who needed medical aid (wheelchairs and artificial legs) were provided for by the PPRC. The payment for seven (7) significant surgeries including eye surgeries and amputation of leg and arm was fully covered by the PPRC. All the elderly indicated that they appreciate the caregiving services provided by the PPRC. Eight (80%) of the residents indicated that they get kind of support they need from the PPRC. About 29 percent of residents were of the view that, they did not like staying in the PPRC and would have preferred to move out of the centre to a rented apartment. These elderly residents wanted to leave the PPRC because to them the PPRC was for leprosy survivors and the elderly who were not in the position to live independently. Five (5) residents (33) percent also indicated that they needed drugs which are quite expensive and are not covered by the NHIS, but the PPRC has given them the assurance they are going to get the

medication for them in a couple of days. The residents in general are grateful for the medical, physiological, psychological and economic support provided by the PPRC. For each caregiving service provided, ranging from food, clothing and shelter. As indicated in Table 4, majority agreed to be receiving as much as they would like, thereby indicating a high level of satisfaction.

Table 6: Elderly Needs Against Caregiving Services Provided by the PPRC

Needs	Number of elderly	Percentage of elderly	Number of Elderly with met needs	Percentage of met needs (N)
Routine check-ups,	15	100	15	100
Clothing	15	100	15	100
Food	15	100	15	100
Shelter	15	100	15	100
ADL	15	100	15	100
IADL	15	100	15	100
Psychological care	15	100	15	100
Family visits	15	100	5	33
Drugs not covered by NHIS	10	67	10	67
Money for daily upkeep	8	53	4	27
Medical aid	8	53	8	100
Surgeries	7	47	7	47
Dressing of wounds	6	40	6	40

Source: Field survey (2019) N=15

The results in Table 6 show that the extent of coverage of physiological needs, as indicated by the residents, was highest. Ten (67%) of the elderly revealed that living and using the available facilities at the PPRC are comfortable.

I am delighted with the care I receive from this place. They provide me with almost everything that I need so I cannot ask for more. Even my family could not provide for my needs as I am being catered for here. I

like being here because I do not have to worry about what I am going to eat, wear or even my hospital bills. (An elderly resident, PPRC, 5th Dec. 2019)

Discussions on service delivery concerning meals attracted mixed reactions. Some elderly appreciated and applauded the meals that they were served. However, others expressed their dissatisfaction in the kind of meals they were served. They noted that they were not served with their traditional meals regularly. This, to some extent, limited their right to choose. These reactions hold because not everybody can adequately be served. In general, 13 (89%) of the elderly indicated the meals they receive as very good.

At first, when I was in the village, what to eat was a problem. The person who was asked to take care of me did not do much. My children gave her everything, including food, but I struggled to eat three square meals a day. Since I came here, they have been taking good care of me. They do not make me starve. I eat three times a day. I like the food they give me. (An elderly resident, PPRC, 5th Dec. 2019)

Another elderly who had a contrary view to the above, had this to say,

I do not like some of the food served. I do not get to eat my local dishes like akple and okro. I have to eat what I am served like that because I cannot provide food for myself. (An elderly resident, PPRC, 5th Dec. 2019)

I feel comfortable and so excited during festive occasions like Christmas and Easter because we are sometimes transported to funfair settings to socialize. (An elderly resident, PPRC, 11th Dec. 2019)

A caregiver also expressed herself in this manner,

> *One thing that excites me is the joy we see in our clients when during funfair activities. I feel proud to be part of their happiness. I wish we could do that often, but because of financial challenges, we are unable to send them out unless for festive seasons. What we sometimes do is to open up the place for the community members to come and socialize with them once in a while. (Caregiver, PPRC, 17th Dec. 2019)*

The results also showed how the PPRC upholds the rights of the elderly, which is one of the core values of the institution. In this regard, the PPRC provides physiological (food, clothing and shelter), economic, medical and psychological needs which are essential to the life of the elderly residents It was discovered that the PPRC makes sure that the rights of the residents are not infringed upon. These include cultural, social and religious rights and the right to privacy. However, some elderly at the PPRC expressed some disregard for their dignity as portrayed toward them by some of the caregivers.

> *Some of the caregivers do not know how to talk politely, they treat us anyhow, we are older than them and they should learn how to speak to us. (An elderly resident, PPRC, 10th Dec.2019)*

The interviews also revealed that there were some disinterests with the support that the PPRC renders. The elderly at PPRC had diverse ailments, and it was expected that they should be categorised and attended to according to their illnesses.

Another resident also added:

> *When my next surgery is done and I can see clearly, I would want them to get me a room outside this place to stay. (An elderly resident, PPRC, 10th Dec. 2019)*

The adequacy of care provided by institutionalised homes stems from the measure of the services that are rendered by such institutions. The care as provided by institutionalised homes remains key to finding how impactful they are toward the elderly in such homes. Most elderly find themselves in institutionalised homes such as the PPRC with the sole aim of receiving the comfort and care that they are deficient of in the families they stem from. The perceptions of the residents were used to measure the adequacy of the caregiving services provided by the PPRC. These caregiving services range from general medical, physiological, psychological and economic assistance for the elderly.

The PPRC in its bid to provide a more comfortable living for the elderly is not able to cover all the medical bills of the elderly on the grounds of lack of financial support. Drugs not covered by National Health Insurance Scheme (NHSI) which are needed to treat specific ailments of the elderly cannot be provided by the PPRC due to financial constraints.

Psychological or emotional needs of the elderly is key for their survival. These needs may be provided from family and friends of the elderly as well as institutionalised homes such as the PPRC. Emotional detachment from the elderly could heavily affect their health negatively. In the absence of family and friends who are to provide some emotional support to the elderly,

the PPRC offers this support through social activities such as funfair games and the likes.

In conclusion, the results show that the care services rendered by the PPRC meet a good standard and achieve the mission of the PPRC as to providing some comfort to the elderly to enable them to live longer. This is because the residents and family members expressed that they were satisfied with the care provided by the PPRC, though some elderly complained about the food (not getting local meals, page 78), Drugs not covered by NHIS could not be provided by PPRC and some residents wished they had private apartments outside the PPRC. It is expected that, whenever an institution such as PPRC, which aims at putting smiles on the faces of the neglected and other deprived elderly admits such elderly, the current state should be better than their former state. This implies that care services rendered by PPRC are adequate.

On the issue of how the PPRC can improve the care needs they offer to the elderly residents, the elderly residents and caregivers indicated that, the government, private organisations and individuals, NGOs and other religious organisation should support the PPRC with funds and other material resources to abet their economic challenge. Eighty percent of the elderly also reiterated that; the government should build more cottages so that the PPRC can accommodate more elderly who need institutionalised care. The elderly also indicated that the PPRC should sensitize the communities on the leprosy stigma associated with the facility so that other elderly would feel comfortable to access the facility.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents the summary, conclusions and recommendations from the study. This study placed the PPRC within the broader context of institutional care to examine the needs of the elderly and care services provided. To assess this idea, four objectives were set for the study. First, the study examined the kinds of services the PPRC provides. Second, it investigated the needs of the elderly in the PPRC. Next, the adequacy of the care rendered by the study institution was analysed. Finally, the study presented the levels of satisfaction as indicated by the respondents on the caregiving services of the PPRC. The following research questions were formulated to guide the study: first, the kinds of services provided by the PPRC; the needs of the elderly residents at the PPRC were inquired. The adequacy of care service rendered by the study organisation.

Summary

The first chapter of this study presented on the background and problem statement. In the face of economic challenges among the family, migration and women engaging in economic activities, the role of the family as the primary provider of care for the elderly is dwindling. Therefore, activities of other institutions in the care for the elderly population becomes crucial. It considers the theoretical positions that underpin elderly care systems. Informed by the reviewed literature and the identified research gaps, the study explored the care services provided by an institutionalised home (PPRC) in the Central Region of Ghana. Out of the general objective, arose

the following specific objectives: What are the caregiving services that the PPRC provides? What are the needs of the elderly in the PPRC? How do the services provided by the PPRC meet the needs of the elderly in the residential facility?

The study used a qualitative study design. The focus of the study and the need to explore the needs of the elderly and the kinds of care services provided by the PPRC rendered the exploratory study design an appropriate approach to adopt. The exploratory study design allowed a more significant opportunity for examining the adequacy of caregiving services by the PPRC. The study participants included all elderly residents and caregivers of the PPRC. It also included some family members who came to visit. The methods used in soliciting data were interviews and non-participant observation. The narratives from the interviews were manually organised in three central themes: needs of the elderly, kinds of caregiving services and adequacy of care services provided by the PPRC. The data collection method and instrument were interview and semi-structured interview guide respectively.

The results on the socio-demographic characteristics of the 15 elderly residents revealed that more males than females were at the PPRC; the minimum age for both sexes was 65 years (entering old age as described by Mckendzie (2012)). Each resident had at least one surviving child. It was also found that the minimum number of years of stay at the PPRC by the elderly residents was three and the longest, 20 years. All the residents had at least one medical condition which constituted the main reason for their movement to the PPRC.

Medical needs emerged as the most occurring need of the elderly, followed by psychological, economic and physiological being the least occurring need. Majority of the residents have never been in contact with their families since they were admitted at the PPRC. All efforts to reach out to their families have been futile. Very few elderly residents received regular visits from their families. These elderly residents who were in contact with their families have the opportunity to spend some weekends with them at home. All the elderly residents had valid National Health Insurance subscription to access virtually free health care from government health facilities.

Accommodation is provided free by the PPRC. At most two residents share a room, toilet and bathroom but each has their own bed, a wardrobe. The rooms are well ventilated. Meals are served three times daily, with rice and beef or fish stew being the most common food served. Other dishes also include yam and plantain with garden eggs or vegetable stew. Banku with leafy vegetable stew and soup is also not left out of the menu.

The PPRC has a Catholic priest who serves as a psychologist and manages the emotional and psychological stress of the elderly residents. The mental and physical health of the elderly residents in PPRC has improved as four successful eye surgeries has been performed for the residents who came in blind. Seven residents have been provided a wheelchair and four given artificial legs. Three (13%) of the elderly are of the view that the PPRC is for people with leprosy and others are refusing to access the facility because of stigma.

The findings of the study also revealed that the elderly residents were satisfied with the care they receive at the institution. Three (13%) indicated

that they were not satisfied and would like to leave the institution but could not complain because they cannot afford life outside of the institution. This is because they feel that the PPRC is for leprosy survivors and the residents are stigmatized. On the other hand, having a place to live and being provided with services such as health care, food, clothing, among others, without having to pay is a great joy for some elderly residents. Therefore, they are satisfied with the care they receive.

The respondents recommended that the state should support the PPRC with funds and medical aids. The residents again recommended that the government should help build more structures to accommodate the increasing elderly persons who may be in need of institutional care.

Conclusions

Based on the main findings of the study, the following conclusions are drawn to inform care for the elderly in the PPRC. Conclusions based on objective two of the study were that, the elderly residents of PPRC require physiological needs such as food, clothing and shelter among others. The results also showed that, health needs constitute the major reason why the elderly moved from their homes to the PPRC. Most of them suffer a lot of deformities due to leprosy and therefore need constant health care which includes specialised health care like eye surgeries, diabetic care and dressing of wounds. Finally, it was revealed that the elderly need comfort and care from their family members. Therefore, emotional support is also a major need for the elderly. From the analysis, it can be concluded that, the elderly at the PPRC have economic, psychological, medical and physiological needs that have to be provided for. The elderly residents and their family members do not

have the financial resources to provide these needs hence; they rely on the PPRC to cater for those needs.

The PPRC provides the elderly residents with food, shelter, clothing, psychological and medical care. With regards to food, the elderly residents are given three square meals daily; breakfast, lunch and supper. At most, two elderly persons share a room with each one having a separate bed. Each morning, those with chronic ulcers had their wounds nursed. If any resident is sick, they are given first aid by a caregiver who happens to be a trained nurse. If the symptoms persist, they are taken to the Ankaful General Hospital. The PPRC pays for some medical expenses of the residents, not covered by the NHIS.

Conclusions based on objective three of the study, analysing the adequacy of caregiving services provided by the PPRC were that, the PPRC has adequate structures in place to cater for the needs of the elderly. They have a safe and secure accommodation and caregivers who are responsible for responding to the medical, psychological and nutritional needs of the elderly. However, the institution is faced with financial constraints which make it difficult to cater for all the needs of the elderly residents especially drugs not covered by NHIS.

Finally, the findings of this research contribute to the existing knowledge on institutional care for the elderly and the needs of the elderly. The findings show that institutionalised care for the elderly has the tendency to affect the physical and psychological wellbeing of the elderly. There is a strong misconception about institutionalised care especially at the PPRC, which is tagged as a place for leprosy survivors. However, the findings of this

study have given insight that the facility upholds the dignity of all elderly residents by providing them with the necessary care needed for their welfare.

Recommendations

What ensue are some suggested recommendations that could inform policy measures and provision of adequate care for the residents of the PPRC for a better physical, social and emotional wellbeing. The study found that some elderly feel lonely and depressed when their families do not visit them. The PPRC can also include visits to other institutionalised homes (children's homes) to their field trips. This will help them socialize with different groups of people such as playing with kids and this will help relieve them of boredom.

In tackling the financial challenges of the PPRC, the PPRC should train active residents (eight) in vocational skills such as bead making, baking, among others in other to generate income. Encouraging the elderly to engage in economic activity will not only generate economic returns but will also improve on the physical and mental health of the elderly as they will become more active.

Moreover, it is recommended that recreational activities should be encouraged in the PPRC. In addition, the government is to provide financial support for the PPRC by providing funds and subsidizing the cost of the utility of the facility.

Finally, the study recommends that local meals of the elderly residents such as akple and fufu among others be added to the menu. These meals should be prepared upon the request of the elderly residents.

Suggestions for Further Research

There is the need for more research to find out how the extended family members feel about their relatives accessing institutionalised care and intergenerational views about the elderly persons accessing care homes to address their care needs. Studies of this nature adopting a combination of qualitative and quantitative methods be conducted in future to provide a more holistic understanding of the perceptions old age home residents have of the general care they receive in such social facilities. Finally studies covering institutional care provided by profit making institutions needs to be researched on.

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APPENDICES

APPENDIX A (CONSENT FORM)

Dear Cherished Respondent,

This study is on ***Institutionalised Care for the Elderly and Caregiving Services in the Padre Pio Rehabilitation Centre.*** This is an academic exercise in partial fulfilment of the requirements for the award of a Master of Philosophy (MPhil) degree by the University of Cape Coast, Ghana. Please note that whatever information you provide will be treated confidentially and used for only its intended purpose. Your voluntary participation is appreciated. There are no risks involved in taking part in this study. As a voluntary respondent, you are not required to answer any question that you do not wish to respond, and you can withdraw at any time during the process. Your answering of this interview schedule will indicate your consent to participate in this study. Thank you!

Introduction

1. Introduction of the researcher, purpose of the research and importance of the input of the interviewee

APPENDIX B

INTERVIEW GUIDE FOR THE STAFF OF ORGANISATIONS

Date of interview……...

Time of interview…….

BACKGROUND CHARACTERISTICS OF RESPONDENTS

1. Sex
2. What is your educational level?
3. Position/title
4. Number of years of working at the organisation

BACKGROUND OF ORGANISATION

Objective: to obtain the institution's background information

5. What is the history behind the setting of the organisation?
6. What is the motivation behind the setting of the organisation?
7. What is the mission and vision of the organisation?
8. How long have you been operating?
9. What is the structure and management of the organisation?
10. What are the services provided?
11. What are your major sources of funding?
12. Who comes here?
13. Any additional information on the organisation?

EXPLORING NEEDS OF THE ELDERLY

14. What are the general needs of the elderly in the organisation?
    a) Economic
    b) Physiological
    c) Medical

d) psychological

15. What are the challenges the elderly face?

KINDS OF CARE PROVIDED AND HOW ADEQUATE

16. What kind of care services does the organisation provide?
    a. Physiological
    b. Economic
    c. Medical
    d. Financial
17. What is your ability to meet the needs of the elderly?
18. How does the government engage in direct delivery of care for the elderly in this institution?
19. How do you provide medical assistance to the elderly in this organisation?
20. What challenges does the institution face in meeting the needs of the elderly?

FINAL COMMENT

21. What collaborations do you have with other institutions?
22. What is the institution's plan for the future?
23. Do you think care homes should be encouraged?
24. What in your opinion should be done to improve elderly care?
25. What do you think should be the role of the family, state, churches in providing care for the elderly?

Thank you so much for your time and cooperation.

APPENDIX C

INTERVIEW GUIDE FOR THE ELDERLY

Date of interview…….

Time of interview…….

BACKGROUND CHARACTERISTICS OF RESPONDENTS

1. Age (as of your last birthday)
2. Sex:
3. Highest educational qualification
4. Marital status:
5. Religion
6. How many surviving children do you have?
7. What was your main (primary) job/occupation before you attained 60 years?
8. How long have you been in this institution?
9. Why did you choose to come here?
10. Who brought you here?
11. Are you happy to be here?

NEEDS OF THE ELDERLY

12. What are your needs as an elderly?
    a) Economic
    b) Physiological
    c) Medical
    d) psychological
13. What aspect of your life has improved?
14. Can you share with me your life experience in this institution?

KINDS OF CARE RENDERED BY THE INSTITUTION AND ITS ADEQUACY

15. What kind of care services does the organisation provide you with?
    a. Physiological
    b. Economic
    c. Medical
    d. Financial
16. What additional care would you like the institution to provide you with?

FINAL COMMENT

17. How can this institution be supported to provide care?
18. What in your opinion should be done to improve elderly care in Ghana?
19. What role would you want your relatives to play in your care at this institution?
20. After having these experiences in this institution, what advice would you give to someone who has discovered that they need institutional care?
21. Is there anything else you think I should know to help me understand your situation better?
22. Is there anything you would like to ask me?

APPENDIX D

INTERVIEW GUIDE FOR FAMILY MEMBERS

1. Age
2. Sex
3. Marital status
4. Occupation
5. What is your relationship with the elderly in this institution?
6. What are the care needs of your elderly family member?
   a) Economic
   b) Physiological
   c) Medical
   d) psychological
7. What is/are the reason(s) for bringing your elderly family member to the institutionalised home?
8. What benefits have you derived from bringing the elderly to the institutionalised home?
9. Are you satisfied with the care provided by this organisation to your elderly family member?
10. What can family members can do to support the elderly in institutionalised care?
11. What can be done to support institutions caring for the elderly?

APPENDIX E

OBSERVATION CHECK LIST

1. Facilities available
2. The state of living quarters/ building (physical conditions of houses)
3. Meals
4. Physical state of the elderly
5. Physical exercises
6. Recreational activities

Probe:

Objective	Further questions

Needs of the elderly	Physical (ADL/IADL) e.g.
	• Walking, bathing, food, shelter, clothing
	• Psychological
	  ○ Emotional
	  ○ Companionship
	• Health, medical service, regular check-ups,
	• Economic
	• Social other

Adequacy of care	• Affordability and accessibility poor and marginalized • Human rights, maintaining dignity and respect, self-expression, choice • Person centred; not based on facilities available • Government responsibility