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A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

by

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Dedication

The process of developing my career was coupled with pretty stressful moments, but I am thankful to God for the successful completion of my graduate program. I therefore dedicate this thesis, first, to God, my maker, for His absolute guidance in my endeavor; my biggest fan Daniel Amoah for his constant encouragement; older adults who live alone at home in Ghana, and all those whose concerns made my decision a reality. I am also thankful for the support of all whose guidance, especially Dr. Donna Wilson, has culminated in this journey with a thesis of aging and living alone.

Abstract

The purpose of this study was to explore the meaning for older adults aged 65years and over of living alone at home in Ghana. This qualitative study used purposive sampling to select a total sample size of 10. An interpretive description design was used to analyze the data. Three themes emerged from the study: (a) how they came to be living alone, (b) the impact of living alone at home, and (c) fears associated with living alone in old age. Understanding the factors that influence living alone among older adults will help nurses and other health care providers to reach out to older adults who live alone and others who may be lonely and socially isolated. The implications of the findings will also guide nurse educators and government as they plan the curriculum and policies that will directly or indirectly affect the lives of older adults.

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Chapter 1: Introduction to the Study

According to the World Health Organization (2006), older adults are increasing worldwide both in absolute numbers and population proportion. The worldôs population of persons aged 60 years and over was over 700 million in 2006 as compared to 600 million in 2000 (United Nations, 2007). Current projections are that by 2050, there will be 2 billion older persons, implying that they will triple in number over a span of only 50 years (United Nations, 2007; WHO, 2006). As such, this population is becoming an increasingly larger unique socio-demographic group, with more research required to understand their concerns and needs.

In the Republic of Ghana, a West African country, persons aged 60 years and over constitute 7% (1.68million) of the total population, a rate which is among the highest in Africa (Chuks, 2007; United Nations, 2001b; World Bank, 2000). In Ghana, around 1,200,000 people were aged 60 and older in 2006, and this number is projected to increase to over 2,900,000 by 2030 (United States Census Bureau, 2007). With current and anticipated ongoing fertility and mortality declines, by 2050 this proportion is expected to rise to 15% (Chuks, 2007; United Nations, 2001b; World Bank, 2000).

Considering this substantial expected growth trend of older persons, in Ghana and elsewhere, it is both ethically and practically necessary to ensure that the needs of this sub-population are understood and solutions found to address or reduce the many challenges faced by older persons. One apparent but largely unresearched major challenge for older adults is social isolation, a concept often expressed or understood as a feeling of loneliness (Constanca & Ribeiro, 2009; Cornwell & Waite, 2009). Social isolation is much more serious, however, than a feeling of loneliness. As will be outlined later, there are many serious health consequences linked to social isolation. Although younger people can be socially isolated and feel lonely, aging and

common events with aging predispose older people to become socially isolated (Forbes, 1990). To date, the research indicates that living alone in old age could be a major factor for social isolation (Iliffe et al., 2007; Lillyman & Land, 2007). The need to investigate social isolation among older persons, who live at home alone in Ghana specifically, is highly relevant as no studies appear to have been conducted on any aspects of social isolation in Ghana. Due to an increase in urbanization and migration in Ghana, younger people seek employment in urban centres, while the older persons are often left behind, with many living alone; a factor that may put many older persons in Ghana at risk of social isolation.

An analysis of African demographic and health survey data indicates that although only 2% of all people in Africa live alone, 10% of Africans over the age of 64 live alone (Bongaarts & Zimmer, 2002). A United Nation (2005) report indicated that the median percentage of people living alone in Africa increased from 2% in 1979 to 8% in 2001. However, Chuksô(2007) analysis of the 2003 Ghana demographic and health survey data indicated that 11.4% of older adults in Ghana 60 years of age and over live alone. This socio-demographic trend of living alone in old age is already apparent in higher income countries such as Canada; for instance, the percentage of people aged 85 and over who lived alone increased from 22% in 1981 to 34% in 2001 (Statistics Canada, 2007). Given the fact that many older persons live alone and many more could be living alone in the future with the population aging and other trends, there is a need to explore the experience of living alone in old age.

Purpose of Research Study

The purpose of this qualitative study is to seek an understanding of the meaning for older people of living alone in Ghana. The primary research question guiding this study is: ñWhat is the meaning for older people of living alone at home in Ghana?ò

Significance of This Study

Researchers have identified to date that social isolation is associated with having a small social network and infrequent involvement in social activities (Constanca & Ribeiro, 2009; Cornwell & Waite, 2009). Older adults tend to have smaller social networks and are thus more likely to experience feeling lonely (Dykstra, van Tilburg, & de Jong Gierveld, 2005; McPherson, Smith-Lovin, & Brashears, 2006). This lack of social networks and aloneness is also because older adults have a greater likelihood of living alone through experiences of widowhood, retirement, poor health, divorce, financial difficulties, and problems associated with urbanization and migration (Ferraro, 2009; Hicks, 2000; Keefe, Fancey, Andrew, & Hall, 2006; Iliffe et al., 2007; Kramarow, 1995; Wenger & Burholt, 2004). Living alone in later life is now considered by some people to be a potential health risk, and older persons living alone are thought to be a key group then as they are at risk for social isolation and all of the negative impacts of social isolation (Lillyman & Land, 2007). Iliffe et al.ǿs study, which involved a health risk appraisal of older persons in London, revealed more than 15% of the studied older persons were at risk of social isolation, and this risk increased with advancing age. Furthermore, that study revealed the risk of social isolation is greater among older persons who live alone (Iliffe et al.). Similarly, Cattan, White, Bond, and Learmouth (2005) postulated that living alone increases the risk of older persons being socially isolated. In the same vein, a study by Marja (2004) revealed that loneliness increases with age, and that it is as a result of increased disability and reduced social integration among older persons.

Older persons who live alone could be socially isolated and consequently experience health consequences (Cohen, 2004). To date, many negative health consequences have been indicated; including inadequate nutrition (Locher, 2005), poor physical health requiring

hospitalization for acute and chronic illnesses (Mistry, Rosansky, McGuire, & Jarvik, 2001), heavy alcohol consumption (Hanson, 1994; Rosenquist, Murabito, Fowler, & Christakis, 2010), cognitive decline (Wilson, Krueger, & Arnold, 2007), elevated blood pressure (Constanca & Ribeiro, 2009; Hawkley, Thisted, Masi, & Cacioppo, 2010), infections (Pressman, 2005), depression (Heikkinen & Kauppinen, 2004), dementia (Barnes, et al., 2004), and increased risk of premature mortality (Brummett, 2001). The negative health consequences associated with older adults being socially isolated and the expected increase in the number of older adults in the future, many of whom may be socially isolated as they live alone, warrant research attention. This study addresses this knowledge gap by exploring the meaning of living alone among older adults who live alone at home in Ghana through a qualitative research approach. Qualitative studies are of particular relevance for gaining in-depth insight into important social phenomenon such as living alone or social isolation (Richard & Morse, 2007).

As indicated above, no studies appear to have been conducted to date in Ghana on living alone or social isolation in old age, and no government or other documents focus in whole or in part on social isolation for this country have been located. As such, social isolation and other issues with living alone in old age has not become an issue in Ghana yet, but it is important that this become known as an issue if it affects older people.

General Introduction to Ghana

Ghana, one of the most thriving democracies on the African continent, is a country located on the West Coast of Africa. It shares boundaries with Togo to the east, la Cote d'Ivoire to the west, Burkina Faso to the north, and the Gulf of Guinea to the south. Ghana, formally known as the Gold Coast, was the first sub-Saharan African country to gain independence from the United Kingdom in March 1957. Ghana has a population of nearly 24 million people, and as

indicated, those aged 60 years and older constitute 7% of the population, out of which 11.4% live alone (Chuks, 2007; The World Factbook, 2011). Since independence, the country has gone through different phases of political development and has now adopted a four year democratic rule system of government, where elections are held every four years. The vice president, John Dramani Mahama, of the National Democratic Congress (NDC) party, was sworn in as president in July of 2012 after the death of the sitting president, Professor John Atta Mills.

In Ghana, most health care services are provided by the government through the Ghana National Health Insurance Scheme Policy, which ensures that all residents of Ghana receive equitable universal access to health services without paying out of pocket at the point of health service delivery (Ghana Ministry of Health, 2004a). The scheme charges an annual flat fee or premium per person irrespective of age or sex. Citizens pay only 20% of the premium, with 80% subsidized by the government. However, people who are poor, people over 70 years of age, and retirees of the Social Security National Insurance Trust (SSNIT) Fund are exempted from this premium (Ghana Ministry of Health, 2004a). State funding for health insurance ensures health care is accessible to older adults and also younger persons.

Frontline health care providers in Ghana, particularly nurses, are very interested in evidence-based practice. As such, research evidence on social isolation and aloneness is needed and is expected to be welcomed by nursing and other groups in Ghana. This research study will provide evidence-based findings to support nurses and other healthcare providers in their practice in Ghana, and perhaps other developing or developed countries. The best available evidence is needed to improve health care.

Contextual Overview of Social Isolation in Ghana

Ghanaian people typically have an extended family system or a network of many close

and distant family members. Extended family is also defined as a social arrangement in which individuals have extensive reciprocal duties, obligations, and responsibilities to relationships outside the immediate (or nuclear) family (Apt, 1996). In Ghana, many homes have older adults like uncles, aunts, and grandparents who assist in the daily living activities of the home. The extended family system has very significant functions in Ghana. According to Nukunya (2003), there are three functions of the family in Ghana: (a) procreation, (b) socialization, and (c) economic co-operation. These functions make the extended family system a form of social security for older persons who live in a country that does not have a developed social welfare system other than the health care services one.

In the past, it was unusual in Ghana to find older persons living alone. However, in 2003, Apt noted that living alone was becoming more common in both urban and rural areas across Ghana due to migration and urbanization for reasons of work. Migration and urbanization have separately and jointly been pinpointed as contributing to the destabilization of the family value that in the past sustained older persons intimately with their family members in African society (Apt). Concern about the well-being of older persons left behind in rural Africa while the young and able-bodied sought employment and life in urban centres was first emphasized by African delegations at the World Assembly on Ageing held in Vienna Austria in1982 (Apt). Since then, migration and urbanization has and continues to increase in Ghana. Between 1970 and 2000, the capital Accra increased its population from about 624,000 people to 1,650,000 (Ghana Population Census, 2000). Furthermore, due to the modernization process in Ghana, the extended family system is changing and ties between family members are not as strong. The nuclear family has become more important than the extended family (Apt, 1996). This change undermines the extended family system, and it has decreased the ability of the nuclear family to

support and integrate older persons in active family life (Apt). Boatingôs (2010) report on health issues in Ghana pointed out that social changes like urbanization, migration, and the increasingly nuclear family system have resulted in many older persons in Ghana living alone.

Chapter 1 Conclusion

This chapter outlined social isolation and living alone and their impact on older persons. The research question, the purpose of this study, and the significance of the proposed study were discussed. Ghana was described as affected by migration, urbanization, and an increased nuclear versus extended family system**.** Research on living alone has not been done in Ghana. Older adults who live alone are increasing and, therefore, gaining an understanding of the needs of this unique sub-population is warranted. Understanding the experiences of older adults who are living alone will help nurses and others provide evidence-based care, care which reflects an understanding of the connection between living alone and social isolation or other issues in old age.

Chapter 2: Literature Review

This chapter outlines the research literature that exists on social isolation among older adults, a main concern associated with living alone. A systematic review approach was used to find and evaluate research literature as this approach has been established as the most reliable and valid means of identifying and evaluating all previous research findings (Kangasniemi, 2010). Carefully conducted reviews can avoid systematic or personal bias, while highlighting research findings, research issues, and evidentiary gaps in scientific knowledge. Systematic literature reviews can serve to increase research on a topic and prevent unnecessary or repetitive studies (Petticrew, 2001).

Description of the Search Method

In order to gain comprehensive information on the experiences of social isolation among older adults (aged 65 and above) who live alone, and to plan the current study, an electronic library search was conducted in mid 2011. This search used a combination of terms for social isolation among older adults as suggested by a librarian. These keywords were as follows: ñlive*,ò ñalone,ò ñwidow *,ò ñdivorce*,ò and ñsingle personò combined with the keywords ñsocial isolation,ò ñold*,ò elder*,ò ñgeriatric*,ò ñsenior,ò and ñgerontology.ò Three library databases were used: CINAHL, MEDLINE, and EBSCO discovery service. CINAHL and MEDLINE index the most significant English-language journals in the areas of nursing, medicine, and healthcare. EBSCO discovery services were suggested by a University of Alberta librarian because it provides access to many more electronic journals in other databases. The results were limited to people aged 65 and over and to English-language papers published after 1959, as the concept of social isolation among older adult was initiated by Durkheimôs work in 1897 on suicide (Durkheim, 1897). Although the experience of being socially isolated may differ

from country to country, all research regardless of country was sought. Furthermore, age 65 and above was specified because this age is now commonly used around the world to indicate old age (Hodes, 2003). Also, people aged 65 and above are typically not workingð a factor that could increase their isolation as they have lost the opportunity to interact with their co-workers.

Initially, over 1,000 articles were identified. A total of 792 articles were then excluded by a title and abstract review after it was determined that they were not articles focused on social isolation among older adults. Out of the remaining 208 articles, 148 were excluded because they were not full text and peer-review published research journal articles. The remaining 60 articles were screened manually and 12 were excluded because they focused on older adults living in care facilities. The remaining 48 articles were read in full and 16 articles were selected for review because they met all of the review criteria. The 32 not selected were retained for future possible use, as they contained helpful information but were all found to be opinion articles and not reports of an investigation. A critical review of each of the 16 research articles was then conducted to learn the objectives of each study, the methodology or research design used, and the findings of each study. Of these 16 articles, 11 were quantitative research reports and 5 were qualitative research reports.

A repeat search was conducted in summer 2012 to update the literature and to better inform the discussion of findings. Two additional quantitative studies that reported on loneliness among older adults in the United States and Australia were found. These two studies were added to the previous 16 articles reviewed, but these studies did not change the themes identified in this review. The information gained from this review of articles was used in planning a qualitative research study of living alone and social isolation in Ghana, and then in reporting the findings of this study.

The following outlines the processes used to gather and analyze the findings in these 18 articles and thus are the synthesized findings of this literature review. As indicated, 18 articles describing a research study were appropriate for full review. The five qualitative studies all utilized semi-structured interviewing and open-ended questions. Among the 13 quantitative studies; 8 utilized questionnaires, 4 used structured interviews, and the remaining 1 employed both questionnaire and interviews to gather data. Of these 18 studies, 1 was conducted in Canada (Van Den Hoonard, 2009), 3 in the United States (Cornwell & Waite, 2009; Kieth, 1986; Perissinotto, Cenzer, & Covinsky, 2012), 4 in Australia (Pennington & Knight, 2008; Pettigrew & Roberts, 2008; Steed, Boldy, Grenade, & Iredell, 2007; Shu-Chuan & Sing, 2004), and 5 in the United Kingdom (Dee, Christiana, & Norman, 1985; Iliffe et al., 2007; Lillyman & Land, 2007; Tunstall, 1971; Shankar, McMunn, Banks, & Steptoe, 2011). Another 1 was conducted in Norway (Birkeland & Natvig, 2009), 1 in Singapore (Wong & Verbrugge, 2009), 1 in Sweden (Graneheim & Lundman, 2010), 1 in Finland (Routasalo, Savikko, Tilvis, Strandberg, & Pitkala, 2006), and 1 in Portugal (Constanca & Ribeiro, 2009).

According to Streubert Speziale and Carpenter (2007), the actual process of systematic review data analysis typically takes the form of clustering similar data and these clustered ideas become first designated as categories and then grouped into larger themes. This clustering was done and the findings of this literature review were subsequently grouped into three themes: (a) social isolation due to living alone (b) additional factors associated with social isolation and loneliness, and (c) intervention/strategies to reduce social isolation or living alone. These themes are described below.

Theme 1: Social isolation Due to Living Alone

Six of the 18 studies reviewed contributed to theme 1 as they clearly linked social

isolation with living alone among older adults **(**Constanca & Ribeiro, 2009; Iliffe et al., 2007; Lillyman & Land, 2007; Shu-Chuan& Sing, 2004; Tunstall, 1971; Van Den Hoonard, 2009). These are discussed below, starting with the first published.

Tunstall (1971) reported on a survey that involved a random sample of 538 older persons aged 65. These participants were gained from 16 general practices (i.e. physician practices/offices) in four different areas of England. The main objective of this survey was to explore if these older persons were: (a) living alone, (b) socially isolated, and (c) feeling lonely. Tunstall reported that 17% of those living alone were often lonely, compared to 4% of those living with others. Also, 68% of those living alone were identified as socially isolated, compared with 3% in other household types. Of the 21% who were defined as isolated, 25% reported that they were often lonely. Similarly, of the 8.6% who were defined as often lonely, 50% were classified as isolated.

Shu-Chuan and Sing (2004) described the characteristics of older persons aged 65 years and over living alone, and examined whether living alone was associated with an increased feeling of loneliness. Participants were recruited for face-to-face interviews using a stratified random-sampling scheme from 6,367 residents in 11 districts in Kaohsiung City, Taiwan. Of the 6,367 scheduled interviews, data analysis was carried out on 4,858 people. Shu-Chuan and Sing found that lack of social support is common among older adults who live alone in the community, and this makes them feel lonely and isolated. Shu-Chuan and Singôs findings also showed that factors associated with living alone and being disconnected among older adults include gender, marital status, occupation, source of income, religion, health, education, and instrumental activities of daily living.

Another study, a secondary analysis of baseline data from a randomized controlled trial,

was done by Iliffe et al. (2007) to explore the significance of social isolation in the older population for general practitioners and service commissioners. The study sample involved a total of 2,641 community-dwelling, non-disabled persons aged 65 years and over in suburban London. Data on socio-demographic details, social network information, and the risk for social isolation based on six items in the Lubben Social Network Scale were gathered. The study indicated that older adults were at risk for social isolation with advancing age, and the risk is also increased among older adults who live alone.

Lillyman and Land's (2007) survey sought the views of older persons aged 60 years and over in Goucestershire, England on social isolation. The survey consisted of a questionnaire sent to 1,000 older persons living in the city and surrounding county. Of the returned 556 questionnaires, 61% noted that they lived alone, while 34% lived with their spouse or partner. Fewer than 4% lived with their family and 1% resided in sheltered or residential accommodation. The experience of living alone for older adults was often related to isolation or feelings of loneliness. This study also found that the major area of concern for older adults after retirement was fear of social isolation; this fear was coupled with events such as loss of mobility, loss of their partner, and closure of local community facilities such as post offices.

Van Den Hoonard's (2009) study compared how older widows and widowers experienced living alone. This study involved two in-depth open-ended interviews each undertaken between 1995 and 1996 with 27 widows aged between 53 and 87 who lived in an Atlantic province in Canada. The comparative follow-up study was carried out between 2001 and 2002 with 26 widowers ranging from age 57 to 91who lived in Florida, United States. This study found both groups were lonely living alone, but it was only men who lost the sense of their house as a home. Van Den Hoonard also stressed the issue of loneliness in older adults by stating that living alone

and ñbeing at homeò is directly connected to the place that they call home. Although living alone and the meaning of home are theoretically different, it is the meaning of home that leads older men and women to interpret living alone in different ways.

A cross-sectional survey, which Constanca and Ribeiro (2009) conducted in Portugal, sampled autonomous old persons living in the community. The objective of this study was to investigate the quantity of older personôs loneliness in the community and analyze the aspects of their lives that could better predict loneliness. The sample comprised 1,266 persons aged 50-101 years old. A structured questionnaire format was used. The majority of participants were married (56.1%), 30.2% were widowed, 8.8% were single, and 5% were divorced. In addition, 23.7% of the participants lived alone and had limited social network. Constanca and Ribeiro found that the proportion of people feeling lonely increased with age: notably 9.9% among the 50ï 64 year age group, 16.3% among the group aged65ï 74 years, 20.9% among the group aged 75ï 84 years, and 26.8% among people aged 85 and over. This study also revealed loneliness is higher among people living alone (32.1%). Loneliness was more frequent among persons who were widowed (30.6%) or single (15.8%), as compared to married people (9.2%). Older persons who perceived their health as poor or very poor had the highest rate of loneliness (78.7%). People having psychological distress also had a higher percentage of loneliness (40.1%). Being widowed, perceiving oneôs own health as poor, having psychological distress, and cognitive impairment were additional indicators of loneliness.

In conclusion, this theme was derived through findings from six research articles that provide information on older persons experiencing social isolation due to living alone (Constanca & Ribeiro, 2009; Iliffe et al., 2007; Lillyman & Land, 2007; Shu-Chuan & Sing, 2004; Tunstall, 1971; Van Den Hoonard, 2009). The studies reveal that social isolation is more

common with increasing age and among older persons who live alone. Older adults tend to have smaller social networks and are more likely to experience feelings of loneliness. This social isolation and its associated feeling of loneliness may be due, in part, to a lack of companionship, social support, integration and a greater likelihood of living alone.

Theme 2: Additional Factors Associated With Social Isolation and Loneliness

Nine studies (seven quantitative and two qualitative) explored factors related to social isolation and loneliness other than living alone (Cornwell & Waite, 2009; Dee, Christiana, & Norman, 1985; Kieth, 1986; Graneheim & Lundman, 2010; Pennington & Knight, 2008; Perissinotto, Cenzer, & Covinsky, 2012; Routasalo, Savikko, Tilvis, Strandberg, & Pitkala, 2006; Shankar et al., 2011; Steed, Boldy, Grenade, & Iredell, 2007). The findings of these nine studies are presented below in order by publication date.

Dee et al. (1985) reported on a study into the problem of loneliness among older persons aged 70 years and over living independently within a community in both rural and urban settings of the United Kingdom. The numbers of participants randomly selected for both settings were 630 and 656 respectively, and data were gathered using semi-structured interviews. A response rate of 96% was achieved. Dee et al. found that older adults in urban centers are more likely to experience feelings of loneliness than those in rural centers. This study also revealed that men are less likely to experience feelings of loneliness compared to women.

Keith's (1986) study was a 1969 to1979 longitudinal retirement history study conducted by the United States Bureau for their social security administration. A national sample of 11,153 older persons aged 63 and over was identified and interviewed. A sub-sample of 375 unmarried men and 1,674 women interviewed in both 1969 and 1979 were studied. The sub-sample included 264 never-married women, 157 never-married men, 1,159 widowed women, 104

widowed men, 251 divorced/separated women, and 114 divorced/separated men. The aim of this study was to examine social isolation among unmarried older persons. This study showed that a large proportion of unmarried men and women experience social isolation when they are old. This study also revealed that the unmarried older persons who were more isolated tended to be divorced women and men. Keith suggested that satisfaction with levels of living and levels of activity were important for happiness even when the unmarried were isolated. Keith recommended that planners and policy makers can help to improve levels of living and can support services that will increase satisfaction with activities among seniors.

The third study, by Routasalo et al. (2006), examined the relationship of loneliness with the frequency of social contacts with older persons aged 74 years and over in urban and rural settings in Finland. The data were collected with a postal questionnaire that involved a random sample of 6,786 older persons. Their report was based on 4,113 returned questionnaires. Routasalo et al. found the most powerful predictors of social isolation and loneliness were living alone, depression, and unfulfilled expectations of contacts with friends. They also found the main factor giving rise to feelings of loneliness was high expectations but low satisfaction between friends and relatives.

Steed, Boldy, Grenade, and Iredellôs (2007) study reported the prevalence and demographic correlates of loneliness among older people aged 65 years and over in private dwellings in Perth, Western Australia. The data were collected with a postal questionnaire that involved a random sample of 353 older persons. Their report was based on a response rate of 77.5%. Steed et al. found that higher levels of loneliness were reported by single participants, those who lived alone with worse self-rated health. They also found that severe loneliness was reported by 7.0% of the sample and feeling lonely by 31.5%. Steed et al. concluded that although

loneliness is not universally reported by older Perth residents, its prevalence is significant and more attention on it is needed from mental health practitioners and policy-makers.

Pennington and Knight's (2008) Australian phenomenological study was a qualitative study that explored the phenomenon of social connectedness in the experiences of 13 isolated older adults and volunteers. The age range of interviewed older persons was 55 to 100 years. The interview format was semi-structured and open ended around the topic of befriending. This study acknowledged that older adults who are not involved in sociable programs do not have the opportunity to develop meaningful relationships and improve their sense of social connectedness, and especially if their friendship support is missing or inadequate. The experience of being socially connected or disconnected with other people was thus made evident as a key factor for social isolation and loneliness.

The study done by Cornwell and Waite (2009) supports the view that the risk of social isolation is higher at oldest ages as compared to the young-old ages. This was a population-based study of community-residing older adults in the United States. National social life, health, and aging project (NSHAP) data were used in this study. The NSHAP involved interviewing 3,005 older adults aged 57-85 years. The objectives of this study were to measure social isolation and social disconnectedness, and examine their distribution among older adults. Their findings revealed that social isolation can be characterized by the subjective experience of a shortfall in older adult social resources such as companionship and support.

Graneheim and Lundman (2010) reported on their qualitative study that involved a sample of 23 women and 7 men, aged 85-103 years. The aim of this study was to explain the experiences of loneliness among the very old living alone. The descriptions of loneliness were comparative: (a) living with losses and feeling abandoned represented the limitations imposed by

loneliness and (b) living in confidence and feeling free represented the opportunities of loneliness. This study found that experiences of loneliness among the very old are complex; in part because they concerned about their relations in the past, the present, and the future. This study also revealed that experiences of loneliness among the very old can be overwhelming or inspiring, depending upon life circumstances and their outlook on life and death.

Shankar et al.ôs (2011) study determined the impact of social isolation and loneliness on health-related behavioral and biological factors using data from the English Longitudinal Study of Ageing (ELSA). The ELSA is a panel study of older persons living in England, aged 50 years and over. Data on health behaviors and on biological factors were analyzed from interviews of 8,688 participants. Loneliness was measured using the revised UCLA scale and an index of social isolation was computed incorporating marital status; frequency of contact with friends, family, and children; and participation in social activities. This study showed that both social isolation and loneliness were associated with a greater risk of being inactive, smoking, and other reporting multiple health-risk behaviors. Social isolation was also positively associated with high blood pressure, negative C-reactive protein, and high fibrinogen levels.

Finally, Perissinotto, Cenzer, and Covinskyôs (2012) longitudinal cohort study of 1,604 participants examined the relationship between loneliness, functional decline, and death in older persons 60 years and over in the United States. A baseline assessment was done in 2002 and follow-up assessment occurred every two years until 2008. The mean age of participants was 71 years and 18% of participants lived alone. Participants were asked if they: (a) feel left out, (b) feel isolated, and (c) lack companionship. Loneliness was a common source of distress and suffering among the elderly. Forty three percent reported feeling lonely, 32% reported lacking companionship, 25% reported feeling left out, and 18% reported feeling isolated. Loneliness was

associated with all outcome measures, and loneliness was also a predictor of functional decline and an increased risk of death among older persons.

In summary, this theme was derived from nine studies that dealt with factors other than living alone associated with social isolation and loneliness among older persons (Cornwell & Waite, 2009; Dee, Christiana, & Norman, 1985; Graneheim & Lundman, 2010; Kieth, 1986; Pennington & Knight, 2008; Perissinotto, Cenzer, & Covinsky, 2012; Routasalo, Savikko, Tilvis, Strandberg, & Pitkala, 2006; Shankar et al., 2011; Steed, Boldy, Grenade, & Iredell, 2007). These studies found factors that influence the experience of social isolation were advanced age, being widowed or divorced, gender, income, culture, education, religion, health, social network, and activities of daily living. In addition, the studies also revealed that loneliness and social isolation may affect health independently through their effects on health behaviors and biological processes which may lead to some health conditions.

Theme 3: Intervention/Strategies to Reduce Social Isolation or Loneliness

Social isolation and loneliness have been recognized as a concern, with effective interventions needed to address or prevent social isolation among older adults. In this theme, two qualitative research articles and one mixed method research indicate that socially-isolated older persons undertake activities and develop coping strategies to reduce, prevent, or address social isolation (Birkeland & Natvig, 2009; Pettigrew & Roberts**,** 2008; Wong & Verbrugge, 2009). The choice of coping strategies may differ according to gender, personality, and individual circumstances. Details of these three research articles are outlined below.

Wong and Verbrugge's (2009) study explored social isolation and coping strategies among Chinese Singaporeans aged 65 year and over who live alone. This study used a mixed method design including purposive sampling with 19 semi-structured interviews. This study

found older adults attempt to succeed at living alone by developing behavioral and psychological strategies to help overcome social isolation. This study also found that although older persons developed coping strategies to deal with their isolation, a large proportion of participants lived alone due to a range of diverse and unfortunate circumstances. For example, 12 of the 19 respondents (63%) were forced to live alone because they had outlived their family network. These older persons developed daily routines which they performed alone, and found comfort and security in those routines. The study also found older persons who live alone develop two kinds of skills to cope with social isolation. These skills are: (a) structural access repertoires and (b) individual access repertoires. Structural access repertoires are the skills that allow older persons to access formal institutional help through social workers. The social workers visited the older persons at least once every two weeks and provided opportunities for them to receive healthcare, meals on wheels, befriending services, home help services, physiotherapy, and religious outreach. Individual access repertoires conversely involved helping older persons ease loneliness and achieve a sense of security. For instance, these older persons left the front grille of their unit entrance locked, but had the door itself opened. This allowed people who walked along the corridor, such as neighbors, to look in and check on them, while also ensuring that unwanted visitors could not enter.

Birkeland and Natvig's (2009) qualitative study of coping with aging among older persons living alone found older persons use acceptance as their main coping strategy. Acceptance means older adults acknowledged their situation, and then tended to be passive and resigned to it. The purpose of this study was to gain an understanding of how older persons cope with living alone. Twenty older persons with an average age of 82 years were interviewed. Semi-structured interviews were employed and data analysis was carried out using a hermeneutic

approach. Birkeland and Natvig found that even if physical constraints put limits on their levels of activity, these older adults performed activities that did not require any physical strength; such as reading newspapers, watching movies, and listening to music.

Lastly, Pettigrew and Robertsô(2008) study involving semi-structured interviews were conducted with 19 Australians aged 65 years and over. The aim of this study was to identify some behaviors that could improve the experience of loneliness among older persons. The data revealed behaviors such as using friends and family as emotional resources, engaging in eating and drinking rituals as a means of maintaining social contacts, and spending time constructively by reading or gardening can reduce social isolation and loneliness.

In conclusion, this theme was based on three research studies on intervention/strategies to reduce social isolation or loneliness among older adults (Birkeland & Natvig, 2009; Pettigrew & Roberts**,** 2008; Wong & Verbrugge, 2009). The studies found older persons developed daily routines such as reading, gardening, watching movies, and seeking help from formal institutions to minimize social isolation. Older persons also utilized their personal resources and individual skills to alleviate loneliness.

Literature Review Discussion

This literature review located 18 published reports of studies on social isolation among older adults that met all criteria for review. Among the 18 articles, 6 directly focused on living alone among older adults **(**Constanca & Ribeiro, 2009; Iliffe et al., 2007; Lillyman & Land, 2007; Shu-Chuan & Sing, 2004; Tunstall, 1971; Van Den Hoonard, 2009). Social isolation was shown to be more common with increasing age. Older adults were also identified as tending to have smaller social networks and are thus more likely to experience feelings of loneliness. This may be due, in part, to older adultsôsubjective experiences of lack of companionship, social

support, integration, and their greater likelihood of living alone. Most of the studies researched social isolation and loneliness using a quantitative approach. This approach typically used pre-set scales to determine levels of loneliness. These scales presuppose a common understanding of what it is to be lonely and isolated, as the tools seek for and measure a certain aspect or aspects of this phenomenon. However, there may be a large number of different conceptualizations of social isolation and loneliness which may not be captured by using pre-set scales. Therefore, more research is needed to understand older adult experiences of social isolation and living alone, and what they want to express when they describe themselves in this way.

Fewer qualitative studies have been carried out to examine older adultsô experiences of social isolation and living alone at home. Among the 18 research articles that were reviewed, only 5 studies used qualitative methods for their study (Birkeland & Natvig, 2009; Graneheim & Lundman, 2010; Pettigrew & Roberts, 2008; Pennington & Knight, 2008; Van Den Hoonard, 2009). It is therefore advisable to conduct qualitative studies that will look in depth at the experiences of older adultôs social isolation and living alone conceptualizations, including older adults who classify themselves or are classified as lonely or isolated.

As these 18 studies were conducted in many different countries, it is evident that social isolation is becoming recognized in many countries as an issue. However, none of these studies were conducted in Ghana or elsewhere in Africa. Since all of the 18 studies in this literature review on social isolation were conducted in developed countries, their findings are not generalizable or comparable to the experiences of older adults in Ghana. Hence, there is a need for Ghanaian studies on older adults living alone at home, so as to begin to understand the meaning of living alone and address or prevent the phenomenon of social isolation. Also, due to the different cultural context and factors influencing the lives of older Ghanaians, it will be

important to gain insight into the factors that create living alone, and thus lead to social isolation or other issues in the Ghanaian context.

Theme 3 focused on older adults managing their isolation and associated feelings of loneliness. Older adults used several coping strategies adopted or employed with the experience of social isolation. However, there was no direct evidence if any of these strategies were entirely successful for relieving or preventing social isolation. In considering the effectiveness of coping strategies employed by an older adult, additional research is required to further identify and assess these strategies to determine if they actually reduce social isolation.

Additionally, much more research must be done on the home as Mallett (2004) reported that while the home is a safe place for integration and feelings of belonging, the home can still be a place of loneliness because of disconnectedness to family members. This knowledge gap requires further research to examine whether these differences between home and place in orientation could be related to the experiences of social isolation among older adults living alone or with others. The study questionð ñWhat is the meaning for older people of living alone at home in Ghana?òð directly addressed this gap.

Literature Review Conclusion

This chapter outlined the search for literature to inform the proposed study, with 18 research articles identified and reviewed. An analysis of the findings in these articles revealed three themes: (a) social isolation due to living alone, (b) additional factors associated with social isolation and loneliness, and (c) intervention/strategies to reduce social isolation or loneliness. The small number of research studies on such a major multifaceted social problem like social isolation points to considerable gaps in the understanding of living alone in old age. However, the findings of these studies collectively suggest that older adults who live alone are prone to

social isolation and feelings of loneliness.

In Africa, a continent that does not appear to have any past research on living alone or social isolation in old age, this issue could be partly due to family members moving to live in other places away from the home community where the older person remains. The absence of family members not only could predispose older adults to loneliness but also deprive them of related social contacts. It is also possible that the older person will move to a new community to live close to their family, but this move could deprive them of their extended social network. This understanding of the experience of social isolation and living alone in developed countries, which was gained by this literature review, gave guidance to the study of Ghanaian older persons. Research holds the promise of raising awareness of living alone in old age, and therefore could stimulate solutions to successfully prevent and address social isolation or other issues due to living alone in Ghana among older persons.

Chapter 3: Research Investigation Method

The purpose of this qualitative study was to explore the meaning for older people (65 years of age and above) of living alone at home in Ghana. The primary research question guiding this study is: ñWhat is the meaning for older people of living alone at home in Ghana?ò A qualitative design which was informed by the traditions of interpretive description was used to examine this experience. A research method, according to Polit and Beck (2004), comprises the techniques used by one or more investigators to structure a research project and question, and then collect and analyze data relevant to the research question. As intended, an interpretive description research method was used to gather information for the purpose of this research studybecause it provides a good direction for qualitative description and it extends into the area of interpretation and explanation for a study of the meaning for older people of living alone at home (Sandelowski, 2000). Thus, interpretive description is a qualitative nursing approach that helps beginners in research to generate credible and meaningful disciplinary knowledge (Sandelowski). In this chapter, the interpretive description approach is discussed, and the specific method for this study is outlined.

Philosophical and Methodological Orientation

The interpretive description method borrows its design strategies from grounded theory, naturalistic inquiry, ethnography, and also from the principles linked with phenomenological approaches evident in data collection (Thorne, 2008; Thorne, Reimer Kirkham, & OôFlynn-Magee, 2004).Thorne, Reimer Kirkham, and MacDonald-Emes (1997) developed the interpretive description approach in response to a need to generate positive variety of knowledge through an alternative research approach (Thorne; Thorne, Reimer Kirkham, et al.). The interpretive description approach merges design options in a suitable manner for the health

discipline (Thorne). Interpretive description approach reflects the evolution of qualitative methodology within the domain of nursing (Thorne, Con, et al., 2004; Thorne, Reimer Kirkham, et al.). Interpretive description is inspired by hermeneutic traditions as it uses an inductive analytic approach in inquiry to build reasoning from specific observations to broader generalizations (Thorne).

Nurses and other applied health researchers have found that the interpretive description approach provides a logical structure and a philosophical rationale to answer qualitative inquires (Thorne, Con, et al., 2004). Considering the philosophical underpinnings of interpretive description that Lincoln and Guba (1985) outlined, various researchers have concluded that (a) multiple realities are constructed in the context of complex human experience and thus reality is subjective, (b) because the researcher and the participant interact and influence one another, they are therefore inseparable, and (c) theory must emerge from the data rather than using a priori theory (Lincoln & Guba, 1985; Thorne, Reimer Kirkham, et al., 2004). In addition, interpretive description, by virtue of its reliance on interpretation, will yield constructed truths rather than facts (Thorne, Reimer Kirkham, et al.). Interpretive description goes beyond mere description as it aims to provide an in-depth conceptual description and understanding of the phenomenon being studied (Thorne, 2008).

To answer questions relevant to nursing that traditional qualitative methods have not answered is the reason for using a method outside these traditional methodologies (Thorne, et al., 1997). Consequently, the interpretive description method evolved as a distinct qualitative approach to offer ña clinical description with an interpretive or explanatory flavorò (Thorne, Reimer Kirkham, et al., 2004, p. 3).

Research Setting

Principally, the research was conducted in the Nkawkaw, Obomeng, and Wawase rural areas that are all located within the eastern region of Ghana. These communities are mostly dominated by the Akan people whose native language is Twi. The Eastern Region was chosen because it has many characteristics of a typical rural African setting. Furthermore, the researcher has insights into the life and living conditions in this part of Africa as she has lived there in the past and she speaks Twi. Gathering data in this region was more expedient then, as well as more appropriate since an outsider may not understand the cultural and other aspects of living in this part of Ghana.

Of the three, Nkawkaw is the district capital of Kwahu West Municipal in the Eastern region and it is one of the major towns in the Kwahu Mountains. Nkawkaw is inhabited by the people of Obomeng and Atibie ethnic groups. Nkawkaw has a population of 60,627, and it has many small communities which are rural as they are distant from the district capital, Nkawkaw. Obomeng is a much smaller community; with a population of about 6,000 and it is one of the villages located within Kwahu south district in the Eastern region. Wawase also has a population of approximately 5,500 and it is a village located within the Kwahu north district in the Eastern region of Ghana. These three communities are subgroups of the Akans who constitute about half of Ghanaôs 24,658,823 population (Ghana Statistical Service, 2010).

Care was taken to obtain the right participants for this study. These participants were persons aged 65 and above, all of whom lived alone, were willing to report being socially isolated or lonely, and were good communicators. According to Thorne (2008), interpretive description can be conducted on any sample size. The aim of sampling in the interpretive description approach is to generate a rationale that is consistent with the research question

(Thorne, 2008). Furthermore, according to De Gagne and Walters (2010), determining an adequate sample size in qualitative research is the researcherôs judgment call, as a sample size of 12 may be large enough to derive significant outcomes for the intended study, while 5 participants may also be enough to reach a point where no new information or understandings are obtained through additional participants. Because the projected size varies depending on the number of interpretations and descriptions of the phenomena being studied (De Gagne & Walters), the final sample size in this African study was determined at 10 participant when no new data emerged from the interviews, as determined by the researcher in correspondence with her supervisor, and also when the researcherôs interpretations were visible and clear and the meanings from all previous narratives were redundant (Benner, 1994). As indicated, the sample size was determined by the student and her research supervisor (Dr. Donna Wilson) when there was enough information to describe and understand the meaning for older adults of living alone at home in Ghana. Dr. Wilson was informed weekly about the data collection and ongoing analysis by email communication.

It was important to maximize the likelihood that each participant could add information that allows for the discovery of meaning. Therefore, probability sampling, or a random sample, was not used as it is not the best way to select participants who would make good informants (Polit & Beck, 2004). The researcher therefore utilized a purposive sampling approach for this study in order to choose participants who reflected an awareness of the anticipated or emerging features within the phenomenon under study (Thorne, 2008; Thorne, Reimer Kirkham, et al., 2004). The participants in this study were older adults who (a) were aged 65 and over, (b) live at home alone in Ghana, (c) had been living in Ghana all their lives, so they were not new immigrants, (d) had the ability to articulate in English or Twi about their experience of living at

home alone (as the researcher speaks Twi), and (e) were willing to participate in a research study that involved at least two interviews and observations at their homes.

The researcher presented letters of consent to contact (see Appendix A) and advertisement (see Appendix B) to leaders of the communities at Nkawkaw (Eastern Region) to seek permission to invite participants to take part in this study. The researcher verbally presented the aim of the research study to the leaders and sought approval for entry into the community. Upon approval, the researcher sought assistance from these community leaders to locate and then meet with potential participants in their homes. Prior to the interview, the researcher explained verbally and gave each potential participant a letter of information about the study (see Appendix C), and reinforced the need for permission to tape-record and obtain their consent to participate (see Appendix D). All participants were reassured that all of the information about them would be kept in a confidential manner and that the final report and verbal communications will not identify anyone by name. The researcher stayed in all three communities for few days during each data collection period and was thus able to visit participants several times. She also stayed with each participant for almost an entire day, mainly in the participantôs home so she could observe their daily activities.

Data Collection and Analysis

The primary data collection strategy was face-to-face open-ended unstructured interviews of each research participant in their home (see Appendix E for guiding questions), followed by observations of the person and their community. During the process of data collection and as the research study progressed, the researcher developed additional research questions (see Appendix F) that were more detailed and focused (Loiselle & Profetto-McGrath, 2011). All participants were interviewed twice as suggested by Seidman (1991) to gain more insight into each

participantôs specific issues and events that appeared important during the first interview; and to gain reflections on the interpretations derived from the previous narratives and any new line of inquiry. Each interview lasted an average of 40 minutes, although the researcher spent almost an entire day with the participant to observe their activities and to gain perspective on their lives. Additional understandings were often gained through this observation. Each interview was recorded using a digital tape recorder and transcribed to enable the researcherôs ongoing analysis of data.

Field notes were made by the researcher prior to, during, and after each data gathering episode; with these field notes including observations of the person such as facial expressions, the greater environment of the person and their home, the person's lifestyle, and other points that were not captured by the interviews and audio recording. Each interview was transcribed using verbatim transcription. After each interview, the researcher reflected upon the interview and added additional information to the field notes, including questions that should be asked in future interviews of that participant or another. This reflection after each interview was important as interpretive description research is undertaken to identify thematic patterns and common characteristics evident in the phenomenon being studied, ones that account for unavoidable individual variations across participants (Thorne, Reimer Kirkham, et al., 2004).

To this end, prior to leaving Ghana and repeated upon her return from the field, the researcher coded each interview and the data from the recorded field notes and observations. As this was done, the findings were compared with those gained from previous participants and shared with the supervisor. This coding and data comparison continued until an understanding of the meaning for older adult of living alone was reached, as agreed upon by both the researcher and her supervisor who also checked the data and data coding. Upon her return to Canada, the

coded data were reviewed and grouped into categories and then themes with the aid of the researcherôs supervisor. All identifying information was removed to ensure confidentiality and anonymity (Polit & Beck, 2004).

The data was analyzed and coded using the approaches described by Thorne (2008). As said earlier, the aim of interpretive description research is to identify thematic patterns, differences among transcripts, and common characteristics evident in the phenomenon being studied (Thorne, et al., 2004).The transcripts were coded using inductive analysis.

The data analysis began while visiting and interviewing participants in Ghana. The researcher listened actively and thought about the meaning of what was being said and constructed possible labels of these meanings, as well as labels later on that resulted from the analysis of the transcripts. The analysis continued as the researcher read through the data several times or more to be familiar and be immersed in the data. During this period of data immersion, the researcher identified common characteristics and patterns in the data from each participant. After getting familiar with the data, the researcher eliminated digressions that were clearly off topic without changing the unique character of the data. The researcher then coded the data.

Coding is aimed at directing the researcher toward gathering data bits with similar properties and considering them in contrast to other groupings that have different properties (Thorne, 2008). The researcher simplified and focused on both similar and different properties of the data and built an understanding from the data on the meaning for older adults of living alone in Ghana. After the researcher understood the overall text, conceptual themes emerged from this analysis (Thorne; Thorne, Reimer Kirkham, et al., 2004; Thorne, et al., 1997). In order to prevent detraction on the part of the researcher from seeing thematic patterns, line by line coding was avoided (Thorne, Reimer Kirkham, et al.). The researcher thus moved in and out of the data in an

interactive manner. This allowed the contextual nature of the data to remain intact and helped the researcher engage in an intellectual process which is the basis for qualitative data analysis.

As per Thorne, Reimer Kirkham et al.ôs (2004) recommendation, the researcher sought to understand the overall picture of the phenomenon under study by asking questions such as ñWhat is happening here?òand ñWhat am I learning about this?ò (p. 174), ñWhy is this here?ò and ñWhat does it mean?ò (Thorne, Reimer, Kirkham, et al., p. 13). Asking such questions stimulates a more coherent analytic framework in the interpretive description method than sorting, filing, and combining huge data sets (Thorne, Reimer Kirkham, et al.; Thorne et al., 1997). Thus an inductive description approach led the researcher to a coherent conceptual description of common themes and patterns related to the meaning for older adults of living alone at home. Direct quotes of research participants were identified for illustrations where relevant in this report.

Additional Research Considerations

Researchers are cautioned by Van Manen (1990) about the need to maintain research trustworthiness through exhibiting close adherence to the corresponding methodological and philosophical strategies. They are also cautioned to be aware of the possible effects that research can have on participants (Van Manen). This section discusses standards that guided this research study for ensuring rigor and to address required ethical considerations.

Rigor. Rigor is aimed at maintaining accuracy (validity) and consistency (reliability) throughout all research studies (Polit & Beck, 2004; Wood & Ross-Kerr, 2011). Speziale and Carpenter (2007) claimed that the main aim of rigor was intended to ñrepresent participantsô experienceò (p.49).

There are a number of different sets of criteria for achieving rigor. For example, Lincoln

and Guba (1985) indicated trustworthiness was based on the criteria of credibility, dependability, confirmability, and transferability. Leinninger (1994) also presented six different criteria for achieving rigor: ñcredibility, confirmability, meaning-context, recurrent patterning, saturation, and transferabilityò (p. 102). The criteria for achieving rigor in research presented by these authors are relatively similar. To enhance the credibility of this study, the researcher utilized the criteria for achieving rigor in qualitative research presented by Thorne (2008): (a) epistemological integrity, (b) representative credibility, (c) analytical logic, and (d) interpretive authority. The information about these three criteria follows.

Epistemological integrity. To achieve epistemological integrity, there should be a defensible line of reasoning from the assumption the researcher makes about the nature of knowledge through to the rules of the research methodology. This includes the researcher making assumptions about the: (a) research question, (b) research process, (c) source of data, (d) findings and results, and (e) way the researcher interprets and discusses the data. The researcher achieved epistemological integrity by carefully documenting any changes in the research process along with the rational for the change. In addition, the researcher established a robust audit trail by: (a) discussing how and why the participants were selected for the study, (b) describing how the data were collected and how long the data collection lasted, (c) explaining how the data were reduced or transformed for analysis, (d) discussing the interpretation and presentation of the research findings, and (e) communicating the specific techniques used to determine the credibility of the data. Thus, the researcher provided enough information so that another investigator analysing the study will reach a similar conclusion. The researcher was also consistent in focusing on the research question during the data gathering episode.

Representative credibility. This criterion is aimed at the consistency between findings

and the interpretations of those findings that the researcher anticipated from the strategy used for sampling. For example, the researcher did not attempt to infer that the findings about the factors for older adults of living alone at home in Ghana were universal for older adults in all countries. Representative credibility was achieved by interviewing each participant twice to gain new insights and develop interpretations derived from the previous narratives and any new line of inquiry. To establish representative credibility, the researcher reviewed individual transcripts and looked for similarities within and across study participants. In addition this criterion was achieved by engaging with participants for a long time in their communities and also helping with their chores. The researcher also included quotations to support the data analysis. The researcher did not use member checking, as the design used does not favor it. Instead of using member checking to achieve credibility, the researcher used data collected at the early stage of the research study to guide set questions for the repeat interviews of participants.

Analytic logic. Analytic logic requires that, based on what the researcher learned from the study, there should be evidence of that logic throughout the report to the degree that the credibility of the report can be confirmed or rejected. Analytic logic also means that the reasoning that was used by the researcher to guide data analysis must be clear. The researcher addressed analytic logic by developing a detailed description of the research context, findings, and population; and outlined the assumptions that were central to the research. Analytic logicis also established by creating a thick description that, when read by another researcher, can be applied in another context. A thick description is one that captures the experience from the perspective of the participant in its fullest and richest complexity (Cohen et al., 2000). The researcher achieved a thick description through dialoguing, probing, and recording each participantôs meaning of living alone at home. An audit trail was also established to record the

researcherôs thoughts and decision making throughout the whole research study to guide other researchers in future studies.

***Interpretive authority*.** Interpretive authority laid emphasis on the trustworthiness of the researcherôs interpretation of the result of data. The researcher used the audit trail to achieve interpretive authority. The audit trail is a record of the study that involves the details of the data collection, data collected, and data analysis, with information on how the interpreter came to understand the findings in the results section (Wolf, 2003). The researcher maintained a reflective journal that documented the researcherôs choices and decisions, including subjective interpretations, which helped maintain rigor. In this journal, the researcher documented a continuous self-critique by examining her thoughts and emotions to understand the impact of her philosophy and experiences on this investigation (Mulhall, 1997). Immediately following each individual interview, the researcher wrote field notes regarding her own personal feelings, biases, and insights. In addition, the researcher made a conscious effort to follow, rather than lead, the direction of the interviews by asking the participants for clarification of definitions, slang words, and metaphors. Furthermore, the researcher kept field notes to record the context of the data-gathering episodes and linked it to the concept of living alone among older Ghanaian people. The researcher sent emerging exemplars, transcripts, fieldnotes, and paradigm cases to her supervisor so that the supervisor was able to ask questions and confirm the efficiency of her audit trail. The researcherôs supervisor also validated the information gathered from the data given by the student researcher with the existing literature.

Rigor is useful for establishing consistency of the study methods over time and it provides an accurate representation of the population studied (Thomas & Magilvy, 2011). Maintaining rigor in qualitative research is an important part of the research experience as it

provides an opportunity for evaluation and further development of knowledge.

Ethical issues. There are many ethical issues or considerations associated with conducting research on older persons. These include: (a) informed consent, (b) anonymity and confidentiality, (c) risk to participants, (d) recruitment procedures, (e) vulnerable individuals, and (f) payments and incentives (Streubert Speziale & Carpenter, 2007; University of Alberta, Health Research Ethics Board). These ethical issues are discussed below.

Informed consent. The main ethical consideration for this study was to obtain informed consent from each of the research participants. Polit and Beck (2004) explained informed consent as ñparticipants have adequate information regarding the research, comprehend the information, and have the power of free choice, enabling them to consent voluntarily to participate in the research or decline participationò (p. 76). Therefore, the researcher was obliged to provide each participant with relevant and adequate information when obtaining consent, and identify how their anonymity and confidentiality would be maintained. In this research study, consent was collected in both oral and written form. Participants were approached in advance of interviews where the research was explained and their consent asked. Enough time was given so that potential participants could consider whether to take part or not, or return with more questions. Only when consent was given was a date for an interview set. Contact details of the researcher and the researcherôs supervisor were given to the participants, so that each person could answer any question that potential participants may have had about the research.

Confidentiality. Polit and Beck (2004) proposed that maintaining confidentiality means that information provided by participants will not be publicly reported in a manner that identifies them and this information will not be made accessible to others. Data are considered anonymous when even the researcher cannot associate the participant to his or her data. To maintain

confidentiality after this study is over, the studentôs supervisor will store the consent forms, field notes, original interview transcripts, and audio tapes in a locked cabinet for five years, after which they will be destroyed.

The anonymity of the research participants was maintained by eliminating their names and identifiers from the transcripts and records; only the student and researcherôs supervisor will have access to the names of the participants on the consent forms. For the purpose of assisting the student researcher, members of the supervisory committee had potential access to the data or data analysis process information during the study. These people understand that the data are sensitive, and they would not have access to any names or other identifying information. No secondary analysis of data is anticipated in the future, but if the researcher or other researchers want access to the collected tape recordings or transcribed data, an ethics board will have to first review the new study to ensure that they use the collected information ethically.

***Risk to participants*.** This study as planned was not considered ethically problematic, although older people who live alone may be very vulnerable, there was no physical discomfort or extreme emotional risk expected to be associated for any participant. Interviews were carried out in a location in which each of the participantôs was comfortable.

This selection was in all cases their place of residence, thus minimizing any risks to their safety. Disclosure risks were possible however as the research took place in small communities and other people would have known when someone is being interviewed. Participants could also tell of neglect, with issues needing police intervention addressed appropriately as expected. In order to minimize these risks, all data were kept confidential and were anonymous. Although none was noted, if any neglect or abuse was detected, the student would have informed the police and/or community elders.

Participants were free to withdraw from the research study at any time; they could do so without giving a reason. None did. No other person was allowed to sit in during the interviews. Participants also did not need to participate in the study and they did not have to answer all questions asked of them, and if any person appeared to be very emotional prior to or during the data collection, the interview would have been stopped or not started by the researcher. None were. In addition, if it was evident that the participant was upset during the interview, the researcher would have stayed until a friend, neighbour, family member, or community leader was called to comfort the participant. Once again, this issue did not arise.

Recruitment procedures. All the participants were recruited on a voluntary basis and were informed that they were free to withdraw from the research study at any time. The socio-cultural context in Ghana requires that the initial contact of community members is made through community leaders. These contacts with leaders in the community might present subtle influences of coercion which might have led to people participating when they did not actually wish to do so. The researcher emphasized the right of the participants to refuse participation or withdraw at a later date, and to do so without the community leader(s) knowing.

Vulnerable individuals. Older people constitute one of the most vulnerable groups in any society, because a disproportionately large number have reduced mobility, compromised health, and diminished mental capacity (Canadian Institute of Health Research, 2005). Special safety precautions are required to protect older people during research studies. The research study excluded older adults who have a chronic condition such as Alzheimerôs disease or advanced cancer that is not responding to treatment, as these people are not able to actively move about and converse safely with people.

Payments and incentives. No incentives or payments were offered in return for

participating in this study. However, a small token in the form of cookies and beverages at the reinterview and soap after the first interview were provided to participants to show appreciation for their cooperation. In addition, the transportation cost (i.e. taxi fare) to the interview location would have been paid, if needed. No taxi fares were paid, however, as all interviews took place in the homes of the participants.

Furthermore, approvals were obtained in advance for this study from the Health Research Ethics Committee (Panel B) at the University of Alberta (see Appendix G) and also from the Nuguchi Memorial Institute for Medical Research (NMIMR) in Ghana (see Appendix H). The NMIMR was established by the University of Ghana Council as a semi- autonomous Institute of the University of Ghana in 1979. Their broad objectives are as follows: (a) to conduct research into infections and communicable diseases prevalent in Ghana and into nutritional problems, (b) to provide training opportunities for post graduate students in medical research, and (c) to provide specialized laboratory diagnostic and monitoring services to improve the quality of public health programs. Approval from both ethics board was needed so all human ethical regulations were considered, including the management of personal and confidential information relating to the study and itsôparticipants.

Dissemination/Knowledge Transfer of Research Study

This research report on the study in the form of an MN thesis is a key document. After this MN thesis is approved by her committee, the findings of this research study will be shared in publications in academic journals and at workshops, local/national, and/or international conferences. For instance, the researcher will likely submit an abstract about the study findings to the Margaret Scott Wright Research Day and will also prepare a manuscript for publication in a peer-reviewed journal. An executive summary of the study will also be available to anyone

who requests it.

Chapter 4: Research Findings

This chapter reports the findings that were gained through repeat interviews and observations in three rural communities of Ghana. The qualitative field research work was undertaken from January to March, 2012 by the researcher, with the data analysis conducted by the researcher with the guidance of her supervisor. The following starts with a description of the participants and their living situations, and then outlines the themes and thematic categories derived from the findings. Quotes and field notations illustrate these themes and their sub-categories. The chapter concludes with a summary of findings, ones that will be the focus of discussion in Chapter Five**.**

Characteristics of the Participants and Their Living Situations

A total of 12 individuals were interviewed, but two were later disqualified as they were each found to be living with another person. It is interesting that these two individuals reported themselves as lonely and living alone and that they wished to be interviewed for this study. Although the interview data from these individuals were not coded and categorized but instead were deleted as expected as they did not meet the criteria for this study, the point that they wished to be interviewed was considered as data for this study. This data indicates that loneliness was not always related to living alone, as some people who lived with others were also lonely.

The remaining 10 participants were mostly female (7/10), ranging in age from 65 to 100 (4 were aged 76 to 86), and all lived alone in a house that was within or nearby one of three Ghanaian rural villages. Some lived in large family houses (ones that had no other inhabitants) and others lived in small homes or one room buildings. The dwellings thus varied considerably in size, and also condition, with the smallest a one-room dwelling that did not have toilets,

electricity, or running water. Most of the others were large multi-room homes that had toilets, electricity, and running water. The 10 participants had various health-related problems with two being unable to walk unaided due to partial blindness.

As indicated above, the interviews and observations of the 10 participants continued until no new information was obtained; the researcher then stopped collecting data and returned to Canada. Data was confirmed to be enough to understand the meaning for older adults of living alone when the researcher and her supervisor reviewed the data prior to her leaving Africa.

Themes and Sub-themes or Categories

The data analysis revealed three themes, each with sub-themes or categories: (a) how they came to be living alone in Ghana in old age, (b) the impact of living alone at home in Ghana, and (c) fears associated with living alone in Ghana in old age. Quotations from the participants are presented using a numbering system to confidentially identify the participants. Each participant is uniquely identified in the order they were first interviewed (i.e. #01, #02, etc.).

Theme 1: How they came to be living alone in Ghana in old age.

As indicated, this qualitative study sought an understanding of the meaning for older people of living alone in Ghana. Although it is commonly thought that no elderly people live alone in Ghana, it quickly became evident that older adults were living alone in rural Ghana because of a number of different circumstances. These circumstances or sub-themes were: (a) no children live at home, (b) death of children and spouses, (c) failed marriages, (d) their unwillingness to burden or bother their children, and (e) neglect.

No children live at home. Some participants did not have children of their own because they could not give birth. Other participants expressed that they lived alone because their

children had all migrated to cities in Ghana or elsewhere to look for employment. In most cases, employment opportunities within the community were minimal. One participant said: ñAll the children have travelled in search for employmentò (#03). This participant was sad, but claimed that he could not avert his situation because employment opportunities to enable the children to stay was absent in the community. Another participant similarly stated: ñI live alone and all my children have travelledò (#06). This participant got financial support from her children, but she was sad because the people in her community were not pleased with her as she is always calling and asking other peopleôs children to fetch water for her.

Death of children and spouses. Death contributed to the reasons why most of these older adults lived alone. Some claimed that they were living in the city before the death of their children and/or spouses occurred. Others said that their children died because they disobeyed them by travelling to other communities with strangers in search for employment.

In a conversation with a participant prior to the interview, the participant indicated that, ñdeath destroys the home; the ladder of death is not climbed by one person.ò This participant was tearful and showed great sorrow, and she intermittently forgot that she was being interviewed. She said: ñthree of my children are deadò (#09). Another participant whose children had died noted: ñThey are all dead; so now, I have no helper; I am left aloneò (#02). She further explained: ñI had six children and lost five of them to death because they were engaged in rootless lives, such as smoking Indian hemp, drinking and violence.ò Her remaining female child living in the city was on medication, as she had suffered from a stroke. Another participant asserted: ñAs soon as I completed school, I got pregnant. After delivery my child diedò (#01). This woman was sad because she lost her only child who could be her source of hope in life.

Some participants also had no children living in or near home or they did not have any

living children. One participant indicated that her only child had died, and she could not bear a child again although she tried with several men and also medication in order to get pregnant. She then considered life in the city as unfavorable to her, so she moved to a rural community to live alone. In one of three interviews, she reported: ñI did not have a child again; I was so tired of medication and Accra (city) living; I kept going here and there. I had several marriages, but I could no longer get pregnantò (#01). This participant said that she would have hanged herself much earlier in life if she knew that she would not be able to bear a child again. Having children is very important in Ghana, in part because children are expected to live with and care for them in old age.

Death of spouses was a common experience for participants as well. One participant had been previously married to two different men and had six children in total, but when asked why she lived alone, she explained: ñDeath has brought all this about; I was previously married to two different men. I had four children with my first husband, and he died; I had two children with my second husband, and he also diedò (#09). This was a sad, partially blind woman who could not walk unaided. Another participant during the interview kept blaming death for her predicament. She was pained because her beloved husband died. During the interview, she stated: **"**My husband did not return from peacekeeping, he was a policemanò (#02). Some participants of the research study blamed death of others for their circumstances of living alone. In most cases, the death of children and spouses had resulted in them living alone.

Failed marriages. Some older adults lived alone because of failed marriages. For instance, during an interview, one participant who had one child left her husband because she thought that he was a bad man. Although she did not want to talk about why she perceived him to be a bad man, when asked, she remarked: ñI lived with my husband and child in this

community, but I left my husband because he was a bad manò (#08). Another participant of the research study claimed that marriage did not assure companionship to him. He thought that marriage was supposed to be a life-long commitment and that lack of money should not be a setback. In an interview, he emphasized: ñMy wife left me because I did not have money to take care of herò (#03). Another participant whose husband had divorced her because she could not give birth as a result of infertility stated: ñIf when I started life I had a man who would not talk about child bearing, I would have had someone to live with and be happyò (#01).

Some of the participants expressed that failed marriages had caused wounds that could not be healed. Others indicated that quitting their marriages was ideal, and they had no regret for their decision. Although these participants in one way or the other had no regrets, they asserted that living alone was full of pain.

Their unwillingness to burden or bother their children. Two of the participants interviewed lived alone because they did not want to burden their children. Although they were not comfortable with the experience, considering its negative effects, they did not want their presence to be a nuisance for their children. Their reasons were not only that they did not want their presence to be a bother, but they also thought that living alone was all about independence. In an interview, this participant reported: ñMy child has asked that I come to stay with her in the city, but I want a life of my ownò (#01). This participant was tearful.

Another participant thought that living with anyone else would be burdensome on that person. She made it known during the interview that she would rather live alone as she wanted to carry her own burden instead of being a burden on someone else. In an interview, she noted: ñI am afraid to relinquish my worries on someone elseò (#09). This participant was sad about living alone. She was voluntarily assisted with her household chores from a lady in another community.

Neglect. Another reason why some of these older persons lived alone was neglect by family members, friends, and neighbors. Although these older adults did not directly disclose any negative impressions about feeling neglected by their families, it was clear that they had been left alone by their children and other family members to manage their own lives. For instance, during an interview, one participant stated: ñI was admitted at the Ridge hospital and in Korle-bu; but was never visited by any of my family membersò (#01). This participant left to the rural community because her relatives in the city abandoned her while on admission at the hospital in the city. This issue of neglect was also reflected by another participant, a linguist whose children had all travelled. He reported that friendship and companionship was all about money. He indicated that he was not visited when he had no money in his pocket. During the interview, he asserted: ñYou are always left alone because your friends know that they will not get anything from youò (#03).

Another participant was sorrowful because her children had been promising to visit her but they did not. She looked so depressed, and she reported that she had decided to look up to God for a better life. She thought that she would be a ñdreamerò if she kept thinking that her children would come to her aid. During the interview, she stated: ñMy children keep telling me that they will come, but they do notò (#06). Another participant similarly reported: ñMy worries are that my children do not visit meò (#10). This man was an active but sad participant whose children had left him to manage his own life. He lacks fatherly love of his children because in his youthful age, he abandoned his male child who then struggled abroad for his own survival. According to him at the moment, his child does not recognize the need to help him.

Neighbors clearly did not notice or assist most participants. Neglect was one of the circumstances that some of these participants were faced with. Although they had relations, and

some were with or without children and friends, they were in essence neglected in their communities and so they had to conduct their lives their own way.

Theme 2: The impact of living alone at home in Ghana.

The second theme that was observed focused on the impact of living alone for older adults, an impact which varied in relation to their (a) economic well-being which impacted their living standard, and (b) health status which impacted their ability to carry out needed activities of daily living.

Economic well-being which impacted their living standard. The economic situation for most of the participants was low**.** The interviews and observations revealed that minimal personal income was not only a reason for why older people lived in rural communities, but personal income also greatly varied, and each personôs income impacted their lives. Some of these older adults moved to the rural communities as it was cheaper to live there. Some worked, but their main sources of income were financial supports from their children and gifts from people within their communities. During an interview, one participant said: ñMy adopted child supports me with an amount of CAD$27 a month, which I take some to the hospital and insuranceò (#01).

Another participant made it clear that without gifts from people, it was unlikely for her to eat. In an interview, she noted: ñRegarding my diet, it is the gifts of other people that enable me to buy food to eatò (#01). Another participant said that life was so difficult it was unbearable. During the interview, she emphasized: ñNothing goes well for me; I do not even have money to buy foodò (#02). Another participant, who also received some financial support from children, asserted that without gifts from other people, it was difficult for her to survive. She said:

Although they sometimes support me financially, it is not enough to take care of me;

> I sometimes resort to other people for support. Some of the elders here also sometimes bring me food; sometimes when I am here and I do not receive food from anyone, it is difficult to survive; I do not always receive food from people. (#03)

Another participant indicated: ñI do not have money so the little I get is what I spend on food, but I like it that way because if I live with someone, it will be difficult to provideò (#04). This woman felt challenged as she thought that it was impossible for her to take care of anyone else. Another participant was not prepared to live with anyone because she did not have money to take care of another person. In an interview, she remarked: ñI could not afford to let someone live with me because there is no money for school feesò (#06).

One participant expressed that a low standard of living had brought hopelessness in her life. During the interview, she lamented: ñI do not have money so it makes me feel hopelessò (#04). Another participant was bothered that because she did not have a choice of what to eat and drink, her standard of living was low. She stated: ñI do not have money; I cannot eat fufu (local food) when I want toò (#05). Another participant said: ñPeople are suffering; they will buy on credit, but cannot pay. I have nothing doing so I just go out to sell then when I am tired, I come home and sleepò (#07).

Some earned money, which helped them live. One participant takes advantage of events such as funeral and social gathering that occur in the community by renting some of her rooms to visitors, so she could make money to take care of herself. She explained this in an interview: ñWhen you see people coming here, it means that there is a funeral, and people want a place to rent for that short time of stayò (#08). She also stated: ñAs for me, because I do not have any work doing, I rent a room out for a tokenò (#08). None earned enough to live comfortably, and none reported having savings to live on.

The economic well being and health status influenced the daily living of the participants under study. The expectations of better living conditions for some of these participants who migrated to the communities failed because they did not have enough income. The participants who received financial support from their children also depended on the gifts and support of other people within their community. Other participants who did not get financial support from their children depended solely on the gifts of neighbors to survive, and in the absence of this support, they had nothing to live on.

Health status which impacted their ability to carry out needed activities of daily living. The experience of living alone was also greatly impacted by health. Some participants were relatively healthy, but most were unhealthy. Some of the health-related problems they faced were broken knees, waist pains, dizziness, and partial or total blindness, and other chronic diseases that had rendered them weak. Some of them had harmful environments as they were dirty and a threat to their own health. During the interview, a participant said: **"**When I came, I was struck down by diabetes then I fell into comaò. She went on to say that; sweeping is a problem for me; for four days, I have not been able to sweep my bedroom because I cannot bend down my headò (#01). This participant was sad because she could no longer do the things she did in the past. Because of her inability to sweep her room for days, her environment was unclean. During the visits to this participant, she remained in her room because she could not do anything. Another participant said: ñMy waist and knee are so painful and it does worry me a lotò (#06). This participant was sad, and had such severe waist pain that she could not do anything on her own. She was also unable to go out because she could not walk unaided. In another interview, she asserted: ñI feel so much pain when walking so I do not take delight in itò (#06).

Another participant who was an active member in her church could no longer ring the

church bells and sing in the womenôs group like she did in the past. Her children had also asked her not to try walking along the roadside because of her bad eye sight. In an interview, she stated: ñWith this bad eye sight that I have, I can fall and die at any timeò (#09). This woman could not tell the color of the dress the researcher wore at the time of interview because she had minimal eye sight. This participant was sorrowful, as she could not go anywhere unaided because her sight had deteriorated.

Some of the participants of the research were not able to walk unaided because they experienced pains in their waist and knees. They emphasized that it was difficult to go out to buy anything for themselves because of their circumstances. In an interview, a participant noted: ñI am not too strong; I had a car accident so I walk with this stickò (#10). The only way they got assistance was when someone passed by.

Although the health of most of these older adults was not favorable, they did not have an option to avert their situation because they had lost family ties, and had to live alone. The health care facilities to serve their communities were limited, which also contributed to their low health state. All the participants, including those who did not relent on their decision to live alone asserted that living alone was difficult, except one participant who asserted that living alone was good. When this participant was asked about his challenges, he made known that living alone was good for him. He further explained: ñLiving alone does not affect my life, I am happy that I live aloneò (#04). More often, a participant lamented: ñliving alone is pain; it is hard; it is mind bugging; it is tearsò (#01). Another participant remarked, ñIt is hard to say something else about living alone; I have seen a lot; living alone is difficultò (#02). Although one participant expressed that living alone was good, all other participants of the study purported that living alone was unfavorable.

Theme 3: Fears associated with living alone in Ghana in old age.

The third theme developed from the data focused on the impact or outcomes of living alone, most of which were associated with a range of different fears. There were three main fears identified, each had actions or outcomes associated with them: (a) a fear of night; (b) a fear of illness; and (c) a fear of crime.

Actions and outcomes associated with a fear of night. All but one participant reported having a fear of the night and taking actions to reduce or address that fear. In the case of most of the participants, caution was given to security so that it would not affect their lives. During the interview, one of the participants reported:

> There are lots of fears; sometimes I will be sleeping then someone will knock hard on my gate, then I am afraid; especially when I know it is a male. Living alone cannot be good because only God knows what happens at night. (#01)

She was worried because getting assistance during the night when something happened was impossible. In an interview, she remarked: ñWhen something happens to your life at night, on whose door will you knock for assistanceò (#01). She also emphasized: ñWhen the thunder strikes at night, I fear a lotò (#01).

Another participant was particular about creating security for herself at night as she lived alone. She ensured that she did not make room for any uncertainty at night. During the interview, she explained: ñHere, the windows are all intact so it is a bit safe, but sickness at night is the problemò (#03). Another participant stated:ñI feel insecure living alone. If not for Godôs guidance, death would have taken over me because; there is no one by me at nightò (#09).

Actions and outcomes of a fear of illness. Some of the participants of the research had the opportunity to visit the hospital for medical check-ups. Others who did not have the means and strength managed their lives in a way that they remained healthy as much as possible.

Despite attempts to stay clear from illness, the fears of participants were based on what could befall them if they became ill. Their concern was the absence of aid if they fell sick. In an interview, a participant said: ñThe worry of sickness has rendered me hopeless that I could not even go anywhere for three days. You cannot even visit anybody for the fear of falling sickò (#01). Another participant noted: ñI always pray that I do not fall sickò (#03). Although this participant lived by faith, he entertained the fear that he would have no helper when ill.

Another participant was uncertain about what could happen to him when he falls sick. When interviewed, he reported: ñI cannot have much money to take care of myself when I fall sick; I may be dead before my children will come to my aidò (#04). Another participant said that living alone is not laughter. In an interview with her, she remarked: ñSometimes you will be ill and you cannot wake up; you have no one by youò (#07).

The participants of the research were vulnerable to various health hazards because they lacked the strength to do things on their own. Some of them lived in unpleasant environments which spurred various health related challenges. Although some of them visited the hospital for check-ups, this did not stop them from entertaining a fear of illness because they had no helper when ill.

Actions and outcomes of a fear of crime. The fear that someone would break in and steal something was another concern of most of the participants of the research study. All ensured that their doors and all entry points within their properties were secured so there could be no intruder. Their experience of living alone had given them a high sense of security awareness. For the fear of crime, they created individual securities, and were mindful to safe-guard their lives and property. During the interview, a participant said: ñI cannot attend evening church service because I am afraid that someone will break in when I am not aroundò (#01). Another participant

had experienced theft several times. She noted:

> If I go out and I do not lock my door, all my belongings will be stolen; whatever I left behind, provided my door is unlocked, would be stolen. Sometimes when I dry my washed clothes on the line, they are stolen; thieves really take advantage of me. (#03)

Another participant disclosed: ñAll you will hear is stealingé stealingé , but by Godôs grace it has not happened to me. If you leave your door ajar, that is when the evil one can enter to harm youò (#05). During the interview, another participant revealed: ñIn this community, there are a lot of thieves so if you do not lock your door that is when they will harm youò (#08). Others also reflected that it was God that protected them from thieves.

The existence of fear in the lives of participants of the study made them create various securities around themselves so that they would not fall prey to threats. However, they believed that these security measures did not assure total protection, as God gives them protection.

Conclusion of Chapter Four

This qualitative study was purposed to seek an understanding of the meaning for older people of living alone in Ghana. An analysis of the findings of this research study revealed three themes: (a) how they came to be living alone in Ghana in old age, (b) the impact of living alone at home in Ghana, and (c) the fears associated with living alone in Ghana in old age.

Participants of the study outlined several circumstances for why they lived alone. While some of the participants lived alone because their children had migrated to the cities to look for employment, others migrated to the communities because of the high cost of living in a city. Among several other reasons for why these older adults lived alone, death of children was evident. Some of the participants outlined that they lived alone because they had failed marriages. Some lived alone because of the death of a spouse, divorce, or spousal separation.

Some of the participants lived alone because they did not want to burden their children. Others lived alone because they were neglected by their immediate families. They were mostly visited by church members and friends.

The economic well-being and health status of most of these participants were affected by their current circumstances. Some survived through petty trading, financial support from children, and/or gifts from some friends and people within their communities. Most participants had various health related problems such as partial or total blindness, dizziness, broken knees, and waist pains which made it impossible for them to carry out their daily activities.

Fears were common. There was the expression of fear at night that someone could break in to harm them; they also feared that in case they were affected by sickness there would be no one to help them. There was also the expression of fear of crime that spurred cautious actions by these older adults. They described the meaning of living alone as ñtearful,ò ñpainful,ò and ñdifficult.ò

Chapter 5: Discussion of Findings

This chapter discusses the findings in Chapter Four in relation to the research reports and other literature that are critically reviewed in Chapter Two. As indicated in the previous chapter, three themes were revealed, each with sub-themes or categories: (a) how they came to be living alone in Ghana in their old age, (b) the impact of living alone at home in Ghana, and (c) the fears associated with living alone in Ghana in old age. The following is divided into a discussion of each theme and their sub-themes. These themes and sub-themes are thus compared and contrasted with the findings of previous studies and/or the stated opinions or viewpoints of other authors. As such, this chapter indicates where the findings of this study are similar to or different from those of other studies. The chapter concludes with a statement about the value of this study for expanding evidentiary knowledge of what it is like to live alone in old age.

Theme 1: How They Came to be Living Alone in Ghana in Their Old Age

In this study, it was evident that factors such as (a) no children living at home, (b) death of spouses and children (c) failed marriages, and (d) their unwillingness to burden or bother their children were common reasons why these older adults lived alone in rural Ghana.

No children living at home. In Ghana, having children is an expectation of marriage (Nukunya, 2003). The absence of children in marriage is blamed on women, and they are then referred to as ñbarrenò (Fledderjohann, 2012). This issue was identified, as one of the participants in this study reported that she had no child of her own as a result of infertility.

In the Ghanaian tradition, children are expected to provide economic security for their parents, as the aged provided for them at their early stages of their lives. Unfortunately, the absence of children was linked to loneliness for the older adults of this study. In addition, when children were present, there are many reasons why they did not live with or near their parents. In

recent times, as a result of urbanization in Ghana, the young generations who traditionally cared for older persons have migrated to the cities, leaving the aged behind in rural areas (Apt, 2003; Tsegai, 2004; World Bank, 2008; WHO, 2004). Out of the 10 participants who were interviewed, six had children who had migrated to cities that were many miles away looking for employment.

Given the strong family bonds that still generally exist in Ghana, it is expected that migrant children will maintain contact with their parents after migrating. However, out of the six participants whose children had migrated to the cities, only one reported that correspondence with her children and financial support received from them was sufficient. Four participants reported that correspondence with their children as well as financial supports from them were not regular. The last participant out of the six participants had completely lost contact with his children. Most of the remaining participants also asserted that they had virtually no support from their extended family members. This lack of support is consistent with the prevailing literature that suggests the role of the extended family is in decline (Apt, 2001; Mason & Lee, 2003).

Wilson, Harris, Hollis, and Mohankumar (2010) identified income and social status, social support network, and personal health practices as important determinants of health that are critical in preventing social isolation in older adults. Similarly, Ryan and Patterson (1987) previously reported that the most important factor associated with loneliness in old age is a lack of contact with children. As evidenced in the living situation of the participants of this study, the feeling of loneliness was exacerbated for most by a lack of regular contact with their children. It was also evident in this study that the degree of interaction between participants and their migrant children affected their living situations. The participant who reported regular correspondence and financial support from her children had a better living situation, although she was still lonely. The participants who reported irregular correspondence or no contact with their

children all had poverty-stricken living situations. This issue is concerning, as one of the main motivations why young people migrate from rural areas to urban centers is to seek for employment so as to provide financial support to their aging parents (Tsegai, 2004).

One of the major reasons why these children were not able to fulfill their financial obligations to their parents was as a result of their own financial challenges. The participants who reported irregular financial support or no contact with children also reported that their children did not have secure employment in the city. Conversely, a participant who reported that she had regularly financial support by her children also reported that her children had good employment in the city. Thus, financial support and correspondence from migrant children to their parents provided financial security, economic well-being, and independence for the older adults of this research study. The absence of personal contact because of long travelling distances to visit parents was a factor for their loneliness and insecurity.

Death of children and spouses. The death of spouses and children was also common. The absence of children as a result of death was experienced by three participants who had experienced either the death of children or spouses. Two more reported that they lost both their children and spouse. Unfortunately, all of these five participants asserted that the death of their children and /or spouse had contributed to their loneliness. It was also evident that some participants who had lost their spouse were poor. The absence of children and spouses was a cause for older adults to be living alone at home. A study done by Adams, Sanders, and Auth (2004) found loneliness related to the death of a spouse can result from the loss of an attachment figure, and the loss or the ñfracturingò of a significant caring relationship (McInnis & White, 2001). Another indicated an inability to share daily thoughts and concerns with the spouse (Smith, 2012). One participant in this study when responding to the question why she was living

alone said, ñDeath has brought all this about; I was previously married to two different men. I had four children with my first husband, and he died; I had two children with my second husband, and he also diedò (#09, see p. 43.).

Other studies have observed that the widowed and divorced elderly persons had statistically significant higher scores of loneliness as compared to those who were married or single (Ceyhan, 2005; Lauder, Mummery, & Sharkey, 2006; Routasalo, Savikko, Tilvis, Strandberg, & Pitkala, 2006; Steed, Boldy, Grenade, & Iredell, 2007). A participant in this study reported that she was living alone due to death of her spouse and children: ñI have no helper; I am left alone. é é .. My husband did not return from peacekeepingé é é . At some point I was always crying; I do not have a child or husbandò (#02, see p. 43.).

Widows outnumber widowers globally because women live longer and most women marry older men (United States Bureau of the Census, 2000). The proportion of older females living with a spouse is much smaller than older males living with females (Oksuzyan, Juel, Vaupel, & Christensen, 2008). In this study, most of the female participants were widows while none of the male participants had experienced the death of a spouse. In the Ghanaian context, where males and husbands tend to be the major income earners in the family, the death of a husband will therefore be expected to have negative financial implications for the surviving partner. The widowed womanôs ability to cope with the situation may be low. Most of the widows reported that their living conditions had deteriorated since the death of their spouse. The living situations of these widows could thus reasonably be expected to be compounded by the migration of any children. Traditionally, the extended family provided economic, emotional, and social support for widows. With this social support system declining because of smaller families, death of spouses, and migration, widows are left to fend for themselves.

In the context of a tradition where women occupy a lower socio-economic status, it is reasonable to expect that widowhood will further exacerbate their status in the community and consequently precipitate a feeling of isolation and loneliness. Most of the participants remained in their homes, but they felt that they had been abandoned by neighbors, friends and relatives after the death of their spouses.

In addition, there is a cultural tradition in Ghana that is in transition, and widows are often caught in the middle. The former tradition in Ghana dictated that when a husband dies the extended family inherits his property (E. A. Omari, personal communication, February 8, 2012). The interstate succession law is now a legal, interventional arrangement by the government that protects widows whose spouses did not make a will prior to their death (Gedzi, 2009). This law ensures that widows have the right to inherit most of their husbandôs property. In Ghana now, widows have the right to either adhere to the tradition or hold to the legal right of their dead husbandôs property. Although not mentioned by the participants, some widows are poor because they avoid the risk of being marginalized by society for going against tradition by pursuing the interstate succession law after the loss of their spouse.

Failed marriages. In this study, four of the participants lived alone as a result of a failed marriage. Marriage in Ghana is paramount, and failed marriages are usually blamed on the woman. In the northern part of Ghana, women who are not married and are beyond their early twenties are often stigmatized (Kuutiero et al., 2011). This is also the case in some other parts of Ghana, including the Eastern region where the research data were collected. The issue of stigmatization was not a concern because the participants were beyond the age of twenty. What were evident among these participants however, were failed marriages. One of several reasons why marriages failed was because husbands could not provide for their wife. Some participants

asserted that they had failed marriages because their spouses were poor. Other participants stated that they had irresponsible spouses, while other marriages failed because of infertility. Even though stigmatization as a result of failed marriage is widespread, it did not appear that society had any rules or rigid traditions or regulations that prevented divorced women from participating fully in community activities. None of the participants reported any barriers to participation from members of their local or larger society. However, it is reasonable to assume that given the widespread stigmatization in the traditional culture, the divorced spouses might develop a sense of self-consciousness that prevents them from fully participating and interacting with the community, a factor that could lead to a detachment from society.

Their unwillingness to burden or bother their children. Even though the traditional Ghanaian culture expects children to care for their aging parents, and many older adults may still live with their families, there may be a growing number of people who find this living arrangement uncomfortable (Apt, 2001). This study found some wanted to live alone to not burden their children. Other studies similarly, found some elderly people previously preferred to live alone and to be independent whenever possible (Johnson & Barer, 1997). In developed countries, where there are higher individual incomes and well developed social security, pension, and public health systems, older people were able to achieve a higher level of privacy and independence (Michael, Fuchs, & Scott, 1980; Mutcher & Burr, 1991).

In low and middle income countries, where there are low individual income levels and a lack of private savings, older people tend to rely heavily on members of their family for their well-being and survival. It is therefore conceivable that individuals in developing countries who have financial independence may be able to live alone. In this study, two of the participants declined to live with their children in the city. Although these two participants reported that

living alone was unpleasant to them, they preferred living independently, as they perceived that living with their children would be burdensome on the children. These two individuals who chose to be independent were economically sound; as shown by their dwellings, clothing, and general appearance. These participants support the suggestion that higher income levels allow the elderly to ñbuyò the ability to live alone comfortably (Gustavson & Lee, 2004). If Ghana transitions into a more economically advanced country, the issue of independence for older adults could increase, thus, more older people could want to live alone. The absence of children at home, death, failed marriages, and unwillingness to burden or bother children exposed the participants to live alone. Living alone had a range of impacts, however, as will be discussed next.

Theme 2: The Impact of Living Alone at Home in Ghana

Theme two revealed the impact of older adults living alone at home in Ghana in relation to their (a) economic well-being which impacted their living standard, (b) health status which impacted their ability to carry out needed activities of daily living, and (c) social isolation and loneliness.

Economic well-being which impacted their living standard. Although there was no defined standard to judge the financial situation of participants of the study, it was clear that most lacked basic amenities. Most of the participants of the study were poor. In Ghana, and in many developing countries for that matter, the domination of informal jobs with low wages and no pension plans are a setback to economic well-being in old age. The risk of living alone among older adults, such as falls, depression, and social isolation, imposes additional financial strains (Chou, Ho, & Chi, 2006; Elliott, Painter, & Hudson, 2009; Iliffe et al., 2007; Lee, Cheng, Liu, Yang, & Jeng, 2011; Mui & Burnette, 1994). Many of the participants interviewed in this study

reported having persistent financial difficulties. Their main sources of income comprised of financial support from their offspring, petty trading, and gifts from friends and neighbors. These participants stated that their sources of income were intermittent and inadequate for meeting their needs. Similarly, a study done by Okumagba (2011) in Nigeria examined the source of support, and the form and frequency of family support received by the elderly. Okumagba found that the financial support received by the elderly from their family was neither regular nor adequate. This inadequacy and irregularity of support may put the health status of the elderly in a compromised state, and it may increase their financial strains and vulnerabilities to other aging-related conditions such as stress and depression.

Health status which impacted their ability to carry out needed activities of daily living. The health status of most of the participants was in a poor state at the time of the research study, as some could not walk unaided and many remained in or near their homes. This low health state also hindered their daily activities within their communities. Physical and health problems in old age were found previously to be associated with loneliness in older adults by Russell, Cutrona, and Wallace (1997). Functional limitations imposed by increasing health problems limit the older adultôs ability to form or maintain social contacts (Civi & Tanrikulu, 2000; Perissinotto, Cenzer, & Covinsky, 2012; Pinquart, 2003; Theeke, 2009). In addition, as health problems erode their ability to function; older adult may become increasingly dependent on others for their activities of daily living. This dependency may precipitate a feeling of frustration that could lead to depressive episodes and feelings of loneliness (National Institute on Aging, 1990).

Participants of this study depended on the support of other individuals for their daily activities such as buying food, fetching water, and cleaning as well as washing clothes. These

dependencies were a result of their reduced physical abilities, which made some participants live in an unkempt environment. Untidy physical appearances such as those observed in this study can then lead to reduced acceptance by the members of the community (Percival & Hanson, 2005). In line with this literature, these health-related challenges can be a limitation to their involvement in communal activities and association with neighbors (Murphy, 2006; Pennington & Knight, 2008). For example, a participant who has developed vision impairment stated that she had to curtail her involvement with church activities. This participant had been an active church member with an extensive network of friends within their church congregation.

The impact of the loss of social contacts can have a profound consequence on the mental and emotional health of anyone. Murphy (2006) observed that in older adults, the development of visual and or auditory impairment creates communication difficulties which can lead to loneliness. Birkeland and Natvig (2009) and Pettigrew and Robert (2008) both suggested that older people with physical disabilities cope by engaging in activities that do not require any physical strength; such as gardening, reading, watching movies, and listening to music. In rural Africa however, engaging in these alternative activities can be challenging for older people with auditory or visual impairment. The chief coping option left for older adults in this situation is acceptance (Birkeland & Natvig). Six of the participants had auditory or visual impairment which reduced their physical mobility. These impairments would reduce their engagement with friends and family, leading to frustration with their living situation. Wong and Verbrugge (2009) found that in developed countries, older adults with disabilities use coping skills which includes accessing well-developed institutional support systems through social workers. It is thought that the support provided by such services helps frail adults to maintain their independence (Kramarow, 1995; Kail & Cavanaugh, 2004). The absence of a developed social institutions such

as Disabled Adult Transit Service (DATS) and ñseniorsò complexes dedicated to serve the needs of older adults with disabilities in Ghana, coupled with a disintegrating extended family system, may explain why most of the participants of this study relied on their faith in God as a coping strategy with living alone and all the challenges this brought.

In addition, people with disabilities may have the tendency to develop an inhibition to express their heart-felt feelings (Percival & Hanson, 2005). This exact sentiment was expressed by some participants as they could not freely share all of their problems to the researcher. These participants appeared to have developed a negative self-perception and they verbalized feeling humiliated by their situation. Dodd (1991, 2007) commented that people in such situations frequently adopted defensive strategies, ones that often led to further isolation from society.

The participants of this study were challenged with several factors that impacted on their health and economic status, thereby affecting their routine activities of daily living. These factors also affected their standard of living, as they were unable to engage in gainful ventures, communal activities, and household chores. In all likelihood, the absence of a developed social institution as an alternative coping strategy contributed to the daily woes of participants, although they mainly trusted that their lives were in the hands of their maker.

Social isolation and loneliness. According to Duggleby, Penz, Leipert, Wilson, et al. (2011), community support and integration with community networks are important in sustaining the psychosocial well being of older adults in rural settings. Most participants of this study were isolated from society and lonely as a result of limited interactions with friends, neighbors, and family.

The reviewed literature in four different areas in England similarly indicated that older adults who lived alone were socially isolated and often lonely (Tunstall, 1971). The absence of

individuals to interact with and to turn to in times of need was a restriction on personôs companionship, as they lacked support for proper care and social interactions. These restrictions can be viewed as an indicator for social isolation (Constaca & Ribeiro, 2009; Hawton, 2011; Iliffe et al., 2007; Lillyman & Lands, 2007; Shu-Chuan & Sing, 2004). The findings of this research study supports the literature presented, as individuals living alone at home reported that they had limited social interactions with friends and family members, and thus often felt lonely.

Conversely, loneliness may not be overly attributed to persons living alone at home; as some individuals could live with their spouses, relatives, or children and still felt lonely. Loneliness may therefore be focused on the absence or presence of social and physical interaction among certain individuals. Van Den Hoonard (2009) in the reviewed literature indicated that the subject of loneliness in older adults can be likened to a place they call home, although the meaning of home in theory is different. This assertion means that some factors may cause loneliness for some individuals who are living with other persons. This point was underscored in the case of the two potential participants who wanted to share their experiences of loneliness even though they lived with relatives. Previous studies have suggested certain individuals may be living with other people, but can be lonely due to lack of communication and other related social factors (Bowling, & Browne, 1991; Foxall, Barron, Von Dollen, Shull, & Jones, 1993; Larsen, Zuznanek, & Mannel, 1985; Wenger, Davies, Shahtahmasebi, & Scott, 1996).

Theme 3: Fears Associated With Living Alone in Ghana in Old Age

Fear at night, fear of illness, and fear of crime were concerns for the participants of this research study. They created their own security by locking their doors and windows so that unauthorized persons could not easily enter their rooms. Their concerns were about injuries they

may suffer if they were victims of crime. Some researchers suggest that elders who live alone may be vulnerable to physical and mental health problems (Nevitt, Cummings, & Hudes, 1991; Peel, Kassulke, & McClure, 2002; Robertson, Campbell, Gardner, & Devlin, 2002). Older adults who live alone may have an increased risk of infections, falls, dehydration, and injuries (Campion, 1996; Lee, Cheng, Liu, Yang, & Jeng, 2011; Pressman, 2005; Shankar et al., 2011). Because older adults who live alone may not be able to call for help when needed, many of them could live in a constant heightened state of fear and anxiety (Campion, 1996).

Fear of debilitating conditions can precipitate a loss of confidence within older adults. For example, Brouwer and colleagues (2004) noted that fear of illness, with or without a history of actually falling ill, may result in or lead to decreased self-efficacy and excessive restriction of activity. Indeed, most of the participants stated that fear of falling ill had led them to restrict their activities. For example, one participant reported that the possibility of falling ill while away from home had prevented him from travelling. Excessive restriction of activities leading to social isolation can also result in decreased physical activity and muscle deterioration (Delbaere, Crombez, Van Den Noortgate et al., 2006; Zijlstra et al., 2009). Given the already compromised health status of some of the participants, restricted or reduced physical activities can lead to a downward spiral of compromised health and immunity leading to susceptibility to infections. In addition, the psychological consequences of curtailing activities may result in the restriction of social participation, which in turn can have an effect on loneliness and depression among the elderly (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Wilson, Mottram, & Sixsmith, 2007).

The fear that someone would break in and steal or vandalize their belongings was another major concern of most of the participants of this research study. Fear of crime does not

necessarily reflect the possibility, or actuality, of crime in their neighborhoods, however (Brogden & Nijhar, 2006; Farrall, Jackson, & Gray, 2009; Fitzgerald, 2008). It is instructive to note that although only one participant reported having being the victim of crime, all the other participants were extremely concerned for their security. As noted by Turcotte and Schellenberg (2007), older peopleôs sense of safety can be affected by relatively slight changes in their physical environments. Furthermore, factors such as the degree to which an individual is integrated into the community as well as the condition of his or her dwellings may affect his or her ability to interpret situations in terms of their relative safety (Turcotte & Schellenberg). Turcotte and Schellenberg noted that individuals with fewer friends or less family involvements as well as those who lived in less stable dwellings feel more unease about their security. This insecurity might explain why participants in this study who lived alone expressed the feeling of being more vulnerable to crime and victimization. In addition, the perception of vulnerability by these seniors may be compounded by their reduced physical capabilities. In a society where friends and neighbors usually visit without prior notice, some of the security precautions taken by these seniors such as the locking of doors may serve to further isolate them from their neighbors.

The participants of this research study entertained fears of night, crime, and illness that could have negative effects on their health. Although there was no report of harm experienced by participants, as a result of the fears they entertained, these fears mean their security is very important to them. These fears in one way or the other are important for living alone in old age.

Ethical Concerns Raised by This Study

The findings from the study were fascinating and although no participants were believed to be harmed in any way, the findings are ethically loaded as they reveal concerns about older people living at home alone in Ghana. The main concern was that some participants relied on charitable financial support from their children, friends, and neighbors in order to meet basic needs like food and clothing. Other participants who did not receive financial support from their children depended solely on gifts from neighbors to survive, and without this support they often had little to nothing to live on. For example, a participant stated, ñSometimes when I am here and do not receive food from anyone, it is difficult to survive; I do not always receive food from peopleò (#03, see p. 47). This participantós subsistence was contingent on the benevolence of others through food donation and other support. Such statements are cause for both sympathy and concern about old people living alone.

An ethical issue of concern was that the basic universal needs of many of these older adults are not being met in these communities, considering the fact that Ghana is a signatory to the First International Conference on Health Promotion, Ottawa Charter, in 1986. The Charter stipulated that food is a precondition of health and that governments share the responsibility of the health of its citizens. It is only fair that attention is accorded these less fortunate older adults. For example, an old age pension or a living subsidy, and community gardens to provide food for seniors with the help of community leaders, could be provided by the government for poor old people.

Using Adlerôs (1970) moral philosophy of human nature and happiness, one can argue that these older adults are being deprived of their happiness and real good. Adlerôs moral philosophy examines both ethics and power. Adler examines what is common to all human

beings and thus morally good for every human being to possess. According to Adler, every human being needs to be happy or have a real good life. Adler identified two types of good: (a) apparent good and (b) real good. According to her, apparent good is that which is considered by the individual to be good because he or she desires it. Real good is that which is good for the individual, whether the person is conscious of it or not. Kukuchi (2005) drew on Adlerôs moral philosophy cited examples of real good to include goods of the body such as food. According to Adler (1970), ethical happiness or a real good life is a common desire for all mankind. This statement means that older adults and every human being ought to have real good or happiness either they are aware of it or not. These real goods become a natural right given to mankind by nature of being human and thus become a moral right. These natural or moral rights cannot be reduced by a government or society, as these older adults have a moral right to a good life and a natural right to pursue happiness.

According to Adler (1970), in achieving a real good life, the individual needs the support of parents, community, and a good society because not everything is within the control of the individual. This statement means that for these older adults to achieve a good quality of life and happiness, they need the support of the government, community leaders, and society as a whole. Adler argued that a good society promotes the happiness of its members through its laws and government. The researcher thus wishes to argue for programs and policies that will help address the above concerns. Nursing homes and subsidies for the elderly are potential solutions to alleviate the poor conditions of many older adults living alone in Ghana.

Limitations of the Study

While this study provides new evidence to the literature about older adults living alone, some limitations should be considered. It must be noted that this study was undertaken in rural

communities where urban problems, such as over-crowding and high crime rates, were rare. The meaning of older adults living alone in urban areas may differ from what was found in this study of rural communities.

Furthermore, because this study required all the participants to be older adults who lived alone, and were 65 years or older, it was not possible to explore the meaning for those older adults who lived with others but perceived they were lonely. Nor did it explore the meaning of living alone in Ghana for younger people. These individuals may indeed have different experiences than those interviewed for this study.

Conclusion

Unfortunately, the meaning of living alone for older adults in Ghana, age 65 and over was not one of fulfillment and peace. Despite the limitations of this study, the meaning of older adults living alone at home has contributed to existing knowledge on the reasons and choices why older adults in rural Ghana live alone, the impact of living alone in Ghana, and the fears associated with living alone in Ghana. The older adults studied basically felt lonely and isolated, as a result of minimal interaction with friends, relations, and neighbors within their communities. In addition, due to aging-related problems such as auditory and visual impairment and reduced muscle strength, their abilities to carry out activities of daily living were affected. Participants were also concerned about fears at night, illness, and crime.

Chapter 6: Conclusion and Implications Arising from this Research Study

The aim of the study was to explore the meaning for older adults of living alone in Ghana. This study is relevant as no previous studies appear to have been done on living alone in old age in Ghana. In the course of this research study, several reasons as well as associated factors for living alone at home among older adults were identified: Having no children at home, failed marriages, death of spouses and children, unwillingness to burden children, poverty, and some related health problems. Social isolation and loneliness were based on their living arrangements. Some lived alone as a result of choice, and in order to avoid being a bother on their children. It is therefore necessary to elaborate on the implications of the findings of this study. This elaboration will help future researchers, policy makers, healthcare workers, and individuals improve upon the living situations of older adults living alone at home in Ghana, and perhaps elsewhere. This chapter discusses the implications for research, nursing practice, and policy.

Implication for Research

The findings of this research study suggest that there is a need to further explore the phenomenon of social isolation and loneliness among older adults in Africa and elsewhere. Although living alone can pose many problems, loneliness is an individual perception and it is possible to experience loneliness while living with or near other people (Bowling, & Browne, 1991; Foxall, Barron, Von Dollen, Shull, & Jones, 1993; Larsen, Zuznanek, & Mannel, 1985; Wenger, Davies, Shahtahmasebi, & Scott, 1996). Research is needed to guide nurses, social workers, and other health care providers to actively reach out to older persons who live alone and others who may be lonely.

In addition, research is needed to explore the meaning of loneliness for older adults living

in urban Ghana and other African countries. The demographic trend in Ghana and most African countries and elsewhere is towards urbanization. It is estimated that by the middle of the century there will be more Africans dwelling in urban than rural areas (Owusu, 2010). This study focused on older adults living in rural Ghana. It is possible that the living experiences of older adults living in rural Ghana is fundamentally different from their urban counterparts. Further research is recommended to compare the living experience of older adults in rural setting with older adults living in urban areas in order to better serve the older adult population. More research is also needed in Africa on reasons for living alone, the impact and outcomes of living alone, and fears associated with living alone in old age.

Implication for Nursing Practice

This study provides new insight into what the experience of living alone means to older adults in rural Ghana. The themes that emerged from this studyð how they came to be living alone in Ghana in their old age, the impact of living alone at home in Ghana, and the fears associated with living alone as an older person in Ghanað are important considerations that nurses caring for older adults in Ghana should understand for optimum client care. The findings of the study suggest that the health and social needs of the older adult who live alone in Ghana are not being met. This population needs to be identified early enough with interventions implemented before health and loss of quality life occur. These issues underscore the need for community nurses to regularly visit and check on this population. Nurses should recognize that older adults who live alone may not seek help. It is therefore incumbent on nurses to actively reach out to these individuals to assess and possibly refer them for further treatment or assistance when necessary.

Furthermore, it is important for nursing faculty in Ghana to integrate the teaching of

gerontological nursing in the teaching curriculum. It will also be desirable for the nursing faculty in Ghana to consider establishing gerontology as a nursing specialty as none exists in Ghana at this time. It is evident from the results of this study that family and community participation is crucial in addressing the needs of the older adults who live alone. It will therefore be prudent for nurses working with this population to advocate on behalf of older adults who live alone by creating awareness in the larger community about their needs and circumstances. These nursing actions may be necessary in helping older adults to remain healthy and be independent in their own homes.

Implication for Policy

The participants of this study relied mainly on charitable financial support from family and gifts from friends and well-wishers for their sustenance. This situation underscores the fading importance of the traditional extended family system in African communities. Healthcare and social workers must consider advocating for policy that promotes government welfare support systems such as an old pension for all older people or old age supplement for poor old people. There should also be creativity in exploring policies and programs that exploit the energies and resources of the extended family and the local community in addressing the needs of older adults.

Policy makers should strive to create an environment that encourages older adults to engage in self-help activities. The Ghanaian Government can encourage the formation of micro-financing schemes that extend no-interest and no-collateral credit to well older adults. These would encourage older adults who are willing and able to work to become self-supporting. In addition, it becomes desirable for the government to establish retraining programs that aim to improve the productivity and self-employment of older adults.

Older adults, in this research study complained of fear at night, fear of illness, and fear of crime. According to the Alberta Community Development (1999), older adults, as they age, become vulnerable and are more fearful of threats to their personal security and safety. There is a gate keepers program that originated in Washington by the Spokane community mental health center (Raschko, 1990). It enrolled postmen and meter readers to identify older adults living alone and possibly at risk for any kind of health problem. This model can be adopted by the government of Ghana with the help of community leaders. This program will help keep older adults environment safe and secure, as the postmen and meter readers could act as neighborhood watchers at the community level.

Comprehensive Home Option for Integrated Care of the Elderly (CHOICE) is a special coordinating care program that which helps to keep older people healthy living at home. This program provides a full range of medical, social and supportive services for older adults. Policy maker could adopt and implement this program to meet the health and social needs of older adults in Ghana.

In addition, most of the participants in this research study were poor, with health-related problems, and significant deficiencies with activity of daily living. These problems call for the government of Ghana to establish nursing homes and/or other care facilities to meet the needs of frail older adults.

Finally, the Homeshare Program was a program that originated in Adelaide, Australia in 1997 (Squire, 2001). It is a program aimed at helping older adults to stay in their homes and have companionship. It helps to address social isolation by bringing together older people, who need some help around the home and younger people who need accommodation. The younger people do 10 hours of agreed upon work each week in exchange for free accommodation. An evaluation

of this program by Squire showed that despite the need for effective coordination, it was successful in reducing social isolation. This program can be started in Ghana with the help of the community leaders.

Final Conclusion and Recommendation

In Ghana, as in most parts of Africa, demographic and socio-economic changes have undermined customary institutions such as the extended family networks that had traditionally sustained older persons. In the traditional Ghanaian culture, it was perceived as unusual for older people to live alone. One reason for this assertion is that in both traditional and modern Ghanaian society, old age is considered as a blessing and older people are perceived as sacred to society. This state is because there is the belief that ñan older person is nearer to the reach of the ancestors than the younger onesò (Sarpong, 1983, p. 16). Older persons in Ghana are therefore thought traditionally cared for within the informal structures of the extended family system. The care of older persons for that matter was a moral imperative practice that influenced the sustenance of the cultural and traditional value systems (Gore, 1992).Thus, there is the perception among a large segment of the Ghanaian population that the needs of the older adult population are well met. However, over the past decades, a number of researchers (Apt, 2003; Burgess, 1960; Goode, 1963; Parsons, 1959) have alluded to the collapse of the extended family system across Africa with a consequent disintegration of the traditional care system. As shown by the findings of this study, a significant number of older adults were cut off from their family ties and family-based support to live in poverty and fear.

This study was purported to explore the meaning for older adults of living alone at home in Ghana. These older adults were extensively isolated and lonely, as they had limited interaction with friends, family members, and neighbors. While one participant chose to live alone by

choice, some others lived alone because they did not want to be a bother to their children. More common reasons why these older adults lived alone were failed marriages, neglect, no children at home, and death of their childrenôs spouses. Other factors like economic well-being and health status impacted on their living situations. These older adults survived through gifts from friends, remittances from relations, and faith in their maker. Against this backdrop, this research study inspires the birth of certain structures that will help improve the living situation of older adults living alone in Ghana. These include but are not limited to the following recommendations:

1. Create specialty programs in nursing schools and nursing curriculum that focus gerontology.
2. Community leaders can liaise with the government to start care facilities for older adults.
3. Assist older adults to engage in self employment within their capabilities.
4. Policy makers should gear toward enhancing the resources of families and communities to resolve the needs of older adults.
5. Community nurses should organize awareness programs about the issues and needs of older adults in their communities.
6. Community nurses should regularly check on older adult health and social needs and make referrals when necessary.
7. Establish a developed social institution that will train people in the community to render social services to older adults in the community

As Ghana develops into a middle-income country, these recommendations could help older adults living alone at home. In addition, they could enhance the response to population aging in Ghana, and other African countries potentially.

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Appendix A: Consent to Contact from Community Level (Eastern Region)

Title of study**:** A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

I am Jane Osei-Waree, a masterôs student at the University of Alberta in Canada. I would like to ask your permission to conduct a study on older adults aged 65 and above living alone in your community. I have been given ethical approval from the University of Alberta Ethics Committee and Nuguchi Memorial Institute for Medical Research (NMIMR) in Ghana to carry out this study. As the researcher, I will interview older adults who live alone about their experiences of living alone.

Interviews will last 40-60 minutes. Interviews will be done at a convenient place and time for each older adult. A second interview may be requested. The interviews will be taped recorded. The interview can be stopped at any time they want, and they can talk or not talk about whatever they choose.

Thank you for considering this request. I will visit or call you soon to discuss this

Researcher
Jane Osei-Waree
Please contact any of the individuals identified below if you have any questions or concerns:

Investigator:

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Appendix B: Advertisement

Title of Research Study: A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

Participants Wanted: Older adults (65 and over) who live alone to talk about their experience of living alone.

I, Jane Osei-Waree, would like to invite you to take part in a nursing study that focuses on older adults. I am a graduate student in the Faculty of Nursing at University of Alberta, Canada. Please contact me by phone or by the community leaders if you are interested in taking part in this study.

The purpose of this study is to explore what it means to live alone for older adults in Ghana. If you are an older adult and live alone, and would be willing to be interviewed one or two times for about 40-60minutes each, please give me your name and phone number, or your house number or directions to your home. Each interview will be done at a convenient time and place for you. I will contact you personally at home or phone you to arrange a time to meet with you to explain the study in more detail and to answer your questions. You will be asked to sign an informed consent form before your interview.

Thank you for taking the time to think about taking part in this study.

Appendix C: Information Letter

Title of Research Study: A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

Investigator: Jane Osei-Waree, RN, MN (Student)

Supervisor: Dr. Donna Wilson, RN, PhD (Professor)

Background: It is important to understand some of the problems that older adults have when they live alone.

Purpose: We are asking you to take part in a study that will help to explain how living alone effects older people in Ghana. This research is part of my graduate program in nursing. The information you give will help to explain the meaning for older adults of living alone. It will also make nurses and others aware of this effect.

I am inviting older adults (aged 65 and over) who live alone to be interviewed one or two times about their experiences of living alone. Each interview will last 40-60 minutes. Interviews will be done at a convenient place and time for you. The interviews will be tape recorded. The interview can be stopped at any time you want, and you can talk or not talk about whatever you choose.

Procedure: Participating in this study will involve:

1. Being interviewed about your experiences of living alone. You may be interviewed a second time to add more information after the first interview.

Possible Benefits: The information collected will help nurses and other healthcare professionals better understand older adults living alone.

Possible Risks: No known discomforts or risks are expected with this study. If, however, at any time you feel uncomfortable or you need to take a break or completely stop, you may do so at

any time.

Confidentiality: All information will be held confidential (private), except when professional codes of ethics or a law require reporting. For this study, other than small examples of dialogue that may be used in publications and presentations, only my committee members and I will have access to the study notes on you and what you say. Only I and my supervisor will know your name. Your name or any other identifying information will not be attached to the information you give. Signed consent forms and information gathered for the study will be stored separately in locked cabinets. Your name will never be used in any presentations or publications of the study results.

The information gathered for this study will be kept for five years after the study has been completed. The information gathered for this study might be looked at again in the future to help answer other questions related to the study. Other researchers may want access to your information. An ethics board will first review the new study to ensure your information is used ethically.

All people who participate in this study must give voluntary consent. By signing the consent form, you give permission for me to interview you and to use that information.

Voluntary Participation: You can stop taking part in this research study at any time without giving any reason. There is no penalty for withdrawing. You are free to say yes or no to any part of the study. You can stop the interview at anytime just by telling me. You are encouraged to ask for clarification about the study. Later on, I may ask you for a second interview, and you can do that or refuse to do that.

Reimbursement of Expenses: You will not be paid to participate in this study.

Contact Names and Telephone Numbers: If you have any concerns about your rights or about

this study, you can contact Dr. Donna Wilson (my supervisor) or Dr. Alex Clark (Research Director, Faculty of Nursing, University of Alberta, telephone 780-492-6764). He has no direct affiliation with the study. You can also contact any of the individuals identified below if you have any questions or concerns:

Jane Osei-Waree, RN, MN, 01-780-616-1174

Dr. Donna Wilson Supervisor01-780-492-5574

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Appendix D: Consent Form

Part 1:

Title of Project: A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

Principal Investigator: Jane Osei-Waree Phone Number: 01-780-616-1174

Supervisor: Dr. Donna Wilson Phone Number: 01-780- 492-6403

Part 2 (to be completed by the research participant):

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your future health care?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your records?	☐	☐

Who explained this study to you?

Jane Osei-Waree_____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject _____

(Printed Name) _____

Date _____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Appendix E: Questions and Probes: Interview 1

Title of Study: A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

For interviews, I will use unstructured open-ended questions related to social isolation:

1. Have you lived alone by choice all your life?
2. How did you end up living alone?
3. Are you able to get out of this home and community?
4. What do you do each day?
5. Do you feel lonely?
6. Why do you feel lonely?
7. What is it like to live alone?
8. Do you think living alone is a problem for you?

Appendix F: Questions and Probes: Interview 2

Title of Study: A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana

1. How do you survive as you live alone?
2. Do you feel insecure living alone?
3. How does living alone affect your life today?
4. Tell me about some of your experiences living alone?
5. What are some of the challenges you face as an older adult?
6. How will you describe your social network at this stage of your life?
7. What do you feel is missing in your life?
8. What do you think are the factors that help older adults to be connected in society?

Appendix G: Ethics Approval (University of Alberta-Canada)

UNIVERSITY OF ALBERTA

RESEARCH ETHICS BOARD

308 Campus Tower
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Notification of Approval

Date:	January 10, 2012
Study ID:	Pro00024928
Principal Investigator:	Jane Osei-Waree
Study Supervisor:	Donna Wilson
Study Title:	A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana
Approval Expiry Date:	January 8, 2013

Approved Consent Form:	Approval Date	Approved Document
	1/10/2012	Appendix D Consent- form.docx
	1/10/2012	Appendix C-Information Letter.docx

Sponsor/Funding Agency:	There are no items to display
Sponsor/Funding Agency:	There are no items to display

RSO-Managed Funding:

Project ID	Project Title	Speed Code	Other Information
There are no items to display			

Thank you for submitting the above study to the Research Ethics Board 1 . Your application has been reviewed and approved on behalf of the committee.

Thank you for submitting the above study to the Research Ethics Board 1 . Your application has been reviewed and approved on behalf of the committee.

Appendix H: Ethics Approval (Noguchi-Ghana)

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979
A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

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My Ref. No: DF.22
Your Ref. No:

11th January, 2012

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 053/11-12 **IORG 0000908**

On 11th January, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **A Qualitative Study of the Meaning for Older People of Living Alone at Home in Ghana**

PRINCIPAL INVESTIGATOR : **Jane Osei-Waree (MPhil Student)**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 10th January, 2013. You are to submit annual reports for continuing review.

Signature of Chairman: .....
Rev. Dr. Samuel Ayeh-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Alexander K. Nyarko
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon