**INTERNATIONAL JOURNAL OF INNOVATIVE RESEARCH IN MULTIDISCIPLINARY EDUCATION**
ISSN(print): 2833-4515, ISSN(online): 2833-4531
Volume 02 Issue 03 March 2023
DOI: 10.58806/ijirme.2023.v2i3n04
Page No.99-108

# I Can't Abandon My Father: Covid-19 and Lay Caregiving at the Crossroads in the Eastern Regional Hospital of Ghana.

Gladys Mawufemor Agbenyefia, (PhD) [1], Kodjo Senah (PhD) [2]
[1]SDA College of Education,P.O. Box AS 19,Asokore- Koforidua
[2]Department of Sociology,University of Ghana,P.O. Box LG 25, Legon

**ABSTRACT:** Lay caregivers play very important roles in the care of sick relations. This primordial support appears to be universal but manifests itself in different ways and circumstances. Ghanaian public health institutions, especially, depend very much on lay caregivers in the management of in-patients. However, with the emergence of Covid-19, and the fear of nosocomial infections one expects less involvement of lay caregivers; looms large. This fear has been heightened by the presence of the deadly corona virus pandemic.

In spite of the respectable volume of works on lay caregivers, there is dearth of literature on the factors that influence relations to provide care in the clinical set-up in spite of the care given by the professional cohort and the possible threats to health of lay caregivers. This is the classic case of a clash between health professionals and non-professionals in the performance of tasks with the same goal orientation: to assist the sick to get out of their sick role. This hospital ethnographic study which focused on the Koforidua Regional Hospital, explored the compelling socio-cultural factors that influence lay caregiving in the hospital environment. The study is especially relevant in the midst of the Covid-19 pandemic. The study involved interviews with patients in a medical ward, health professionals and lay caregivers in the regional hospital.

The study revealed that lay caregivers, among other reasons, are influenced by socio-cultural factors such as reciprocity and kinship moral obligations, and the perceived poor attitude of the health staff towards patients. Institutionally, although the medical staff found lay involvement unwelcome, shortage of staff, the severity of a patient's condition, and lack of certain facilities make lay involvement a 'tolerated nuisance.'

**KEYWORDS**: lay caregivers; hospital; professional staff, Covid 19

## INTRODUCTION

In recent times, the face of health care delivery globally has changed drastically due to the corona virus (covid 19) pandemic. Both the developed and developing countries have experienced the devastating nature of covid 19 in varying degrees. This pandemic which has been declared by the World Health Organisation (WHO) as air borne has called for stricter measures in the prevention and the spread of the virus. Ghana recorded her first-two cases of Covid 19 on the 12th March, 2020 which called for measures to restrict the movement of people in order to contain and manage the virus. Schools were closed down on the 16th of March, 2020 and lockdowns were imposed on some areas in the country. Different protocols were put in place including regular washing of hands under running water and physical distancing among others. In both developed and developing countries, the devastating nature of Covid-19 has called for restructuring of health care delivery systems to meet the needs of patients. Thus, hospitals where most Covid-19 patients are treated have adopted stringent protocols to save the lives of health professionals, patients and all who deal with the facilities. Evidence so far shows that due to the highly infectious nature of Covid-19, all who deal with hospitals in one way or the other are at higher risk of nosocomial or opportunistic infections including Covid-19. From two cases on 12th March, 2020, Ghana's cases rose up to 54, 771 by December 2020 and 130, 920 by November, 2021 with a total dead of 1, 239 https://www.statistics/1110892/coronavirus-cummulative-cases-in-ghana. Out of this national figure, the Eastern Regional Hospital (ERH) recorded 173 confirmed cases as at December, 2020 out of which 22 patients died. From January 2021 to November 2021, the hospital recorded a total of 942 confirmed cases out of which 84 passed on. This record shows that since the covid was confirmed in Ghana on the 12th of March, 2020 to November, 2021, the ERH recorded one thousand and a hundred and fifteen (1115) confirmed cases out of which one hundred and six (106) dead (Source: hospital records).

As Bohmig posits, in many jurisdictions, hospitals are generally seen and understood as religious spaces. The mentioning of a hospital assumes a space where science and data are the drivers of the medical process (concepts having pre-eminence) (Bohmig 2010:169). Similarly, Norwood describes the hospital space as an "insulation from the outside world" where religion has little focus

structurally and ideologically (Norwood 2006:8). To reiterate this Eurocentric understanding of the hospital, the WHO Expert Committee Report (1963) defines a hospital as: "… a residential establishment which provides short-term and long-term medical care consisting of observational, diagnostic, therapeutic and rehabilitative services for persons suffering or suspected to be suffering from a disease or injury and for parturients. The hospital may or may not also provide services for ambulatory patients on an out-patient basis".

However, in Ghana, the hospital is not an uncommon place to find the interplay between religion and social lives of its attendees-the patients. This is the case because the hospital evokes the fear of uncertainty and even death. People who visit the hospital with their health conditions, though expectant of a positive resolution to these health challenges, often too, are filled with uneasiness and anxieties because they are not certain whether their health will be restored through the application of the biomedical therapies administered by the health facility. This state of ambivalence which cripples the emotions and psychology of patients is often neglected by the management of health facilities or even through the application of the biomedical medications.

Due to this state of ambivalence, one category of people who have filled the lacuna in the health care delivery system since time immemorial are lay caregivers and one might have thought that; considering the highly infectious nature of covid 19, lay caregivers will back out from their usual care activities in the hospital for the fear of being infected but this is not the case. A visit by the researchers to the Eastern Regional Hospital during the covid 19 times did not show any difference between the activities of these lay caregivers years ago and what is happening today. Lay caregivers are still being actively involved in the care of their family members on admission in the wards of the hospital for various reasons.

Lay caregiving in a professional environment has become a necessity to family members and members of one's social network for the reason that ill-health is a fact of life; in its severe form, it is disruptive and exacts a heavy toll not only on the sick, but also on their social network. Every society, therefore, develops pragmatic ways of dealing with ill health - from its definition to perceived causation and prevention to therapy management (Senah, 1981). Other researchers have also indicated that the management of illness and therapy by a close kin is a central aspect of the medical scene in most Africa countries including Ghana as traditionally, those seriously ill were the charge of family members, friends and neighbours who played very important roles in their care either at home or the shrine, in the home of the traditional healer and spiritual healing centers (Agbenyefia, (2017); Akrong, 2009; Jansen,1978/1982;Sackey, 2009; Senah, 1981; Twumasi, 1975). The critical question addressed by this paper is: What motivates lay care givers to continue to offer their services to relatives on admission in hospital in spite of their knowledge of the existence of the pandemic?

**Family Caregivers in the Hospital**

Literature revealed several reasons why family caregivers are involved in providing care for family members even in the hospital environment. However, whereas [Tzeng & Yin (2011), Herath, (2014)], report that some lay caregivers and nurses call for lay involvement in health care delivery; Ugochukwu et al. (2013) see lay involvement in health care provisioning as a default rather than a design.

Senah, (1981); Wacharasin & Homchampa (2008) see family members' involvement as moral obligation, an expression of affection towards the sick and as a way of maintaining family values and preserving family dignity. Sapountzi-Krepia et al. (2008); and Stavrou et al. (2014) also report that family members believe their sick relatives are safe in the hospital under their watch. They indicate that their presence at the hospital makes them keep an eye on the patient, monitoring changes in their conditions and assisting in care which make them have the assurance that their sick relative is safe in an unfamiliar environment. To Remen (2006), family involvement in bedside inpatient care is increasingly being emphasized as a means to provide safer and error-free bedside care in hospitals. Similarly, Doherty and Mendenhall (2006) indicate that the calls for patients and families to become active participators in health care is on the increase as patients and families are believed to have wisdom that is not "medical" or "technical", but still, is as equally important as that of health-care providers. The services of these lay caregivers are considered very useful in rendering quality health care.

A study conducted by Tzeng and Yin (2008a) in a Taiwanese hospital revealed that lay caregivers see caring for their loved ones as being one of their responsibilities, showing filial piety for their parent, and being afraid that the patient could not obtain appropriate care among others. Similarly, Hasselkus (1992), indicates that in the medical setting, the family caregiver serves as the primary resource to the physician for historical information about the patient and is very useful even when the patient was cognitively impaired or *not* cognitively impaired. The caregiver therefore becomes more useful by providing additional information considered useful for the physician. In addition, Lavdaniti et al. (2011) indicate that in Greek hospitals, even though the nursing staff assists patients, the provision of care by informal caregivers is a common phenomenon because the family has a central role in maintaining the health status of its members and providing informal health care is critical in helping its members to manage illness as well as in assisting in the recovery and rehabilitation process. Family caregivers are also useful in the provision of feedback to evaluate treatment effectiveness, medication management and follow-up with doctor appointments.

Additionally, Ugochukwo et al. (2013), add that even though it is recognized that the family plays a role in the care of ill family members around the world, in many low-resourced sub-Saharan African countries, care in hospitals, including food and medication, is supplied by the family and a family member stays with the patient most of the time. These family members also render certain key services which are supposed to be the preserve of the health professionals to their sick loved ones. To them, this may be by default rather than design. It could be deduced that whereas lay caregiving in some countries is a choice, in some sub-Sahara African countries it is compulsory or a must.

**Theoretical Orientation**

The intersection of familial/cultural and professional healthcare delivery points to two main theoretical issues in this paper. From the Foucauldian perspective, the hospital and its wards can be described as a 'heterotopia', a relatively segregated place in which several spatial settings co-exist (27). Within this space, different practices and power structures interconnect: caring practices, therapeutic practices, family and cultural practices, dying practices, and research practices. The intersection of various lines of interest, identity, unequal authority, and activity results in a co-existence of a multitude of spatial arrangements: a sterile space, a treatment zone, a place of caring, a place where mothers meet their babies, and a place where their babies die or survive. Many people are involved in this setting: doctors, nurses, administrators, patients, and families, who subscribe to a set of cultural norms and base their expectations and decisions on a mixture of professional information, traditional knowledge, and individual background(28–30). While frontline staff are responsible for delivering professional patient care and must determine how to incorporate infection control interventions within their daily practice, awareness of the risk posed by themselves is critical in influencing their actions.

The Social Exchange and Cultural Care provide a strong analytical tool for appreciating Lay Caregivers (LCs) involvement in professional health care delivery. The social exchange theory describes the various reasons and forms of exchange that take place within the social system. It must be noted that in this study, exchange does not only take place between the sick and the family caregivers but also between the professional and family caregivers.

According to Mauss (1990), early exchange systems center around the obligations to give, to receive, and, most importantly, to reciprocate. They occur between groups, not only individuals, and they are a crucial part of life that work to build not just wealth and alliances but social solidarity. The social exchange theorists also believe that social behaviour is influenced by the rational calculation of an exchange of rewards and costs (George Homans, John Thibaut, Harold Kelley and Peter Blau). They explained that people will engage in an action that will bring them more benefits than cost. Cropanzano and Mitchell (2005: 876-7) further indicate that, an exchange relationship is influenced greatly by rules of reciprocity.

Similarly, the cultural care theory indicates that cultural and social structure factors of health consumers are important in understanding caring or health-seeking behaviours (Leininger's 1991b). These social structure factors which greatly influence clients' health seeking behaviour include "religion (spirituality), kinship (social ties), politics, legal issues, education, economics, technology, political factors, philosophy of life and cultural beliefs and values with gender and class differences". To Myrdal, (1968) health has both intrinsic and instrumental value which is desired for its own sake and more importantly it also forms the wheel around which a society's progress and survival revolve. Therefore, the desire to keep members healthy is of a great concern not only to the family, but also to the members of their social network and the society at large. Lay caregivers therefore found it morally obligatory and culturally appropriate to provide care for their relatives on admission in the hospital to enhance social solidarity among them.

**Methodological Approach to the Study**

This paper is derived from my PhD thesis that examined the role of lay caregivers in therapy management in the Eastern Regional Hospital in Koforidua. The data were collected before and during the Covid 19 pandemic. The qualitative exploratory case study design was employed to understand the factors that motivate lay caregivers. The researchers found this research design most appropriate because our main goal is not to generalize about the phenomenon under study but to derive an in-depth understanding of the socio-cultural and institutional factors influencing lay caregivers to provide care within a highly-professional work environment. According to Creswell, (2014), qualitative inquiry typically focuses on relatively small samples selected purposefully and unique cases which are informative. This makes the qualitative design most appropriate.

The study was carried out in the adult medical ward of the of the hospital because the patients there can communicate with understanding and also be able to provide the information needed for the study. Relatives and non-relatives of patients on admission who spent three or more days at the hospital and health professionals who spent at least two years at the hospital constitute the population for the study. Data was collected using multiple approaches such as observation, key informant interviews, individual in-depth interviews and focus group discussions. Even though the population under study is not hard to reach, the researchers employed the snowball sampling technique in recruiting participants purposefully. This is due to the fact that there were more lay caregivers in the hospital who cared for patients in other wards who were not of interest to the researchers. Since the population

was those in the medical wards (male/female) and those who care for their relatives in the same ward know each other, the snowball sampling was considered most appropriate as one caregiver led the researchers to other caregivers in the medical wards.
A total of forty (40) participants were sampled for the individual in-depth interviews made up of thirty-two (32) lay caregivers and eight (8) health professionals. Two focus groups made up of six (6) and eight (8) discussants respectively were also sampled for the study. The semi-structured interview guide and digital audio recorder were used to collect data from all participants. All data collected was managed systematically and analysed using Nvivo Pro 11.

## RESULTS

The factors influencing lay caregiving in the hospital are multifaceted. However, from the data collected, these factors could be put into three main groups. These are socio-cultural, institutional and professional and non-professional conflict factors.

### Socio-Cultural Factors

Socio-culturally, carers provide care for various reasons. This is due to the fact that some socio-cultural norms enjoin us to provide care for the sick. Also, it is believed that caring is a vital tool in curing. Caring as a moral obligation, caring for reciprocity and caring as a tradition are the main socio-cultural factors influencing lay caregivers to provide care even during covid.
Majority of the participants in the individual interview identified caring as a moral obligation towards the sick. This assertion was confirmed by some discussants of the FGDs. For some participants, the relationship that exists between them and the patient makes it imperative to fulfill this moral obligation to care for the hospitalised sick. This relationship is influenced by some commitment towards each other. A statement made by a middle-aged woman speaks volumes of how kinship ties with its associated primordial rules play important roles in our commitment towards one another. Even though the woman lost her sister the day this data was collected, this is what she said: *"I would have been ashamed of myself and the guilty of not caring for my sister would haunt me the rest of my life if I had refused caring for her for the fear of contracting covid. Even though she is gone, I am a self-fulfilled person for caring for my sister two weeks before her journey to her maker"*. Similarly, another carer added *"I am here to care for my father. He brought me into this world and I can't abandon him for fear of covid. If I come back and found him dead, who should I ask?"*.
Friendship networks are also found very useful in providing care for the sick on admission in the absence of close kinsmen. This was the case of Dela, a student of Koforidua Technical University who considered caring for her friend morally obligatory because her friend's relatives were not around. She indicated: *"I am caring for my friend because we are in school and her family members are not here. Everyone is afraid of the other because of covid and it is only people who are close to you can assist you during this covid times. Even the health professionals are afraid and will not do everything for the patient"*.

The age of the patient was considered as the basic moral justification for caring in the hospital. According to these caregivers, it is morally wrong to leave the elderly sick (60 years and above) in the hands of people who are not related to care for them. The LCs indicated that the illing aged are already weak and need constant attention which the professional health care providers cannot provide due to their heavy workload schedule. Leaving such a person without a regular family caregiver will be morally wrong. As Parsons' sick role theory states, the sick must avoid obligations which may worsen his/her condition. This is what a 53- year-old woman caring for her mother has to say: *"With her age, I feel it is my responsibility to care for her because the nurses do not come here often. Whether she eats or not I have to do everything"*

Other minor factors influencing the moral obligation included but not limited to the proximity of LC to the sick, financial status of the LC, the order of birth/age of LC and the sex of both the sick and LC. According to LCs, the person closer to the sick in terms of geographical location finds it morally obligatory to care for the sick. This assertion was justified by the fact that availability is the best resource. Some LCs also indicated that the individual who is financially sound in the family should find it as his /her moral obligation to care for the sick. As two LCs indicated, they were providing the support for the sick because they have money and can easily meet the needs of the inpatient. One stated 'how can I sit at home and let my sister come? If the doctors prescribe a medicine, how will she get money to buy it?' In support of this claim, other LCs intimated that they were providing only physical care but financial care was provided by the most financially sound relative in the family.

Concerning order of birth/age of LC and sex of the sick, some LCs stated that customary norms enjoin the elder child or the elderly person in the family to take up care responsibility of the sick. This is based on the belief that this individual is experienced enough or may be psychologically matured enough to go the stress of caring for the sick even in the hospital environment. This assertion was confirmed by a 58-year-old woman taking of her father. She states '*I'm the eldest, that's why I've left my job to come here. So that whatever happens, people will know that I've done my part'.* Even though Blum & Sherman, (2010); Oliver et al., (2013); and Wacharasin & Homchampa, (2008) indicated that informal caregivers are mostly relatives and caring predominately a female task, some LCs indicated that the sex of the sick is important in considering who cares for him/her. This therefore lays obligation on people of the same sex with the sick to take up the care responsibility. This implies that if a female is sick, a female should provide

care and the vice versa. Even though is true in some cases, it was found that some LCs were caring for patients of the opposite sex but majority of the carers were females (Agbenyefia, 2017).

According to Marcel Mauss (1990), exchange occur between groups, as well as individuals, and they are an essential part of life that work in building not just alliances and wealth but social solidarity as well. This exchange is centered not only around giving and receiving but most importantly reciprocating what have been received. Reciprocity was expressed in different forms by lay caregivers during data collection. To some LCs, the patient on admission has done something good for them and in return they want to reciprocate by providing care in this crucial moment of their lives. Reciprocity as a moral value is seen in expressions in most of the Ghanaian languages and has greatly influenced LCs. "*According to my mother she suffered before giving birth to me, and I have been through a lot with her in life. If she is sick today and I can't stay with her for a moment, God will punish me. I could remember that I was sick for two years, I became I cripple and at the same time couldn't do anything and my sick bed was a hell. Later I was discharged from the hospital because they thought I will not survive so nobody dreamt that I could survive. The way my mother suffered just to give me life, I can't just stay at home without caring for her"*. (LC18, A 38-year-old daughter)

There is a saying in Akan (a Ghanaian language) which states 'amamre yen sisa' which literally means 'tradition cannot be changed' explains the behaviour of some caregivers. This tradition which makes it obligatory for family members to be responsible for the care of a sick member has also be expressed by Twumasi (1975) that it is the responsibility of family members to take care of their sick loved ones until the persons is healed or passes on and failure to do that by family members is a reproach to the whole family. Wacharasin & Homchampa, (2008) also indicated that, lay caregiving helps to maintain family values and preserve family dignity. Other studies carried out by Akrong (2009) of Ghana, Jansen, (1982) of Central Africa and Machinga, (2011) of Zimbabwe] also emphasised the traditional colour attached to caring. This an unwritten moral code of conduct since antiquity was one of the socio-cultural factors influencing LCs. This ideology has been reinforced by lack of social support services that care for the aged and provide social security for the needy. A 54-year old mother states *'our tradition demands that when someone is sick, a very close relation stay with the patient and takes caree of him or her. As a parent I have to start caring for my daughter before the other family members comes in to assist'.*

**Institutional Factors**

These factors refer to the conditions that are present in or absent from or are imagined to be present or absent from the hospital environment which negatively influence the provision of quality health care for in-patients. Shortage of staff, attitude of health professionals and inadequate supply of logistics were the three major factors identified during the data collection.

Shortage of staff or inadequate staffing has been recorded globally in literature, Quaicoe-Duho (2015), Oulton (2006) as one of the many factors giving room for lay caregivers involvement in professional health care delivery even at the hospital. Lay caregivers and professional health care providers all confirmed that the Eastern Regional Hospital is operating with inadequate staff rendering it incapable to provide quality care for in-patient without the assistance or complementing roles of the LCs. In a response to the question 'why do you still have family members caring for their relatives even during Covid?,' this is what one of the Ward Matron said *'as for this people (lay caregivers), we cannot do without them. With our number, we need them to assist in providing the personal care needs for their relatives while the few professional staff around see to the medical needs'*. Similarly, an LC added that if they are not around to assist the nurses, their relatives would not get the best care because the number of patients on the wards are more than the staff can properly handle.

The negative attitude of some healthcare providers has also influenced LCs to continuously stay in the hospital once a relative is admitted to the hospital. Even though some LCs praised some of the health professionals for their good work, the fact remains that the attitude of some nurses compelled some LCs to provide care for their loved ones on admission. According to these LCs, some HPs do not pay proper attention to patients and have developed apathy towards the work they do. They indicated that, some HPs do not monitor infusions fixed on the patient. Sometimes, infusions get finished and if a relative is not around to call a nurse, the patient, especially the immobile ones are left unattended. The expression made by a 54year old mother summarises the views of the majority of the LCs: '*I have seen a lot. There are some patients who are suffering and if they had attended to them earlier, some might have survived. If a patient does not have a relative who will call the nurses out of passion or put pressure on them, they will not attend to him. If he is there alone and something is happening to him, the nurses will not have that passion for him and attend to him quickly…. for this hospital if somebody is sick it is important that a relative comes to stay with him. The person will have 'ayemshehse' (passion) for the sick, but if you leave the person in the hands of nurses alone it will not help. You could see that somebody is falling down and a nurse should have supported that patient but some will not do but rather shut at the sick and he will fall. In fact, the nurses are doing their work but they should try and give off their best. Sometimes some patients wouldn't have died but due to petty petty faults, they died'*. Some LCs also expressed their views on the apathy that the current crop of nurses exhibit in the work environment. They complained that the HPs are more money conscious than having the well- being of the patients at heart.

Some however indicated that if you are able to open your hands to the HPs, you are sure your patient will be well attended to even in your absence. They therefore suggested proper screening should be done during selection interviews so that people do not enter the profession due to its perceived monetary rewards.

Inadequate logistics was identified as the third major institutional factor creating room for lay caregivers' involvement in professional health care delivery. The logistics are not only in short supply but some are also obsolete and cannot be used in modern medical diagnosis. With advancement in technology, modern medicine depends greatly on technology to do a near perfect diagnosis for better treatment of patients. However, the Eastern Regional Hospital like other secondary hospitals in Ghana lack these equipment and tools as a result, medical officers would have to refer their patients to private laboratories in town to access some of these vital services. The question we have to answer here is that without the lay caregivers, who assist the sick to access these services outside the hospital, the nurse or the doctor? Some HPs also complained of inadequate supply of basic working tools such as fridges for storing drugs, lack of personal protection equipment, modern thermometer, pulse oximeters, urine dipsticks, rapid diagnosis test, infusion pumps and modern BP apparatus among others. Apart from inadequate tools and equipment, doctors prescribe certain medications that are not in stock at the hospital and LCs would have to go to town and purchase these medicines for their family members. The absence of a lay caregiver to respond quickly to such a request or even his or her inability to buy the prescribed drug when needed has implications on the patient. This makes the LCs an important if not indispensable component in achieving a holistic and quality health care provisioning.

**Professional and Non-Professional Conflict Factor**

The study found that generally, both doctors and nurses found lay involvement in health care giving unacceptable. However, as one Ward Matron observed: *In our circumstance, what can we do without assistance from patients' relatives?* Despite this positive statement the Ward Matron made about the usefulness of lay caregivers, the LCs on the other hand complained bitterly about the inhumane treatment meted out to them by some workers. Some LCs complained that they are treated with disdain however, they invite them to assist in caring for the patient. One of them indicated "*they sack us like dogs from the wards especially when the doctors are coming on ward rounds but when the patient soiled himself or herself, they invite us to come and attend to the patient. If they do not see our usefulness, why not provide all the care needs of the patients in their care"?* This situation which we can ironically describes as "we don't want you but we need your services" has actually made room for easy penetration of non-professional into the professional work environment. The study further revealed that nurses, even though not happy about LCs intrusion in their outfit, find their presence more beneficial than doctors. This is explained by the fact that nurses do more of the care work in the wards and find the LCs' services as a relief from the nasty part of their work and would therefore suggest policies are made to make LCs very integral component of the health care delivery system. Furthermore, the logicality of the illogical situation is manifested in a 'visitors' hostel' situated on the hospital compound and run by the hospital administration. The ERH has a visitors' hostel put up by the management of the hospital for relatives who wish to stay in the hospital to assist in caring for their loved ones. The question then is 'if the HPs find the involvement of the LCs in care delivery unacceptable, why create the opportunity to make them feel welcome and comfortable? Apart from the hostel which facilitates lay caregiving, management has also made an identification card with the label 'patients' relative' which is given out to the lay caregiver enabling the individual to get easy entry to the ward to care for the patient. In a response to what the hospital management has done differently during this covid period to reduce the spread in the hospital as far as lay caregiving is concerned, the Ward Matron explained '*this time round we have strictly limited the patients' relative to only one regular person.*

**Other Factors Influencing Lay Caregiving**

The study revealed other factors motivating lay caregiving. These include but not limited to severity of patient's condition, the need to report patient's condition periodically to HPs (instead of nurses doing the time-and-motion care) and the burden of guilt feeling should the relative (patient) die without support.

Some patients were admitted on severe health conditions. While some could not either walk at all or without help, others were bedridden or unconscious. Their condition therefore made them to rely on family members or friends for the provision of some personal care needs which some health professionals are not ready to provide. Similarly, in some cultures, it is unacceptable to allow a stranger to see the nakedness of a family member. Lay caregivers therefore indicated that their relatives' inability to perform their personal care needs made them to support them because they do not believe the HPs will take proper care of their loved ones.

As indicated earlier, some patients were unconscious therefore could not explain their conditions to the doctors or nurses when they come on their routine rounds. Lay caregivers therefore provide regular and timely information on the health conditions of their loved ones. Some LCs indicated that since HPs work on shift basis, if they do not keep proper records on what happens to the patients from time to time, vital information which could have helped in further diagnosis may be missing. One of them expressed this "I am with my husband all the time so if there is any change in his behaviour, I will draw the attention of the nurses when they come.

Sometimes, when he is given medication, he vomits and at other times, he refuses to eat. I take record of all these and when the doctors come, I inform them. If I leave him in the hands of a nurse who is on the night shift and she did not record these happenings, how will the doctor know about them when he comes in the morning? We pay proper attention to everything that happens to the patients because we have only one patient unlike the nurses who have many patients to attend to and therefore do not care so much about them"

It is believed that caring can occur without curing but curing cannot occur without caring. The burden of guilt feeling should the relative (patient) die without support therefor came out strongly as one of the factors influencing lay caregiving in the hospital. Lay caregivers believe that the patient may die whether they provide support or not. However, they will feel very 'bad' if they fail to provide support before the patient dies. To some LCs caring gives the patient the assurance that the family care about them and this can even facilitate healing and prolong their lives. One LC had this to say 'I am giving my best to my mom so even when she dies, I know I have done my best. However, if she should die without my support the guilt feeling will live with me my lifetime. I will ask myself if my mom could have lived longer if I had assisted her. Even when I cry at her funeral, the guilt of not giving her my best will be with me. My conscience will judge me'.

**Types of Care/Support Provided**

Reblin and Uchino (2008) and Frohlich (2014) report that social support whatever form it takes has a positive impact on health outcomes emotionally and socially. Foa and Foa (1980) also indicate that man's resources could be put into socio-emotional and economic and while economic ones are tangible and are often financial, socio-economic ones deal with social and self-esteem needs of the person and also expresses how valuable a person is. They further indicate that these needs are very essential for the recovery of the sick. Lay caregivers provide different forms of care to their loved ones on admission. These can be put into three major groups: physical, emotional and financial.

The physical care provided are personal care needs which the patients could not perform themselves due to their ill-health conditions. Physically, LCs provide care in a form of feeding, bathing, turning the patient in bed and washing of their clothing. Other studies carried out have shown that family members provide most if not all the physical care needs of the patient (Stavrou et al., 2014). Food is also provided by family members since most of the patients do not eat food provided by the hospital since it does not meet the patients' tastes and mostly not served on time. Lay caregivers also provide emotional care for their loved ones. They indicated that they engage the patient in conversation which relieves him/her from thinking about the ill-health condition. Others also intimated that their mere presence in the hospital gives the assurance to the sick that he or she is thought of and it is refreshing enough to aid healing. In relation to this assertion, Mattson (2011) indicates that social support can lead to improvement in several areas of health and wellbeing and communications that help people cope with a situation makes people feel better about themselves. As ill-health takes the sick from his or her regular sources of income especially those in the informal sector of the economy, financial assistance from family members cannot be ruled out of the numerous cares these lay caregivers provide for the sick (Sackey, 2009). Provision of financial support was therefore considered as a moral obligation since treatment could not be given the patient without money being paid for some of the services. In summary, Danielson et al (1993:16) indicate that the family influences recovery in so many ways: by the medical care it can afford, by the caregiving functions it serves and by the support it gives ill members. They argue that "the health-care provider who recognises the influence of the family will have a powerful ally in healing

The factors influencing lay caregiving and the form of support given are graphically represented in figure 1 below.

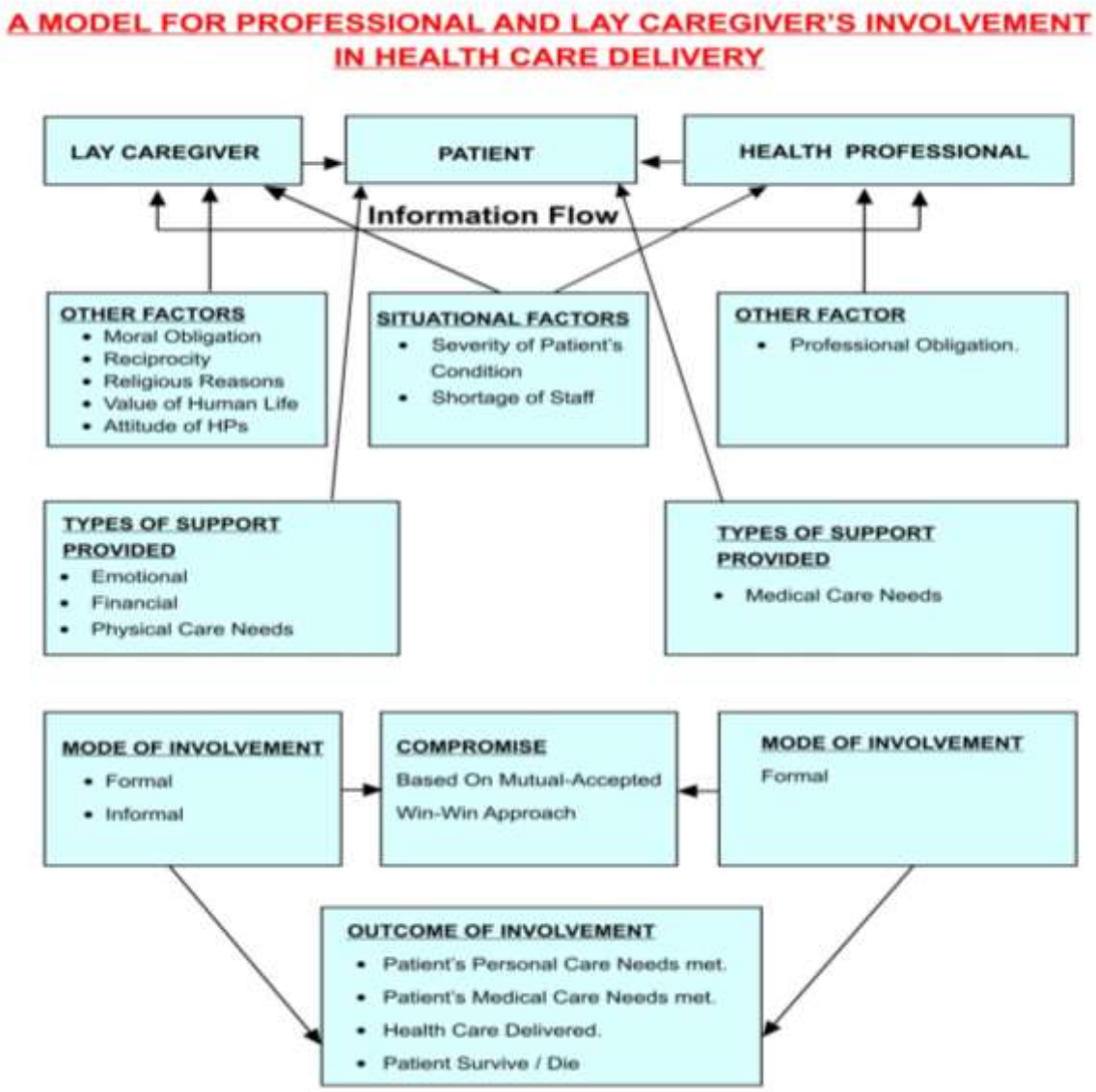


**Figure 1. A Conceptual Model for Lay Caregiver's Involvement in Professional Health Care Delivery**
**Source**: Authors Own Construct Per the Findings of the Study

## CONCLUSION AND RECOMMENDATIONS

In a Covid-19 era when the non-sick must be protected from Covid and other nosocomial infections, this study articulates not only the relational dynamics between health professionals and non-professionals in a non-Western health care setting but also an uninvestigated medium of Covid spread. The concerns of the daughter who cannot abandon her father in a hospital in spite of professional care available and in the face of known health risks are relevant for understanding culture and health care and for enhancing hospitals protocols against Covid-19. Furthermore, it noted from the study that lay caregivers' involvement in professional health care delivery is rooted in social exchange. This exchange is influenced by the culture of the people and the perceived reward to be received at the end of such actions. Societal norms such as rules of reciprocity and moral obligations influence lay caregivers greatly.

It is recommended that the Ministry of Health in conjunction with the Ghana Health Service should formulate policies that create room for lay caregivers' involvement in provision of care for in-patients at the hospital. There is also the need for government to recruit more health personnel to reduce the workload on the few working in the wards. Work overload which leads to fatigue has resulted in negligence of duty by some health professionals and fostered lay involvement in the provision of health care to in-patients. Finally, logistics such as modern BP apparatus, sophisticated laboratory and x'ray equipment and adequate drugs should be supplied to the hospitals to make professional work very effective.

**REFERENCES**


1) Assimeng, J.M. (1999). *Social Structure of Ghana: A Study in Persistence and Change*. Tema [Ghana: Ghana Pub. Corp]
2) Agbenyefia, G. (2017). *The Interface Between the Health Professionals and Lay Caregivers At The Koforidua Central Hospital in The Eastern Region of Ghana*. Link: ugspace.ug.edu.gh/handle/123456789/26850
3) Akrong, A. (2009). Spiritual healing and Care in African Indigenous Churches. In C. Oppong, P. Antwi & K. Waerness (Eds.), *Care of the Seriously Sick and Dying. Perspectives from Ghana* (pp. 92-113). Noway: Unifob Global.
4) Blum, K., & Sherman, D. W. (2010). Understanding the Experience of Caregivers: A Focus on Transitions. *Seminars in Oncology Nursing, 26*(4), 243-258. doi: http://dx.doi.org/10.1016/j.soncn.2010.08.005
5) Bohmig, C. (2010). Ghanaian Nurses at a Crossroads: Managing Expectations on a Medical Ward. Leiden, African Studies Center, ISBN 9789054480938
6) Creswell, J. W. (2014). *Research Design*. Los Angeles, CA: Sage.
7) Cropanzano, R., & Mitchell, M. S. (2005). Social exchange theory: An interdisciplinary review. *Journal of management, 31*(6), 874-900.
8) Danielson carol B, Brenda, H.-B., & Patricia, W.-F. (1993). *Families, health & illness: perspectives on coping and interventions* USA: Mosby-Year Book Inc.
9) Doherty, W. J., & Mendenhall, T. J. (2006). Citizen health care: A model for engaging patients, families, and communities as coproducers of health. *Families, Systems, & Health, 24*(3), 251.
10) Foa, E. B., & Foa, U. G. (1980). Resource theory *Social exchange* (pp. 77-94): Springer.
11) Frohlich, D. O. (2014). The social support model for people with chronic health conditions: A proposal for future research. Social Theory & Health, 12(2), 218-234.
12) Foucault M. (2002). *The birth of the clinic*. Routledge;
13) Hasselkus, B. R. (1992). Physician and family caregiver in the medical setting: Negotiation of care? *Journal of Aging Studies, 6*(1), 67-80.
14) Herath, C. (2014). Study on factors leading to re-hospitalization and the care provided. *International Journal of Psychology and Counselling, 6*(2), 18-21.
15) Janzen, J. M. (1978/1982). *The Quest for Therapy: Medical Pluralism in Lower Zaire*. London, England: University of Califonia Press Ltd.
16) Lavdaniti, M., Raftopoulos, V., Sgantzos, M., Psychogiou, M., Areti, T., Georgiadou, C., . . . Sapountzi-Krepia, D. (2011). In-hospital informal caregivers' needs as perceived by themselves and by the nursing staff in Northern Greece: A descriptive study. *BMC nursing, 10*(1), 19.
17) Leininger, M. M. (1991b). Selected culture care findings of diverse cultures using culture care theory and ethnomethods. *NLN publications*(15-2402), 345-371.
18) Machinga, M. (2011). Religion, health and healing in the Traditional Shona Culure of Zimbabwe. *Practical Matters, 4*, 1-8.
19) Mattson, H. (2011). Linking Health Communication with Social Support *Mattson's Health as Communication Nexus*: Kendall Hunt Publishing Co.
20) Mauss, M. (1990). *The Gift: The Form of Exchange and Reason for Exchange in Archaic Societies*, Routledge, New York
21) Myrdal, G. (1968). *Asian Drama: An Inquiry in the Poverty of Nations*. NY: Pantheon Press.
22) Oliver, D. P., Wittenberg-Lyles, E., Washington, K., Kruse, R. L., Albright, D. L., Baldwin, P. K., . . . Demiris, G. (2013). Hospice Caregivers' Experiences With Pain Management: "I'm Not a Doctor, and I Don't Know if I Helped Her Go Faster or Slower". *Journal of Pain and Symptom Management, 46*(6), 846-858. doi: http://dx.doi.org/10.1016/j.jpainsymman.2013.02.011
23) Oulton, J. A. (2006). The global nursing shortage: an overview of issues and actions. *Policy, Politics, & Nursing Practice, 7*(3_suppl), 34S-39S.
24) Quaicoe-Duho, R. (2015). Ghana reports general improvement in doctor ratio Retrieved 14 June, 2017, from http://www.graphic.com.gh/news/health/ghana-reports-general-improvement-in-doctor-ratio.html
25) Remen, R. (2006). Including your patients in a culture of safety. In M. McGreevey (Ed.), *Patients as partners: How to involve patients and families in their own care.* (pp. 7-31). Oakbrook Terrace, IL: The Joint Commission.
26) Reblin, M., & Uchino, B. N. (2008). Social and emotional support and its implication for health. *Current opinion in psychiatry, 21*(2), 201.
27) Sackey, B. M. (2009). Family Networking and Relationships in the Care of the Seriously Ill. In C. Oppong, P. Antwi & K. Waerness (Eds.), *Care of the Seriously Sick and Dying, Perspectives from Ghana* (pp. 188-210). Norway: Unifob Global.

28) Sapountzi-Krepia, D., Raftopoulos, V., Psychogiou, M., Sakellari, E., Toris, A., Vrettos, A., & Arsenos, P. (2008). Dimensions of informal care in Greece: the family's contribution to the care of patients hospitalized in an oncology hospital. *Journal of clinical Nursing, 17*(10), 1287-1294.
29) Senah, K. A. (1981). *Kingroup in Health Management: A Case study in a Rural Community in Ghana* Unpublished M.A.thesis
30) Stavrou, V., Zyga, S., Voulgaris, S., & Sgantzos, M. (2014). Informal Care in a Formal Setting: the Case of a Neurosurgery Clinic in Western Greece. *International Journal, 7*(1), 102.
31) Twumasi, P. A. (1975). *Medical Systems in Ghana*. Assembly Press, Accra: Ghana Publishing Corporation.
32) Tzeng, H.-M., & Yin, C.-Y. (2011). An appraisal of non-staff visitor involvement in bedside patient care in a specific hospital in the Midwest United States. *International Journal of Nursing and Midwifery, 3*(8), 91-98.
33) Tzeng, H. M., & Yin, C. Y. (2008a). Family involvement in inpatient care: Are families there to offer support or are they concerned about quality of care? . *Clin.Nurs. Res, 17*(4), 297-311.
34) Ugochukwo, C. G., Uys, Karani, Okoronkwo, & Diop. (2013). Roles of nurses in Sub-Saharan African region. *International Journal of Nursing and Midwifery,, 5*(7), 117-131.
35) Wacharasin, C., & Homchampa, P. (2008). Uncovering a Family Caregiving Model: Insights From Research to Benefit HIV-Infected Patients, Their Caregivers, and Health Professionals. *Journal of the Association of Nurses in AIDS Care, 19*(5), 385-396. doi: http://dx.doi.org/10.1016/j.jana.2008.04.012
36) Zaman S.(2005) *Broken Limbs, Broken Lives: Ethnography of a Hospital Ward in Bangladesh* [Internet]. Amsterdam: Het Spinhuis; 2005 [cited 2020 May 5]. 250 p. Available from: http://eprints.gla.ac.uk/107498/
37) Zaman S. *Poverty And Violence, Frustration And Inventiveness: Hospital Ward Life In Bangladesh.* Soc Sci Med. 2004 Nov;59(10):2025–36.