## Abstract

Elder abuse and neglect has become a global public health concern. Data and studies of elder abuse in Ghana is very scarce and no study exist of health workers perceptions of elder abuse in Ghana. Current sociocultural and economic trends have contributed to changes in the phenomenon of elder abuse requiring serious efforts to prevent detrimental effects of abuse and neglect of older adults. A semi-structured interview guide was used for data collection. Using content analysis, the findings showed that elder abuse and neglect occur in both hospitals and nursing homes, which might be attributed to different personal, situational and institutional characteristics as well as cultural and traditional value systems. Various factors at the level of interpersonal relationships contributed negatively and positively to elder abuse and neglect between residents themselves, and between the health workers themselves as well as between residents and the health workers. Some residents' perception that they are socioeconomically higher than others seemed to be implicated in their frequent conflicts with other residents and with health workers. In other instances, when health workers perceive excessive power for being *'a carer'* in their roles in providing care for *'a dependent'* resident, this might be misused in a power relationship, which could either contribute to elder abuse or used in a way to provide adequate care. Situational characteristics such as aggressive exchanges between residents and health workers and institutional characteristics such as limited facilities and resources to care for residents are all factors that were implicated in elder abuse and neglect. Implications of findings are discussed within the frameworks of Bronfenbrenner's Ecological Model and the Social Exchange Theory. More specifically, the findings also have implications for interactions between the microsystem level and the exosystem and how the exosystem such as social welfare services and mass media can play a role in the management of older adult abuse and neglect. Finally, culture and traditional views, beliefs system and the socioeconomic levels seem to be implicated in elder abuse and neglect.

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# Table of Contents

# Chapter One

## 1.1. Background and Statement of the Problem

The World Health Organization defines elder abuse as *"a single, or repeated act, or lack of appropriate action, occurring within any relationships in which the expectation of trust is a cornerstone which causes harm or distress"*. Elder abuse can be in the form of physical, psychological, financial or material, and neglect (1). Keller and colleagues (2) describe the following forms of abuse of older adults, which could be intentional or unintentional. Intentional is "when a caregiver, due to unwillingness or irresponsibility, ceases to provide an older person with the help this person may need. Unintentional is when the caregiver does not provide assistance, due to either ignorance or incapacity" (p. 318). Physical abuse involves the inflicting of physical discomfort, pain or injury intentionally (2, 3). Examples are hitting, slapping, burning, sexual assault, physical restraint or coercion evidenced by unexplained injuries, abrasions and bruises, bleeding etc. Psychological abuse involving inflicting mental pain, fear of violence or isolation (3). Examples are name-calling, humiliation and intimidation, inappropriate refusals, withholding of security and affection etc. Financial or material abuse involves exploitation such as misappropriation or misuse of funds or belongings and possessions of residents (3). Examples include theft, fraud, using undue influence and control on older adults to give up on ownership etc. Neglect generally refers to withholding of necessities of physical and mental health of older adults whether intentionally or unintentionally (3). Violation of rights refers to depriving older adults of their legal, human rights, personal liberty etc (3).

According to WHO report issued (1), around 1 in 6 people 60 years and older experienced some form of abuse in community settings during the past year (1) The WHO report further stated that rates of elder abuse are high in institutions such as nursing homes and long-term care facilities, with 2 in 3 staff reporting that they have committed abuse in the past year. While

many countries are experiencing rapid ageing populations, with people aged 60 years and older to be more than double, from 900 million in 2015 to about 2 billion in 2050, elder abuse is predicted to increase (1). Recently, a systematic review and meta-analyses by Yon and colleagues (1) concluded that over the past year, 15.7% of people aged 60 years and older were subjected to some form of abuse (4). This study comprised best available evidence from 52 studies in 28 countries from diverse regions, including 12 low- and middle-income countries (1).

Yon and colleagues (4) in their quantitative syntheses of the prevalence of elder abuse aimed to quantify and understand prevalence variation at the global and regional levels and also by subtypes in institutions. Consequently, the authors reported that the overall prevalence was 15.7% (1 in 6 older adults), and by subtypes, the authors reported that 11.6% (8.1-16.3) for psychological abuse, 6.8% (5.0-9.2) for financial abuse, 4.2% (2.1-8.1) for neglect, 2.6% (1.6-4.4) for physical abuse, and 0.9% (0.6-1.4) for sexual abuse. The finding also indicated that 64.2% of staff perpetrated some form of abuse in the past year. Overall, the authors suggested that it seems from the estimates that abuse of older adults are much higher in institutions than in community settings (4).

Abuse of older adults in institutions can be categorised into resident-to-resident abuse or staff-to-resident abuse (5). Staff self-reports on perpetrating abuse seems to be high (4, 6). Staff perceptions of what accounts for abuse of older adults are varied. According to Yon and colleagues (6) the authors found in their systematic review and meta-analysis that staff are more likely to abuse aggressive residents. Some staff perpetrate abuse as a form of retaliation against physically aggressive residents or withhold choices from aggressive residents. Some staff reported that they have committed thefts against resident older adults (6-8). Abuse of older adults has devastating consequences such as physical effects (e.g. Injuries, lasting disabilities, worsened health conditions), psychological effects (e.g. anxiety, loneliness, depression and

loss of dignity, trust and hope) (9) and social effects (e.g. social isolation, lack of communication and social support) (10).

Data on the extent of the problem in institutions such as hospitals, nursing homes, and other care facilities are scarce (4). Even more scarce is data and studies of abuse of older adults in Ghana, and Africa as a whole. To begin with, a search only found sparse and scanty studies in Ghana on the perceptions and prevalence of staff-to-resident abuse of older adults in Ghana. In Ghana, the scanty existing literature have focused on discriminations and abuse associated with ageing and witchcraft. Study of ageing in Ghana began in the 1970s, but not much has been done on elder abuse in communities and healthcare institutions (i.e. nursing homes and hospitals) even to date. The late Professor Araba Apt who is credited with pioneering studies of ageing in Ghana asserted that the popular and current view regarding older adults in Ghana is that young people these days have no regard for the elderly, which may be due to changes in sociocultural and economic trends, requiring serious efforts to prevent detrimental effects of abuse and neglect of older adults (11, 12). In 2017, during the World Elder Abuse Awareness Day on June 15, the Director of Guardians of Gray Masters Foundation, a local non-governmental organization in Ghana reported that older adult in Ghana suffer physical, spiritual and emotional torture each day. Abigail Appiah, the Director further reported that majority of the cases go unreported with many of the abuses occurring in homes, healthcare institutions (i.e. nursing homes and hospitals) and in religious homes/spaces. She further reported that although the government of Ghana has a National Ageing Policy approved in 2010, it has not been effective waiting for the passage into law, the National Aged Bill and the setting up of the National Council on Ageing (13). It is usually through such media reports and the efforts of non-governmental organizations that one can learn about the existence of abuse of older adults in institutions and communities/homes in Ghana.

Related to the problem of ageing and witchcraft in Ghana is also the problem of traditional value systems. In Ghana, the status of women has long been determined by traditional values, cultural norms, gender role socializations and patriarchy, which tend to discriminate against girls and women, even in their old age (14). Violence and abuse of women in Ghana have been identified as a public health concern and research priority issue (14-17). Older women abused in Ghana face a situation that is characterized by pervasive poverty, illiteracy, widowhood, predominantly rural dwelling, and the subjection to insidious cultural practices and superstitious beliefs (18). Ethnographic research in Ghana on a rights based program addressing witchcraft accusations by a national elder advocacy organization and on rights based interventions in three witches camps found that mostly, older women are marginalized, abused, neglected or even killed for being accused as a witch (19).

### 1.2. Rationale and Significance of the study

Owing to the lack of adequate research and information on the phenomenon of elder abuse in Ghana, the present study will enable the capture of first-hand information from health workers in both nursing homes and hospitals regarding their perceptions (i.e. their experiences, definitions, thoughts and opinions) about abuse and neglect of older adults in Ghana. Health workers are considered major stakeholders in the care for older persons; hence, their perceptions about elder abuse and care altogether can be very important in knowledge production and policy interventions.

The phenomenon of elder abuse and neglect in Ghana is less than well studied, although studies of ageing in general began in the 1970s in Ghana as well as the existence of National Ageing Policy, and the National Aged Bill. In 2018, the sector minister for the Ministry of Gender, Children and Social Protection reiterated governments commitment to pass the National Aged Bill into law (20) Thus, findings of the present study will bring to the fore the perceptions of health workers as carers of older adults in healthcare institutions (i.e. nursing homes and

hospitals) in Ghana. Further, the present study will contribute to inform the development of relatively holistic intervention programmes that take cognizance of and incorporate the perception of healthcare workers regarding elder abuse in healthcare institutions (i.e. nursing homes and hospitals). The findings of the present study will foster attitudinal change on the part of the larger community towards elder abuse.

### 1.3. Aims and Research Questions

The overall aim of this study was to explore how Ghanaian health workers (in nursing homes and hospitals) perceive abuse and neglect of older adults as well as to explore the nature and scope of abuse and neglect of older adults as it exists in Ghana. The following research questions were formulated:

i. What do health workers in Ghana consider and define as abuse and neglect of older adults?
ii. Do health workers in nursing homes versus hospitals experience different episodes of abuse and neglect of older adults?
iii. How is abuse and neglect of older adults communicated and reported among health workers?
iv. What do health workers in Ghana consider to be important suggestions to prevent abuse and neglect of older adults?

# Chapter Two

## Theoretical Framework and Review of Relevant Literature

### 2.1 Theoretical Framework

Rather than developed from a unified existing theory of elder abuse and neglect, theories that explicate the aetiology of abuse are usually a constellation of several theories (21). Malmedal (21) stated that authors and researchers mainly sketch out models with three recurring key factors in the elder abuse literature. The three key factors are environmental conditions, staff characteristics and resident characteristics (21). Still, little is known about theorising in the field of elder abuse and neglect in nursing homes and hospitals (21).

### 2.2 Factors associated with the abuse of older people in residential settings

The factors associated with abuse of older people in residential care settings are complex and varied, comprising personal, social and organisational factors including key factors such as environmental conditions, staff characteristics and resident characteristics (21, 22). Pillemer and Bachman-Prehn (23) suggested three sets of overarching variables. *Institutional characteristics*: these included characteristics of the nursing home or the centre providing care such as size, type of organization (i.e. for profit or not-for-profit) and cost of running the centre. *Staff characteristics*: these included educational level of staff, age, position, and attitudes towards people. *Situational characteristics*: these included stress and burnout of staff and the frequency of staff – resident conflict.

There are, however, some interesting findings. The association between facility related factors which fall under institutional characteristics, such as size and location (urban/ rural), and staff characteristics with abuse and neglect have showed varied findings. It was found that staff members working in urban areas were less likely to commit acts of abuse and neglect of emotional and physical character than staff in rural areas (22). Staff members working in nursing homes with 30 residents or less are more likely to commit acts of physical character than staff in larger nursing homes, also staff with higher levels of education account for greater

levels of emotional and physical abuse than staff with lower education level (22). Although limited, several studies have examined the relationship between job satisfaction and the quality of care. It was found that, when job satisfaction decreases, acts of emotional abuse and neglect on elders in their care committed by staff increases (22). A study from a nursing home in England showed that job satisfaction and stress had an impact on staff motivation to provide good care (24).

### 2.3 Ageing in Ghanaian families, historical and cultural contexts

According to the 2016 Ghana demographics profile, the total population of persons above 64 years old is 1, 126, 634 persons (male 520,589/female 606,045) and the general life expectancy at birth for both sexes in Ghana is 61 years. Most Ghanaians live in the rural areas and older women are mostly the majority (25, 26). The average older adult woman in Ghana is likely to live in the rural area, widowed, living in an extended family household, and poor (25). Majority of older women lack basic education, are not in any form of paid employment, and are widowed, separated or divorced. There is also a wide economic discrepancy between urban and rural Ghana, and a high prevalence of poverty and deficits in formal services and amenities in rural Ghana (25-28).

Many African families had a caring family structure in which care for older adults was paramount due to the low probability of survival rates for older adults which did not present too much constraints on the family structures as well as on family resources (11). With increasing choices for nuclear family structures, the modern nuclear family, particularly in the urban areas is no longer able to continue its caregiving roles in the current 'monetized urban' life (11). The social and economic changes brought about by migration, modernization and urbanization will continue to affect the traditional systems of care for older adults (11). According to Tawiah (28) other issues in Ghana that affect older adults that might risk their abuse and neglect include marital status of the older adults, and school attendance of the older

adults, health condition, and cultural practices. For example, older adults who live alone risk social isolation (28). Comparative data on the living arrangements of older adults in selected sub-Saharan African countries noted that, in view of increasing migration of younger generations, urbanization and modernization, it is more likely that living arrangements will be disadvantageous to the older adults (28).

Traditional beliefs and practices have also affected older adults in Ghana in terms of contributing to abuse and neglect. Older persons are usually accused for bewitching younger persons who are unable to achieve better standards of living (28). According to (29) older adults are seen as having accumulated life experience. Therefore, they are associated with a wide array of knowledge as well as of potentially destructive knowledge glossed as "witchcraft". They may be feared for having this power and thus treated with respect, but also use this power to curse another and bring misfortune. Although both women and men may use witchcraft, the association between women and witchcraft is particularly negative in Ghana and other African contexts. Most vulnerable in witchcraft accusations are late middle aged, post-menopausal women and older women. These accusations were thought to be nothing more than gossips in the early 1970s (30). In recent times, the situation has changed. The belief in witchcraft has become widespread in especially rural Ghana and transcends educational levels, social status and religious affiliations (28). Older adults accused of witchcraft are banished into so – called witches' camp, an increasing occurrence in Northern Ghana that strips them of their dignity and human rights by subjecting them to abuse and torture (28)

### 2.4 Review of related studies of aetiology of elder abuse and neglect in Ghana

A study conducted by Mba (27) to examine elder abuse in parts of Africa and the way forward reported that, despite their acknowledged social, political, roles in traditional affairs, and economic contributions, many older adults experience abuse and neglect and are largely excluded. The study also reported that, in the rural areas of Ghana, older women were more

likely to live in extended family households, while older men lived in nuclear households. This is a result of the longer life expectancy of women, their likelihood to outlive their spouses and be widowed and not to be able to remarry. In addition to this, due to modernization and urbanization the traditional social welfare system, which is the extended family system which acts as a source of support is breaking down (11, 27). This results in decreasing protection and care, and increasing isolation of rural older adults, especially, women (27).

According to Sossou and Yogtiba (31) although both older men and women are vulnerable to abuse and neglect in Ghana, it seems that older women are more exposed to abuse and neglect than older men due to the cultural belief and practice of male dominance in patriarchal societies. Another previous study that specifically explored abuse and neglect of older women in Ghana and the traditional practices that adversely affect their human rights, reported that although accurate data on abuse is lacking due to cultural inhibition and non – reporting. The situation of the older adult Ghanaian women is characterized by pervasive poverty, illiteracy, widowhood, predominantly rural dwelling, and subjection to insidious cultural practices and superstitious beliefs that leave them exposed to abuse and neglect (31).

As Manjoo (32) pointed out cultural practices have the biggest influence in the context of family and state as sources of abuse of older adults in Ghana. In Ghana, stereotyping of older women as witches is very common as stated earlier (32). What makes it even more problematic is that, in some instances, suspicions or accusations of witchcraft are followed by lethal or nonlethal assault of the supposed witch (33). In parts of northern Ghana, older women accused of witchcraft are removed by NGOs and government representatives to “witch camps” to ensure their safety and protection from families and communities’ inhumane and degrading treatment (33). These women live in dehumanizing conditions in the “witches’ camp” and their rights and dignity as human beings are denied.(28, 33).

## 2.5 Situating Bronfenbrenner's Ecological Model in the present study

Several institutions, researchers and professionals (1, 21, 22, 34-37) emphasize a comprehensive, ecological perspective to inform the complexity of elder abuse and neglect in communities and institutional settings. Specifically, to understand elder abuse and neglect, the ecological model has to be situated within the context of elder abuse and neglect in a way that it can provide a lens for finding answers to the research questions that guide the conduct of the study as well as to provide broad explanations, helping the researcher to guide his/her interpretations of the data.

In the present study an ecological approach is used as an overarching theoretical framework and supported by the Social Exchange Theory. An ecological theoretical framework postulates human development and aging as the outcome of the interdependent or reciprocal interaction between the person and his/her contexts of life (e.g., family, work, school, and peer relationships) (38). Specifically, Bronfenbrenner's human ecological model (39-41), postulates that an individual's development is affected by many different levels of systems. Related to this approach is Garbarino's works in child maltreatment (35, 36). Bronfenbrenner (39-41) argued that, to understand human behaviour and be able to fully explain behaviours, there is need to examine the nested levels of influence across the multiple interrelated systems namely, microsystem, mesosystem, exosystem, and macrosystem (39-41). Across development, a fifth layer called chronosystem is included which shows how socio-historical conditions, transitions and changes in individuals and their environment across time affects development. The chronosystem mirrors the dynamic environmental transitions, encompassing entries, exits, milestones, and turning points over time in the life of the individual (41) (See figure 1).

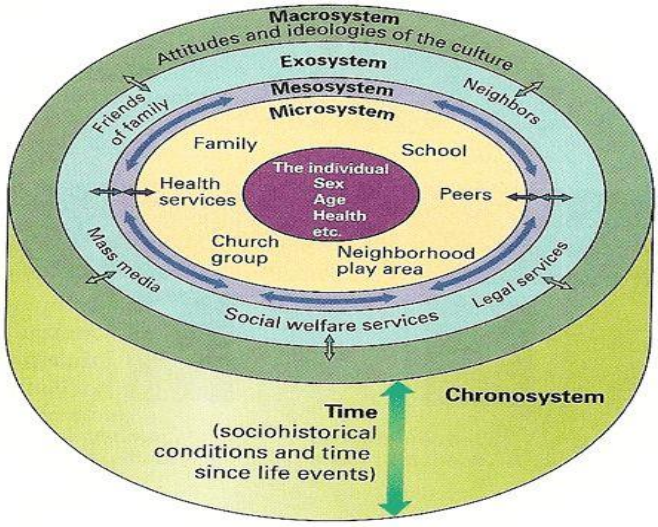


*Figure 1: Bronfenbrenner Ecological Model of Development. (Source Bronfenbrenner, 1992)*

According to Bronfenbrenner (40) an individual as a small unit of the ecosystem is influenced by the microsystem that consists of family, peers, schools and health services/facilities (40). The microsystem is a pattern of activities, roles, and interpersonal relations experienced by the person in a given setting with particular physical and material characteristics. It encompasses the relationships and interactions people have with their immediate surroundings. The focus is on the patterns of the roles, activities and personal relations that people have in the face-to-face settings that form their particular social encounters. The next system called the mesosystem networks the relationship between the elements of the microsystem. It interconnects between family and peers, and family and neighbourhood, family and health services. In this way, the mesosystem comprises the interrelations among two or more settings in which the person actively participates (40). That is, this layer concerns the interactions between several microsystems within which the person shift between various roles as a result of moving between one microsystem to the other (42). The exosystem is a bridge between large social settings that affects the behaviour of the individual. The exosystem refers to one or more settings that do not involve the person as an active participant, but in which events occur that affect, or are affected by, what happens in the settings containing the person. The exosystem

consists of social welfare services, mass media, legal services and religious institutions (41). The macrosystem composes of the attitude and ideologies of the culture and values in which the person lives. It includes factors such as ethnicity, race, religion, and socioeconomic status, and belief systems which all shape the life of the person (41, 42). Figure 2 is an adapted version of Bronfenbrenner's Ecological Model for understanding the complexity of elder abuse and neglect in institutional settings such as nursing homes and hospitals.

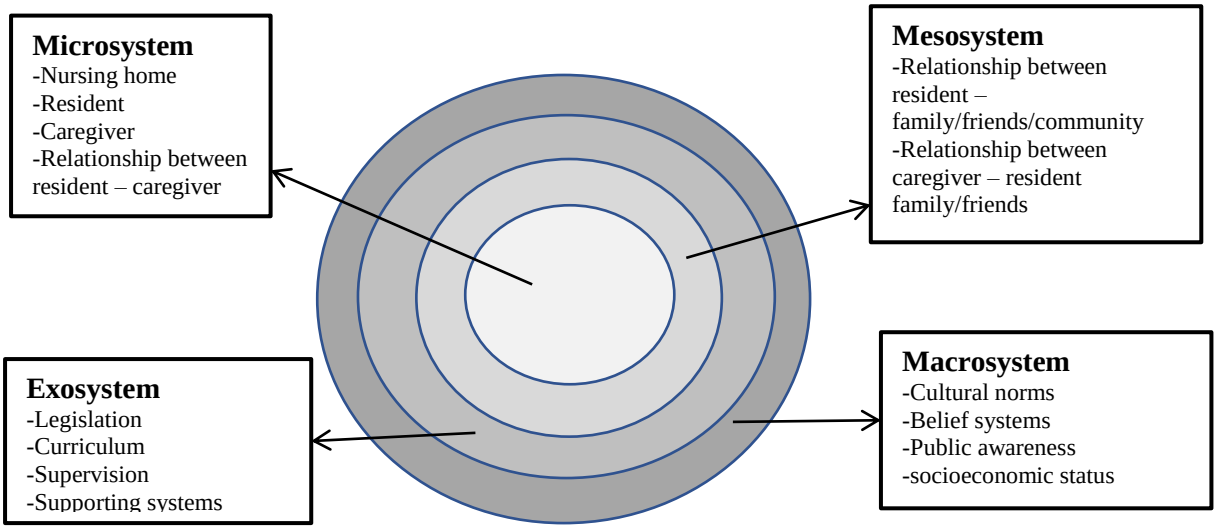


*Figure 2. Modified illustration of an ecological model for understanding the complexity of elder abuse and neglect in institutional settings (Source Malmedal, 2013).*

An ecological model sees an older adult (i.e., resident) as a unit in a series of nested structures which include, but transcends, the nursing homes and hospitals, relationship between resident and family/friends/community, welfare services' legislation and supporting systems, and the cultural norms and beliefs, socioeconomic status and the public's awareness of elder abuse and neglect. Since older adults receiving care (resident), in nursing homes, communities and hospitals interact with multiple systems nested within each other, this interaction between caregivers and residents may be influenced by key characteristics such as location, size or physical design of the nursing homes and hospitals, the levels of stress tolerance of caregivers and general staff attributes, aggression from residents and general residents attributes,

remuneration and legislation for institutional care settings for older adult, and the cultural beliefs and practice systems of staffs and residents (21).

*The microsystem* is comprised of patterns of activities, roles and interpersonal relationships with particular physical and material characteristics. In the microsystem, acts of elder abuse and neglect may result from risk factors associated with the direct relationship between residents and caregivers within nursing homes in the communities or hospitals. As with differences in their individual personal attributes, the residents and caregivers meet in a situation where their characteristics come into direct contact (21). The caregivers' interpretation of residents' behaviour, and also the residents' perception of the caregiver's role in providing care, the residents dependency on the caregiver, could contribute to either the incidence of elder abuse and neglect or contribute to reduction in elder abuse and neglect if favourable to both sides namely the resident and the staff caregiver.

It is *the mesosystem* that provides the connection between the structures of the older adult's microsystem. Here, the interrelationship between a resident's family/relatives and staff caregivers may affect the relationship between the resident him/her-self and the staff (21). Resident's lack of contact with family and friends, and staff's lack of contact may also be related to the occurrence of elder abuse and neglect. Some older adults may require long-term care due to risks for health problems, including chronic diseases that can restrict daily living activities. The need for both family care and institutional care to this group of older adults increases while also increasing related levels of stress with providing care for the older adult. Such increases in levels of stress may increase the likelihood of elder abuse and neglect in nursing homes in communities and in the hospitals among staff caregivers as well as even in families (21, 38, 43).

*The exosystem* refers to one or more social setting that indirectly affects older adults when they interact with some structures in their microsystem. Here, there is typically no active participation of older adults in the system which affects their involvement in the microsystem. For example, formal legislations such as health care centre policies and laws, religious institutions, and health and welfare services in the community may affect older adults in what kind of care is available to them and in the way they receive care. Events in the mesosystem have an indirect effect on older adults (21). For example, the National Ageing Policy approved in 2010 in Ghana, if supported by the National Aged Bill waiting to be passed into law, could make a mandatory reporting system for use when staff suspect abuse. This will be helpful to detect actual cases of elder abuse and neglect while contributing to understanding elder abuse and neglect. It could be understood that any resource made available by the exosystem will work either to enrich or impoverish the quality of interactions within the micro- and mesosystems of older adults.

On the level of *macrosystem*, government, cultural values, laws and customs of the older adult's culture, subcultures, broad social ideologies, and values and beliefs systems are some factors that can contribute to elder abuse and neglect. Traditional values and cultural norms in Ghana have shaped attitudes towards older adults as illustrated in a common Ghanaian proverb stated earlier, which is "just as older adults helped you as you cut your first teeth, so must you help them as they lose theirs". The traditional view was that as a collectivistic society, there was a reciprocal and interdependent relationship between older adult and younger persons. However, younger persons working to meet the demands of economic and social life do not have sufficient time to care and regard older adults anymore (25-27, 31). This means older adults may be transferred into nursing homes in the communities and hospitals to be cared for by paid caregivers. In some cases, the relatives of older adult may also neglect them in the nursing

homes. Indeed, a cultural attitude that does not emphasize value and regard for older adults can affect nursing homes environments, hospitals and other care centres for older adults (21).

## 2.6 The Social Exchange Theory for Elder abuse and neglect

Focusing on interpersonal relations, the social exchange theory conceptualizes behaviour as involving decision – making processes used in arranging or negotiating care for the dependent older adult (44, 45). Having been used predominantly in the context of family violence, the social exchange theory is now applied to understanding elder abuse and neglect. It postulates that a disadvantaged part(y) will use violence and/or aggression to restore balance when the sociodynamic balance in a relationship is upset or perceived to have been upset. Therefore, decision making in the relationship between dependent older adult and caregiver will be based on assessment of rewards and penalties that are available to the caregiver (or the abusive individual) in his/her role as caregiving (44, 45). An abusive individual in this theory perceive himself or herself as not receiving their fair share of rewards from their relationship with the dependent older adult or even the family of the dependent older adult. Therefore, the abusive person resorts to violence as a way to restore balance to his/her deserving reward.

It has also been suggested that generational assistance and the norm of reciprocity in the context of social exchange accounts for whether adequate care would be given to an older adult by a younger person such as a child (38, 46). For example, in the early life years, generational assistance is given from parents to children, while in later life years it is expected that adult children reciprocate the assistance they received while young to their now older parents. Here, parents are seen to make deposits of care in their younger ones in anticipation that their children will later pay off when parents are ageing and needing help (44, 46). However, help from adult children to ageing parents will be given with more or less quality and frequency depending on the quality of the relationship that existed between the children and parents in their early years of life (38, 46).

# Chapter Three

## Methodology

### 3.1 Research Design

This study used a qualitative research methodology that sets out to explore health workers' perception of elder abuse in nursing homes and hospitals in Ghana. The qualitative research methodology is flexible and allows modifications and reconstructions to what is learned in the progression of the study by taking into account the influence of cultural, social and other familiar factors, which also contribute to a deeper analysis of the data (47, 48). Qualitative research also enables full exploration of health workers experiences, paying attention to relationships and values which would have been a limitation for choosing traditional quantitative methods (47).

### 3.2 Study site and Procedure

Polit and Tatano (49) suggests that the choice of study site should be relevant to the overall aim of the study, and consistent with finding answers to the research questions (49). Consequently, a city in Ghana was chosen as the study site. The name of the city is withheld to protect identity issues related to the study. The city represents an urban area, which means caregiving roles for older adults would be variable and may provide interesting phenomenon for study both in the nursing homes and hospitals. It has been suggested that social and economic changes brought about by urban life affect traditional system of care for the older adult in Ghana and the modern family, particularly in the urban areas are no longer able to continue its caregiving roles (11). Data was collected from one hospital and two nursing homes (first and second nursing home). Having obtained ethical clearance, additional permission to interview health workers caring for older adults was sought from the CEO of the first nursing home, and from the administrator of the second nursing home, with letters attached to the ethical clearance certificate from the Institutional Review Board of the hospital. At the hospital, permission to interview health workers caring for older adults was sought from the senior

nursing officer-in-charge with a permission letter and the ethical clearance certificate for the data collection.

### 3.3 Sample and Selection

Respondents were purposely selected for the interviews. Participation required respondents to be health care workers either as nurses, nursing assistants or care givers of older adults. Five (5) nursing assistants and two (2) caregivers were interviewed in two nursing homes and four nurses were interviewed in the hospital. Below is the sample characteristics:

**Table 1: Sample characteristics**

| Respondent | Age (years) | Highest education | Occupation | Years worked | Place of work |
|---|---|---|---|---|---|
| Respondent 1 | 25 | Tertiary (i.e., post-secondary education) | Nursing assistant | 8 months | Nursing home |
| Respondent 2 | 25 | | Nursing assistant | 4 months | |
| Respondent 3 | 27 | | Nursing assistant | 4 months | |
| Respondent 4 | 26 | | Nursing assistant | 1 year | |
| Respondent 5 | 23 | | Nursing assistant | 6 months | |
| Respondent 6 | 72 | | Care giver | 9 years | |
| Respondent 7 | 29 | | Care giver | 4 years | |
| Respondent 8 | 39 | | Nurse | 15 years | Hospital |
| Respondent 9 | 28 | | Nurse | 6 years | |
| Respondent 10 | 51 | | Nurse | 25 years | |
| Respondent 11 | 30 | | Nurse | 3 years | |

Overall, 11 respondents comprising, fours (4) nurses, five (5) nursing assistants and two (2) care givers of older adults were interviewed.

### 3.4 The Qualitative Interview

The qualitative interview gives respondents the opportunity to describe and talk about their experiences, understandings and perceptions in detail (47). The data collection method was individual semi-structured interviews. A qualitative interview helps to observe the respondent's reactions regarding the questions posed by the interviewer/researcher. The individual semi-structured interview was a very flexible medium of communicating freely about the topics of interest in the interview guide between the respondents and me, and the

respondents were encouraged to speak candidly. Using individual semi-structured interviews also gave me the opportunity to gather as much as possible many nuanced descriptions of the respondents' understanding of elder abuse.

### 3.5 The Interview Setting

The setting in which the data is collected can potentially influence the data (50). Therefore, it is important to be aware of the specific context/setting in which the interviews are conducted, mostly in the everyday environments of the respondents to facilitate uninterrupted descriptions of the phenomenon being described by the respondents. At the hospital, the interviews were conducted in the office of the nurse-in-charge, ensuring that there were no interruptions and noise that could distract the interview process. Similarly, at the nursing homes, the interviews were conducted in a reserved office.

### 3.6 Materials

The main materials used during the interviews were the interview guide and the tape recorder. Notes were taken to ensure that I did not forget nonverbal information from the respondents that could supplement the recorded interviews. The interview guide was developed in collaboration with my supervisor within the broader framework of *Bronfenbrenner's ecological model* described in Section 2.5. The interview guide was designed in a funnel shape that begins with exploring broader concepts and narrows down to focus on more specific perceptions and understandings about elder abuse as perceived by the health workers. the interview guide was gender neutral and avoided bias from myself. That is, the questions contained in the interview guide were not directly a result of my experiences, expectations or (dis)likes, but the questions were all the result of the literature review. Since health workers were asked about their involvement in the abuse of older adults in their care, which might be a painful recollection, the interview guide also sought to explore different contexts, strategies and actions for handling and dealing with such incidents by health workers. The interview guide is attached at appendix A, page 54

### 3.7 Language used for Interviews

English is the official written and spoken language of the people of Ghana. In Accra where the study was conducted, many indigenes speak Ga whereas Akan Twi is the widely spoken by other people from other parts of the country who have come to settle in Accra. Usually many people learn to speak one or both languages. All interviews were conducted using English language since all the health workers interviewed could speak and write English.

### 3.8 Transcription and Data Analyses

The recorded interviews were transcribed verbatim, with all frequent repetitions, pause, emphasis and emotional laughter and sighs that accompanied responses. During the initial transcriptions, I constantly reflected upon the nuances in the analyses of the data, which also made me more aware of the perceptions that the health workers had described to me. Qualitative content analyses are used for the analyses of the data. As described by Graneheim and Lundman (51), the qualitative content analyses in nursing research has been applied to several kinds of data, yielding different kinds and depths of interpretations. In using content analyses, two important distinctions have to be made namely, *manifest content* and *latent content* (51).

Manifest content refers to analyses of what the text says, including a description of the visible, obvious component. Latent content refers to analyses of what the text talks about, including interpretation of what the text talks about. While both manifest and latent content deal with interpretation of the text, the interpretations vary in depth and level of abstraction (51). The basic decision in using content analyses is to select the unit of analyses. According to Graneheim and Lundman (51), the unit of analyses should be whole interviews or observational protocol. The meaning unit is a group of words, statements, or paragraphs relating to the same central meaning in content and context. Following meaning unit is condensation, whereby the text is reduced or shortened but still preserving the core of the text, resulting in what is referred to as condensed text. This process involves providing descriptions of the text that are close to

the original text. This is followed by descriptions and interpretations of text on a higher logical level including creating codes, categories and themes of different levels (51).

Categories are groups of content sharing something in common in meaning that are internally homogenous and externally heterogeneous and could be based on theoretical assumptions. In this way, it is usually the case that no data will fall between two categories or fit more than one category (51). Nonetheless, it may not always be possible to create mutually exclusive categories regarding human experiences that are so fluid in nature. A category would usually be made up of sub-categories and represent an expression of the manifest content. Meanings in categories may be lost when there are no themes. Themes are a way to link the meanings in categories together and may cut across several categories. Therefore, a condensed meaning unit or category can fit into more than one theme (51).

In sum, I read through the transcribed and recorded interviews several times to obtain the sense of the whole data. I created meaning units that led to the creation of condensed meaning unit. In this process, I tried to provide descriptions of the text that are very close to the original text itself. Then I followed it by interpretation of the condensed meaning, which also resulted in the creation of sub-themes based on the categories that I have coded out of the interpretations. The coding processes were done by the number of times a certain word or statement appeared in the condensed meaning unit or the meaning unit itself and might be more indicative of importance. The coding was done by reading through the text repeatedly and manually writing down text similarities and occurrences. Once this was finished, I transferred them into a Table in an excel file to provide a comprehensive overview and easy guidance for the discussion. Presented in Figure 3 in the next page is an example of the analyses process.

*Figure 3: Example of how themes were derived*

| Meaning Unit | Condensed meaning unit | Sub themes | Themes |
|---|---|---|---|
| We call those numbers and they accept either he was their father or brother. They come for the remains and have a grand funeral. | Relatives interested in grand funerals | Cultural conformity | Culture |
| When he was alive, they were never bothered about the food they ate or even clothes they wore | Relatives not bothered about aged when alive | | |
| She had four children whom we never saw here. When the woman died, a big party was organized here. I was really surprised such a party was never organized for her when she was alive. | Children never visited but had a big party when client died | | |
| I think Ghanaians like funeral. So instead of taking care of their relative, they will rather want the patient to die so they can have a big funeral with all family members wearing the same cloth. | Relatives prefer aged to die so they can celebrate rather than taking care of them | | |
| There was another patient that was on admission and we wrote drugs, and no one was coming and finally the patient died. As soon as the patient died we saw people coming in for the dead certificate and the rest. | Relatives came for death certificate after ignored aged died | | |
| Abandon that fellow and only waiting to hear that person is dead and then you will come back for the body. I mean are you heartless? | Relatives are heartless to abandon their aged waiting for their death | | |
| As soon as they hear the patient is dead you will see them coming as if it is good news to them. | Relatives come around when abandoned aged is dead | | |
| When they are here, you don't find any relatives with them but when they die, that is when you find out that they have a family. | Find out client have relatives after they are dead | | |
| Since she came on admission we have not seen the husband before but the very day the woman passed on the husband with the kids were here and he was asking us what the cause of the death was. | Client never visited by family but husband and children came around to ask cause of death | | |
| It because either the man never cared for the children or maybe he had the potential and there wasn't any support even though the man could have done something to help. So, when it happens like that along the line, the children feel reluctant to care even though they have the means to help. | Children are reluctant to care for parents when they were not supported by them | Children retaliation | |
| For one reason or the other you don't do what is expected of you, you think the father never cared for you when you are young, so you are trying to pay him in his own coin. The children feel reluctant to care for their father even though they are resourced | Children don't take care of parents who didn't take care of them even when they are resourced | | |
| The man didn't care about the children so as and when they like they come around. Even when he was discharged it took them some time before they came and picked him | Aged abandoned by children because he didn't take care of them | | |
| The children neglected their father simply because they said their father did not take care of them so when he was sick they just pushed him to the road side to beg | Sick aged rejected by children to beg on the streets because he didn't take care of them | | |
| There is this woman whose children come once a while to give her food and money. They leave food at a distance because they believe the woman is a witch. | Children of a client keep distance when they visit her believing she is a witch | Witchcraft accusations | |
| They call them wizards, witches, insult them and even sometimes they beat them. They take them to prayer camp and claim they are beating the witchcraft out of them | Aged are called wizards and witches and are maltreated for that | | |

### 3.9 Ethical Concerns

Ethical approval was obtained from the Norsk Senter for Forskningdata (NSD), (Norwegian Centre for Research Data (Project number: 55593). Ethics approval letter is attached at Appendix C, page 62. Additionally, prior to starting the data collection in the nursing homes and hospitals, ethical approval was obtained from the Institutional Review Board (IRB) of the hospital where data was also collected. This is also attached at Appendix D, page 64. All identifying features have been concealed to not reveal the identity of the hospital.

### 3.10 Informed Consent, Confidentiality and Anonymity

In the present study, I had no direct contact with the older patients/residents themselves but asked the questions to the health workers. Therefore, it is the health workers who were provided the informed consent forms to be completed and signed before participating in the interviews. The informed consent form described the purpose of the research, how confidentiality would be protected, and that the health workers could withdraw from the study at any time without giving any reasons or explanations, there would also be no negative repercussions, and that participation is voluntary. Respondents were given assurance of confidentiality by promising to protect the health workers' identities from other persons in the setting and from the general reading public. The informed consent form stated that the health workers' responses will be anonymised. Anonymity entails making use of pseudonyms instead of the health workers' real names, ensuring that the health workers are not identifiable in print. Respondents kept one version of the informed consent forms.

As a researcher I must uphold professional ethics and principles regarding confidentiality and anonymity so that the responses cannot be traced back to the health workers. No direct references are made to any of the health workers who participated in the study. In transcribing the recorded interviews, I used numbers (e.g., Respondent 1) to identify the responses, and no names and residential address were collected as part of the data collection. A copy of the consent form is attached at Appendix B, page 57.

# Chapter Four

## Findings

The analysis of the data resulted in five major themes. As shown in the Methods, these themes were derived through the content analysis process, which started with the meaning unit and eventually to sub-themes and major themes. The major themes and subthemes are summarized/presented in Table 1. The five main themes and corresponding subthemes is presented in this section along with quotes from the interviews to exemplify the meanings.

**Table 2. Main themes and subthemes derived from the analyses.**

| MAJOR THEMES | SUBTHEMES |
|---|---|
| **1. Communication** | • Negative and positive relationship among the older adults<br>• Negative and positive relationships among health workers<br>• Negative and positive relationship among older adults and health workers<br>• Negative and positive relationship between relative and older adults<br>• Disagreement between health workers and relatives<br>• Uncooperating older adults |
| **2. Incidence of Abuse and Neglect** | • Health workers knowledge about older adult abuse<br>• Health workers contribution to older adult abuse<br>• Causes of older adult abuse by health workers<br>• Aggressive exchange between health workers and older adults<br>• Neglect of older adults by relatives |
| **3. Skills and Work Conditions** | • Health workers motivation and satisfaction of work<br>• Stress and burnout from work<br>• Limited work resource |
| **4. Management and Prevention of Abuse** | • Measures to reduce elder abuse<br>• Health workers professionalism in managing older adult abuse<br>• Hospital help abandoned aged |
| **5. Culture** | • Cultural conformity<br>• Children retaliation<br>• Witchcraft accusation |

### 4.1 Communication

This theme mainly describes how relationships among older adults, health workers and relatives with each other and among themselves contributed to good or bad communication.

There were various communication factors that acted as barriers and constraints, and even contributing factors to the relationship among health workers and the older persons. Some factors might have also contributed positively to the relationships between the older persons themselves and between the health workers themselves as well as between the older persons and the health workers. Because relationships thrive or degenerate based on good or bad communication respectively, and because relationships are an important part of the healthcare delivery service in general and especially in the case of caring for older adults some relationship factors are described below.

### 4.1.1 Negative and positive relationship among the older adults

Several factors contributed to poor relationship among older adults, but also some other factors could be considered as positively influencing the relationship among them. Some of the older adults did not talk to each other while some were very quiet and would not even engage or create any form of relationship with anyone at all. Some of the older adults also did not even learn to know the names of those they shared the same room with and did not talk to each other. As can be seen, this could foster a situation whereby relationships among the older adults would be poor and negative hence affecting communication among the older adults themselves: *"They don't know each other's names. Even those in the same room. They don't talk to each other" (Respondent 2).*

Due to the wide differences in the socioeconomic status and the social gradient in Ghanaian societies in general, it seems that some of the older adults who have lived in higher socioeconomic status or in higher social status did not quite cope well in an institutionalised setting like the nursing home. According to the respondents, some felt more superior than others as they would not tolerate anyone or even share some common items with other older adults and the least provocation will lead to a conflict: *"Some of them feel they are better than others. So, at times you give something to someone and the other doesn't want to touch the*

*same thing because they feel superior…" (Respondent 3).* Although there were relationship problems and conflict among the older adults that created communication problems, there were times where some adults lived in harmony and supported each other: *"…sometimes you will see patient who are recovering very well sometimes trying to help the highly dependent [older adults]" (Respondent 8).* These responses showed that some of the older adults were supportive of each other and had a positive relationship among them.

### 4.1.2 Negative and positive relationship among health workers

In the healthcare delivery service, communication among health workers plays a very important role and the thoughts expressed by the interviewees suggest that some health workers had good relationships among themselves, but the opposite was also present. Conflicts among health workers could occur due to misunderstandings and challenges. The interesting thing is that even though conflicts ensued after misunderstandings because of their professional training and practice they could resolve any differences and come together again: *"Staff-to-staff relationship?... yea it's good but sometimes we have challenges. We are in a human institution, one way or the other things might not go on well but professional as we are, we know how to handle it" (Respondent 8).* Despite the poor relationship among some health workers others said that they had good relationships. Some of them described working as a team and showing unity when it comes to working together with other colleagues. This helped them to work cooperatively and more effectively: *"Relationship among the staff is kind of …We are together. We are one. We work as a team here. We joke, we laugh. At times we eat together. Relationship is very cordial" (Respondent 1).* As seen from the responses above, some of the health workers had a lot in common, which might have also contributed to the good relationship among them.

### 4.1.3 Negative and positive relationship between older adults and health workers

The relationship between the health workers and the older adults also come out to be one of the interesting subthemes. There were times when the relationship between the older adults and the health workers were poor. It seems that this was mainly due to some factors such as too much workload or work pressure, attitudes of the older adults that got the health workers angry and also some utterances from the older adults that irritated the health workers: *"... we fall short sometimes when there is work pressure; work that is supposed to be done by 6 or 7 people you see 3 people doing it and definitely the professional approach sometimes will be lacking" (Respondent 8). "…at times they will do things that will make you angry. And you can even do something that will make you regret… sometimes it is a little bit rough" (Respondent 2).* For some of the health workers who perceived that they may also soon became old and be in a similar condition like the older adults they are caring for, they expressed a good and positive view of the relationship that existed between themselves and the older adults: *"The relationship is very good. For instance, I have the perception that one day I will be like them, so l must treat them well like I will want some to treat me one day*" *(Respondent 5).*

### 4.1.4 Negative and positive relationship between relatives and older adults

Relationship between the older adults and their relatives could be pleasant or unpleasant. Some relatives who visited their older adults in the hospitals sometimes engaged in confrontations with the older adults. Mostly, these were the results of misunderstandings between the relatives and the older adults: *"…sometimes there are conflicts between patient and relative of which we are also able to solve it" (Respondent 10).* However, and even more importantly for the psychological and emotional health of the older adults some felt excited to see their relatives who visited them, and others were very happy to see their children eat breakfast with them every morning: *"There is a client here who can't talk well but when she saw her relative, she was making sound of excitement because she was happy to see them" (Respondent 4). "She is*

*very happy…one woman whose children come here every morning to have their breakfast here with her and go" (Respondent 6).*

### 4.1.5 Disagreement between health workers and relatives of older adults

In cases where health workers suspected that relatives of the older adults have abandoned and neglected the older adults, this have resulted in confrontations and disagreements in what caused the physical and obvious signs of abuse and neglect on the older adults. Some of the older adults are brought to the ward with severe bedsores and other signs that clearly showed that they were not given proper care, yet the relatives would be arguing with the health workers and trying to deny that they neglected or abused their older adults. Sometimes, some of the relatives get offended and therefore never return to the hospital again to visit their older adults: *"When we confront the relatives that we think you have neglected the patient, sometimes we may not see them again (Respondent 9).*

Another challenge that the health workers would soon be going through is neglect of the older adults by their relatives while in the hospital or nursing home. It seems that when older adults were neglected the health workers also got angry with the relatives who abandoned their older adults without visiting, buying medications and other needed items but came around to inquire about what caused the death of their aged: *"Since she came on admission, we have not seen the husband before, but the very day the woman passed on the husband with the kids were here and he was asking us what the cause of the death was. We reacted bitterly to that and we did not give him any information of that kind. We did not take it kindly with him because we realized that was what he wanted. We were not happy with him" (Respondent 8).* The health workers would therefore withhold certain information from relatives who had abandoned or neglected their older adults until the death of the older adults and then the family or relatives would come around to make inquiries concerning the cause of death.

### 4.1.6 "Uncooperating" older adults

As cognitive abilities decline with age, it seems inevitable that some older adults might not easily understand instructions or might not hear the instructions at all. Some of the health workers indicated that older adults are very difficult to work with since they do not listen and it is difficult to get them to comply with instructions and rules. Some health workers even said that being in the company of older adults was very stressful: "*Being with the older adults is a very stressful thing. It is not easy at all. At times you must talk for a very long time before they listen to you" (Respondent 1). "It is because you keep telling them the same thing every day and they are not listening to you" (Respondent 7). "That woman is difficult…" (Respondent 3).*

## 4.2 Incidence of Abuse and Neglect

This theme describes the knowledge among health workers regarding elder abuse and neglect, what actions or inactions by the health workers that they perceive as contributing to the phenomenon, cause of elder abuse and family factors that also contribute to abuse and neglect of older adults in Ghana.

### 4.2.1 Health workers knowledge about older adult abuse

The responses showed that there were different sources from which health workers heard about elder abuse and neglect outside their workplace. Health workers had heard about elder abuse and neglect on radio, and on television. Some also said that they witnessed elder abuse and neglect in their homes: *"I stayed in a house where there was an old woman. Her children didn't have anyone to take care of her. She was staying with one of her daughters. When she (daughter) wakes up she goes to work and by the time she comes home, her mother has soiled herself and will be waiting for her. When she comes home, she beats her and the woman (aged) will be crying…" (Respondent 3).*

Some health workers also said in addition that because no episode of elder abuse had occurred in their unit, this has not become necessary to discuss and did not see it as a problem to tackle

now: *"... this thing hasn't even come to my mind because I haven't had the experience, so I haven't thought of it" (Respondent 6).* Even though some health workers said they had some knowledge about elder abuse and neglect, other health workers did not know anything at all about elder abuse and neglect and could not tell whether they have ever witnessed any older adult being abused: *"Not heard about elder abuse... It is today that you are telling me about elder abuse" (Respondent 6).*

### 4.2.2 Health workers contribution to older adult abuse

It seems that some of the health workers themselves by their actions or inactions might have been active or passive contributors to the occurrence of elder abuse in the hospital and nursing homes. In some instances, some of the health workers justified verbally abuse of the older adults: *"We are the ones taking care of the people and we know we must shout at them at times…" (Respondent 5).* In other instances, physical abuse was justified: *"…because she gives me extra work of cleaning the whole place, l beat her up before doing it" (Respondent 2).* It seems that the health workers by their active involvement endorsed elder abuse in their workplace. In one example, the health workers were even excited that the CEO of the nursing home was the one that beat the older adult because of what they perceived to be a wrongdoing by the older adult: *"…we were even happy because she herself has done such a thing [the CEO herself beat the older adult]… what l took was that, when the man repeats the same act and the CEO is not around, we also have the right to beat him" (Respondent 2).*

### 4.2.3 Causes of older adult abuse by health workers

Since some health workers were involved in or perpetrated some acts of elder abuse, it became necessary to ask about what the causing factors might be for a health worker caring for an older adult to now turn to abuse the person. It seems that mostly the health workers physically abused the older adults because they said the older adults maltreated them or reacted to them in ways that were disrespectful. For example, some older adults would slap a health worker, throw food on the health worker or even in extreme cases throw their excreta on the health worker: *"A*

*client soiled herself and I was trying to make her feel good, then she just slashed faeces on my face" (Respondent 1). "...l felt someone holding my hair and was pulling so hard..." (Respondent 5).* Most health workers believed that abusing the older adults was not their intention or something they premeditated but the older adults left them with very little to no choice than to beat or hit them because of the way the older adult might have reacted to them: "*…But it's their fault…at times they will do things that will make you angry. And you can even do something that will make you regret…you are working with time so if he is still not responding, you might get irritated and hit him…" (Respondent 2). "…sometimes they will do something for you to hit them. This is not your intention but what they will do will make you do such a thing" (Respondent 7).*

### 4.2.4 Aggressive exchanges between health workers and older adults

Sometimes some of the older adults show acts of aggression to the health workers who in return, retaliate with aggression too, mostly physical abuse such as hitting or beating the older adults. When the older adults did something that angered the health workers, it seems that the health workers would mostly retaliate in same or maybe even in higher proportion: "… *he [older adult] had painted the whole washroom with faeces. I asked why he did that, and he started an argument with me. I told him he shouldn't be doing that, but he got angry and threw his hand at me. He hit me, so I also beat him up" (Respondent 3). "... l was talking to him and he was saying a whole lot of things that he was going to beat me. He used his leg to hit my shoulder so that day, the way l beat him…" (Respondent 2)*. Interestingly, it seems that regarding aggressive exchanges between older adults and health workers, the health workers in the nursing homes answered that they have had such exchanges with the older adults while there were none so much as strong as hitting or beating from the health workers in the hospital.

### 4.2.5 Neglect of older adults by relatives

It seems that in some cases when the relatives bring their older adult for admission, they decide to abandon them. For example, some of the health workers in the hospital indicated that some

relatives bring their older adults to the hospital for admission and avoid been contacted by providing wrong contact information: "*Sometimes you call them [relative] and they will deny that they are the relatives [of the older adults] …they only want a place to push their ill relative. And whatever happens to them they don't care" (Respondent 9).* It seems also that some relatives neglect their older adults to avoid the responsibilities that come with having your older adult on admission such as payment of fees and medications. For example, one health worker in the hospital said that she understands that the relatives complain about the cost and expenses involved in having their older adult in the hospital when they could use the monies on themselves rather than to pay for the expenses of the older adults on admission: *"…you could realize that the money that the relative have will be spent on the older adults instead of using it on her own life, so you realized the person will be complaining…" (Respondent 9)*. Some of the family members and relatives also think that since the older adult will die anyway, there is little need to spend any monies on them while on admission: *"…they think that the patient will not survive and so there is no need to waste money, time and energy and the patient will still not come back" (Respondent 8).*

Some of the older adults had been brought to the hospital to receive treatment and later be discharged when they recover. Some of these older adults did not want to go back to their relatives. Some of them broke down and cried when they were informed that their condition has improved and therefore will be discharged to return home and some of them were also reluctant to go home. According to the health workers, the older adults believed that if they returned home, they were going to receive inadequate care and might even be abused and brought back to the hospital anyway: *"Some of them start crying when they are about to be discharged. They complain that no one will take care of them and would prefer staying at the ward because at the hospital when they call, somebody will come but, in the house, no one will respond…" (Respondent 9). "…when the patient was supposed to be discharged, he decided*

*not to go home…" (Respondent 10).* Some of the health workers also indicated that even when relatives of older adults visited them in the hospital, they showed signs that they were not taking adequate care of them in the house prior to bringing their older adults to the hospital. Some relatives usually shouted at their older adults when they refused to eat, pushed the older adult around and got angry at them with the least provocation: *"The woman [older adult] brought out the food that she was chewing and spat on the relative. The relative became angry, started screaming and wanted to hit her [older adult] back" (Respondent 9). "…so, the relative became annoyed and started pushing things here and there. When she was done and was going how to even reposition her mother [on the bed], she just pushed the mother away, placed everything down and left" (Respondent 8).*

## 4.3 Skills and Work Conditions

This theme describes the similarities and differences in the health workers experience and shows some differences between health workers in hospitals and nursing homes. Stressful conditions, including lack of adequate staffing and equipment, is demotivating and leads health workers to want to quit the job.

### 4.3.1 Health workers motivation and satisfaction of work

The motivation for work is an important factor but that can be influenced by many other factors too. Most health workers in the hospital were satisfied with their work as nurses caring for older adults. Some of the health workers even said that they will always choose their current job over any other jobs and did not have any plans to quit from their current jobs. Others prefer nursing to other professions and happy working with the aged: *"l am satisfied with what I am doing... I am happy working with them…*" *(Respondent 7). "…this is what I chose to do, and I am doing it and I am in love with it simply because I don't sit down and think of doing anything else apart from nursing" (Respondent 8).*

When the same questions about motivation were posed, most health workers in the nursing home were of a different view. Some of them suggested that there is more work in the nursing

home than in the hospital and the routine has become mundane. The work was no longer fulfilling to them since there were nothing new to learn in the nursing home: *"…it is not fulfilling or challenging to me any longer because the routine has become normal" (Respondent 7)."…I want to be on the hospital to learn more. Because here there is no theatre, there is nothing new it's just the same thing [in the nursing home"] (Respondent 5).*

Generally, the health workers indicated dissatisfaction with the financial remuneration of their work. While they indicated that the work they do is a very difficult and challenging work, they believed that they were under-paid for the work they do. Some of them suggested that their salary does not match the work they do and could therefore influence their decision to quit their current job: *"…it's not easy here. Coming to duty alone… and because they are old, they can't control their bowel. You must clean them, wash their cloths for them, clean their room, bathroom and so on and it is stressful (Respondent 5). "…if l get a better job, I will quit" (Respondent 3). "No, my salary doesn't match the workload" (Respondent 9).*

### 4.3.2 Health workers and burnout from work

Some health workers complained about the amount of workload and how demanding it was to care for older adults. Some suggested that the workload was stressful when others said it was very heavy. Some of them also suggested that there were too many activities in caring for the older adults and others also classified the work as tedious and difficult. It seems that this could also be attributed to understaffing. For example, some suggested that there were too few health workers on shifts taking care of too many older adults. Additionally, some indicated that the workload was too much for them because the ratio between health workers and the older adults was not adequate: *"The workload; I will say it's a little stressful…and here too we don't come at the same time we run shift. Sometime there will be one nurse on duty taking care of eight clients, it's really stressful." (Respondent 5).* "*…we are little understaffed… the workload is the problem, when there are emergencies, critical ill patient and admission makes you exhausted" (Respondent 10).*

### 4.3.3 Limited work resources

The motivation for work and stress and burnout due to work are all related to the resources that the institution has put in place to enhance health workers' work. Some health workers were frustrated and stressed out due to not enough equipment and resources to work with. Similarly, when there are enough equipment and resources available to make work run smoothly, the health workers would generally be positive towards their work. Some of the health workers indicated that the unavailability of proper equipment constrained their ability to work. For example, some of the health workers said that there were limited equipment to care for the older adults such as no patient monitor equipment to monitor unconscious patients: *"... I think we are limited in some way because at times we really need monitors to be monitoring those unconscious patients, but we don't get to make use of it. ...When you want something to do the work and you don't get that is when you are stacked" (Respondent 10).* Related to unavailability of patient equipment was also the absence of other resources that are sometimes used in diversionary therapy to help divert the pain of older adults such televisions. These show serious lack and limited equipment and resources to care for the older adults in Ghana: "…*our patients do not have any kind of diversional therapy. The televisions are not working*…" *(Respondent 9).*

## 4.4 Management and Prevention of Abuse

This theme describes ways in which elder abuse and neglect can be managed or prevented and how health workers professionalism and the hospital/nursing home contributed to manage or prevent elder abuse and neglect.

### 4.4.1 Measure to reduce older adult abuse

Measures to manage the phenomenon elder abuse and neglect seem to be low and inadequate in Ghana as indicated by the responses of the health workers. Some of the health workers gave their opinion about what measure they thought could prevent abuse of the older adults and neglect in Ghana. Among the measures were educating the general public about elder abuse

since most people are unaware of what could be classified as abuse and neglect. Some of the health workers drew comparison between child abuse and elder abuse and suggested that the same way that media attention has been dedicated to child abuse, the media should also take a leading role in educating the public since the media has been very instrumental in contributing to reduce incidence and prevalence of child abuse in Ghana: *"…educating the public about abuse and the things that may qualify as an abuse. Because most people will be doing things that may not know its abuse…the media should also come with advertisement depicting elder abuse like what they have for child abuse" (Respondent 11).* Other measure that were suggested included enforcement of laws to protect older adults since they are a vulnerable group. People should be made to face the full rigor of the law when they are found to have abused or neglected any older adults: *"…you only need to set an example with one, so I think these relative should be dealt with, whether imprisonment to deter others from neglect" (Respondent 9)."I think there should be some rules or laws that should guide us and when you violate any of them, actions should be taken against the culprit because the elderly deserve to live" (Respondent 8).* Some of the health workers also suggested that the licenses of health workers who abuse older adults be revoked to stop them from practicing.

### 4.4.2 Health workers' professionalism to managing older adult abuse

Managing elder abuse could be daunting for the health workers as it could involve very conflicting situations and dilemmas. Since some of the situations that surround episodes of elder abuse can create a dilemma for the health workers, some of them suggested that it was better to stay away or keep distance if the older adults are angry or they refuse to comply with instructions. Some also suggested that it seems that engaging older adults in a long conversation could provoke them to anger and therefore it was important for health workers to be aware of themselves and not unnecessarily engage older adults in lengthy conversations: *"…we shouldn't engage patient in lengthy talks. We shouldn't shout at them, we shouldn't beat them…if a man is angry… just leave him. For instance, if he's angry about the food just leave*

*him" (Respondent 5).* To be professional means that health workers must be aware that anything that causes physical or emotional harm should not be meted out onto the older adults. Among them include not shouting at older adults, not hitting and beating older adults but rather talk to older adults in a low tone and just be nice to them: *"We need not to torment them and cause unnecessary harm to them. Even if they are about to die, they should die peacefully" (Respondent 8).* Additionally, the professionalism of the job required that the health workers accept that their work is to care and provide comfort for the older adults for which reason they are remunerated for work done. According to the health workers, they need training to acquire special skills to be able to efficiently care for the older adults: *"We should understand that they are now in different world altogether whereby taking care of them need a special skill and attention*" *(Respondent 8).*

### 4.4.3 Hospital help abandoned older adults

When relatives abandon their older adults and fail to provide the required financial support to pay for their admission fees and medications, sometimes it becomes the burden of the health workers or the hospital itself. For example, there were times when health workers had to buy medications for abandoned older adults. Older adults who were abandoned could not pay their hospitals bills so in cases like that the hospital is compelled to write off the bills or to ask the older adult to find ways to pay half of the bills. Usually, what happens is that the social workers are contacted to come in to help process for financial support to cover half of the bills for the older adults: *"At times their bill becomes a burden to the hospital and social worker must come in and sometimes the hospital would have to dash them the bill." (Respondent 11). "…no one was coming so, one of the nurses on the ward bought some of the drugs…" (Respondent 8).*

## 4.5 Culture

This theme describes the influence cultural values and traditional beliefs/practices have in the phenomenon of older adult abuse and neglect in terms of cultural conformity and witchcraft

accusations. It also describes the role of generational assistance and the norm of reciprocity in contributing to elder abuse and neglect.

### 4.5.1 Cultural conformity

Some of the health workers suggested that relatives who abandoned and neglected their older adults would show up when they receive news that their older adult has died. The health workers think funerals are a big part of the cultural and traditional elements of Ghanaians and might have influence this behaviour. More than spending money to take care of their older adults while the older adults are alive, they quickly organize themselves and show up for the deceased body and arrange funerals for them. The health workers impression is that some of the relatives prefer their older adults die than to live since living would mean spending their money on their older adults: *"I think Ghanaians like funerals. So instead of taking care of their relative, they will rather want the patient to die so they can have a big funeral with all family members" (Respondent 9).* "*They (relatives) come for the remains and have a grand funeral. But when he was alive, they were never bothered about the food that he ate or even clothes he wore" (Respondent 7).* As for some health workers, the only time they saw that an older adult had relatives was when the older adult had died, and the relatives had come to verify the death and claim the deceased body: *"Since she came on admission, we have not seen the husband before but the very day the woman passed on, the husband with the kids were here and he was asking us what the cause of the death was" (Respondent 8).*

### 4.5.2 Children retaliation

Some health workers indicated that some relatives such as children abandoned and neglected their older adults because the older adults being mothers/fathers failed to take care of the children. Hence, the children also are now refusing to take care of their older mothers/fathers. It seems that some of the children were reluctant to care for their older parents because the children thought it was the time to payback their parents for not taking care of them. Relatives could complain about using their money for treatment of the older adults at the expense of

themselves: *"That man didn't care about the children, so the children also come around as and when they like. Even when he was discharged, it took them some time before they came and picked him up (Respondent 11).*

### 4.5.3 Witchcraft accusation

Some of the health workers suggested that some older adults who are abused and neglected by their relatives are accused as witches or wizards who should be left to their own fate. For example, some family members called their older adult a witch and when the children of the older adult come to visit their mother the children always keep distance because they believed their mother is now a witch: *"... there is this woman whose children come once a while to give her food and money. They leave food at a distance because they believe the woman is a witch" (Respondent 7). "In Ghana we don't have enough nursing homes and most of the older adults are kept in their homes and maltreated because they are old. Sometimes they call them wizards, witches, insult them and even sometimes they beat them. They take them to prayer camps and claim they are beating the witchcraft out of them. Some will also starve them" (Respondent 5).* According to the health workers, the problem of witchcraft accusation is very rife and widespread among older adults in Ghanaian societies.

# Chapter Five

## Discussion

In this Chapter the findings will be discussed considering other previous findings within the frameworks of Bronfenbrenner's Ecological Model and the Social Exchange Theory to understand the meaning and relevance of the findings in general. The findings show that elder abuse and neglect occur in both hospitals and nursing homes, which might be attributed to different factors and explanations. The discussion is primary based on clarifying areas of importance to be able to put concluding remarks into appropriate perspectives.

The data collected for the purpose of this study mainly describes the microsystem level, which is the individual (i.e., interpersonal relationships between older adults, relatives of older adults and health workers) and the immediate context (i.e., hospital and nursing home). However, there were some responses that implicated the interactions between the microsystem level and the exosystem and how the exosystem such as social welfare services and mass media can play a role in the management of elder adult abuse and neglect. Finally, culture and traditional views, beliefs system and the socioeconomic levels of some Ghanaians seem to be implicated in elder abuse and neglect, which can be discussed within the macrosystem level. The Social Exchange Theory could provide explanations for children retaliation and aggressive exchanges between health workers and older adults.

### 5.1 Addressing interpersonal relationships at the microsystem and across structural factors at the exosystem

Many different and complex factors contribute to elder abuse and neglect in the hospital and nursing homes comprising personal characteristics and relationships, social interactions and organisational factors as well as environmental factors (22). According to Bronfenbrenner's ecological model, activities, roles and interpersonal relationships explain the motivations for behaviours and development at the microsystem. In different situations, health workers and older adults or the relatives come into direct contact or relationships within a given social

encounter. Differences in individual personal attributes and the way that different people interpret different situations could contribute to elder abuse or even reduce it. Some older adults perceive themselves to be socioeconomically higher (i.e., *"better than others"*) than others or just more superior and that could have created the situation that those who perceive themselves to be better did not engage with the others or fight with the others at the least provocation. On the other hand, it seems that for older adults who were friendly with each other, their positive relationship and good bonding contributed to good communication among themselves. This is particularly important for being able to support each other as can be seen in the responses. Some respondents in both the hospital and the nursing home showed that among older adults who were friendly they supported each other in carrying out some minor activities and walking around, which seemed to have created a good bond among them, hence creating a positive relationship among themselves.

In other situations, the characteristics of the health workers or the older adults might explain the kind of relationship that will ensue between them or explain what could cause disagreement between them. A health worker who perceives excessive power for being *'a carer'* in his/her role in providing care for *'a dependent'* older adult might misuse this power relationship, which could contribute to elder abuse or use the power relation in a way to provide adequate care. The kind of interpersonal relationship that exists between health workers and resident older adults (at the microsystem) and the way that the health workers relate with the older adults suggest some power dynamics. One that shifts mainly to the side of the health workers, who seem to use that power by virtue of their roles in the settings that form their particular social encounters.

In the hospital and nursing homes, older adults are found within nested levels of interrelated systems and influences, which affect the relationship and interaction between older adults and health workers in their social encounters. In situations of stress and burnout, this might increase

the probability of negative outcomes in the resident – staff power relations (40, 42). For health workers in the hospital, it seemed that the underlying power dynamics in their interpersonal relationships with resident older adults was not apparent or maybe deemphasised. Respondents 8 and 9 seem to emphasise different things regarding how health workers relationships with the resident older adults contribute to episodes of abuse. According to Respondent 8, it is when there is overload of work and pressure due to inadequate staff that may contribute to one health worker or the other abusing older adults as the "*professional approach sometimes will be lacking"* (Respondent 8). Regarding health workers in the nursing homes, it seems that they want to reprimand the older adults for what they perceive to be something the older adults have done wrong and could sometimes neglect the older adults as a way of not *"[saying] something that will hurt them [older adults]"* – Respondent 6. This could also qualify as a form of intentional neglect whereby the health workers willingly and with intent ceases to provide care for older adults.

As elaborated in Bronfenbrenner's ecological model, in the microsystem, acts of elder abuse and neglect may result from risk factors associated with the direct relationship between residents and caregivers. One of the risk factors identified by Pillemer and Bachman-Prehn (23) is situational characteristics namely, levels of staff stress and burnout. Nonetheless, for health workers in the hospital it can be argued that despite the situational characteristics of stress and burn out, health workers in the hospital "*must make sure to meet whatever needs the patient has even if [*they are*] understaffed"*. The same may not be argued for health workers in the nursing homes. What could be the explanation for this in the nursing home? It was also most of the health workers in the nursing homes whose responses suggested dissatisfaction with the financial renumeration of their *"…really stressful work…with one health worker taking care of eight older adults…and the only one on duty"*. Meanwhile, other health workers in the hospital are paid higher salaries as Respondent 5 indicated in her response as *"My*

*colleagues on the field* [colleagues in the hospital] *are taking two thousand cedis plus [Ghs 2,000 +] [*about NOK 3000 and more per month*],… but here* [in the nursing home] *I receive three Hundred Cedis [Ghs 300] for eight patients [*about NOK 450 per month*]*.

It seems that elder abuse and neglect in the hospital may be lower than in the nursing homes. A better way to explain this could be discussing the structural arrangements in the hospital versus the nursing homes. In this case, the Ghana Health Service directly regulates the hospitals in Ghana whereas the nursing homes I visited for the data collection was headed by a CEO who said she was a retired nurse and did not directly have supervision from the Ghana Health Service. The same is true of the second nursing home whose administrator has no direct supervision from the Ghana Health Service. Additionally, the hospital has strict regulations that might explain the near absence of health workers physically abusing older adults on admission. As Pillemer and Bachman-Prehn (23) argued, institutional characteristics are among variables that influence elder abuse and neglect. The exosystem consists of social welfare services, mass media, legal services and religious institutions. Contrasted with the nursing homes, the hospitals in Ghana are under the direct supervision of the Ghana Health Service. In the context of Bronfenbrenner's ecological model, The Ghana Health Service is an institution whose regulations affect the settings in which the older adults are contained in the hospital. Thus, regulations and oversight responsibilities by the Ghana Health Service on the hospital could be said to affect the way that older adults are cared for even though the older adults themselves are not active participants in that institution (i.e., the Ghana Health Service). This is not available in the case of older adults in the nursing homes, which might explain the apparent differences in health workers in the hospital versus health workers in the nursing homes and how their interpersonal relationships with the resident older adults as well as how regulations from a superior institutional authority shape the episodes of abuse of older adults.

## 5.2 Conflicts, aggressive exchanges, understaffing and job dissatisfaction

The findings show that elder abuse and neglect are connected to disagreements and conflicts between older adults and health workers, understaffing and job dissatisfaction. It was quite clear that some health workers suggested that the reason why they physically abused an older adult was because the older adults reacted in a disrespectful way by throwing food or excreta on the health worker or when the older adults refused to comply to instructions. Related to disagreements and conflicts was aggressive exchanges between health workers and older adults. It is important to mention here that, there were no responses of hitting or beating older adults during aggressive exchanges and conflicts by health workers in the hospital, while almost all health workers in the nursing home claimed to have hit or beaten an older adult due to something the older adult did to anger the health worker. The social exchange theory conceptualizes behaviour as involving decision – making processes used in arranging or negotiating care for the dependent older adults (39, 40, 42). In light of this theory, when a health worker feels annoyed and angered by something the older adult has done such as *"…painting the washroom with faeces…"* or *"…throwing his hand at [the health worker]…*", the health worker may resort to beating or hitting the older adult as a way to restore balance. Additionally, behaviours related to abusing older adults by health workers could be the result of perceived imbalances in their interpersonal relationships with the older adults at the microsystem level or even perceiving imbalance at a higher order mesosystems level, whereby health workers feel disadvantaged because of policies, laws, regulations and conditions of services of their job. When health workers perceive to receive unfair share or rewards in their roles as caregivers, they may resort to abuse, aggression or violence to restore balance in the sociodynamic relationships that has been upset (38, 43-46).

When a unit is understaffed, this could lead to elder abuse and neglect by health workers as it creates stress and pressure on the health workers. Different systematic reviews have found

associations between staffing and quality of care in nursing homes. A previous study found that higher or adequate staffing levels (especially licensed health workers) is associated with improved quality care of older adults in the nursing homes (52). In another systematic review, the authors found that about 40% of quality indicators in nursing home studies show association with staffing levels (53, 54). Job dissatisfaction has also been implicated in elder abuse and neglect in residential care settings, finding that job dissatisfaction had a negative impact on health worker motivation to provide good care for older adults (55), and that when job satisfaction decreases, incidence of emotional abuse of older adults increases (22).

Some of the health workers also suggested that the abuse of older adults should be blamed on the older adults themselves who refuse to comply with instructions or accept assistance. The blame for abuse of the older adults was now pushed onto the older adults who have been abused by the health workers because according to the health workers the older adults provoked them to react and also the older adults failed to cooperate with them, which led to them being angry and resulting in the abuse. This finding has been found in previous studies (21, 22). This is a very interesting finding when considered in the light of the other responses. It seems that it was the limited resources and facilities coupled with understaffing that should be blamed rather than the older adults themselves. For example, the reason some of the health workers blamed the older adults for abuse was because there was little time and resources to work so when older adults do not listen to instructions and since "*you [staff] is working with time so if he [older adult] is still not responding*…[health worker] *get irritated and hit him [older adult]…*".

### 5.3 Culture, tradition and norm of reciprocity

Culture and traditional values form part of the macrosystem level in Bronfenbrenner ecological model (39-41). While traditional values have shaped attitudes towards older adults in Ghanaian communities, for example, in a popular Ghanaian proverb "just as older adults helped you as you cut your first teeth, so must you help them as they lose theirs", so too has some belief

systems. To this end, one would expect that given the collectivistic and interdependent nature of familial and social relations in Ghana, relatives would at no point in time abandon and neglect other members (10, 11, 14). Findings from this study showed that some relatives abandoned their older adults and only showed up when they received news of the death of the older adults as it is culturally frowned upon to not show respect for the dead family member. It is a commonly held belief in Ghana that under no circumstances should anyone do anything to disrespect their dead family relatives. Additionally, as van der Geest (55, 56) indicated funerals are important occasions for the family to affirm its prestige and to celebrate its excellence (56, 57). Therefore, it becomes an unbearable disgrace to not show respect for the dead or to organize a poor funeral (56). Not going to collect the dead would be a sign of disrespect and cast severe social criticisms on the family. So, to avoid the social criticisms and condemnation from the community, the family upon hearing of the death of their older adults must quickly now intervene (56). This can be explained at the macrosystem level, comprising attitude and ideologies of the culture and values in which the person lives, and belief systems which all shape the life of the person. Failure to collect the dead and organize a befitting funeral could cause serious social consequences for the family. Death in the Ghanaian society is treated confidential, within very close family relations as a way of not disrespecting the dead until is announced and preparations can start for the funeral.

Some older adults were accused by their own relatives for being witches or wizards. This could be explained by the traditionally held view that older adults have accumulated life experience that are associated with a wide array of knowledge as well as of potentially destructive knowledge – which is what can be used for witchcraft (26, 27). Therefore, especially post-menopausal women more than men, are feared for having this power that can be used to curse and bring misfortune. Older adults accused for being witches are banished into so – called

witches' camp, an increasing occurrence in Northern Ghana that strips them of their dignity and human rights by subjecting them to abuse and torture (13, 14).

It has also been suggested that generational assistance and the norm of reciprocity in the context of social exchange accounts for whether adequate care would be given to an older adult by a younger person such as a child. According to the responses, some children of older adults refused to care for them as a form of retaliation for the older adult's own failure to invest adequately in the children. In the early life years, generational assistance is given from parents to children, and then in later life years it is expected that adult children reciprocate the assistance they received while young to their now older adult parents. Here, parents are seen to make deposits of care in their younger ones in anticipation that their children will later pay off when parents are ageing and needing help. However, when children perceive that they did not receive the support they needed or "*…the man never cared for the children…",* then *the children feel reluctant to care even though they have the means to help"*.

## 5.4 Strengths and limitations

This study has several strengths including interviewing the health workers in their own places of work. This could contribute to making them comfortable and providing accurate responses. The inclusion of health workers from both nursing homes and hospital, which gives us a broader overview of elder abuse and neglect as it pertains to Ghana is another strength. The respondents are of various ages and years of experience, which means that they have varied encounters that inform their responses on the phenomenon of elder abuse and neglect in Ghana. The application of semi-structured interview also enabled respondents to speak on broader aspects as follow-up questions were posed. As the researcher is a Ghanaian herself, this allowed deeper reflections on the meanings of the responses in ways that fit within the broader explanatory frameworks of the ecological model and the social exchange theory. As for limitations, this is the researcher's first major qualitative study and therefore has little

experience in terms of qualitative data collection and analyses. As a student researcher, this create limitations in research experience, which means there could be some aspects of interviewing techniques that may be missed. Nonetheless, efforts were continuously made during the interviews and analyses to ensure improvements in the ongoing research. Non-inclusion of quantitative data, which could have presented results on incidence, prevalence and distribution of abuse of older adults and other availability of resources or facilities means that some important information might be missing, which could have improved the results and discussion of the present study. As data was collected from health workers who might be implicated in negative practices, some health workers may have not been very open despite using semi structured interview. Data from older adults themselves could have improved the results and discussions.

## 5.5 Trustworthiness of the Study

As for qualitative studies, Krefting (58) argued that they should be evaluated by providing alternatives to reliability and validity which are used in quantitative researches. Therefore, since qualitative research seeks to unravel the social world of respondents and how they experience, think, describe and understand their encounters, trustworthiness was adopted for this study. Trustworthiness has four criteria which are: Credibility, Transferability, Dependability and Confirmability (58). According to Krefting (58), credibility refers to conducting the research in a proper practice and methodology. In this study methodological and research questions were clearly outlined and their relevance at each stage of the study was evaluated together with my supervisor, bringing to fore different nuances and perspectives.

The question of whether the respondents gave truthful information is crucial to the credibility of the findings. To ensure this was achieved, respondents were assured of anonymity of themselves and the nursing home and hospital. All aspects of the ethical approval were strictly adhered to. Another aspect of credibility, which was difficult to achieve, was to return the

analyses to the respondents in order to confirm their responses. This was not possible due to practical reasons because I returned to Trondheim after collecting the data. Transferability implies giving a dense description of the data so that other researchers in the field could replicate the study in other settings (58). This, however, should not be confused with generalization since the findings should remain in the confinements of the specific context of the social world being studied. The findings from this research are context specific and have been discussed as what pertains to the Ghanaian context from the perspectives of health workers. Dependability in qualitative research is what equates reliability in quantitative studies (58). To be able to achieve dependability, it is suggested to keep absolute track of the entire stages of the research process, the data collection and analyses (58). Therefore, every stage in this study has been described, discussed and debated where necessary, beginning from project description and presentation with my supervisor. This has ensured the dependability of the study and its findings. Researchers must ensure that they do not influence the research process and analyses with their personal viewpoints and characteristic to ensure objectivity (58). For example, the interview questions were derived from the literature review and evaluated together, and sometimes debated with my supervisor who has expertise in the field of elder abuse to avoid any personal biases from the researcher.

## 5.6 Conclusion and implications

Health workers in the hospital and nursing homes are among the important sources to collect information and data about elder abuse. Overall, the findings show that poor and negative relationships between health workers, older adults and relatives of older adults and among the older adults themselves are implicated in elder abuse. The findings highlight the need to reduce the stress and pressure on health workers, improve resources and facilities in the hospital and nursing homes to be able to improve the quality of care for older adults. The findings also highlight the role of culture in Ghana, and traditional beliefs regarding accusations of older

adults as witches. Most importantly, the findings have drawn attention to the need to include private nursing homes in the Ministry of Health's supervisory roles to improve the structural arrangements and conditions of the nursing homes as well as the quality of care for older adults. The findings have important implications for studying the relationship between individuals (i.e., older adults, staff and relatives of older adults), their immediate context, and the attitudes and cultural systems that may contribute to or help to manage elder abuse. Future research may explore the dynamic relationships into detail for specific forms of elder abuse.

### 5.6.1 Concrete recommendations for management and prevention of elder abuse and neglect

- Hospitals and nursing homes that care for older adults in Ghana must provide regular staff training and education to increase staff skills in the care for older adults.
- The Ministry of Health must expand oversight responsibilities to cover private nursing homes.
- The mass media should be encouraged to contribute with raising awareness of the public on matters relating to elder abuse and neglect.
- Policies and laws protecting older adults such as the national ageing policy and the national aged bill should be given adequate attention and force to implementation.
- Institutions should regularly check on health workers conditions to create an environment for health workers to feel valued, motivated and appreciated for their work.

### 5.6.2 Relevant topics for further research

- Through national survey studies, investigate risk factors for each of the types of elder abuse and neglect in the nursing home and hospitals, on all levels (not only the microsystem level).
- Explore how nursing home residents themselves experience being exposed to abuse and neglect by health workers.

- Develop and carry out intervention studies testing the effect of different support and training programmes by health workers.
- Investigate the effectiveness of regulations and institutional policy that protect health workers who blow the whistle on abuse and neglect, and whether these regulations lead to increased report rate.

# References


1. World Health Organization (WHO). Violence in the Western Pacific Region 2014 [Available from: https://iris.wpro.who.int/handle/10665.1/12400.
2. Keller E, Santos C, Cusack D, Väli M, Ferrara D, Ludes B, et al. European council of legal medicine (ECLM) guidelines for the examination of suspected elder abuse. 2019;133(1):317-22.
3. Vida SJTCJoP. An update on elder abuse and neglect. 1994;39(8_suppl):34-40.
4. Yon Y, Mikton CR, Gassoumis ZD, Wilber K. Elder abuse prevalence in community settings: a systematic review and meta-analysis. 2017;5(2):e147-e56.
5. McDonald L, Beaulieu M, Harbison J, Hirst S, Lowenstein A, Podnieks E, et al. Institutional abuse of older adults: What we know, what we need to know. 2012;24(2):138-60.
6. Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi DJ. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. 2018.
7. Lindbloom EJ, Brandt J, Hough LD, Meadows S. Elder mistreatment in the nursing home: a systematic review. 2007;8(9):610-6.
8. Harris DK, Benson M. Neglect. Theft in nursing homes: An overlooked form of elder abuse. 2000;11(3):73-90.
9. Lachs MS, Pillemer K. Elder abuse. 2004;364(9441):1263-72.
10. Melchiorre MG, Chiatti C, Lamura G, Torres-Gonzales F, Stankunas M, Lindert J, et al. Social support, socio-economic status, health and abuse among older people in seven European countries. 2013;8(1):e54856.
11. Apt N. Rapid urbanization and living arrangements of older persons in Africa. United Nations, Population Division Living arrangements of older persons: critical issues and policy responses Population Bulletin of the United Nations. 2001:288-310.
12. Apt NA. Ageing and the changing role of the family and the community: An African perspective. International Social Security Review. 2002;55(1):39-47.
13. Appiah A. Elderly suffer physical, spiritual and emotional torture each day - Guardians of Gray Masters Foundation Accra, Ghana2017 [Available from: https://www.myjoyonline.com/news/2017/june-15th/elderly-suffer-physical-spiritual-and-emotional-torture-each-day-guardians-of-gray-masters-foundation.php.
14. Mba C. Elder abuse in parts of Africa and the way forward. 2007;6(4):230-5.

15. Apt NA. Ageing and the changing role of the family and the community: An African perspective. 2002;55(1):39-47.
16. Apt NA. Population Division. Living arrangements of older persons: critical issues, Nations prPBotU. Rapid urbanization and living arrangements of older persons in Africa. 2001:288-310.
17. Apt NA. Care of the elderly in Ghana: An emerging issue. 1993;8(4):301-12.
18. Sossou M-A, Yogtiba J. Abuse, neglect, and violence against elderly women in ghana: implications for social justice and human rights. 2015;27(4-5):422-7.
19. Crampton AJA, Quarterly A. No Peace in the House: Witchcraft Accusations as an" Old Woman's Problem" in Ghana. 2013.
20. Ministry of Gender. Aged Bill Being Prepared To Be Passed Into Law2018. Available from: http://mogcsp.gov.gh/index.php/aged-bill-being-prepared-to-be-passed-into-law/.
21. Malmedal W. Inadequate care, abuse and neglect in Norwegian nursing homes. Trondheim: Norwegian University of Science and Technology; 2013.
22. Malmedal W, Hammervold R, Saveman B-I. The dark side of Norwegian nursing homes: factors influencing inadequate care. The Journal of Adult Protection. 2014;16(3):133-51.
23. Pillemer K, Moore DW. Abuse of patients in nursing homes: Findings from a survey of staff. The Gerontologist. 1989;29(3):314-20.
24. Redfern S, Hannan S, Norman I, Martin F. Work satisfaction, stress, quality of care and morale of older people in a nursing home. Health & social care in the community. 2002;10(6):512-7.
25. Mba CJ. Population ageing in Ghana: research gaps and the way forward. Journal of aging research. 2010;2010.
26. Mba CJ. The health condition of older women in Ghana: a case study of Accra City. Journal of International Women's Studies. 2013;8(1):171-84.
27. Mba CJ. Elder abuse in parts of Africa and the way forward. Gerontechnology. 2007;6(4):230-5.
28. Tawiah E. Population ageing in Ghana: a profile and emerging issues. 2013.
29. Crampton A. No Peace in the House: Witchcraft Accusations as an" Old Woman's Problem" in Ghana. Anthropology & Aging Quarterly. 2013.
30. Van der Geest S. Ɔpanyin: the ideal of elder in the Akan culture of Ghana. Canadian Journal of African Studies/La Revue canadienne des études africaines. 1998;32(3):449-93.

31. Sossou M-A, Yogtiba JA. Abuse, neglect, and violence against elderly women in Ghana: implications for social justice and human rights. Journal of elder abuse & neglect. 2015;27(4-5):422-7.
32. Manjoo R, editor Violence and abuse against older persons in the public and private spheres. New York, NY: Expert Group Meeting Human Rights of Older Persons, New York; 2012.
33. Adinkrah M. Witchcraft accusations and female homicide victimization in contemporary Ghana. Violence against women. 2004;10(4):325-56.
34. World Health Organization (WHO). The Toronto declaration on the global preventionof elder abuse. . Geneva, Switzerland: Author 2002.
35. Garbarino J. The human ecology of child maltreatment: A conceptual model for research. Journal of Marriage and the Family. 1977:721-35.
36. Garbarino J, Eckenrode J, Barry FD. Understanding abusive families: An ecological approach to theory and practice: Jossey-Bass San Francisco; 1997.
37. Garner J, Evans S. An ethical perspective on institutional abuse of older adults. The Psychiatrist. 2002;26(5):164-6.
38. Schiamberg LB, Gans D. Elder abuse by adult children: An applied ecological framework for understanding contextual risk factors and the intergenerational character of quality of life. The International Journal of Aging and Human Development. 2000;50(4):329-59.
39. Bronfenbrenner U. Toward an experimental ecology of human development. American psychologist. 1977;32(7):513.
40. Bronfenbrenner U. Ecological systems theory: Jessica Kingsley Publishers; 1992.
41. Bronfenbrenner U. The Ecology of Human Development in Retrospect and Prospect. 1975.
42. Bronfenbrenner U, Morris PA. The bioecological model of human development. Handbook of child psychology. 2006.
43. Schiamberg LB, Barboza GG, Oehmke J, Zhang Z, Griffore RJ, Weatherill RP, et al. Elder abuse in nursing homes: An ecological perspective. Journal of elder abuse & neglect. 2011;23(2):190-211.
44. Steinmetz SK. Duty bound: Elder abuse and family care: Sage Publications, Inc; 1988.
45. Steinmetz SK. Family violence. Handbook of marriage and the family: Springer; 1987. p. 725-65.

46. Hareven TK. Aging and generational relations over the life course. Aging and generational relations over the life course: A historical and cross-cultural perspective. 1996:1-12.
47. Kvale S. Dominance through interviews and dialogues. J Qualitative inquiry. 2006;12(3):480-500.
48. Kvale S. Interviewing as research. Interviews: An introduction to qualitative research interviewing. London: Sage Publications; 1996. p. 3-13.
49. Polit DF, Beck CT. Nursing research: Principles and methods: Lippincott Williams & Wilkins; 2004.
50. Elwood SA, Martin DG. "Placing" interviews: location and scales of power in qualitative research. The professional geographer. 2000;52(4):649-57.
51. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. J Nurse education today. 2004;24(2):105-12.
52. Bostick JE, Rantz MJ, Flesner MK, Riggs CJ. Systematic review of studies of staffing and quality in nursing homes. Journal of the American Medical Directors Association. 2006;7(6):366-76.
53. Castle NG. Nursing home caregiver staffing levels and quality of care: A literature review. Journal of Applied Gerontology. 2008;27(4):375-405.
54. Castle NG, Engberg J. The influence of staffing characteristics on quality of care in nursing homes. Health services research. 2007;42(5):1822-47.
55. Redfern S, Hannan S, Norman I, Martin F. Work satisfaction, stress, quality of care and morale of older people in a nursing home. Healthsocial care in the community. 2002;10(6):512-7.
56. Van der Geest S. Funerals for the living: Conversations with elderly people in Kwahu, Ghana. African Studies Review. 2000;43(3):103-29.
57. Van der Geest SJSs. Dying peacefully: considering good death and bad death in Kwahu-Tafo, Ghana. Social science medicine. 2004;58(5):899-911.
58. Krefting L. Rigor in qualitative research: The assessment of trustworthiness. The American journal of occupational therapy. 1991;45(3):214-22.

# Appendix A

## Interview Guide

### 1. Background Information

Can you give some facts about yourself?

* Age
* Education
* Occupation / position
* Work Experience
* Duration of experience from current employment
* Type interns
* Full-time or part-time
* Marital status
* Child care / other

### 2. Description of Workplace

Can you tell me about the unit/ward you're working in?

* Number of beds
* What type of patients (dementia, greatly in need of care?)
* The physical surroundings
* Human resources, skilled / unskilled staff

Can you describe the working environment at the unit/ward?

* Among the staff
* Staff vs. patients
* Patients vs. patients
* Much conflicts
* Work environment
* Turnover / absence * Workload * Satisfaction at work?
* Plans to quit?
* Do you feel burned out?

### 3. Episodes of Abuse And Neglect

I am particularly interested to hear about episodes/acts that can be defined as abuse and neglect of patients/ nursing home residents.

What kind of acts would you define as abuse? And what kind of acts would you define as neglect?

* Intentional abuse vs. non-intentional
* Abuse / Neglect / Offense

### 4. Witness of Abuse

Have you at work witnessed episodes that you would define as abuse?

Can you describe one?

If you have not directly witnessed such an episode, have you had a suspicion that abuse has ever occurred?

* Who was present? Gender, age, type of patient / staff / relative
* What happened prior to the episode?
* The intention?
* Detail description
* Was the incident reported?
* Who was it reported to?
* Your experience of what happened
* Were there provocations ahead, from patients?

Why would you define this act as abuse?

What do you think was the reason why this abuse took place?

Could anything have been done to prevent this?

How was it managed?

### 5. Own Experience

Have you at work been involved in episodes that you would define as abuse?

Can you describe such an episode?

* Who was present? Gender, age, type of patient / staff
* What happened prior to the episode?
* The intention?
* Detailed description
* Was the incident reported?

* Who was it reported to?

* Experience

Why would you define this act as abuse?

What do you think was the reason why this act took place?

Could anything have been done to prevent this?

How was it managed?

**6. Closure**

Do you ever speak about abuse and neglect in your workplace?

* Have you heard about such acts?

* What are the reactions from the staff if abuse and neglect is discussed?

What are in your opinion the key factors to prevent abuse and neglect from occurring?

REMEMBER TO SAY THANKS

# Appendix B

## Consent Form

**Title:** Elder Abuse and Neglect: Health Workers' Perception in Ghana

**Principal Investigator**: Christiana Anyan

**General Information about Research**

This study will explore health workers experiences, and thoughts about elder abuse and neglect as well as finding out the types of abuse that are reported and occur in the hospitals and nursing homes. The study will further explore the approach health workers adopt to cope and deal with the situation when they come across in their line of duty. The health workers shall be requested to grant an interview using an interview guide (please find a copy attached). An audio recorder will be used to record the interviews and recordings of the interviews will remain anonymous. The interview will last about thirty (30) minutes.

**Possible Risks and Discomforts**

The interview guide has been used in many studies already without known risks or negative outcomes. However being a nurse myself, if l notice any discomfort from participant during the interview or after the interview they will be referred to counselling unit at the 37 Military Hospital.

**Possible Benefits**

Elder abuse is a public health concern and more knowledge may contribute towards reducing and preventing elder abuse and neglect in Ghana. Although the government of Ghana has a National Ageing Policy approved in 2010, it has not been effective waiting for the passage into law, the National Aged Bill and the setting up of the National Council on Ageing. The findings of this study will contribute to advocacy by government and non-governmental organizations that work to reduce and prevent elder abuse in Ghana. Additionally, the present study will contribute to inform the development of holistic intervention programmes that take cognizance

of and incorporate the perception of healthcare workers regarding elder abuse in healthcare institutions (i.e. nursing homes and hospitals). Apart from contributing to the empirical evidence on health workers' perceptions of elder abuse and neglect in Ghana, the findings of the present study will foster attitudinal change on the part of the larger community towards elder abuse.

**Confidentiality**

I will ensure confidentiality and protect information about you to the best of my ability. Participation is strictly anonymous: you would not be identified by your name. All information provided in this study will be held in absolute confidence; the tapes would remain in the custody and control of the researcher always and would not be given out for any purpose to anyone who is not working directly with the researcher. The researcher will not share information which could identify you with anyone or in publication. The information would be destroyed when the entire research is over.

**Compensation**

A gift voucher of Two Hundred Ghana Cedis (Ghc 200) will be given to each participant after the interview. The participant shall receive the gift voucher whether he/she is able to complete the interview or not. Since the venue of interviews will be determined by the participants for their comfort, transportation will be paid to those who incur transportation cost.

**Voluntary Participation and Right to Leave the Research**

Participation in the study is voluntary. Participants have the right not to answer any question(s) they feel uncomfortable with and to discontinue the study at any time during the interview without stating any particular reason. There will be no negative repercussions and the recording from that participant will be deleted.

**Contacts for Additional Information**

Christiana Anyan 0244293727 email: chtistysamoah@gmail.com

Professor Wenche Malmedal +4773412297 email: Wenche.k.malmedal@ntnu.no

**VOLUNTARY AGREEMENT**

If you have any further questions or concerns, please contact me at chtistysamoah@gmail.com, or by telephone, 0244293727. You can also contact my supervisor, Wenche Karin Malmedal at wenche.k.malmedal@ntnu.no

_____ _____

(Signature of Researcher: Christiana Anyan) (Date)

**Consent of Informant**

I certify that the purpose of the study has been thoroughly explained to me in a language I understand to my satisfaction and I have received a copy of the consent form. I understand that any information obtained from me for this research will be kept confidential. To further ensure privacy, I have the option of using a pseudonym. I understand that participation is voluntary and I have the right to refuse participation at any time in the course of the interview and will still receive my compensation. I agree to participate in this study.

_____ _____

(Informant: Signature/Initials/thumb Print) (Date)

Wenche Malmedal
Postbok 8905
7491 TRONDHEIM

Vår dato: 11.10.2017 Vår ref: 55593 / 3 / PEG Deres dato: Deres ref:

# Tilrådning fra NSD Personvernombudet for forskning § 7-27

Personvernombudet for forskning viser til meldeskjema mottatt 31.08.2017 for prosjektet:

| | |
|---|---|
| *55593* | *Elder abuse and neglect: Health workers' perception in Ghana* |
| *Behandlingsansvarlig* | *NTNU, ved institusjonens øverste leder* |
| *Daglig ansvarlig* | *Wenche Malmedal* |
| *Student* | *Christiana Anyan* |

## Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er unntatt konsesjonsplikt og at personopplysningene som blir samlet inn i dette prosjektet er regulert av § 7-27 i personopplysningsforskriften. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

## Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeskjemaet og øvrig dokumentasjon
- vår prosjektvurdering, se side 2
- eventuell korrespondanse med oss

## Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

## Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

## Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Ved prosjektslutt 31.05.2019 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Vennlig hilsen

Katrine Utaaker Segadal

Pernille Ekornrud Grøndal

Kontaktperson: Pernille Ekornrud Grøndal tlf: 55 58 36 41 / pernille.grondal@nsd.no
Vedlegg: Prosjektvurdering
Kopi: Christiana Anyan, chriany@stud.ntnu.no

**Institutional Review Board**

[redacted]

13 August 2018

[redacted]

## ETHICAL CLEARANCE

On 7th August 2018, the [redacted] Institutional Review Board (IRB) at a Board Meeting reviewed and approved your protocol.

**TITLE OF PROTOCOL: Elder Abuse and Neglect: Health Workers' Perception in Ghana**

**PRINCIPAL INVESTIGATOR: Christiana Anyan**

Please note that a final review report must be submitted to the Board at the completion of the study.

Please report all serious adverse events related to this study to [redacted] within seven (7) days verbally and fourteen (14) days in writing.

This certificate is valid until 6th August 2019.

[redacted]

INSTITUTIONAL REVIEW BOARD
DATE 13-08-18

[redacted]

[redacted]

To whom it may concern
37 Military Hospital, Accra
15/05/2018

Dear Sir/Madam,

**Introduction of Mrs. Christiana Anyan for Data Collection in your hospital**

I write to introduce Mrs. Christiana Anyan; a master student in Global Health, at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway. As part of Mrs. Anyan's Master's research project, she is required to carry out an independent research project under the supervision of a senior academic staff. Christiana Anyan has chosen to carry out her study on:

"Elder abuse and neglect: health workers' perception in Ghana".

The project aims to find out health workers experiences, and thoughts about elder abuse and neglect. The study will further explore the approach health workers adopt to cope and deal with the situation when they come across in their line of duty. Elder abuse is a public health concern and more knowledge may contribute towards reducing and preventing elder abuse and neglect in Ghana. The health workers shall be requested to grant an interview using an interview guide (please find a copy attached) which has been used in many studies already without known risks or negative outcomes. The recordings of the interviews will remain anonymous. Participation in the study is voluntary and participants can discontinue the study at any time during the interview without stating any particular reason. There will be no consequences and the recording from that participant will be deleted.

15/05/2018

Sincerely,

Wenche Malmedal, RN, MSc, PhD (Supervisor)
Associate professor, Department of Public Health and Nursing
Norwegian University of Science and Technology
N-7491 Trondheim, Norway.

NTNU
Fakultet for medisin og helsevitenskap
Institutt for samfunnsmedisin og sykepleie

Vår dato 14.05.2018 | Vår referanse LIER
Deres dato 14.05.2018 | Deres referanse

To whom it may concern

Accra
14.05.2018

Dear Sir/Madam,

**Introduction of Mrs. Christiana Anyan**

I write to introduce Mrs. Christiana Anyan; a master student in Global Health, at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway. As part of Mrs. Anyan's Master's research project, she is required to carry out an independent research project under the supervision of a senior academic staff.

The project aims to find out health workers experiences, and thoughts about elder abuse and neglect. The study will further explore the approach health workers adopt to cope and deal with the situation when they come across in their line of duty. Elder abuse is a public health concern and more knowledge may contribute towards reducing and preventing elder abuse and neglect in Ghana.

Christiana's project is being supervised by Wenche Malmedal (PhD) in the Department of Public Health and Nursing at the Norwegian University of Science and Technology.

Sincerely,

Ragnhild Lier
Adviser

NTNU
Norwegian University of Science and Technology
Faculty of Medicine and Health Sciences
Department of Public Health and Nursing

Siri Forsmo
Head of Department

**Postadresse**
Postboks 8905
7491 Trondheim
Norway

**Org.nr. 974 767 880**
postmottak@mh.ntnu.no
www.ntnu.no/ism

**Besøksadresse**
Håkon Jarls gate 11
Samfunnsmedisinbygg et, 1. etg.

**Telefon**
+47 73597577

**Saksbehandler**