Original Article

Elder Abuse in A Private Home Care and A Public Health Facility in Ghana

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Abstract

The elderly receiving care in healthcare settings are particularly vulnerable to abuse because most suffer from several chronic diseases that lead to limitations in their functioning, and some are also dependent on their caregivers. In addition, many are unable to report abuse because they are fearful that reporting may lead to retaliation, which may negatively affect their care. This study sought to investigate the prevalence of elder abuse amongst aged persons seeking care at a private nursing home and a public health facility in Ghana. Results showed that, except for sexual abuse, all four types of abuse were experienced by aged persons in varying frequencies at the healthcare facilities. The prevalence of self-reported abuse showed that 3/30 (10%) and 23/80 (28.8%) aged persons from the Private facility and Public facility were being abused. The prevalent abusers of the aged persons were their relatives, 19/26 (25.8%), nurses, 4/26 (9.2%) and children, 3/23 (3.8%). The healthcare facility was significantly associated with the experience of elder abuse (P=0.039). The findings of this study strengthen the case for national action to expand efforts in researching into supporting and preventing victims of elder abuse. The advocacy for the need for multidisciplinary professionals for the care of the elderly is essential.

Keywords:

Ghana; Infertility; Psychological threats; Social threats; Women

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Introduction

Elder abuse has attracted sustained efforts from researchers and policy makers around the world over the past two decades. Yet, it has not received significant attention from researchers in Ghana (Sossou & Yogtiba, 2015). Consequently, no major foundation in the country has identified this field as one of its priorities. However, some research on the abuse of the aged has focused on the risk factors of elder abuse in the community (Danyoh, Dampson, & Dzakadzie, 2018; Sossou & Yogtiba, 2015). Nonetheless, the elderly receiving care in healthcare settings that offer long-term supportive services are at particular risk of abuse (WHO, EA, 2018). They are vulnerable because most of them suffer from several chronic diseases that lead to limitations in their functioning, and many are also dependent on their caregivers. In addition, many are either unable to report abuse because they are fearful that such reporting may lead to retaliation which may negatively affect their care while on admission (WHO, EA, 2018). Elder mishandling, mistreatment or abuse refers to intentional actions that cause harm or create a serious risk of harm to a vulnerable elder by a caregiver who stands in a trust relationship to the elder (Sossou & Yogtiba, 2015). It may also be described as failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm (Yon, Ramiro-Gonzalez, Mikton, Huber, & Sethi, 2018). The World Health Organization's (WHO) report on elder abuse says it is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm to an older person. It includes physical abuse, psychological or emotional abuse, sexual abuse, abandonment or neglect and financial or material fraud (WHO, EA, 2018). The types of abusers may include family members, informal and formal caregivers and acquaintances (Yon et al., 2018).

Physical abuse among the elderly occurs when force is used against an elder, resulting in some type of bodily pain, impairment or injury. It also refers to any conduct that violates the physical integrity of an older person (Bigala and Ayiga, 2014). In a hospital or a nursing home setting, this type of abuse includes hitting, smacking and shoving. It also extends to physical restraints, drug restraints and confinement being used inappropriately (WHO, EA, 2017). Psychological and emotional abuse occurs when elderly patients are treated or spoken to in ways that cause them trauma or emotional pain. Likewise, it reflects any form of degrading or humiliating conduct such as instilling fear, mockery, name-calling and isolation of an older person (MacNeil et al., 2010). This can be both verbal and non-verbal. Verbal forms include ridiculing the elder, blaming an elder or using them as scapegoats for things they did not do and yelling at or threatening an elder. Nonverbal forms include failing to acknowledge an elder or his or her needs, terrorizing behaviors that are meant to scare the elder and forcing the elder into isolation from caregivers, family and friends (WHO, EA, 2018). Sexual abuse is any kind of carnal contact that is conducted without consent. This may include sensual touching, forcing an elderly person to witness or watch sexual acts or pornographic materials or forcing the elder to undress against his or her will (Pillemer, Burnes, Riffin, & Lachs, 2016). Healthcare fraud occurs when medical professionals, including doctors and nurses, take advantage of elderly persons. Some of these behaviors may include charging for procedures without performing them, providing unnecessary referrals or prescriptions, double-billing or charging more for services, providing too many or not enough medications, and providing treatments or medications for medical conditions that are fraudulent in nature (WHO, 2018; Mudiare, 2013).

Effects of mishandling of the aged can lead to bodily injuries such as scratches, bruises, broken bones and disabling injuries. For much older elders, the consequences of mishandling can lead to physical deformities, delayed convalescence or even death (Cohen, Halevy-Levin, & Gagin, 2010).

Very little is known about elder abuse particularly in low- and middle-income countries. The scope and nature of the problem is only beginning to be defined in such countries (WHO, EA, 2018; WHO, EA, 2017).This study therefore sought to contribute to the literature for low- and middle-income countries on the prevalence of elder abuse at a private nursing home and a public health facility in Ghana.

Methods

The study employed a descriptive quantitative design that sought to describe the situation of elder abuse

at a private nursing home and a public health facility in Ghana. Descriptive research designs involve observing and describing the behaviour of subjects in their present state (Maltby, Williams, McGarry, & Day, 2010). They are often precursors to quantitative research designs. The quantitative research design involves appreciable sample sizes, concentrating on the diverse and quantity of responses. In the end, the data is presented in numerical format that can be analyzed to ascertain significant relationships (Maltby et al, 2010).

The study sites for the current study were a private nursing home designated as "Private" and a public health facility designated as "Public". These designations were necessary to maintain the anonymity of the study sites. The study sample comprised aged persons above the age of 60 years receiving care at Private and Public. A census for populations was used in determining the sample size for Private. A total of 30 aged persons were present at the nursing home at the time of data collection. Thus, all the 30 inpatients were included in the study. Adopting the Yamane's formula for sample size determination (Yamane, 1967), a total of 80 aged persons were sampled for the Public. Consequently, the convenience sampling method was used to include aged persons in the medical wards of the Public into the study.

A structured questionnaire was developed and used for data collection, based on the objectives of the study and reviewed literature. The questionnaire consisted of 9 sections and these included items on the demographic characteristics of the aged persons, the types and frequency of abuse, prevalence of self-reported abuse and prevalent abusers of the aged persons, and the current health status of the aged persons. The questionnaire was also designed to gather information on the current state of care the aged persons were receiving in the healthcare facilities and what they thought could be done to improve their care at the facilities. Data collection took place from April to September 2019, and this began at the Private facility, followed by the Public facility. Convenient times were chosen for the aged persons at each facility when the aged persons were free to participate in the study. Study details were explicitly explained to the aged persons in a language they would understand to enhance satisfactory compliance. Those who agreed to participate in the study signed or thumb printed the consent form, and data collection commenced. Some of the questionnaires were self-administered, while others were completed with the assistance of the researcher.

Approval to conduct the study was given by the management board of both facilities and the Regional Directorate of the Ghana Health Services (GHS). The methods for the study ensured that there was no potential harm of any manner to the aged persons during the data collection. An information sheet containing a summary of the research was given to every aged person to read and understand prior to data collection. Those who could not read received an explanation of the content in their preferred language of understanding. The study also ensured that privacy of aged persons was respected without any compromise. Any information deemed private as agreed between the researcher and aged persons was kept confidential and used only for the purpose of the research.

The SPSS version 23.0 (Chicago, Illinois, USA) was used to analyze the data through various stages. In stage one, descriptive statistics was used to describe the demographic and health profiles of the aged persons. In stage two, composite variables for the types and frequency of abuses among aged persons at the facilities were constructed to determine the overall averages (mean, mode and standard deviations). This summed up the experiences of the aged persons from the rating scale on the abuse subtypes. Decision on abuse was based on the range of scores in which the composite variables lie. The Pearson's chi-square statistic was used to test the significant difference of the abuse subtypes by study site. In stage four, a logistic regression model was used to identify the significant predictors of elder abuse. Results were considered significant at $P<0.05$.

Results

Demographic Characteristics of Study Participants
A total of 110 aged persons comprising 30 persons from the Private facility and 80 persons from the Public facility were involved in the study. The male participants were 43/100 (39.1%) and the female participants were 67/110 (60.9%). Their ages ranged

from 60 to 99 years old. Most of the aged persons 62/110 (56.4%) were between the ages of 60-69, 32/110 (29.1%) of them were between 70-79-years, and 2/110 (2.5%) were 90-99 years (see Table 1). The educational level of the aged persons ranged from the primary level to the tertiary level. Aged persons who had attained up to the primary educational level formed the majority –76/110 (69.1%) – of the study sample. This was followed by aged persons who had attained up to secondary educational level, 21/110(19.1%).

The majority of the aged persons, 72/110 (65.5%), were business owners; 21/110 (19%) and 11/110 (10%) were civil servants and those who worked in various private business organizations respectively. On the other hand, 6/110 (5.5%) had remained unemployed. (See Table 1). Those who were married accounted for 29/110 (26.4%), divorced persons formed 23/110 (20.9%), widows/widowers accounted for 50/110 (45.5%) and unmarried persons accounted for 8/110 (7.3%).

Ninety-seven out of 110 (88%) aged persons had some pre-existing illnesses. The most common illness was hypertension. This was followed by Diabetes Mellitus type 2 (DM2) and stroke. Other aged persons also had comorbidities. They included hypertension and arthritis, Hypertension and DM2, hypertension, DM2 and stroke and stroke with glaucoma.

The duration of stay of aged persons at both facilities ranged from less than a year to more than 10 years. Those who had stayed for less than a year accounted for the majority, 56/110(50.9%). Only 3/110 (2.7%) had been in the facilities for more than 10 years (See Table 1).

Table 1: Demographic characteristics of the study sample stratified by study sites

Private	F	%	Private	F	%
Gender			**Gender**		
Males	12	40	Males	12	40
Females	18	60	Females	18	60
Total	**30**	**100**	**Total**	**30**	**100**
Age (years)			**Age (years)**		
60-69	11	36.6	60-69	11	36.6
70-79	8	26.7	70-79	8	26.7
80-89	11	36.7	80-89	11	36.7
90-99			90-99		
Total	**30**	**100**	**Total**	**30**	**100**
Education			**Education**		
Primary	17	56.7	Primary	17	56.7
SHS	7	23.3	SHS	7	23.3
Tertiary	6	20	Tertiary	6	20
Total	**30**	**100**	**Total**	**30**	**100**

Private	F	%	Private	F	%
Occupation			**Occupation**		
Civil servant	4	13.3	Civil servant	4	13.3
Private business employee	4	13.3	Private business employee	4	13.3
Entrepreneur	20	66.7	Entrepreneur	20	66.7
Unemployed	2	6.7	Unemployed	2	6.7
Total	**30**	**100**	**Total**	**30**	**100**
Marital status			**Marital status**		
Married	6	20	Married	6	20
Divorced	8	26.7	Divorced	8	26.7
Widow/widower	13	43.3	Widow/widower	13	43.3
Unmarried	3	10	Unmarried	3	10
Total	**30**	**100**	**Total**	**30**	**100**
Duration of stay					
< 1 year	9	30	< 1 year	47	58.7
1-5 years	20	66.7	1-5 years	20	25.0
6-10 years	1	3.3	6-10 years	10	12.5
>10 years			>10 years	3	3.8
Total	**30**	**100**	**Total**	**80**	**100**

f – frequency
% – Percentage
SHS – Senior High School

The types and frequency of abuse among the aged persons were assessed. The types of abuse studied were physical abuse, psychological/emotional abuse, neglect, sexual abuse and financial fraud. A rating scale was used in measuring the occurrence of abuse. The scale, which adopted the frequency type, had a range of responses which included "Never, Sometimes, Often and Always". The numerical score was scored as 1 for Never, 2 for Sometimes, 3 for Often and 4 for Always. The measures of overall averages (mean, mode and standard deviations) were used in analyzing the data.

Types and frequency of abuse among aged persons at the Private and Public facilities

Except for sexual abuse, all other types of abuse were experienced by aged persons in varying frequencies at the healthcare facilities. All variables of sexual abuse studied in the current work had not been experienced by aged persons in both facilities. Composite variables for the types of abuses among aged persons at the facilities were constructed to determine the overall averages (mean, mode and stan-

dard deviations). This summed up the experiences of aged persons from the rating scale on the abuse subtypes. The decision on frequency of abuse was based on the range of scores in which the composite variables lie (See Table 2).

For physical abuse, the overall average score showed that aged persons were "never" physically abused (See Table 3). Concerning psychological/ emotional abuse, the overall average showed that aged persons were "never" psychologically/emotionally abused. Regarding neglect, the overall average score showed that aged persons were "never" neglected. Pertaining to sexual abuse, the overall average score showed that aged persons were "never" sexually abused. On the subject of financial fraud, the overall average score indicated that aged persons were "never" subjected to financial fraud (see Table 3).

Table 2: Decision on the types and frequency of abuse experienced by aged persons at the health facilities

Type of Abuse	Decisions			
	Never	Sometimes	Often	Always
Physical	5 – 9	10 – 14	15 – 19	20
Psychological	6 – 11	12 -- 17	18 – 23	24
Neglect	6 – 11	12 -- 17	18 – 23	24
Sexual	7 – 13	14 – 20	21 – 27	28
Financial Fraud	6 – 11	12 -- 17	18 – 23	24

Table 2: Decision on the types and frequency of abuse experienced by aged persons at the health facilities

Overall Average Score						
Study Sites	**Measure**	**Physical Abuse**	**Psychological Abuse**	**Neglect**	**Sexual Abuse**	**Financial Fraud**
Private	Mean	5.1667	6.7000	6.6333	7.0000	6.4000
	Mode	5.00	6.00	6.00	7.00	6.00
	Standard deviation	0.53067	1.11880	1.62912	0.00000	0.49827
Public	Mean	5.5250	7.9125	8.4625	7.0000	6.3500
	Mode	5.00	6.00	6.00	7.00	6.00
	Standard deviation	1.19042	2.29581	3.51828	0.00000	1.14847

Aged persons also reported their perception of abuse and individuals who were abusing them.

Prevalence of self-reported abuse and prevalent abusers of aged persons at the health facilities

The results showed that 3/30 (10%) and 23/80 (28.8%) aged persons from the Private and Public facilities were being abused at their healthcare facilities (See Table 4). The prevalent abusers of the aged persons were the nurses, children and relatives of the aged persons who were assisting in their care giving at the health facilities. In the Private, the aged persons were abused by the nurses, 2/3 (6.7%) and relatives, 1/3 (3.3%). In the Public, 2/23 (2.5%) were being abused by the nurses, 3/23 (3.8%) were being abused by their daughters, whilst the majority, 18/23 (22.5%), were being abused by their relatives (See Table 5). Healthcare facility was significantly associated with the experience of elder abuse (P=0.039).

Table 4: Prevalence of self-reported abuse among aged persons stratified by study sites

Prevalence of Abuse		Frequency	Percentage
Private	Yes	3	10
	No	27	90
	Total	**30**	100
Public	Yes	23	28.8
	No	57	71.3
	Total	**80**	**100**

Table 5: Prevalent abusers of aged persons stratified by study sites

Prevalence of Abuse		Frequency	Percentage
Private	Nurses	2	6.7
	Relatives (e.g. siblings, nephews, niece etc.)	1	3.3
	Total	**3**	**10**
Public	Nurses	2	2.5
	Daughters	3	3.8
	Relatives (e.g. siblings, nephews, niece etc.)	18	22.5
	Total	**23**	**28.8**

A logistic regression was performed to determine significant predictors of elder abuse. Independent variables were categorical. These included, gender, age, level of education, occupation, marital status and duration at the facility. Categories with the highest coding were the reference categories. Table 6 showed that the likelihood of elder abuse is 16.8 times more likely in respondents who have attained up to senior high education than a tertiary level. Further, the likelihood of elder abuse is 41.8 times more likely in private business employees than the unemployed.

Table 6: Logistic regression showing odds ratio of predictor variables on elder abuse

	B	S.E.	Odds Ratio	Lower (95% CI)	Upper (95% CI)
Gender					
Male	-0.354	0.616	0.702	0.210	0.299
Female ®			1.000		
Age					
60 – 69	-19.287	24187.338	0.000	0.000	
70 – 79	-18.798	24187.338	0.000	0.000	
80 – 89	-19.522	24187.338	0.000	0.000	
90 – 99 ®			1.000		
Level of Education					
Primary	1.131	1.192	3.099	0.299	32.071
Junior High	2.220	1.154	9.209	0.960	88.329
Senior High	2.819	1.289	16.752*	1.338	209.656
Undergraduate	0.542	1.509	1.719	0.089	33.078
Postgraduate ®			1.000		
Occupation					
Civil servant	0.989	1.173	2.688	0.270	26.790
Private business employee	3.733	1.733	41.786*	1.400	1247.168
Entrepreneur	1.949	1.035	7.020	0.923	53.378
Unemployed ®			1.000		
Marital status					
Married	-0.186	1.043	0.830	0.107	6.412
Divorced	0.154	1.030	1.167	0.155	8.781
Widow/Widower	0.902	0.988	2.465	0.355	17.093
Unmarried ®			1.000		
Duration at Place					
Less than 1 Year	-18.922	21063.321	0.000	0.000	
1 – 5 years	-17.754	21063.321	0.000	0.000	
8 – 10 years	-17.419	21063.321	0.000	0.000	
More than 10 years ®			1.000		
Constant	35.127	32073.227	1801004413469907.500		

* - *P<0.05*
® - *reference category*

The prevailing issues of aged persons due to ill health and stay at the healthcare facilities were assessed based on some physical and psychological question items. The major effects on the aged persons were continual periods of crying, depression, feelings of loneliness, feelings of helplessness, hopelessness and feelings of guilt, shame, fear, anxiety and denial.

Thematic analysis was used to group comments by aged person on the current situation of the care they were receiving at the healthcare facilities and what they thought could be done to improve the care they were receiving. In all, 11 themes emerged from comments by aged persons on their current care and 13 themes emerged from opinions on ways to improve the care they were receiving at the facilities (See Table 7 and 8).

Table 7: Aged persons' comments on the current situation of care at their healthcare facilities

Private	Public
Delays in rendering some services.	Delays in rendering some services.
Not enough food.	Disrespect from the nurses.
Nurses must learn to exercise a lot of patience when caring for us.	Not satisfied with care being received
Privacy of residents in their rooms should be improved.	Nurses must learn to exercise a lot of patience when caring for us.
Provision of more entertaining activities in the home.	Nurses should limit the use of their phones during working hours.
Satisfied with care being received.	Privacy for aged persons should be improved at the doctor's offices.
	Satisfied with care being received.
	The long waiting times to see the doctor should be checked.

Table 8: Aged persons' opinions on ways to improve health care at their health care facilities

Private	Public
Great family support from family members should be encouraged.	Adequate remuneration for the nurses
The Government should support such home care centers.	Great family support from family members should be encouraged.
Nurses must learn to exercise a lot of patience when caring for us.	Healthcare for the aged should be made free of charge.
More home doctors should be employed.	Improve medication.
More nurses should be employed.	More nurses should be employed.
Satisfied with care being received.	Nurses must learn to exercise a lot of patience when caring for us.
	Nurses should be trained on the proper care of the aged.
	Provision of more entertaining activities in the hospital
	There should be periodic health education on proper self-care of the aged.
	The provision of geriatric doctors

Discussion

The study sought to investigate the prevalence of elder abuse amongst aged persons seeking care at a private nursing home and a public health facility in Ghana. Based on the self-report by aged persons, results showed a high prevalence of elder abuse in institutional settings. The overall prevalence of abuse was 26/110 (38.8%) and the prevalent abusers were relatives 19/26 (25.8%), nurses 4/26 (9.2%) and daughters 3/23 (3.8%). Findings are consistent with anecdotal evidence and belief that elder abuse in institutional facilities is widespread (Yon et al., 2018). This result connects with existing studies that have provided a wide range of estimates. For example, in studies based on self-reports by older adults or their proxies, prevalence estimates have ranged from 31% in Israel for overall abuse to 86.9% for neglect in the USA and South Africa (Bigala & Ayiga, 2014; Cohen et al., 2010; Griffore, Barboza, & Mastin, 2009). The high rate observed in this study is likely due to lack of strong commitment in state machinery to promote and protect the interest of the elderly, lack of public notice, refusal and lack of interest in the discussions of the problem, poor family care systems and the specific lack of knowledge on elder care from caregivers. Confronting the problem of elder abuse is a collective responsibility of family members, citizenry and responsible agencies involved directly or indirectly in the care of the aged. Firstly, there should be adequate education on the right knowledge to recognize elder abuse. Secondly, there should be no fear in discussing elder abuse. Finally, health and social service providers, formal and informal caregivers and the general public must be encouraged to report suspected cases of elder abuse to appropriate agencies for redress and appropriate interventions.

The prevalent abusers were relatives of the aged persons. This result is worrisome, and it could reflect the degrading moral, cultural and social ethics in the Ghanaian society. In the Ghanaian cultural system, the care of the elderly is primarily the responsibility of their children and relatives (Cadmus & Owoaje, 2012). Additionally, other members of the community where the aged live, extend this responsibility because the elderly are regarded as the repositories of knowledge and custodians of culture, which affords them a level of reverence (Bigala & Ayiga, 2014). This sharply contrasts with the situation of the elderly care in this present study. In his work, Chao-Yin (2010) reported that elder abuse may also be perpetrated by aged persons' own sons and daughters-in-law due to the changing social contract between generations, in which the younger generation regard old parents as a burden, leading to neglect, loneliness and destitution. In this current work, 3/23 (3.8%) of the aged persons reported being abused by their own daughters.

Sexual abuse was not reported in any frequency amongst aged persons. The overall average value showed that the frequency of this abuse was never reported amongst the aged persons. This is coherent with Danyoh et al., (2018) who also recorded an overall average of "never" of sexual abuse in their study. In the Ghanaian context, there is an observed culture of silence in relation to sex and sexual matters. Sex is an unspoken word. Adults in the Ghanaian society have usually refrained from discussions of sexual matters amongst themselves and with the youth. Young people are naturally reluctant to ask questions relating to sexual issues, as they would be seen as uncultured. Religion has also contributed to the culture of silence about sexual issues in Ghana. Religion often teaches moral education instead of sex education. Discussions on sex education are associated with encouraging immorality. The religious viewpoint is that sex education could make sexually quiescent individuals more likely to indulge in sexual experimentation rather than avoiding it. Thus, most sexual influencers are desisted from the Ghanaian setting and this could account for the observation in this study. Similar results have been found in studies where sexual abuse was minimal or negligible among the aged persons (Yon, Mikton, Gassoumis & Wilber, 2017).

The prevailing issues of aged persons due to ill-health and stay at the healthcare facilities were crying, depression, loneliness, feelings of helplessness and hopelessness and feelings of guilt, shame, fear, anxiety and denial. There is reported association of increasing age dependency and ill-health status occurring in both community and institutional settings (Gasior et al., 2012; Naughton, Drennan & Treacy, 2010). Increased risk for elder abuse has been associated with declining health in Ireland and with those needing help with Activities of Daily Living

(ADL) in Germany (Naughton et al, 2010). This is consistent with the sample characteristics of aged persons between the ages of 60-99 years reporting frailer health and greater dependency on their relatives and nurses for assistance in ADLs. It is worthwhile to note that 97/110 (88%) of aged persons reported illnesses due to some non-communicable diseases (NCDs). In addition, such health descriptions may also be compounded by home care centers and health facilities. Nursing homes and other seniors' residential facilities have been found to contribute to stress among elders (Natan, Matthews & Lowenstein, 2010).

Implications for practice

The study has shown a lapse in nursing care, particularly for aged persons. Hence, specialist training for nurses in geriatric care is encouraged. The advocacy for the need for multidisciplinary professionals for the care of the elderly is essential. Moreover, given the establishment of long-term care settings in the country, there is the need for incorporation of the latest evidence of good practice into national policies and the implementation of quality care guidelines in the care of elders.

Conclusion

The study reported abuse subtypes and prevalence of elder abuse in institutional settings based on a comprehensive a priori instrument. Elder abuse in institutions has not realized the same public health priority as other forms of abuse. Much attention and resources are needed to ensure that nursing homes as well as health facilities ensure optimum care for the complex needs of aged persons. Findings of this study strengthen the case for national consideration and action to expand efforts in researching into preventing and supporting victims of institutional abuse. Investment in developing interventions for the care of aged persons must be a public health priority.

Conflict of interest

The authors declare no conflict of interest in this study.

Acknowledgements

We thank the management, doctors, nurses and aged persons of both facilities for making this study possible.

References

Bigala, P., & Ayiga, N. (2014). Prevalence and predictors of elder abuse in Mafikeng Local Municipality in South Africa. *African Population Studies, 28*, (1), 463-670.

Cadmus, E., O., & Owoaje, E., T. (2012). Prevalence and correlates of elder abuse among older women in rural and urban communities in South Western Nigeria. *Health Care Women International 33*, (10), 973-984.

Chao-Yin, L., R., N., (2010). Caring for older adults: The parables in Confucian texts. *Nursing Science Quarterly 23,* (3), 266-267.

Cohen, M., Halevy-Levin, S., Gagin, R., et al. (2010). Elder abuse in long-term care residences and the risk indicators. *Ageing Society,* 30, 1027–40.

Danyoh, D., J., Dampson, G., D., & Dzakadzie, Y. (2018). Abuse or disabuse: coping with elderly abuse in the Ashaiman municipality, Ghana. *European Journal of Research and Reflection in Educational Sciences, 6* (4).

Gasior, K., Huber, M., Lamura, G., et al. (2012). Facts and Figures on Healthy Ageing and Long-Term Care. In: Rodrigues R, Huber M, Lamura G, editors. Vienna. European Centre for Social Welfare Policy and Research.

Griffore, R., J., Barboza, G., E., Mastin, T., et al. (2009). Family members' reports of abuse in Michigan Nursing Homes. *Journal of Elder Abuse & Neglect 21*, 105–14.

MacNeil, G., Kosberg, J., I., Durkin, D., Dooley, W. K., DeCoster, J & Williamson, G., M. (2010). Caregiver mental health and potentially harmful care giving behaviour: The central role of caregiver anger. Gerontologist, 50, 76-86.

Maltby, J., Williams, G., A., McGarry, J., & Day, L. (2010). Research Methods for Nursing and Healthcare. Edinburgh Gate: Pearson Education Limited.

Mudiare, P., E., U. (2013). Abuse of the aged in Nigeria: Elders also cry. *American International Journal of Contemporary Research 3*, (9), 79-87.

Natan, M., B., Matthews, P., & Lowenstein, A. (2010). Study of factors that affect abuse of older people in nursing homes. *Journal of Nursing Management* (Harrow), 17, 20–4.

Naughton, C., Drennan, J., Treacy, M., et al., (2010). Abuse and neglect of older people in Ireland: Report on the National Study of Elder Abuse and Neglect. Dublin.

Pillemer, K., Burnes, D., Riffin, C., & Lachs, M., S. (2016). Elder abuse: Global Situation, Risk Factors, and Prevention Strategies. *Gerontologist, 56*, 194–205.

Sossou, M., A., & Yogtiba, J., A. (2015). Abuse, neglect, and violence against elderly women in Ghana: Implications for social justice and human rights. *Journal of Elder Abuse & Neglect*, Routledge, 422-427.

WHO (2017). World Health Organization. Elder Abuse Fact Sheet 357. Geneva: World Health Organization.

WHO (2018). World Health Organization Regional Office for Europe. Regional Report on Institutions Providing Long-term Care for Adults with Psychosocial and Intellectual Disabilities in the European Region. Copenhagen.

WHO (2018). World Health Organization, Elder Abuse. Retrieved from http://www.who.int/entity/ageing/projects/elder_abuse/en/index.html.(Accessed September, 10, 2019).

Yamane, T. (1967). Statistics: An introductory Analysis (2nd ed.). New York: Harper and Row.

Yon, Y., Mikton, C., R., Gassoumis, Z., D., & Wilber, K., H. (2017). Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health, 5* (2), e147-e156. https://www.ncbi.nlm.nih.gov/pubmed/28104184.

Yon, Y., Ramiro-Gonzalez, M., Mikton, C., Huber, M., & Sethi, D. (2018). The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *European Journal of Public Health*. Retrieved fromhttps://www.ncbi.nlm. nih.gov/pubmed/29878101.