Copyright© 2020

Nursing and Midwifery Council of Ghana

All Rights Reserved. No part of this document or work may be reproduced or used in any form or by any means: graphic, electronic or mechanical, including photocopying, recording, taping or information storage and retrieval system without permission from the Nursing and Midwifery Council of Ghana. Upon request, however, copies of this document or work may be obtained from the Editorial Board.

ISSN (Print Version): 2026-5883

Contact Details

GA-289-0376
P. O. Box MB 44, Accra

E-mail:
info@numidhorizon.com
numidhorizon@nmcgh.org

Website:
www.numidhorizon.com

Telephone:
+233 (0)20-4697732, 0303976831
In this Issue

v Mesage from Registrar
Felix Nyante (MPA, MA, FWACN, FGCMN, BEd, Dip, SRN)

vi Editorial
Abigail A. Kyei (DHA, MPH, BA (Nursing), FGCMN, RN, RM)

1 Availability and Preference for Healthcare Services in Rural Ghana: A Study at the Bole District of the Northern Region
Moses Abile (MPhil, RN) 1
Lily Yarney (PhD) 2

11 Maternal Satisfaction in receiving Spinal Anaesthesia for Caesarean Section: Cross-sectional survey at the Tamale Teaching Hospital, Ghana
Alirimbe Ahaji Elvis (Bsc, RN) 1
Emmanuel Amangbe (MSc, BA) 2

21 Family Related Factors Influencing Exclusive Breastfeeding in Rural Northern Ghana: A Qualitative Analysis
Shamsu-Deen Ziblim (PhD) 1
AdadowYidana (PhD) 2
Iddrisu Seidu (MSC Public Health) 3

31 Elder Abuse in A Private Home Care and A Public Health Facility in Ghana
Reginald Arthur-Mensah Jnr (MPhil Clinical Microbiology) 1
Theodora Shirley Amarth (BSc. Nursing) 1
Paa Kofi Adu-Gyamfi Tawiah (MPhil Pharmacology) 1
Abigail Agartha Kyei (PhD Health Administration) 1

43 Structural Elements of Integrated Treatment System for Alcoholic Patients in Two Rehabilitation Centres in Ghana.
Sandra Fremah Asare (MSc, BSc) 1
Adwoa Bema Boamah Mensah (PhD) 2
Ofeibea Asare (MPH) 2

54 Student Nurses’ Perceptions of Clinical Skills Laboratory as a Learning Space in South Africa
Luke Laari (PhD Candidate, MN, Hons Nursing Education, BSc Nursing, RGN) 1
Barbara M. Dube (PhD Candidate, MN, RN) 1
The Numid Horizon: An International Journal of Nursing and Midwifery is honoured to publish the fourth edition.

This special edition was commissioned by the Editorial Board to mark the 50th anniversary of the Nursing and Midwifery Council, Ghana. The Council in June 2020 kick-started its anniversary celebration. The Council will climax the anniversary celebration with a thanksgiving ceremony in March 2021.

This Journal is one of the numerous achievements of the Council. In order to reach our milestone as a regulatory body of International repute, the Council and its Partners have set out to Sustain the Innovations. This is our driving force for the anniversary celebration and beyond.

Numid Horizon: An International Journal of Nursing and Midwifery since its inception in 2017 has provided an avenue for the publication of research relevant to nursing and midwifery.

I am impressed about this publication of new research and current knowledge across a broad range of clinical, social and inter-professional topics including:

1. Student Nurses’ Perceptions of Clinical Skills Laboratory as a Learning Space in South Africa
2. Maternal Satisfaction in receiving Spinal Anaesthesia for Caesarean Section: Cross-sectional survey at the Tamale Teaching Hospital, Ghana
3. Family Related Factors Influencing Exclusive Breastfeeding in Rural Northern Ghana
4. Elder Abuse in A Private Home Care and A Public Health Facility in Ghana
5. Structural Elements of Integrated Treatment System for Alcoholic Patients in Two Rehabilitation Centres in Ghana
6. Availability and Preference for Healthcare Services in Rural Ghana

All submitted research articles to this journal have undergone rigorous peer review, based on initial editorial screening and reviewing by independent reviewers.

Responsible documentation of research studies in the nursing and midwifery fields, which include a complete, accurate and timely account of what was done and what
was found during a research study, is an integral part of good research and publication practice and that is what this journal stands for.

I am delighted to also note the Council and its Partners namely; University of Ghana Medical Centre, Mental Health Authority, Teaching Hospitals, Ghana Health Service, Police Hospital, 37 Military Hospital, Ghana College of Nurses & Midwives and School of Nursing & Midwifery, University of Ghana, Legon have taken up the responsibility to also groom young nurses and midwives of 35 years and below as part of the global Nightingale Challenge (NC). The NC and Workshop were launched at the Council’s Head Office in June 2020. Sixty Seven (67) Nurses and Midwives across the country have been selected to take part in the Nightingale Challenge and Workshop. The Challenge is expected to end on July 21, 2021. The Nightingale Challenge is one of the programmes of the global Nursing Now campaign. It is expected that out of the NC, the mentees would publish some of the projects they are undertaking in the implementation researches in this journal.

To conclude I would like to give special kudos, and thanks to all our Nurses and Midwives in this era of Covid-19 pandemic who are making lifesaving efforts and personal sacrifice to help combat the spread of the novel disease.

A moment of silence is further demanded for those who also lost their lives in an effort of helping victims of the pandemic.

I would like to also take this opportunity to thank the contributors of this journal and to express my appreciation to the Editorial Board, Reviewers and the Researchers for making this publication successful.

I hope that you share our pride in this wonderful international journal.

Sustaining the innovations.
The Concept of Healthcare is diversified in terms of the number of investigators and consumers of healthcare services. In the history of many low income and lower middle-income economies, consumers of healthcare were at the mercy of healthcare practitioners mainly because the practitioners enjoyed the monopoly of expert knowledge over their clients (Havighurst & Richman, 2010). In the course of time however, consumers have become more knowledgeable about their health and what they should expect in terms of services from healthcare practitioners. Healthcare workers have had an awakening on the need to pay attention to how they package their services in order to attract the clientele they once took for granted. This fourth edition of the Numid Horizon: An International Journal of Nursing and Midwifery, delves into the response of the consumers of healthcare to the kind of services they receive and their open expression of satisfaction or otherwise. Through the findings in the articles presented, it behoves on health workers in low and lower middle-income countries to concentrate on the real needs the clients and improve their services in order to grow the healthcare industry (Oyerinde, 2016).

The first article in this edition brings to light the preferences of some rural dwellers in Ghana as they compare the availability and packaging of services from orthodox and alternative healthcare facilities. The need for integration of services comes out clearly and must be taken into serious consideration (Hamanyanga, 2019), especially in the light of the promotion of Universal Health Coverage. The power of consumer preferences is further supported by an article on maternal satisfaction in terms of spinal anaesthesia; it goes without saying that the friendly services the consumers received and the excellent communication that went on between the staff and the clients created satisfaction among mothers.

An article on the family related factors that influence breast feeding takes another angle in the provision of healthcare services beyond the facilities as compliance to health advice and practices move into the families and communities of the consumers. The need for healthcare providers to seriously consider the beliefs, cultural practices, and sense of family responsibility of an important health practice like exclusive breastfeeding cannot be overemphasised. Crowning the issue of provision of services to meet the consumer needs are two articles on the services rendered to the elderly in society in
some healthcare facilities in Ghana and the implied abuse of the elderly and rehabilitation of patients diagnosed with alcohol/drug abuse and the ensuing effects of their treatment. The fact that practices in the past were overlooked leading to the neglect of the vulnerable in society like the elderly and mentally challenged people does not mean such practices must continue; and Fineman (2008), captures this truth by stating that “it becomes possible to reconsider how society should realistically and fairly apportion responsibility for human vulnerability and dependency across the life-course” (p. 111).

Underlying the services nurses and other healthcare practitioners render to clients, is the need for training to become competent. The journal closes with a final article rounding off earlier issues and discussions with undergraduate nursing students’ perceptions of clinical skills laboratory as a learning space in higher education.

References


Availability and Preference for Healthcare Services in Rural Ghana: A Study at the Bole District of the Northern Region

Moses Abile (MPhil, RN) ¹
Lily Yarney (PhD) ²

Abstract
Healthcare access is an essential component of human development; but countless people around the world, especially in developing countries, do not have access to healthcare, as they require. Consequently, the WHO and other actors in the healthcare area are adopting strategies to promote Universal Health Coverage, especially in lower and middle-income countries such as Ghana. The study assessed the availability of both Orthodox and Alternative healthcare facilities in the Bole District of the Northern Region of Ghana and examined the community members’ preference for the two healthcare systems. The study employed quantitative research designs. Quantitative data were collected using questionnaires. A total of 435 purposively selected individuals participated in the study. A Chi-square test of independence was used to analyze the quantitative data, while the qualitative data were categorized into themes and analyzed. The study revealed the existence of 22 Orthodox (91.7%) and 2 Alternative Healthcare (8.3%) facilities in the Bole District. The majority of respondents (55%) prefer accessing Orthodox Healthcare relative to Alternative Healthcare, whereas the remaining 45% prefer Alternative healthcare to Orthodox Healthcare. Age and educational level correlated significantly with preference for type of healthcare facility. Findings of the qualitative data supported the results of the quantitative data. It is recommended that orthodox healthcare facilities be made more available in rural communities and safe integration of both systems should be explored so as to improve accessibility of healthcare with the aim of meeting universal health coverage goals for the country.

Keywords:
Access to health, Alternative Healthcare, Orthodox Healthcare, Preference, Utilization, Availability.

1. Nursing and Midwifery Training College - Gushegu, Ghana
2. University of Ghana - Legon, Ghana

Corresponding Author:
1. Nursing and Midwifery Training College - Gushegu, Ghana
   Email address: mosesabile@gmail.com
   Phone contact: 0248872043
Introduction
Healthcare access is an essential component of human development, but countless people around the world, especially in developing countries, do not have access to healthcare, as they require. Consequently, the World Health Organization (WHO) and other actors in healthcare are adopting strategies to promote Universal Health Coverage (UHC), especially in lower- and middle-income countries such as Ghana. UHC seeks to ensure that all people have access to quality healthcare without incurring major financial burden. This is required to maintain and improve health (WHO, 2016). Access to health services could contribute to optimum health outcomes through prompt use of healthcare services. This requires three stages: obtaining entrance into the healthcare facility, being able to access the location of the facility where required services can be given and getting the services of a health staff that an individual can trust and communicate with. (HealthPeople.gov, 2016).

The presence of primary healthcare facilities and the ability to readily access them are a major issue in sub-Saharan Africa. A study conducted in Gabon revealed unequal access to healthcare (Makita-Ikouaya et al., 2010). The authors recommended analyzing geographical and physical needs of healthcare when planning the construction of healthcare facilities in the city as part of measures to bridge the inequality gap. Walker (2017), in a related study, discovered that many users did not have adequate knowledge, or were unaware of the services provided by the health institutions in the study area. The finding raises the possibility that some individuals may not access healthcare simply because they are not aware that the healthcare institutions can meet their health needs, thereby leading to inequality in healthcare. Consequently, the author recommended that health institutions should improve the awareness of the services they provide to users.

In Ghana and other parts of the world, there are various forms of healthcare systems, namely orthodox and traditional or alternative healthcare systems. Orthodox medicine refers to modern medicine or allopathic medicine whereby biomedical advancement is leveraged to render healthcare services (WHO, 2001). Traditional medicine, also known as complementary or alternative medicine, is defined as the combination or singular application of varied health practices, methods, ideas, knowledge, beliefs and approaches, which may incorporate whole or parts of animals, plants as well as mineral components with or without spiritual connotations for the purposes of preventing, diagnosing or treating an ailment (WHO, 2002, cited in Gyasi et al., 2010). The combination of Orthodox and Alternative healthcare has attracted several debates. For example, Wiese et al. (2010), in a review of the relationship between modern healthcare and alternative medicine, indicated that the adoption of the Complementary and Alternative Medicine by the mainstream healthcare has evolved through three (3) distinct stages namely: stage of pluralism, incorporation and finally integration. Pluralism implies the patient playing the role of a consumer by choosing the most appropriate approach, whereas incorporation involves choosing sections of alternative healthcare to include in the Western medical practice. The integration, on the other hand, refers to a respectful partnership between varied perspectives of healthcare treatment in a mutually beneficial manner. Despite calls for stakeholders and policy-makers for integration of both orthodox and alternative healthcare services, a study conducted by Opoku-Mensah and Ahenkan (2015) identified barriers such as legal issues, attitude of people and policies as hindering the integration of Orthodox Medicine and Alternative Healthcare. Given that people do access the various forms of healthcare in the country, the authors recommended placing the Alternative Healthcare services under the National Health Insurance Scheme to promote access and reduce unequal distribution of healthcare services. More importantly, the authors called on researchers to provide additional insight into healthcare service utilization in Ghana. Responding to the call by Opoku-Mensah and Ahenkan (2015), the current study is designed to investigate the healthcare services utilization in Bole District in the Northern Region of Ghana (now Savannah Region of Ghana). The Bole District has experienced a reduction in OPD attendance from 131,356 in 2014 to 122,433 in 2015, representing seven (7%) decline (Bole District Health Directorate, 2016). Although the factors contributing to the decline are not immediately known, there is the possibility that a decline in the utilization of orthodox healthcare services could be compensated for by a
rise in alternative healthcare services. That is, health services users can switch from orthodox to alternative healthcare services. Granted the foregoing, it is extremely important to examine healthcare services utilization in Bole District to understand how the various healthcare systems should be strengthened and reformed. Consequently, the current study is designed to investigate the availability of Alternative healthcare systems and more importantly preference for orthodox or Alternative healthcare systems in Bole District. The general objective of the study was to find the availability and preference for healthcare services in the Bole District of the Northern Region of Ghana. Specifically, the study sought to: examine the availability of Orthodox and Alternative healthcare facilities in the Bole district; and ascertain the community members’ preferred choice of healthcare system when sick in the Bole District.

Design and Methods

Research Design
The study used the case study design in investigating the availability and preference for healthcare of community members in the Bole District of the Northern region of Ghana. This research design was used because it allows the collection of detailed information by employing various data collection methods over a period of time and involves in-depth analysis of the factors influencing access and utilization of healthcare (Creswell, 2014).

The Study Area
The study was conducted in the Bole district, one of the twenty-six (26) administrative districts in the Northern region. For the purpose of healthcare services delivery, the district is sub-divided into six areas namely: Bamboi, Bole, Mandari, Mankuma, Jama and Tinga (Bole District Health Directorate, 2016). The Population of the Bole District in the year 2016, per the 2010 population census projections, was 71,059, with an annual growth rate of 2.8%. The main ethnic groups in the district are the Gonjas, Brifor, Vaglas, Dagaabas, Mos and Lobis.

The Study Population
The study population was made up of all people who are 18 years and above and living in the Bole district at the time of data collection. The adult population was selected since they are more likely to have had experience with regard to access and use of healthcare services in the district.

Sampling Selection and Data Collection Measure
The purposive sampling technique was used to select the communities where the study took place namely: Bole, Bamboi and Jama communities. These communities were sampled to ensure that community members living in both the district capital and very remote areas of the district are fairly involved in the study. The participants were conveniently sampled from the communities at various places such as markets, schools, streets and health facilities. Of the four hundred and thirty-five (435) questionnaires administered, four hundred and one (401) questionnaires were completed and received, representing a response rate of 92%. The questionnaire was pre-tested at a nearby district, Sawla Tuna Kalba, to ensure that the data collection measures are appropriate and suitable for the population. A research assistant trained in the administration of questionnaires assisted in the data collection.

Ethical Considerations
Before community entry for data collection, an introductory letter was obtained from the Department of Public Administration and Health Services Management of the University of Ghana Business School. The letter was presented to the Bole District Health Directorate for approval for the study. The participants gave consent to partake in the study by thumb printing or signing a consent form after the purpose of the study had been explained to them. Respondents were assured that their anonymity would be guaranteed during and after data collection to ensure privacy and confidentiality.

Data Analysis
Data were analyzed using Statistical Package for Social Sciences (SPSS) version 21. Descriptive statistics such as percentages and frequencies were used to summarize the demographic characteristics of respondents as well as the availability of healthcare facilities in the Bole district. To establish whether the observed variation in preference for Alternative and Orthodox Healthcare among different age groups and educational levels were statistically significant, a Chi Square test of independence was used to test the association.
between age, educational level and preference for Orthodox and Alternative Healthcare among the participants. Statistical significance was set at 0.05.

Results

Demographic Characteristics of Respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>18-29</td>
<td>261</td>
<td>65.1%</td>
</tr>
<tr>
<td></td>
<td>30-39</td>
<td>88</td>
<td>21.9%</td>
</tr>
<tr>
<td></td>
<td>40-49</td>
<td>31</td>
<td>7.8%</td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>60 and above</td>
<td>9</td>
<td>2.2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>234</td>
<td>58.4%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>167</td>
<td>41.6%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td>Educational level</td>
<td>No education</td>
<td>37</td>
<td>9.2%</td>
</tr>
<tr>
<td></td>
<td>Primary</td>
<td>44</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>178</td>
<td>44.4%</td>
</tr>
<tr>
<td></td>
<td>Tertiary</td>
<td>142</td>
<td>35.4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td>Employment status</td>
<td>Employed</td>
<td>271</td>
<td>67.6%</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>130</td>
<td>32.4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>233</td>
<td>58.1%</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>151</td>
<td>37.7%</td>
</tr>
<tr>
<td></td>
<td>Divorced/widowed</td>
<td>17</td>
<td>4.2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td>Religion</td>
<td>Christianity</td>
<td>186</td>
<td>46.4%</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
<td>-----</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>Islamic</td>
<td>200</td>
<td>49.9%</td>
</tr>
<tr>
<td></td>
<td>Traditional</td>
<td>15</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Income level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 500 Ghs</td>
<td></td>
<td>234</td>
<td>58.3%</td>
</tr>
<tr>
<td>500-1000 Ghs</td>
<td></td>
<td>89</td>
<td>22.2%</td>
</tr>
<tr>
<td>More than</td>
<td></td>
<td>78</td>
<td>19.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Distance to nearest health facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1km</td>
<td></td>
<td>127</td>
<td>31.7%</td>
</tr>
<tr>
<td>1-5km</td>
<td></td>
<td>64</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>401</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field Data, 2017.

**Healthcare Facilities in the Bole District**

Healthcare facility availability varied across the various locations in the district. Likewise, the services provided by these health facilities vary across the various health facilities in the Bole district, including:

1. Ante-Natal care and Family planning services.
2. Delivery services such as normal labour and Complicated/advanced delivery services including caesarean section.
3. Immunization of children as well as preventive and curative child health care.
4. Adolescent health services.
5. HIV counselling and testing, HIV/AIDS care and support services including antiretroviral treatment (ARV) therapy and prevention of mother-to-child transmission of HIV (PMTCT).
6. Diagnosis, treatment and management of chronic medical conditions such as tuberculosis, malaria and hypertension.
7. Surgical operations including basic surgical operations such as incision of minor lacerations and comprehensive surgical operations such as laparotomy and other related services such as blood transfusion.

Details of the Orthodox healthcare facilities available in the Bole District, the facility type and their number, number of communities they serve and their catchment population are presented in table 4.2a.
Table 4.2a: Orthodox Health Institutions and their locations in the Bole District

<table>
<thead>
<tr>
<th>No.</th>
<th>Facility</th>
<th>No. of Communities</th>
<th>Catchment Population</th>
<th>No.</th>
<th>Facility</th>
<th>No. of Communities</th>
<th>Catchment Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dist. Hosp.</td>
<td>170+</td>
<td>71,059+</td>
<td>1.</td>
<td>B/Nkwanta</td>
<td>6</td>
<td>2,687</td>
</tr>
<tr>
<td>2.</td>
<td>Bamboi HC</td>
<td>25</td>
<td>14,678</td>
<td>2.</td>
<td>Carpenter</td>
<td>6</td>
<td>2,070</td>
</tr>
<tr>
<td>3.</td>
<td>Bole HC</td>
<td>44</td>
<td>21,151</td>
<td>3.</td>
<td>Chache</td>
<td>6</td>
<td>1,656</td>
</tr>
<tr>
<td>5.</td>
<td>Mandari HC</td>
<td>27</td>
<td>6,610</td>
<td>5.</td>
<td>Dakurpe</td>
<td>8</td>
<td>4,854</td>
</tr>
<tr>
<td>6.</td>
<td>Mankuma HC</td>
<td>22</td>
<td>6,610</td>
<td>6.</td>
<td>Gbenfu</td>
<td>7</td>
<td>2,849</td>
</tr>
<tr>
<td>8.</td>
<td>St. Martyrs HC*</td>
<td></td>
<td></td>
<td>8.</td>
<td>K/Kwesi</td>
<td>5</td>
<td>1,807</td>
</tr>
<tr>
<td>9.</td>
<td>BOSEC</td>
<td></td>
<td></td>
<td>9.</td>
<td>Maluwe</td>
<td>4</td>
<td>3,131</td>
</tr>
<tr>
<td>10.</td>
<td>Clinic</td>
<td></td>
<td></td>
<td>10.</td>
<td>Sakpa</td>
<td>5</td>
<td>346</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
<td>Seripe</td>
<td>8</td>
<td>2,773</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
<td>Sonyon</td>
<td>4</td>
<td>2,681</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td>13</td>
<td>Wakawaka</td>
<td>4</td>
<td>1,962</td>
</tr>
<tr>
<td>Total</td>
<td>170</td>
<td>71,661</td>
<td></td>
<td>Total</td>
<td>81</td>
<td></td>
<td>32,174</td>
</tr>
</tbody>
</table>

Source: Adapted from the BDHD 2015 Annual Performance Review
## Availability of health facilities in the Bole District

<table>
<thead>
<tr>
<th>Health Facility Type</th>
<th>Number(s) of Facility</th>
<th>Ownership/Managing Authority</th>
<th>Location</th>
<th>Operational Status</th>
<th>Services offered</th>
<th>State of Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthodox Healthcare Facilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>1</td>
<td>Government</td>
<td>Bole</td>
<td>Operational</td>
<td>1-14</td>
<td>Good</td>
</tr>
<tr>
<td>Public Health Centers</td>
<td>7</td>
<td>Government</td>
<td>Bambui, Boles, Jama, Mandari, Mankuma, Tinga, BOSEC</td>
<td>Operational</td>
<td>1,2,3,5,6,7,13</td>
<td>2 Good 3 Satisfactory 2 Poor</td>
</tr>
<tr>
<td>Mission Health Centers</td>
<td>1</td>
<td>CHAG</td>
<td>Bole</td>
<td>Operational</td>
<td>2,3,5,6,13</td>
<td>Satisfactory</td>
</tr>
<tr>
<td><strong>Alternative Healthcare Facilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional Medicine</td>
<td>13</td>
<td>Government</td>
<td>Banda Nkwanta, Carpenter, Charche, Chibrinoya, Dakurpe, Gbenfu, Kakiase, Kwame Kwesi, Maluwe, Sakpa, Seripe, Sonyon, Wakawaka</td>
<td>Operational</td>
<td>1,2,3,5,6,7,8</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Herbal Clinic</td>
<td>1*</td>
<td>Private</td>
<td>Bole</td>
<td>Operational</td>
<td>11</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>1*</td>
<td>Private</td>
<td>Bole</td>
<td>Closed</td>
<td>11</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

*indigenous practitioners

*Source: Bole District Health Directorate, (2015)*

The table 4.2b depicts the various healthcare services available at facilities in the Bole district, along with information about the operational status as well as the state of their infrastructure.
Preference for Orthodox and Alternative Healthcare systems

The findings of the study showed that 55.4% of the respondents preferred Orthodox Healthcare to Alternative Healthcare. A total of 44.6% respondents also indicated they prefer Alternative Healthcare to Orthodox Healthcare.

Figure 4.3.: Community Members’ Preference for Healthcare in Percentage

Community members’ preference for healthcare services provided by either Orthodox or Alternative Healthcare facilities differed among the different age groups and educational levels. The study results showed a statistically significant relationship between community members’ preference for either Orthodox or Alternative Healthcare and age (p-value = 0.013). There was also statistically significant relationship between respondents’ educational level and their preference for healthcare (p-value = 0.000).

Discussions
The findings of the study reveal that although community members in the Bole District can easily access and use primary healthcare facilities such as the CHPS compounds and some health centers, most community members in the district have to travel long distances before they can access and utilize the services of a secondary healthcare facility such as a polyclinic and a hospital. These secondary healthcare facilities are located at Bole, Sawla or Wenchi, which are the nearby district capitals. There are seven (7) government-owned health centers and one CHAG health center as well as thirteen (13) Community-based Health Planning Services (CHPS) which provide primary healthcare services such as ante-natal care services, diagnosis and treatment of minor...
health conditions such as simple malaria as well as conduct of normal birth deliveries. (BDHD, 2016). This information further supports the finding that primary healthcare services are more accessible and can be used conveniently by community members as compared to secondary or tertiary healthcare services in the Bole District.

Although some respondents prefer Alternative healthcare services, there were no health facilities solely dedicated for herbal medical practice such as herbal clinic or hospital, with the exception of some few retail herbal shops where over-the-counter herbal products are sold. This implies that the majority of respondents who use herbal products in the district either obtain them from herbal clinics or resorted to unlicensed herbal products from the local Traditional Medicine practitioners. However, with the inadequate standardization and professional bodies monitoring the activities of Alternative healthcare practitioners especially in rural areas (Opoku-Mensah & Ahenkan, 2015), it is quite difficult to know the exact number of Alternative Healthcare facilities operating in the Bole District. Two hundred and twenty-one (221) respondents, representing fifty-five percent (55%) of community members, indicated that they prefer Orthodox Healthcare system to Alternative Healthcare system, whilst the remaining preferred Alternative Healthcare to Orthodox healthcare. More importantly, there were statistically significant relationship between preference for healthcare service facilities (i.e., Orthodox and Alternative healthcare services) and educational level and age. With respect to education, the study showed that an individual’s educational level had a positive association with preference for orthodox healthcare. More specifically, respondents without any formal education preferred Alternative to Orthodox healthcare, whereas people with formal education preferred Orthodox to Alternative healthcare. The issue of educated people preferring Orthodox to Alternative healthcare services has been reported by previous studies (Duru et al., 2016; Opoku-Mensah & Ahenkan, 2015). Duru et al. (2016) stated categorically that there was a significant relationship between educational level of individuals and their preference for orthodox healthcare. Consistent with previous studies (Duru, et al. 2016; Opoku-Mensah & Ahenkan, 2015; Nottidge, et al. 2011; Omonona, et al. 2012), the finding of the study showed that respondents who are young are more likely to use Orthodox healthcare services, whereas older respondents indicated preference for Alternative healthcare services.

**Implications for Healthcare Delivery**

Based on the findings of the study, it is reiterated that the capacity of some primary healthcare facilities should be upgraded into polyclinics to reduce the travelling time and distance of community members in remote areas of the country. The Ghana Health Service should integrate the services of qualified Herbal Medical Officers in some health facilities to meet the needs of clients who prefer herbal medicine. Appropriate measures on co-payment should be formulated by the stakeholders of healthcare, namely community members, healthcare providers and NHIS officials and the agreed measures should be well communicated to the entire community to ensure smooth cooperation between health providers and community members.

**Conclusion**

The study has unearthed the availability of orthodox health facilities in the Bole District, as well as preference for Orthodox and Alternative healthcare facilities. The findings reported in this study could be beneficial to healthcare policy makers, healthcare providers and consumers. The findings would support discourses relating to integrating both Orthodox and Alternative Healthcare Systems in the modern healthcare provision to contribute to the attainment of Universal Health Coverage in Bole District.

**Conflict of interest statements**

The authors declare that there is no conflict of interest.

**Acknowledgements**

We acknowledge the community leaders of the study areas in the Bole District of the Northern region of Ghana and all the respondents for their cooperation during the study.
References


Maternal Satisfaction in receiving Spinal Anaesthesia for Caesarean Section: Cross-sectional survey at the Tamale Teaching Hospital, Ghana

Alirim bey Alhaji Elvis (Bsc, RN) 1
Emmanuel Amangbey (MSc, BA) 2

Abstract
Spinal anaesthesia is the only type of anaesthesia that allows maximum patient participation, which is an appropriate module to use for the assessment of patient satisfaction since the patient will have full knowledge of what has transpired. This study assessed the level of satisfaction of mothers given spinal anaesthesia for caesarean section. A quantitative cross-sectional survey of 171 mothers who underwent spinal anaesthesia for caesarean section at the Tamale Teaching Hospital was recruited for the study. A structured questionnaire was administered within 24 hours after caesarean section at the postnatal unit. The results revealed a high level of satisfaction among mothers. Pain control (90.1%), communication by anaesthetists (93.0%) and patient care (89.5%) were cited by mothers as the reasons for the high level of satisfaction. Even though the study observed a high level of satisfaction by mothers who received spinal anaesthesia for caesarean section, the study concludes that adequate measures should be taken to sustain patients’ level of satisfaction.

Keywords:
Maternal Satisfaction; Spinal Anaesthesia; Caesarean Section

1. Theatre Department, Sandema District Hospital, Ghana
2. National Insurance Authority, Upper East Regional Office, Ghana

1. Corresponding Author:
National Health Insurance Authority, Upper East Regional Office, Ghana
Email: amagranewton@gmail.com
Introduction
The choice of anaesthesia for caesarean section (CS) depends on multiple factors such as the indication of surgery, the urgency of the operation, and the patient as well as the surgeon’s desire (Siddiqi & Jaffri, 2009; Dharmalingam & Zainuddin, 2013). Anaesthesiologists always choose the method that is believed to be the safest and most comfortable for the mother, least depressing to the newborn and provides optimal working conditions for the obstetrician (Siddiqi & Jaffri, 2009). Spinal anaesthesia (SA), also called spinal block, is a form of regional anaesthesia involving the injection of a local anaesthetic into the subarachnoid space, generally through a fine needle (Bryant & Knights, 2011).

Spinal anaesthesia is commonly used in Caesarean section which entails the delivery of an infant through incisions in the abdominal and uterine walls (Sanjay, 2006). Over the years, SA has gained worldwide acceptance as its physiological effects provide a better outcome for caesarean section than general anaesthesia which is associated with significantly high maternal morbidity and mortality (Hawkins, Koonin, Palmer & Gibbs, 1997). In recent times, SA has gained patronage at the Tamale Teaching Hospital as clinical data confirm that, out of 1,786 caesarean sections performed in 2016, 83% (1,479 mothers) were given spinal anaesthesia (Tamale Teaching Hospital, 2016).

Patients’ satisfaction has gradually emerged as an important global parameter in the appraisal of quality of health care (Sharma & Karma, 2013). Hence, assessment of health care facility performance comes out best when it includes measurement of the level of patient’s satisfaction. Patient satisfaction takes into consideration the positive evaluation of the patient’s experience, which has several short and long-term effects on the functional outcome of patients. Previous studies on maternal satisfaction with spinal anaesthesia for caesarean section have revealed varied results across different geographic settings (Melese, Gebrehiwot, Bisetegne & Habte, 2014; Siddiqi & Jaffri, 2009; Dharmalingam & Zainuddin, 2013). Generally, many of these studies have reported high levels of satisfaction between 85% and 100% among mothers (Shisanya & Morema, 2017). Satisfaction rate could be overestimated because patients like to please service providers by giving desired responses (Dharmalingam & Zainuddin, 2013; Siddiqi & Jaffri, 2009).

Despite the steady rise in the patronage of spinal anaesthesia and expression of satisfaction of mothers around the world (Fassoulaki, 2010; Kimani, 2012), there is a dearth of studies on mothers’ satisfaction from receiving spinal anaesthesia for CS in Ghana. There is little research for a procedure that is given to over 80% of mothers who underwent caesarean section in the hospital (Tamale Teaching Hospital, 2016). This study was therefore conducted to assess patients’ perspective regarding spinal anaesthesia, their level of satisfaction and the factors influencing satisfaction during CS. The results of this study are relevant because understanding the perspectives of mothers about the care and treatment they have received will aid in improving the quality of spinal anaesthesia care and ensure that health care services are meeting the needs of patients.

Design and Methods
Research Design
This study used a quantitative cross-sectional survey design which is most suitable for studies aimed at finding the prevalence of a phenomenon, by taking a cross-section of the population (Babbie, 1989). Cross-sectional surveys are useful in obtaining the overall “picture” as it stands at the time of the study.

Setting
The study was carried out at the Post Natal Unit of the Tamale Teaching Hospital (TTH). Tamale is the capital of the Northern region of Ghana. At the time this study was conducted, the region shared boundaries with the Upper East and Upper West regions to the north; Ivory Coast to the west; Togo to the east and Brong Ahafo and Volta regions to the south (GSS, 2014). According to the 2010 population and housing census, the total population for the Tamale Metropolis stood at 223, 252 people, comprising 111, 109 males and 112, 143 females (GSS, 2014). The Tamale Teaching Hospital was chosen because it is the largest health facility in the northern part of Ghana which is accessible to patients. This hospital was selected also because of the fact that it was a referral facility for the then five regions of the north. The Tamale Teaching Hospital (TTH) is a tertiary referral hospital that provides health care services to
the residents of Tamale and the rest of northern Ghana as well as neighbouring countries of Ivory Coast, Burkina Faso and Togo.

**Study population and Sampling Technique**

In this study, the target population comprised all mothers who received spinal anaesthesia for CS between the periods, 25th April and 30th June, 2017. Out of the 179 mothers who received SA for CS within the two months’ period, only 171 consented to participate in the study within 24 hours of their postpartum period. Therefore, all the 171 mothers were recruited for the study. The interviews were conducted within 24 hours to obtain appropriate experiences of mothers who were given SA, as memories of hospitalization and child-birth and feelings of satisfaction with them could have changed over time thereby making the results unreliable.

**Data Collection**

Data was collected using a structured questionnaire developed by the lead author. The questionnaire was reviewed by an expert at the School of Medicine and Health Sciences, University for Development Studies. The questionnaires were administered by the lead author through face-to-face exit interviews with the mothers. The study response rate was 100% and the lead researcher administered the questionnaire personally. All questions were in English language but were interpreted to the understanding of respondents in Dagbani, with the assistance of a Research Assistant who was fluent in both English and Dagbani. The questionnaire was divided into four sections and had open and closed-ended questions. Section A of the questionnaire comprised questions that elicited information on sociodemographic variables such as age, occupation, marital status, employment status, levels of education, ethnicity, religion and parity of the respondents. Section B included questions on respondents’ surgical information, whilst Section C was focused on anaesthetic information such as the number of times respondents received spinal anaesthesia and the experiences thereof. The final section involved questions on the level of satisfaction by respondents. Prior to the data collection, the questionnaire was pre-tested at TTH and ambiguous questions were restructured to provide better comprehension.

**Data Management and Analysis**

The study employed a descriptive statistical analysis. The administered questionnaires were carefully edited, coded, processed and analysed with the Statistical Package for the Social Sciences Software (SPSS), Version 20 and Microsoft excel. The data was analysed using frequency tables and percentages generated. To determine the level of satisfaction with spinal anaesthesia, a three-point Visual Analogue scale (very satisfied, somehow satisfied and not satisfied) was used to rate responses in the various anaesthesia periods (preoperative explanations, intraoperative, postoperative and perioperative).

**Ethical Consideration**

Institutional ethical approval was obtained from the Obstetric and Gynaecological units and Management of the Tamale Teaching Hospital. Ethical clearance was also obtained from the University for Development Studies. Verbal consent was obtained from the study respondents after explaining the purpose of the study to them. Additionally, the privacy, confidentiality and anonymity of respondents were ensured. Ergo, respondents are not directly identified in the study. Mothers who declined to participate in the study were assured that their refusal would not affect their access to health care in the future.

**Results**

The study comprises 171 respondents. A summary of the demographic background of the respondents is provided in Table 1. The age distribution of the respondents shows that 54.4% were between ages 20 to 29 years, 42.7% were between 30-39 years, 1.8% of the population were below 20 years and 1.2% were 40 years and above. The mean age of mothers was 28.83 years. A significant proportion (47.9%) of the respondents had attained secondary and tertiary level education, whilst 31.6% did not have formal education. The majority (95.3%) of the respondents were married. Many of these respondents (78.4%) practised the Islamic faith. The majority of the surgeries (83%) were multi gravid and 67.3% of the total number was performed as emergency CS.
Table 1: Respondents Demographic and Obstetric Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Grouping</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-19</td>
<td>3</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>93</td>
<td>54.4</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>73</td>
<td>42.7</td>
<td></td>
</tr>
<tr>
<td>40 and above</td>
<td>2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>54</td>
<td>31.6</td>
<td></td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>10</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td>JHS</td>
<td>25</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>SHS</td>
<td>24</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td>58</td>
<td>33.9</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>8</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>163</td>
<td>95.3</td>
<td></td>
</tr>
<tr>
<td><strong>Religious Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>35</td>
<td>20.5</td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>134</td>
<td>78.4</td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government worker</td>
<td>46</td>
<td>26.8</td>
<td></td>
</tr>
<tr>
<td>Trader</td>
<td>57</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>5</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>4</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>11</td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>Tradesman/Artisan</td>
<td>23</td>
<td>13.4</td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>10</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td><strong>Obstetric Information</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prime</td>
<td>29</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi</td>
<td>142</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>115</td>
<td>67.3</td>
<td></td>
</tr>
<tr>
<td><strong>Type of Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>56</td>
<td>32.7</td>
<td></td>
</tr>
</tbody>
</table>
Adverse effects of spinal anaesthesia

Table 2 shows the adverse effects associated with spinal anaesthesia and CS as reported by 67 (39.2%) of the respondents. The study revealed that a high proportion of the 67 mothers experienced pain and discomfort (53.3%). Nausea and vomiting were experienced by 36.7%, while rigor and palpitation were the least experienced effects (1.7%).

### Table 3: Mothers satisfaction with level of communication of anaesthetist

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous enquiry and reassurance</td>
<td>72</td>
<td>69.9</td>
</tr>
<tr>
<td>He was polite and reassuring</td>
<td>20</td>
<td>19.4</td>
</tr>
<tr>
<td>Very educative</td>
<td>10</td>
<td>10.7</td>
</tr>
<tr>
<td>Total</td>
<td>102</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 4: Mothers’ dissatisfaction with anaesthesia communication

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetist non-communication during surgery</td>
<td>6</td>
<td>50.0</td>
</tr>
<tr>
<td>Language barrier</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>No reassurance, no education</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Don’t understand him</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
</tr>
</tbody>
</table>

### Intraoperative Pain Control

Apart from the lack of adequate communication, pain management is also a parameter for the evaluation of the level of satisfaction by mothers. Most (63.2%) respondents indicated that they were very satisfied with the kind of intraoperative pain control that was administered as compared to 26.9% and 9.9% mothers who were somehow satisfied and not satisfied respectively (see Figure 4.4).
Respondents’ overall satisfaction with spinal anaesthesia given
Figure 2 shows that 89.4% of respondents were generally satisfied with spinal anaesthesia given them (before, during and after delivery). The proportion of respondents who were not satisfied with the spinal anaesthesia given constituted 10.5%
Respondents’ reasons for their overall satisfaction with the spinal anaesthesia

Pain management was noted by 73.6% of mothers as the reason for their satisfaction with the spinal anaesthesia they received. Other reasons cited include, continuous enquiry and reassurance by the anaesthetist (71.8%), mothers’ ability to talk while the operation was ongoing (34.6%), and mothers’ opportunity to see their babies immediately after delivery (50.0%). Finally, mothers were generally satisfied as they did not notice any problem during the operation (35.5%).

Table 5: Mothers’ overall satisfaction with the spinal anaesthesia

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never experienced pain</td>
<td>81</td>
<td>73.6</td>
</tr>
<tr>
<td>The anaesthetist’s continuous enquiry &amp; reassurance</td>
<td>79</td>
<td>71.8</td>
</tr>
<tr>
<td>I could talk while the operation was ongoing</td>
<td>40</td>
<td>34.6</td>
</tr>
<tr>
<td>I saw my baby</td>
<td>55</td>
<td>50.0</td>
</tr>
<tr>
<td>I did not notice any problem during the operation</td>
<td>39</td>
<td>35.5</td>
</tr>
</tbody>
</table>

*Multiple reasons

Reasons for mothers’ dissatisfaction with the spinal anaesthesia

Mothers who were dissatisfied noted that they felt pain and discomfort (77.8%) during the operation. Some reasons including back pain (33.3%), dizziness and poor communication (5.6%) were cited for their dissatisfaction with spinal anaesthesia. The study revealed that 86.5% of the respondents answered in the affirmative when asked whether they will accept spinal anaesthesia in the future, while 13.5% said no, for various reasons as outlined in table 6.

Table 5: Mothers’ overall satisfaction with the spinal anaesthesia

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain and discomfort during the operation</td>
<td>14</td>
<td>77.8</td>
</tr>
<tr>
<td>They injected my back several times</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>I had nausea and vomiting</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Never wanted to see my dead baby</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Poor communication</td>
<td>1</td>
<td>5.6</td>
</tr>
</tbody>
</table>

*Multiple reasons

Discussion

Spinal anaesthesia has been demonstrated to be superior to general anaesthesia for scheduled caesarean delivery (Birnbach & Browne, 2007). This study therefore sought to assess the level of maternal satisfaction with spinal anaesthesia for Caesarean Section at the Tamale Teaching Hospital. Researching mothers’ satisfaction is key in understanding the
experiences of mothers in receiving spinal anaesthesia, and the results can help in improving the quality of anaesthesia and health care. Most of the respondents had attained tertiary education, which resonate with World Health Organisation’s (2011) report that women with formal education are most likely to request caesarean section.

The study found that the majority of the cases operated upon were emergencies as compared to planned cases. This could be due to the fact that caesarean section is not the first line mode of delivery. Most expectant mothers go to labour before caesarean section is prescribed for various reasons which could be of maternal, foetal or combined indications. This contributes to increased risk of emergency caesarean sections (Ji, Jiang, Yang, Qian & Tang, 2015). Pain and discomfort during operation was reported by most mothers as an adverse effect associated with SA and CS. Other adverse effects identified include nausea and vomiting, breathing difficulty, dizziness, palpitations and rigor. These findings are similar to existing literature which has shown that the cause of discomfort from SA are immobility of lower limbs, post-operative nausea and vomiting (Bhattarai, Rahman, Sah & Singh, 2005). The resultant effects of these reported adverse effects are dissatisfaction with consequences such as sexual dysfunction, aversion to further pregnancy or birth, and increase in complaints and litigation (Kimani, 2012).

The level of satisfaction was high with regard to the communication and or interaction between anaesthetists and the mothers throughout the anaesthesia process. The results revealed that most of the clients were told what to expect for anaesthesia before the procedure was performed. However, some of the mothers who underwent planned operation were not told what to expect for anaesthesia. The ideal situation of the hospital demands that all planned cases visit the anaesthesia clinic for preoperative assessment during which the patients are counselled on all available options and told what to expect. Respondents cited various reasons for their satisfaction with the anaesthetist’s communication. These include continuous enquiry and reassurance by the anaesthetist, the polite attitude of the anaesthetist and the education or explanation given about the procedure by the anaesthetist. This supports Canale’s (2015) argument that the patient will prefers the nurse to be more caring. Mothers who were not satisfied gave reasons such as the anaesthetist non-communication with them, language barrier, no reassurance, no education from the anaesthetist and the inability to understand the technical communication of the anaesthetist. The reasons stated are similar to a study by Duffy, Gordon, Whelan, Cole-Kelly, Frankel, Buffone, Lofton, Wallace, Goode & Langdon (2004) which indicates that effective communication and reassurance of the physician is essential to effective health care delivery and patient satisfaction.

The study highlights the presence of good intraoperative pain control as the majority of mothers expressed their satisfaction. Siddiqi and Jaffri (2009) in a study conducted on intraoperative pain control in Pakistan found a satisfaction score of 74.08%. This could be traced down to strict supervision on drug dosing.

The study identified high overall levels of satisfaction by mothers in receiving spinal anaesthesia for CS. The results are consistent with Kenya’s National Hospital survey which reported 95% overall satisfaction (Kimani, 2012). On the contrary, mothers who expressed their dissatisfaction attributed it to pain and discomfort during surgery, multiple injections at the back, nausea and vomiting, dizziness and poor communication. Ensuring good quality of spinal anaesthesia and improving clinical skill of anaesthesiologists might improve mothers’ satisfaction rate (Shisanya & Morema, 2017). Despite the reasons given, the majority of mothers indicated that they will accept spinal anaesthesia for the next possible operation, all factors being equal. This supports the assertion by Fassoulaki (2010) that 80% of mothers have preference for spinal anaesthesia in their future caesarean sections in Greece.

This is a cross-sectional study, so causality cannot be defined. Moreover, satisfaction is a feeling; hence, it is non-quantifiable and subjective. Satisfaction is therefore prone to change even in a single respondent with time. This makes it very difficult to measure or even reproduce the same results given the exact settings.

http://www.numidhorizon.com
Implications for anaesthesia practice
The evidence from the study suggests that health care providers should educate prospective mothers on the various anticipated modes of delivery to address the reactive approach to caesarean experience. This would ensure that pregnant women are well-prepared for any of the available delivery modes. It will also help to dispel anxiety with respect to the mode of delivery. The evidence highlights and supports communication flow between anaesthetists and patients, which help to dispel anxiety during surgery.

Conclusion
The study assessed maternal satisfaction in receiving SA for CS and it was found that the majority of the cases operated were emergencies as compared to planned cases. Pain and discomfort during operation were reported by most of the mothers as an adverse effect associated with spinal anaesthesia and CS. Other adverse effects identified include nausea and vomiting, breathing difficulty, dizziness, palpitations and rigor. Level of satisfaction was generally high in terms of communication and or interaction between anaesthetists and mothers throughout the anaesthesia process. Mothers cited various reasons for their satisfaction with the anaesthetist’s communication. The study identified high overall levels of satisfaction by mothers in receiving spinal anaesthesia for CS due to effective pain management, anaesthetists’ continuous enquiry and reassurance, ability to talk while the operation was ongoing, as well as seeing their babies in the theatre. On the contrary, mothers who expressed their dissatisfaction attributed it to pain and discomfort during surgery, multiple injections at the back, nausea and vomiting, dizziness and poor communication. Despite the reasons given, the majority of mothers had preference for spinal anaesthesia for the next possible operation, all factors being equal.

Conflict of Interest
The authors declare that there is no conflict of interest.

Acknowledgements
We thank all the respondents who participated in this study.
References


Family Related Factors Influencing Exclusive Breastfeeding in Rural Northern Ghana: A Qualitative Analysis

Shamsu-Deen Ziblim (PhD) 1
AdadowYidana (PhD) 2
Iddrisu Seidu (MSC Public Health) 3

Abstract

Exclusive breastfeeding has been recognised as an important public health concern for the primary prevention of child morbidity and mortality. Consequently, the WHO and UNICEF have recommended exclusive breastfeeding for the first six months after delivery, followed by the introduction of complementary foods and continued breastfeeding for 24 months or more. Even so, exclusive breastfeeding is not adequately practised in Ghana. This study sought to understand and explain the family influence on exclusive breastfeeding practices in rural northern Ghana. An exploratory qualitative research design was used to explore the central phenomenon of breastfeeding in rural northern Ghana. Individual interviews were conducted. The participants were 25 and included breastfeeding mothers, paternal grandmothers, paternal grandfathers, fathers of babies, traditional birth attendants, and a breastfeeding support group leader. All interviews were audio-taped, transcribed, and analysed using content analysis. Four main themes emerged in relation to the forms of family influences on exclusive breastfeeding: family knowledge of exclusive breastfeeding; primary and secondary participants in child care; family beliefs and practices; and learning to breastfeed. It emerged that infant feeding and care is a family responsibility rather than being individually centred. A family’s knowledge, belief systems, and way of participation in infant care heavily influence a woman’s ability to practise and sustain exclusive breastfeeding. The implication is that at any point in time, family players should be considered in any campaign on exclusive breastfeeding.

Keywords:
Exclusive breastfeeding, Family, Ghana, Influence, Rural community

1. Department of Community Health and Family Medicine, School of Medicine and Health Science, University for Development Studies, Tamale, Ghana Tel: +2332444202799 Email: zshamsu72@gmail.com

2. Department of Community Health and Family Medicine, School of Medicine and Health Science, University for Development Studies, Tamale, Ghana Tel: 0207036488, Email: adadowy@yahoo.com

3. Centre for Development and Advocacy, Tamale, Ghana Tel: +233 209070308, Email: saha.seidu1@gmail.com

1. Corresponding Author:
Department of Community Health and Family Medicine, School of Medicine and Health Science, University for Development Studies, Tamale, Ghana Email: zshamsu72@gmail.com Tel: +2332444202759
Introduction

According to the World Health Organization (WHO), exclusive breastfeeding refers to the situation where ‘the infant has received only breast milk from his/her mother or a wet nurse, or expressed breast milk and no other liquids, or solids, except drops or syrups consisting of vitamins, minerals, supplements, or medicine’ (WHO, 1991). Research has shown that suboptimum breastfeeding, especially not exclusively breastfeeding a child for the first six months of life, contributes to about 1.4 million deaths and 10% of the disease burden in children under the age of five years in low-income countries (Black et al., 2008). For a baby to grow to his or her full potential, the baby needs the right food at the right time. To this end, there has been a renewed interest and global commitment to promote breastfeeding as the ‘best’, ‘perfect’, and ‘natural’ feeding method for newborns (Whalen & Cramton, 2010; Issaka, Agho, & Renzaho, 2017).

Exclusive breastfeeding is deemed important because of its role in reducing infant morbidity and mortality (Sloan, Sneddon, Stewart, & Iwaniec, 2006; Mututho, Willy, & Patrick, 2017). It has also been established that infants who are exclusively breastfed for the duration of six months are significantly protected against major childhood diseases including diarrhoea, gastrointestinal tract infection, allergic diseases, childhood leukaemia and lymphoma, inflammatory and bowel disease (WHO, 2010; American Academy of Pediatrics, 2012). Breastfeeding has many health benefits for an infant and has been reported to be an ideal food for an infant’s healthy growth (Mututho, Willy, & Patrick, 2017). Exclusive breastfeeding is also found to be protective against sudden infant death syndrome by reducing the risk by 50% at all ages during infancy, and these benefits tend to increase as long as duration and exclusivity continue (Vennemann et al., 2009). Also, exclusive breastfeeding protects children against single and recurrent incidences of Otitis Media, (Duncan et al., 1993).

In the lower-income economies where many HIV positive women decide to breastfeed because of lack of safe, affordable, acceptable, and sustainable replacement feeding, exclusive breastfeeding will help minimize HIV-1 transmission. This was reported in a prospective study of 549 HIV infected breastfeeding mothers in South Africa (Coutsoudis, Miriam, Nadia, & Coutsoydides, 2011). The study established a significantly lower risk of HIV-1 transmission in children who were exclusively breastfed for up to 3 months in contrast with those who had mixed feeding prior to 3 months. Studies by Iliff et al. (2005) and Coovadia et al. (2007) also confirmed that the relative risk of HIV-1 infection is lower for exclusive breastfeeding infants. Specifically, Coovadia et al. (2007) showed that infants who received breast milk and solid foods were 11 times more likely to be infected with HIV than those who received exclusive breastfeeding.

Consequently, the WHO and UNICEF (1990) have recommended exclusive breastfeeding for six months, followed by the introduction of complementary foods and continued breastfeeding for 24 months or more. Despite this recommendation and the essential role of exclusive breastfeeding in infant survival, attempts to promote the practice in lower-income economies have generally achieved less than the desired outcomes. In Ghana, where 28% of all under-five children are stunted and 9% are wasted (Ghana Statistical Service & ICF Macro, 2009), exclusive breastfeeding practices tend to be short-lived. While an estimated 84% of children younger than 2 months are being exclusively breastfed, the percentage of children who continue to receive exclusive breastfeeding by age 4 to 5 months plummets to about 49% (Ghana Statistical Service & ICF Macro, 2009).

Previous studies on the dynamics of the practice have been focused on factors and barriers to exclusive breastfeeding (Aidam, Perez-Escamilla, Larney, & Aidam, 2005; Otoo, Larney, & Pérez-Escamilla, 2009; Senarath, Dibley, & Agho, 2010). Some too have examined the health outcomes of exclusive and non-exclusive breastfeeding (Dieterich, Felice, O’Sullivan, & Rasmussen, 2012; Kramer, 2003); while others have also studied social influences on breastfeeding decisions and practices. In the lower-income economies, successful breastfeeding is an interactive process between the mother and the baby’s physical and psychological needs. In some instances, these needs are dictated by the kind of family and social support and the ability of the woman to effectively lactate (Galvo, 2006) and paternal involvement in breastfeeding promotion programmes (Susin & Giuglian, 2008).
In an ethnographic study of socio-cultural influences on infant feeding in South Africa, Thairu, Gretel, Nigel, Ruth, & Ncamisile (2005) found a strong influence of family (husbands' mother, father and sisters including the woman's mother) on decisions regarding exclusive breastfeeding, which varied along what the authors described as 'social independence'. Young mothers below age 19 were mainly less socially independent and tend to be influenced more than their older counterparts. Research has shown that a single person who wields much influence on a decision regarding infant feeding in Africa is the infant's paternal grandmother (Reinsma et al., 2012; Rochat, 2016) whose experience, support, and advocacy are often needed by new breastfeeding mothers (Grassley & Eschiti, 2008). This appears to be so because in highly patriarchal societies, decisions related to childbirth and breastfeeding are often determined by mothers-in-law (Carter, 2002). This is because of the cultural dynamics that legitimizes authority in patriarchal societies.

A study conducted by Dun-Dery and Laar (2016) on exclusive breastfeeding in Ghana focused on professional working mothers in cities. In the case of Victor, Dery, and Gaa (2016), the focus was on knowledge, attitudes, and determinants of exclusive breastfeeding among Ghanaian rural lactating mothers. Other studies include Ayawine and Ae-Ngibise (2015) on determinants of exclusive breastfeeding in two sub-districts in Ghana; Asare, Preko, Baafi, and Dwumfour (2018) on breastfeeding practices and determinants in Tema Manhean, Ghana; Danso (2014) on exclusive breastfeeding among professional working mothers in Kumasi; and Fosu-Brefo and Arthur (2015) on effects of timely initiation of breastfeeding on child health in Ghana. Although these previous studies provided important insights into the several influences on breastfeeding, further exploration is necessary for understanding how family members might influence exclusive breastfeeding recommendations. Almost all the studies cited above on exclusive breastfeeding were largely quantitative. Thus, the aim of this study was to understand and explain the influences of members of a patriarchal family on exclusive breastfeeding practices in rural northern Ghana.

**Design and Methods**

An exploratory qualitative research design was chosen to study the central phenomenon of interest, specifically family influences on exclusive breastfeeding outcomes. The design allowed in-depth understanding of the phenomenon of interest (Denzin and Lincoln, 1998). The study population included breastfeeding mothers, paternal grandmothers, paternal grandfathers, fathers of babies, traditional birth attendants, and a breastfeeding support group leader living in the Moglaa community. The inclusion criterion was all target categories who live in the study area and those who provided consent to be interviewed. In total, 25 participants comprising, nine (9) breastfeeding women, seven (7) grandmothers, four (4) fathers, two (2) grandfathers, two (2) traditional birth attendants, and one (1) breastfeeding support group leader were selected for the study. Both the purposive and snowball sampling techniques were used. The purposive sampling technique was employed because the focus was on breastfeeding mothers. After the first participant was identified, the snowball technique was used to identify other breastfeeding mothers. This process continued until a point of saturation was reached. Family members, traditional birth attendants, and a supportive group leader related to some of the breastfeeding women were identified through purposive sampling. Data collection for the study was conducted between April and June 2017 using semi-structured interview questions. The method of data collection was an in-depth individual interview. The relevance of choosing this technique is that it seeks to build an intimacy required for mutual self-disclosure (Johnson, 2002). The interviews lasted for about 35 to 50 minutes, and they were conducted in the native language – Dagbani of which the researchers are fluent. The venues for the interviews were according to the convenience of the participants.

**Data analysis**

The interviews were audio-recorded and later transcribed and analyzed using content analysis procedures. A manual approach was used to form themes and sub-themes from the transcripts. This was deemed an appropriate analytical method since the purpose of the study was known (Ritchie, Spencer, & O'Connor, 2003; Rossman (2006). The transcripts were repeatedly read to achieve immersion. A close examination yielded the themes and sub-themes re-
understand. Each participant was informed of the right to opt-out of the study at any point.

Results
The results from this study have been presented under each of the four identified themes with quotes to illustrate these themes.

Family Knowledge of Breastfeeding
There was evidence of familiarity with the idea and practice of exclusive breastfeeding among participants. Nursing mothers demonstrated a good knowledge of the benefits of exclusive breastfeeding and early initiation of breastfeeding to expel the placenta.

‘As necessary, when the placenta delays or fails to come out after delivery, breastfeeding should be initiated to facilitate its release’. (TBA breastfeeding support group leader)

There was a consensus among breastfeeding women about the importance of first breastfeeding after delivery that colostrum gives strength and improves intellectual abilities:

‘It’s good for our children because it gives them strength and good intellect’ (Breastfeeding mothers)

Male family relations, mostly paternal grandfathers and fathers exhibited a lack of interest in getting a better understanding of the details of breastfeeding recommendations. They referred to mothers and grandmothers as people tasked with the responsibility to breastfeed. These individuals tend to view breastfeeding as a feminine activity.

‘Breastfeeding matters are meant for mothers or the grandmothers to handle, not us!’ (Grandfather)

‘Breastfeeding is the responsibility of our mothers (the baby’s grandmother). They are responsible for all the training a woman would require especially for the first-time mothers who have no such experience’ (Father).

In the case of the grandmothers and traditional birth attendants, their responses depict people with little understanding of the essence of exclusive breastfeeding. They rather gave their babies water.

‘Hmmm, I will never allow my child to be thirsty. I will always give him water. I heard something like that...’

Research setting
The study was conducted in Moglaa, a community within the Savelugu Municipality, one of the twenty-six municipalities/districts forming the Northern Region of Ghana. The municipality is predominantly agricultural with about 97% of the active population engaged in peasant farming. Moglaa was chosen for this study because it has only Dagombas who still cherish their indigenous cultural practices. Like many rural communities in the municipality, the family system in Moglaa is patriarchal and predominantly based on the extended family structure where membership includes grandparents, fathers, mothers, uncles, aunts, and cousins. Each family is headed by a man and members live in one compound house, with shared experiences, strong solidarity, and regular interactions.

Rigour of the study
Credibility and trustworthiness of the study were achieved through engagement with participants who were deemed qualified to make sure that the right data was collected during the interview. There were follow up probes for clarification on answers that were not clear. This was done to ensure that the findings were rich and robust. Member checking was done to follow up on emerging themes. The credibility of the data was achieved by making sure that all the participants were knowledgeable and could share their experiences on breastfeeding. Transferability was assured by describing the participant’s characteristics for any researcher who might want to conduct a similar study. Dependability was achieved by engaging a third-party qualitative data analyst who analyzed and confirmed the findings.

Ethics consideration
It is necessary that qualitative research ought to be ethical and apply the right principals in the conduct and report of the study (Cohen & Crabtree, 2008). Informed consent was obtained before the commencement of the interviews. Upon agreement to participate, each participant was given written consent to sign/thumbprint before taking part in the study. Detailed explanation was given to the participants using simple terms in the language they could understand. Each participant was informed of the right to opt-out of the study at any point.
who will insist that the child should be breastfed appropriately. You know, if a child is not fed well, he/she will not develop well” (Traditional birth attendant).

Among the secondary care providers, a baby’s paternal grandmother was identified as the most important person whose participation goes beyond sheer guidance for novice breastfeeding women.

‘The grandmother takes care of the child to enable you to do your work; she is also responsible for bathing the child every day’ (Breastfeeding woman).

In the absence of the grandmother, another elderly woman with experience of childbirth and care from the family assumes responsibility as the principal secondary care provider. There was, however, an acknowledgement that, young women, married or unmarried, are occasionally tasked with babysitting but are rarely consulted on matters of breastfeeding. Participation of adult male family relatives in everyday infant feeding and care was again reported to be uncommon. They are, however, found to be supportive when a child is sick, excessively cries, or fails to sleep at night.

‘Not much’ and another, ‘except when the child is sick or is crying’ (Breastfeeding women).

Primary and secondary caregivers

From the data, it was observed that breastfeeding was acknowledged as a responsibility of primary caregivers of newborns while the rest of the family participate as secondary care providers. This observation was made because the breastfeeding mother is the one who feeds the baby and only receives support from other members of the family when needed. Primary caregivers are expected to breastfeed in a manner consistent with what secondary caregivers may define as appropriate. Failure to breastfeed a baby in accordance with the family expectation could cause family and community disapproval.

‘My firstborn later refused to eat Tuo Zaafi [a staple food in the community] and people were saying it was my fault since I delayed introducing him to food’ (Breastfeeding woman).

In another interview, a TBA also confirmed the assistance needed from family members for effective breastfeeding of infants:

‘Members of a family help in many ways. Some women are for instance very lazy or reluctant to breastfeed. In such cases, it is members of the family who will insist that the child should be breastfed appropriately. You know, if a child is not fed well, he/she will not develop well’ (Traditional birth attendant).

Family beliefs and practices

The findings of this study also revealed some practices that are associated with breastfeeding and infants’ welfare. Two broad forms of these cultural and/or religious practices were reported: ‘pakopillamoag’ and ‘nyuhibu’. The pakopillamoag (literally translated as ‘white widows’ herbal concoction) is primarily performed to protect newborns against diseases and sicknesses associated with contact with unmarried widows who are sexually active.

‘We still have the ‘pakopillamoag’ in this community because all the women I recently assisted to deliver did use that herbal concoction after their births. If the baby is a boy, he is bathed with the concoction for three days; and for baby girls, it is done for four days. Besides bathing, the baby is further made to drink a little of the herbs. Once it is done, the baby will be protected against diseases /harm from ‘pakopilla’ (Traditional birth attendant).

These practices tend to defeat the campaign for ex-

(exclusive breastfeeding) on one occasion when I visited the Savelugu Hospital and we were told not to introduce water to the babies until 6 months later. I didn’t say anything, what I did was to remain silent about it and continued to give a small quantity of water to him each time I bathed him. Water adds energy to the body so if you don’t give the child water, he/she will continue to remain light weighted’ (Grandmother).

They could not comprehend how a human being can survive without water for six months.

‘Just imagine someone living without water for up to six months’ (Traditional birth attendant).

‘The child’s grandmother insisted that the child cannot abstain from drinking water until 6 months. As such, she used to secretly give him water after bathing him. Later he [the baby] started having stomach aches and then the doctors said there was plenty of water in his stomach’ (Breastfeeding mother).

Primary and secondary caregivers

From the data, it was observed that breastfeeding was acknowledged as a responsibility of primary caregivers of newborns while the rest of the family participate as secondary care providers. This observation was made because the breastfeeding mother is the one who feeds the baby and only receives support from other members of the family when needed. Primary caregivers are expected to breastfeed in a manner consistent with what secondary caregivers may define as appropriate. Failure to breastfeed a baby in accordance with the family expectation could cause family and community disapproval.

‘My firstborn later refused to eat Tuo Zaafi [a staple food in the community] and people were saying it was my fault since I delayed introducing him to food’ (Breastfeeding woman).

In another interview, a TBA also confirmed the assistance needed from family members for effective breastfeeding of infants:

‘Members of a family help in many ways. Some women are for instance very lazy or reluctant to breastfeed. In such cases, it is members of the family who will insist that the child should be breastfed appropriately. You know, if a child is not fed well, he/she will not develop well’ (Traditional birth attendant).

Among the secondary care providers, a baby’s paternal grandmother was identified as the most important person whose participation goes beyond sheer guidance for novice breastfeeding women.

‘The grandmother takes care of the child to enable you to do your work; she is also responsible for bathing the child every day’ (Breastfeeding woman).

In the absence of the grandmother, another elderly woman with experience of childbirth and care from the family assumes responsibility as the principal secondary care provider. There was, however, an acknowledgement that, young women, married or unmarried, are occasionally tasked with babysitting but are rarely consulted on matters of breastfeeding. Participation of adult male family relatives in everyday infant feeding and care was again reported to be uncommon. They are, however, found to be supportive when a child is sick, excessively cries, or fails to sleep at night.

‘Not much’ and another, ‘except when the child is sick or is crying’ (Breastfeeding women).

Family beliefs and practices

The findings of this study also revealed some practices that are associated with breastfeeding and infants’ welfare. Two broad forms of these cultural and/or religious practices were reported: ‘pakopillamoag’ and ‘nyuhibu’. The pakopillamoag (literally translated as ‘white widows’ herbal concoction) is primarily performed to protect newborns against diseases and sicknesses associated with contact with unmarried widows who are sexually active.

‘We still have the ‘pakopillamoag’ in this community because all the women I recently assisted to deliver did use that herbal concoction after their births. If the baby is a boy, he is bathed with the concoction for three days; and for baby girls, it is done for four days. Besides bathing, the baby is further made to drink a little of the herbs. Once it is done, the baby will be protected against diseases /harm from ‘pakopilla’ (Traditional birth attendant).

These practices tend to defeat the campaign for ex-
exclusive breastfeeding. Breastfeeding mothers reported being aware of the practice, and stated that it is done just after delivery. When asked about how the concoction is administered, one breastfeeding mother explains that the practice is done during the bathing of the child

‘The baby is bathed in it and made to drink a small quantity…Just after delivery’ (Breastfeeding woman).

Not all of the participants reported having observed the practice in their families. Those who reported abstinence (four breastfeeding women) from the practice had either abandoned the traditional model or were motivated by their faith (Islam or Christianity). On the whole, participants who professed Christianity were more likely to completely give up any use of concoction in relation to breastfeeding, while those who professed Islam were more inclined to use an alternative concoction deemed appropriate for the Islamic faith.

‘The baby’s father gave him a concoction prepared by writing some Quranic verses for him to drink. The purpose is to protect the baby from evil forces and harm’ (Grandmother).

Besides the ritual concoctions meant for newborns, participants again identified ‘nyuhibu’ [which literally refers to the process of aiding someone to drink something] as a Dagbon traditional ritual concoction that is performed to essentially increase breast milk supply.

‘Cow milk, millet, and other ingredients are the ingredients required to prepare the drink’ (Grandfather).

Only a few people who have the know-how can make it; and ‘we have only two of them in this community’ (father). Unlike the pakopilla herbal concoction, the ‘nyuhibu’ ritual concoction is made for only breastfeeding women;

‘And once they drink it, the milk will become plentiful by the end of that day’ (Fathers).

Participants also held a belief that a drop of breast milk on a baby’s penis would lead to impotence in adulthood. Such effect of breast milk is believed to have a connection with the presence of the ‘bad hair’ (the hair with which a baby is born) which is usually shaved on the 7th day of birth. It is thus strongly recommended to cover a baby’s pubic area whilst breastfeeding until the 7-day period is over.

‘What is encouraged especially during the first week of breastfeeding is to cover a baby boy’s penis while breastfeeding. This will prevent the breast milk from dripping on the penis which, when happens, causes impotence later in life. In some cases, the impotency can only be overcome after the death of the man’s mother (Traditional birth attendant).

Breastfeeding support from significant others

Support on how to breastfeed was provided for first-time mothers by women breastfeeding support group, family tutelage and observation. Mothers were informed and assisted by nurses to initiate breastfeeding immediately after delivery. Subsequent information about breastfeeding recommendations were given by the leadership of the breastfeeding support group in the community. The group was originally founded by some few women as a ‘self-help’ platform to promote their children’s welfare. It was later absorbed by the clinic to serve as a link between breastfeeding women and the Reproductive and Child Health Unit of the Community Clinic. Group leaders convene with members (nursing mothers) twice every month at the clinic. It has four leaders who are regularly given updates on breastfeeding and child health.

‘The leaders are supplied with pictorial breastfeeding pamphlets. Copies of these pamphlets are given out to nursing mothers to enable them to learn more about breastfeeding’. (Breastfeeding support group leader).

In addition to the clinic and the women support group, breastfeeding mothers again identified grandmothers and traditional birth attendants as other important sources of breastfeeding knowledge. They provide guidance on appropriate breastfeeding positions and how to ensure good attachment.

‘Normally, we educate breastfeeding women on the kinds of food items that can increase milk supply. We also educate them on how to properly position
the baby for optimal feeding’ (Grandmother).

‘It was her [the baby’s paternal grandmother] who guided me on the basic techniques of infant feeding such as how to correctly position the child for successful breastfeeding’ (Breastfeeding woman).

‘TBAs are very active in teaching us about breastfeeding…. Pregnant women in some cases may give birth at home and they will be in charge’. (Breastfeeding woman)

Observation was also identified by some respondents and confirmed by family members as a learning tool. Breastfeeding in the presence of family and friends or even in public places is an acceptable practice in most rural and urban Ghana. This provides an indirect learning platform for expectant mothers to learn. Observational learning, in most instances, was linked to breastfeeding mothers’ previous role as baby caretakers. With the exception of two participants, the rest of the breastfeeding participants recalled being a baby caretaker at some point in their lives.

‘You will have another opportunity to learn something about breastfeeding’ (breastfeeding mother)

‘A caregiver may even offer her own breast to a baby although it contains no milk yet. This is one of the strategies baby caregivers normally use when a baby is crying for milk and the mother is not immediately available’.

Discussion

Family members’ have been observed to have fundamental influences on efforts and decisions to exclusively breastfeed. While breastfeeding women were found to be well-informed on exclusive breastfeeding and other desirable forms of infant feeding practices such as early initiation of breastfeeding and the use of colostrum, important players in the family, including grandfathers and fathers, exhibited little understanding of breastfeeding recommendations due mainly to cultural and gender explanatory factors. However, in a study by Draman, Mohamad, Yusoff & Muhamad (2017), there was a mutual decision among parents on exclusive breastfeeding. Men’s little knowledge about breastfeeding matters is consistent with Thet et al.’s (2016) study in Myanmar, but contrary to Mithani, Zahra, Zohra, & Shehnaz’s (2015) where fathers could tell the advantages of breastfeeding and the need to exclusively breastfeed.

Unlike their male counterparts, grandmothers were found to be very supportive and influential on how infants are breastfed (Kerr & colleagues 2008; Thet et al. 2016). Similar studies have also reported the advocacy function of grandmothers (Grassley & Eschiti, 2008) who manage indigenous knowledge (Aubel, 2006). Besides their influence, grandmothers had also been moderately informed about exclusive breastfeeding recommendations. Some of them questioned the relevance of allowing babies to be ‘thirsty’ over a six-month period. Their lack of commitment suggests a need for proper targeting of important family relatives with information on breastfeeding recommendations.

These findings also highlight some breastfeeding beliefs and practices with both cultural and religious significance. The ‘nyuhibu’ ritual as reported in this study is mainly carried out to increase breast milk supply. Although newborns are not directly involved in the ritual, its success or failure might significantly influence how a baby is fed. What appears to be detrimental or impact negatively on EBF is the ‘pakopilla’ ritual since it involves feeding an infant with small quantities of herbal teas for a number of days. This bears the semblance of the findings of Ndekugri (2017) where the administration of water is seen as a welcome gesture. In the case of findings of Wanjohi et al.’s (2017) study, it is a taboo to feed babies on colostrum in some communities in Kenya. The effect of religion, especially Christianity, in eliminating similar traditional practices connected to breastfeeding has been previously documented by Aborigo et al. (2012) in a related study in northern Ghana.

This study established that a breastfeeding woman is expected to breastfeed in line with the dictates of her family. Equal participation of members in infant feeding is not expected because childcare is constructed and understood in terms of gender. This is contrary to what was found by Draman et al. (2017) where breastfeeding was a mutual affair. In this current study, female members of a family have significant involvement in matters of breastfeeding than their male counterparts, which also explains why de-
exclusive breastfeeding. Such increase in awareness about modern breastfeeding recommendations and infant health in general would especially be vital in modifying families’ conceptions of appropriate infant feeding. While some religious and cultural beliefs about breastfeeding seem entrenched, important family advocates and religious leaders, if properly educated about exclusive breastfeeding, could be used to modify and/or discourage practices that involve feeding new-borns with herbal products and ritual concoctions.

Conclusion
In a patriarchal society, infant feeding and care is family oriented rather than individually centred because the decisions are not made by the biological mother of a child alone. A family’s knowledge and way of participation in infant care heavily influence a woman’s ability to sustain exclusive breastfeeding. The findings of this study also highlight the existence of some beliefs and practices at the family level that impede breastfeeding mothers’ quest to exclusively breastfeed. The study recommends that education should be given to the family on the effect of some of their beliefs system that affect the health of mothers and babies. The study, therefore, recommends that breastfeeding mothers should be educated at their various health facilities on the effects of given concoction to newly born babies.

Conflict of interest
There is no conflict of interest in the conduct of this study.

Acknowledgement
We thank all the participants for providing us with detailed information.
References


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

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

1. Corresponding Author:
Department of Nursing and Midwifery
Pentecost University
Email: regartmens1@gmail.com
Tel: 0501373351
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

<table>
<thead>
<tr>
<th>Private Gender</th>
<th>F</th>
<th>%</th>
<th>Private Gender</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>12</td>
<td>40</td>
<td>Males</td>
<td>12</td>
<td>40</td>
</tr>
<tr>
<td>Females</td>
<td>18</td>
<td>60</td>
<td>Females</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>11</td>
<td>36.6</td>
<td>60-69</td>
<td>11</td>
<td>36.6</td>
</tr>
<tr>
<td>70-79</td>
<td>8</td>
<td>26.7</td>
<td>70-79</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>80-89</td>
<td>11</td>
<td>36.7</td>
<td>80-89</td>
<td>11</td>
<td>36.7</td>
</tr>
<tr>
<td>90-99</td>
<td></td>
<td></td>
<td>90-99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>17</td>
<td>56.7</td>
<td>Primary</td>
<td>17</td>
<td>56.7</td>
</tr>
<tr>
<td>SHS</td>
<td>7</td>
<td>23.3</td>
<td>SHS</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Tertiary</td>
<td>6</td>
<td>20</td>
<td>Tertiary</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Private</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil servant</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Private business employee</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Entrepreneur</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil servant</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Private business employee</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Entrepreneur</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>Widow/widower</td>
<td>13</td>
<td>43.3</td>
</tr>
<tr>
<td>Unmarried</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>Widow/widower</td>
<td>13</td>
<td>43.3</td>
</tr>
<tr>
<td>Unmarried</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of stay</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>1-5 years</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of stay</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>47</td>
<td>58.7</td>
</tr>
<tr>
<td>1-5 years</td>
<td>20</td>
<td>25.0</td>
</tr>
<tr>
<td>6-10 years</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

f – frequency  
% – Percentage  
SHS – Senior High School

**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

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td>Physical</td>
<td>5 – 9</td>
</tr>
<tr>
<td>Psychological</td>
<td>6 – 11</td>
</tr>
<tr>
<td>Neglect</td>
<td>6 – 11</td>
</tr>
<tr>
<td>Sexual</td>
<td>7 – 13</td>
</tr>
<tr>
<td>Financial Fraud</td>
<td>6 – 11</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Study Sites</th>
<th>Measure</th>
<th>Physical Abuse</th>
<th>Psychological Abuse</th>
<th>Neglect</th>
<th>Sexual Abuse</th>
<th>Financial Fraud</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>5.1667</td>
<td>6.7000</td>
<td>6.6333</td>
<td>7.0000</td>
<td>6.4000</td>
</tr>
<tr>
<td></td>
<td>Mode</td>
<td>5.00</td>
<td>6.00</td>
<td>6.00</td>
<td>7.00</td>
<td>6.00</td>
</tr>
<tr>
<td></td>
<td>Standard deviation</td>
<td>0.53067</td>
<td>1.11880</td>
<td>1.62912</td>
<td>0.000000</td>
<td>0.49827</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>5.5250</td>
<td>7.9125</td>
<td>8.4625</td>
<td>7.0000</td>
<td>6.3500</td>
</tr>
<tr>
<td></td>
<td>Mode</td>
<td>5.00</td>
<td>6.00</td>
<td>6.00</td>
<td>7.00</td>
<td>6.00</td>
</tr>
<tr>
<td></td>
<td>Standard deviation</td>
<td>1.19042</td>
<td>2.29581</td>
<td>3.51828</td>
<td>0.000000</td>
<td>1.14847</td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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.

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

<table>
<thead>
<tr>
<th>Prevalence of Abuse</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>28.8</td>
</tr>
<tr>
<td>No</td>
<td>57</td>
<td>71.3</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Prevalence of Abuse</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Relatives (e.g., siblings, nephews, niece etc.)</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>Daughters</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>Relatives (e.g., siblings, nephews, niece etc.)</td>
<td>18</td>
<td>22.5</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>28.8</td>
</tr>
</tbody>
</table>
Table 6: Logistic regression showing odds ratio of predictor variables on elder abuse

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

* - P<0.05
® - reference category
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).

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.

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

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

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

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


Structural Elements of Integrated Treatment System for Alcoholic Patients in Two Rehabilitation Centres in Ghana

Sandra Fremah Asare (MSc, BSc) 1
Adwoa Bema Boamah Mensah (PhD) 2
Ofeibe Asare (MPH) 3

Abstract
In Ghana, much attention has been given to the care and treatment of medical-surgical conditions other than mental health issues and the treatment of drug addiction. The predominant understanding is that alcohol/drug addiction or abuse is a chronic disorder on a par with other chronic conditions such as diabetes and asthma. This research study was conducted on the basis of making additions to existing scientific knowledge on rehabilitation of patients diagnosed with alcohol/drug abuse and how treatment helped in early recovery. It is a qualitative research with exploratory descriptive design. The study selected two (2) major rehabilitation centres in the Kumasi Metropolis namely: Cheshire Rehabilitation Centre and Remar Rehabilitation Centre. A total of twenty-eight (28) participants were selected for the study. Sixteen (16) patients were selected purposively for the study. Thus, eight (8) rehabilitants were chosen from each centre. The study also sampled eight (8) relatives of patients from both homes and two (2) care givers from each centre who also undertook the interview voluntarily using a semi-structured interview guide. Audiotaped interviews were conducted with the participants at the two rehabilitation centres. The data was transcribed and coded using grounded theory and conversation analysis. The data was managed with ATLAS.ti. The study revealed that, though both rehabilitation centres were doing their best, they were under-resourced both in qualified personnel and finances. Unavailability of prescribed medications too caused incessant relapse. The results confirmed the finding of other studies which showed that no rehabilitation physicians are identified in any of the rehabilitation facilities in Ghana.

Keywords:
Rehabilitation; Experiences; Under-resourced; Rehabilitants; Recovery; Ghana.

1. Seventh- Day Adventist Nursing and Midwifery Training College, Kwadaso-Kumasi
2. School of Public Health, Kwame Nkrumah University of Science and Technology, Kumasi
3. Department of Nursing, Kwame Nkrumah University of Science and Technology, Kumasi.
4. Career Development Center, Kwame Nkrumah University of Science and Technology, Kumasi.

1. Corresponding Author:
Department of Nursing, SDA NMTC
P. O. Box PC 96 Kwadasso-Kumasi.
Email: asarefrema6@gmail.com.
Introduction
In the context of integrated rehabilitation, it is hypothesized that factors affecting the rehabilitation process need to be looked at comprehensively in order to achieve patient satisfaction. In the paucity of knowledge on rehabilitation process, it is almost impossible to determine the rehabilitation outcome or treatment modalities that facility users experience. This is the situation in most rehabilitation centres in Ghana over the years.

Perceived alcohol use for pleasure is part of many societies (World Health Organization, 2011). Cultural values have been reported to have a powerful influence over the use of alcohol throughout the world. Africans, in particular, are accustomed to the consumption of fermented beverages which tend to have less alcoholic content than distilled beverages. Alcohol has been part of the social and religious life of Africa since the third century and continues to be an integral part of ceremonies such as child naming, marriage, funerals, judicial processes and legal contracts (Ssebunnya et al., 2020).

Despite scientific evidence suggesting that alcohol is a major source of health and social problems, the earlier studies reported low prevalence and detection of alcohol use disorders at health facilities (Nawaldda et al, 2018, Rathod et al, 2018) alluding to the fact that there is poor appreciation of the health problems associated with heavy alcohol consumption. In Ghana, it is estimated that 40% of the population of over 30 million people are affected by a moderate to mild mental disorder relating to alcoholism. Most of these people are likely to get the quickest results from therapy; yet, the behavioural service gap is 98%. This means that only 2% of those in need of rehabilitation is currently receiving any sort of treatment (Asare et al., 2011).

Treatment non-adherence is one of the major causes of unnecessary suffering, relapse, hospitalization and suicide among alcohol and drug dependants (Ssebunnya et al, 2020). Consequently, the main goals of therapies of all types is to empower the patient and give them some control back over their world and rechart the meaning and purpose of their lives under altered circumstances (Redfied & Kaplan, 2016). The application of rehabilitation approaches and technologies to adults with alcohol related psychiatric disabilities is a relatively new and exciting development in Ghana. The planning process is just the beginning of change. Planned therapies for clients must ensure strategies which enable commitment by taking action. There is some evidence that client commitment change talk is associated with positive Alcohol Use Disorders outcomes (Romano & Peters, 2016).

Research has shown that standardized frameworks provide the basis for structure implementation and outcome measures globally (W.H.O, 2011). However, Adzrago et al. (2018) reaffirm that attitudes of rehabilitation service providers either ensure patients’ compliance and recovery or serve as barriers to compliance and recovery from alcohol and drug addiction. This conception brings to the fore the need to shed more light on the perspectives and expectations of the patient undergoing detoxification and treatment.

Materials and Methods
Design
The study adopted the qualitative exploratory descriptive design to explore the integrated rehabilitation systems for alcohol dependants and the procedures they go through during the processes. Rehabilitants who were recovering successfully and had been at the centre for at least 3 months were subjects of interest.

Setting
This study selected two major rehabilitation centres in the Kumasi Metropolis: Cheshire Rehabilitation Centre and Remar Rehabilitation Centre. These are the main rehabilitation centres in the Northern sector of Ghana, so they are geographically positioned well in accommodating patients with various forms of addiction across the country and have a bed capacity of about fifty (50) each. Their main goal is to accommodate and provide care and treatment for patients who are battling with addiction and are struggling for sobriety and to provide physical, psychological, and moral support. Both homes also serve as referral centres for patients who have been hospitalized and such recommendation is made by a psychiatrist. Each centre has caregivers including non residential, part-time attending psychologists and counsellors etc.
Population and Sampling Technique
A total of twenty-eight (28) participants took part voluntarily in the study. Sixteen (16) patients comprising eight patients from each centre were selected purposively for the study. The study also sampled eight (8) relatives of patients from both homes who also undertook the interview voluntarily and two (2) caregivers from each centre using a semi-structured interview guide for Cheshire and Remar Rehabilitation Centres respectively. The sample size was determined by theoretical saturation. Persons who were not related to the patients of the rehabilitation home were excluded. To be recruited, participants satisfied some inclusion criteria such as being on admission for more than three months, being a caregiver and being a relative of a rehabilitant on admission. The aim was to bring into perspective the treatment systems adopted within the roles of caregivers in the rehabilitation process. The study used semi-structured interview guides to generate qualitative data from the following groups: alcohol dependants in Remar Rehabilitation Center as well as Cheshire Rehabilitation Center, Caregivers at both Centers and the family and/or relatives of rehabilitating patients.

Data Collection Procedure
The data collection was done through face-to-face, in-depth interviews by the researcher. A pilot study was conducted at Accra Remar Rehabilitation Center to test the appropriateness of the guiding questions of the interview guide. This pilot study exercise also served as a hands-on examination on exact framing of questions, whether they elicited the right responses, whether the questions were adequate or whether they contained any irrelevant items. In the end, the analysis of the pilot study revealed the need to include additional questions to the survey instrument. When participants who met the inclusion criteria were selected, the researcher then scheduled appointments for a one-on-one, in-depth interview with the participants at their earliest convenience. The interview lasted between sixty (60) and ninety (90) minutes and were audio-taped and recorded with respondents’ approval. Field notes were taken during each interview to conclude nonverbal signs. A semi-structured interview guide was used for the interviews and thereafter transcribed, coded and analyzed with the aid of ATLAS. Ti – a qualitative data analysis software for processing varied sets of or multi-objective data. All interviews conducted on the rehabilitants were done in Twi – a local Ghanaian language and English for the caregivers.

Data Analysis
All the recorded interviews were transcribed verbatim. Data analysis was done concurrently with data collection using the process of inductive thematic analysis. Owing to the fact that some of the parents of the patients recruited did not have regular appointments with the rehabilitation caregivers, the researcher had to make use of scheduled phone interviews to administer some survey instruments. Therefore, to check accuracy, the lead author (SFA) initially analyzed the data and the second author/supervisor (EKN) confirmed the findings to ensure that the respondents’ realities were truly represented.

Rigor/Trustworthiness of the study
Trustworthiness in a study is achieved through strategies that demonstrate credibility, transferability, dependability and confirmability (Patton, Guba & Lincoln, 2006). By achieving trustworthiness, the researcher demonstrated the quality of the research process. Member checks at the end of each interview were used to fully understand and correctly present the respondents’ stories to ensure credibility. For credibility, authors provided a detailed study methodology description which included procedure for recruitment, data collection and data analysis. To ensure confirmability, field notes detailing verbal and non-verbal cues recorded during the interview were used to corroborate the transcripts. The study provided the basis for its applicability in other contexts. Again, the study allowed for external judgments to be made about the consistency of its procedures and the neutrality of its findings (Patton, Guba & Lincoln, 2006; Guba & Lincoln, 1981)

Ethical Consideration
The researchers obtained ethical approval from the Committee on Human Research, Publications and Ethics (CHRPE) of the Kwame Nkrumah University of Science and Technology as well as the study centres. Verbal consent of the eligible study subjects were obtained before recording was done. The study subjects were assured of records confidentiality and the usage of codes to avoid identification. Conse-
Before they are accepted, we made sure they have self-will to stop the addiction habit. Then they are prepared psychologically to adjust to their environment” (CG1).

The study revealed that mostly, patients who were sent for rehabilitation were not triaged as a result of their worse condition on admission.

“Most of the clients we receive here come in a worst state. Some abscond from the psychiatric hospitals and rejoin their friends for drinking/smoking. Relatives may find them in a hide-out upon a tip-off before they are brought here. With such cases, we have no option than to admit” (CG2).

It was observed that, there was no screening or any assessment tools in both centers. One of the patients who came through a referral system also narrated his admission procedure.

“Before my discharge from the hospital, the psychiatrist called my parents that going for rehab would be the best for me. My parents obliged. So I was brought here 3 months ago. As soon as I entered, here, I was asked if I am willing to change, I said ‘yes’. They gave me a form to fill and offered me some form of advice and that’s when the procedure started” (C8).

Results

Demographic Characteristics
In this study, a total of twenty-eight (28) participants were included as follows: Eight (8) females and twenty (20) males ranging from the ages of twenty (20) to forty eight (48) years old. Five (5) had separated from their spouses because of the alcohol/drug dependency, seventeen (17) of the rehabilitants were single but all four (4) caregivers were in active marriage. The spouses of two (2) of the guardians or parents were outside the country.

Themes and Subthemes
The study found six (6) emerging themes which included Screening, Admission Comprehensive Assessment; Stabilization, Treatment and Support; Monitoring and review; Supervised withdrawal; Departure Planning and Community-based support program. These were basically the routine procedures adopted by both rehabilitation centers, though each had their own way of treatment procedures but almost followed the same path towards successful recovery of rehabilitants.

Screening, Admission and Comprehensive Assessment
This was the first protocol procedure for both rehabilitation centres. All the caregivers for this study gave account of how patients were admitted into each rehabilitation center. At Remar Center, counselling was firstly done since they did not have any health professional readily available all the time. Patient-turned counsellors gave account of how admission was done.

“The counselling is done at the main office before you are brought here. I just give you some advice and also take you through the rules and all the other activities that go on here. I even use myself as a satisfied client to give them the counselling.” (C1)

At Cheshire, the administrator also described the admission procedure in the following words:

“We believe that will be able to prevent relapse. If we follow that, the clients will be able to respond well to their treatment regimen, so they all go through the same treatment.” (CG3).

Whilst staff attitude counted, the patients also indicated that the medication served was purposively to stabilize them. One patient recounted his experience:
“The staff are good. I don’t have any issue with them. They give me injections sometimes but every day I swallow a drug” (C4).

“They give me oral drugs to swallow too, but I get a reaction from that which I don’t like at all. I feel sick when I take the drugs and I have reported to them. They say they will change it for me” (C8).

The study finding suggested that stabilization was usually the foremost step and that was followed by patients’ observation to determine what treatment should be administered. Patients in Remar Home were given periodic counselling sessions with “once a while” professional counsellors who visit them at their convenience, while in Cheshire, the counselling process was administered by the caregivers mostly. In both homes, the findings suggested that spiritual counselling from Rev. Ministers was also an accepted practice and some of the patients attested that they found it very helpful in their recovery process. It was also found out in this study that successful patients, after medication and counselling therapy, were taken through occupational therapy to keep them occupied and to rebuild or sharpen their skills in order to earn a living after discharge.

“We have occupational therapy and recreational therapy. These are the two main therapies we take them through to keep their minds active. These are the procedures that we use. We hardly give medications because, to us, it’s will-power and nothing else. While the occupational therapy helps them gain skills for their future, recreational therapy helps them to socialize” (CG2).

A 29-year-old male patient – turned counselor at Remar Rehab also stated this: “Eeeeemm, with the counseling, we take on that role ourselves. We counsel them on their condition and encourage them with their medication that will help them to get well.”

According to the respondents, most of them came in unsound and did not have insight into their conditions, and others were aggressive. So the first thing was to calm them down, so that they could respond to treatment on time.

“When they are calmed down then we take them through psychiatric interviews to assess their willingness to study. So, we give them medication as the first procedure then we engage them in recreational activities” (C3).

**Monitoring and Review**

We found that patients were usually under continual observation during their stay at the Centers. At one of the centres, it was noticed that patients were kept under very strict conditions with a well-fenced structure. This was to ensure that patients followed their medication and undertook all the therapeutic exercises and also did not find ways of getting access to alcohol.

“The treatment procedures that rehabilitants go through to rehabilitate these patients are activities, prayers and self-help discussions. The director also has one-on-one discussion with them on Sundays” (CG4). This, the study found commendable as some patients found it very helpful to their recovery, but others indicated that it was very frustrating and that the conditions were too harsh. Meanwhile, it was observed that rehabilitants at Remar had no fenced wall around their building, and they had no security personnel, thereby leaving them at risk by being attacked by invaders. However, patients who were committed to their course of finding help did not mind. “We don’t have a fence wall so our doors are always locked to keep us safe” (C6).

The study also found that the medications usually used for the rehabilitants here were the benzodiazepine family that typically produces a calming effect. Thiamine, which is a vitamin, was sometimes served.

“We give Vitamin B1 because alcohol dependents are at high risk for being deficient in that (Thiamin) and may put them at risk of Wernicke-Korsakoff syndrome” (CG2).

**Supervised Withdrawal**

Whilst a patient was recovering, it was observed that the patient could be sequentially and medically be withdrawn to less intense treatment methods. At Cheshire, rehabilitants were involved in self-help group activities, periodic counselling, detoxification and occupational therapy. Patients who were at this
stage are usually put in groups and given self-help sessions. The caregivers in both homes indicated that this was the practice.

“… during the admission procedure, we try to find the future plans that they have. They all have different pursuits: some want to work for themselves, others will want to go into formal employment; they all have different future plans. So, as I said, the first is the medical therapy and the last one we look at what you want to do in future, then we train you towards your vocational interest.” CG2.

Departure Planning
This is the stage where caregivers put measures in place to prevent a relapse. The findings indicated that departure planning in both homes leaves a lot to be desired.

“We make guardians and parents aware that their wards would not be institutionalized so definitely they would be discharged home when we see significant improvement”

Departure planning starts on the very day of admission of patients. At Remar, the response indicated that some patients absconded. When departure planning is not made an integral part of the treatment process, patients easily relapse into their previous condition as was the case with a lot of patients at both treatment centers. Most patients might have experienced rehabilitation process more than once. The following is an example to illustrate this point:

“I went to Remar Home in Accra before and now here am I” (C5).

Community-based Support Program
Having explained the meaning of relapse and established the predominance of relapse incidences, the researcher followed up to ask how patients are followed up after discharge.

“After discharge, we call to check on their progress from their parents or the one who brought them here” (CG2).

“Since the family took care of their needs almost all the time, we asked that community or the environment where they were living before the problem set in should be changed if possible. The one who is to monitor you in your new environment would be contacted” (CG3).

A lot can be inferred from the responses to the questions under this theme. First, the study findings indicated that residential support programs were lacking in the rehabilitation process. Rehabilitated patients usually have to rely on their family and friends who are almost always busy enough. In the cases where the community including family, friends, church members and acquaintances all lend their support, the person quickly got well-established and resumed a normal, well-balanced life. As indicated in the following responses, most of these patients belonged to certain social groups before the addiction took place: “My family and the church where I worship are very supportive; they pay me visits and also support me financially” (C8).

The reversal of a patient’s condition set in motion when they did not receive the needed support from their community, social groups, family or church members. In certain cases, this lack of support was because the family was simply fed up or that they were simply unaware of the intensity of his condition, or they did not know what kind of support was required of them. This was evidenced in the responses below:

“My family were not supportive, my mother was the one who even called in the police to arrest me, and they later brought me here although they pay for all my medications, I don’t feel loved” (C12).

However, one family member of a rehabilitant stated that they chose rehabilitation instead of alternative treatment because they saw it as the best way to get their ward out of addiction. “Friends were suggesting we sent him to a prayer camp because they believed he was under evil attack, but we declined and brought him here. I think it was a good decision we took because here, he is confined, given medication and being monitored too” (C3).

DISCUSSION
In the present research, our aim was to describe the major steps patients are taken through, towards successful recovery process in two major rehabilitation
centers in Ashanti Region. Studies have shown that there is a growing number of alcohol related mental health illnesses (MHIs) in the nation, and there is no standardization of the medical screening examination (MSE) in the emergency department as well as rehabilitation centers (Uhlenbrock et al, 2017). The study found that the first and foremost step to begin the rehabilitation process was screening. However, there was no specific tool for the screening but the caregivers within the centers had their own way of screening and assessing patients for admission. It was found that patients who were sent there in unstable conditions were not triaged but medications were prescribed and administered straight away. However, other studies have proved that a triage tool – specifically, known as Triage Algorithm for Psychiatric Screening (TAPS) for psychiatric chief complaints and cost effective – is needed for the emergency department and rehabilitation centers. (Uhlenbrock et al, 2017). Such a tool could be effective for assessment if it were available in these centers. Assessment was also observed to be done through counselling for patients who were rather stable. The aim was to investigate patients’ willingness for the detoxification and their efforts towards their successful recovery. It also aimed at reassuring them of professional assistance.

For stabilization, treatment and support, the study found that self-will played a major role on the part of the patients either to stay for treatment or walk away. As Miller & Rollnick (2013) suggested, self-efficacy is a person’s confidence in his or her ability to change a behaviour, such as a behaviour that risks one’s health. The researchers totally agree on this emphasis. In line with other studies, we agree with the fact that personal recovery is an individualized process through which people develop a positive identity and live a meaningful life, with symptoms of alcohol related mental illness (Ariss et al, 2019). Another study by Leamy, Bird, Le Boutillier et al, (2011) established the fact that recovery has been described as comprising five processes: connectedness with others; hope – giving a purpose to recovery and enabling the person to achieve it; identity – i.e., being aware that one is not defined by the illness, although it is a small part of one’s identity; finding meaning in life; and taking responsibility for recovery. The study also found that counselling given by successfully recovered patients to new or in-coming rehabilitants really served a source of motivation. Another study has emphasized that addressing patients by preferred names and pronouns is one way to help decrease potential psychosocial stress encountered during admission (Alastanos & Mullen, 2017). For prescribed medication, clinical staff indicated that thiamine and Vitamin B1 were normally prescribed for the patients to counteract any withdrawal symptoms. We found that some patients were on maintenance antipsychotic treatment.

Monitoring was observed to be done by clinical staff (caregivers). Various studies have found that psychiatric rehabilitation helps people with serious mental illness to have a better outcome for their daily living, work, learning, and social environments by designing customized, recovery-oriented rehabilitation plans based on their perceived difficulties, resources, needs for care, objectives, and preferred and valued roles. Evaluations in psychiatric rehabilitation are used to design individualized recovery-oriented intervention plans, and to assess their effectiveness on clinical and functional outcomes (Anthony & Farkas, 2012; Franck, Bon, Dekerle, Plasse et al, 2019). We found that patients were on regular monitoring because they were confined. Monitoring of progress of recovery was done in the form of written reports by the caregivers. Responding to needs is one of the key elements of high-quality care that facilitates recovery. Therefore, psychosocial rehabilitation interventions that focus on participants’ goals should be more effective than other types of intervention (Green, Perrin, Leo, et al., 2013; Sanches, van Busschbach, Michon, et al., 2018). Rehabilitants usually had to rely on their family and friends who are almost always busy enough, as nurses too were scanty or not available at all to follow-up after care. In addition, evidence showed that clients mandated to treatment tend to engage in a great deal of sustained talk, which is consistent with being in the pre-contemplation stage and predicts negative substance use treatment outcomes (Apodaca et al., 2014; Moyers et al, 2017). Other studies have declared that clinicians who work to help manage acute withdrawal in patients often do not have a large body of literature for research as to the best approaches for detoxification (Pergolizzi Jr et al, 2018). In line with our present findings on rehabilitation centers in Ghana, Adzrago
et al, (2018) reported that no rehabilitation physicians are at post in any rehabilitation centers in Ghana. The authors could attest to this fact. The study findings indicated that more health professionals and residential support programs are lacking in the rehabilitation process.

In supervised withdrawal and for many individuals with substance use disorders, the entry point for addiction treatment can be through withdrawal management (e.g. detoxification) services. Previous studies found that managing withdrawal symptoms is an important element of detoxification, but detoxification itself is not a final treatment for drug dependence, in that patients may relapse after detox (Vipler et al, 2018; Pergolizzi Jr et al, 2019). Our study confirmed that most patients were only able to access rehabilitation programs out of pocket. Moreover, the researchers agree with other authors on the recommendation that information must be collected regarding policies, health, disability, rehabilitation, social security systems, the need for rehabilitation, and the existing rehabilitation services and workforce (Gutenbrunner, Bickenbach, Melvin, Lains & Nugraha, 2018). Our study found that a lot of education to sensitize the public about healthy lifestyles was also lacking as occasional drinking was seen as normal. The researcher therefore agrees with Panebianco et al, (2016) that more extensive so-

On Community-Based Support program for rehabili- tants, research has found that one of the aims of the World Health Organization’s Global Disability Action Plan is to strengthen rehabilitation services (Gutenbrunner et al, 2018). The researchers were reliably informed that both rehabilitation centers did not receive any funding and were dependant on benevolent organizations for support. However, other studies have indicated that Community-based Rehabilitation (CBR) guidelines, with sufficient and sustained support, can assist in providing access to rehabilitation services, especially in less resourced settings with low resources for rehabilitation (Gilmore et al, 2017). The environment in which the patient was seeking to re-integrate into has the potential to assist his transition or exacerbate his condition. In the cases where the community, including family, friends, church members and acquaintances all lend their support, the person quickly gets well-established and resumes a normal, well-balanced life and it boosts self-esteem. In their findings about needs and unmet needs on rehabilitation services from eighty six articles, Kamenov, Mills, Chatterji & Cieza (2019) concluded that the main reasons for the unmet needs for rehabilitation were the absence of or unequal geographical distribution of services within a country, lack of transportation, and unaffordability of the services. Our study confirmed that most patients were only able to access rehabilitation programs out of pocket.
of integrated treatments available for rehabilitation of patients and their process of recovery. Inferring from the findings of this study, it is imperative that special attention must be given to the needs of each of the following groups when planning treatment services for rehabilitants in Ghana: Addicts without supportive family; Addicts with supportive family; Addicts recovering from their condition and Addicts who live in environments with easy access to substances. Moreover, the National Health Insurance Scheme should be expanded to cover rehabilitation services in Ghana to relieve families and care providers of financial constraint.

Conflict of Interest
The authors declare no conflict of interest in this study.

Acknowledgement
We are grateful to all patients and caregivers who participated in the study and to all authors whose works were used as references.

Funding
The study was sponsored by the African Union’s Nwalimmu Nyerere Scholarship fund for the corresponding author. The A.U had no further role in the study design; in the collection, analysis and interpretation of data; in the writing of the report; or in the decision to submit the paper for publication.
References


Abstract
The acquisition of quality clinical experience within a supportive and pedagogically regulated clinical learning environment is a major concern for both nurse educators and educational institutions. In nursing, the mastery of clinical skills is required to become a trained nurse. This study explored the undergraduate nursing students’ perceptions of clinical skills laboratory as a learning space in higher education in South Africa. A qualitative exploratory descriptive design was used. Thirty-two (32) undergraduate nursing students, eight from each year group, were recruited from a selected university in South Africa for four focus group discussions. Data collection happened between June and November 2016. A thematic content analysis was used to give a narrative account of the findings. Four themes emerged from the data which include privacy on feedback, knowledgeable and accessible personnel, scheduling for access, and time limitation. Most students indicated that the learning environment was technologically competent in assisting them to link theory to practice before going to the ward to work on real patients. Some students, however, noted that access to the clinical skills laboratory needed improvement. Adequately retooling the clinical skills laboratory with regards to human resource will facilitate learning in that environment and will improve the quality of practical training nursing students receive.

Keywords:
clinical skills laboratory; learning environment; nursing students
Introduction

The link between theory and practice during education is a central topic in a debate that takes a position in various disciplines. The notable contribution is by Arreciado Maranon and Isla Pera (2015) who contend that the education of university students is based on a pyramid of knowledge in which basic sciences take pride of place and clinical placements are relegated to the last stage of the ladder. Available literature (Rochmawati, Rahayu, & Kumara, 2014) in nursing suggests that this hierarchical distinction between theoretical knowledge and its practical application is evident, as clinical placements occur after knowledge has been acquired resulting from the assumption that it is in this setting that nursing students will learn to apply their acquired knowledge (Arreciado Maranon & Isla Pera, 2015). However, it is the combination of what is taught to students, what they will do or see in clinical placements, and what they will experience throughout their university education at the clinical sites that will create their idea of a professional nurse in their future practice (Bjork, Berntsen, Brynildsen, & Hestetun, 2014; Ellard et al., 2014; Flott & Linden, 2016).

Nursing education is a process that demands theoretical and practical learning and requires the acquisition of theoretical knowledge and skill (Hooven, 2015). However, literature search indicates few studies on students’ perceptions of the clinical skills laboratory as a learning environment (Wells & Dellinger, 2011).

A study by Serçekuş and Başkale (2016) on Nursing students’ perceptions about clinical learning environment with a purpose to research factors that affect the clinical learning environment was conducted. A qualitative approach was used with 36 nursing students recruited from a School of Nursing in Turkey. The findings indicate that students are negatively affected by communication errors and feedbacks given in the presence of their colleagues by clinical facilitators and that the constant presence of clinical facilitators may be the source of stress for some students in their practice environment. The finding revealed that peer support and favourable communication with peers have a positive impact on student clinical learning. Communication with hospital staff and clinical facilitators were found to be important. The study further revealed that student learning is affected by the level of confidence and support displayed by clinical facilitators.

The authors concluded that, in order to ensure the most favourable learning environment for students in the clinical area, it is essential that cooperation is increased between lecturers and clinical facilitators, instructor skills are developed, and students are supported in the clinical learning environment (Serçekuş & Başkale, 2016). This study gave a good conclusion. However, it failed to indicate what students’ views were regarding their clinical environment, equipment and availability of facilitators. This consequently leaves a gap requiring a study that will determine perceptions of students of the clinical skills laboratory learning environment.

Another study by Aktaş and Karabulut (2016) with the aim to explore nursing students’ perception of the clinical learning environment and its association with academic motivation and clinical decision making was conducted. The authors used a descriptive survey design with second-, third- and fourth-year undergraduate students (n = 222) in the Bachelor of Nursing Science degree.

The results indicate a statistically significant positive correlation between the clinical learning environment and the nursing students’ academic motivation (r = 0.182, p < .05). However, there was no correlation between the clinical learning environment and clinical decision-making (r = 0.082, p > .05). They found that nursing students’ academic motivation increased as the quality of their clinical learning environment improved. The study concluded that provision of a qualified clinical environment is prerequisite for the training of qualified nurses (Aktaş & Karabulut, 2016). This study looked at students’ perception but in association with the clinical motivation in Turkey. Therefore, a similar study in Africa on students’ views regarding their clinical practice environment was needed, which was the purpose of this study.

In Nepal, a study by Nepal et al. (2016) to assess Nepalese nursing students’ perceptions regarding the clinical learning environment and supervision was conducted. The study used the cross-sectional questionnaire design of both government and private hospitals in Nepal where the undergraduate nursing
college students undertook their clinical practice. Students with clinical practice experience were recruited from second to fourth years of the bachelor's nursing program (n = 350). The result indicated that students' practicum satisfaction level at government hospitals was significantly higher than those at private hospitals. Students undertaking their practicum in private hospitals evaluated their clinical placements significantly more negative than those in government hospitals (Nepal et al., 2016). They concluded that clinical learning environment is an important environment in nursing. Exploring and describing the students' perceptions are imperative. Nurse educators ought to bridge the gap between theory and practice. However, the literature search indicates a paucity of literature on undergraduate nurses' perception of the clinical learning environment as a learning space (Hickey, 2010, p. 35; Salamonson et al., 2015; Yeh, Huang, Chan, & Chang, 2016). There is, at least, evidence by Haraldseid, Friberg, and Aase (2015) that suggests that students are not satisfied with the type of practical training they receive from nurse educators. Haraldseid et al. (2015, p. 1) established that students perceived a discrepancy in the information that they received from clinical facilitators during training, giving them the impression that the faculty was unprepared. According to the participants in their study, the faculty was difficult to access and that although students desired more time to practice in the clinical skills laboratory, there was little opportunity for them to do so (Haraldseid et al., 2015).

Similarly, a study by Wellard, Solvoll, and Heggen (2009) revealed that students valued the ability to train in surroundings that resembled the environment of their future workplace, to depend on the knowledge that the settings will not differ substantially. Not being able to train in such surroundings often led to frustration and diminished satisfaction among the students (Wellard et al., 2009). The authors noted that students and staff emphasise the importance of creating an environment that resembles the practical nursing setting. In addition, Ringel et al. (2015) argued that students felt uncertain in the clinical skills laboratory when equipment was old, reused or unavailable (Ringel et al., 2015).

Literature searched revealed that, although there are studies on students' perception of their learning in the clinical environment globally, there is a dearth of evidence in Africa regarding this phenomenon. To investigate the views of nursing students is, therefore, important in order to generate knowledge and make necessary recommendations to improve practice in the clinical skills laboratories which is a key area in the training of nurses. What this study did differently was to add the first-year students so that data gathered on their perceptions will throw more light on the findings which were not the case in the sampling of Nepal et al. (2016) and Aktaş and Karabulut's (2016) studies.

**Design and Methods**

The study used the qualitative exploratory descriptive design. According to Grove, Burns, and Gray (2013, p. 237), a descriptive design is narrower in scope and can be complemented with an exploratory design that is able to provide a detailed and accurate picture of a phenomenon under study. An exploratory design was used to increase the knowledge of the field of study and was not intended for generalisation to large populations (Grove et al., 2013, p. 700). This was aimed at exploring the undergraduate nursing student perceptions of the clinical skills laboratory environment as a learning space as basis for confirmatory studies.

**Setting**

The study was conducted in the clinical skills laboratory of the College of Health Sciences, University of KwaZulu-Natal (UKZN), at the Howard College Campus. Howard College is one of the five campuses of the University of KwaZulu-Natal in Durban, South Africa.

**Population and Sampling Technique**

The population of the study was the undergraduate nursing students registered in UKZN. The UKZN accepts students from across South Africa as well as from other countries. When this study was conducted in 2016, 240 undergraduate nursing students were registered, which consisted of 78 first years, 62 second years, 63 third years, and 37 fourth year students.

Purposive sampling was used to select eight students from each year group to participate in the focus group discussions. Each year group (eight students) formed a focus group. The reason for selecting a sample was to attain a description that would pre-
cisely depict the features being studied and to have the opportunity to access detailed information from the population (Cohen, Manion, & Morrison, 2011). Purposive sampling was suitable for identifying and selecting information-rich cases related to the students’ perceptions of clinical skills laboratory environment as a learning space. It involved choosing the individuals with particular characteristics to serve as participants based on their continuous and regular presence in the clinical skills laboratory, and continuing that process until the required number for a focus group had been obtained (Cohen et al., 2011, p. 133). The purposive sampling was used because of its simplicity and popularity with qualitative studies (Creswell, 2013, p. 269).

Data collection tool and process
After ethical clearance from the University, a written permission was sought and granted from the registrar and the academic leader to sample the undergraduate nursing students for the study. Four focus groups were formed, one from each year group. A total of 32 students were recruited, eight in each year to form a separated group.

The Focus Group Discussion (FGD) took place in a cubicle at the clinical skills laboratory with the principal investigator and the research assistant. After signing the consent form and self-completion of their demographic data, the discussions were started. A semi-structured interview guide was used to guide the FGD with probes such as tell me more, what else can you add, in addition to how, why and what in order to make the answers clearer.

The discussions were audio recorded, which lasted between 60 and 90 minutes each, with each group arranging the time of the meeting at their convenience. The data collection process started from 15th June to 25th November 2016.

Data analysis
The analysis was done using thematic analysis principles. The first author transcribed the audio recording verbatim and saved it in the word document format. To avoid inaccuracies, the audio recordings were listened to repeatedly during transcription to facilitate completeness of the transcripts. After the transcription, the transcripts were coded, organised and integrated into emerging themes. This was done systematically and objectively with the assistance of NVIVO version 11.

These themes were discussed with the second author to ensure that each participant’s ideas were well captured without being biased.

Trustworthiness
Trustworthiness such as credibility, transferability, dependability, and confirmability were ensured (Cohen et al., 2011). Credibility was ensured by establishing and maintaining good rapport with the participants and building a trusting relationship. Participants were given adequate time for rich narration of the phenomenon. Transferability was ensured by providing thick description of the context, selection and characteristics of participants, data collection methods and analysis. Dependability was achieved by reading and scrutinizing the data to be sure they are just exactly what the participants narrated. Confirmability was ensured by member checking, audit trail and inter-coder processes.

Ethical considerations
Permission to conduct this study was given by the HSSREC of UKZN with reference number HSS/1383/016M. Full disclosure of the study was given to the participants and they all volunteered to participate through signing a consent form.

Results
Out of the 32 students, four were males and 28 were females. Five students were between the ages 21 and 25 years, while 27 were between the ages of 18 and 20 years. Participants were all single and had never been married. In addition, these participants were all Christians by religious affiliation.

The study findings revealed four themes namely privacy on feedback, knowledgeable and accessible personnel, scheduling for access, and time limitation. The findings under these themes indicated that participants believed the clinical skills laboratory is clean and conducive to learning. The participants mentioned items such as availability of computers to watch clinical videos which explain the procedures to them before practice. They considered it a good environment for learning as it is kept quiet and up to stan-
Knowledgeable and accessible personnel

The respondents indicated that as a self-directed learning space, which requires them to research for information about what they want to do before coming, the facilitators are available during practice to guide them. The students believe the facilitators are very knowledgeable;

‘The personnel here are great, they do help us but they torment us sometimes, ...I get happy when I am here because I learn’ (FYNS).

‘Knowledge-wise the facilitators are good…I think the facilitators are good and I have not seen any issues’ (FINALS)

The majority of the participants indicated that they were happy with the way the facilitators treat them because they are able to access any help in relation to their practice from the clinical skills facilitators.

Access and scheduling

Another theme that emerged was access and scheduling. Regarding access, the participants stated that there is access to the skills laboratory, as students are able to practise on their own and when they feel confident to be able to perform a procedure on their own, they ask to be assessed on that competency. The available equipment is accessible to the students, except where some equipment is in short supply because of the numbers of students.

‘The equipment is well-arranged and that makes it easier for students since they are labelled according to the procedures’ (FYNS).

‘With the accessibility of the equipment, I saw some issues there, some of the equipment is not readily available for us’ (SYNS).

Concerning scheduling, the findings revealed that students prefer to walk in to practise instead of booking. Participants noted that the online booking system was difficult and posed a challenge to students who stay at a location without internet connectivity. They blamed the channels of communication used in the skills laboratory, stating it makes the process cumbersome. A participant stated:
‘We understand this is not a hospital, but the booking, sometimes you book, and you do not get the response and you have to wait until the confirmation comes’ (TYNS).

Another issue that the analysis revealed was the disparity between the clinical skills laboratory environment and the hospital environment. The participants noted that the clinical skills laboratory environment lacked some logistics and that the interaction with patients, which is available in the hospitals, is absent in the clinical skills laboratory.

The participants also noted that apart from the aforementioned, disparities also existed in the way they access material for their practice. According to the students, all materials needed in clinical skills laboratory are arranged already and brought to them in a basket, whereas in the hospital they must go and look for it, based on what procedure they want to perform and their client's needs. They believe the arrangement of items in baskets for the students hampers their learning ability regarding how fast they can link the equipment needed in each procedure and this makes it difficult for them to identify instruments in the hospitals when they are sent to pick instruments during procedures. A final year student stated:

‘If we request, they bring what we want in a basket and I think it’s wrong. We must be allowed to go there to look for what we want because at the hospital, I was told to take some instrument I didn’t know what it was because I was always given a basket to practise… they should allow us to take the things ourselves so that we know what we need and not to be given to us’ (FINALS).

An interesting revelation was that as the first-year students were happy that items are arranged and given to them upon request, the final year students saw that as thwarting their ability to locate items on their own.

Time limitations
One key limitation all participants observed was the duration students were allowed to stay in the clinical skills laboratory to practise. They indicated that there is a 2-hour allocation for each student per day, which they considered as being inadequate, as there are not enough facilitators to attend to them on time.

Discussion
The findings show that participants had a positive perception regarding the learning environment of the clinical skills laboratory. They indicated that the environment is one of the best places for learning clinical skills. In addition, they felt that it was neat, well ventilated, friendly, conducive to learning and well arranged in such a way that it simulated the real clinical areas. They noted that the arrangement of beds and mannequins resembled the real hospital environment where real sick patients seek treatment. This finding confirms the study by Abdallah, Irani, Sailian, Gebran, and Rizk (2014) that clinical skills laboratory is designed to resemble a hospital ward to optimise the simulation of clinical learning situations. Besides the ordinary interior and layout of a patient’s room, toilets, medical supply room, etc., an auditorium in the clinical skills laboratory seats a good number of students for demonstration and reflection. They considered the clinical skills laboratory to be equipped with all necessary reusable, stationery and medical equipment. Single supplies, such as nasal cannulas, wound dressings and syringes, are distributed to each student in a free equipment kit at the beginning of the course. All these are made to simulate the hospital as much as possible (Abdallah et al., 2014).

The findings also indicate that most of the students agreed that clinical skills laboratory learning environment is relaxed during practice and that the atmosphere is conducive for teaching. According to some participants, the atmosphere in the clinical skills laboratory motivates them to learn. This finding suggests that students appreciated learning in the clinical skills laboratory and preferred to practice than to go for lectures because they believe it gives them the opportunity to develop their interpersonal skills in nursing. This is in line with another study that reported creating an authentic environment, facilitating motivation, and providing resources for multiple methods and repetitions within clinical skills training which are all important for improving clinical skills laboratory learning environment from the student’s perspective (Haraldseid et al., 2015).

Participants in this study noted that the learning environment is technologically competent and that the items students need are provided. They noted the availability of computers with internet connectivity.
ties that reflect the use of student-centered learning (Rochmawati et al., 2014). Similarly, Haraldseid et al. (2015) noted that the space in the clinical skills laboratory is designed to simulate the real clinical learning space and is defined as a practicum environment where students apply a theory to practice. Harmonising the clinical learning environment is therefore important for students to be able to achieve desired learning outcomes (Wells & Dellinger, 2011).

The findings suggested that there should be opportunities for the clinical facilitators, clinicians and other nurse educators to discuss matters relating to students' practice, specifically to reduce the discrepancies between practices taught in the clinical skills laboratory and what happens in the clinical settings. Each year group should be treated differently to accommodate each year group and their learning needs. However, recruiting only students is a limitation since clinical facilitators could have spoken regarding their views of the environment. Clinical facilitators were not interviewed; views from their perspective could have given a better understanding of the learning space.

Conclusion
While most students found the clinical skills laboratory to be a useful learning environment, its use would be improved by providing adequate human and material resources and ensuring that what is taught is in line with clinical practices in hospitals. To reduce the nuisance and embracement students might experience, equipment in the clinical skills laboratory should be based on current equipment in the hospitals as some equipment in the clinical skills laboratory is either very current or out of date, making a transition from clinical skills laboratory to the hospital difficult. For the learning space to simulate hospital environment, cell phones should be restricted in the environment since cell phones are restricted in the hospitals.

Conflict of Interest
The authors declare no conflict of interest.

Acknowledgements
The researcher would like to thank the University of KwaZulu-Natal for funding this study.
References


Requirements for renewal of license expanded

The Nursing and Midwifery Council is pleased to inform all Nurse Assistants, Nurses and Midwives that the requirements for renewal of license have been expanded to include accredited Continuous Professional Development (CPD) Programmes.

Renewal of license is currently based on accumulated CPD points and not solely on participating in workshops as was done previously.

All Nurse Assistants, Nurses and Midwives registered with the N&M are required to obtain minimum CPD credit points as follows:

The aim of introducing these CPD programmes are to ensure that Nurse Assistants, Nurses and Midwives remain up to date in knowledge in respect of changes in health patterns, standards of professional education and practice, health sector reforms and technological advances.

### Do you know you can:

- Participate in a journal club meeting which will earn you 1 point?
- Keep a monitored practice journal or reflective diary for 2 points?
- Facilitate a journal club meeting for 2 points?
- Review educational materials, journals, articles, books for 10 points?
- Publish journal, article, book chapter for 20 points?

<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Required CPD Points</th>
<th>Online CPD Points</th>
<th>Practicum</th>
</tr>
</thead>
</table>
| 1   | Nurse Assistants  
     a. CHN/NAP  
     b. EN/NAC | Fifteen (15) | 7 | 8 |
| 2   | a. Staff Nurses/Staff Midwives  
     b. Senior Staff Nurses/Midwives | Twenty (20)  
     Twenty-five (25) | 10  
     15 | 10  
     15 |
| 3   | a. Nursing/Midwifery Officers/Health Tutors  
     b. Senior Nursing/Midwifery Officers/Senior Health Tutors | Thirty (30) | 15 | 15 |
| 4   | a. Assistant Lecturers and above  
     b. Principal Health Tutors and above  
     c. Principal Nursing/Midwifery Officers and above  
     d. Nurse/Midwife Specialist and above | | | |

For more info:
Website: www.nmc.gov.gh  
Tel: 0501079037, 0200862772, 0302541423