Describing the experiences of older persons with visual impairments during COVID-19 in rural Ghana

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Abstract
Purpose – This study aims to describe the lived experiences among older persons with disability during the coronavirus pandemic in rural Ghana.
Design/methodology/approach – This study is based on a qualitative methodology consistent with a phenomenological approach. Semi-structured interviews were conducted with 20 participants. Thematic analysis was used for data analysis.
Findings – During the pandemic, care rendered to older persons with disabilities by their caregivers easily declined because of the lockdown measure. This made the participants suffer in profound loneliness and hunger, and forced some to generate suicidal thoughts. On the other hand, the participants who lived with their family members were also kept indoors for several weeks to reduce their chances of contracting the virus. This was because participants’ family members loosed confidence in the Ghanaian health-care system in protecting their older relatives.
Originality/value – To the best of the author’s knowledge, this is the first study to explore the experiences of older persons with disabilities during coronavirus disease 2019 in rural Ghana. The Ghanaian Government should consider formalized care to ensure continued care of older persons with disabilities especially during pandemics and future related uncertainties.

Keywords Thematic analysis, Older persons, Qualitative methodology, Visual impairment, Suicide ideation, Caregivers, COVID-19, Lockdown, Rural Ghana, Formalized care

Paper type Research paper

Introduction

The coronavirus disease 2019 (COVID-19) was initially discovered in Wuhan, China in December 2019 (Liu et al., 2020). It is an infectious respiratory disease considered highly contagious and deadly which has spread across many countries so quickly (Liu et al., 2020). Some symptoms of COVID-19 are fever, headache, dry cough and sore throat (Li et al., 2020). The impact of the pandemic has taken the world by surprise. Globally, as of July 22, 2020, 14,765,256 confirmed cases have been documented with 612,054 deaths to the disease (WHO, 2020). These figures are set to increase as there is no vaccine yet (Li et al., 2020). Although many developed countries in the world are suffering from the adverse effect of the disease (Henning-Smith, 2020), developing African countries are among the most defenseless (Lloyd-Sherlock et al., 2020).

As COVID-19 is a health-related pandemic, the health-care system of any country is one of its primary bases of response. However, in developing African countries such as Ghana, the quality health-care system to help reduce the spread of the outbreak is lacking in a considerable number of ways (Adokiya and Awoonor-Williams, 2016; Agyemang-Duah et al., 2019). For example, in terms of appropriate laboratory equipment, adequate laboratories and availability of health-care professionals (Gostin, 2014). It is also important
to note that the impact of pandemics on the already devitalized health-care system results in further crippling of the health sector in Ghana (Adokiya and Awoonor-Williams, 2016; Cudjoe and Abdullah, 2020). Having said this, confirmed cases of COVID-19 in Ghana are rising fast which is associated with an increasing number of death cases (Cudjoe and Abdullah, 2020). As of July 22, 2020, 28,989 confirmed cases of COVID-19 have been documented with cases of death up to 153 in Ghana. These figures are also expected to increase (WHO, 2020).

Research suggests that persons at any level of age are at risk of COVID-19 (Wang et al., 2020). However, older persons especially those living with disabilities are among the most vulnerable (Lloyd-Sherlock et al., 2020). COVID-19 has been found capable of overcoming weaker immune systems which are mostly common among older persons (Liu et al., 2020). In addition, older persons living with disabilities already face several challenges (Kahana et al., 2019) and these challenges were mostly documented before COVID-19. Consequently, older persons living with disabilities become more of a concern during this difficult time. This is mainly because they are not fully included in policymaking and also they are mostly deprived of access to vital services (Ocran, 2019; Heikkinen, 2006; Lloyd-Sherlock et al., 2020). Such situations make their care and support likely to be uncertain especially among those living alone (Edusei Kwaku et al., 2016).

Over the years, cultural ideals and damaging stereotypes have mostly conceptualized and forced some perceptions concerning persons living with disabilities in Ghana (Ocran, 2019). These ideas encourage persons in the Ghanaian society to perceive persons living with disabilities as been punished by the gods of the land (Opoku et al., 2018; Kassah, 2008). The care system in Ghana is highly informal where other persons in the community, especially the family, care for older persons (Aboderin, 2004). However, research reports that the family mostly perceives their care as a waste of financial resources (Kassah, 2008). Unfortunately, without formal education, persons living with disabilities grow to become limited and inadequately prepared for the available well-paid jobs in Ghana (Opoku et al., 2018). Although the Ghanaian Government provides a social allowance for disabled persons, it has been reported as not enough in covering their daily expenditure (Enoch et al., 2016; Ocran, 2019). These misconceptions and challenges in Ghana make older persons with disabilities feel socially and emotionally isolated, policy-wise excluded and within a stigmatized environment (Kassah, 2008).

The increasing number of confirmed cases and death rates of COVID-19 in Ghana makes this study timely to inform policy and academic debates. In addition, as majority of the aforementioned experiences among older persons living with disabilities’ care were published before COVID-19, very little is known about their lived experiences during the pandemic. Therefore, this study sought to describe the experiences of such a vulnerable population to obtain a richer understanding to also inform policy and further research. This study sought to answer the research questions below:

**RQ1.** What are the experiences among older persons living with disabilities before COVID-19 during their later life?

**RQ2.** What are the experiences among older persons living with disabilities during COVID-19 during their later life?

**RQ3.** What are some solutions to older persons living with disabilities challenges during COVID-19?

**Methods**

A qualitative study with a phenomenological approach was used to explore the experiences concerning COVID-19 among older persons living with disabilities. The phenomenological approach used in this study reflects the sense of openness in exploring participants'
experiences. Such openness facilitated the discovery of patterns in the data to understand the phenomenon under study. A qualitative design was also used because the purpose of this study was to describe the experiences among participants to generate rich context (Alasuutari, 2010). All activities including recruiting of participants, data collection and data analysis were performed by the sole author (AKT). My research interest focuses on care and support among vulnerable populations. Ethical clearance was obtained from the Committee on Human Research Publication and Ethics at a university in Ghana.

Participants

Participants were recruited from Petu, a village in the Ashanti region of Ghana. Ashanti region is situated in southern Ghana with a population of 4,780,380 (Ghana Statistical Service, 2013). Majority of the region’s population lives in urban areas leaving few people in rural areas (Ghana Statistical Service, 2013). It would have been advantageous to provide the demographics of Petu; however, none has been documented. In view of this, I contacted the village chief about the number of people in the village. He gave an estimate of about 3,000–4,000 inhabitants. The village of Petu is generally small and mainly dominated by older persons as adult children mostly migrate elsewhere for better livelihoods. In addition, the village of Petu is characterized by poor roads, lack of hospitals, social amenities, educational and recreational facilities. The closeness of Petu to surrounding urban areas is also very far apart.

Eligibility criteria to participate in this study was based on participants living with disability (older persons with visual impairment), participants with living experience at Petu for five years or more, participants who were 60 years or older as the study was about older persons (60 years and above is the official recognition for older persons in Ghana) and the ability to speak in English or Twi (Ghanaian local language). These eligibility criteria were collectively to ensure that participants had more experience and exposure at the study location to inform the study. Purposive sampling approach was used to recruit participants. While broadcasting the study within markets and religious centers at Petu using posters, snowballing approach also aided in recruiting older persons with disabilities. Snowballing approach was used because the first approach yielded few participants. The first approach yielded 6 older persons with disabilities whereas snowballing approach yielded 19 older persons with disabilities. In total, 25 older persons with disabilities volunteered to partake in the study. Data reached saturation on the 20th participant. This was noticed when no new information was obtained from participants (Bryman, 2016). I therefore decided to end recruitment.

Participants’ age ranged between 60 and 79 years. Out of the 20 participants recruited into the study, 15 participants lived alone whereas 5 participants lived with their family members. A total of 12 of the participants were women whereas 8 were men. While those who, lived with their family members were cared for by their family members, participants who lived alone were cared for by caregivers. Unlike family members, caregivers in this study were not related to participants. They lived in their various houses within the village. Like family members, caregivers were not paid by participants who lived alone. All caregivers were women and lived at Petu. In the findings section, participants who lived alone will be denoted with the letter (a) whereas participants who lived with their family members will be denoted with the letter (b). Although it was not planned at the outset of this study, all participants were only visually impaired. Thus, participants were able to walk and use their hands but were not able to see. I ascertained participants’ cognitive state by merely engaging them in conversations before each interview session. Moreover, I inquired from participants’ immediate neighbors about their subjective knowledge concerning participants’ cognitive state before interviews began (participants gave their consent to this on the basis of study protocols). Five participants were living with lung diseases. Participants’ pre-medical conditions were confirmed when they provided their medical...
history form or diagnosis to the researcher. All participants were unemployed at the time of data collection. None of the participants had ever been educated. Lastly, they were all Christians.

The recruitment process lasted for the first three weeks of March 2020. The COVID-19 situation impacted the recruitment process. For example, during recruiting participants using snowballing approach, some persons contacted were reluctant to engage with me because they feared of contracting the disease or wanted to protect themselves from engaging with people they did not know because of the pandemic. None of the participants showed symptoms of COVID-19 at the time of recruitment as outlined by Li et al. (2020). I allowed a two-week interval between contacting participants on coming into the study and the time of conducting actual interviews to be sure about their state of health as far as COVID-19 was concerned (Li et al., 2020). None of the participants showed symptoms of COVID-19 after the two-week interval. COVID-19 protocols such as wearing of nose masks and social distancing were observed at the recruitment stage of the study.

**Interview**

Before conducting each interview, participants agreed to items on the information sheets and signed their consent forms. In practice, I read out each item on the information sheets and consent forms to participants. Following this, participants signed their consent forms by appending their thumbprint, which I assisted with. All participants were briefed on the ethical protocols and purpose of the study. Mainly, participants were reminded that their participation in the study was voluntary. Thus, they had the power to opt-out at any time. Participants’ names were replaced with numbers to make their contribution to the study anonymous. For example, the first participant to be interviewed was denoted as participant 1 whereas, the last participant interviewed was denoted as participant 20. Five participants became anxious and stressed during interview sessions. I tackled these ethically by pausing each interview and continuing after some minutes (Bryman, 2016). Interviews were conducted in May 2020.

Participants were interviewed face-to-face using an open-ended semi-structured interview. Interviews were audio-recorded with participants’ permission. All participants chose to be interviewed in the Ghanaian local language (Twi). This was because they were fluent in Twi more than English language. After each interview, I transcribed interviews into Twi and later into English language. Transcription was verbatim. An advantage of this activity was the command I had over the English and Twi language. An interview guide was developed to have a sense of how focused the questions were in relation to the topic. Not all items on the interview guide were asked in the same order. Some participants brought up some intended topics earlier than stipulated on the interview guide. This is allowed in qualitative research (Bryman, 2016). Questions on the interview guide were: “What are some experiences before COVID-19 in terms of your care and support during your later life”; “What are some of your experiences during the COVID-19 pandemic”; “How did these experiences during COVID-19 affect you?”; and “What are some ways you think your challenges could be addressed.” In addition, the use of probes such as “Please tell me more concerning that” was vital. The use of probes enhanced the richness in dialogue between participants and me. With regard to how participants’ demographic data/background and medical history was collected, I asked: “Can you tell me a little about yourself.” Interviews lasted between 35 and 45 min. All participants received GHC 10 for their contribution and time. All participants agreed to be interviewed in their homes, wearing nose masks while practicing social distancing. Interviewing participants in their homes facilitated no interruptions. For trustworthiness, transcripts were sent to participants in Twi language for them to provide comments or revisions. In practice, I read each participant’s transcript to their hearing in Twi. No additional comments or revisions were received from participants. All transcripts were saved on a password-protected computer. The use of a
reflexive journal was resourceful as it showed the position of the researcher during data collection. Reflexive journaling also enhanced trustworthiness (Meyer and Willis, 2018). For example, it was observed that participants talked more about their experiences on the topic and felt comfortable while sharing their experiences. The art of reflexive journaling attributed this effect to my gender as a male. This was because men are culturally or traditionally respected in Ghana (Huang et al., 2018). Next, my expertise in conducting interviews on care and support projects aided on how to begin and close interviews in a conversational style. Such experience also helped me to empathize with participants during interview sessions. Lastly, conducting interviews in Twi language reduced any form of ambiguity in dialogue because participants were able to express themselves.

Analysis

Data analysis was conducted concurrently with data collection. This allowed the determination of data saturation (Bryman, 2016). Thematic analysis was used to analyze data inductively (Braun and Clarke, 2006). First, transcripts were read and reread which facilitated my familiarity with participants’ experiences. Although transcripts could have been analyzed traditionally/by hand, I felt it could have slowed down the research process. Therefore, transcripts were uploaded into NVivo 12 software which facilitated quicker access to transcripts and codes. Thereafter, open coding began as there was no coding frame to refer to. Field notes and memos kept during interview sessions were useful as it aided in identifying and modifying codes generated. It also served as an audit trail (Braun and Clarke, 2006). Thereafter, codes were classified in groups of similar concepts and revised again where relevant. Codes were then revisited and compared to transcripts simultaneously while posing questions to elicit, verify and develop coherent meanings that represented the data. This aided in the creation of themes and sub-themes (Table 1). For trustworthiness, a summary of emerging themes was sent to participants in Twi language to check whether they represented their experiences. In practice, I read summaries of emerging themes to participants’ hearing in Twi language because of their visual impairment. All participants accepted the final set of themes and sub-themes developed.

Results

Lockdown lasted for three weeks, dated March 30, 2020 to April 20, 2020. These dates are relevant in this section because some participants made references regarding their experiences during the lockdown period.

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Theme 1: before the pandemic

Because of the participants’ dependency on others as a result of their disabilities, the need for caregivers in their daily lives was vital. Caregivers’ role was to support participants in almost every aspect of their lives. Participants reported that their caregivers did their best in ensuring they were cared for before COVID-19. Caregivers aided in the provision of participants’ basic care such as bathing and cooking. Interestingly, even when caregivers had other responsibilities elsewhere such as religious responsibilities and familial roles, they sent other people who were also capable of caring for persons living with disabilities to perform their role:

Before the pandemic, at least, I was comfortable. My caregiver cared for me with a kind heart and was very accommodating. She did everything for me. I very well remember when it comes to my cooking, eating, cleaning the house and even purchasing food stuffs from the market, she was always available. (Participant 9a – 79 years)

I remember my caregiver had a program at her church, she factored me in her plans. She sent me another person to take care of me; in terms of my food especially. Things were in place before the pandemic. (Participant 15a – 63 years)

Participants who lived with their family members also reported that their family members took care of them with no strict rules before the pandemic. They reported that they could walk around the compound of their homes with the help of their family members for fresh air:

Because I cannot see, I need constant care in everything I do. My family members have always been there for me, especially during my old age. Before the pandemic, I was cheerful and well-tended. (Participant 16b – 70 years)

Theme 2: challenges during the pandemic

Participants who lived alone reported that their caregivers had left them behind in light of practicing social distancing. This made participants have no one to take care of them. Participants were in constant fear because of the absence of their caregivers. These experiences worsened when the Government of Ghana imposed a three-week lockdown protocol to control the spread of the disease. All participants tended by caregivers reported that they did not bath for days during the lockdown. However, it was to the advantage of these participants to have lived in their various houses for many years. This at least allowed them to adapt to the basic plan of their various homes, most especially, where their kitchen cabinets were situated. Participants reported that they relied on mostly fruits. However, this did not last for the entire lockdown period. Few days to the end of the lockdown, participants who lived alone reported that foods they could readily eat got finished. Therefore, participants reported experiences of hunger as their caregivers were not around to restock their kitchen with fruits or cook for them:

I have nobody to take care of me other than my caregiver. Since this pandemic struck us, my caregiver had to stay home to protect herself and her family. This made me stay at home with no care and support. Although I created some mess along the way, with the aid of my walking stick, I could manage my way to the kitchen cabinet. But these fruits did not last for the entire lockdown period. So I became very hungry. I cried through it all. I live alone and people hardly come here to check on me except my caregiver, yet she was far beyond my reach. The 3-week lockdown was such a tragedy. (Participant 14a – 68 years)

Following the thread of experiences concerning hunger and sadness among participants who lived alone, five participants reported experiences of committing suicide to end their pain and hunger. These experiences were mostly reported when participants’ food got finished. This suggests that participants felt tired and defenseless amid their experiences of hunger and pain. They could have stepped out for food but they needed help with that as it
is usually their caregivers who ran such errands for them. This forced participants to stay home and hungry for the few remaining days of the lockdown:

When my fruits got finished, all that I could think about was to kill myself to end it all. At that moment, I thought my life was meaningless and will not worry anybody if I appear dead after the lockdown. It was so painful and I wish such experience for nobody. I stayed hungry for 3 days and this was the longest I have stayed without food in my life. I felt very weak. I suffered. Hmm [...] [Expressing worry], (Participant 9a – 79 years)

Majority of the participants who lived alone also reported cases of loneliness. Most of them reported that they were mostly home with nothing to do. This event in the data suggests that caregivers were notably the confiders of participants. It was also observed that participants were in constant paranoia. The pandemic made them to constantly question their safety and upkeep as their caregivers stopped work indefinitely. The few participants living with lung diseases expressed high levels of anxiety as they learned they could easily die from the disease if infected. Participants living alone complained of insufficient protective materials such as hand gloves, nose masks and hand sanitizers. Caregivers could have provided participants with these materials from the market but they had to stop their care roles indefinitely because of the lockdown protocol and COVID-19 scare:

I was in the house all by myself with nobody to talk to. It made me sad. I was in constant fear. If I will like to eat or even bath, I had no help from any direction but to kept to myself all day throughout the lockdown period. I always asked myself what I will do if I get infected. My caregiver wasn’t around to provide me with protective materials. She had to stay home since she was afraid of contracting the disease. I was all alone. (Participant 15a – 63 years)

My lungs are very weak as confirmed by my doctor. I am old and restricted in many ways. Just last week, I overheard people saying people living with other major diseases like my lung problem could easily die when infected. Here was I, all by myself and afraid to die in the house. I am even amazed I didn’t die of fear and loneliness during the lockdown. This shows nothing but how aging in Ghana is. (Participant 14a – 68 years)

Another recurring event in the data was participants’ reason for living alone rather than living with their respective families. Their main reason for living alone was that they were rejected and maltreated by their family members at a tender age because of their disabilities. This forced majority of the participants to relocate from their family houses to a place of their own:

I remember when I was with my family long ago, even when I was drinking water, my stepmother will say I am making noise. There was nothing that I did in that environment that ended in peace. In the olden days, life was very strict. They didn’t like me. All these treatments happened to me because of my disability. So I decided and had help from one gentleman in the year 1994 to relocate elsewhere. Although it was not a good idea to live alone in my condition, it felt good when I moved out. I enjoyed peace. (Participant 12a – 63 years)

Data analysis also uncovered that participants were already stigmatized in the village even before the pandemic. Because of their disabilities, many people living in Petu other than their caregivers wanted nothing to do with them. This was worse during the lockdown period. It was during the lockdown period that they felt that their caregivers meant a lot to them:

[...] ooh. God bless my caregiver. She really means a lot to me. I already knew she meant a lot to me but this pandemic led me to know her real worth in my life. People in this community didn’t check on me during the lockdown. None of them gave it a thought whether I had eaten or bathed. It was very serious and very heart breaking. In Ghana, when one is disabled, that is the person’s end. (Participant 3a – 64 years)

When the lockdown protocol was partially relaxed by the Government of Ghana after the third week, participants reported that their caregivers’ rate of coming in to care for them
reduced. Participants said their caregivers shared their concern about contracting the disease hence, affecting the frequency they could tend to participants daily:

After the government relaxed the lockdown measure, my caregiver was not coming in to care for me like before. I do not blame her though, the Corona virus disease easily kills. Now everybody is protecting their family members by staying home. My caregiver told me she will be coming but not all the time as before. At least this is better for me than nothing. hmmm […] [Expressing worry]. (Participant 1a – 60 years)

The few participants who lived with their family members were also not without challenges. As older persons could easily die when infected with COVID-19, family members kept their older family members (participants) in their rooms all day for several weeks. Although these participants did not enjoy such experience, it was to keep them from engaging with others and even their family members to avoid them from contracting the disease. Data analysis revealed that participants’ family members resulted to this harsh strategy because of the poor health-care system generally in Ghana. Thus, they feared that their older relatives could die if infected. Primarily, this was because of the unavailability of better medical attention and facilities at Petu. The lack of strategic quarantine facilities and hospitals at Petu influenced participants’ relatives to lose confidence in light of fighting the pandemic squarely:

My family kept me up in my room while the country was also under lockdown due to the disease and all in the name of social distancing. It was not easy for me. I hardly engaged with anyone. It is not their fault because if I get infected, the poor health care system in the cities might not be of any hope. In addition, there is no hospital here at Petu. So if I get infected here, I can easily die. Moreover, we heard on the radio that materials and logistics in treating infected people were not enough and encouraging. The health care system is weak and overwhelmed. It was because of these reasons that is why my family members kept me in my room for several weeks. (Participant 19b – 70 years)

Several participants reported that the funds available for disabled persons were not enough. Although it aided in buying some food stuffs and personal items, it was not meant to lessen the economic burden of serious pandemics such as COVID-19. Participants reported that traders have taken the opportunity of the pandemic to increase prices of commodities substantially in the village. In addition, participants expressed delays in the payment of their disability funds:

The funds given to us by the government were already not enough despite it aided in buying some food stuffs. It hardly covers the sudden expenditure on toiletries, hand sanitizers, gloves and nose masks. Traders in this village are enjoying it. They have increased prices of items. We can hardly afford these expenses. The payment of the fund usually delays too. (Participant 1a – 60 years)

The money given to us by the government is not enough. More often my family members also come to me for their share. You know. I am the oldest so when they come to me for money I cannot deny them their share. Now prices of many commodities in this village have been increased due to COVID-19 scare. What are we to do? (Participant 18b – 66 years)

**Theme 3: coping strategies**

Although caregivers cared for participants very well before the pandemic, nine of the participants who lived alone called for free or subsidized institutional care for older persons living with disabilities. Their reason for formalized care was that they believed it will reduce their experiences of stigma in Petu. They further explained that with institutional care, they will be in a peaceful environment where their care needs will be of priority. Participants who lived alone were easily convinced that if they were to be in an institutional care facility, they would not have suffered the aforementioned experiences such as hunger and the desire to
commit suicide. They believed institutional care will lessen their challenges especially during COVID-19 and future related pandemics.

It will be very good if the government establishes a care home for us. It will even be best if it was free or subsidized because money is hard to come by in this village. I know this is not the norm in Ghana, but it will serve as a major pillar for our safety in this village. People look down on us because of our disabilities. Even during the lockdown period, nobody came to check on me. Honestly, if I was in an institutional care facility, I believe my wellbeing would have been secured during the lockdown. (Participant 15a – 63 years)

Participants reported that the Government of Ghana should take COVID-19 as a wakeup call to rejuvenate and revitalize the health-care system of Ghana so that it will be able to cope with any form of uncertainties and surprises in the future. In addition, participants called on the Ghanaian Government to establish health-care facilities at Petu which will also increase their confidence and also to reassure them of basic health care if needed:

The government of Ghana should really invest in its health care system. It lacks so many things that are essential in treating people who have been infected with the disease. This will help in surviving future pandemics as well. Older persons living with disabilities are the most defenseless so they should act now. Whilst at it, the government of Ghana should consider building hospitals here at Petu. We need better healthcare, especially during pandemics such as this. Our safety also matters. (Participant 17b – 79 years)

Participants reported that there will be a need for the Government of Ghana to increase the fund given to persons living with disabilities. They reported the increase of the disability fund will help them in securing essential items such as hand sanitizers, soaps and even to support themselves and their family members as well:

We call on the government of Ghana to come to our aid once again. The disability fund is very essential to us. However, the economic situation in Ghana has changed due to the pandemic yet, the disability fund has not been increased as well. This will help us in getting more essential items during the pandemic. (Participant 16b – 70 years)

Lastly, participants suggested that professionals with focus on older persons (such as gerontologists) could do more good, yet they are not valued in the country. Majority of the participants reported that issues concerning older persons have been relegated to the background for far too long. In view of this, participants suggested that professionals such as gerontologists will be able to correspond their challenges especially during COVID-19 and future related pandemics to appropriate governmental agencies for their voices to be heard:

We are now old and cannot fight for our rights like we did years back. This is where we need experts [Gerontologists] to talk for us. However, this profession is looked down upon in Ghana. This must change. The government and its education agencies must give full recognition to this field/profession since they are our best option as far as older persons’ welfare are concerned. We do matter. We really do. (Participant 10a – 65 years)

Discussion
This qualitative study described the nature of COVID-19 among older persons living with disabilities’ care in Petu. The care system in Ghana is highly informal as indicated by Aboderin (2004), where other people living in Petu (mainly women) cared for older persons living with disabilities. Through informal caregiving, participants enjoyed daily care and support from their caregivers and family members before the pandemic. However, all these efforts and dedication showed by their caregivers, most especially, and family members ceased when lockdown protocol was executed by the Ghanaian Government.
Participants stayed hungry getting to the end of the lockdown period. Such experiences were common among participants who lived alone. Their experiences influenced some to have suicidal thoughts to end their pain and hunger. Although experiences of suicidal ideation among persons living with disabilities have been reported in several Ghanaian literature such as the one by Acheampong and Aziato (2018), their sample focused on mothers aged 21–57 years. Therefore, this study adds to the literature on how older persons living with disabilities aged 60 years and above could develop suicidal ideations and notably during lockdown circumstances (COVID-19).

As documented by Liu et al. (2020), the few participants in the present study who were living with pre-medical conditions were scared for their lives because they heard they could die from the disease if infected. This was not surprising as the village lacked health-care facilities and professionals to provide needed care for older persons if infected with COVID-19. It is also important to add that not only were participants afraid of the pandemic but their caregivers also. Caregivers’ concern about contracting the disease disrupted participants’ daily care and support even after the lockdown protocol. The lack of health-care facilities at Petu and the long distance between Petu and surrounding urban areas where health-care facilities are readily available might have influenced caregivers to reduce their caregiving roles during the pandemic. Therefore, influencing them to stay at home for their good.

In line with previous literature (Kassah, 2008; Opoku et al., 2018), participants of the present study hoped for other alternatives of care such as the attention from other people in the village. However, their long experiences of stigmatization denied them of such care as also indicated by Kassah (2008). This finding suggests that stigmatization against older persons with disabilities exist during normal and challenging times such as COVID-19. It also implies that people at Petu had little compassion for participants. Even though COVID-19 is noted as a terrible time especially for older persons (Cudjoe and Abdullah, 2020), participants received little attention at Petu. Therefore, this study is important as it shows how unconfident and unsafe older persons with disabilities felt in such an environment during the lockdown period. The next alternative care could have come from their immediate family members; however, they maltreated them in the past because of their disabilities. This situation in the present study is also reported by Opoku et al. (2018). This event in the data may be explained given the notion that some Ghanaian cultures and family members recognize disabled persons as cursed and therefore not relevant enough.

During the pandemic, participants who lived with their family members were also not without challenges. The fear of been infected with the disease forced their family members to keep participants in their rooms for several weeks. This strategy mainly recurred in the data because of the poor health-care system in Ghana, which they believed may fail in caring for participants if infected. Given the lack of health-care facilities at Petu might have influenced the five participants’ family members on keeping them indoors for their safety. The lack of confidence in the Ghanaian health-care system also propagated fear and panic among participants. This situation is also documented by Agyemang-Duah et al. (2019). This showed nothing but distrust in Ghana’s health-care system, especially when participants knew that older persons were among the most vulnerable to the disease. Therefore, the present study suggests that Ghana’s already weakened health-care system became threatened by the pandemic while making rural older persons defenseless and paranoid. This event in the data is also documented by other studies such as Lloyd-Sherlock et al. (2020) and Adokiya and Awoonor-Williams (2016).

The already not enough disability funds for older persons with disabilities became less valued as it could not satisfy participants’ extra expenditure during the pandemic. This event in the data is also documented by Ocran (2019) who indicates sudden financial challenges among participants during the difficult times.
The Government of Ghana seems to be the best option for participants’ welfare. Participants suggested the relevance of the Ghanaian Government in transforming their lives for the better through inclusive policymaking. Although the relevance of gerontologists in Africa is less recognized as indicated by Lloyd-Sherlock et al. (2020), it was evident in the data for the field of gerontology in Ghana to be fully recognized. Concerning participants’ challenges during the lockdown period, they believed that gerontologists could have served as their mouthpiece to raise their basic needs before government-related agencies to enhance their well-being. Perhaps, participants’ lack of education might have denied them the official way of reaching the Government of Ghana with their challenges. Therefore, calling on gerontologists who are professionals to channel their challenges through bureaucratic channels on their behalf.

For the participants who lived alone, experiences of hunger, decline in family support, suicidal ideation and stigmatization influenced their desire for formalized care. This might be as formalized care will be a designated facility for disabled persons benefiting from continued care while combating stigmatization during difficult times such as COVID-19. While caregivers were right to stay in their own home for their safety, participants suffered by been alone and hungry. This further explains participants’ desire for formalized care. This event in the data adds to the literature concerning how older persons with disabilities could be cared for during difficult times in rural Ghana. This is because formalized care is not the norm for older persons’ care in Ghana. It will therefore be advantageous for future researchers to explore this area further for a richer understanding and its applicability in rural Ghana.

**Limitation**

The findings of the present study cannot be generalized to a larger or different sample. Therefore, readers should interpret findings with caution. As there were no confirmed cases of COVID-19 in Petu, opportunities to determine real-life experiences, challenges and solutions were missed. With the present study been conducted (analysis) by only one researcher, different perspectives or interpretations might have been missed.

**Recommendations for policy**

Experts with focus on older persons such as gerontologists, social workers and community outreach workers could offer insightful council for policymaking bodies such as the Government of Ghana and related humanitarian agencies in favor of older persons with disabilities (Lloyd-Sherlock et al., 2020). The Government of Ghana should implement more rigorous laws to protect disable older persons from the ongoing stigma and maltreatment. Establishing health-care facilities in rural areas could reduce fear and panic among older persons and especially during critical times such as the COVID-19 pandemic. On-time payment and a possible increment in the disability fund will be able to secure the financial standing among older persons with disabilities during difficult times. The urgency of formalized care in rural Ghana seems plausible to ensure continuity of care among older persons with disabilities during normal and difficult times.

**Conclusion**

This study described the experiences among rural older persons living with disabilities during COVID-19. It was evident that older persons with disabilities in Petu were not fully captured by government policies and welfare services. The lockdown measure affected participants especially, those who lived alone. Thus, caregivers’ rate of attending to participants who lived alone reduced and it was during such times that they needed caregivers’ service the most. However, such service was missed. This resulted in several challenges during the lockdown period. Findings show that the Ghanaian Government has
a lot to do for older persons with disabilities’ daily care and support in rural areas. Therefore, from the findings, the Government of Ghana should begin to consider the need for formalized care for older persons with disabilities.

References


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