Caregiver's perceptions regarding assisted care in the Cape Coast Metropolitan area

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Abstract

Objectives: This study explored and described perceptions of caregivers regarding inception of assisted care.

Background: In old age, people increasingly need help from others. Older people's inability to take care of themselves makes them dependent on their families. Their survival is at risk when they become frail or fall ill, and a single bout of ill health may well be terminal.

Methods: This study used three questions in its investigation: How do the aged prepare for their ageing? What services constitute the traditional model for care? How would respondents feel if this care was replaced with assisted care that took the form of modernized traditional care? The study used a mixed method, sequential approach in which qualitative data was collected before quantitative data. The quantitative data was used to augment the qualitative data. Data was collected through focused group discussions and questionnaires from 388 respondents ranging in age from 13 to 72 years and over a period of 5 months i.e. from September 2016 to January 2017. The Focus Group Discussions, (FGD) were digitally recorded and transcribed verbatim. Quantitative data was entered into SPSS version 23 and cleaned. Both sets of data were coded and analysed.

Results: The study revealed that the primary role of care givers was to provide care for their aged; that they had no idea how the aged they served prepared for their ageing, and that the idea of assisted care was well received, with strong approval from almost all of the 388 respondents.

Conclusion: Care givers perceived assisted living as an area where they could learn new skills and have an opportunity to earn money from legitimate work. The study also showed that care givers pay less attention to the work they were doing because it was unpaid.

Key words: Activity of daily living, assisted care, Cape Coast Metropolitan area, older persons, preparedness.

Introduction

The role of the older people in the African family is to provide care for children who will in turn provide care for them in their old age; hence the Shorna saying, "karere kagokurerawo" (look after it and it will look after you). The more children one has the more chance there is of receiving care when one is no longer able to provide for oneself. The system ensured that the needs of individuals were catered for within the family. Nobody will starve when other members of the family have plenty. No children would live alone even if all the direct (or biological) members of their family died. The concept that "it takes a village to bring up a child" was applicable (1). Care for dependent members is a core dimension of family life. As elsewhere, some aged in sub-Saharan Africa serve both as care providers to orphans and vulnerable children in contexts of HIV, poverty and labour-related migration (2-4) and as recipients themselves of long-term care (5). Transformation from a rural society to a rapidly urbanizing society also has influential consequences (6) for social attitudes to ageing and the needs of older adults (7). Older people have diminished capacity to sustain themselves through own income, savings, assets, or pensions. Their consequent vulnerability to risk of poverty from life events such as sudden retirement, redundancy, or death of a spouse (8), makes them dependents on younger adults or families for support. In some west African countries such as Ghana and Nigeria there is over-reliance on family support in customary value systems and arrangements where adult children and family are saddled with older people's needs (9).

Background

Traditionally, older people, especially women, care for grandchildren in the absence of their parents. The major change that has occurred is that care must now often be provided without the support of sons and daughters or other kin because of HIV/AIDS- related deaths (10). Indications are that the West African family system no longer affords sufficient protection to many of their aged, and sizeable proportions of the aged report receiving insufficient support from kinsmen with evident shortcomings in family support (9). In addition, more women are entering the labour market, reducing the availability of caregivers, who in most cases are traditionally women.

Family members are important decision-makers when they are present and involved, but their role in clinical decisions varies depending upon interest, knowledge and availability of decision makers. They can be an important link to an aged person's history and desires, especially in cases where the aged are unable to communicate such wishes for themselves. The voice of aged residents for advocacy is particularly important as nursing homes seek to provide care that is individualized and increasingly person-centred. However, it is important that family members be considered as partners in decision-making (11). Family members value aged resident's comfort and quality of life, an area of nursing care that can be attended to by nursing home staff, often without hospital-level medical intervention (12). Family caregivers play an essential role, usually unpaid, in caring services, but a family member caring for an older person may not be prepared for the challenge. The needs of older patients are diverse and may include assistance with medication, transportation for treatment, activities of daily living, and emotional support; activities that caregivers find particularly stressful include helping patients with their self-care, managing their treatment and symptoms, and dealing with the suffering of a family member. Families may also be affected by other stressors, such as changes in roles and employment and disruptions in schedules (13). However, these caregivers respond to stressors differently; older spouses may be particularly vulnerable because of their own frailty.

There are negative effects on caregivers' psychological, social, and physical health functioning. Social and economic deficits in relation to caregiving may include lifestyle disruption, less socializing and greater out-of-pocket and lost productivity costs. In addition, caregivers' stress and "burnout" have been associated with an increased risk of institutionalization (14). In most developing countries, formal social security systems have limited coverage and inadequate benefit payments (15,16). Thus, older people depend on family support networks, a reality that is well appreciated in most parts of sub-Saharan Africa (17-19). It is thus recognized that traditional social security systems are changing, weakening and rapidly disappearing, due to pressures from urbanization and industrialization (20). Youths migrate to cities while the elderly move back to the rural areas. However, elderly persons in Nigeria usually reside in rural communities, particularly those who have retired from their place of work (21).

It is difficult to obtain a clear picture of the care which old people in rural Ghana enjoy. Some have been successful in life and have been able to give their children a good education, resulting in a good social position which enables the children to take good care of them. They buy their elderly parents everything that is needed for their comfort and the houses of such people are often filled with children, nieces, nephews and grandchildren. Their good life attracts relatives who bring company and presents (22). As described by Geest (1995) the quality of life of the less well-to-do elderly is harder to gauge, with contradictory indications. One moment they may complain that they have no money for food, that their children are far away, seldom visit them, and do not remit sufficient money on which to live comfortably; at other times, they may praise their children for the way in which they look after them, since it would be shameful to admit that their children neglect them. In the past young people took good care of the aged, but times have changed (22).

Institutional setting or home

Health status varies while ageing, and the aspects of home also change over time, even when the elderly person stays in the same home environment. In advanced age, it becomes increasingly important to live in a home

that suits one's physical needs. Similarly, cognitive and emotional issues such as security and familiarity in the home become increasingly important (23). In Australia, aged who require long-term care but live at home or in the community rather than in institutions need assistance with three or more activities of daily living (24).

Types of assisted care options

Whether the reason for moving into an assisted living facility is prompted by a serious medical condition or the desire for a lifestyle change because it is becoming more challenging to live independently, it is important to assess the current situation and look at all the options to make the right choice with an environment that is healthy, happy and more fulfilling (25). With so many senior housing options available, it's easy to feel confused and overwhelmed by the vast number of care types and styles of aged living communities which do not exist in Ghana. It is important to learn the terminology and the differences between aged care solutions that are out there so that the right choice can be made (26). Assisted care givers assistance is with activities that people do every day without needing assistance. They include eating, bathing, dressing, toileting, transferring (walking) and continence. An individual's ability to perform these activities of daily living (ADLs) is an important element in understanding the type of services that are needed. In most instances, these services are provided to seniors who may need a little extra help or in some instances more help like 24 hours, 7 days a week, or even a live-in arrangement.

The available options include independent living facilities (IL or ILF), where a senior living option is designed to enable independent older persons to enjoy an active lifestyle in a community of their peers. This design typically involves apartment-style housing for an age-restricted community of residents. They also are sometimes made up of freestanding homes or condominiums which provide optional private duty services. In most cases, the facility develops a relationship with a private duty company that provides services to the residents as needed. An assisted living facility (AL or ALF) is another aged living option that combines apartment-style housing, organized social interaction, and private duty support services as needed. Health care services are often provided by outside providers who either rent an office in the building or visit the building periodically. Assisted living is designed for individuals who require assistance with everyday activities such as meals, medication management, or physical assistance with bathing, dressing, and transportation. Some residents may have memory disorders, including Alzheimer's, or they may need help with mobility, incontinence, or other challenges. A skilled nursing facility (SNF) is an institution or part of an institution that meets criteria for accreditation established by the sections of the Social Security Act that determines the basis for medical insurance reimbursement for skilled nursing care. A continuous care retirement community (CCRC) is a campus which incorporates all levels of care on one property. Generally, the nurses and therapists of the SNF unit provide care as necessary to the AL and IL residents. However, the priority of the healthcare staff on the campus is to care for the SNF residents. Often external providers of the health care and private duty services are brought in to deliver care to the residents of the IL and AL portions of the property (27).

Materials and Methods

Design and setting

The objective of the study was to explore and describe the reaction of caregivers to the inception of assisted care. Study design was mixed method in which qualitative data was strengthened by quantitative data. It used a sequential approach in which the researcher sought to elaborate on or expand the findings of one method with application of another method. This involved beginning with a qualitative method for exploratory purposes following up with a quantitative method using a large sample so that there could be generalization of results to the population (28). In-depth interviews and focus group discussions were therefore collected first, and questionnaires were then designed based on the findings from the qualitative phase.

The study was carried out in the Cape Coast Metropolitan area, one of the seventeen (17) districts of the Central Region of south Ghana. The Metropolis is further divided into 25 sub-districts for administrative purposes by government. For the 25 sub-districts, 10 were randomly selected using SPSS version 20 software. The selected sites were Ola, Adisadel, Aboom, Amoako-Mempeasem, Duakor, Third Ridge, Pedu, Koforidua, Dehia and Krofofrodu. Efutu, another adjoining community, was used to test study instruments. These 10 sub-districts were further classified into three different zones: urban (elite residential communities), peri-urban (either urban or rural, but densely populated) and rural (lacking almost all social amenities). For clearer understanding in the study, the zones were demarcated as zones A, B, C.

In view of the differing population density of the communities, proportional-to-size approach was used in distribution of potential respondents from which participants were recruited. It was concluded by the PI and research team that the urban and rural areas should each be given 25% of sample size and the peri-urban was given 50%, since it was heavily populated with old people.

Sampling and data collection techniques

An initial total of 384 caregivers was proposed for the study and, in the field 388 ultimately consented to give their time and information for the study. Of this number, 44 were recruited to participate in the FGD. The inclusion criterion was strictly those taking care of an elderly person in the age group of 65 years and above. The PI and the research assistants collected all the qualitative data using a semi-structured guide to conduct focus group discussions. The four main questions for all the groups were: (a) What was the level of the welfare for the aged in their care in relation to activities of daily living? (b) How did these aged prepare for their current situation? (c) On a scale of 1-10, how strong were they? (d) What were their views on the inception of

Figure 1: Sub-districts of Cape Coast Municipality- GIS, UCC, 2014

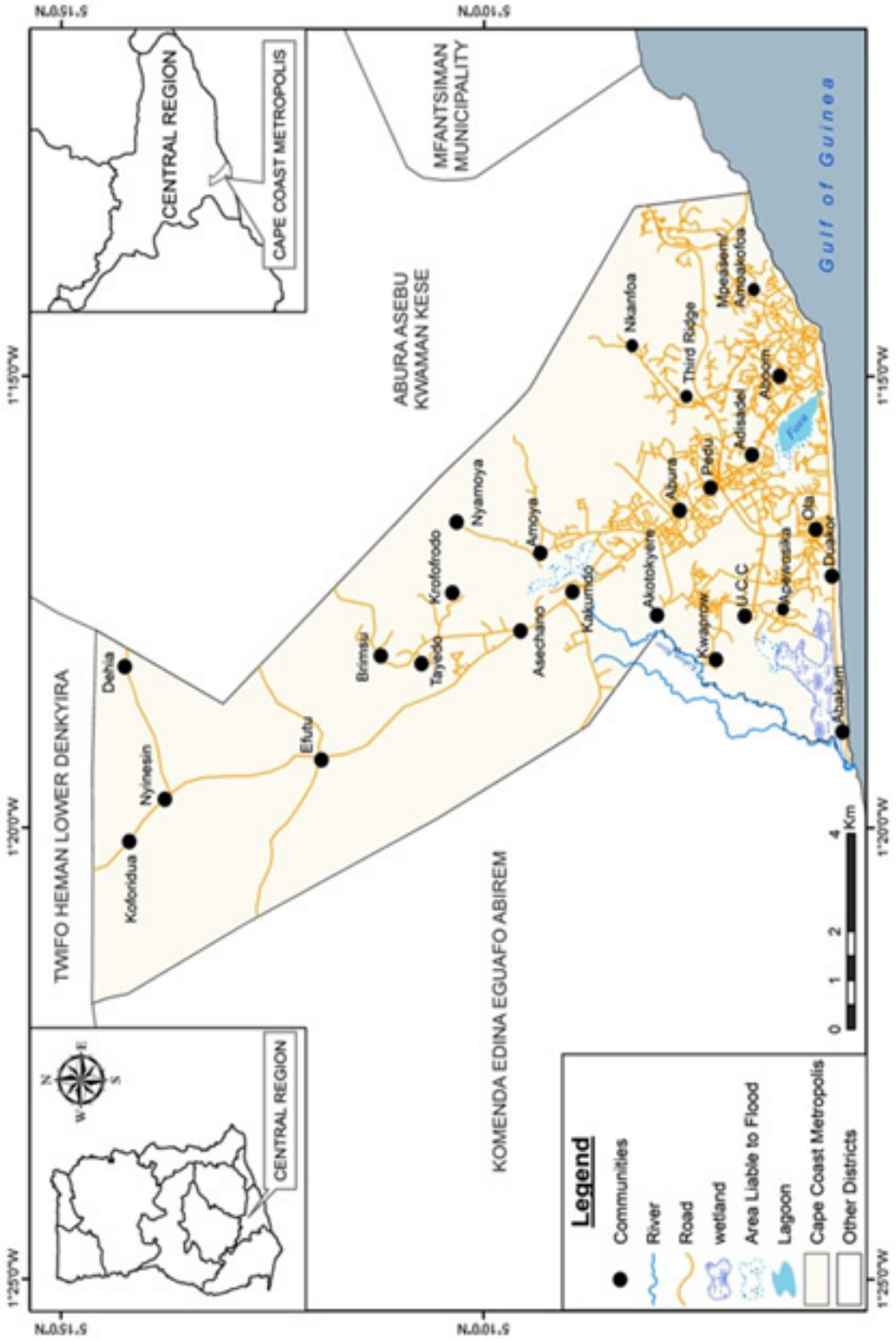

Table 1: Study sites, zones and activities

Sites	Zones	Activity/ number of participants	Activity /number of respondents
Site 1 Site 2 Site 3 Site 4	A	FGD / 12	Questionnaire / 97
Site 5 Site 6	B	FGD / 20	Questionnaire / 194
Site 7 Site 8 Site 9 Site 10	C	FGD / 12	Questionnaire / 97

assisted care in Cape Coast? The questionnaires were both structured and semi-structured. The questions were divided into five sections: Section A, data on personal information; Section B, data on preparedness of the aged for their ageing; Section C, data on current care practices looking at activities of daily living; Section D, data on care that needed to be added to what the aged received; Section E, caregivers' views on the inceptions of assisted care in the Cape Coast Metropolitan area. An assembly member (AM) for each zone was identified and appointed and given the assignment of looking for a convenient venue for the discussion in a week's time. After each discussion, a day was booked for those who attended the discussion to inform other caregivers that questionnaires would be distributed for them to fill. This was to stimulate other key informants in the communities, through grapevine communication, about the impending data collection. The age range of the target population was 13 to 72 years. The population was skewed to females because all participants and respondents were females. Five field workers and a research assistant were recruited, based on their knowledge and experience of the topic under study, and were given 3 days of training. Data collection began in October 2016 and ended in January 2017. Three successful FGDs were done in the identified zones followed by the quantitative aspect of data. Duration of the discussions was between 40 minutes and one hour. With the quantitative data, a total of 388 questionnaires were completely answered. Systematic random sampling was employed in which every second house was sampled. Questionnaires were given to those solely in charge of the aged. Due to the cooperative nature of caring, the study attracted more caregivers than initially planned. All caregivers at the point of data collection were included and taken through the questionnaire. Those not able to read and write were taken through the questions one by one by the field workers and research assistant, in the local language, until the questionnaire was completed.

One of the challenges that were encountered was eagerness of the caregivers to give more information than we could handle; also, because it was election year, any gathering quickly attracted attention from community members, which sometimes made it difficult to control the crowd. Participants were given refreshments in view of the length of time they spent with researchers.

Ethical issues

Participants and respondents were assured of confidentiality and anonymity before each procedure started. They were given consent forms to read and sign and those who could not read and write were given detailed explanation of what they were about to do before thumb printing. Minors were asked to present their guardian, who either agreed or declined to allow their participation in the study.

Data management and analysis

The tape-recorded FGDs were transcribed verbatim from native language into English by the PI and trained research assistant. The transcripts were checked for accuracy and quality and cleaned for anonymity by the PI. When no discrepancies were identified, the files were coded for analysis. The method of analysis was interpretive descriptive content analysis to gain insight into the caregivers' perceptions regarding the inception of assisted care in Cape Coast Metropolis (29). At the initial stage, the contents of the data files were read to identify major thematic areas. The main task was to display data in a way that meaningfully indicated conceptual distinctions and provided content that illuminated the concept. Three key elements of interpretive descriptive content analysis were followed: detection, (which involved identification), assigning the substantive content, and displaying the dimensions of the topics under study. These dimensions came out with one major theme and six sub themes: welfare, government plans, support systems available, activities of daily living by assessing the strength of the aged by caretakers on the scale of 1 to 10; caretakers' perception of assisted care and strategies for the programme.

Findings

The environment in which people find themselves, coupled with their background characteristics, have implications for their health and welfare. It has been established that there is a relationship between residence, living arrangements, personal characteristics such as age, sex, marital status and level of education, with health and welfare (30,31). The themes identified in the FGDs and questionnaires were participant' characteristics, welfare of the aged, government plans, support systems, payment plans and reaction to assisted care.

Participant characteristics

Community members who learned about the purpose of the study were all willing to give researchers information. From the 44 participants recruited for the FGDs, most had primary education but could read and write and could speak English. They were mainly married or never married, and some were widowed or separated/divorced. Their ages ranged between 13 and 72 years; they were all Christians, and were once fishmongers, petty traders or artisans, but were now unemployed since assuming their new role as caregivers. Some had children while others did not. Those who were parents had between two and ten children. Participants from zone A said (in chorus), '*not all of us attended school'* (FA). One participant added *'I have, most of us have been to school but we cannot write'* (FA1). In relation to marriage, participants echoed the statement that '*all of us have been married before but now either divorced, widowed or separated*' (FB1). Another added that *'I lost my husband because I had to come home and care for my mother*' (FB2). In relation to occupation, one reported, '*I was once a fishmonger, but I do sell few items on table in front of our house'* (FB2). A participant from the third group said '*we were once working as fishmongers, artisans, government workers, petty traders but none of us is working now.* With this new role, I cannot add work to it' (FC1). When asked the number of children they had, typical responses were '*I have three children and they are all grown up now'* (FA1). '*I have six children'* (FB2). They all reported being Christians, indicating recognized Christian sects such as Roman Catholic, Disciples of the Twelve Apostles, Anglican, Methodist and Awoyo.

Demographic characteristics of questionnaire respondent caregivers were combined with those of FGD participant caregivers.

Table 2 (next page) shows the age distribution of respondents providing information. The latest age group 19.3% was 30-39-year age group and the smallest 8.5% was the age group 70 years and over. In sex distribution, the study was skewed to female caregivers at 98.4%. A majority were married, with a small number 3.9% being widows or widowers. Christianity was the main religion in the community. Highest level of educational attainment of respondents was primary 43.3% and secondary 27.6%. Main occupation categories were others 49.9%, followed by unemployed. Participants did not consider housekeeping chores as an occupational role but chose instead to classify themselves as unemployed or others. More than 50% of respondents had ever had one child or more, and they mostly lived in the same residence as the aged, with only 10.4% living out.

Welfare, Knowledge and Social Support for the Aged

Welfare

Minimal care provision by caregivers, and minimal provision for basic needs from government plans or social support for the aged, had evidently negative effects on well-being. Participants' responses on the welfare of the aged were not encouraging:

Some of them are living with their children but they are not happy …. They are saying their mum is a difficult person, so they do not want to support her … to make her give in to their demands …. The woman is around 90+ years (FA2)

Some are in the same house with their sisters and children, but they are at loggerheads with each other …. They don't allow their children to help those in need …. It is so difficult for them to ask for a favour from their sister's children …. The children will not even go when they send them on errands (FA3)

Another participant commented on the special needs faced by weaker elderly people:

Sometimes you must perform the necessary care from them …. If they are not assisted in those things it will not be the best … because they have regressed into childhood and need to be assisted (FA5).

Medical conditions such as dementia were mentioned as particularly difficult for caregivers:

I want to add that some of the old ones due to some medical conditions such as dementia become troublesome, the youngsters do not understand them very well and tend to avoid them and do not want to stay with them leading to neglect (FA4).

Table 3 indicates how respondents perceived the strength of their wards on a scale of 0 to 10, where the zero signifies total dependence and 10 signified independence, knowledge of government planning for the aged and social support for the aged in CCM.

Government plans

Government is responsible for its population socially, politically and psychologically. Government plans are implemented through social welfare, and on-going communication and openness of these plans is important. This openness is tied to departmental core missions, and updates and new initiatives help to improve openness.

Table 2: Demographic characteristics of caregivers

Demographic Variables		N = (388)	% (100)
Aged (years)	10 – 19	31	8.0
	20 – 29	59	15.2
	30 – 39	75	19.3
	40 – 49	70	18
	50 – 59	64	16.5
	60 – 69	56	14.5
	70 +	3.3	8.5
Sex	Male	6	1.6
	Female	382	98.4
Marital status	Single / never married	103	26.5
	Married	259	66.8
	Divorced /separated	11	2.8
	Widowed / widower	15	3.9
Religious affiliation	Christian	341	87.9
	Islam	42	10.7
	Traditional religion	1	0.3
	No religion	4	1.1
Level of education	No education	67	17.3
	Primary education	168	43.3
	Secondary education	107	27.6
	Tertiary education	46	11.8
Occupation	Unemployment	77	19.8
	Housekeeper	4	1.0
	Artisan	66	17.0
	Pension	40	10.3
	Other (trader & student)	201 (173 & 28)	49.9 (44.7 & 7.2)
Children ever born (CEB)	None	103	26.6
	1-3	165	42.4
	4-6	86	22.2
	7-10	34	8.8
Place of residence	Live-in	347	89.4
	Live-out	41	10.4

Table 3: Welfare, Knowledge of Government Plans and Social Support for the Aged

Activity levels of the aged	N=388	%(100)
0 - total dependent	21	5.4
1-3 (dependent)	96	24.7
4-6 (partial dependent)	89	22.9
7-9 (semi-independent)	88	22.7
10 (independent)	94	24.2
Knowledge of Government plans for the aged		
Yes	32	8.2
No	356	91.8
Social support	Yes %	No%
Any community supports	7.7	92.3
Community service through guidance and counselling	28.6	71.4
Aged solving problems at the community centre	31.7	68.3
Aged spending time at the family house to organize festivals such as outdooring, puberty rites, marriages, funerals	42.0	58.0

Government plans

Government is responsible for its population socially, politically and psychologically. Government plans are implemented through social welfare, and on-going communication and openness of these plans is important. This openness is tied to departmental core missions, and updates and new initiatives help to improve openness. When participants were asked if they knew if government had plans that could transform their lives, two of the responses were:

We have ideas of some of the plans e.g. the NHIS and the amount of renewal …. apart from this nothing. (FB1)

I am on pension, so I know about that one too. (FB3).

Support systems

Caregivers involved with caring for the aged are required to provide individual or group support which may be either physical or emotional. When asked what caring systems were in place for the aged, participants mentioned caregivers, activities of daily living and visits from significant others. They indicated that they thought immediate family members were the right people to give care to their own kin. Two indicative responses were:

If the caregiver is her child, then she will be treated well because at that age I feel their character is so weird or the life they led that people saw leads to how they are treated in their period of old age …. It will be sad if we want to look at such things to care for them …. because when they start falling sick in their old age … they are faced with what they planted when they were active. (FA7)

There are some whose children are not around …. they are all away, so a different person altogether comes to take care of their kin ... perhaps this person will not have that patience for the old person's nagging. Caring depends on relationship. (FA5)

Activities of daily living

These are the basic activities performed by individuals on a daily basis that are necessary for independent living at home or in the community. Whether individuals can perform these activities on their own or rely on family caregivers for assistance serves as a comparative measure of their independence. On this point, participants mentioned various services rendered which included personal hygiene, mobility, feeding, elimination, medication, transportation, rest and sleep. Visits from family members and significant others were important for caregivers and they were very grateful for church visits for their kin.

Her friends visit us, and the church also send delegations to check on us monthly …. For relatives we see them all the time …. They are all around us … so there is no problem (FB10).

In another instance, the caregiver's mother was connected with church and was frequently visited by the priest:

My mother held a position and have been pensioned from church, so the Rev. Father comes to give her communion at home (FB9).

Respondents were asked if the aged were involved in the community services such as providing guidance and counselling of the community members, since old age is associated with experience and wisdom, and the response was largely negative. It was also noted that the aged mostly did not assist the local judiciary in family disputes in the traditional courts that were held in the community centres and did not to get involved with family issues.

Perception of assisted care

Participants were asked if they wanted something like assisted care, following a thorough explanation of the programme that was given to them by the PI. There were quick responses commenting on the difficulties and shortcomings in the care given at home:

To me the care at home is not good because these days our economy is bad, and everybody wants to work …. So, caregivers are in hurry to leave for their respective work places. (FA9)

Unfortunately, some were not able to have children …. It is so difficult for them. … They are rejected on the grounds of barrenness and poverty … so I think it is a good idea for this programme to come to Ghana (FB10).

One participant was very much against the programme:

In Ghana, we do not need these things … to be frank with you …. People will insult you … and cast insinuations that you could not look after your parents who matter most in your life … For me, I do not agree to this programme (FA5)

Others expressed support for the programme:

I like it …. Just like we leave our children with attendants, we anticipate attendant recklessness. Now we need to do this for our parents … because we are all working. We need to accept this programme than leave your frail mothers all alone at home …. With the mindset that we can care for them knowing that we cannot because when we get up … we leave for work and come home tired or depressed. But when we are aware they are well catered for … we will be at ease. On public holidays, we can go and visit them or bring them home for some time but not abandon them. However, at that place she will meet her age mates and make friends, entertain themselves … unlike at home. Right now, most of us are leaving in areas that are like apartment kind of building not family houses … and when you come back … they are so sad. But if they are at a place where they are happy … I will be happy too. For me I am for it …. it should come on (FA7).

Some of us have the money but not caretakers … so we are ready for this programme … some even have children but not caretakers … so life is so difficult for us sometimes (FA4).

Participants were made aware that the proposed home would not receive any subsidy from government or an insurance company, and that the premium available was solely for the NHIS. They were asked what should be done to start with the programme if they were interested, with the options that the PI outlined being initiatives by children and/or self, by family members or by government. Some felt that it was the responsibility of the children to look after their own, and that government must also help:

Create an aged home so that the children will pay towards the upkeep of their parents … because they are busy and will not get adequate time for their parent(s) …. but care must be given (FA4).

I think government should take the cost … he has the money (FB4); we do not have the money so government should take the cost, or part of the cost (FB11).

Some were unable to offer suggestions because the decision makers were not readily available to make the necessary choices:

I think we need to discuss with the children (employer) before I can come out with a concrete answer … because they have to know about this programme. (FB6)

Backing the information received from the FGDs, Table 4 gives the quantitative data on reaction to the study.

Overall responses showed reluctance towards aged parents being taken from caregivers and sent to an institution. About 40% indicated in the negative, and this was followed by a further 28.6% who said their reaction would be indifferent for the same reason. Others in this regard were of two views - either sad or indifferent depending on their current situation.

In regard to payment for upkeep of the aged, most respondents 70.4% indicated that they would want government to take up the cost. A much smaller group 16.2% felt that the children of the aged, or in a few cases, 1.0%, other family members, should bear the cost, and there were also respondents who thought that combinations such as government and children or children and relatives should take responsibility.

Strategy for the programme

When participants were asked what strategies were needed to be put in place, they suggested a day-care centre and a place to hold subsequent meetings for proper planning:

Table 4: Distribution of assisted care in Ghana

Reasons for the acceptance of assisted care in Ghana	N	%
Be around people of their own age		
Very happy	104	26.8
Indifferent	111	28.6
Very unhappy	157	40.5
Others	16	4.1
Payment for upkeep		
Government	273	70.4
Children	63	16.2
Relatives	4	1.0
Others	48	12.4
Sharing living space with peers		
Yes	167	43.0
No	221	57.0
Prior knowledge on assisted care		
Yes	119	30.7
No	269	69.3
Acceptance of assisted care in Ghana		
Yes	381	98.2
No	7	1.8

This programme must be of the day care type and/or a boarding or lodging and the stay in the home must be monthly or depending on what the children can take. (FA4)

The first thing we need is infrastructure …. a place for holding meetings to think through the programme. (FB11)

Discussion

The intention of this study was to explore community perceptions on assisted care as a modernized option in caring for the aged in the Cape Coast Metropolis. Healthcare policy that spells out how the aged are to be cared for exist but there is a strong preference for caring to be done in the homes. Ghana is a middle-income country with a young population, and in the study the modal class was 30-39 years and female. In a study by (32), 54% of the caregivers were 54 years or older, 72% were single, and 66% of the households were headed by women. Most of the caregivers 57% had little or no education. In our study, almost all the women participants were married with basic or primary level education, in keeping with MDG2 that calls for compulsory basic education for all, and in line with a rising primary school net enrolment rate in developing regions which reached an estimated 91% in 2015, up from 83% in 2000 (33). Study respondents who indicated 'No education' might have dropped out of school or were never enrolled. The UNDP (2017) document further noted that the number of out-of-school children of primary school age worldwide has fallen by almost half, to an estimated 57 million in 2015, from 100 million in 2000. Participants indicated that the aged were living with their own children and were not happy, which shows that most aged or elderly would like to stay with a relative. This corresponds with a finding by (21) that the elderly living with children appear to have a greater opportunity of good well-being than those living alone. This could include elderly who still have young children and grandchildren to cater for. Although diversion of caregivers to meet the needs of young children can have a negative impact on the health of the elderly, elderly women may be wishing to live with their married children even if this means that they are saddled with taking care of their grandchildren; they prefer to live in the family home even if prevailing conditions are not favourable.

Due to increasing longevity, declining mortality and fertility, older adults account for an increasing proportion of the world's population today, and this number continues to grow (34). This may be because of feasible public health strategies for health promotion, so that people are living longer, becoming healthier and stronger, and can therefore carry out their day-to-day activities with minimal assistance or support. Notably, more than 71% of respondents in our study said their aged could do things for themselves.

Respondents were not aware of government plans and policies; this could be because they could not read even though they had been to school and could speak English. Although there were no spelt out cultural rules governing the support systems that were in place, respondents believed that the best caregivers for their aged were family members, especially their children. It could be an indication of the absence of assisted care or ignorance about how care is delivered in assisted living. Culture is

mostly transmitted from generation to generation through folklore, socialization and artefacts, and according to (35), the flow of culture across geographical boundaries make people learn, and people who live near each other especially, are likely to share cultural values. This idea does suggest that similarities in culture creates emergent and coherent cultures that individuals can clearly be labelled as 'inside of' or 'outside of'. Even where people knew they are busy and should assign the care of their aged to someone else for help, they adamantly resisted because culture does not allow it. Care is an unambiguous affair, an observable fact. Its two basic constituents are emotional and technical/practical, with the latter referring to concrete activities carried out for others who may not be able to do these things on their own (36). Parents take care of their children by feeding them, providing shelter, educating and training them, and so forth. Healthy people take care of sick people and young people take care of old people. Geest (2002)'s ethnographic study found that some of the most common activities for which the elderly people need help from others are getting food, taking a bath, washing clothes, and going to the toilet. Helping them financially and providing company are also indispensable tokens of care. Finally, in the eyes of many, the most important type of 'care' is the organization of a fitting funeral when the elder dies. As indicated by the focus group participants and questionnaire respondents, caring meant assisting the elderly in day-to-day activities which included fetching water for them to bathe, preparation of food, running errands such as banking services, and reading letters from loved ones. Informants also noted that quality of care in the home was not good, yet at the same time they were sceptical about assisted care. They were unhappy at the idea of elderly people living together. This could be because of fear of the unknown, having had no previous experience of the concept, or for cultural reasons, because they were afraid of what people might say. Some of the caregivers said that their marriage had failed because they had to leave their husbands and children to come home and care for their aged parents. Others had left their employment to care for elderly parents and family members.

Payment for upkeep seemed to be a big problem for informants, most of whom wanted government to take on the responsibility or offer some form of subsidy, as in the case of the National Health Insurance Scheme which they were familiar with. Strategies suggested for initiating assisted care were day care and temporary lodgings as somewhere the aged could be accommodated at times when the primary caregiver would not be available.

Conclusion

The study produced some important findings. Care for the aged in their homes is often inadequate. Caregivers are often overwhelmed by the number of roles required of them, which compromises the care given to the aged. Lack of modernized care facilities worsens these problems. These caregivers lack necessary knowledge about assisted care and remain committed to traditional ways of caring for the aged. Some feared social disapproval should they not be able to look after their parents as a primary social obligation. They acknowledged that they had no idea of government plans for the aged apart from the NHIS. In addition, they wanted assisted care to be introduced in Ghana, with payment for the care being in partnership between government and individuals. The styles preferred were day-care and temporary live-in.

Ethical approval

The study was approved by the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (HSSREC /0608/016D) and the Dodowa Health Research Centre (IRB Ghana Health Service) of Ghana (DHRCIRB/06/06/16). Voluntary participation was accorded with written and signed consent.

Limitations of the study

Purposive sampling procedure were followed; adjustments to the age range of the elderly meant that some caregivers were automatically excluded, so that was a gatekeeper approach to collection of data. We also recognized researcher impact on the study participants.

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