

# Caring for "parentless" children

An exploration of work-related experiences of caregivers in children's homes in Ghana

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Ernest Darkwah

Thesis for the Degree of Philosophiae Doctor (PhD)  
University of Bergen, Norway  
2018

UNIVERSITY OF BERGEN



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2018

Date of defence: 19.11.2018

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Year: 2018

Title: Caring for "parentless" children

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Print: Skipnes Kommunikasjon / University of Bergen

**Dedication**

Dedicated to my wife Cynthia, my children Lorraine and Dean, my mother Diana and the memories of my late father Benjamin and brother Fred.

**Scientific environment**

I was admitted for a Master of Philosophy degree in Health Promotion and Development in August 2014, and converted to a PhD candidate in August, 2015 at the Faculty of Psychology, University of Bergen. This PhD project has been made possible by financial support from the Norwegian State Education Loan Fund (Lånekassen) through a quota scholarship position. Additional financial support also came from the Meltzer Fund at the University of Bergen, the Multicultural Venues in Health, Gender and Social Justice (MC-Venues) research group, the Nordic Africa Institute, Uppsala, Sweden and the Faculty of Psychology, University of Bergen. All research activities were carried out at the University of Bergen, Faculty of Psychology, Department of Health Promotion and Development (HEMIL-Senteret). The MC-Venues research group hosted the research. The Graduate School of Human Interaction and Growth (GHIG) were responsible for the training component of the PhD programme.

## **Acknowledgments**

The steadfast love of the Lord never ceases. His mercies never come to an end. They are new every morning. Amen. Thanks to God the Most High for keeping his promise to lead me to greater heights year after year. May his name be praised.

This PhD was financed by the Norwegian government through the State Education Loan Fund (Lånekassen). I am grateful to the government and people of Norway for opening their doors and providing the resources to people from other countries and cultures for the exchange of scholarship and ideas. It has been a wonderful experience living and studying in Norway especially in Bergen with such beautiful people, mountains and fjords. The University of Bergen has been such a great place to study with fellow students from all over the world and departments and faculties ever ready to respond to student needs. The experience has been priceless. I am also grateful to the MC-Venues Research Group, the Nordic Africa Institute, Uppsala, Sweden and the Meltzer Fund for the financial support I received from them.

My most profound and sincerest gratitude goes to my absolutely amazing, most brilliant, ‘SUPER’-supervisor Associate Professor Marguerite Daniel who has instilled in me so much hope and confidence to last me a lifetime. Over the few years that I have come to know you, your confidence in my academic ability, seeing in me capabilities that I never thought I have and pushing me into places I never thought I could fit have changed my outlook to life and made me believe in myself. Your sheer brilliance at problem solving is out of this world. As I begin my academic and research career, all that I wish for is that I can follow your example and standards of professionalism, humanity, goodness and excellence to be a pillar of support for whoever comes my way as you have been unto me. You have been more than just a supervisor; you have been my “white mother”. May God’s blessings overflow in your life. I am forever grateful.

To my co-supervisor Dr. Maxwell Asumeng, who was my main supervisor at master’s level, your excellent guidance and encouragement have helped bring me this far in my academic life. It has been your help and support that have enabled me climb from a

master student to a PhD graduate. Your willingness to support my every move made it possible for me to clear academic hurdles and your insightful and thought-provoking comments always push me to climb higher. Thank you.

To Team HEMIL, my department and second family, I will never forget the care and staunch support I received from everyone throughout my studies. There was never a challenge that Hemilists were not prepared to help me overcome; there was never a time that I needed something for my studies that HEMIL would not provide. The super ladies Maria Alejandra Luttgens Mathieu, Grete Line Simonsen and Dr. Benedicte Carlsen would just not let my questions go unanswered; and Associate Professor Ragnhild Hollekim made sure I got as much teaching experience as possible by inviting me on her courses. Ours at HEMIL is not just an academic department but a close family where every member is fiercely loved. I would never miss a chance to come back.

My heartfelt gratitude also goes to Professor Charity S. Akotia (Dean of School of Social Studies, University of Ghana) for being there for me anytime that I have needed you. From my days as an undergraduate student at the University of Ghana to today, you have never had any doubt recommending me for positions and through that pushing me higher and higher. May God reward you for all the help and support you keep giving me at every stage of my life.

To Professor Emeritus Maurice Mittelmark, you offered pieces of priceless advice to turn me into a PhD candidate when I arrived at HEMIL as a master's student. You gave me brilliant ideas right at the conception stage of this project, and you accepted to be part of my reading team when the draft thesis was completed. To you and the rest of the reading team Associate Professor Fungisai Gwanzura Ottemoller and Assistant Professor Paul Kellner, I am most grateful for your efforts and inputs.

I am also sincerely grateful to Pastor Nicholas Amankona Takyi, my brother Isaac Kwaku Kyere and the entire family of Christ Believers International Ministry (CBIM), Bergen, Norway for your prayers, support and companionship and all the assistance

you have given me since I joined the church. CBIM really offered me a home away from home. God bless you all.

Finally, to my wife Cynthia Akosua Agyapong you have stood with me and fought with me against all odds, against every single challenge. With you by my side, the victories have been sweet. You are a dream come true. Thank you. To my siblings Richard, Mavis, Frank, Kwasi Anokye, Jacklyn and Jacklyn, thank you so much for your wonderful love and support; and to you my late brother Fred Adu Darkwah (AKA High Tension), your kid brother has finally become the doctor you so wanted him to become. Wherever you are, I hope you can look down and smile with pride. Love you.



## **Abstract**

**Background:** Child caregiving work is an essential occupational activity that makes important contributions to the wellbeing of children in the global community. In residential institutions that provide care for children without parental care (CWPC), the often difficult backgrounds of the resident children imply that people signing up for employment as caregivers face challenging work tasks. In the context of Ghana, West Africa, the nature of the socio-cultural and political landscape for raising children adds to the backgrounds of the children to suggest that the work situation could be even more complicated for people entering this occupation. Interestingly, when research is initiated into this complex world of care, the focus tends to be on outcomes for the children. Policy and research priorities have often been to understand the various ways in which the lives and development of the children are affected by that environment. In this sense, attention is rarely paid to the experiences of the employees whose job it is to look after the children. How caregivers experience and navigate this work environment and the impacts that their work has on their health, wellbeing and work practices is therefore largely unknown. This lack of knowledge bodes ill for scientific understanding and evidence-based occupational intervention to support caregivers on whose successes the children's growth and wellbeing depend.

**Purpose:** This project was designed to explore this largely unknown area of work. The idea was to generate insights regarding the work-related experiences of employed caregivers in children's homes (CHs) in a context like Ghana. Using the standpoint of the health promotion theory of Salutogenesis, the project aim was specifically to generate knowledge about caregiver perception of the CWPC in their care, the care work itself and their motivation for doing what they do in the context where they do it. It was also to try to understand the types, nature and sources of possible stressors confronting caregivers in their work and the resources that they draw on to manage their work situation. Finally the project was intended to explore in-depth, the implications that the structuring and funding of CHs have for caregiver work performance and health.

**Methodology:** A qualitative approach with phenomenological design was adopted for this exploration. This approach and design were chosen because of the interest in obtaining in-depth insight into caregivers' subjective as well as shared lived experiences and meaning making of the phenomenon of caregiving as a job within the children's home context in Ghana. A combination of participant observation, focus group discussions and individual interviews was used to collect data. The final textual data were analyzed using thematic network analyses.

**Findings:** It was found that caregivers perceived the residential children as children of God, belonging to 'white men' (due to the use of children's rights laws to raise them) and difficult to raise. Caregivers were mainly motivated by faith or religion, personal social circumstances (such as childlessness) and economic gain. Interestingly, it emerged that aspects of the work environment that were identified as stressors also tended to be resources for caregivers. These included the children, issues related to child rights, the job itself, the work environment, institution-community relations and relationships between caregivers and their own families. Caregiver faith and intrinsic motivation stood out as the primary reported resources. It was also found that the structure adopted by children's homes impacts caregiver work performance by increasing work stress levels, complicating some caregivers' ability to bond with the children and limiting the amount of time that some caregivers have to spend with their own families. These impacts then exposed caregivers to physical, mental and social health risk factors including injuries from slips and falls, mental strain, and loss of social support. Further, it emerged that funding source impacts the frequency of training caregivers receive, the extent of help caregivers receive with their own healthcare costs as well as the extent to which caregivers utilize international regulations like child rights principles in doing their jobs.

**Conclusion:** Caregiver perceptions of the CWPC in their care and motivations for the care work are primarily influenced by their belief systems, cultural values, personal social desires and interpretation of international children's rights laws. While certain perceptions of CWPC (e.g. as "God's children") lead caregivers to show a willingness to engage perceived difficulties in the work, interpretations of international children's

rights laws as “foreign”, spoiling of children, threatening to their jobs and non-fitting to the Ghanaian socio-cultural context affects their attitudes and behaviours towards their jobs and the children. Caregivers experience stress from multiple sources in their work and rely primarily on religion and personal strength as resources to deal with the stressors with little support from their institutions. The structuring of the institutions further complicates the stress situation for caregivers with sources of funding sometimes adding to caregiver stress and other times buffering caregivers against stress. The findings suggest a need for stakeholders’ careful attention to work design and strategizing for residential institutions like children’s homes taking into account caregiver health and well-being. Careful attention to education and the strategies adopted for the implementation of international law and principles in local contexts is also suggested by the findings.

## **List of Abbreviations**

|         |   |
|---------|---|
| CH:     | Children's Home   |
| CRI:    | Care Reforms Initiative                                       |
| CWPC:   | Children without Parental Care                                |
| DSW:    | Department of Social Welfare                                  |
| GRRs:   | Generalized Resistance Resources                              |
| NSD:    | Norwegian Social Sciences Data Services                       |
| RDs:    | Resistance Deficits   |
| SDG:    | Sustainable Development Goal                                  |
| SOC:    | Sense of Coherence  |
| SRDs:   | Specific Resistance Deficits                                  |
| UNCRC:  | United Nations Convention on the Rights of the Child          |
| UNGA:   | United Nations General Assembly                               |
| UNGACC: | United Nations Guideline on the Alternative Care of the Child |
| UNICEF: | United Nations Children's Fund                                |

## **List of publications**

### **Paper I**

Darkwah, E., Daniel, M., Asumeng, M. (2016). Caregiver perceptions of children in their care and motivations for the care work in children's homes in Ghana: Children of God or children of white men? *Children and Youth Services Review*, 66 (C) 161-169 <https://doi.org/10.1016/j.childyouth.2016.05.007>

### **Paper II**

Darkwah, E., Asumeng, M., Daniel, M. (2017) Caring for “Parentless” Children: An exploration of stressors and resources experienced by care workers in Children’s Homes in Ghana. *International Journal of Child, Youth and Family Studies* 8(2): 59–89 <http://dx.doi.org/10.18357/ijcyfs82201717850>

### **Paper III**

Darkwah E., Daniel, M., Asumeng, M. (2018). The impact of organizational structure and funding sources on the work and health of employed caregivers in children’s homes in Ghana *Occupational Health Science (accepted)*

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## **1. Introduction**

Child caregiving work is an essential occupational activity that makes important contributions to the wellbeing of children in the global community (World Health Organization, 2004). Children make up over 26% of the world's over 7 billion population according to 2017 estimates from the United Nations Organization (United Nations Organization, 2018). Although the definition of a 'child' is often complex and therefore debatable (Morrow, 2011, Sagud, 2015), an age range of 0-17 is often accepted as comprising the childhood stage of a person (UNICEF, 2015). Observed cognitive and socio-emotional developmental immaturity among people within this age group often leads to accepted perceptions that they are vulnerable. This has made it necessary for societies to strive to organize resources to provide care and protection for them. To this end, researchers acknowledge that significant investments have been made by the world community over the years towards increasingly making the world environment supportive of the safety, growth and wellbeing of children across the world (Morrow, 2011). One such investment was the introduction of the United Nations Convention on the Rights of the Child (UNCRC) in 1989.

Just like its adult population, the world's children come with different characteristics and demographics. Different generations of children have lived and continue to live under different environmental, political and socio-economic circumstances. These circumstances often act to influence children's experiences and vulnerability statuses. For example, estimates in the literature indicate that about 19% of children live in poverty across the world, one in four live in an area affected by armed conflict or disaster, over 15.5% live with disability and over 53 million lack parental care (Newhouse, Suarez-Becerra & Evans, 2016; Cooke, Hague & McKay, 2016; Gore et al., 2011; UNICEF 2015). These descriptions mean that aside from mechanisms put in place to cater to the general needs of all children, additional specific systems, institutions, actions and measures have had to be adopted in different contexts to respond to some children depending on their specific needs and situations. Thus, there are special schools catering for the needs of children with special learning needs, special hospitals dedicated to responding to the medical and health needs of children,

global aid agencies providing relief and other essential services to children caught in difficult social and political circumstances and child welfare services and institutions responding to shelter, protection and social care needs of children who are deemed to lack parental care.

For the particular group of children who lack parental care, often referred to as children without parental care (CWPC) (United Nations General Assembly, 2010), social systems including residential care institutions (though a last resort<sup>1</sup>) have often been set up by nations across the world to cater for their needs. Over the years however, continuous research and observations of the impact of such residential institutions on the growth and wellbeing of this group of children have yielded controversial results leading to negative public perceptions and arguments for their closure (Gray, Ariely, Pence. & Whetten, 2017; Vashchenko, Easterbrooks & Miller, 2010; Crockenberg et al., 2008; Department of Social Welfare (DSW) Ghana, 2008; Freundlich, Avery & Padgett, 2007; Johnson et al., 2010; Rosas & McCall, 2008). For example, it is estimated that world-wide rates of violence against children are six times higher for children in institutional care compared to children in family-based care (Pinheiro, 2006). Such negative occurrences are frequently blamed on the individuals who work in these institutions as caregivers to provide care for the children (Anas, 2010; 2015). Such reports however, rarely feature the caregiver side of the story. The project presented in this thesis describes one national context - Ghana, West Africa - where such residential institutions play a lead role in providing alternative care for CWPC despite government attempts to reduce their use and ultimately phase them out (DSW, 2008). It is a context where people working as caregivers have recently been in the media for the wrong reasons. Specifically, the work-related lived experiences of this group of workers were explored in-depth with the idea to bring out the caregiver side of the story.

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<sup>1</sup> Residential care institutions are often considered as a last resort care arrangement due to their observed negative influences on children's growth and development.

## **1.1 Children without parental care**

Children without parental care (CWPC) are classified among some of the most vulnerable groups of children in the world (Rus, Parris, & Stativa, 2017). To this end, the care and protection of this group of children is a matter of important concern to governments and the international aid community. According to Ennew (2005), seeking out necessary resources to organize care for CWPC is often a priority particularly for the aid community. It has also become an important yard stick for measuring development progress at global, regional, national and local levels (UNICEF, 2017). The United Nations Guidelines on the Alternative Care for Children (2010) defines CWPC as: “all children not in the overnight care of at least one of their biological parents” (United Nations General Assembly, 2010:6). Researchers and aid agencies interpret this definition to mean that children who fall into this category include those who have lost one or both parents through HIV/AIDs, conflict, illness etc., children living in residential care, with extended families, foster families, on the streets, in juvenile detention and those abandoned by or separated from their biological parents for whatever reasons (EveryChild, 2009; O’Kane, Moedlagl, Verweijen-Slamnescu & Winkler, 2006). Global statistical estimates indicate that over 150 million of the world’s children are CWPC (UNICEF, 2015). A majority of these children live in the developing world with Sub-Saharan Africa (over 56 million) and South Asia (over 40 million) topping regional rankings. This is often due to the prevalence of disease, armed conflict, disasters and poverty in these regions (Maundeni & Malinga-Musamba, 2013; United Nations Children’s Emergency Fund, 2014; Hermenau, Rygaard, Landolt, & Hecker, 2017). In Ghana, researchers estimate that there are about 1.1 million of such children who form about 4.7% of the entire population and 10.4% of the entire children and adolescents population (Bettmann, Mortensen & Akuoko, 2015, UNICEF, 2006).

## **1.2 Care systems for CWPC**

Historically, the provision of care for CWPC has been known to vary across contexts. Such care is often organized on the bases of socio-cultural beliefs about children and childhood, legal, political and economic provisions available in a context. For

example, Abebe (2009) notes that the mode of care preferred for such children in Africa has varied over time and has been dependent on such factors as the relative development of governance structures, availability of resources and the attitudes of different stakeholders. Thus different care options have emerged over the years as societies have strived to meet the care needs of these vulnerable children. Generally, it is observed that family care settings offer a better environment that fosters the growth and wellbeing of all children (Department of Social Welfare Ghana, 2008; Ivanova & Bogdanov, 2013; Whetten et al., 2009). In this sense child welfare experts have advocated for societies to strive to keep families together through the provision of support services to enable children grow with their own families (Krueger, Thomstone & Crispin, 2013; Nelson et al., 2007). In situations where it is deemed necessary for the child to be separated from their family, experts have still advocated for alternative care arrangements that provide a familial environment for such children (Dozier et al., 2014; Groza, Bunkers & Gamer, 2011; Nelson et al., 2007). Consequently, alternative care options such as living with relatives or with a foster family have often taken center stage in providing care for CWPC. However, researchers note that continuous social change, diseases, conflict, disasters, poverty and other occurrences over time have meant that CWPC populations have increased over the years in many parts of the world stretching resources to the limit and overburdening these preferred care systems (Deters and Baja, 2008; Gray et al 2017; Hermenau et al., 2017). In the face of these difficulties other, less preferred alternative care arrangements such as residential institutions have had to be set up to meet the growing demand (Hermenau et al., 2015). As a result of this, the number of residential institutions providing alternative care to CWPC have increased across the world with statistics indicating that over 1.3 million children live in such institutions in Central and Eastern Europe alone while over 300,000 live in them in Middle East and Africa (UNICEF, 2009; UNICEF, 2010).

Traditionally in Ghana, providing care for CWPC used to be a responsibility of extended family members. However the Department of Social Welfare and other researchers note that development agendas, increasing economic difficulty, urbanization and modernization in the post-independence era have gradually undermined and altered long-standing traditional social cohesion and cultural norms

that made caring for CWPC an important responsibility of the adult kin of the lost parents (see Department of Social Welfare, 2008; Agyeman-Duah, 2008; Castillo et al 2012; Manful and Badu-Nyarko, 2011). The deterioration of such social structures has meant that Ghanaian social actors, private individuals, non-governmental organizations (both local and foreign) as well as religious organizations have found the establishment and use of residential institutions (popularly known as Children's Homes (CHs)) a necessary response to the growing CWPC problem. Started by European missionaries, CHs became an important part of Ghanaian society in the pre and post-independence era. They offered care and protection for children who were abandoned for reasons ranging from death of parents through cultural taboos surrounding their births and parentage to social and economic difficulties faced by their parents and family (Department of Social Welfare, 2008).

Over the years however, following reported negative influences of such residential institutions on the growth and wellbeing of children, successive governments of Ghana have made sustained efforts to gradually reduce and ultimately phase out the use of CHs as an alternative care option for CWPC. A specific action to achieve this purpose was the introduction, in 2005, of the Child Reforms Initiative (CRI) (Department of Social Welfare, 2008). The CRI was a government initiative based on the provisions of the United Nations Convention on the Rights of the Child (UNCRC) and similar to the United Nations Guidelines on the Alternative Care of the Child (UNGACC). It is credited with modest achievements of closing down some CHs in Ghana (Better care Network, 2014; Department of Social Welfare, 2008). Interestingly, despite such actions, the establishment and use of CHs has still continued steadily in Ghana as economic hardship, diseases, parental deaths and the lack of an effective child welfare and family support system keeps increasing the number of children becoming orphaned or abandoned (UNICEF, 2012a). Paper I of this thesis presents a table showing a brief trend of development of CHs in Ghana for the past three decades. Presently, reports indicate that there are over 148 CHs providing alternative care to some 4,457 CWPC across Ghana (Alhassan, 2017; Better care Network 2014, Bettman, Mortensen & Akuoko, 2015; Department of Social Welfare Ghana, 2007). Among this number, the DSW notes that only 10 are being regulated by the

government with guidelines from the UNCRC. The practices of the remaining CHs remain unknown and therefore unsupervised.

### **1.3 CWPC care as paid work**

The growing number of CPWC across the world and the corresponding increase in the number of residential institutions necessarily means that an increasing number of people are obtaining employment in the residential child care sector. This is because residential institutions for CWPC often operate by admitting children into residence and hiring and training individuals called caregivers to provide pseudo-parental care for them (SOS Kinderdorf International, 2004). The implication is that aside from being a social environment where a group of vulnerable children receive care, the residential institutional environment is also essentially an occupational environment where a group of people ‘parent’ for pay. The jobs of people who take up this kind of employment are primarily to assume ‘parental’ responsibilities including feeding, clothing and providing emotional, social and psychological support for the children within the confines of the institution (Bettman, Mortensen & Akuoko, 2015; SOS Kinderdorf International, 2004). By implication, Bettman et al., (2015) note that timely and appropriate interpretation and response to the emotional and relational needs of the children as well as ensuring that the children have eaten and are wearing clean clothes at all times is a primary duty of the caregiver. Children’s cognitive and physical development is also associated with the caregiver’s ability to provide sufficient socio-emotional and psychological support (Bass et al., 2016; Groark et al., 2005; Johnson et al., 2010, WHO, 2004). With evidence that the quality of care a child receives impacts their positive functioning in later life (Johnson, Browne & Hamilton-Giachritsis, 2006), it becomes clear that the caregiver’s work outcomes have both immediate and long term consequences for the very lives of institutionalized CWPC.

However, the definitions and descriptions of children who fall into the category of CWPC mean that these are essentially children with difficult backgrounds (Hermenau et al., 2017; Rus et al., 2017; United Nations General Assembly, 2010). Islam and Fulcher (2016) note that it is their difficult background experiences that lead authorities to deem it necessary to place some CWPC in CHs in the first place.

Examples of CWPC experiences have been observed to include abuse, maltreatment, deaths of parents and various forms of trauma (Hermenau, et al., 2017; Islam & Fulcher, 2016). Essentially, CWPC, unlike other children, may require special attention and care implying that whoever becomes a CWPC caregiver will have challenging work tasks of parenting these ‘parentless’ children.

In Ghana, this background description of CWPC combines with the nature of the socio-cultural and political landscape for raising children to suggest that people entering this occupation face an even more difficult task. Following her ratification of the UNCRC, Ghana has initiated several policy and legal actions including the introduction of a Children’s Act (Act 560, 1998) (Government of Ghana, 1998), the establishment in 2001 of a Women and Children’s Ministry, now Ministry of Gender, Children and Social Protection and the introduction of the Child Reforms Initiative (CRI) in 2005. These actions have been described by the DSW as a way to demonstrate the commitment of the government of Ghana towards fulfilling its obligation of safeguarding the rights, safety and wellbeing of all Ghanaian children in line with the UNCRC. Consequently, Ghanaian law requires all CHs to abide by the principles outlined in the UNCRC in carrying out their mandate. Specifically, all employed caregivers are required to follow the UNCRC principles in performing their parenting work (Department of Social Welfare, 2007).

Yet Ghanaian social norms of child upbringing emphasize certain practices that are at odds with at least some of the provisions in the UNCRC (Adongo, 2011; Ame, Agbenyiga & Apt, 2011; Kyei-Gyamfi, 2011). According to Twum-Danso (2009a) socialization norms in Ghana expect children to submit to the control of their parents or adult caregivers without asking questions. Parental Control - the amount of supervision parents exercise, the decisions parents make about their children’s activities and friends, and the rules parents hold for their children (Amato, 1990)<sup>2</sup> - is a key ingredient in good parenting in Ghana. Adults performing parental roles expect and are expected to maintain this form of control (Darkwah, Daniel and Yendork,

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<sup>2</sup> This is a classical definition, but the literature does not provide any recent updates that provide a definition of “parental control” as a unified concept. It rather gives different types of control such as psychological control, behavioral control etc.

2018). In Ghana, disciplinary actions such as corporal punishment are important characteristics of this idea of ‘good parental control’ and ‘proper child care’ is strongly associated with good ‘parental control’ (Kyei-Gyamfi, 2011; Twum-Danso, 2012). This means that provisions in the UNCRC which, for example, seek to protect children from abuse by prohibiting parental actions like corporal punishment have been a source of tension between local Ghanaian communities and child rights advocates (Twum-Danso, 2012). Consequently, despite some reported successes, there have been difficulties implementing at least parts of the international child rights principles in local Ghanaian communities where cultural and religious norms urge adults not to ‘spare the rod and spoil the child’ (Kyei-Gyamfi, 2011; Twum-Danso, 2012; Adongo, 2011; Twum-Danso, 2009a). The interesting question then becomes how caregivers (themselves probably having been socialized with these local norms) bring themselves to work with laws they very likely disagree with and see as a hindrance to ‘proper parenting’ - the job they are expected to do.

Bringing the child rights versus ‘proper parenting’ debate into the CH context in Ghana hints at further possible complications of the work situation for caregivers. Researchers have identified challenges in bonding resulting from the natural, non-blood relationship between hired parents and children in the institutional space as a problem for co-operative work (Browne, 2009; Bullock, Courtney, Parker & Thoburn, 2006; WHO, 2004). The potential dilemma and possible mental strain that having to adhere to child rights may present caregivers risks further straining the caregiver-child relationship. Yet, this relationship is crucial for successful work performance in child care professions (Browne, 2009; Han, 2008). Faced with this complex work situation, caregiver interpretations, perceptions, understanding and motivations may be key in determining how they approach the care work and the children who are the central elements of their jobs. This may in turn play a role in the outcomes of their work for themselves and their institutions.

The foregoing discussion suggests that the context within which caregivers have to work in Ghana is potentially a stressful one. It is a work context where cultural values, international law and other work place factors clash to produce an atmosphere that is



hardly conducive for work as sensitive as caregiving. Accordingly, it would be rational to expect that caregivers in this sector would face some level of workplace stress - a significant employee health and low productivity risk factor (International Labour Organization, 2012). The experience of stress by workers in an environment where vulnerable children live and grow can have negative impacts for both the workers and the children. Work place stress is described as the harmful physical and emotional responses that occur when the requirements of a job do not match the capabilities, resources or needs of the worker (National Institute for Occupational Safety and Health, 1999). It is one of the most common risk factors in today's workplaces (American institute of Stress, 2018), and can have negative consequences including cardiovascular diseases, loss of concentration, burnout, emotional exhaustion, aggression, incivility and general counter-productive behaviours for workers (Gacovick & Tetrick, 2003; Michie, 2002; Spector, Fox & Domagalski, 2006; Torkelson, Holm, Bäckström & Schad, 2016). In the human care services, workplace stress is associated with negative outcomes such as caregiver ambivalence, depression, anxiety, agitation and caregiver-client tensions as a result of work-related stress (Groark et al., 2005; Wieclaw, Agerbo, Mortensen & Bonde, 2006;).

Existing occupational health literature, however, suggests that in such work contexts effective organization or structuring of work, resourcing, training and funding could be a way to support employees and help engender successful work performance and positive health outcomes (Bakker & Demerouti, 2007; Huhtala, Feldt, Lämsä, Mauno, & Kinnunen, 2011; Hyvönen, Feldt, Salmela-Aro, Kinnunen & Mäkikangas, 2009). Work resources in particular have been found to have neutralizing impacts on the effects of work stress on employees (Bakker & Demerouti, 2007). For this reason, scholars define work resources as physical, psychological, social or organizational aspects of the job that reduce job demands and associated physiological and psychological costs, are functional in achieving work goals and stimulate personal growth, learning and development (Schaufeli & Bakker, 2004). Work strategies, design or structuring and funding could all be part of resources or stressors and affect work performance, health and work experiences of employees (Chen & Huang, 2007; Griffin, Neal & Parker, 2007; Kantén, Kantén & Gurlek, 2015; Wilson, DeJoy,

Vandenberg, Richardson, & McGrath, 2004). Against this evidence it can be argued that the effectiveness of structuring or organizational forms of CHs and dynamics of resourcing and sourcing for funds would be key factors on which their successes and that of their employees would depend in the Ghanaian context.

CH structuring in Ghana, as in other parts of the world, often comes in two main forms: the usually preferred *family-style organizational form* in which CWPC live as ‘brothers’ and ‘sisters’ with a ‘mother’ (employed core caregiver) in a family home inside the CH compound long term; and the often criticized traditional *dormitory-style organizational form* where CWPC live in large ‘dormitory’ accommodation with shift-working caregivers attending to them (Abebe, 2009; Dozier, Zeanah, Wallin, & Shauffer, 2012; SOS Kinderdorf International, 2004). CHs in Ghana also obtain funding from varying sources. DSW data shows that while a few are owned, operated and funded by the government, the larger proportion are owned and funded by individuals and private, often not-for-profit organizations (Better care network, 2014; Department of Social Welfare, 2008; Frimpong-Manso, 2016). Funding consistency and funder expectations therefore also make up key issues that caregivers have to deal with. Together, organizational forms and funding sources of CHs may help (as resources) or complicate (as stressors) the working conditions of caregivers.

Overall, the impression is that the CH care work context presents a complex environment within which people taking up employment as caregivers have to perform their work roles. How caregivers experience and navigate this environment and the impacts that their work has on their health, wellbeing and work practices should necessarily be an important focal point of scientific and policy investigation (Castillo et al., 2012; Pretorius, 2013). Knowledge generated from such investigations could be valuable in providing insights into that work space and possibly the underlying factors that may play roles in the often negative work outcomes reported from residential institutions.

Interestingly, when research is initiated into this complex world of care, the focus tends to be on outcomes for the *children*. Policy and research priorities have often been to understand the various ways in which the lives and development of the children are

affected by that environment (see Crockenberg et al., 2008; Freidus, 2010; Groark et al., 2005; Johnson et al., 2010; Perry, Sigal, Boucher & Paré, 2006; Trout, Hagaman, Casey, Reid & Epstein, 2008; Yendork & Somhlaba, 2015). Attention is rarely paid to the experiences of the employees whose job it is to look after the children (van Ijzendoorn et al., 2011; Wolff, Dawit & Zere, 1995; Wolff & Fesseha, 1998). The result of this trend has been a considerable build-up of literature that sheds much insight into better alternative care arrangement options and interventions for CPWC in residential institutions without offering much about the situation of *workers* in these institutions. While it is understandable that CWPC are vulnerable and need all the attention the scientific and policy community can give, it should also be noted that the welfare of these children significantly and necessarily depends on the health, wellbeing and occupational successes of their employed caregivers. The dearth of research into caregiver experiences in this complicated work space bodes ill for scientific understanding and evidence-based occupational intervention to support caregivers in their work. The caregiver's situation in this work environment is, simply, largely unknown.

This project was designed to explore this largely unknown area of work. The idea was to explore and generate insights regarding the work-related experiences of employed caregivers in CHs in a context like Ghana. The project specifically sought to generate knowledge about caregiver perception of the CWPC in their care, the care work itself and their motivation for doing what they do in the context where they do it. It was also to try to understand the types, nature and sources of possible stressors confronting caregivers in their work and the resources on which they draw to manage their work situation. Finally, the project was intended to explore, in-depth, the implications that the structuring and funding of CHs have for caregiver work performance and health.

## **2. Theoretical framework**

Employee experiences within their work settings are often explained within a wide range of theoretical frames depending often on the context in which the employees work and the objectives with which research is conducted (Badayai, 2012; Bakker & Demerouti, 2014; Torraco, 2004). For example, theories such the Job Demand–Resource Model (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner & Schaufeli, 2001) Demand-Control Model (Karasek, 1991) and the Demand-Control-(support) Model (Johnson & Hall, 1988) are popular for research aiming to understand the dynamics of work demands-resource relationships (which largely borders on work stress) and their implications for workers and organizations (van Vegchel, 2005). The Health promotion theory of salutogenesis, though not specifically a workplace research theory, has made inroads into workplace health promotion research for similar purposes (Vokt, Hakanen, Jenny & Bauer, 2015; Grødal et al., 2017). Proposed by Antonovsky (1979), the theory places major emphasis on questions surrounding how some individuals manage to remain healthy and even thrive in the face of stressful life situations (Becker, Glascoff & Felts, 2010). Thus, the popularity of this theory in this area of research is perhaps due to the fact that it places the general experience of stress by individuals and the role of resources in dealing with stressors into perspective, and seeks to explore how individuals utilize resources to deal with stress not by removing stressors, but by thriving while the stressors are still present (Bakibinga 2012; Wennerberg, Eriksson, Danielson, & Lundgren, 2016). In this sense, salutogenesis is seen as a positive health theory that instead of focusing on what causes disease rather focuses on what causes health (Super, Wagemakers, Picavet, Verkooijen, & Koelen, 2016; Wenneberg et al., 2016). Applied to workplaces, the theory provides a framework within which organizations and researchers assess various categories of resources, labeled generally in salutogenetic language as Generalized Resistance Resources (GRRs) (Vokt, Jenny & Bauer, 2013; Mittelmark et al., 2017) and how these can be used to help employees move towards health despite stress. In some cases, some researchers have sought to integrate the salutogenesis theory or aspects of it (e. g. the concept of sense of coherence) with theories such as the Job Demand-Resource Model to further explore the job demands–resource

paradigm to expand knowledge on the demand–resource relationship (Vogt, Hakanen, Jenny & Bauer, 2015).

## **2.1 Generalized Resistance Resources (GRRs)**

Within Salutogenesis, Generalized Resistance Resources (GRRs) are defined as the range of factors (biological or personal, material, psychosocial etc.) which make it possible for individuals to manage tension or stress effectively (Lindstrom & Eriksson, 2006; Volanen, 2011). By implication, and in Antonovsky’s own words, GRRs could be “any characteristic of a person, a group, or an environment that can facilitate effective tension management” (Antonovsky 1972 p. 99). GRRs are thus multi-level occurring at individual, family and community ecological levels (Mittlemark et al., 2017). Examples include knowledge, coping mechanisms, self-esteem, experience, social support, religion and philosophy, cultural capital and many others (Lindstrom and Eriksson, 2006; Volanen, 2011).

The general theoretical assumption around GRRs is that they facilitate an individual’s ability to cope with stress effectively helping to shape outcomes of stress experiences by providing an underload, overload or balance (Mittlemark et al., 2017). However Salutogenesis theory also acknowledges that certain factors, materials or characteristics may counteract individual’s ability to move towards health through GRRs. These are labelled as Generalized and Specific Resistance Deficits (GRDs & SRDs) (Wennerberg, Eriksson, Lundgren, & Danielson, 2017). Interaction between GRRs and stress and the outcomes of this interaction is therefore often further explained within the framework of a strength-deficit continuum described as the Generalized Resistance Resource-Resistance Deficit (GRR-RDs) continuum (Mittlemark et al., 2017; Wennerberg et al., 2017). In this sense the higher an individual is on this continuum, the higher the likelihood that the outcome of the stress–resource interaction will be positive and they are able to perceive consistency and balance in their life situations. Overall the successful application of GRRs in particular across the lifespan is seen within Salutogenesis as the cornerstone to the development of a Sense of Coherence (SOC), a higher resource with cognitive,

motivational and behavioural components central to a movement towards health within stressful situations (Lindstrom & Eriksson, 2005).

## **2.2 The Sense of Coherence**

According to Antonovsky (1996), the sense of coherence (SOC) reflects a global orientation that demonstrates the extent to which one perceives that stressors, deriving from one's internal and external environments are structured, predictable and explicable, that resources are available for one to meet the demands posed by the stressor and that the stressful demands are challenges worthy of investment and engagement. In this sense, SOC has three components: *comprehensibility* (a view that the world is understandable and that a sense of order can be sustained even in unknown circumstances), *manageability* (the extent to which an individual feels there is adequate resources to deal with life's stressors) and *meaningfulness* (a view that things make sense and that what people do in life is worth the energy they invest in it) (Antonovsky, 1993). Thus comprehensibility is often seen as the cognitive component of the SOC describing the individual's cognitive evaluation of a life situation; Manageability is the behavioural component describing the individual's will and plan to act in response to the situation; and meaningfulness is a motivational component describing the individual's affective tendencies towards the situation (Antonovsky, 1996). The availability of GRRs to an individual plays a key role in determining the SOC that is developed and the strength of the SOC in turn influences the person's ability to manage the situation and move towards health (Antonovsky 1996). In essence a strong SOC tends to serve as a GRR capable of helping the individual withstand the impact of the stressful situation. Figure 1 is a simplified presentation of the salutogenic model of health demonstrating the development of the SOC and the role of GRRs in this development:

**Figure 1: The Salutogenic Model of Health and Sense of Coherence (Adapted from Mittelmark, 2010)**

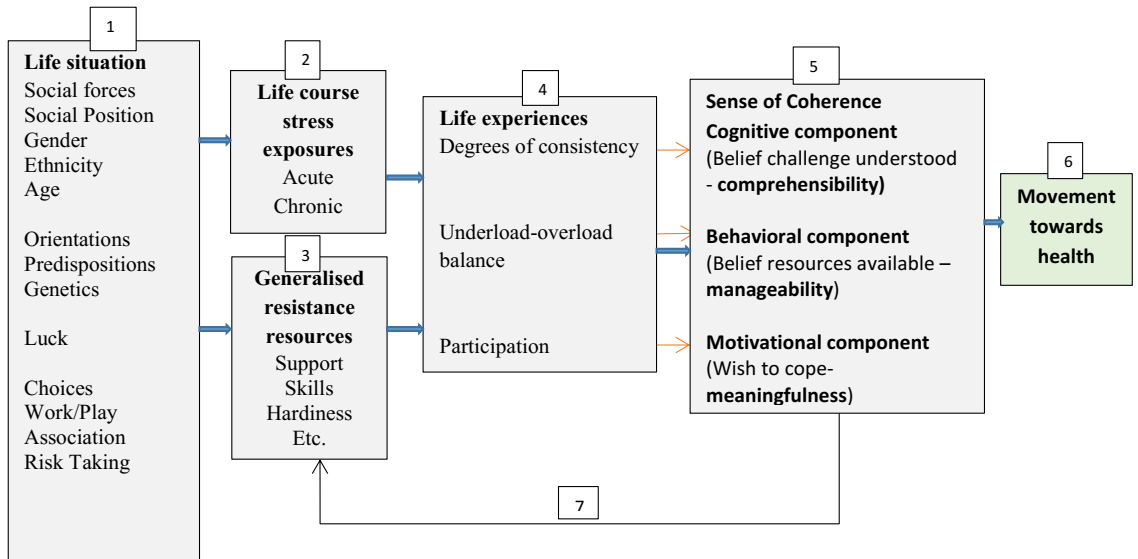


Figure 1 demonstrates that an individual’s life situation (1) exposes them to certain stressors (2) and resources (3) which in turn determine how the individual experiences that situation (4). The degree of consistency that the individual perceives in these experiences, their evaluation of balance (underload-overload) and the extent to which they are willing to engage the situation (participation) translates into their SOC (5). The strength of the SOC then aids in a movement towards health (6) and also aids the individual in further identification and utilization of GRRs (7). In essence the SOC is described as the origin of health within salutogenesis theory (Mittelmark et al., 2017)

The concept of SOC and its role in explaining individual health trajectories has been investigated across many life settings. Applied to workplaces, Salutogenesis theory predicts that work environments where employees experience comprehensibility, manageability and meaningfulness are enabling of the development of SOC which promotes employees’ health and well-being at work (Feldt, Kivimaki, Rantala, & Tolvanen, 2004; Mayer & Boness, 2011). To this end Vogt et al., (2013) define work-related sense of coherence (Work-SoC) as the perceived comprehensibility, manageability and meaningfulness of an individual’s current work environment. The

assumption is that the SOC in the work place is a function of the interaction between the individual employee's characteristics and the characteristics of the work environment (Vogt et al., 2013). Research over the past few years has confirmed this workplace environmental effect on the SOC and demonstrated that the work-SoC is not only mitigating of the negative health effects of work place stressors but distinctively has significant impacts on positive health, work and organizational outcomes (Idan, Braun-Lewensohn, & Sagy, 2013; Mayer & Krause, 2011; Vaandrager & Koelen, 2013). Employee and organizational outcomes that have been correlated to the SOC include work engagement (Fourie, Rothmann, & Van de Vijver, 2008), emotional exhaustion (Feldt, 1997), stress symptoms (Albertsen, Nielsen & Borg, 2001), performance orientation (Moerane 2005) and even organizational change (Pahkin, Vaananen, Koskinen, Bergborn, & Kouvonen, 2011).

Ultimately, the argument is that in a context of adversity, a high sense of coherence built through the availability, identification and utilization of GRRs enables individuals to navigate the situation to improve their physical and psychosocial well-being and negotiate to achieve health in a culturally relevant way (Ungar, 2011). The context of CH work within which this project was carried out is essentially a 'context of adversity' considering the negative public rhetoric and media bashing, the complexities presented by the clash between cultural norms and international law, and the special nature of the children that caregivers have to work with. In addition, CH institutions in general have been subject to threats of closure not only in Ghana but around the world due to research findings that portray them as negative for the growth and wellbeing of the children who live in them (Department of Social Welfare, 2015; Ivanova & Bogdanov, 2013). In the Ghanaian situation several government attempts have been made, as described earlier, to close down or phase out CHs. CH workers are therefore presented with a life situation (an occupational one in this case) where, aside from having to navigate a complicated work space, they also rationally have to deal with feelings of job insecurity. In order to fully understand their experiences and make meaning of it, it was essential that the research be placed within the framework of a theory that allows for observing and recording how individuals and groups navigate difficult life situations to remain healthy. The salutogenesis theory and the concept of



sense of coherence provided such a framework and therefore were adopted. It should however be noted that in using the Salutogenesis theory and the Salutogenic Model of Health, key concepts like the GRRs and SOC were not necessarily “measured”. They were rather used as guide to frame research questions and lead the inquiry (See Appendix 1). The salutogenesis theory was used as inspiration and orientation to research providing a point of view or lens for critical discussion and interpretation of much of the findings that emerged. For this reason, two of the papers (Papers II & III) use salutogenesis theoretical lenses to explain findings and support the rationale behind the study respectively. The idea here was not to necessarily test the theory or use it as the bases for the research, but rather use it to inform the conduct of this research, and as a standpoint from where caregiver experiences could be understood.

### **2.3 Research aim, objectives and questions**

The overall aim of this project was to explore the work-related experiences of caregivers in children’s homes in Ghana. To achieve this aim, three main objectives were developed each informed by two research questions.

Objectives:

1. To explore caregiver perceptions of the children in their care and motivations for the care work (Paper I)
  - a. Research question 1: How do caregivers perceive CWPC in their care?
  - b. Research question 2: What motivates caregivers to work in the context of CHs?
2. To investigate the sources, types and nature of stressors and resources as experienced by caregivers in the CH context of care work (Paper II)
  - a. Research question 3: What stressors confront caregivers in their work?
  - b. Research question 4: What resources do caregivers draw on to manage the work situation?
3. To find out how organizational forms and funding sources of CHs impact the work and health of employed caregivers in the CH context (Paper III)

- a. Research question 5: How does the organizational form of a CH impact the caregiver health and ability to carry out work duties?
- b. Research question 6: How do funding sources and funder expectations impact caregiver work and health?

### **3. Methodology**

#### **3.1 Project setting**

The project was carried out in Ghana, West Africa. Ghana covers a land area of approximately 227533.00 sq. km. The country is located on Africa's west coast. It shares borders with Burkina Faso to the north, Ivory Coast to the west, Togo to the east and has a coastline on the Gulf of Guinea to the south. It has an estimated population of about 28 million people spread across 10 administrative regions (Ghana Statistical Service, 2013; National Population Council, Ghana, 2018; World Bank, 2016). With an estimated population growth rate of 2.5% (2000-2010 estimates), the country's population is rapidly growing despite reported decline in fertility (Ghana Statistical Service, 2013). People below the age of 19 make up about 48.9% of the population making it a very youthful one. The proportion of children (0-15) is described as "substantial" – ranging from 21.6% to almost a third across the 10 regions (Ghana Statistical Service, 2013:7). Issues about the lives and wellbeing of children are therefore quite important in the national agenda. Social problems including parental deaths, poverty and child abuse expose some children in Ghana to conditions that lead national authorities and other entities to explore alternative care options for them (Department of Social Welfare, 2008). Such alternative care options include the establishment of CHs. Field work and data collection for this project were conducted in three of such CHs selected from three regions: the Greater Accra region, the Eastern region, and the Northern region.

##### *3.1.1 Greater Accra Region*

Hosting the capital city Accra and located inside Ghana's southern coastal belt, the Greater Accra region is the smallest administrative region in land size. It is however the second most populous with an estimated population of 4,613,637 (Ghana Statistical Service, 2016). The region is home to the seat of government and has Ghana's highest proportion of urban dwellers (90.5%) - a situation attributed to the high concentration of industries and commercial activities in the region (Ghana Statistical Service, 2015). Despite a relatively lower poverty rate in this region, many

children lack appropriate parental care, with an estimated 61,492<sup>3</sup> children living on the streets as at 2011 and therefore exposed to dangers such as abuse (Böhm, 2017; Department of Social Welfare, Ghana, 2011). Consequently, the region has seen an increase in the number of CHs being established and a corresponding increase in the number of adults gaining employment as caregivers in these institutions.

### *3.1.2 Eastern Region*

The Eastern region is located in the southern belt of Ghana occupying 8.1% of Ghana's total land area and is categorized among the forest or farming regions of Ghana (Government of Ghana, 2016). With an estimated population of 3,028,597, the region is the 3<sup>rd</sup> most populous in the country (Ghana Statistical Service, 2016). Despite being named as part of Ghana's "food basket" (Spillan & Domfeh, 2017: 149), poverty rates in this region are still considerably high leading many of the young adults to migrate to the Greater Accra region in search of a better life. This situation and its consequent social problems such as broken families often leave many children without appropriate parental care. This has contributed to CHs being established here to respond to the children's needs.

### *3.1.3 Northern Region*

Although the largest of Ghana's ten regions by land size (70,384 sq. km or 31% of Ghana's total land area), the Northern region is among the least populated regions in Ghana (estimated population of 2,858,793). It is also classified among the country's three poorest regions (Ghana Statistical Service, 2016). The region has the largest mean household size of the ten regions (Ghana Statistical Service, 2015). This has had implications for children in this region as they are often expected to help generate income for their families by helping with work on the farms or in some economic activity. The 2014 child labour report of the Ghana Living Standards Survey (GLSS) indicates that rural savannah areas of Ghana (predominantly comprising the northern sector) recorded the highest percentage (88.5%) of child labour in its population compared to populations in Southern Ghana (Ghana Statistical Service, 2014). The

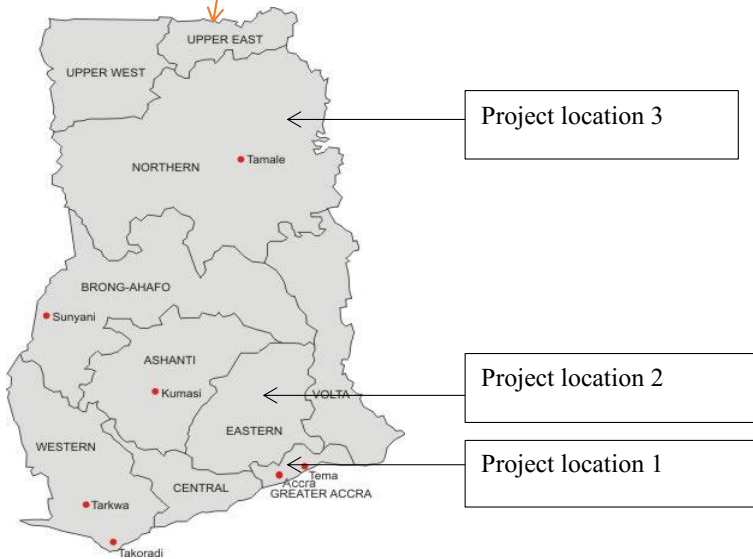
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<sup>3</sup> Statistics from government sources are not peer-reviewed

Northern region has therefore been an area where some CHs have been established with the aim to provide alternative care for vulnerable children (Alhassan, 2017).

Overall, these three regions are home to some of the largest CHs in Ghana. The CHs in these regions are a mix of government-owned and private-owned institutions receiving funding and resource support from both local and foreign sources. As in other parts of the country, the CHs here also have different organizational forms. Some adopt the traditional dormitory-style organizational form while others operate the often preferred small family-style forms. These regions therefore provided a suitable context for exploring work-related experiences of people who work in CHs. Figure 2 shows Ghana's location inside Africa and the specific locations inside Ghana where the project was carried out:

**Figure 2: Ghana's location inside Africa and the specific project locations in Ghana**



### **3.2 Research approach/ Methodology**

I adopted a qualitative methodological approach for this project. The decision to use this approach stemmed from the natural fit between the nature and goals of qualitative methodology and the aims of this project. Founded on constructivist and interpretive worldviews of subjectivity in human experience, the qualitative approach to research is premised on the belief that human subjective experiences of a phenomenon are important sources of knowledge about that phenomenon within the context where it is experienced (Cresswell, 2009; Green & Thorogood, 2014). The approach is therefore considered useful in exploring emerging areas and for research in which the emphasis is on understanding human experiences of phenomena in specific contexts (Patton, 2002). This research approach often follows a process theory in which explanations that narrate how a series of events develops to produce particular outcomes are provided (Van de Van, 2007). Qualitative methodology emphasizes obtaining detailed information in order to provide in-depth understanding of the issues under study. To achieve this, qualitative researchers actively participate in the research process through interaction with the research participants to create knowledge (Green & Thorogood, 2014). Carr (1994) observes that its emphasis on context and depth allows qualitative research to produce more holistic view of phenomenon under investigation. However, this focus on context means that qualitative research is often criticized for having limited scope to generalize (see Yardley, 2000; Malterud, 2001). The idea behind this project was to develop in-depth insight into the complexities of the unique work environment created within children's homes in Ghana and how caregivers subjectively navigate this work environment. I embarked on this enterprise with the belief that exploring the subjective experiences of caregivers about their jobs and the phenomenon of care within that context would make valuable contribution to scientific and public understanding of that work environment. With this aim, I found qualitative methodology the most suitable methodological approach to answering my research questions.

### 3.3 Epistemology, Ontology and Axiology

Qualitative research is often steeped in an *epistemology* of social construction. Epistemology refers to the nature of knowledge and how researchers assume knowledge can be created (Mertens, 2008). The epistemology of social construction assumes that people construct meanings for themselves based on their experiences within a context (Carter & Little, 2007). Qualitative research knowledge is therefore actively constructed through interaction of subjectivities between the researcher and the researched within a context where both parties are present (Carter & Little, 2007). This is the epistemological standpoint from which I approached this research. The knowledge generated in this research was actively constructed from a combination of my observations of the care work and caregiver narrations of their subjective perceptions, opinions and interpretations of the phenomenon of care within the context of their institutions.

In addition to epistemology, the relevance of research is often evaluated on the basis of its ontological underpinnings (O'Reilly & Kiyimba, 2015). Researchers are therefore often encouraged to explain their ontological assumptions to clarify how the information they present should be understood. *Ontology* refers to conceptualizations or philosophies about reality and its features (Cresswell, 2013, O'Reilly & Kiyimba 2015:5). In this sense, ontological debates often centre on the nature of social reality and whether it exists independently of human interpretations and conceptions (Ormston, Spencer, Barnard, & Snape, 2014). In conducting this research I followed an ontology of 'subjective' reality (often known as relativism) as opposed to 'objective' reality (often known as realism) (Bryman, 2008a; Denzin & Lincoln, 2005). Relativists believe that social reality is historically bound and actively constructed by individuals through a complex interaction between their own cultural backgrounds, beliefs and interpretations of the world. Reality therefore is multiple, complex, subjective and differs from person to person. Realists on the other hand believe that reality is "independent of the human mind regardless of whether it is comprehensible or directly experienceable" (Levers, 2013: 2). I sought to generate information about the realities of the phenomenon of institutional child care from an



insider point of view by exploring the subjective experiences of the people who are directly involved in it. By interacting with caregivers and exploring their subjective experiences and the meanings they attach to these experiences, multiple realities emerged. Caregivers shared their own interpretations and therefore realities of the care work, the children, their institutions and the Ghanaian context within which they provide the care services. These multiple realities taken together created the knowledge presented in this research.

The interaction between the researcher and the researched within a context often raises axiological questions regarding how information gathered using this approach is interpreted. *Axiology* (philosophy of values) describes the intricate ways in which value systems may influence the generation and interpretation of information during research and therefore affect the ‘knowledge’ created (Hiles, 2012). Carter and Little (2007) observe that the epistemology of qualitative methodology is in itself axiological as the creation of knowledge from capturing how people relate and give meaning to their social, cultural and material contexts necessarily factors in the value framework within which the meanings are obtained. To address questions of axiology, qualitative methodology allows researchers to openly acknowledge the roles their own values might play in the process of generating knowledge. This makes the qualitative approach to research flexible and, unlike quantitative approach, allows for the emergence of information and subsequent subjective interpretation. In using the qualitative approach, I maintained awareness of the inevitability of my own values combining with those of my participants to influence the creation of knowledge here. The reflective processes I adopted to navigate this value influence is discussed later on in this chapter (see Section 3.7).

### **3.4 Project design**

I used phenomenological design for this project. According to Smith, Flowers and Larking (2009), phenomenology is mainly centered on capturing and understanding the lived experiences of individuals and their interpretations of those experiences within a context. The central issue of concern in this design is how people perceive

particular experiences related to a specific phenomenon which then presents a window of opportunity to getting a broader insight or understanding into their social world.

Certain key features of phenomenology made it particularly suitable for this research project. Phenomenology emphasizes *subjectivism* – the idea that an object or a phenomenon may mean different things to different people or different things to the same person under different circumstances (Langdrige, 2007:9). In this sense, studying people’s subjective interpretations of a phenomenon is essential for the acquisition of knowledge about their behavior towards that phenomenon. Husserl’s concepts of *Noema* (*what* is experienced) and *Noesis* (*how* something is experienced) are also important features of phenomenology that feed into subjectivism. The argument is that what people experience and how they experience it is the basis of their meaning making and informs the structure of their intentional acts within the context of experience (Rassi & Shahabi, 2015). O’Reilly and Kiyimba (2015:14) summarise phenomenology as:

“...a way of thinking that emphasizes the need for researchers to achieve an understanding of their participants’ worlds from the participants’ point of view and the ways in which those participants make sense of the world around them”

The idea in using phenomenology as the research design in this project was therefore to adopt an open and explorative approach where participants define and describe the phenomenon of child care in the context of children’s homes in Ghana without any limiting predefined response alternatives. This way, participants were able to expatiate on what they experience, how they experience it, what those experiences mean to them and how it affects them. This provided a better opportunity to understand the participants’ world of child care work which was the aim of this project.

Two forms of phenomenology - descriptive phenomenology and interpretive phenomenology - were used in this project. Descriptive phenomenology is simply defined as the ‘pure’ description of participant experiences while interpretive phenomenology refers to the interpretation of such experiences (Matua & Van Der Wal, 2015). The two forms therefore represent different levels of conscious awareness

on the part of the researcher. The former allows the researcher to stay as close as possible to what is actually experienced and the latter further removes the researcher from the experience allowing for the development of abstract conceptualizations and the extraction of participant meanings from the experiences recounted (Smith, Flowers & Larking, 2009). Matua and Van Der Wal (2015) further observe that while descriptive phenomenological approach helps illuminate often poorly understood aspects of experience, the interpretive approach helps explore contextual features of an experience relative to other influences of the people experiencing the phenomenon. Since this study was about capturing lived experiences of caregivers and then further understanding the meanings that caregivers attach to these experiences, it was essential that I combined both forms of phenomenology in order to obtain deeper understandings of caregiver experiences. I utilized the descriptive form of phenomenology during the initial stages of the research through participant observation. I stayed close to the experiences of the caregivers working with them and engaging in informal conversations and interactions. This helped in obtaining rich caregiver descriptions of their experiences. I utilized interpretive phenomenology later in the study where I conducted focus group discussions and interviews. Here, I was further removed from participants who were left to openly recount their experiences and interpretations of those experiences.

The ability of a researcher to fully capture the lived experiences of others without fusing it with his or her own personal experiences and interpretations is however a subject of ongoing debate inside qualitative research circles and has become a point of criticism for phenomenological design (Le Vasseur, 2003). On the one side of the debate is the bracketing argument which promotes the idea that it is essential for qualitative researchers to seal off (bracket) their own personal prior experiences and interpretations of a phenomenon in order to fully capture the experiences of others without any bias (Dowling, 2007). Supporters of this idea believe that bracketing is possible and is an important means through which qualitative researchers can actually 'see' a phenomenon purely as it is. On the other side of the debate is the argument that human beings are essentially products of their experiences and histories and therefore see and interpret the world through the lenses of their own pre-understanding (Laverty,

2003). Supporters of this idea believe it impossible for human researchers to completely bracket off their own previous experiences and encounter new phenomena without referring to their past experiences. The idea here is that there is always some prejudice in the understanding and the construction of knowledge in using the qualitative approach to research including phenomenological design. In the midst of this debate, Whitehead (2004) notes that adopting self-reflective processes, through which openness to these prejudices can be achieved by the researcher, helps qualitative researchers understand others and view new phenomena without having to filter them through their own previous experiences. Thus, maintaining an awareness of one's own prejudices helps qualitative researchers safely use the phenomenological design without taking anything that is said for granted. I followed this advice in using the qualitative research approach and the phenomenological design for this project. I maintained constant awareness of the potential to view and understand participant experiences through the lenses of my own history and background and stayed open to participant stories as they were told. A detailed discussion of the specific processes and actions I took to maintain awareness of my positionality is given later in this chapter (see section 3.7)

### **3.5 Participants**

#### *3.5.1 Selection of children's homes*

I approached three children's homes in the three regions described in section 3.1 to participate in the project. I chose these homes on the basis of their different characteristics such as size, ownership and organizational form. The idea was to collect information from CHs with different sizes, structures and characteristics to help generate balanced information regarding the phenomenon of caregiving and the roles of the different CH characteristics in caregivers' work. All three CHs agreed to participate. Two were owned and resourced by private, foreign entities and one was owned and resourced by the government. Also, two were operating in a family-style organizational form and one was operating in a traditional dormitory-style form. At the time of data collection there were over 500 children living in the three selected CHs.

### *3.5.2 Recruitment/ Sampling of participants*

I used a combination of purposive and snowball sampling techniques in that order to recruit participants from the selected CHs. Purposive sampling focuses on identifying and recruiting a specific group of people to participate in a research due to the researcher's judgement of their knowledge and experience about the phenomenon under study (Etikan, Musa & Alkassim, 2016). Snowball sampling relies on participants already in the study to suggest other potential participants (Palinkas et al., 2015). I purposefully sought to recruit core or principal caregivers (CH employees who are in day-to-day contact with the resident children working as hired parents) because they experience the caregiving work first hand. However, in order to obtain information from a broader spectrum of experiences to better understand the entirety of the care work in the CH context, I also recruited other institutional staff for participation. These included institutional directors, teachers, health workers and social workers.

I began the recruitment process before I started participant observation and continued recruiting during participant observation. I approached each participant individually through informal conversations to ask for their voluntary participation in focus group discussion and interviews. Some agreed to participate in both and others agreed to participate in either focus groups or interviews. Once these primary participants were recruited, they were asked to suggest any other institutional staff they thought could provide more information on the research topic. Such staff was approached and requested to participate. The inclusion criterion was six months or more of working in CWPC caregiving. This was to ensure that data were collected from individuals with substantial experience in that line of work. Eventually, a total of fifty-seven workers from the three CHs participated in the research. There were forty-one core caregivers ('mothers', 'fathers' and 'aunties' in charge of raising the children in the dormitories or family homes), three social workers, two resident health workers, five teachers, three institutional directors, and three volunteers who were former institutional

children) involved in the study. Table 1 presents detailed demographics of the participants involved:

**Table 1: Detailed demographics of participants**

| Item                               | Category                                 | Number |
|------------------------------------|--|--------|
| Sex                                | Male                                     | 9      |
|                                    | Female                                   | 48     |
| Age Range                          | 25 -35                                   | 5      |
|                                    | 36 - 45                                  | 5      |
|                                    | 46 - 55                                  | 38     |
|                                    | 56 -58                                   | 9      |
| Education                          | Post -Graduate                           | 2      |
|                                    | Bachelor level                           | 5      |
|                                    | Professional/Voc/Dip                     | 15     |
|                                    | Middle school                            | 35     |
| Work Role                          | Manager/Director                         | 3      |
|                                    | Mother/Principal                         | 30     |
|                                    | Assistant<br>Mother/Auntie               | 11     |
|                                    | Former institutional<br>child/ Volunteer | 3      |
|                                    | Resident Nurse                           | 2      |
|                                    | Teacher                                  | 5      |
|                                    | Social Worker                            | 3      |
| Length of<br>Service (in<br>years) | 0 - 10                                   | 13     |
|                                    | 11 - 20                                  | 24     |
|                                    | 21 - 30                                  | 13     |
|                                    | 31 - 40                                  | 7      |
| Marital<br>status                  | Single                                   | 18     |
|                                    | Married                                  | 17     |
|                                    | Divorced                                 | 15     |
|                                    | Widowed                                  | 7      |

Source: Fieldwork data

### 3.6 Data collection methods

Data collection took place from June 2015 to March 2017. The data collection was in three phases. The first phase took place from June to August, 2015 at project locations one and two (See Figure 2, page 22). Only participant observation and focus group discussion took place at location two during this phase of data collection. The second phase involved interviews from March to April, 2016 at project location two and the third took place in March, 2017 at project location three (see Figure 2, page 22). Three qualitative data collection techniques were employed at each location: first, participant observation, then focus group discussions and finally, individual interviews. The decision to use these methods in that order was deliberate and informed by three main factors. First, abuse and corruption scandals that had previously

engulfed the institutional child care work sector in Ghana meant that I needed a data collection strategy that enabled me to interact informally over an extended period of time with CH staff in order to gain their trust and acceptance and encourage participation. Second, I intended to build a data collection pattern of triangulation in which information collected with one technique adds more depth to that collected with another technique. This was to fulfill rigour and reliability requirements of qualitative research. Third, evidence from qualitative research literature suggests that studies that adopt an emic perspective (in which the researcher seeks to understand things from an insider point of view) require the presence of the researcher in the same context as the 'actor' (Denzin & Lincoln, 2012: 5). Considering that my aim was to obtain an insider perspective of the phenomenon of institutional child care work, combining these methods gave me a good opportunity to be present in the same context with participants.

### *3.6.1 Participant observation*

I began the data collection process with participant observation. This technique involves a process that enables researchers to learn about the activities of people under study in their natural setting through observing and participating in those activities (DeWalt & DeWalt, 2002). Kawulich (2005) notes that the technique has been used across many disciplines to collect data about people, processes and cultures in qualitative research. Participant observation is also known to hold the advantage of giving opportunity to researchers to familiarize themselves and build rapport with research participants and the research environment (DeWalt & DeWalt, 2002). The technique helps increase transparency and dependability of qualitative research information through its ability to help address barriers like power relations between the researcher and the researched and foster a collaborative work relationship (Guest, Namey & Mitchel, 2017; Kawulich, 2005). In this research, these attributes of participant observation came in handy considering events that had occurred on the institutional child care work scene in Ghana prior to data collection. Investigative journalists had gone under cover into some CHs and had come out with secretly recorded videos alleging abuse of children and corruption among institutional staff (Anas, 2010; Anas 2015; Modern Ghana, 2010). This had brought the entire residential care worker population in the country into the media spot light for the wrong reasons

with some caregivers eventually being jailed or losing their jobs. Consequently, CH institutional staff had become quite suspicious and distrustful of strangers coming into their institutions looking for information. Thus, though participant observation is an ethnographic technique and not necessarily a key technique for a phenomenological study design, using it was necessary to enable me build rapport by interacting with them daily. Workers gradually warmed to me and became interested in the study once they understood that the research was about listening to their views, experiences, perceptions and motivations for the job. The nature of my participation in using this technique was not that of a “professional caregiver” or organizational employee per se. I rather made myself a kind of an extra hand and volunteered helping children with homework, joining in compound cleaning, cooking, playing games and holding informal conversations with children and workers alike. Aside from the advantage of giving me opportunities to observe caregivers in their natural work environment and pick up first-hand information regarding caregiver handling of various work situations, the participant observation offered a platform for recruiting potential focus group discussants and interviewees. Three participant observations were conducted one in each institution, with an average period of one month. During these periods I was careful to keep field notes and reflections in journals as a first data set and to help me further understand caregiver perceptions in that context. These notes also helped me to further develop my interview guide.

### *3.6.2 Focus group discussion*

The participant observation was followed by focus group discussions involving participants identified through the observation in order to build on the information obtained through the observation. Focus group discussion can be described as organized discussions involving a selected group of individuals who share similar backgrounds or circumstances to gain information about their shared norms, views and experiences about a phenomenon (Krueger & Casey, 2014; Barbour, 2005; Skovdal & Cornish, 2015). The technique is popular for the ability of the interactions involved to trigger issues in the minds of participants that could hitherto be overlooked in, for instance, individual interviews (Morgan, 1997). Using focus groups in this project



allowed caregivers to express subjective as well as shared experiences, meaning making and perceptions about the phenomenon of care and the complexities of the care work in the context in which they work. The group compositions were carefully done to ensure that participating caregivers were comfortable with the themes under discussion. A thematic guide with themes centering on caregiver perceptions of the children in their care, the care work itself, their motivations, stressors and resources and their health and work roles within their current organizational forms and funding sources was designed and utilized for the focus group discussion (See Appendix 1). Only core caregivers ('mothers' and 'aunties') were involved in the discussions. This was done to reduce potential participant discomfort and intimidation that could occur when higher institutional officers and subordinates are put together in such groups (Krueger & Casey, 2014). Three focus group discussions were carried out in total (one in each institution) with an average group size of eight and duration of two hours and ten minutes. I played the role of facilitator in each discussion. Despite the care taken to make sure discussants were comfortable with the themes under discussion, I still observed instances where some discussants seemed either uncomfortable to go deeper in their contributions or simply held back and agreed to what others were saying. I noted down such participants and later requested interviews with them. Some focus group participants therefore also participated in individual interviews.

### *3.6.3 Individual interviews*

In order to further explore individual opinions and gain deeper insight into caregiver self-interpretations of the care work situation (Skovdal & Cornish, 2015), I conducted individual in-depth, face-to-face interviews to complete data collection in each institution. I used the interviews to try and collect additional information to build on that obtained from the participant observation and focus group discussions, gain more depth into already shared experiences and provide a private space for caregivers who might have been possibly uncomfortable to share some of their experiences in public. In accordance with suggestions in the qualitative research literature (see Wolcott, 2005; Hammersley & Atkinson, 2007; Kvale & Brinkmann, 2009) I began the interviews with the same semi-structured thematic guide used in the focus groups. I started with

general open-ended questions based on the themes used in the focus groups and then gradually probed deeper with more specific questions based on participant responses (See Appendix 1). In all, 53 interviews were conducted with 19 interview participants having already participated in focus groups. Each interview took place at a time and place chosen by the participant and in either Twi (local Ghanaian Language) or English depending on the preference of the participant. The interviews lasted for an average of one hour and 35 minutes.

Admittedly, it could be argued that the combination of these three data collection techniques make this project look ethnographic. However it must be noted that ethnographic research is more about cultural roles and practices than lived-experiences of a *specific phenomenon*. This project is phenomenological in the sense that the focus was on exploring lived-experiences of a group of workers about the specific phenomenon of institutional child care. The systematic combination of these three data techniques was to ensure multiplicity of data sources for the study. Their use culminated in a tripod of data sources upon which triangulation was achieved. Achieving triangulation was crucial for me in my data collection process as it contributed to increased rigour and helped me identify convergence, inconsistencies and contradictions in perspective between what I observed and what participants shared.

### **3.7 Trustworthiness**

#### *3.7.1 Role of the researcher*

Strategies for collecting data in qualitative research such as participant observation, focus group discussions and face-to-face in-depth interviews which were used in this study are designed to be explorative, often involving continuous contacts between the researcher and the participants (Silverman, 2013; Green & Thorogood, 2014). This leads to the development of a researcher-participant relationship which eventually makes the researcher become involved in generating and interpreting information (Cresswell, 2007, Råheim et al., 2016). The qualitative research approach therefore accepts the role of researchers in generating knowledge and does not claim complete objectivity in its practice. This exposes qualitative research to criticism from research

traditions such as quantitative research which is steeped in logical positivistic philosophy and emphasizes objectivity and statistical rather than personal interpretations of data (Golafshani, 2003). The lack of objectivity however does not compromise the quality and integrity of qualitative research findings. As long as researchers openly identify the values and biases that they bring to the study and take conscious steps to reduce the extent to which they influence the knowledge generated, trustworthiness can be improved (Kvale & Brinkmann, 2009). Trustworthiness of qualitative data refers to the extent of confidence that a qualitative researcher took appropriate steps to ensure that data was ethically collected, analyzed and reported (Carlson, 2010). I discuss below some of the procedures I adopted to reduce my influence on the participants and the research process and to collect data that is largely representative of participant experiences within the context.

### *3.7.2 Reflexivity*

Qualitative research understands that the researcher is an important instrument in collecting, describing and interpreting information and could therefore also be an important influence on the overall outcome of the research. In this sense, Carlson, (2010) observes that it is an important requirement of qualitative researchers to utilize reflexivity - a conscious process of self-reflection in which researchers recognize that they have significant influences on the research development and participant engagement (Curtin & Fossey, 2007; Råheim, 2016). Doing this, according to Kvale (1996), could help reduce biased subjectivity in which researchers avoid reporting evidence that contradicts their own expectations and opinions and rather report, interpret and draw their own conclusions. In this sense I am fully aware and acknowledge that the role that I played in this research was influenced by my educational and professional backgrounds and experiences.

Coming from a professional teaching background both at primary school and university levels, I am well experienced in taking the lead role in classroom-like situations and explaining issues to students. I have therefore often found myself taking the larger share of power in such discussions. One main challenge that has been identified in qualitative research data collection is unequal power relations between

interviewers and interviewees with interviewers often dominating and exerting influence on interviewees consciously or unconsciously and thereby compromising responses (Cresswell, 2009; Green and Thorogood, 2009). Being aware of this, I made sure that during the focus group discussions which resembled classroom discussions, I only played the role of a facilitator or moderator. I consciously avoided assuming any position of power or dominance but rather only moderated the discussions by intermittently introducing the issues to be discussed and leaving participants to recount their experiences and interpretations. This conscious awareness was maintained throughout the research process including during participant observations and interviews.

Further, I am a Ghanaian with high education relative to the educational statuses of the participants, and living abroad (which increases my social status in local Ghanaian communities). This meant that it was possible that power differentials could influence the researcher-participant relationship in a way that could put me in a position of power and the participant feeling obliged to respond in ways that may please me as suggested by Råheim et al., (2016). This was one of the reasons participant observation was important for this project as that allowed me to take specific steps to try to create a welcoming, non-authoritarian, non-threatening and open environment as a way to encourage openness and authenticity

Also, I went into the field at a time when CHs in Ghana were in the media for the wrong reasons. A video running under the title “‘CARE’ less – The Devil and the Orphanage,” recorded under cover, had surfaced alleging caregiver abuses of children. This had triggered public antipathy towards CH workers and legal action against the operators and managers of some of the homes (Anas, 2015). I was fully aware that my potential participants would likely be suspicious when I went in there asking questions with an audio recorder. I reflected on this and acknowledged that this could have significant implications for the data that I obtained. It was therefore important for me to find a means of getting accepted and making the participants comfortable enough with me to share their experiences without necessarily holding back. The situation required that I spend significant time building rapport with my potential participants in

order to establish trust and get them to understand that I was not a threat to them. Indeed, some participants and even some officers from who I sought ethical clearance gave me the cold shoulder during the initial weeks of the fieldwork. Again, once inside the institutions the participant observation was very helpful in achieving co-operation from caregivers.

Aside the expectation of being treated with suspicion, there was the flip side of things - the possibility that I could be seen by my participants as an 'all-knowing, special Ghanaian international scholar'. This is because such statuses are sometimes ascribed to Ghanaian's on advanced level studies on scholarship in western universities. I knew from my previous experiences working as a research assistant to Ghanaians in universities abroad that such people are treated with extra niceties and courtesy. I maintained awareness that this could turn my research upside down with participants rather seeking my views and encouragement about the work they do instead of giving me theirs.

Reflecting on these made me watchful and observant, taking care not to let my own biases or personal circumstances affect the information I received or my interpretation of things. I brought myself to the level of my participants by participating in as many institutional activities as I could, often seeking advice from them on what I should do in certain situations. By helping children with homework, helping clean the compounds and taking photographs of donors and children while observing and noting things down, caregivers gradually relaxed around me and began to express their candid opinions, experiences and interpretations of their work to me. At all times, I made it a point to assure participants that I very much respected their views and experiences and was learning from them.

Staying and working with caregivers over an extended period of time posed a potential threat to the credibility of the data I collected. My time in the institutions made it inevitable that I would become a pseudo-caregiver myself and would have some kind of experience or perception about the caregiving work. This could develop biased subjectivity (Kvale, 1996) and influence my interpretations and representations of the caregiver experiences that I finally document in the study. It was important for me to

reflect on this and try as much as possible to bracket off my own experiences in order to understand those of my participants. As much as I tried to do this, it is important for me to also openly accept that having been in those institutions for a total of three months gave me experiences of the caregiving work that possibly have influenced the way the information is presented in this study - and this, I do.

### **3.8 Quality Assurance**

#### *3.8.1 Credibility/ Validity, Dependability/ Reliability and Transferability/ Generalizability*

From the onset, it is important to note that the use of the terms ‘validity’, ‘reliability’ and ‘generalizability’ are quite contested in qualitative research. The controversy is because of their quantitative connotations and their deep roots in positivistic philosophy as these terms are overwhelmingly used in quantitative research (Golafshani, 2003). Despite this, Given and Saumure (2008) observe that the concepts that these terms refer to are crucial for ensuring trustworthiness. It is therefore important for me to address these concepts as they applied to my research. For the benefit of the qualitative research community of which I am a part, and the largely quantitative fields of workplace health promotion, occupational health psychology and industrial and organizational psychology within which I place this research, I discuss this quality assurance part of the thesis using both qualitative and quantitative ideas and elaborate on how I achieved quality qualitatively.

***Credibility/Validity*** is defined as the determination of the extent to which a measurement instrument actually measures what it is intended to measure (Long & Johnson, 2000). It is a concept used to indicate the credibility (to use qualitative terminology) of the information produced in a research. Indeed Given and Saumure (2008) note that the term credibility instead of validity is often preferred in qualitative research circles due to the fact that while validity, as used in quantitative terms, reflects the accurate ‘measurement’ of a variable, credibility reflects accurate or thick ‘description’ of a phenomenon. According to Cresswell (2009) validity is established through statistical techniques in quantitative research, but steps such as triangulation (using different data sources to reach the same conclusion) and member-checking (a

procedure in which refined parts of interviews are taken back to participants to establish the accuracy of the meanings a researcher has given to themes and descriptions) are two important ways of checking validity or better still, credibility of qualitative research data. However, member-checking in particular has been criticized due to the presence of ‘traps’ such as time lapse between the date of data collection and the actual member-checks providing experiences that may lead participants to second-guess their earlier experiences (Carlson, 2010, Birt, Scott, Cavers, Campbell, & Walter, 2016). But qualitative researchers do agree that this can be countered if it is done during the interview process where the researcher can be confirmatory and repetitive in asking questions. Carlson’s argument informed my decision to go for a combination of participant observations, focus group discussions and interviews to build a ‘tripod’ of data sources. The multiplicity of sources inherently afforded triangulation and tied in well with the ontology of the qualitative research approach used for the study. I did my member checking through a confirmatory and repetitive pattern of questioning and discussions during the interviews and focus group discussions to ensure that caregivers re-confirmed the experiences they were recounting. This way, I ensured validity of the data gathered and improved trustworthiness of the findings obtained.

***Reliability/Dependability*** of research data is described by Green and Thorogood (2009) as referring to accuracy and consistency in collecting, coding and reporting of data as well as thoroughness of analysis. Also a contested concept, qualitative research establishes reliability (preferably called dependability in qualitative terms) in ways that are different from other research paradigms like the quantitative paradigm. This difference, according to Golafshani (2003), stems from differences in understandings of the concept in that, while reliability essentially entails repeatability and replicability for quantitative researchers, qualitative researchers study ever changing phenomena and therefore do not consider repeatability and replicability as important in ensuring reliability. Florio-Ruane (1991) observes that the reported descriptions in a qualitative study are static and frozen in the ‘ethnographic present’ as the qualitative investigator’s observations are necessarily tied to the situation under study. The differences in opinion notwithstanding, both quantitative and qualitative researchers

have found it essential to ensure reliability or dependability, as the case may be, to improve trustworthiness of their findings (Graneheim & Lundman, 2004; Long & Johnson, 2000). Creswell (2009) suggests steps such as peer debriefing (explaining one's analyses and conclusions to colleagues) and auditing of the decision trail (where a researcher presents details of all procedures to the final conclusions of the study sources for others to evaluate the worth of the study by following the lines of action) as good for improving reliability in qualitative research.

In order to improve reliability/dependability in this study I used the same semi-structured thematic guide in all interviews and focus group discussions to ensure that the caregivers responded to similar questions thereby maintaining consistency throughout those phases of data collection. I carried out all interviews, focus group discussions and participant observation myself. In order to reduce the extent to which my own experiences in the field influenced my findings, my project supervisors each independently read through the data transcripts and we held discussions of the analysis, findings and conclusions for feedback purposes. I have also made it a point to give a clear, step-by-step presentation of all procedures, decisions and action in the study report in a bid to improve dependability in this study.

***Generalizability/Transferability*** is defined by Green and Thorogood (2009) as the extent to which the account of a particular situation or population can be extended to other persons, times or settings other than those studied. However, while this is important to other research paradigms, Polit and Beck (2010) note that qualitative research does not necessarily aim to generalize but, rather, to provide rich, contextualized understanding and insight of some aspect of human experience by intensively and systematically studying particular cases. Deeply believing in the subjectivity or uniqueness of human experience, qualitative researchers do not subscribe to claims that their research findings can be taken out and applied to other contexts or settings. However, findings obtained from individual qualitative studies like this present one add to already existing qualitative research literature on the subject of investigation. Together, this body of literature potentially generalizes across contexts (Skovdal & Cornish, 2015).



The intention with which this study was conducted was therefore not that of broad generalization, but rather that of providing rich, context-specific descriptions of caregiver accounts of their experiences and meaning making of the CWPC caregiving work in the children's home context of Ghana. Added to existing qualitative literature on this topic, the findings here can help provide broader generalizations as Kvale (1996) notes that the findings of qualitative studies may, through analytical generalization, be applied to other situations. In view of this qualitative researchers are encouraged to provide sufficient evidence to allow readers to make critical assessments of the extent to which the study's findings could apply in another setting. In keeping with this, I have strived to provide sufficient evidence through a step-by-step presentation of my research steps and thick descriptions of the caregivers' accounts to allow readers make their own critical assessments and analytical generalizations.

### **3.9 Data analysis**

The processes adopted to analyze data collected in the project have been described in each of the papers making up this thesis. The data were re-analyzed for each paper. The analysis process began with measures to ensure transparency in the data storage, management and transcription. All data from interviews and focus groups were audio-recorded with the consent of participants and stored in password-protected folders on my personal computer. I performed all translations and transcriptions myself before merging the final textual data from audio recordings with field notes and journals from the participant observation. To increase reliability in qualitative data analysis, Parker (2011) suggests that researchers strive to maintain consistency in the coding process. In the coding process, inter-coder reliability – a process where different coders code textual data and discuss for coding agreements and resolution of disagreements - (Green & Thorogood, 2014) is suggested as crucial for increasing reliability (MacPhail, Khoza, & Abler, 2016). To this end a coding team comprising three PhD students using qualitative methods for their research and myself was set up to code the data individually. The team met after all members had completed their coding

to discuss the codes for agreement. Coding disagreements were thoroughly discussed until consensus was reached.

Nvivo 10 Software, which is suggested by Pope and Mays (2008) as efficient for analyzing qualitative data was used for managing the data analysis. For all three papers in this thesis, analyses were done following a thematic analysis approach. Sandilowski and Barroso (2003) note that qualitative analysis processes such as thematic analysis allows for a transparent presentation of research results by laying bare the degree of transformation of data from description to interpretation. Thus, despite criticisms of thematic analysis approaches as poorly branded and lacking concrete existence relative to analysis approaches like content analysis (Vaismoradi, Turunen, & Bondas, 2013), its ability to help identify, analyze and report patterns within textual data (Braun & Clarke, 2006: 79) makes it a popular approach for qualitative analysis. The choice of this method for analyzing the data collected in this project was based on this strength. Specifically, Attride-Sterling's Thematic Network Analysis (TNA) (Attride-Sterling, 2001) was used in this project. TNA follows a systematic process where codes are carefully identified from textual data which are then clustered into basic themes, organizing themes and overall global theme(s) (Attride-Sterling, 2001). The approach provides a rigorous analysis process which allows for a better understanding of the underlying meanings in the data by laying bare the linkages between themes and producing a better picture of participant experiences. In following this approach, I first identified and clustered codes expressing the same or similar ideas in the transcripts into key basic themes. Basic themes centering on the same or similar ideas were then clustered into organizing themes after which the organizing themes came under global themes which captured the essence of the information obtained. The global themes form the bases for the conclusions drawn in all three papers. The tables showing the systematic analysis process in each paper are presented in the individual papers.

### **3.10 Ethics**

Ethical clearance for the project was obtained from the Norwegian Social Sciences Data Services (NSD) in Norway (See Appendix 2). The project was also conducted under permission from the Department of Social Welfare (DSW) of the Government of

Ghana which holds supervisory authority over all residential institutions for children in Ghana (Appendix 3). The DSW reviewed the ethical clearance obtained from the NSD and deemed it sufficient enough for the project to be carried out. Permissions were also sought from the administrative offices of the specific institutions involved. All participants were individually approached and recruited after thorough explanations of the research had been given. Written informed consent (see Appendix 4) was obtained from all caregivers who participated before participant observations started. All interviews and focus group discussions were audio-recorded. For purposes of confidentiality, the files were kept in password-secured folders on my personal computer. I was the only one with full access to the raw data. My supervisors had access to anonymized form of the data. Assurances of anonymity were given to participants and for this reason it has been difficult for me to name the specific institutions involved. I faced further ethical dilemmas during the conduct of this research as it gradually became clear to me that full disclosure of my findings would clash with my participant protection obligations. I discuss this later on in the next chapter (Section 5.2).

## **4. Findings**

This thesis includes three published papers based on data collected in this project. Each paper addresses a specific project research question. Paper one explores general caregiver perceptions and motivations (research question one), paper two explores specific work-related stressors and resources confronting caregivers (research question two) and paper three explores the impact that organizational and funding structuring have on caregiver health and ability to carry out their work duties (research question three). In this chapter I present a summary of the papers and the main findings obtained.

### **4.1. Paper I: Caregiver perceptions of children in their care and motivations for the care work in children's homes in Ghana: Children of God or children of white men?**

This paper addressed the first project research question. The aim here was to explore the general perceptions that caregivers have of the children in their care, the care work in which they are involved and their motivations for being in that work. The rationale was that such information could help provide some general insights into caregiver realities on the job and some level of understanding of caregiver behaviours towards the children and attitude towards their jobs. Considering the Salutogenesis theoretical position that individual factors such as subjective perceptions and understandings of their environment are instrumental in their development of comprehensibility, manageability and meaningfulness of their life situations, this exploration was important for establishing a framework for understanding caregiver work behaviours and feelings. Further, obtaining these insights would set the stage for deeper probes into the data for answers to the more specific questions presented in project research questions two and three.

Data analysis for this paper was done using the data set obtained after fieldwork phase one which covered research locations one and two. The findings are therefore based on information obtained from 35 participants coming from the different work designations in the CH institutions' organograms. Two specific sub-questions were explored in this first paper:

1. How do caregivers perceive CWPC in their care?
2. What motivates caregivers to work in the context of CHs?

It was found that caregivers perceived the children as belonging to God and then also belonging to white men. One thing became clear: caregivers definitely did not see the resident children as Ghanaian. The reasons for these perceptions bordered on personal religious beliefs and the insistence by CH authorities and the government of Ghana for caregivers to utilize children's rights laws in doing their jobs. It emerged that caregivers perceived the UNCRC in particular as foreign and somehow forced on their society by white people who use those laws to raise their children. Caregivers admitted to raising their own children differently from how they raised the institutional children and thought that their own children, raised using traditional Ghanaian child upbringing norms, were better behaved and "more Ghanaian" than the children in the CHs raised with child rights regulations and therefore behaving like "white men's children". Caregiver perceptions of the care work were therefore that it was confusing and complicated, presenting them with overwhelming stress and mental strain because of child rights.

However, despite their perception that the care work was complicated and difficult, caregivers were motivated by a range of factors to keep doing it. These included religious convictions, personal life circumstances and economic gain. There was almost a unanimous agreement among caregivers that doing the CWPC care work served to fulfill a religious obligation (that, for example, CWPC are children of God and caring for them is a duty for Christians the performance of which brings blessings from God). Some care workers felt caring for children is about the only employable skill they have while others were motivated by the fact the pay helped them fund their own children's education. Others still, felt a personal sense of fulfillment being called "mother" by the children in their care as they have no children of their own.

On the basis of these findings, it is suggested in the paper that stakeholders consider re-orienting CH workers on child rights and find better ways of implementing the children's rights approach to better fit the Ghanaian local context in order to help drive caregiver understanding and acceptance. This was because the confusion between

religious duty and child rights restrictions seemed to frustrate caregivers as they struggled to see themselves as ‘good parents’ and therefore tended to perceive and treat the children not as their own. This, they felt, complicated their work and, to some extent, possibly influenced their behavior towards the children. We also suggested that stakeholders take a cue from our findings regarding the factors motivating caregivers in their work and build on them to expand motivating elements in the work environment to better drive caregiver commitment and positive behaviours as suggested in the workplace research literature.

Having made these observations from our initial analysis of the data regarding how caregivers perceived their work and the work environment, the stage was set for more pointed investigation into the specifics of the stressors that caregivers perceived their work presents them. It was also time to look for possible resources, if any, that caregivers draw on in dealing with these stressors. This was the focus of Paper II.

#### **4.2 Paper II: Caring for ‘parentless’ children: An exploration of work stressors and resources as experienced by caregivers in children’s homes in Ghana**

This second paper addressed the second project research question. It was based on evidence in existing literature that stress in the workplace has possible negative impacts on the health, wellbeing and behavior of individuals but availability and utilization of resources are able to reduce some of the effects of stress on people (Bakker & Demerouti, 2007; Huhtala, Feldt, Lämsä, Mauno, & Kinnunen, 2011; Spector, Fox, & Domagalski, 2006; Torkelson, Holm, Bäckström, & Schad, 2016;). The health promotion theory of salutogenesis provides grounds to support this stress-resource relationship by stressing that individual’s ability to actually identify elements in their environments and perceive them as resources is crucial in the extent of utilization of these resources and their subsequent impact on future health trajectories. Having observed caregiver complaints of work stress and confusion in their jobs in the first paper, this second paper was designed to dig deeper into the caregiver work situation and to try to identify the specific types and natures of stressors and how caregivers identified resources to manage the situation. From a workplace health promotion standpoint, the paper utilized the SOC framework of salutogenesis to

explore the stress-resource relationship in this work context where the lives of vulnerable children depend significantly on the health, wellbeing and productivity of their employed caregivers. The paper had two objectives:

1. Explore the stressors in CWPC caregiving work as experienced by caregivers in CHs in Ghana.
2. Investigate the resources available, as identified and utilized by caregivers doing CWPC care work in CHs in Ghana

The data set used for this paper comprised data collected in phases one and two at project locations one and two. That is, data collected in phase two were merged with that collected in phase one and analyzed all over again for this paper. The participant size therefore increased to 41.

Systematic data synthesis yielded two broad global themes: *Stressors* and *Resources*. The global theme *Stressors* comprised of five organizing themes (child-related stress, job-related stress, institutional & work environment stress, work-family conflict & stress and community-related stress) formulated from eleven basic themes. Global theme *Resources* comprised of three organizing themes (children as resources, organizational resources and personal resources) also formulated from eleven basic themes (more details in Paper II).

Thus, perceived sources of stress were varied and covered several aspects of the work environment. Children's rights issues again emerged here, as in paper one, as key sources of stress presenting caregivers with dilemmas between their parenting values and the provisions in the international law. This dilemma seems to have engendered tensions between caregivers (who preferred and were expected by the local community to follow local norms of child upbringing) and institutional authorities (who were more concerned with following international law and through that attracting funding). This seemed to also be a key stressor here for caregivers. Caregivers' relationships with their own families seemed to have been affected by their jobs as some were required to live full time within their CH compounds to provide 24-hour care for the children. These findings are revealing in the sense that little is known in the existing literature about the implications that caregivers jobs have on their own lives and families. These

findings drove our interest in delving deeper to investigate the scope of impact that the structuring of CHs have on caregiver work performance and health. This investigation was made in Paper III.

Interestingly, at all levels of the work environment, there seemed to be aspects that served both as stressors and resources for caregivers. It was found that the children (previously described as sources of stress) and certain agents in the work environment, such as social workers and administrative workers, were key resources for the caregivers. Religious and moral convictions emerged as the most widely identified and utilized resource as caregivers reported deriving meaning through a sense of religious duty to satisfy God and not themselves or their employers by not giving up on the job. Other personal intrinsic motivation factors such as the need to prove oneself a 'worthy woman' in Ghanaian society by raising children became resources for some caregivers. From a salutogenesis theoretical standpoint, it was eventually observed that caregivers demonstrated comprehensibility of the work situation, a sense of manageability premised on a conviction that support from God will help them through, and meaningfulness on the basis that doing the work was pleasing to God and therefore worth it.

On the basis of these findings it was suggested that stakeholders consider interventions focusing especially on reducing stress levels and on improving intra-institutional relations and cooperation both among workers and between core caregivers and institutional superiors. It was also suggested that interventions should further target improving institution–community relations and reforming policy to allow workers more contact with their own families to reduce work–family conflict and improve their own health. Again a suggestion was made that stakeholders take advantage of the sense of meaning and hopefulness that caregivers have in their jobs and build on that to increase caregiver satisfaction.



### **4.3 Paper III: The impact of organizational structure<sup>4</sup> and funding sources on the work and health of employed caregivers in children's homes in Ghana**

This third and final paper of the project explored the data for answers to project question three. The aim was to find out how the organizational form and funding sources of CHs impact caregiver work performance and health. It was based on existing research evidence that suggests that the forms or styles in which work is organized and carried out and the sources from which organizations obtain funding and other resources for their operations may have impacts on employee outcomes including work performance and health (Chen & Huang, 2007; Griffin, Neal & Parker, 2007; Kanten, Kanten & Gurlek, 2015; Wilson et al., 2004). Existing research from residential care institutions shows that the structuring, work design, work routine and funding sources of such institutions often differ (Abebe, 2009; Dozier et al., 2012; SOS Kinderdorf International, 2004). Papers I and II confirmed this in the Ghanaian context by revealing that some CHs are structured in forms reminiscent of *dormitory institutions* where resident children sleep in large rooms or dormitories and receive care from shift-working caregivers while others are structured in the form of *family units*, where small numbers of children live full time with a caregiver in a small family home inside the compound of the institution. It was also confirmed in those papers that some CHs were primarily funded by the local government with some assistance from private individuals and institutions while others were primarily funded by private, often western sources. It was important for a project that aims to explore the experiences of workers in CHs to include in this exploration, investigations into how caregivers experience working in the different work and funding structures and the impacts that these have on their work and health. Two sub-research questions were therefore explored in this paper:

1. How does the organizational form of a children's home influence the work and health of employed caregivers?

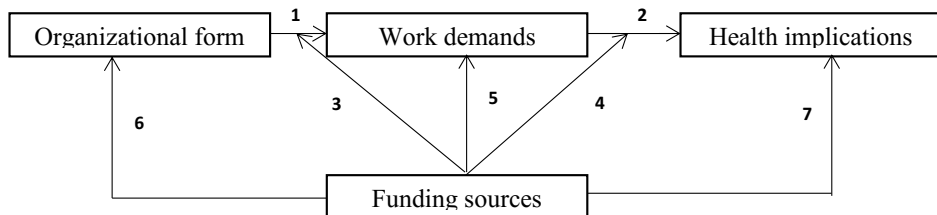
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<sup>4</sup> I used the term '*organizational structure*' here as it appears in paper III in compliance with the preference of the Journal's editor. I however feel '*Organizational forms*' better reflects the focus of the study and so is used in this thesis in place of '*organizational structure*'

2. How do funding sources and funder expectations affect caregivers in children’s homes in Ghana?

The dataset used for the analysis in this paper was obtained from all three project locations because the paper was prepared after all three phases of data collection had been completed. The emerging findings showed a network of interaction among the impacts that organizational forms and funding sources have on caregiver work performance and health. Figure 3 gives a diagrammatic view of the complexities of interaction observed:

**Figure 3: Observed impact pattern between organizational forms, funding sources, work demands and health implications for caregivers in CHs**



As shown in Figure 3, it was observed that the nature of the organizational form imply certain demands are made on employed caregivers regarding their work content and routine (Arrow 1). These demands then have implications for caregiver physical, mental and social health and well-being within and outside the work environment (Arrow 2). The nature and extent of impact that organizational forms have on the caregivers’ work and health is however influenced by funding sources (Arrows 3 & 4). For example, it was found that organizational form (dormitory or family style) presents caregivers with stressful work demands but through different pathways: the dormitory style stress is due to high caregiver-child ratio while the family unit stress is due to longer work periods (24hours) without break. These stressors present caregivers with health risks such as burnout and mental strain. However, caregivers acknowledged that the severity of the health implications depends at least in part, on the availability of work resources and support, which also depends on funding sources (Arrow 4). Funding sources further seemed to directly influence the organizational form (family unit or dormitory style) as the operation of these forms come at different costs (Arrow 6). Caregiver health issues were also directly influenced by funding

sources which, for example, determined whether caregivers get support with their health care costs or not (Arrow 7). It also directly influences work demands such as the extent to which caregivers adhere to work principles like following the UNCRC (Arrow 5). Private (often western-funded) CHs are stricter in ensuring caregivers follow the UNCRC regulations in raising the children. Interestingly this directly places caregivers on a 'collision course' with members of the local communities who view the UNCRC as foreign child upbringing laws that only spoil children. Caregivers therefore face some sort of social hostility from local community folk. This hostility is, on some occasions, extended to the residential children who are viewed and treated differently by local folk compared to treatments and views of local children raised by their local parents or families. Notably also, the *family unit* organizational form (which is the often preferred care arrangement for children in residential care) holds peculiar challenges for caregiver social and mental health within and outside the organization. It was found that this organizational form requires caregivers to live full time with the children in their care implying that caregivers are effectively separated from their own families. This is especially so for caregivers whose work stations are outside their home towns or communities. Caregivers complained about losing social contacts and social capital and feeling alienated from their families and local communities which, they said, presents them with mental strain. Thus while the findings confirm that this organizational form is actually better for the children in residence as observed in previous studies, the paper also reveals that on the caregiver side, this organizational form holds negative implications for them as employees.

On the basis of the findings, it is concluded in the paper that the current organizational forms adopted by CHs do not adequately ensure health and safety of employed caregivers. It is suggested in this paper that there is the need to review and modify them such that caregiver health and well-being, which are crucial for the growth and well-being of the children in residence, are given significant consideration. It is also suggested that CH funders need to take into consideration the implications that their

expectations and principles may have on those who are employed to work in CHs in order to avoid ‘iatrogenic violence’<sup>5</sup> to these workers.

## **5. Discussion**

This section presents a discussion of the main findings obtained from the project. It elaborates on implications for employed caregivers, policy and possible stakeholder actions that could help make the CH environment more supportive of caregivers’ work and health as well as the wellbeing of the children they care for. I begin the section with some highlights of the value of this project by pointing out some of its main contributions to scientific knowledge especially of this unique workplace and worker experiences in this context. I also discuss some challenges resulting from a complex interaction of ethics and methodology that I faced during the conduct of the research and the limitations this has placed on the extent to which findings have been reported.

### **5.1 Contributions to scientific knowledge**

Taking all three papers together, this project contributes some important scientific insights into the uniqueness and complexities of residential institutions for child care as work environments. It highlights how several factors, internal and external to this work context, interact to produce outcomes for employees, their institutions, the children (who are the beneficiaries of the work of employees), and families whose members take up employment as caregivers in CHs. First, the project presents evidence to make a case for the scientific, research and policy-making community to view and think of the institutional child care environment not only as a social environment where some vulnerable children live and grow but also as an occupational environment deserving of occupational research, occupational policy and health promotion attention. It reveals how one-sided research and policy attention to children in this context risks overlooking important occupational factors affecting employees and possibly contributing to the numerous negative outcomes reported of residential institutional child care. It arguably breaks ground by revealing important negative outcomes of the institutional environment, this time, for people who sign up to work

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<sup>5</sup> Iatrogenic violence is a situation in which aid that is intended to help actually ends up causing harm ( See Daniel, 2014 in Paper III)

there – knowledge that is relatively scarce in the existing literature. Through this revelation, the project expands occupational health and workplace health promotion knowledge to include some of the unique factors that come together to determine the physical and psychosocial health and wellbeing consequences of parenting as an occupation. The method and design utilized have enabled a vivid presentation of what it is like to be a caregiver in a residential institution for children in a cultural context such as Ghana. From an insider perspective, the project brings factors such as form and funding, personal views and beliefs, motivation and cultural values into the occupational health debate. The project therefore highlights the value of qualitative inquiry in knowledge generation in different disciplinary areas and the need to utilize this approach in generating in-depth information that can help policy action. However, the limitations of this approach, as will be pointed out later in this discussion chapter, also establish a basis for further, more expansive research possibly using a variation of methods (quantitative, mixed-methods etc.) to delve deeper into the world of residential institution care work to obtain information to complement, challenge, modify or augment the evidence presented here to help gradually build a solid knowledge base about this type of work.

A further contribution of this project is that it adds to already existing debate about the role of funders (especially external funders) and funder conditions and expectations on practices of funding beneficiaries. It highlights the tensions, within and outside beneficiary projects that are associated with these expectations. It also brings into focus the complexities and difficulties associated with introduction and implementation of international human rights resolutions and laws in different socio-cultural contexts and the various aspects of social and occupational life that are affected by them.

## **5.2 Ethical challenges complicated by methodology: Integrity versus participant protection**

The scientific research community believes in values that require all researchers to follow standard ethical guidelines in the generation of scientific knowledge. Two such values are integrity and participant protection. Stemming from the Latin term ‘*integra*’

meaning ‘wholeness’ or ‘completeness’ (Steneck, 2003), the concept of research integrity has been defined in various ways by different scholars. Watts (2008:441) defines it as “honesty and probity within the conduct of qualitative research and underpins ethical practice in all the activities that comprise data collection and analysis”. Steneck, (2003) defines it as the quality of possessing and steadfastly adhering to high moral principles and professional standards in the conduct of research. Whichever way we look at it, research integrity has everything to do with a commitment to ethical responsibility and professional standards when conducting research. Requirements of integrity make honesty and straightforwardness imperative values in the collection, analysis, and reporting of data. They demand that research outcomes are reported in whole in order to provide the highest benefit to society and the scientific community (Beisiegel, 2010; Marco & Larking, 2000).

According to Steneck (2003), ensuring the integrity of research (process and outcome) and maximum protection for all participants (human or animal) are crucial in ensuring that researchers generate scientific knowledge that is reliable or trustworthy and in a way that does not abuse or endanger the rights and wellbeing of participants or informants. However it is acknowledged that following through on all ethical principles during research could be challenging (Bulmer, 2001; Wiles, Crow, Heath & Vikki, 2008). Research aims, methodology and design coupled with peculiarities of the research setting, participants and the research situation could complicate things for the researcher in ensuring that all ethical principles are thoroughly followed (Kaiser, 2009; Tilley & Woodthorpe, 2011). This was the case in this research. I faced a situation where my research aims and my chosen methodology left me struggling between publishing the full details of my findings and risking endangering the job security and wellbeing of my participants or withholding some aspects of my findings and risking renegeing on my research aims and by so doing, endangering its integrity.

The motivation or inspiration behind this research came from two main observations I made first from occurrences on the institutional CWPC care sector in Ghana and then from the existing literature on institutional caregiving for CWPC. When CWPC care institutions in Ghana were rocked with scandals of abuse, fraud and corruption

between 2010 and 2015, the media fallout was huge and this resulted in prosecutions and dismissals of some institutional staff. I became interested in the situation after feeling that the caregivers or institutions were not being given a fair platform to explain themselves. Having a background in industrial and organizational psychology, I understood that organizational behavior, or the behaviors of employees at work have a complex network of antecedents and predictors. Any attempts at intervention therefore must first seek to understand these complex underlying causes. I realized that the national discourse on the fallout from the secretly recorded videos paid little attention to the potential causes of the alleged behaviours and rather concentrated on the consequences for the resident children.

This drove me to the scientific literature. I attempted to check for existing research on such institutions and what has been reported from caregivers' point of view about their jobs. I found little in this regard despite a considerable amount of research having been done in these institutions. The idea behind my project was therefore to explore and gather first hand, information from caregivers in such institutions regarding their experiences in that work environment. I intended to provide them with a listening ear and to project their seemingly unheard voices to the public platform to help engender debate and inform policy on possible ways of intervening and helping create a supportive, enabling work environment for them. To achieve my aims successfully, adhering to integrity requirements regarding the reporting of findings became even more crucial. The significance of my research lies primarily in educating policy makers, stakeholders, the scientific community and the general public on what it is like to be a caregiver in a CH setting within the Ghanaian context. To stay true to my aim of providing a platform for the voices of caregivers to be heard, I had to choose a method of inquiry that would allow me gather detailed information on caregiver experiences and which provides opportunity for caregivers to tell their own stories. The qualitative method and especially the phenomenological design were best suited for this purpose and so were chosen. In using this method, I have an ethical obligation to report my findings in full in accordance with integrity requirements of straightforwardness, wholeness, honesty and sincerity, especially regarding findings affecting the health, wellbeing and successes of caregivers in their jobs.

Yet, some findings emerging from a combination of qualitative data collection techniques adopted in the research were very sensitive. Some so sensitive that I have been reluctant to share them in the publications from this project. The sensitivity of the findings and the nature of the research setting make it imperative that I follow another ethical principle in research - participant protection - to the core. The importance of protecting my participants in the wake of some of the findings that emerged became all the more critical when certain events occurred during participant observation in one participating institution. While doing the observation, I also took the opportunity to recruit discussants for later focus groups. By the second week, a number of caregivers had agreed to participate in the focus group discussion so I went ahead and scheduled a date. When the date came for the group meeting, all but two caregivers who had previously agreed and signed informed consent forms pulled out of the group discussions. I inquired why, and was informed that a higher authority figure had come to the compound in my absence to warn caregivers that if anything negative came out of their participation in the research, it would be their “heads on the table”. The discussion had to be called off and it took another two weeks of convincing for some of the caregivers to rejoin the study. This experience gave me an idea of the atmosphere of fear under which the caregivers worked and the level of distrust authorities had for ‘researchers’. Having managed to convince them to trust me and talk to me about their jobs, the onus was on me to do everything possible to protect these participants from any form of harm. The ethical principle of participant protection took on a whole new level in the research.

Having witnessed incidents in which some caregivers had found themselves in trouble with the law and others lost their jobs as a result of talking to people posing as visitors and donors, it was no secret that my participants’ fates (at least in regards to their jobs) rested in my ability to protect them. Failure to do this would not only pose a risk to those who participated, but also to the institutions (in terms of funding) and to the children in residence whose lives depend it.

To protect my participants, it was important for me to find ways to increase anonymity and confidentiality. In order to increase anonymity, ethical guidelines advice non-



collection of any data that may give away the identity of a participant or that may suggest a link to an individual participant (Kaiser, 2009; Walford, 2005). Additional steps towards anonymizing participants could be assigning pseudonyms. Blanket anonymization – the situation where all names, places and any form of identifying information are disguised across the data-set is also another suggested strategy (Clark, 2006). Yet Singleton and Straits (1999) still argue that complete anonymity in social research is hardly achievable. Singleton and Straits were proven right by my chosen methodology.

On the basis of its emphasis on collecting in-depth information on people's lived experiences within a context, the qualitative method, unlike quantitative method, does not emphasize the inclusion of large numbers of participants as this could possibly limit the depth of information collected (Small, 2009; Baker & Edwards, 2012). Instead, emphasis has been on saturation - the idea that qualitative researchers keep going until no new information is being offered by participants (Mason, 2010). Since qualitative research does not necessarily aim at broad generalizations, utilizing limited numbers of participants to allow for the collection of information that is able to allow thick descriptions of lived experiences or subjects under study is preferred. In this way qualitative research is able to fulfill its objective of generating deep understanding of people's subjective experiences. In this research, I felt that following the qualitative method's preference for a small number of participants complicated my ability to increase anonymity. Data collection involved three CHs in three different regions. Considering the nature of distribution of CHs in Ghana, I was quite sure that providing detailed descriptions of the CHs I visited would expose them to anyone with a good knowledge of the CH terrain in Ghana and thus compromise anonymity. I felt that if I had, for example, involved around fifty institutions in the research, I would be better able to increase anonymity in the light of the findings that have emerged.

Further, I obtained permissions from the authorities of each participating institution in person before beginning data collection in accordance with ethical guidelines. The participant observation technique also meant that I became familiar with almost the entire staff of all the institutions involved. In this sense, my name and institutional

affiliation are well known to authorities of the institutions involved. Publications about children's homes in Ghana in my name with even only descriptions of the regional (not town) locations of the homes would easily give these authorities a chance of recognizing information from their workers. Should such publication feature any information that the authorities deem damaging to their institution (which some of my findings potentially are), I fear that the repercussions would not be good for the caregivers who talked to me. Having observed possible distrust among caregivers, with some caregivers admitting to fears that some of their own colleagues might blow the whistle on them for favours from their authorities, I fear that any serious investigation launched by institutional authorities into some of the potentially damaging revelations would be able to determine who said what.

However, the nature of these findings is such that they actually do affect the health and wellbeing of the caregivers, to the extent that some caregivers shed tears while recounting those experiences. It would be a disservice to them if these findings were not reported in full to help find a solution. In the face of this dilemma I have strived to include some of the findings but have had to exclude some in any public reports (including this thesis) until a more appropriate means is found to communicate them in a way that guarantees the work safety and security of my participants.

### **5.3 Discussion of findings**

This project aimed to develop scientific insight into the work situation of people employed as caregivers in children's homes in Ghana. It was designed to contribute knowledge into how employee perceptions and motivations, workplace stressors and resources and organizational characteristics such as structuring and funding impact the work and health of employees in this unique work context. The project was premised on the observation that though much research has been conducted in residential care facilities for children, the focus has overwhelmingly been on how the residential care environment and attitudes of employed workers affect the health and well-being of the vulnerable children in residence. Much less is therefore known about how caregivers as employees experience the care work and the residential institution as an occupational environment. The results obtained provide important insight into these

issues that can help policy and in designing interventions that are enabling and supportive not only of the children in residence but also of caregivers as employees. Taking the findings from the three papers together, the project sheds light into three key areas of caregiver work-related experiences. First, it provides detailed descriptions of caregiver perceptions of the children they care for, the care work and their motivations for engaging in it. Second the study findings contribute important information on the nature and types of stressors caregivers experience in their jobs and the resources that they identify and utilize to manage these stressors. Finally, the study explains the implications that organizational characteristics such as organizational form and funding sources have for the work performance and health of caregivers. This section presents thorough discussions of these findings.

### **5.3.1 Caregiver perceptions of children in their care**

A number of workplace research studies have reported on the possible influences that employee perceptions of their work and work environment can have on various work-related outcomes (Bhatnagar & Srivastava, 2012; Castle & Engberg, 2007; Chuang & Liao, 2010; Richter, 2004; Schwartz, 2011). While some such research has come from the care work sector in general (see Collins, 2007; Carr, 2014; Castle & Engberg, 2007; Owen & Meyer 2013), little is known about this topic in the specific work contexts of residential institutions for children without parental care (Castillo et al., 2012; Pretorius, 2013; Vashchenko et al., 2010). Interestingly, positive employee perceptions, work behaviours and motivations are particularly crucial for the achievement of work goals in this work context as the successful provision of care depends significantly on the caregiver (Bettman, Mortensen & Akuoko, 2015; SOS Kinderdorf International 2004; World Health Organization, 2004). The findings that emerged in this project show that caregivers tend to perceive the care work as difficult and confusing and the children as “belonging to God”, “difficult” and “foreign” due to the institutions’ insistence on using children’s rights laws in raising them. Children’s rights laws (perceived as foreign in local Ghanaian communities) are viewed as laws that spoil children, and in the case of the children’s home, laws that threaten caregivers with job loss and prosecution (as demonstrated in the findings obtained in paper II).

Because of these perceptions, caregivers admit to often preferring to leave the children alone instead of attempting to correct them in any way, when they are perceived to have gone wrong behaviorally. Ambivalence towards the job of providing care was evident. Though such behavior among caregivers has been reported in previous residential institutional research (see Richter, 2004 p.46; Sikorska-Simmons, 2006), the focus has often been on its negative effects on the growth and welfare of the children in residence. The findings obtained here add to that knowledge by offering insights into some of the reasons behind this ambivalence in the first place.

Caregiver challenges working with child rights represent professional dissonance – a situation where employees feel that their job tasks contradict their beliefs and values – in the CH work environment. According to psychologists, this is a precursor to mental strain for the employee and associated with negative work behaviours (Taylor & Bentley, 2005; de Lange, Taris, Kompier, Houtman, & Bongers, 2005). For example de Lange et al., (2005) suggest that when such dissonance occurs, there is a tendency for employees who feel unable to change things or obtain work somewhere else to just give up and accept the work situation as it is and rather change their behaviours to match the situation. This may affect commitment and satisfaction with the work. The professional dissonance effect may therefore potentially be contributing to the ambivalence observed and other negative behaviours observed by earlier researchers of caregivers in CHs.

The observation of this form of dissonance sheds light on the level of absorption of the UNCRC into Ghanaian social and relevant occupational contexts. It raises axiological questions about the effectiveness of existing implementation techniques adopted by institutional and local authorities regarding this international law. Further, the findings support previous observations made by researchers regarding how implementation of international laws like the UNCRC in local contexts can cause social tensions (McMillin, 2010; Secker, 2013; Shuchita, 2010). It goes further to suggest that such tensions may not only be occurring in families but also workplaces among people who are supposed to work with it. At present, the findings lead to the belief that the UNCRC, instead of its intended purpose of helping all children receive good care may

actually be reducing the amount and quality of care that some institutional children receive.

### **5.3.2 Motivation for the care work**

As with perceptions, several studies suggest that employee motivation is associated with a plethora of work behaviours (see Baumeister & Vohs, 2007; Dobre, 2013; Miljkovic, 2007). The association between motivation and employee behavior has also been suggested to affect the performance of organizations as entities (Dobre, 2013). The implication is that the motivations with which employees work, is an important predictor of their own work outcomes and outcomes of their organizations. It was found in this project that caregiver motivation for the care work was varied encompassing faith or religion, personal life circumstances and financial gain. Among these emerging themes of motivation, religious motivation or motivation by faith stood out as the most commonly reported motivational resource for caregivers. The perception that CWPC belong to God seemed to drive some caregivers to show commitment to work despite the perceived difficulties. They were convinced that doing the work well was pleasing to God and was therefore worth it. From a salutogenesis theoretical point of view, religion could be described in this study as a generalized resistance resource (Mittelmark et al., 2017) that keeps caregivers going despite the perceived difficulties. Caring for parentless children had a significant religious meaning to the caregivers and this sense of meaningfulness seemed to make them willing and able to face the adverse circumstances confronting them on the job. Previous research has suggested that employees who attach religious meanings to their jobs often show a higher aptitude for work engagement and commitment (Bakibinga, Vinje, & Mittelmark, 2014; Bhunia and Mukhuti, 2011; Marques, Dhiman, & King, 2009; Smith & Rayment, 2007). This was confirmed in this study. The implication is that religion is a unique resource in the Ghanaian context that policy makers and stakeholders can tap into to increase employee sense of meaning and, through that, increase work behaviours like commitment and work engagement. Further positive outcomes such as satisfaction and mental wellbeing of caregivers on the job could also be achieved by tapping into this resource (Arnetz et al., 2013). In other societies

where religion may not hold so much meaning to employees, the findings here suggest that stakeholder identification and utilization of elements of meaning for employees could help improve employee successes despite the existence of stress. As suggested in work stress research, taking steps to remove or reduce the amount of stress workers face on the job is one important way of reducing work stress, but this study's findings support the salutogenesis argument that increasing means for individuals to thrive despite stress is another, perhaps more effective way of dealing with the effects of workplace stress.

Aside from religious motivations, we found that personal life circumstances and financial gain were motivating factors for caregivers in their jobs although financial gain was not seen as a key motivating factor. Caregivers almost unanimously agreed that their remunerations were small and did not match the demands made on them by the care work (See Paper I). Yet some felt that without that small remuneration, their lives would be harder considering that it helps them to pay for their own children's education and serves as a source of valuable income. What became evident was that caregivers had more social reasons motivating them in their jobs than financial reasons. For example, the desire to be called "mother" and be accepted in social circles as a "complete woman" was a key motivating factor for caregivers who had no children of their own while the opportunity to live in a decent accommodation which came with the care work in some of the participating organizations was a motivating factor for those who could not afford it on their own. The implication is that for some of the caregivers, the care work did not only help the children in residence but also helped them (caregivers) satisfy their own needs. This is consistent with earlier research findings which suggest that caregiving is not always a negative experience but could also be a positive experience for the caregiver (van Groenou, Boer & Iedema, 2013). In this sense, there is an opportunity for organizational authorities to seek avenues to increase the ways in which doing the work well could benefit caregivers as a way of increasing the sense of meaning or worth of the job to employees.

The project findings further contribute to the pay-for-motivation argument in workplace motivation research by adding information from the context of CWPC care work. It supports arguments that though financial motivation is important, factors such as employee personal interpretations of the work they do, their value systems relative to their jobs and other perceived social rather than financial benefits of the work are often more motivating (Emerole, 2015; Perry et al., 2006; Njoroge & Yazdanifard, 2014)

### **5.3.3 Stress-resource experiences in the care work**

The workplace research literature describes various stressors that confront workers in different work contexts under various circumstances (Gacovic & Tetrick, 2003; Michie, 2002; Spector, Fox, & Domagalski, 2006; Torkelson, Holm, Bäckström, & Schad, 2016). Findings from this project reveal that in the particular context of CWPC care work, stressors confronting caregivers are varied and complex with the children, intra-institutional human relations, institution-community tensions, work-family conflict and confusion with children's rights laws standing out as key stressors for caregivers. Many studies explain the multidimensional effects that stress at the workplace has on the health (physiological and psycho-social), well-being and behaviours of employees and the successes of organizations (National Institute of Occupational Safety and Health, 1999; International Labour Organization (ILO), 2012; Torkelson, Holm, Bäckström, & Schad, 2016). Theories such as the Job Demands-Resource model (JD-R) explain that one way of fighting workplace stress is for organizations to provide resources that match the levels of stress for employees. In addition to providing material resources, the concept of SOC in Salutogenesis suggests that comprehensibility, manageability and meaningfulness are important cognitive resources that can help individuals move towards the "ease" end of the "ease-dis-ease" continuum in stressful situations (Mittelmark et al., 2017). This way, even if the sources of stress are persistent, individuals are still able to thrive (Lindstrom & Eriksson, 2006; Super et al., 2016).

Findings obtained in this project generally support particularly the salutogenesis theoretical viewpoint. It was found that despite the persistent stressors confronting

them, comprehensibility of the care situation and the meaningfulness derived from religious and social interpretations of the job seems to keep the caregivers motivated and willing to engage these stressors by exploring the resourceful sides of their environment to deal with the demands made on them. This seems to have led to caregivers identifying some of the sources of stress such as the children and work colleagues also as resources. Thus, a sense that resources exist in the work environment to deal with the stressors (which reflects manageability) is active among caregivers and seems to keep them going. This suggests that caregivers understand the patterns, sources and consistency of stressors in their jobs as well as resources that normally work against these stressors. It provides an opportunity for CH organizational leaders to act in ways aimed at building on this seeming SOC as a resource among caregivers to improve their health and performance on the job. While stakeholder actions that target, for instance, allowing more caregiver-family contact, and broader community education about the positives of children's rights laws would be effective ways of reducing stressors coming from these sources, frequent caregiver training would empower them to handle their work roles through reflective processes better. This would build caregiver resilience and resourcefulness on the job and help improve their SOC even more (Super et al., 2016). The findings also suggest that caregivers could be in a position to help the design of interventions as they can provide information on what would help. Caregivers themselves therefore become stakeholders in the CHs and should be consulted in the planning and implementation of any interventions aimed at helping them.

In addition to providing more resources to caregivers, the persistent stress at every turn of the work for caregivers shows that there is a significant need for interventions targeted at minimizing the sources of stress for caregivers. Stressors such as work-family conflict and institution-community tensions in particular can have negative implications for caregiver mental health and social wellbeing (Pom, Fleming & Jacobsen, 2016; Winefield, Boyd & Winefield, 2014; Kalliath et al., 2014; Kalliath, Kalliath & Chan, 2017). Caregiver feelings of being under-valued, unsupported and unappreciated by their organizations as reported in the findings are also recipes for poor work outcomes and organizational ineffectiveness (Kalleberg, 2009; Suazo &



Stone-Romero, 2011; Vantilborgh, Bidee, Pepermans, Griep, & Hofmans, 2016). It is possible that these feelings and perceptions contribute to negative work behaviours that have been reported of caregivers in previous studies (see Groark & McCall, 2011; Vashchenko et al., 2010) and the consequent overall negativities of residential care for children's growth and wellbeing, at least in the Ghanaian context. Considering that negative behaviours reported about caregivers working in residential institutions for children often are similar across contexts (Groark & McCall, 2011; Vashchenko et al., 2010; Zimmerman, 2012), these findings from Ghana make a case for authorities and stakeholders in residential care wherever such institutions are used across the globe to pay attention to the work situation and work experiences of caregivers as an important part of efforts to improve the residential care system. Attention to the residential care environment both as an occupational context for caregivers and as a residential pseudo-family environment for CWPC would help better than the present largely 'one-way' approach where the effects of that environment for children receive all the attention.

#### **5.3.4 CH organizational forms and caregiver work and health**

This project further sought to contribute knowledge on how employees are affected by the design and structuring of the CH institutions they work for. The idea was to shed light on impacts of the organizational form (family style or dormitory style) on two employee outcomes: work performance and health. This is because existing occupational health literature (see Folami & Jacobs, 2011, Wilson et al., 2004; Raya & Panneerselvam, 2013) suggests that organizational structuring and job design likely influence the types and nature of stressors and resources, motivations, perceptions and work attitudes of workers.

Results from the data analysis confirmed this prediction. Some of the caregiver stressors observed for example in papers I and II were found to be orchestrated by the forms in which the CHs are organized (paper III). The structuring of the CHs influences caregiver work practices by presenting them with certain challenges. The findings show that both dormitory style and family style CH organizational forms present caregivers with the key work stressor of work overload. In the dormitory style

CH, the structuring is such that few caregivers take charge of large dormitories with overwhelming numbers of children to care for. The work overload here is therefore as a result of high child-caregiver ratio. In the family style CH, the structuring is such that the caregiver commits to living with a relatively small number of children in a family home inside the institutional compound full time. Caregivers perform care duties 24 hours per day, seven days per week without break. The sense of work overload derives from the never-ending work day. The implication of these forms of arrangements is that the caregivers in both organizational forms, we observed, tend to resort to practices that fall short of what is expected of them.

In the dormitory style CH, caregivers are unable to pay adequate attention to each child in the lot and therefore often leave the children to fend for themselves inside the institutions. This form of organizing care also means that caregivers struggle to build bonds with individual children because of their numbers. This bonding difficulty is exacerbated by the shift-work arrangements typical of the dormitory style CHs. Bonding is considered crucial in care professions (especially in child care services) for the care relationship between the caregiver and the care recipient as it helps foster cooperation. In care work reminiscent of parent-child relationships therefore, such bonding becomes important for caregiver work successes (Moretti & Peled, 2004; WHO, 2004). The absence of or difficulty in building this bond due to the organizational form makes the work difficult for the caregivers in this study as the children do not accord them “parental respect” (a crucial component of parenting in Ghana) and the caregivers also tend to treat the children not as their own. The caregiver ambivalence and alienation of the children reported in paper I were therefore found in paper III to be partly attributable to the organizational forms, especially in the dormitory style CH. Existing evidence shows several negative impacts of dormitory-style structuring of residential care facilities for the growth and development of the CWPC who live in them (Delap, 2011). The findings obtained here suggest that these negative impacts may be due, in part, to the impacts that such structuring style has on the work performance of caregivers. These findings, though coming from Ghana, may apply to other non-Ghanaian contexts where this organizational form is used.

In the family style CH where the child-caregiver ratio is comparatively low (though one caregiver is in charge of the care of about 10 children), caregivers were still observed to be in desperate need of assistance. The organizations hire assistant caregivers called Aunties, but these Aunties are in short supply and go on rotation. The implication is that, core caregivers (mothers) who had not yet been assigned aunties were on their own. Caregivers in this situation try to get some older children in their homes to help with chores but that also is risky because of how children's rights laws are interpreted and applied in their institutions. The implication is that caregivers become exhausted with their physical and psychosocial wellbeing affected. Considering that any factor that negatively impacts employee health also negatively affects employee work performance (Dollard & Bakker, 2010; Kirsten, 2010), the negative implications that the family-style organizational form was found to have on caregivers' health in this study serves as basis for its negative implications for their work performance.

The design and routine of the family style organizational form, the findings show, places limitations on the social contact that caregivers can have with their own families and communities (papers II & III present more discussion on this). As a positive relationship is observed between employee family contact and the performance of their organizations in the existing literature (See Adjei, Eriksson, & Lindgren, 2016), the findings imply that this deprivation or limitation holds potential to affect not only employee mental health and social wellbeing, but also their work performance and hence the performance of the institutions they work for. By having limited social contact with their local communities, absenting themselves in community social functions due to their work and not being able to offer social support to others in their local communities, caregivers risk receiving little social support themselves as the norms of social life in the Ghanaian context are based on rules of reciprocity (Yidana, 2014). While the limitation in family contact may be an attempt by institutional authorities to ensure that caregivers pay maximum attention to the CWPC in their care and focus on their jobs, it risks rather achieving the opposite, where caregivers' attention become divided between wondering about the welfare of the children they have left home and concentrating on the children they are under

contract to care for. For single-parent caregivers whose work stations are out of their own family residential areas, the situation is that of caring for other people's children while your own children go into the care of others.

### **5.3.5 Funding sources impact on caregiver work and health**

As depicted in figure 3., we found that the funding sources of the CH is the most important factor influencing almost every aspect of the care work environment for caregivers. Consistent with earlier findings reported by Showalter and Itzkowitz (2002) suggesting that funding agencies affect the entire length and breadth of human service organizations, we observed that from the organizational form adopted by the institution through specific work demands made on caregivers to how caregivers' fare in performance and health, funding sources played a key role. Further, the findings (as reported in paper III) present an impression that although funder expectations and formal government regulations are aligned, the former rather than the latter holds more sway in informing institutional authorities' expectation of caregivers and serves as main guidelines for caregiver work practices especially in the private-funded institutions.

Funding sources influence caregiver work performance by playing key roles in, for example, the availability of resources such as logistics and groceries that caregivers need to perform their work roles. The implication is that in government-funded CHs - which were found to be financially poorer compared to privately funded CHs - caregivers admitted being comparatively poor in work performance. Funding sources, it was found, also influence caregiver training which then has an impact on caregiver work performance. On this level too, the implication is that government-funded CHs were comparatively poorer in work performance. The impact that funding source had on extent of adherence to and application of children's rights laws, as shown in the findings, also suggests that caregivers in private-western funded CHs likely understand, accept (though grudgingly) and are more familiar with working with those laws than those in government-funded CHs. The reported work role confusion brought on by the observance of children's rights laws was therefore more profound among government-funded CHs. The consequent negative repercussions of this role confusion

are therefore correspondingly likely higher for government-funded CHs and the children living in them.

In addition to the implications for work performance of caregivers, these findings raise interesting questions regarding the commitment of the government of Ghana and its partners towards ensuring the safety and wellbeing of children in the country. Certainly, insufficient budgetary allocation to its CHs and lackadaisical approach to employee training in the CHs it owns and runs does not portray seriousness about the welfare of 'all children'. Consistent with information contained in the press release of the African Child Policy Forum (2011), the findings in this project suggest a contrast between the government's rhetoric regarding its seriousness with child welfare and protection and the realities on the ground regarding its budgetary allocation to child welfare institutions such as CHs. While the negative consequences of the lack of sufficient budgetary allocation is widely reported for children living in such institutions, what is not so often reported are the implications of this for the work performance and health of workers employed in child welfare institutions. The findings obtained in this project shed more light on this. Although residential institutions are seen not to be the best alternative care arrangement for CWPC (Department of Social Welfare, Ghana, 2007; EveryChild, 2011), evidence exists that suggests that well designed, properly funded and resourced CHs with well-trained caregivers can provide adequate, and arguably even better care for CWPC relative to often popular alternatives such as foster care in some circumstances (MacKenzie, 1999; Gray et al., 2017, Whetten et al, 2009). In this sense paying adequate attention to funding, resourcing and training caregivers in CHs would better help the government of Ghana in its efforts to ensure health, safety and well-being of all children.

Although caregivers in the privately-funded CHs were better resourced, better-trained and therefore more capable of performing their work roles, funder expectations and adherence to them implied that work environment tension (between institutional authorities and caregivers) and institution-community tensions were higher for these CHs. Institutional authorities who are accountable to funders strictly enforce international children's rights laws with a view to meeting funder expectations and

thereby sustaining funding. Doing this brings them into periodic disagreements with caregivers, who having accepted to work with the laws, still harbor reservations especially regarding child discipline. Being primarily funded by western donors also portrays the institutions to local community folk as “foreign institutions”. The strict applications of children’s rights laws in raising children in their care therefore lead local folk to perceive caregivers as adults who are taking money from foreigners to raise children in ‘foreign’ ways which only spoil them. The children are then perceived as “foreign” children spoiled and disrespectful. Caregivers therefore find themselves in a situation where they feel unappreciated by both their employers and the communities in which they work. Certainly working in such an environment bodes ill for caregiver work performance and mental health.

It is understandable for foreign funders to prioritize the welfare of the children for whose sake they are providing the funds in the first place. However the findings from this project suggest that their values and expectations which form the bases of conditions attached to their funding seems to be causing some harm in the socio-cultural context. Bearing the brunt of this harm is the employed caregiver. While safeguarding the health and welfare of the vulnerable children in residence should admittedly be of tremendous importance to all stakeholders, it must be realized that the achievement of this objective is necessarily tied to the health and wellbeing of employees tasked with this objective. In this sense, as argued by Skovdal et al., (2011), stakeholders need to devise means of aligning expectations of funders (especially foreign funders) to the norms of the socio-cultural context within which their projects are located in order to reduce dissonance between socio-cultural values and funder values. This will ensure that employed project staff are able to carry out their duties in a supportive work environment.

#### **5.4 Limitations**

The extent of contribution this project makes to scientific knowledge in general and this area of research in particular is not without limitation. First, the quest to obtain in-depth descriptions of lived experiences of caregivers in this context meant that a large number of institutions and participants could not be included. This is a limitation

brought on by the qualitative approach adopted to obtain adequate answers to the research questions. The implication is that the findings may not adequately generalize on the caregiving work scene especially across contexts. Further studies are needed to obtain a more comprehensive picture of the caregiver work situation even in the Ghanaian context. However, it presents information that establishes an argument for caregiver work situations to be given important research attention in any context where residential institutions for children are used across the world.

Second, the focus on understanding caregiver realities inside this context of work and contribute knowledge to the workplace research literature means that views and experiences of other key players in that context were missed. Such key players include the resident children, individuals and entities who donate funds, et cetera. Obtaining information related to caregiver experiences from these sources could help provide valuable 'third party' views of the caregiving work to augment the first-hand information obtained.

The subjectivity versus objectivity debate also comes into play in this project. The qualitative approach is known for its objectivity weakness despite the fact that individual subjective experiences are important in obtaining scientific insights into phenomena. The information generated is essentially as the caregivers see it and experience it in this context and therefore is highly contextual. Thus, the project findings are an important learning resource but users should keep these limitations in mind.

## **5.5 Conclusion**

This project aimed to develop insights into the occupational side of the residential child care context by exploring lived experiences of people who work as caregivers in this context. The findings contribute knowledge on how caregivers perceive the children in their care, what motivates them in the care work, the stressors they face, the resources they draw on and how their work and health are affected by organizational factors such as organizational form and funding sources. It is concluded here that caregiver perceptions of the CWPC in their care and motivations for the care work are primarily influenced by their belief systems, cultural values, personal social desires

and interpretation of international children's rights laws. While perceptions of CWPC (as "God's children"), economic motivations and a quest to fulfil cultural norms of "womanhood" lead caregivers to show commitment to their jobs and a willingness to engage perceived difficulties in the work, caregiver interpretations of international children's rights laws as "foreign", spoiling of children, threatening to their jobs and non-fitting to the Ghanaian socio-cultural context seems to orchestrate ambivalence towards their jobs and the children.

Further, multiple sources of stress confronting caregivers in their jobs including the children, issues related to child rights, the job itself, the work environment, institution-community relations and relationships between caregivers and their own families lead caregivers to experience the care work as difficult and confusing, and to see themselves as unappreciated and undervalued. In the midst of these difficulties however, caregivers seem to possess comprehensibility of the work situation showing awareness of the patterns and consistency of stressors confronting them. This awareness provides them the opportunity to prepare mentally for the job. Their religious interpretation of the work further seems to generate some sense of meaningfulness to them which spurs them on to actively identify and utilize available resources to engage the stressors. The salutogenesis theoretical argument that a sense of coherence (comprehensibility, manageability and meaningfulness) in a given situation serves as cognitive resource that helps individuals to remain healthy despite stress therefore seemed to play out among caregivers in this work context. Consequently the project participant profiles show considerably long periods of service for caregivers with some caregivers having been in service for close to 40 years (See Table 1, page 30).

Differing organizational and funding structures characterizing CHs played key roles in forming caregiver perceptions and motivations and in influencing their stress-resource experiences, work performance and health. Stressors like work overload and work-family conflict seemed to be particularly associated with the organizational forms of the CHs as both dormitory style and family style organizational forms left caregivers feeling overwhelmed with work responsibilities while the nature of the family style



organizational form left caregivers feeling estranged from their own families. Crucially, this project reveals that the family style form of organizing care for CWPC (which is often the preferred model of CWPC care because of its benefits to child growth) may be good for the children but not so much for the caregivers. The work demands orchestrated by the organizational forms, further present physiological and psychosocial health risks to caregivers the severity of which is influenced by funding sources. Funding sources play an underlying role in almost every aspect of the CH work environment influencing the organizational form, types and nature of demands made on caregivers, availability of material resources and support for caregiver health costs. For foreign funded CHs, funder expectations and strict adherence to international children's rights laws seem to orchestrate tensions both inside the CH (between institutional authorities and caregivers) and outside (between caregivers and local community folk).

### **5.6 Recommendations for policy and stakeholder action**

In view of the findings obtained, certain stakeholder and policy actions could help intervene and make the CH environment better support caregivers as workers and give the children who live in them a better chance of receiving better quality care. Recommendations in this regard have been made in the discussion above. The overall findings obtained also provide basis for recommendations concerning possible directions and considerations for future research in this area. First, though suggestions for measures that could help make the CH work environment more supportive for caregivers have been made from the researcher perspective, future research that focuses on capturing caregiver suggestions in this regard would help provide more solid basis for policy action. Second, the qualitative methodological approach adopted in this project has helped in providing rich contextual data of the '*whats*' and the '*whys*' of caregiver experiences with their jobs. Future research that adopts quantitative approaches and include larger numbers of CHs could help provide valuable information on '*how much*' the observed experiences prevail on the entire CH scene in Ghana. This could help provide a more comprehensive picture to aid policy decision making and intervention. Third, this study reveals certain caregiver

perceptions regarding, for instance, the impact of the application of international children's rights laws in CHs on children. It would be interesting for future research to gather experiences from the perspective of a larger number of former CH children living in local communities to seek corroboration or differences to better inform policy and intervention.

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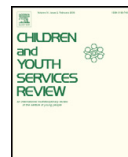
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# Caregiver perceptions of children in their care and motivations for the care work in children's homes in Ghana: Children of God or children of white men?



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## ARTICLE INFO

### Article history:

Received 16 February 2016

Received in revised form 12 May 2016

Accepted 12 May 2016

Available online 14 May 2016

### Keywords:

Care

Caregivers

Children's homes

Caregiving job

Institutional context of care

Children without parental care

## ABSTRACT

The perceptions and motivations that workers have in their work and work environment are important determinants of the quality of work they do. For people who work in residential institutions where children who have lost the care of their parents receive care, these perceptions and motivations become a crucial part in determining the quality of services or care the children are given. This study set out to explore the perceptions and motivations of caregivers in the institutional context in Ghana. Adopting a qualitative, phenomenological approach, data were collected from 35 caregivers in two children's homes in Ghana through participant observations, focus group discussions and in-depth interviews. It emerged that caregivers perceived the children in their care first as children of God and then as children of white men and were predominantly motivated by their religious convictions to keep doing 'the work of God'. Other motivations included personal life situations and economic aspects of the job. Implications for the workers and children in this environment are discussed.

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## 1. Introduction

Globally, the care and protection of children without parental care (CWPC) is a matter of important concern to governments and the international aid community. The United Nations Guidelines on the Alternative Care for Children (2010) defines CWPC as: "all children not in the overnight care of at least one of their biological parents" (UNGA, 2010, p.6). By this definition, children who fall into this category include those who have lost one or both parents through HIV/AIDs, conflict, illness etc., children living in residential care, with extended families, foster families, on the streets, in juvenile detention and those abandoned by or separated from their biological parents for whatever reasons (EveryChild, 2009; O'Kane, Moedlagl, Verweijen-Slannescu & Winkler, 2006). UNICEF estimates that there are over 150 million of such children worldwide with Sub-Saharan Africa topping regional rankings with 52 million (UNICEF, 2015).

In Ghana, unconfirmed data estimates that there are about 1.1 million of such children making up about 4.7% of Ghana's entire population and 10.4% of the entire children and adolescents population (Bettmann, Mortensen, & Akuoko 2015; UNICEF, 2006). Organizing resources to

provide care and protection for such children has therefore taken increasing importance in the agenda of the Government of Ghana in recent years.

Traditionally, according to Abebe (2009), the mode of care preferred for such children has varied across Africa and has been dependent on such factors as the relative development of governance structures, availability of resources and the attitudes of different stakeholders. In the context of Ghana, researchers (e.g. Agyeman-Duah, 2008; Castillo, Sarver, Bettmann, Mortensen, & Akuoko 2012; Manful and Badu-Nyarko, 2011) and the Department of Social Welfare (DSW) Ghana (2008) note that development agendas, increasing economic difficulty, urbanization and modernization in the post-independence era have gradually undermined and altered long-standing traditional social cohesion and cultural norms that made caring for CWPC an important responsibility of the adult kin of the lost parents.

In the face of the seeming deterioration of such social structures, Deters and Baja (2008) observe that private individuals, non-governmental organizations (both local and foreign) as well as religious organizations have found it necessary to provide alternative care for such children through the establishment of residential institutions called Children's Homes (CHs) in which hired 'parents' provide care for the children. Started by European missionaries, the DSW notes that these institutions became an important part of society in the pre and post-independence era. They offered care and protection for children who were abandoned for reasons ranging from cultural taboos surrounding

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their births and parentage to social and economic difficulties faced by their parents (DSW, 2008). Over the years however, the national rhetoric has gradually become negative towards such institutions and public sympathy has dwindled due to research findings that have often revealed alleged abuses of such children in such institutions (Anas, 2010, 2015; DSW, 2008) as well as observed psycho-social developmental deficiencies in children who grow up in such institutions compared to their cohorts in normal family homes (Crockenberg et al., 2008; DSW, 2008; Freundlich, Avery & Padgett, 2007; Johnson et al., 2010; Rosas & McCall, 2008). As a matter of fact, the government of Ghana has made sustained efforts such as the 2005 introduction of the Child Reforms Initiative (CRI) (DSW, 2008) to try to reduce and ultimately phase out the use of residential institutions in providing care for vulnerable children. A government of Ghana document based on the provisions of the United Nations Convention on the Rights of the Child (UNCRC) and similar to the United Nations Guidelines on the Alternative Care of the Child (UNGACC), the CRI is credited with modest achievements of closing down some CHs (Better Care Network, 2014; DSW, 2008). Despite this, the establishment and use of CHs has still continued steadily in Ghana. Table 1 presents a brief trend of development of CHs in Ghana for the past three decades:

Presently, the DSW reports that there are over 148 CHs operating in Ghana with only 10 being regulated by the government with guidelines from the UNCRC. The practices of the remaining CHs remain unknown and therefore unsupervised. While this in itself is a worrying development to the government and child-oriented organizations, it is important to realize that the evidence of increasing number of CHs in Ghana only means that more CWPC are getting placed into residential institutions for care, and more people are getting employed as 'parents' for these 'parentless' children. In the interest of the welfare of these children, it is important that research insights are developed into the perceptions and motivations with which these hired parents perform their duties in providing care for these vulnerable children.

This is because, organizational behavior researchers report that the quality of employee work output and work behaviours are partly dependent on their interpretations of the features of the work environment and their motivations for doing what they do (Bhatnagar & Srivastava, 2012; Castle & Engberg, 2007; Chuang & Liao, 2010; Richter, 2004; Schwartz, 2011). In the institutional caregiving context, these environmental features necessarily include the children in care. Therefore, the perceptions of caregivers in this environment regarding the children as well as their motivations for the work they do could be a crucial part of the sum of factors that influence the kind of 'care' the children receive. For example, the part of the existing literature that is focused on the human services and care industries have documented higher caregiver resilience (Collins, 2007), better quality of care (Carr, 2014; Castle & Engberg, 2007; Owen & Meyer 2013), and improved caregiver-client relationships (Schwartz, 2011) in situations where caregivers hold positive perceptions of their work and work environments and have high motivations for the jobs they do. In work situations where employee perceptions are mostly negative, the opposite has been reported (Sikorskra-Simmons, 2006). These assertions have however been largely premised on data from care workers for sick and elderly people and not CWPC.

**Table 1**  
Trends in development of CHs in Ghana (1980–2013).  
Source: Better Care Network (2014).

| Date | Number of CHs | Ownership  |         |
|------|---------------|------------|---------|
|      |               | Government | Private |
| 1985 | 3             | 3          | 0       |
| 1996 | 13            | 3          | 10      |
| 2006 | 161           | 3          | 158     |
| 2013 | 114           | 3          | 111     |

Further research has delved deeper to develop insights into different kinds of perceptions and motivations and their impacts on the work outcomes of workers in varying work contexts. Reports have revealed that workers with, for example, economic motivations perceive their jobs as a means to making a living (Heneman & Judge, 2000). In such cases, it has been observed that the commitment with which they work sometimes depends on such perceptions as pay-work equity or balance (Akintoye, 2000; Curall, Towler, Judge & Kohn, 2005). The suggestion is that, though pay alone is not an adequate motivating factor (Carr, 2014; Ghazanfar, Chuanmin, Khan & Bashir, 2011; Janicjevic et al., 2013), should there be a perceived imbalance between work and pay, work output could still be affected (Carr, 2014; Deconinck & Bachmann, 2007). Bhatnagar and Srivastava (2012) observe that, in the care industry, this outcome may be for the simple reason that caregivers struggle to meet the needs of their clients when they perceive that their own needs are not met. Other researchers have revealed that workers with motivations centered on factors like religion often perceive their jobs as divine duty to be carried out without complaint. Such workers find strength, meaning and spiritual fulfillment in their work and their quality of work may remain high despite adverse circumstances that may be present in the work environment (Bakibinga, Vinje & Mittelmark, 2014; Marques, Dhiman & King, 2009). Thus, whatever a caregiver's motivations and perceptions, there are possible implications for their work output and these may in turn have implications for the services that the clients or people in their care receive.

The paucity of research investigations into these issues in the institutional care work sector for CWPC therefore leaves that context of work and care largely unknown and does not help policy and intervention in that regard. To this end, Castillo et al. (2012) notes that surprisingly little is known about the factors that affect the work of institutional caregivers to CWPC in Ghana. This study explores the perceptions that institutional caregivers of CWPC have of the children in their care, the work they do and the nature of their motivations for the CWPC care work in which they are involved.

### 1.1. Objective/research questions

The overall objective of the study was to develop insights into how caregivers in children's homes perceive the children in their care and their motivations for the caregiving work in the institutional context. Two specific research questions were explored:

1. How do caregivers perceive CWPC in their care?
2. What motivates caregivers to work in the context of CHs?

## 2. Methodology

### 2.1. Approach and study design

The qualitative methodological approach and Phenomenological design were adopted for this study. Both descriptive and interpretative forms of phenomenology were used. This approach and design were most appropriate for this study because the aim was to explore and obtain insights into subjective caregiver perceptions and motivations regarding the children in their care and the phenomenon of caregiving in the institutional context respectively. While it is admissible that using a different approach like quantitative surveys could have equally worked in this study, the particularly restrictive nature of questionnaires used in quantitative surveys as observed by (Creswell, 2009) would have restricted this study's ability to fully capture participants' expressions of their lived experiences in the institutional caregiving context. Using the qualitative approach and phenomenological design therefore was the most appropriate thing to do in accordance with the aim of the study.

## 2.2. Participants and study location

Thirty-five (35) participants from two children's homes located in the Greater Accra and Eastern Regions of Ghana, West Africa and under the regulation of the government were recruited for this study. CHs in Ghana are either run by the government or by a private entity. In order to obtain a balanced view of caregiver experiences, we sought to collect data from government-run and private-run settings. Given limited logistics and other resources available to the research team, we selected these two institutions because they were the largest government-owned and private-owned institutions in the country. The institutions were accessed through permissions from the Department of Social Welfare and authorities at the head offices of the private-run institution. The study focused on obtaining data from individuals who work as 'mothers' and 'fathers' because these workers have day-to-day interactions with the children in care and were described by their institutions as 'core caregivers'. Such workers therefore formed the majority of the participants. Other institutional workers such as social workers, institutional directors and managers (gatekeepers), former institutional children volunteering and educational workers in the institutions were also recruited as participants because they work in that environment and do experience the phenomenon of care in that context. Additional data were collected unofficially from one member of the local community where one of the participating CHs was located. Table 1 presents detailed descriptions of the participants involved in the study:

## 2.3. Data collection procedures

Data collection took place from June to August 2015 in Ghana. Data were collected through participant observation, focus group discussions and in-depth interviews in that order. All caregivers were asked to participate in focus group discussions and interviews. Some agreed to participate in both, while others agreed to either focus groups only or individual interviews only. Data were collected according to the preference of the participant. However, during the focus groups, some individuals seemed to have more to say but seemed reluctant. The facilitating author identified and approached such participants and requested for interviews with them. Those who agreed were interviewed in addition.

### 2.3.1. Participant observation

Though participant observation is not necessarily a key technique for a phenomenological study design, it was used for its advantage of giving us the opportunity to observe caregivers in their natural work environment and pick up first-hand information regarding caregiver handling of various work situations (DeWalt and DeWalt, 2002). The informal conversations over time that this technique offered us were beneficial in giving us rich information on caregiver perceptions of the children and the CWPC care work. It also afforded us the opportunity to gather information regarding local community perceptions of the children and actions towards the CHs, though this aspect of data was not pre-planned. In previous occurrences regarding institutional caregiving in Ghana, undercover investigative journalists have broadcasted videos criticizing caregiver handling of children in their care. This occurred just a few months before data collection for this study began. The implication was that, the research team risked being treated with suspicion and caregivers could be unwilling to volunteer information. Using participant observation therefore gave us the opportunity to stay with institutional workers for a period and interact with them on a daily basis to better explain our study. This enabled us to win their trust and build rapport that made them comfortable enough to be willing to participate in the study. The participant observations also provided the context for us to observe and recruit potential focus group discussants and interviewees through informal friendly conversations. The observing author took the opportunity to keep notes in field notebooks and reflections in journals to give room for reproducibility and also to

help us further understand caregiver perceptions of care in that context and develop our interview guide for the later interviews.

### 2.3.2. Focus group discussions

Focus group discussions followed the participant observations. These were used because of the ability of the interactions involved to trigger issues in the minds of participants that could hitherto be skipped in participant observations and individual interviews (Morgan, 1997). The discussions also provided grounds for us to observe and pick out individuals who seemed to have more to say as additional interviewees. They also enabled us to observe shared experiences and norms in that work context for those involved. Two focus group discussions were conducted in all, one in each institution. A total of 14 caregivers, all of them 'mothers' and 'aunties' took part in the focus group discussions. The mothers were women in charge of home units and the aunties were assistants to mothers. Sample themes for discussion included: "what are the work roles of a caregiver in this institution?", "How do you perceive the children in your care", and "What motivates you in this job?"

### 2.3.3. Individual interviews

Data collection was rounded off with in-depth, face-to-face interviews with participants selected through both the participant observations and focus group discussions. Following up our focus group discussions with individual interviews at times and places convenient to the participants enabled us to obtain additional information to enrich the data and improve its consistency and trustworthiness. The three sets of data (participant observations, focus group discussions and interviews) provided a tripod of data sources upon which triangulation was successfully achieved. It also enabled us to explore issues that some participants were reluctant to talk about during the focus group discussions. In all, 25 interviews were conducted with 7 participants having been part of the focus group discussions. The interview language was either Twi (Local Ghanaian language) or English (official language of Ghana) depending on a participant's preference. All interviews were conducted with the aid of a thematic interview guide with the same themes used in the focus group discussions. Questions therefore included: "what are your work roles as a caregiver in this institution?", "How do you perceive the children in your care", and "What motivates you in this job?" This was done to ensure consistency and corroboration between data gathered from all sources. Deeper probes of those themes were made during the individual interviews. Traditional methods of member-checking (e.g. Padgett, 1998) in which transcribed interviews are taken back to participants for confirmation were not used in this study due to observed weaknesses identified in that method. For example Carlson (2010) observes that the presence of 'traps' such as time lapse between the dates of data collection and the actual member-checks in the traditional way of doing member-checking could provide experiences that may lead participants to second-guess their earlier accounts. This makes member-checking in that way problematic. The interviewing author therefore made it a point to be repetitive and confirmatory during the interviews as a way of seeking corroboration between what was being recorded and what the participant actually meant. That in addition to the multiplicity of data sources was deemed enough to ensure validity.

## 2.4. Ethics

The study received ethical clearance from the Norwegian Social Science Data Services (NSD). Permissions were also obtained from the head office of the Department of Social Welfare of the Government of Ghana and the local institutions that have supervisory authority over the CHs involved before data collection began. All interviews and focus group discussions were audio-recorded with the full prior written informed consent of the participants. Raw data were stored in a password-protected folder on the personal computer of the lead author. He was the only person with full access to the raw data and

co-researchers had access only to anonymized data. In all cases, participants were assured of confidentiality and anonymity and their right to refuse participation and or withdraw from the study was clearly explained to them before the study began.

### 2.5. Data analysis

Data analysis began with transcriptions and translations of the focus group discussions and interviews in September 2015. Since the lead author conducted and moderated all interviews and discussions and is also a native speaker of Twi, he also did all the transcriptions and translations alone.

Transcriptions were followed with coding of all texts (field notes, focus group discussions and interviews) using NVIVO 10 software. To ensure validity and consistency, we adopted the inter-coder validity technique (Green & Thorogood, 2014) where colleague researchers each code the transcribed data separately after which all researchers meet to discuss the codes for a consensus. The transcribed data were coded separately by all three researchers after which we met to discuss the codes. Coding disagreements were discussed thoroughly until consensus were reached.

The coding process was followed by a systematic thematic network analysis (Attride-Stirling, 2001) in which similar codes that centered on a unit of meaning were put together to form a basic theme. A similar process was used to group basic themes into organizing themes and then organizing themes into an overall global theme that represents the main information obtained from the data. Table 2 presents the thematic analysis process:

As presented in Table 2, the analysis of the textual data collected from the interviews, focus group discussions and participant observations followed a careful, systematic and rigorous process that began with codes which then developed into basic themes, organizing themes and a global theme. Such systematized analysis of the textual data enabled clear presentation of each step in the analytic process and paved way for insightful and rich exploration of the text's underlying patterns, as observed by Attride-Stirling (2001). It clearly demonstrates the interconnections between the various emerging themes and how they

summed up into one umbrella theme (Global theme) that captures the essence of the information obtained from the study (Table 3).

## 3. Findings

The findings present how caregivers who work as parents for CWPC in children's homes in Ghana perceive the children in their care, the jobs they do and the motivations they have for doing what they do. These findings are presented here in accordance with the basic and organizing themes that emerged from the data.

### 3.1. Caregiver perceptions of the children in their care

#### 3.1.1. Children of God

The perceptions that caregivers had of the children in their care seemed to be influenced more by the caregivers' belief system or religion. Participants held a general impression that the children in their care were "children of God" and therefore taking good care of them brings God's blessing to the caregiver and not taking good care of them would amount to disappointing God:

*"...you see, this job is God's work that we are doing. These are children of God. If you do it well from the bottom of your heart, you will receive a lot of blessings from God...I don't let the small money discourage me, if you say you will look at the pay, you will disappoint God"* (Mother, 54 years old, 34 years in service).

This view was shared by the majority of respondents, especially those who worked as core caregivers (mothers and assistant mothers or aunts) in their institutions. The popular notion was that caring for CWPC is a religious duty of Christians. Since all respondents except one described themselves as Christians, caring for CWPC in those institutions to receive blessings rather than pay seemed to be a strongly held principle. As a matter of fact, there seemed to be a strong prayer team made up of all the mothers in one of the institutions, and informal conversations with some of the team members after one of their evening prayers confirmed this:

*"...but in all these, God takes care of us because these children do not have parents, they belong to God. If God's hands were not here with us, we wouldn't be able to cope with this work here..."* (Assistant mother, 43 years old, 17 years in service).

An interesting view that startled us was the belief that God actually intentionally takes away the biological parents of some children, in order to give the chance to other individuals to receive his blessings by taking up parental responsibility for those children:

*"...My brother (referring to interviewer) as for me, honestly speaking, I believe that whatever God does has a reason behind it. These children lost the care of their parents, not because they have sinned, but so that people like me will also have the opportunity to receive God's blessing by taking care of them. Look at the house I am living in, how would a person like me live in a house like this, if I hadn't taken up these responsibilities...My children have finished secondary school because I came to help these children...that is God making a way for me...nothing will make me give up on this job..."* (Mother, 55 years, 18 years in service).

#### 3.1.2. Special and belong to the white man

Aspects of the institutional environment such as the dominance of the use of child rights principles to raise or train the children however seemed to create conflicting perceptions among the caregivers regarding who owns the children in their care. These interesting paradoxes, and perhaps, confusion in caregiver perceptions regarding the children were revealed when the caregivers, who had previously described the

**Table 2**  
Detailed participant demographics.  
Source: Filedwork data, 2015.

| Item              | Category                | Number |
|-------------------|-------------------------|--------|
| Sex               | Male                    | 7      |
|                   | Female                  | 27     |
| Age range         | 25–35                   | 5      |
|                   | 36–45                   | 5      |
|                   | 46–55                   | 18     |
|                   | 56–58                   | 6      |
|                   |                         |        |
| Education         | Post-graduate           | 1      |
|                   | Bachelor level          | 2      |
|                   | Professional/voc/dip    | 11     |
|                   | Middle school           | 20     |
| Work role         | Manager/director        | 3      |
|                   | Mother                  | 18     |
|                   | Assistant mother/auntie | 6      |
|                   | Former child/volunteer  | 2      |
|                   | Resident nurse          | 2      |
|                   | Teacher                 | 1      |
|                   | Social worker           | 2      |
|                   | Local community member  | 1      |
| Length of service | 0–10                    | 6      |
|                   | 11–20                   | 14     |
|                   | 21–30                   | 7      |
|                   | 31–40                   | 7      |
| Marital status    | Single                  | 5      |
|                   | Married                 | 14     |
|                   | Divorced                | 8      |
|                   | Widowed                 | 7      |

**Table 3**  
Thematic analysis of data.

| Codes   | Basic themes   | Organizing themes                               | Global theme   |
|---|--|---|--|
| ...These are children of God, I am privileged to care for them.<br>...These children are the eyes of God.<br>...If you care for them well, God will bless you.<br>...If you care for God's children, your sins will be forgiven.<br>...God took their parents, to give us a chance to care for them and receive blessing.<br>...Children refuse chores and errands.   | Children of God  | Caregiver perceptions of children in their care | Caregiver perceptions & motivation regarding the caregiving work |
| ...We can't train them like our children, it is against their rights.<br>...These children do not learn our ways, we just serve them.<br>...It's more difficult to understand these ones, because they come from different homes.<br>...Spoilt by right-consciousness<br>...They are special because they are white men's children.<br>...We train them with foreign laws not our laws.<br>...They challenge authority so we don't feel like we are parents to them.<br>...They will survive better in the white man's country with those rights, not here.   | Different from our own children  |   |  |
| ...If I quit this job, I have disappointed God.<br>...God blesses us for doing this job.<br>...My church people respect me because I'm raising these children.<br>...As a Christian it is my duty to care for children like these ones.<br>...Sometimes, God sends me gifts through strangers because I am helping these children.<br>...I just like children.<br>...This job is my calling.<br>...I don't have children of my own so I raise these children so that one day they will call me mother.<br>...Raising children is all I know in this life, what else would I do?<br>...If it wasn't for this job, I wouldn't be living in this nice house.<br>...It's easier compared to selling on the market.<br>...I can get a loan from the bank through this job.<br>...The salary is not good, but it's better than nothing. | Religious motivations<br><br>Personal motivations<br><br>Economic & external motivations | Caregiver motivations                           |  |

children as God's children then turned around to describe them as belonging to the white man:

*"...because white people don't beat their children, the children here also are not beaten...that is what these children know so some of them refuse to do anything we tell them and we dare not force them or insist that they do it because they are special, they belong to the white man..."* (Mother, 50 years old, 30 years in service).

From informal conversations with caregivers, it became clear that much of the confusion about who the children really are in the eyes of the caregivers results from a clash between the perceived religious duty of raising 'God's children' by God's rules of "spare the rod and spoil the child" and the child rights principles that prohibit beating to discipline. It emerged through informal conversations that child rights regulations were perceived by the caregivers as being brought into Ghana by white men. Since the majority of the participants demonstrated this identity confusion regarding the children, what was clear was that CWPC in the institutions were definitely not considered Ghanaian by their own caregivers. The perception of the children as not belonging in Ghana seemed to also be held by some members in the local communities in which the CHs were located. One afternoon, a woman stormed the compound of one of the institutions holding a cane and angrily chasing a boy of about 10 years old into the compound. The security men stopped her at the gate and refused to allow her to enter. When she left, the observing author followed her and caught up with her on the street and asked her what happened:

*"...Since these people here don't know how to properly train a child, I wanted to discipline the boy in front of them to show them that we are not white people... he has become a friend to my boys at home and comes home to play with them. For some time now, my boys refuse*

*to do anything I tell them and the younger one told me that this boy says they have a right to refuse to do anything I tell them to do if they don't feel like doing it. Can you imagine that?...my children are not like the ones here, they are Ghanaian and have to respect their parents and do what they are told, not like these ones who are only spoilt by those rules from those white people..."* (Female community member, Eastern Region).

In fact, this perception held by the caregivers and some members in the community seemed to be posing challenges to the children in care in attempts to integrate them into local families. It emerged through the participant observation that there were a number of cases in one of the institutions in which children fostered into local families from the CH were returned after the foster parents became frustrated with the rights-consciousness of the children they fostered. In one such case, the observing author asked one girl of about 17 years old why she had been returned and she said the woman (foster mother) always got angry when she (the girl) invoked her rights in some situations.

### 3.1.3. Different from our own children

Indeed some caregivers perceived the children as spoilt and different from their own children at home but laid the blame not on the children but on the child rights principles with which they were supposed to raise them:

*"...But I thought they said you came from abroad? So you know all those things they are saying about human rights or child rights or whatever. Since you came here, don't you see what those things have done to these children? Some don't even know how to hold a cutlass and we don't have the white man's machines here too, how can they become good farmers to feed this country? will the food come from the book?"*



Mmm, if they say child rights, let us child-right them and see what they become.... As for me, I will not raise my own children the way we are made to raise these ones" (Mother, 47 years, 15 years in service).

Another participant said:

"...Oh how? we definitely do not raise our own children like these ones here...These ones have everything brought to them: food, clothes, even toys to play with, I mean everything. They are just like white men's children. So they don't see the need to learn anything or do any hard work ... and you can't ask them to do what our children do at home anyway, because it is against their rights here. We just serve them so they are spoiled..." (Resident Nurse, 49 years old, 15 years in service).

Some other participants saw the children as different from their own children, not because of child rights but because of their varying backgrounds:

"...Oh I think these ones are different...yes I would say that because, you see, these ones come from different homes, like here in each home, there are about 10 children from 10 different backgrounds...It's a lot more difficult for the mother to understand them than it is to understand her own children, so yes they are not the same as our own children..." (Social Worker, 35 years old, 3 years in service).

The perceptions of the caregivers regarding the children in their care could be summarized as children of God spoiled by the white man's rules. Clearly, these were individuals who felt obliged by their religious convictions to provide good care for the children they had been employed to raise but who also felt that they were being forced to spoil the children by using child rights principles brought by the white man. The possible implications of this clash between religion and human rights in an institution that deals with the lives of vulnerable children are discussed later on in this paper.

### 3.2. Caregiver motivations

#### 3.2.1. Religious motivation

Like their perceptions of the children in their care, the caregivers' motivations for the work they do seemed deeply rooted in their religious convictions. The principal motivation for almost every caregiver seemed to be a conviction that the work was a duty assigned by God. Purely, caregivers had intrinsic motivations stemming from the fact that doing the job well seemed to give them a sense of spiritual fulfillment and perceived blessings from God. To some, it was an insurance policy against life's troubles:

"...As for me, I always testify to people about this job that if you do it from your heart and you do it well, God can take you out of any temptations or illnesses that may be headed your way. Again, even when I don't have money on me for my own family, which happens often, I just pray small, and sometimes a stranger that I don't know from anywhere just gives me money. That is all God's blessing for doing this job..." (Mother, 57 years old, 18 years in service).

Belief in reciprocity backed by religion was also a motivating factor especially for caregivers who themselves were once CWPC raised in the very CHs where they were now working as volunteers:

"...Oh well, I could have gone to look for work somewhere else like some of my colleagues have done...but I guess I just feel that God touched somebody's heart to come and work here when I was a child and needed care, so if by God's grace I am out of it, I also have to come and help

others...God said do unto others as it were done to you..." (Former institutional child, 27 years old, 1 year in service).

A second former institutional child working as a teacher in a school located in one of the institutions said:

"...I think what motivates me every day in this job is that I know I also came from this place...God made it possible for me to receive care when I lost the care of my own parents...When I was growing, I always told myself that I will always serve God with all I have...and I think that is what I am doing here..." (Former institutional child, 32 years old, 2 years in service).

#### 3.2.2. Personal motivation

Aside such religious motivations which were recurrent in focus group discussions and in-depth interviews, the caregivers also seemed to have motivations related to their personal circumstances in life. Some of the caregivers saw the job as a platform to raise children for themselves because they were childless and others saw CWPC caregiving as their calling and the only skill they have:

"...I have never had children in my life. I have lost two marriages because of that. But since I have been here, I have had children calling me mama...It feels good to know that I can also raise children. This keeps me motivated in this job. The stress is a lot, but I guess it is worth it..." (Mother, 55 years old, 17 years in service).

Another participant said:

"...Since my childhood, all I have done is raising children. When my parents went to the farm when I was young, I would be the one in charge of all the younger children cooking for them and making sure they were ok. This is the only thing I know in this life. I don't have high education, I don't know how to sew or dress people's hairs. What else would I do? It's definitely my calling..." (Mother, 53 years old, 22 years in service).

#### 3.2.3. Economic motivation

While these personal issues seemed to be key motivating factors for some of the caregivers, others, particularly some managers and administrators felt motivated by the economics aspects of working for the institutions they worked for.

"...as an educated man, the first thing you think about is getting a job that will enable you provide for your family. So when this job opportunity came, it was quiet good for me considering the present economic situation in Ghana. And when I thought about the fact that I would be helping these children get a future, it made it all the better to work here than somewhere else. If the salary is not enough, I could still get a loan because I have a payslip..." (Director, 56 years old, 10 years in service).

Still, others were motivated by the fact that though the pay was small, it still helped them to pay for their own children's education and helped them secure loans because they had pay slips.

"...What keeps me going? Well, I am a widow with 5 children, and this job is what has helped me pay for their education since my husband died. So I wouldn't say that I am not motivated by the pay. Even though it's small, I don't know what else I would do to get a free house to live in and save my earnings for my children's education...When I need a loan, the office always serves as my guarantor" (Mother, 52 years old, 28 years in service).

Thus, aside a general consensus on religion as a motivating factor, caregivers generally differed in what motivates them to do the work they do or what keeps them going.

#### 4. Discussion

This study aimed at exploring caregiver perceptions of the children in their care and their motivations for being in the job of CWPC caregiving in the institutional setting in Ghana. The findings obtained provide opportunities for interesting discussions regarding the existing literature and implications for the children in children's home in Ghana, the care work and workers in that context.

##### 4.1. Children of God versus children of white men

Significant contradictions and paradoxes emerged in caregiver perceptions of the children in their care. The caregivers described the children as children of God who are to be loved and then turned around to describe the same children as children of white men who are spoiled by child rights. This is both interesting and concerning in that it could have either negative or positive implications or both for the children in that context.

First, the popular perception of CWPC as children of God and the CWPC caregiving work as the work of God among the caregivers is something that could have a positive influence on their work output and care quality. Existing literature (e.g. Bakibinga et al., 2014; Marques et al., 2009; Smith & Rayment, 2007) confirms that workers with spiritual or religious convictions about their work often perceive the work as divine duty to be carried out without complaint. They find strength, meaning and spiritual fulfillment in their work and their quality of work remains high despite possible adverse circumstances in the work environment. This is corroborated by previous researchers who observe that organizations experience better work outcomes when their employees find spiritual fulfillment in their work (Bhunja and Mukhuti, 2011; Duchon & Plowman, 2005; Giacalone & Jurkiewicz, 2010). Other researchers also note that spirituality is an important contributor to individual ethical performance in the workplace and is negatively related to organizational frustration (Mitroff, 2003; Kolodinsky et al., 2008). Indeed the caregivers in this study seemed to draw strength and fulfillment from believing that they do the work of God and care for God's children. Religion seemed to be a very important resource upon which the caregivers relied. To this end, the children seemed to have a special place in the hearts of their caregivers who saw them as different from their own children and deserving special treatment. For the children in this environment, this is good news because the indication is that they would likely receive the best of efforts from their caregivers.

However, the contradicting view of the children as belonging to the white man and spoiled could counter the likely positive influences of religion on the caregiver attitudes and behaviours towards the children. As observed in the existing literature, in care work situations where employee perceptions are mostly negative, caregiver-client relationships and quality of care are often negatively impacted (Richter, 2004 p.46; Sikorska-Simmons, 2006). In this particular study, the popular perception, as demonstrated in the findings, was that white men's children are not properly disciplined and therefore spoiled. The perception of the children as belonging to the white man was therefore negative and stemmed from caregiver views that the child rights principles that guide their practices were brought by the white man and are therefore only good for raising white men's children and not Ghanaian children. To these caregivers, the children in their care are simply not Ghanaian children. This suggests a need for critical reflections on the role that the use of child rights ideologies and principles for raising the children in this context seems to be playing in forming caregiver perceptions of the children in their care. It brings into perspective, Harris-Short's (2003, p1) criticism of the UNCRC as having been conceptualized on a legal system that is "founded on a 'society of states' in which the voices of the local and particular are effectively silenced" and is evidence for observations made through studies (see McMillin, 2010; Secker, 2013; Shuchita, 2010) concerning social problems that the utilization of the

rights approach to raising children in different contexts can cause. If a caregiver thinks that asking a child in the children's home to cook or run an errand is against their right but such a task is essential for the training of her child at home, then there is an indication of either a serious miseducation on the principles of child rights or a serious misunderstanding of the same among caregivers. This could be problematic in the sense that while the children are "very rights-conscious" in the exact words of a caregiver, the caregivers say they feel the necessity to sometimes "*set aside the child rights nonsense and discipline the child properly for the sake of its own future*". In such a situation, there is bound to be tension in the caregiver-child relationship. It confirms the observation made by Twum-Danso (2014) that the individualistic, western nature of the UNCRC makes it liable to causing intergenerational tensions and dissonance between children and adults in the African Context. In the institutional context of CWPC care, bonding, which is an important protective factor for the development of children in residential institutions (Bettmann et al., 2015, Johnson et al., 2010), may be negatively impacted in this case. Thus, the UNCRC that was ratified and adopted by Ghana in the hopes of improving the welfare of Ghanaian children could be doing the opposite for children in the institutional context.

The description of the children as belonging to God or belonging to the white man is also an indication of possible alienation of the children by their caregivers and some members in the local community. The caregivers certainly do not consider the children as similar to their own or sharing the same cultural identity with their own children as they admit that they raise their own children at home in ways that are different from how they raise the children in care. Certainly, this seeming identity confusion among caregivers of the children in their care could become a recipe for confusion for the children in the development of a sense of identity and self-perception in an environment that is already problematic for children's identity development (Kools, 1999; Shpitsyna, 2008, p. 42; Smith, 2011, p. 72;). The environment in which they are being raised is filled with information that reinforces a sense of foreign identity or non-belongingness as their caregivers and some members of the local community seem to struggle to place them in the Ghanaian social and cultural context. This holds implications for the future integration of these children into local Ghanaian society which is the ultimate goal of institutional caregiving and is, in fact, contained in the mission statement of one of the institutions involved in this study.

For the caregivers who work in this context, the observed contradictions in perception could indicate possible confusion or frustration about their work roles and with the rules that govern their work. Caregivers felt that they were employed as 'parents' for these children but were not being allowed to be 'good parents' because they were being forced to use rules that only end up spoiling the children. From observations in the literature (Bhatnagar & Srivastava, 2012; Castle, 2008; Chuang & Liao, 2010; Meadows, Mclanahan, & Brooks-Gunn, 2007; Pilowsky, Wickramaratne, Yoko, & Wiseman, 2006; Schwartz, 2011), such confusions and or worker frustrations could have negative effects on caregiver mental health and wellbeing, quality of work life, work efficiency and quality of work output. Considering that the work output of the caregivers in this context is the care that they provide for the vulnerable children in residence, the findings made here suggests a need for review of the organization of the institutional context for CWPC caregiving, and perhaps, worker reorientation with child rights.

##### 4.2. Personal, religious or economic motivations? Or all?

The findings also reveal contradictions in caregiver motivations for the work as some cited religious rather than economic motivations as solely their reasons for doing the job but then attributed their present economic statuses to the work. The caregivers, especially those in the private-run institution acknowledged that they were living in houses



that were of higher quality than the houses in the local community where the institution was located and were clearly enjoying their statuses and resources but still refused to attribute their commitment to the work and the children to this benefit. Most caregivers insisted that they were motivated by their belief system and a conviction that the work they do is God's work and not doing it well would mean disappointing God. For others, it was personal life circumstances such as childlessness, lack of alternative employable skills and widowhood rather than economic benefits that kept them going. Yet, most agreed that economic benefits such as access to loans and regular income were available to them because of the work they do. Perhaps, it is a combination of personal, religious and economic benefits that motivates the caregivers to keep doing what they do.

However, it was clear that the sense of religious duty or the religious motivations for the work seemed stronger as caregivers alluded to the fact that though their pay was small, they were spurred on by the belief that they do the work of God. Caregivers therefore demonstrated a need to give their best despite 'small pay'. This is consistent with reports from Ghazanfar et al., (2011), Janicijevic et al., (2013) and Carr (2014) that pay alone is not an adequate determining factor of worker output and behaviours, and seems to disagree with the argument of Akintoye (2000) and Curall et al., (2005) who suggest that the commitment with which economically motivated workers work sometimes depends on such perceptions as pay-work equity or balance. Caregivers who cited economic benefits as motivating for them still described those benefits as small, and not the key determinants of their commitment to the work and the children. Even when some attributed their present statuses of living in comfortable residences to their work, there were still those religious undertones, as they still believed that it was the blessings of God for caring for his children.

The observations regarding caregiver struggles with child rights reveal issues with caregiver understanding of, comfortability with and utilization of child rights principles in caring for CWPC in CHs in Ghana. This needs to be addressed by both the government and other stakeholders through such measures as workforce training and capacity building (Carr, 2014). The confusion with child rights seems to be frustrating caregiver perceptions of and identification with the children in their care which could negatively impact care quality. Beyond the CH, this observation could offer snapshots of parent-child relationships that may be happening in the homes of caregivers themselves. For one, it is clear that the caregivers feel that child-rights are only meant for children in CHs or the "special white man's children" and not their own children. This study confirms the plethora of observations present in the existing literature concerning the difficulties in implementing child rights principles in contexts like Africa. An intensification of education for caregivers in institutions where CWPC receive care is therefore recommended. Perhaps, emphasis on the African Charter on the Rights and Welfare of the Child (ACRWC) rather than the UNCRC might work better in the Ghanaian context in the sense that the ACRWC places responsibility in the hands of both parents and children which seems to be in tune with the specific views of parent-child relationships expressed by caregivers in this context.

Future research could delve into questions raised in this study concerning how the wider communities perceive CWPC in CHs in Ghana. The observation made in this study in this regard only came from a one case scenario. Further, broader explorations would be beneficial in bringing out a more comprehensive picture of the situation. Investigations into how different or similar the perceptions of the wider communities are relative to those expressed by the caregivers in this study could offer important basis for policy and intervention in that context. With CWPC being perceived as belonging to God and being raised to fit the white man's standards, it would also be interesting for future research to investigate, or perhaps, explore experiences of former CWPC who have tried to integrate or may have successfully integrated into Ghanaian local communities.

## 5. Limitations

Having a qualitative phenomenological design, this study is highly contextual implying that the findings made could only best apply to the context of study. This, coupled with the limited number of participants and institutions involved, makes the study limited in cross-context generalization. Adopting a participant observation technique in data collection in which the observing author stayed in each institution for a total of one month also meant that observer experiences of the phenomenon of child care in that context also possibly influenced the data collection process. The study therefore also may be limited in objectivity in the traditional sense of the word.

## 6. Conclusion

After, exploring caregiver perceptions of the children in their care and their motivation for the institutional CWPC caregiving job in Ghana, it emerged that caregivers perceived children in their care first as children of God (to be loved and cared for), and then as children of the white man (spoilt by child rights). The confusion between religious duty and child rights restrictions seemed to frustrate caregivers as they struggled to see themselves as 'good parents' and therefore tended to perceive and treat the children not as their own. Caregivers also showed contradicting motivations for the work they do as they seemed to place more emphasis on religious motivations for the work but were clearly also enjoying economic and personal benefits that came with caring for CWPC in the institutional setting.

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## **CARING FOR “PARENTLESS” CHILDREN: AN EXPLORATION OF WORK STRESSORS AND RESOURCES AS EXPERIENCED BY CAREGIVERS IN CHILDREN’S HOMES IN GHANA**

**Ernest Darkwah, Maxwell Asumeng, and Marguerite Daniel**

**Abstract:** The experience of stress by workers in any work environment has negative impacts on employee health and productivity. However, work resources are known to have possible neutralizing impacts on the negative effects of stress depending on the availability of those resources and the extent to which employees are able to identify and utilize them. This study explores this stress–resource relationship and its implications in a work context where the lives of vulnerable children depend on the wellbeing and productivity of their employed caregivers. Qualitative exploratory techniques were used to investigate the sources and nature of stressors experienced by caregivers and the extent to which caregivers identify and utilize resources available in that work environment. Participants comprised 41 caregivers from 2 children’s homes in Ghana. It emerged that aspects of the work environment that were identified as stressors also tended to be identified as resources for caregivers. These included the children, the work environment, institution–community relations, and relationships between caregivers and their own families. Caregiver faith and intrinsic motivation stood out as the most frequently reported of the resources upon which caregivers drew to cope with their jobs.

**Keywords:** children’s homes, caregivers, stressors, resources, parentless children, workplace stress

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In Ghana, children's homes (CHs) are residential institutions that provide care for children without parental care (CWPC). Described as a last-resort alternative care measure for such children (Department of Social Welfare, 2015; Manful, Takyi, & Gamba, 2015), CHs typically take CWPC into residential care and employ caregivers to assume parental care. Caregivers' responsibilities include feeding and clothing the children, as well as providing emotional, social, and psychological support (Bettman, Mortensen, & Akuoko, 2015; SOS Children's Villages International, 2010). The caregiver's ability to carry out socioemotional and psychological support responsibilities is crucial for the child's cognitive and physical development (Groark, Muhamedrahimov, Palmov, Nikiforova, & McCall, 2005; Johnson et al., 2010; Richter, 2004). In the Ghanaian context, caregivers may face many difficulties in carrying out these responsibilities, including a high child-caregiver ratio, poor institutional facilities, and poor work resources (Castillo, Sarver, Bettmann, Mortensen, & Akuoko, 2012). With some of the children in residence having been previously exposed to trauma, including abuse, maltreatment, and death of parents, caregivers face a stressful job in "parenting" these "parentless" children.

When child care workers are under stress, there can be negative impacts for both the workers and the children. The National Institute for Occupational Safety and Health (NIOSH; 1999a, 1999b) defines workplace stress as the harmful physical and emotional responses that occur when the requirements of a job do not match the capabilities, resources, or needs of the worker. The International Labour Organization (ILO; 2012) notes that stress in the workplace has the potential to inflict negative consequences on employee health and wellbeing, reducing productivity and thus impeding organizational success. In CHs, the work outcomes and productivity of employee caregivers and their institutions can have direct consequences for the health and welfare of the children in their care.

### ***The Work Stress–Resource Interface and the Institutional Care Work Environment***

Work stress has been recognized for some time as the most common risk factor in today's workplaces (Chenoweth, 1998), with a wide range of negative physiological and psychosocial consequences, such as cardiovascular disease, loss of concentration, burnout, emotional exhaustion, aggression, and incivility (Gacovic & Tetrick, 2003; Michie, 2002; Spector, Fox, & Domagalski, 2006; Torkelson, Holm, Bäckström, & Schad, 2016). In the human care services, reported negative effects of work stress include caregiver ambivalence, depression, anxiety, agitation, and caregiver–client tensions (Groark et al., 2005; Wieclaw, Agerbo, Mortensen, & Bonde, 2006;). Such consequences could be particularly worrying in CWPC care institutions since the CWPC care work environment is one in which employee work outcomes have direct consequences for the children.

However, researchers have revealed that the availability of resources in work environments has the potential to reduce the harmful physiological and psychosocial effects of stressors on workers (see Bakker & Demerouti, 2007; Huhtala, Feldt, Lämsä, Mauno, & Kinnunen, 2011; Hyvönen, Feldt, Salmela-Aro, Kinnunen, & Mäkikangas, 2009). Resources are physical, psychological, social, or organizational aspects of the job that reduce job demands

and associated physiological and psychological costs and that are functional in achieving work goals and stimulating personal growth, learning, and development (Schaufeli & Bakker, 2004).

The documented relationship between stressors and resources is confirmed by the health promotion theory of salutogenesis, which refers to resources as a range of factors (biological or personal, material, psychosocial, etc.) that make it possible for individuals to view their lives as consistent, structured, and understandable, and therefore to better manage tension and stress (Antonovsky, 1993). By focusing on health rather than disease, the theory takes a positive approach to promoting health (Eriksson & Lindström, 2008; Hanson, 2007). It builds on popular work stress–resource theories such as the Job Demand–Resources Model (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). It argues that the availability of resources in any environment, and the ability of individuals to identify and utilize those resources, are key to empowering them to comprehend, manage, and make meaning of their situations — to develop a *sense of coherence* (SOC). The SOC is a central concept within the theory of salutogenesis, which argues that the extent of the SOC people have in a given situation determines the degree to which their present stress will affect their future health trajectories. Scholars who utilize the salutogenesis theory regard the SOC as having three key components: comprehensibility, manageability, and meaningfulness. Comprehensibility is the extent to which one believes that the world is understandable and that a sense of order can be sustained even in unknown circumstances; manageability is the extent to which one feels that one has adequate resources to deal with life’s stressors; and meaningfulness is the extent to which one believes that things make sense and that what people do in life is worth the energy they invest in it (Antonovsky, 1993). Together, these three components influence the extent to which people manage to remain healthy despite stress in their environments. Many workplace interventions focus on a disease prevention approach by trying to remove stressors at work, whereas a health promotion (salutogenic) approach to addressing work stress would strive to foster the growth of each employee’s SOC, promoting health despite the stress.

The work stress–resource relationship and the implications of this relationship for workers in diverse work environments have been well researched (Bakker & Demerouti, 2007; Brauchli, Jenny, Füllemann, & Bauer, 2015; de Jong, Le Blanc, Peeters, & Noordam, 2008; Schaufeli & Taris, 2014). A considerable amount of such research comes from the care industry, but the particular work setting of residential institutions that provide care for CPWC is conspicuously absent from this body of research. Instead, research in the institutional CWPC care environment has largely focused on the children and the various ways in which their lives and development are affected by that environment (see The St. Petersburg–USA Orphanage Research Team, 2008; Freidus, 2010; Groark et al., 2005; Johnson et al., 2010; Perry, Sigal, Boucher, & Paré, 2006; Trout, Hagaman, Casey, Reid, & Epstein, 2008; Yendork & Somhlaba, 2015). This research has often been critical of caregivers, sometimes resulting in negative public rhetoric against them (see Anas, 2010, 2015). There is general agreement that little is known and therefore little is being done about the work situations of institutional CWPC caregivers (Castillo et al., 2012; Pretorius, 2013).



The dearth of research into how caregivers in CWPC care institutions experience their work constitutes a significant gap in the workplace health promotion and occupational health literature. Inspired by the salutogenesis theoretical approach, this study explores the stress–resource experiences of caregivers in CWPC care institutions in Ghana, and the implications of these experiences for their work and wellbeing. We interpret caregiver accounts of experiences at work in terms of the SOC elements of comprehensibility, manageability, and meaningfulness.

### ***Objectives***

The objectives of this study were to:

1. Explore the stressors in CWPC caregiving work as experienced by caregivers in CHs in Ghana.
2. Investigate the resources available, as identified and utilized by caregivers doing CWPC care work in CHs in Ghana.

## **Methodology**

### ***Approach and Study Design***

Because this study explores subjective caregiver lived experiences of care within the context of CHs, the qualitative research approach with a phenomenological (descriptive and interpretative) design was used. Compared to other methods, this approach and design gave us a better opportunity to probe the whys and hows of caregiver experiences of the phenomenon of care (Cresswell, 2009; Green & Thorogood, 2014).

### ***Participants and Setting***

Data were collected from 41 caregivers in two CHs located in the Greater Accra and Eastern regions of Ghana, West Africa. One of the participating institutions was owned and run by the government while the other was owned and run by a private, externally funded organization. Participants were mainly core caregivers involved in providing day-to-day quasi-parental care for the children. Within their organizations, they were often called “mothers”, “fathers”, and “aunties”. Other institutional staff such as managers, social workers, nurses, former institutional children, and educational workers also participated in the study. Table 1 presents details of participant demographics.

Table 1 *Details of Participant Demographics*

| Item              | Category                             | Number |
|-------------------|--------------------------------------|--------|
| Sex               | Male                                 | 8      |
|                   | Female                               | 33     |
| Age Range         | 25–35                                | 5      |
|                   | 36–45                                | 5      |
|                   | 46–55                                | 22     |
|                   | 56–58                                | 9      |
| Education         | Post-graduate                        | 1      |
|                   | Bachelor level                       | 3      |
|                   | Professional/Vocational/Diploma      | 11     |
|                   | Middle school                        | 26     |
| Work Role         | Manager/Director                     | 2      |
|                   | Mother                               | 22     |
|                   | Father                               | 1      |
|                   | Assistant mother/Auntie              | 7      |
|                   | Former institutional child/Volunteer | 3      |
|                   | Resident nurse                       | 2      |
|                   | Teacher                              | 2      |
|                   | Social worker                        | 2      |
| Length of Service | 0–10                                 | 6      |
|                   | 11–20                                | 14     |
|                   | 21–30                                | 13     |
|                   | 31–40                                | 8      |
| Marital status    | Single                               | 8      |
|                   | Married                              | 14     |
|                   | Divorced                             | 12     |
|                   | Widowed                              | 7      |

### ***Data Procedures***

Data were collected in two phases. The first phase took place from June to August 2015 and the second in March and April 2016. Data collection techniques involved participant observations, focus group discussions, and in-depth interviews.

### ***Participant Observation***

The participant observation technique was used in order to observe caregivers in their natural work environments and record first-hand information and reflections regarding caregiver handling of various work situations in our field notes and journals respectively. The strategy also offered us the opportunity to interact informally with caregivers at work; this enabled us to develop a rapport with some of the workers that made them comfortable enough to share their work experiences with us. The observing author stayed at each institution for four weeks helping children with homework and helping clean the compounds while interacting with caregivers as they went about their daily work activities. During data analysis, consistency and trustworthiness were improved by triangulation of the total data set as we sought corroboration between these field notes and the data gathered from focus group discussions and in-depth interviews.

### ***Focus Group Discussions***

The participant observations were followed by focus group discussions in each institution. Discussants were recruited through friendly interactions during the participant observations. There were 16 participants in total, all of them mothers and aunties in their respective institutions. The mothers were women in charge of home units and the aunties were assistants to mothers. Sample themes for discussion included: “What are the work roles of a caregiver in this institution?”, “What stresses you in this job?”, and “What resources do you rely on in handling your work roles?”. Using this data strategy enabled us to obtain information about the shared experiences and norms of the caregiving work. The discussions also brought out corroborations and contradictions in experiences within that environment, highlighting the individuality or subjectivity of the experience of care. This enriched our data as it enabled us to obtain detailed descriptions of the care work and the subjective stressors and resources inherent in that work for individual workers.

### ***In-depth Interviews***

In order to increase the multiplicity of data sources, additional data were collected through in-depth, one-on-one interviews with participating caregivers selected through both the participant observations and focus group discussions. The interviews provided an opportunity to elicit information that might have been missed during the two previous data collection processes; moreover, they gave us the third set of data needed for triangulation. A total of 32 interviews were conducted at times and places convenient for the participants. Seven of the interviewees had been part of the focus group discussions. Interviews lasted an average of 1 hour and 43 minutes; the interview language was either English or Twi (a local Ghanaian language), depending on the preference of the participant.

### ***Ethics***

Ethical clearance was obtained from Norwegian Social Science Data Services (now the Norwegian Centre for Research Data) before data collection began. Additional permissions were obtained from the Department of Social Welfare of the Government of Ghana and the authorities in charge of the institutions where data were collected. Before participant recruitment began, the study, its purpose, participant rights to withdrawal, and rights to seek clarification were explained to all targeted participants. Those who agreed to participate were given informed-consent forms to sign before being recruited for participation. Audio recordings of all focus group discussions and interviews were made with the full written consent of the participants.

### ***Data Analysis***

We analyzed the data by first transcribing and translating the focus group discussions and interviews. A coding team consisting of three PhD candidates and the lead author was formed, and each member separately coded transcripts using the NVivo 10 software. Members then met to discuss the codes. Coding disagreements were discussed thoroughly until consensus was reached. We then conducted a systematic network analysis of the data following Attride-Sterling (2001). This process yielded basic, organizing, and global themes. The global themes in this case are stressors (see Table 2) and resources (see Table 3).

Table 2 Thematic Network Analysis of Data, Global Theme: Stressors

| Codes  | Basic Themes   | Organizing Themes                         |
|--|--|---|
| Children here challenge authority and refuse chores<br>Children do not listen to anything we tell them<br>Children fight a lot<br>Children refuse errands and talk back at caregivers  | Difficult children   | Child-related stress                      |
| Difficult to bond with children<br>Children struggle to see us as parents<br>Paying equal attention to many children is difficult<br>Varying backgrounds of children makes it difficult  | Difficult care worker–child bonding                        |   |
| Work overload and no rest<br>There is nothing about this job that is not stressful<br>We have to supplement with our own pocket money<br>We are powerless over the children; how can we raise them?<br>No training to handle mentally ill children   | Difficulty providing care                                  | Job-related stress                        |
| Shift schedule is only on paper<br>Caregiver–child ratio is 1:10 or more<br>You can't tell when you are going to close from work<br>You can't tell what you will be required to do on any day  | Work ambiguity and poor routine                            |   |
| Caregivers are rushed to hospital often<br>High blood pressure is on the rise among us<br>Light-headedness and dizziness are common experiences here<br>Our health is deteriorating and no one cares<br>There is so much exhaustion here and no way out<br>Slips and falls are common experiences due to rush  | Poor employee health and safety                            |   |
| There is dissatisfaction and uncertainty about our pension<br>We have become sad and afraid<br>Employee mistrust and conflicts have become normal here<br>Fear of query for poor child dressing or lateness to school<br>Superiors reprimand caregivers in front of children<br>We fear secret recordings by visitors<br>The salary is nothing to write home about<br>Superiors betray us in the face of trouble | Work environment tensions and mistrust                     | Institutional and work environment stress |
| You feel guilty of being bad parents following those laws<br>Too much child rights spoil the children and make them difficult<br>We are not allowed to be real parents<br>We just follow the rules<br>Children here don't know anything apart from their rights<br>UN training gives the children no sense of responsibility   | Confusion regarding child rights                           |   |
| When we leave they are sleeping, when we come back they are sleeping<br>I feel the gap between my children and me widening<br>Our families feel abandoned<br>I feel trapped  | Tension with and alienation from own family                | Work–family conflict and stress           |
| I don't know if I can mix up with family again as I used to<br>Family thinks institution is rich because white men are involved<br>Family expects more financial contributions from me<br>Families do not really understand our work   | Family misperception and overexpectations                  |   |
| They insult us for the children's bad behaviour<br>Everybody just pays attention to the children not us<br>Nurses insult us when we send sick children to hospital<br>I think they see us as child abusers   | Community apathy, suspicion, and mistrust                  | Community-related stress                  |
| They treat us like criminals<br>Some say we just spoil the children and get paid for it<br>Donations have reduced, they think we are rich<br>Public opinion about us is demoralizing   | Negative community opinion and relations with care workers |   |

Table 3 *Thematic Network Analysis of Data, Global Theme: Resources*

| Codes  | Basic Themes                           | Organizing Themes        |
|--|--|--------------------------|
| Children crack jokes and that relieves stress a little<br>Children dance and cheer<br>We laugh together as a family  | Humour and stress relief from children | Children as a resource   |
| Older children help at home sometimes<br>Prayers and support from former children<br>Some children are well-behaved and give ideas   | Children are a resource                |                          |
| I just like children<br>Seeing the children happy inspires me to work hard<br>When my children excel, I forget the stress in the job<br>My joy is in seeing the children grow and prosper  | Children are a source of inspiration   |                          |
| We get things all right but we need more<br>When you need anything, you write a requisition and you get it if it's available<br>We receive adequate household money to buy things for the household<br>They never let the children lack anything   | Adequate job materials                 | Organizational resources |
| We get frequent training<br>Officers assist us in this job sometimes<br>Social workers are here to provide support<br>In times of difficulty we call on the director, a social worker<br>The institution helps me get loans because I have a pay slip  | Institutional support for workers      |                          |
| The institution has partner donors who provide resources for us<br>The office goes on air and to the banks to raise money during difficulty<br>Foreign organizations know this institution so they bring us things<br>Our thanks go to the donors, we work because of them   | Donor support                          |                          |
| When there is a family emergency, I rely on them to cover me<br>I am supervisor but I don't sit down and watch them suffer, I join in<br>Mothers have a prayer team<br>We share our joys and pains together sometimes  | Worker-to-worker support               |                          |
| Because God watches over us, anytime I'm rushed to hospital, I come back alive<br>God takes care of us<br>I receive God's blessings for doing this job<br>God touches people to give me things when I am in need<br>If you care for God's children, your sins will be forgiven<br>They did it to Jesus                 | Religion as a resource                 | Personal resources       |
| Some friends of mine pray with me for strength in this job<br>My church sisters encourage me<br>My own mother commends me all the time for doing this job<br>My husband is proud of me, he calls these children his children<br>You get some friends from the community encouraging you                                | Family and friends                     |                          |
| As long as I do this job, I have a comfortable place to live<br>There is prestige out there in working for this institution<br>I have a salary, even if it is small<br>This job helps me pay for my own children's education<br>Some caregivers don't have children so they came here to raise children for themselves | Economic and social motivation         |                          |
| Difficulties are there but I am stronger<br>I don't let difficulties get to me<br>They can say whatever they want, it won't stop me<br>My mother trained me to care for children<br>This is my job, I've got to do it  | Individual characteristics             |                          |

## Findings

Interesting findings reflecting stress–resource experiences that characterize the care work for workers in institutions for CWPC emerged through the analyses of the textual data. For clarity, these findings are presented here systematically in accordance with the basic, organizing, and global themes.

### *Stressors*

Stress experiences recounted by caregivers in this context arose from many different aspects of the work and institutional environment. Sources of stress ranged from stressors related to the children in residence, through stressors associated with worker-to-worker relationships, employer–employee relationships, and institutional rules and routine. Other sources of stress were found in tensions in the relationships between caregivers and their biological families, and between caregivers and the communities within which their institutions are located.

**Child-related stress:** The children in residence were identified as a major source of stress by the caregivers. Beyond the usual difficulties associated with parenting children that arise even in family homes, the caregivers seemed to perceive the residential children as particularly difficult to handle for a range of reasons:

These children we are supposed to parent are not like normal, regular children. These ones are extra difficult to handle because they do not see you as their parent, and therefore can challenge your authority on any day.... They are government children, not yours. (Mother, 54 years old)

For some other caregivers, the difficulty in handling the children arises because they come from very different backgrounds:

You see, these ones are not biological siblings, so they don't share a bond ... in that case they fight a lot.... Look around, I have many children in this unit, I tell you, I defuse over 12 to 15 fights every day.... That leaves me exhausted after every working day. (Mother, 48 years old).

For another mother, the fights were not so much about lack of bonding; it was rather an in-group versus out-group issue:

You know, in this institution, the policy is that biological siblings must always be kept together ... so, what you see happening is that occasionally, each set of siblings becomes a little “gang” defending themselves against the other “gangs”. That is trouble, sir, it is so much trouble. (Mother, 51 years old)

Still other caregivers perceived the stress related to the children as stemming from the fact that the children have learnt about their rights and often take advantage of them to refuse chores and talk back to caregivers:

What stresses me most about this job is when there is so much to be done in this house, and yet even the older children refuse to help with any chores.... In my own house, I could use my authority to get my children to do their chores ... but here, for fear of infringing on their rights, you just have to leave them and do everything yourself.... It's not easy here. (Assistant mother, 43 years old)

**Job-related stress:** Caregivers also recounted experiencing stress coming from the characteristics of the job itself. For many of the workers, their jobs are ambiguous, poorly structured, poorly resourced, and overloaded, giving them no rest:

When you come to work, there is so much to do that you have no rest.... Just imagine two workers taking charge of 40 children ... you have to make sure they are all ready for school on time, that they have all eaten ... if even one of them falls sick and needs hospital attention, it means one worker has to go on hospital duty leaving only one remaining to take charge of the rest of the children. (Mother, 45 years old)

Another participant said:

What kills them in this job is that you just don't know what you will be expected to do when you report for work and you don't know when you will close.... You could be heading to hospital, to a school disciplinary hearing, running errands on the market, etc. ... the list is endless. ... You could simply spend the whole day trying to convince the office people to give you materials needed to run the home.... I just pity the mothers, they suffer a lot. (Social worker, 32 years old)

The complaint about materials needed to run the homes came almost entirely from the government institution. Another participant said:

I can't count to you the number of times I have had to use my own small salary to get things for these children.... These children have been trained to think that they should get everything they want, so if they come to you asking for something and you don't give it out, it's trouble ... and who knows what they will tell visitors ... before you know it, there is news in the media about how you are denying the children anything they ask for ... and the public will set upon you.... The stress here is just too much. (House father, 33 years old)

During focus group discussions, there was a general agreement that one of the most stressful aspects of the work is handling mentally ill children:

We don't even know if this is a Children's Home or a mental hospital.... We have no training handling children who are mentally ill, yet they keep bringing them in and we just don't know what to do with them.... There is one in my unit who chews the paint on the walls, and beats up almost all the small children every day.... Myself, I am afraid of him, because he has slapped me once. (Assistant mother, 36 years old)

**Institutional and work environment stress:** Issues affecting the health and safety of caregivers in the institutional environment, as well as rules and regulations regarding child rights and how caregivers are expected to parent, were identified as key stressors. In addition, the institutional atmosphere seemed tense and there seemed to be a lack of trust between workers, and a wariness of visitors to the institutions:

We work in an environment where we don't know who to trust ... your fellow worker could be the one who tells a lie about you to the authorities.... I have become very careful these days.... When you get in trouble, no one has your back ... you are on your own. (Mother, 50 years old)

The participant observation phase of data collection in the government institution revealed some of this distrust of visitors, as most caregivers opted to stay away from the observing author and refused to communicate with him in any way. During focus group discussions, there was unanimous agreement in both institutions about concerns for health and safety. Some caregivers complained about lack of institutional support in seeking health care for workers:

With all this stress, what do you expect? ... High blood pressure is on the rise in this environment, ask anyone, they will tell you, and slips and falls are common ... it is normal here ... and if you need health care, you only have your salary to rely on. (Mother, 57 years old)

During the interviews, one resident nurse said:

They [caregivers] even need medical attention more often than the children here.... If you stand on your legs from 6 a.m. to 11 p.m., tell me, what do you think will happen to you? Lightheadedness, dizziness, and what have you.... When people hear that someone is being rushed to the hospital from here, they often think it is a child, but very often, it is a caregiver ... and who pays for it, they pay themselves. (Resident nurse, 49 years old)

Other caregivers, primarily from the private institution, praised their institution for being very helpful in supporting them during health emergencies but still complained about the level of health deterioration caused by the work:

Oh, everybody knows that in this institution, the authorities take our health matters very seriously.... In fact, they are very helpful in providing funds and resources ... but ... you may provide resources ten times for me if I am rushed ten times to the hospital, but the fact that I am being rushed that frequently means something has to be done about the job.... It is too stressful. (Mother, 51 years old)

The work environment, according to the workers, was also dominated by laws that some perceived as foreign. Almost everyone seemed confused by these laws, but felt compelled to obey them. These were child rights regulations that seemed to limit the extent of authority and control that care workers could exercise over the children — control that care workers felt was central to their role as parents:



Just imagine this, you tell me to parent a child, and yet forbid me from disciplining that child... How then do you expect me to be a parent? ... Does it make sense to you? (Social worker, 32 years old).

The caregivers' frustration at having to parent in accordance with child rights principles was demonstrated in focus group discussions, when some caregivers became emotional while narrating how some of their children in the institution would stand up to them, and say things that their biological children would never dare to:

How would you feel if a young child like that stood up to you, shouted obscenities at you, and walked out on you? ... [Wipes tears off face] ... Can my own child say that to me? ... This is what we have to endure in this environment ... because we need a job... These children's minds have been poisoned with rights and we suffer the consequences. (Mother, 55 years old)

For some other caregivers, the concept of child rights confuses them and makes their work more difficult:

For me, I am even confused with this child rights thing ... ok, so the child has a right to do or refuse to do what I tell them, and every child has a right to be loved... [laughs] ... How do you expect me to develop love for a child who does not respect me and who can choose to obey me or disobey me at no consequence? ... It's just funny... I just leave them alone, it is they who will suffer when they eventually get out there and do not know how to show respect. (Assistant mother, 43 years old)

Interestingly, the prediction of suffering for institutional children who are rights-conscious was corroborated during interviews by two of the three participants who themselves were once CWPC and who were now volunteering in their respective institutions. One said:

Yes, that is very true, I didn't find it easy integrating during the first few months out there.... It just seemed like I was the only one who knew anything about child rights.... I got insulted when I tried to stop my neighbours from disciplining their children by spanking, and I found it difficult mixing up because everyone kept saying I didn't respect ... (Former institutional child, 27 years old)

In one of the institutions, there were times when a particular superior officer would openly caution a caregiver in front of the children, asking her if she wanted the institution's name in the media for the wrong reasons. In a follow-up interview after one such incident, an administrative officer said:

It's not that we don't treat our workers well, but those who own and fund this institution expect us to use the rights approach, it's a condition upon which we receive funding ... so if any information gets in the media that the children are complaining, what do you think will happen to us? (Administrative officer, 49 years old)

An educational worker in one of the institutions also demonstrated frustration with the dominance of “foreign” child rights laws as conditions for funding when he said:

You mean these children here? ... Yes, those UN rules don't teach them any sense of responsibility ... and the ways in which they want us to raise them too, sometimes it works, sometimes it doesn't work, so you just leave it at that ... because at the end of the day, that is what brings the funds to run this place. (Educational worker, 36 years old)

**Work–family conflict and stress:** Caregivers were also challenged by tensions within their biological families. The data collection process revealed a seeming unease in most caregivers when having to talk about their relationships with their families and how their work was impacting that relationship. There were accounts of feelings of alienation and distrust on the part of both caregivers and their families. Family misperception about the care work and overexpectation of the monetary rewards associated with that work were also reported:

Hmm ... well that is a problem I am struggling to deal with right now.... You see, when I leave for work, everyone is sleeping, when I come back, everyone is sleeping ... and on weekends, there is no guarantee that I will not be called for work.... From the way my children react to me, I feel like they don't know me any more. (Assistant mother, 47 years old)

For another caregiver, the work was creating distrust between herself and her husband and putting strain on their marriage:

Let me ask you this: If your wife went to work at dawn and came back late at night from Monday to Saturday, wouldn't you even think she has been passing behind to see another man under the cover of work? ... Well, that is what I'm being accused of every now and then ... but I also hit back often, because while I'm away at work, I don't know what's happening behind my back ... if some woman has been coming into my house, how would I know? ... It's putting strain on the marriage, but I know God will save this marriage for me [Wipes tears off face]. (Mother, 53 years old)

Through informal conversations during the participant observation phase, some caregivers shared experiences in which they had been asked to pay more during an extended-family contribution for a funeral or other occasions because they work with white people:

Sometimes it's sad, sometimes it's just funny ... I mean you can't help laughing.... Can you believe that one of my uncles died and during contributions for the funeral, I found out that I was being punished with a bigger contribution because I didn't attend family programs regularly? ... When I complained, they said I should pay more because I work with white people and have money. (Mother, 53 years old)

One mother recounted, through tears, how her children accused her of abandoning them to care for other people's children and how that realization made her feel trapped in her current situation:

Well, this has been my dilemma, this has been my burden, my children confronted me once.... I work hard here to earn my salary and send to them, but they accuse me of abandoning them to care for other people's children. [Wipes tears] ... Can you blame them? ... And if I stop, what are we going to eat at home? ... I feel trapped. (Mother, 45 years old)

Participant observation revealed that while one of the institutions organized the work in shift schedules, the other had a policy of permanent stay for all mothers, with a certain number of leave days per month for family visits. However, it was clear that neither system was ideal. The shift schedule never really worked as planned. The workers complained that they often had to keep working even when their shifts were over because the incoming mothers were ill and unable to make their shifts. "Hospital duty", when a caregiver had to stay with a child being admitted to hospital, also often kept them from returning home after their shifts. With regard to the leave policy, there was a clause attached requiring the caregiver to find a replacement before taking leave, but due to a shortage of replacements, caregivers rarely could actually take the leave owed them. While there were provisions for caregivers' biological children to pay them visits on the institutional compounds, male children were not allowed to sleep over; this restriction also applied to spouses. According to institutional authorities, the restriction was aimed at preventing potential sexual abuses of the children, especially the girls.

**Community-related stress:** Caregivers also reported experiencing stressors in the communities within which the institutions were located. Under normal circumstances, Ghanaian social norms lead people to empathize with vulnerable children and their caregivers, and, if possible, make donations to support them. While such empathic ways were still being practised in the communities where the participating institutions in this study are located, caregivers thought the extent of community support was dwindling. Participant observation data revealed that, for the private institution especially, this was probably because of a widespread perception that the institution received funds from foreign donors and was therefore rich, with the children in residence being better off than the ones living in their family homes in the local community. Indeed, the landscape of the institutional environment, the children's clothing and general outlook, the type of family homes built for the mothers and their children, and the general facilities in the institution that mothers and their children could access were in a far better state than those in the local community, as the observing author noted.

For some caregivers, this was creating a kind of animosity between the institution and the community, with some community members often accusing the children at the private institution of looking down on the local community children:

Well as you can see, our children here are better clothed, better housed, and better fed than those in the local community ... just look around.... How do you expect them [the community] to see the children here as vulnerable? ... And of

course, some of the children here act it out when they go to the community ... you know children ... and that makes us targets of hostility in the community, though not very often. (Social worker, 53 years old)

An administrative worker at the private institution recounted an experience where a local church came to donate some items and ended up taking those items back:

You know we can't allow these vulnerable children to just live like the CWPC that they were before they came here.... Our mandate is to provide for them the kind of care that they never had.... I tell you ... a church came here to donate some clothing and when they came and saw how our children here were dressed, their leader told me they were taking their items back because it didn't even match what our children were already wearing ... so you see ... it's a difficult situation.... Somehow doing the right thing has become a case for judging you. (Administrative worker, 49 years old)

During participant observation, an informal conversation with one 16-year-old residential child seemed to corroborate this. The child expressed pity for the local community children and said he kept some of his own food and gave it to his friends from the community when they came to school hungry. He recounted how some of his friends from the community got expelled from school for non-payment of fees, and ended up not going back. The question thus arises as to which child really was the vulnerable one, the institutional child or the child from the community?

For the government institution, the challenge in the community for the caregivers was a seeming community perception that those caregivers were just getting paid to spoil the children:

Some of them think we are just here to spoil the children with some foreign laws and get paid for it ... but for us, we know it's the rules of the job ... so we don't blame them so much. (Mother, 53 years old)

Another caregiver said:

It's demoralizing when you make all these sacrifices to care for these children and the community treats you this way. They think we are thieves who just steal materials meant for these children for our own children ... especially since that Anas case<sup>1</sup> happened. (Assistant mother, 50 years old)

Additionally, the attitudes of local hospital nurses towards caregivers who accompanied sick residential children needing medical attention was also described as stressful:

What I hate is hospital duty.... Those nurses there don't think anything good of us, you face all sorts of insults and sarcasm ... because they think we mistreat

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<sup>1</sup> The "Anas case" was an undercover investigative journalist's report alleging caregiver corruption and abuse of children in some children's homes in Ghana.

the children and steal things meant for them ... they just treat us like criminals.  
(Mother, 54 years old).

An employee in the administration department of one institution said:

For me, I don't see that anybody cares about these mothers ... everything is about the children ... but I tell you, their work is so difficult.... It kind of makes them feel unappreciated, you know ... because when something happens, they won't take time to investigate, they just blast them in the media. (Administrative worker, 54 years old).

### ***Resources***

Facing daily stressful circumstances in the workplace was not the only experience shared by the caregivers who participated in this study. Amidst all the stress, there were accounts of resource experiences that made positive contributions to the caregivers' ability to continue with the work. Interestingly, the very sources that produced the stressors recounted were also identified and utilized as resources, according to caregiver accounts. However, the discussions about resource availability and utilization revealed notable differences between caregivers regarding the extent to which the sources of stress also became resources for them. These differences were largely associated with whether they worked in the private or the government institution.

**Children as a resource:** After describing the children in their care as "difficult" and a key source of stress in their work, caregivers shared experiences in which the same children were portrayed as resources that motivated them to keep working and helped them to cope with stress. For some, just the sight of their children "doing well" inspired them to keep working. Some felt they received support from the children's prayers. Others described some of the children in their care, especially the very young ones, as "funny", "adorable", and a source of humour and stress relief from daily tensions in the work:

I would say these same children are resources ... you see, especially the little ones in kindergarten, they make you laugh a lot.... When they come back from school and begin to sing those kindergarten songs and begin dancing, oh my God, it's so adorable and sweet ... you tend to forget all the stress momentarily.  
(Mother, 53 years)

Some caregivers thought some of their children were important resources because they helped with basic house chores:

Well, it is not as if all the children are so bad or difficult.... You see, among them all, you find some two or three being very helpful with chores that the majority of them refuse to do under the cover of their rights ... so some of them are resources for us as well. (Assistant mother, 47 years old)

For another participant, it is her former residential children who are now living independently that serve as resources for her:

The children that I have raised to become adults and who are now living and working in the cities, they are my resources.... Last time when I was rushed to hospital, one of them came to help pay my bills; another time, one of them came here with a lot of foodstuffs for me. Seeing them doing so well on their own inspires me and makes me forget about all this stress.... I will never give up on this job. (Mother, 57 years old)

It became clear during the participant observations and later focus group discussions and interviews that descriptions of the children as a resource were more frequent among care workers in the private institution. Government institution workers tended to rate the working conditions of workers in the private institution as better when it came to children helping with chores:

You see, this place is not like the other rich private children's homes.... There, the mothers live in a home with their assigned children like a family ... so they are able to get the children to help them because the bond is stronger ... but here, it's like a boarding house, just look at the numbers ... so they don't help. (Mother, 53 years old).

Another government institution worker described the children as being a resource in a way that was different from how the private institution workers saw it:

Well, I can say that the children are resources for some of us.... It's not like they help us to do the job in a physical way ... but when you see them running around and happily playing in the compound, and you cast your mind back to how they looked when they first came, it kind of makes you proud of what you have accomplished with them. That in itself is an inspiration that keeps you going. (Assistant mother, 49 years old)

**Organizational and institutional resources:** Though caregivers encountered stress in every aspect of their work, there were also instances in which they recounted deriving resources from their institutions. This helped them remain productive and healthy despite the stress. Again, there were significant differences between workers from the two institutions. In most cases, caregivers from the private institution had more to say about positive practices in their institution that helped them stay healthy and productive, while the government workers had little to say in this regard. For example, a private institution worker said:

The office does very well, they never make the children lack anything ... as soon as you request, they strive to provide for you ... so we cook and eat what we want.... If a mother or worker gets a funeral, the office bus is made available and they give you the support you need. (Mother, 50 years old)

In contrast, a government institution worker had this to say:

Well, the resources we get from this institution are not much.... Often, we even have to support the children with our own salaries ... you see, because sometimes the money from the government delays, and that means we

experience shortage of materials needed to run the place ... and the office people too sometimes think we misuse the things, so you will have to talk and talk before they give you one thing. (Mother, 54 years old)

Thus, while workers from both institutions generally agreed that their institutions provide support, the differences were in the extent of support provided.

Caregivers from the private institution agreed during focus group discussions that they received frequent training on how to handle their duties well:

Oh sure, they train us frequently ... they are very good at it.... We are even about to embark on a training program next week.... They teach us about child rights and how to deal with some of the difficulties ... the problem is that it is difficult to teach a person how to do a job meant for three people, alone. (Mother, 51 years old)

Meanwhile, caregivers from the government institution agreed that they barely had any training:

Well, I can say I have attended two training sessions in my 15 years here ... so yes ... they train us but not much. (Mother, 54 years old)

Workers from both institutions did agree during focus group discussions and informal conversations that the social workers and their respective institutional directors have been important resources for them in times of difficulty in various ways.

One other resource that was mentioned by workers from both institutions was donor support. Indeed, all participants confirmed that donor support was the major lifeline of their organizations and that the resources provided by donors were key in helping them cope with the work and remain productive:

You see, sometimes when we are short of materials and the mothers have brought in so many requisitions, it becomes stressful for me as the head here because the responsibility ultimately falls to me, but God being so good, in moments like that you see donors walk in from nowhere to donate the same items that were needed so bad.... That is a resource that reduces the stress for me and the mothers as well. (Institutional head, 53 years old)

Another participant said:

Well, thanks to our donors ... those who come from their hearts to donate to this home so we can breathe a sigh of relief in this job ... it is because of them that we are able to do our jobs. (Assistant mother, 49 years old)

Again, despite earlier accounts of tension and mistrust between coworkers, there were reports of workers supporting each other in their daily activities. Indeed, it was observed during participant observations that some caregivers had formed a prayer group and periodically met to pray together. After a prayer session, one mother said:

Well, if you find yourself in this job, you will realize that you cannot do without prayer and you cannot do without one another.... So yes, tensions may be there, but we still manage to be resources for ourselves and each other. (Mother, 59 years old)

Another said:

When I attend these meetings, it renews my spirit because I become convinced that God will take care of me and I am able to carry on.... Without this, I don't know if I would still be working here. (Assistant mother, 47 years old)

**Personal resources:** The children and elements within the institutional environment were not the only resources that caregivers managed to identify and utilize in their work roles. Reaching deep into themselves and finding strength and motivation from personal convictions seemed to be the strongest resource that almost every participating caregiver relied on. From religious convictions to economic motivation, from a sense of self-efficacy to a quest for self-fulfillment, caregivers shared experiences that clearly revealed that their greatest resources were themselves:

My faith in God as a Christian is my greatest resource.... God blesses me for taking care of these vulnerable children.... Knowing that I am doing something that pleases God is all that I need to go on in this job. (Mother, 51 years old)

Another said:

I know that God loves me because I love these little ones.... That alone inspires me to stay in this job and forget about the stress. (Assistant mother, 43 years old)

With all participants except one identifying as Christian, the perception that doing what is necessary to help the children grow is a duty assigned by God seemed to be one to which almost all caregivers subscribed. Thus, faith was a strong personal resource identified and utilized by caregivers.

Some caregivers considered the care work as something that they were very capable of doing because of skills they had acquired through their experiences of parenting their own children. For these workers, their personal experiences and capabilities were their key resources in the job:

I joined this work after all my children entered tertiary education. When you have had that much experience of parenting four children to their adult ages, you realize that there is no job you can do better than parenting children. I rely on my experience a lot in this job. (Mother, 57 years old)

Also, a quest for self-fulfillment and the attainment of that fulfillment became a resource for some other caregivers:



In our part of the world, a woman is not fulfilled until she has had children and raised them.... Well, I wasn't fortunate enough to have my own children and I lost a marriage because of that, but I was determined to experience motherhood, and doing this job has given me that experience. I consider myself fulfilled and this is a resource that makes me find this job easy to do, especially when the children see me and run to hug me shouting, "Mother! Mother!" (Mother, 53 years old)

Other caregivers felt that the economic benefits they obtained from working for their institutions made them always strive to be innovative in handling their work duties and by so doing become resources themselves:

I earn a living by doing this job.... There are countless jobless people roaming the streets ... so I always try to be innovative, think of options around situations that crop up in this job and find solutions.... That helps me keep this job ... it always works. I consider myself a resource. (Father, 34 years old)

Thus, it became clear that while caregivers experienced different forms of stress at different levels of their jobs and organizational environment, some of the sources of stress were also seen as sources of resources that helped them cope. It also became clear that the experience of resources differed significantly among care workers depending on the type of institution they worked for.

## **Discussion**

A complex web of work stress and resource experiences, subjective or shared, emerged in our findings. The participant accounts show how caregivers understand, make meaning of, and manage the care work situation. In terms of the salutogenesis theoretical framework that inspired the study, this demonstrates how the elements of comprehensibility, manageability, and meaningfulness play out for workers in the line of duty. We therefore discuss the findings in accordance with these elements.

### ***Comprehensibility***

Our findings indicate a general sense of comprehensibility of the work situation and the work environment on the part of caregivers. This is evident in participant accounts which demonstrate clear consistency in the types, nature, and sources of stress confronting them. For example, themes such as the children, child-rights principles, relations with fellow workers and the local community, and work–family conflict consistently emerged as key sources of stress across the institutions. From the salutogenic point of view, the consistency in participant accounts regarding what is stressful for them in their line of work is indicative of the level of predictability of the work environment for caregivers. For example, the fact that caregivers regularly experienced children challenging their authority, having to care for too large a group of children, and mistrust and apathy from the community demonstrates a pattern of consistency and predictability that gives caregivers an understanding of what to expect and a readiness to draw on available resources to cope. Thus, while the consistency of stress is not helpful and

does not in any way make the work better, from a salutogenic standpoint, it helps caregivers understand the patterns of stressors in their work, giving them a chance to prepare mentally to face the challenge. It also puts caregivers in a position of knowledge of the complexities of their work and therefore able to assist when interventions are required. For example, should stakeholders decide to design training programmes for caregivers, the caregivers themselves would be able to help with information on what to include in the training content, considering that they know better which aspects of their work they need help with. This level of comprehensibility is an important step towards developing the SOC needed to move towards health despite the stress (Antonovsky, 1993; Eriksson & Mittelmark, 2017).

It should, however, be noted that the level of employee comprehensibility of the workplace does not in any way reduce the tremendous amount of stress to which caregivers are exposed. Comprehensibility is not an excuse for the failure of stakeholders to reduce the stress levels. The consistent presence of stress in that work environment is a cause for concern. This confirms findings from Castillo et al. (2012) and Akpalu (2007) regarding resource shortages and inadequate support services in CHs, such as insufficient training for caregivers.

Our findings also show that worker–worker, employee–employer, and institution–community relationships were fraught with mistrust and suspicion, as was the relationship between caregivers and their own families. This could affect the crucially necessary cooperation, both intra-institutional and between the institution and the community, needed for the institution to run smoothly. Occupational health- and workplace health-promotion literature provides considerable evidence that suggests that this cooperation is key in determining the nature of work outcomes (see Brown, Gray, McHardy, & Taylor, 2015; Brunetto, Farr-Wharton, & Shacklock, 2010; Hagar, 2012). Evidence from work–family conflict research also suggests that the observed frictions between care workers and their families have the potential to affect employee outcomes such as work commitment (Benligiray & Sönmez, 2012; Malik, Awan, & ul-Ain, 2015). Our findings suggest a need for intervention to improve work relations between institutional leaders and core caregivers, as well as among caregivers themselves. The caregivers’ evident comprehensibility of the care situation and environment shows their awareness of what the key issues are in their work situation, which puts them in a position to make important contributions to intervention attempts to support them. The design and implementation of any such interventions should therefore consider involving the full participation of the caregivers.

### ***Manageability***

Despite the stress, some caregivers demonstrated a sense of manageability of the work situation. Within the realm of salutogenesis, the concept of manageability is tied to perceptions of availability of resources in the environment and depends on individuals’ ability to identify and utilize existing resources (both internal and external) to deal with the challenges at hand (Eriksson & Lindström, 2008; Eriksson & Mittelmark, 2017; Hanson, 2007). Our findings confirm this. We observed that key internal resources such as faith or religious conviction, values, and motivations were consistently identified and drawn on to manage the stressful work environment. We also found that some caregivers seemed able to pick out existing external

resources to manage the prevailing stressors. In general, this was easier for employees in the private organization, which tended to have more resources available than the government organization. Most caregivers for the private organization were able to identify and utilize the “few helpful children” out of the general bunch of “rights-conscious” and therefore “difficult” children. Private CH caregivers also seemed better able to draw on their training and work out inter-employee differences to foster better cooperation and support. With their organization partly paying for their healthcare, caregivers for the private organization seemed better off than those in the government organization. Thus, the private CH workers had a higher sense of manageability and tended to experience the care work more positively than the government CH workers..

The implication here is that where more resources are available and used, workers tend to manage stress better. This is a confirmation of earlier stress–resource research outcomes (e.g., Bakker & Demerouti, 2007; Hyvönen, Feldt, Salmela-Aro, Kinnunen, & Mäkikangas, 2009). The finding also supports earlier findings by Baffoe and Dako-Gyeke (2013) and Darkwah, Daniel, and Asumeng (2016) that suggest a need to provide more resources such as training for caregivers in CHs, especially those in the government sector. For example, training caregivers in methods of encouraging the older children to help with chores while remaining within the framework of child rights would be quite helpful. By learning ways to regulate a child’s behaviour using approaches other than smacking or beating, caregivers could achieve desirable results while still respecting the children’s rights. Perhaps caregivers would then see child rights principles from a more positive perspective, helping to reduce the perceptions of stress attributed to the United Nations Convention on the Rights of the Child.

Further, our findings suggest that aside from providing more resources, an alternative way to support employees in this context, and perhaps other work contexts, would be to build their capacity to identify and utilize available resources. This is in line with the salutogenesis argument that people move towards health when they are able to identify and utilize resources available in their environments. In other words, an increase in resources would not necessarily help reduce stress on caregivers by itself; in order for the increase to help, caregivers must be able to identify and utilize the resources. We recommend that CWPC care institutions and perhaps other work organizations pay more attention to employee capacity-building in this regard.

The resources inequality observed here between the public and the private institutions is congruent with findings from Hearle and Ruwanpura (2009), who reported that bureaucratic and other delays in government processes often put government-funded care institutions at a disadvantage, leaving them with fewer resources and making the work more difficult for caregivers. In order to adequately address this situation, stakeholders, both local and international, may need to pay attention not only to the children in residence but also to the working conditions of the caregivers. Improved working conditions will have direct positive consequences for the health and wellbeing of both workers and children.

### ***Meaningfulness***

In the midst of the stressful work environment, most caregivers still seemed to derive meaning from the work they do and seemed to believe that the effort they expended to engage with the stressors was worth it. Caregivers seemed to derive an intrinsic sense of satisfaction when the children excelled academically, and worked from a belief that doing care work is religiously and morally right. Within the salutogenesis framework, this implies strength in the face of adversity, which indicates a positive move towards health despite prevailing stressful conditions. This finding confirms earlier research that has reported that religious convictions about one's job orchestrate psychological conditions of meaningfulness and renew motivation, which in turn influences work engagement (Park, 2012; Rothmann & Buys, 2011; Saks, 2011). This also supports the conclusion of Paloutzian, Emmons, and Keortge (2010) that employees who are motivated by religious interpretations of their work roles invest more time, energy, and commitment towards achieving work goals.

Our findings also reveal that those caregivers who saw the job as an opportunity to achieve the status they wanted gained a sense of personal accomplishment. Some caregivers tended to relish the challenge of the mothering role in order to satisfy a need to prove themselves equal to a social role of which others thought them incapable. Thus while their work provides them with the means to make a living, it also helps them to fulfill a social goal. These beliefs and feelings have the potential to be good foundations upon which institutional leaders and stakeholders could build to further improve caregiver resilience in the work context.

While our findings point to actions that can be taken to reduce the stress levels in residential child care work, opportunities have also been identified for measures to be put in place to increase the moral, religious, and intrinsic values of this work. Training, resourcing, and capacity-building to increase caregiver motivation and satisfaction could help provide some buffers against the prevailing stressors in this work environment. These suggestions are supported by motivation research outcomes that show positive relationships between employee incentive and work performance (Ibrahim & Brobbey, 2015; Sekhar, Patwardhan, & Singh, 2013). To the extent that caregivers who demonstrated this sense of meaningfulness seemed less likely to give up and were willing to keep going in the job, our findings also confirm those reported by Geldenhuys, Łaba, and Venter (2014) and Rosso, Dekas, and Wrzesniewski (2010), who reported positive relationships between psychological meaningfulness of work and work commitment.

### ***Impact on the children in residence***

The implications of our overall findings for the children, who are the key “outcomes” of the work of caregivers, is best discussed in connection with the sociocultural context within which the care service is provided. In the Ghanaian sociocultural context, children described with some of the attributes mentioned in our findings (e.g. difficult, quarrelsome, disrespectful, challenging authority) are generally tagged as “bad children” for whom disciplinary measures including corporal punishment are acceptable (Kyei-Gyamfi, 2011). These kinds of caregiver perceptions of the children could possibly trigger handling or responses that may not be in the

children's best interests. Against the background of previous revelations made by investigative journalists that appear to show physical abuses of CWPC in CHs in Ghana (Adongo, 2011; Anas, 2010, 2015), our findings suggest that for the sake of the children there is need for debate about possible interventions to address caregivers' negative perceptions and beliefs about the children in their care.

Further, beyond the CH environment, our findings suggest a need for policy review regarding the organization and resourcing of CWPC care institutions. This supports earlier arguments by Engle et al. (2011) who call for support for care institutions for CWPC as part of the care continuum. Implementation styles and processes of Western-backed approaches to child care in the local contexts should also be reviewed. Beyond the Ghanaian context, our findings suggest that an approach that respects the cultural context and local norms, and that specifically involves parents and other concerned adults in design and implementation, could significantly promote the effectiveness of introducing the principles and practices of international conventions to local populations. This could help prevent feelings of encroaching western hegemony that often trigger resistance from local populations. As can be seen from our findings, the popular perception seems to be that child rights are foreign and are being forced on local caregivers under the cover of funding. The rights-based approach to parenting, which is crucial in these institutions, is thus being experienced as a source of stress instead of as a resource.

### ***Limitations***

This study adopted a qualitative approach to explore the general subjective experiences of workers within a specific occupational, social, and cultural context. Because we utilized techniques such as participant observation, the roles of the researchers in generating and interpreting the data limit its objectivity. Further, only two CHs participated in this study; therefore the evidence generated may best apply to the location where the study was conducted. Cross-context generalization of the findings should be done with caution though lessons learnt from it could apply to other similar contexts, especially in the sub-Saharan African region. The limited generalizability here also implies that it may be unsafe to draw general conclusions about differences between private and government institutions on this evidence.

### **Conclusion**

This study was conducted to explore stress–resource experiences of CWPC caregivers in the context of CHs in Ghana. We found sources of stress experienced by caregivers to include the children in residence, interpersonal relationships at work, child rights regulations, institution–community relations, and relationships between caregivers and their own families. Interestingly, at all levels of the work environment, there seemed to be aspects that served both as stressors and resources for caregivers. It was found that some of the children and certain agents in the work environments, such as social workers and administrative workers, were key resources for the caregivers. Religious and moral convictions, as well as personal, intrinsic motivations to engage in the work, emerged as the sources of support and meaning most generally reported by the caregivers. We also observed that some workers exhibited SOC,

demonstrating the components of comprehensibility, manageability, and meaningfulness of the work and the work situation, which seemed to help them develop a sense of wanting to go on. Our findings suggest a need for interventions focusing especially on reducing stress levels and on improving intra-institutional relations and cooperation both among workers and between core caregivers and institutional superiors. Such interventions should also target improving institution–community relations and reforming policy to allow workers more contact with their own families to reduce work–family conflict. We also encourage more debate and further research on local implications of strategies adopted to enforce international conventions such as the United Nations Convention on the Rights of the Child. Finally, we believe that our findings reveal an opportunity for institutional leaders and stakeholders to develop interventions to help caregivers increase their intrinsic sense of satisfaction through training and capacity-building.

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# **The impact of organizational structure and funding sources on the work and health of employed caregivers in children's homes in Ghana**

## **Abstract**

*The strategies by which work is organized and carried out and the sources from which organizations obtain funding and other resources for their operations may have impacts on employee outcomes including work performance and health. This study explored how organizational structure (boarding vs family unit) and funding sources (government vs private) impact the work and health of individuals employed as caregivers in children's homes in Ghana. Using qualitative research techniques we collected data from fifty-seven caregivers across three children's homes in Ghana. We found that the structure adopted by children's homes impact caregiver work performance by increasing work stress levels, complicating some caregivers' ability to bond with the children and limiting the amount of time that some caregivers have to spend with their own families. These impacts then exposed caregivers to physical, mental and social health risk factors including injuries from slips and falls, mental strain, and loss of social support. We also found that funding source impacts the frequency of training caregivers receive, the extent of help caregivers receive with their own healthcare costs as well as the extent to which caregivers utilize international regulations like child rights principles in doing their jobs. Our findings suggest a need for stakeholder reconsideration of work design and strategizing for the homes taking into account caregiver health and well-being.*

**Key words:** Children's Homes. Organizational structure. Funding sources. Caregivers. Children without parental care. Family-style. Dormitory –style. Health. Work stress

## **Introduction**

Institutions that provide accommodation and alternative care for children without parental care (CWPC) exist widely despite international criticism of such care arrangements (Dozier, 2012; Engle et al, 2011; Whetten et al, 2009; Zeanah et al, 2005). In Ghana, such institutions are known commonly as Children's Homes (CHs). CWPC<sup>1</sup> are "all children not in the overnight care of at least one of their parents" (United Nations General Assembly, 2010: 6). They include children who have lost one or both parents through disease, conflict, illness etc., children living in residential care, with extended families, foster families, on the streets, in juvenile detention and those abandoned by or separated from their biological parents for whatever reasons (Darkwah, Daniel & Asumeng 2016; EveryChild, 2009; O'Kane et al, 2006). Statistics indicate that there are around 111 CHs providing alternative care to some 4,457 CWPC across Ghana (Better care Network 2014, Bettman, Mortensen & Akuoko, 2015; Department of Social Welfare Ghana, 2007). These institutions primarily offer a social environment in which care and protection are provided for vulnerable children through the hiring and training of workers referred to as caregivers. By employing people and paying them to deliver care services however, CHs also become work organizations and the CH environment becomes an occupational environment for the people employed to deliver the

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<sup>1</sup> In this paper CWPC refers to children in residential care



care services (Islam & Fulcher, 2016). Occupational health issues therefore come into play in the CH environment. Individuals employed in this occupational context work in a variety of roles including ‘core caregivers’ (employees who are in day-to-day contact with the children in residence working as hired ‘parents’), social workers, health workers, teachers, institutional directors and volunteers (Darkwah, Daniel & Asumeng, 2016).

The nature of the care services required of employees in this context is complex (Darkwah et al, 2016; World Health Organization, 2004). As noted by Islam and Fulcher, (2016), there is no intervention that is more immediately consequential than those provided by residential child care workers. Their responsibilities range from providing physical protection and care to responding holistically to emotional, psychological and all other needs of the children (Bettman et al, 2015; Groark et al, 2005; WHO, 2004; Zeanah et al, 2005). Further, CWPC in care institutions often come from troubled backgrounds, the reason for which it is deemed necessary to admit them into the institutions in the first place (Frimpong-Manso, 2016; Rizzini & Rizzini, 2009:165; United Nations Children’s Fund, 2003; United Nations General Assembly, 2010). There can be little doubt that providing adequate care for these children poses a considerable challenge to employed caregivers and the institutions they work for. The delivery of the care service in this sector therefore requires complex planning, organization and funding. Particularly, it becomes clear that the *organizational structure*<sup>2</sup> (the strategies or styles in which care is organized and delivered to the children) and *funding sources* (the organizations or persons providing monetary and resources support) of these institutions would be two crucial factors in determining the successes of the institutions in carrying out their responsibilities (Hearle & Ruwanpura, 2009; Smyke, Dumitrescu & Zeanah, 2002). Most importantly, these two factors could also hold significant implications for the *health* – (physical, mental and social well-being (World Health Organization, 1948)) as well as the *work* (specific activities or tasks that caregivers are expected to perform) of employed caregivers.

### ***Organizational structure of CHs and possible implications for employees***

Care institutions vary in their structuring (Abebe, 2009). While some operate as conventional boarding facilities with dormitory-style accommodation and shift-working caregivers, others operate as ‘villages’ with family-like environments where the children live as ‘brothers’ and ‘sisters’ with a ‘mother’ (employed core caregiver) in a family home permanently (Abebe, 2009; Dozier et al, 2012; SOS Kinderdorf International, 2004). Globally, when governments have to utilize the ‘last-resort’ of residential institutions to organize care for CWPC, care strategies with family-like environments are preferred (Department of Social Welfare Ghana, 2008; Whetten et al, 2009). This is due to observations that children grow best in family environments where care is continuous allowing children and caregivers to develop lasting bonds (Frimpong-Manso, 2016; Yendork & Somhlaba, 2015). However, such organizational structuring is expensive to operate and resource deficits coupled with rising numbers of CWPC have meant that both family-style and conventional dormitory-style institutions still

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<sup>2</sup> We use ‘*organizational structure*’ to refer to how work activities are organized in the CHs. In other studies in the literature, the concept has much broader definitions and goes beyond just this.

operate in places like Africa (Abebe, 2009; Mann, Long, Delap & Connel, 2012). Such is the case in Ghana where both *dormitory-style* and *family-style* CH structures exist (Frimpong-Manso, 2016).

Cross-disciplinary workplace research consistently demonstrates that how work is structured or organized in an organization has influences on work performance, health and work experiences of employees (Chen & Huang, 2007; Griffin, Neal & Parker, 2007; Kanten, Kanten & Gurlek, 2015; Wilson et al, 2004). In the specific context of care work, research indicates that the care recipient's needs (which often informs the work strategy or structure adopted) determines the demands made on the caregiver which in turn have implications for the health and well-being of the caregiver (Beach et al, 2005; Pinguart & Sorensen, 2003; Talley & Crews, 2007). Further, arguments put forward by the health promotion theory of Salutogenesis (Antonovsky, 1993) hint at the possible influences of environments on individuals by arguing that the nature of an environment may present stressors and resources to individuals in that environment which in turn have implications for their functioning or health. The theory holds that whether individuals manage to remain healthy or function properly depends on: (1), the extent to which they experience that environment as understandable and that a sense of order can be sustained even in unknown circumstances (Comprehensibility), (2), the extent to which individuals believe that there are adequate resources to deal with prevailing stressors (Manageability) and (3), the extent to which individuals are convinced that things make sense and what people do in life is worth the energy they invest in it (meaningfulness). According to Antonovsky (1993), these make up the Sense of Coherence (SOC) and this SOC is significantly associated with health trajectories or outcomes. Thus, by their nature and characteristics, the varying organizational structures and care strategies adopted by CHs may present employed caregivers with varying opportunities or resources as well as stressors in their line of work that may have implications for the specific demands made on them and their physical, mental or social well-being. For example, while the 'mother' in a family-style CH is, by principle, committed to staying with the children in the home full time (including day and night every day (Cahajic et al, 2003)), the caregiver in the dormitory-style CH is limited in her interaction with the children by working hours (Abebe, 2009).

Interestingly, research on the impact of the organization of care and the characteristics of the care environment in the CWPC institutional work space tends to emphasize the outcomes of these arrangements and organizational characteristics for the *children*. Attention is rarely paid to how these impact care workers (van IJzendoorn et al, 2011; Wolff, Dawit & Zere, 1995; Wolff & Fesseha, 1998). The resulting evidence therefore sheds much insight into better alternative care arrangement options for CPWC without offering much about the situation of workers in these arrangements and what could be done about it. Interventions have therefore been carried out more in the interest of the children than in the interest of employees.

### ***Funding sources of CHs and possible implications for caregivers***

Ownership and funding sources of work organizations are also known to have influences on various employee and organizational outcomes (Comondore et al, 2009; Lyons, Duxbury &

Higgins, 2006; Mihajlov & Mihajlov, 2016). For example, while research in some contexts suggests that employees in government-owned organizations fare better than private-owned organizations (Mihajlov & Mihajlov, 2016) others suggest the opposite in other contexts (Ntukidem & Ntukidem, 2011). In a meta-analytic review of the literature, Comondore et al, (2009) found differences in nursing care quality between institutions owned and funded by for-profit organizations and those owned and funded by not-for-profit organizations. It was concluded that not-for-profit institutions provided higher quality care. In the child-care work sector, ownership, operational responsibility and funding sources of care institutions have been observed to differ. Institutions may be funded through sources such as government and Non-governmental Organizations (NGOs) as well as benevolent individuals and religious organizations (Abebe, 2009; Ennew, 2005). In Ghana, the government owns, operates and funds a few CHs, with the larger proportion owned and funded by individuals and private, often not-for-profit organizations mostly operating without governmental oversight (Better care network, 2014; DSW, 2008; Frimpong-Manso, 2016).

Funders typically have their expectations of the institutions they support. The funding strategy and requirements from funders may, like its organizational form, pose significant influence to CHs and on the work demands made of caregivers. For instance, CHs in Ghana are, by law, required to raise CWPC in their care with compliance to children's rights provisions enshrined in the United Nations Conventions on the Rights of the Child (UNCRC) (Department of Social Welfare, 2008). Funders, both local and foreign expect CHs benefitting from them to fully comply with this law. The use of UNCRC principles in raising children is however a contentious issue in local Ghanaian society. Cultural norms of child upbringing in this context emphasize practices such as corporal punishment and strict parental control – practices that clash with some of the provisions in the UNCRC (Kyei-Gyamfi, 2011; Twum-Danso, 2012). Funder insistence on the use of these laws therefore often generates tensions between child rights-centered programmes (especially foreign-funded ones) and local folk (see Darkwah, Daniel & Yendork, 2018) Thus similar to arguments raised by Daniel (2014) concerning how humanitarian aid may help or harm recipient communities, funder expectations and requirements of care institutions for CWPC may exert impacts that may help or stress those employed as caregivers. Further, Hearle and Ruwanpura (2009) observe that government grant systems for orphan care institutions in South Africa posed severe challenges to caregivers by way of bureaucratic application procedures and corruption among government officers. Colburn (2010) also found that private orphanages in Ghana fared better in providing care for CWPC than public orphanages due to monitoring and resource differences. Yet such existing comparative investigations into CHs overwhelmingly emphasize the outcomes of such funding and resource differences for the health and wellbeing of the resident children and much less on what these mean for the health, wellbeing and working lives of caregivers as employees. The implication is that the work situation of employed caregivers on whose successes the health and wellbeing of the resident children significantly depend is largely understudied.

## ***Research Questions***

This study was conducted for the purpose of providing insight into the work situation of employed caregivers in CHs. The idea was to explore how employees experience working in the different CH organizational structures and the influences that funding sources and funder expectations have on their work and health. Two research questions were explored:

1. How does the organizational structure of a children's home influence the work and health of employee caregivers?
2. How do funding sources and funder expectations affect caregivers in children's homes in Ghana?

## **Method**

### ***Setting***

The study was carried out in three regions of Ghana, West Africa. The regions have some of the country's largest government-owned and private-owned CHs which receive funding and resource support from different sources. The CHs present in these regions also have different organizational structures. Some operate with traditional dormitory-style structure (even though they like to see themselves as families) while others operate the typical family unit structure. These settings were therefore purposefully sampled in order to collect data from across the different organizational structures and funding sources.

### ***Design***

We adopted a qualitative approach with phenomenological design for this exploration. We chose this method and design because of our interest in obtaining in-depth insight into caregivers' subjective as well as shared lived experiences and meaning making of the phenomenon of caregiving as a job within the different CH organizational and funding structures. Researching occupational health issues in this work setting is still a new and emerging area so the qualitative approach gave us a better opportunity to explore with an inductive approach to capture emerging insights. Since a qualitative approach is best suited for in-depth analysis of the *whys* and *hows* of individual lived experiences and how people construct reality for themselves in different contexts (Cho & Trent, 2006; Swift & Tischler, 2010), using the method and design was appropriate for answering our research questions.

### ***Participants***

Fifty-seven caregivers drawn from three CHs participated in the study. The caregivers held different positions and responsibilities in their organizations and therefore played different roles in the provision of care services. We included caregivers with the different responsibilities in order to better capture information from a broader spectrum of experiences regarding the phenomenon of CWPC caregiving. There were 41 core caregivers ('mothers', 'fathers' and 'aunties' in charge of raising the children in the dormitories or family homes), three social workers, two resident health workers, five teachers, three institutional directors, and three volunteers who were former institutional children) involved in the study.

## ***Data Procedures***

The lead author collected data using a combination of participant observation, focus group discussions and in-depth interviews. The techniques were employed in a systematic way such that information from one built on information from others. He began with participant observations where he stayed with or paid frequent visits to each participating institution for at most one month, observing caregivers as they went about their daily routines and taking the opportunity to develop rapport with caregivers. He kept a field notebook in which he jotted down observations. He also used the participant observation phase to recruit focus group discussion and interview participants through friendly informal conversations in which the study and its purpose were explained to interested caregivers.

Focus group discussions followed shortly after participant observation in each institution. Three focus group discussions were held in total with an average of eight participants (all of them ‘mothers’ and ‘aunties’) per discussion. The group discussions were used to collect information on lived experiences and shared norms regarding the phenomenon of CWPC caregiving and how the particular CH organizational structure and funding source influences this activity. The lead author played a facilitator role in each of the group discussions. Themes put forward for discussion were: “what are the work responsibilities of a caregiver in this institution?”, “how does the organizational form/style of this institution affect your work as a caregiver”, “who are the main funders of this institution?” and how do the funding source and funder expectations influence your work as a caregiver?”. The discussions took place on the institutional compounds and took an average of two hours and ten minutes to complete.

In-depth, face-to-face interviews completed the data collection. The interviews were used to try and collect additional information, gain more depth into already provided experiences and provide a private space for caregivers who might have been possibly uncomfortable to share their experiences in public. In all, 53 interviews were conducted including 19 interview participants who had already participated in focus group discussions. Each interview took place at a time and place chosen by the participant and in either Twi (local Ghanaian Language) or English depending on the preference of the participant. The interviews were conducted using a thematic interview guide with the same themes as those used for the focus groups. The interviews lasted for an average of one hour and 35 minutes.

The order of progression (observation - focus groups - interviews) was done purposefully to first pick up initial data from general open observation which would then serve as bases for more specific thematic discussions in the focus groups. Combined information from the observations and focus groups then served as bases for further, deeper probes during interviews. Overall, the combination of the three qualitative data techniques ensured multiplicity of data sources for the study and also culminated in a tripod of data sources upon which triangulation was achieved.

## ***Ethics***

We obtained ethical clearance for the study from the Norwegian Social Sciences Data Services (NSD). The Department of Social Welfare (DSW) of the Government of Ghana

reviewed this institutional clearance and deemed it satisfactory for the study to be conducted before data collection began. We then obtained permissions from the authorities of the individual institutions involved. We fully informed participants about the nature and purpose of the study and also informed them about their right to refuse participation or withdraw participation at any point without any sanctions. We made it clear that participation was voluntary and would come at no compensation. Those who agreed signed informed consent forms before being involved in the study. The focus group discussions and interviews were audio-recorded with the full consent of the participants. All collected data were stored in a password-protected folder on the personal computer of the lead author. Co-authors and co-coders had access only to anonymized forms of this data.

### **Data Analysis**

We began our analysis process by first transcribing and translating all audio-recorded data. The transcripts together with field notes from participant observation were then coded by individual members of a coding team. The team agreed to adopt an inductive coding process where members studied the transcripts carefully and picked out units of information that specifically described the situation being recounted in the transcripts as codes. To ensure inter-coder reliability, each individual member separately coded the data before the team met to discuss the codes and find consensus on coding disagreements to obtain a final coding frame. This inductive coding process was followed by a deductive thematic network analysis following Attride-Sterling's approach (Attride-Sterling, 2001). We adopted this approach in order to be able to identify emerging themes in the text and better understand the complexity of participant experiences by uncovering the underlying meanings and interconnections between the various emerging themes. We began with clustering codes that expressed similar meanings into basic units or Basic Themes. Basic themes expressing similar meanings were then further clustered into Organizing Themes and the same procedure was used to cluster organizing themes into a larger umbrella theme called Global Theme. The Global Theme captures the essence of the entire data-set collected. Table 1 presents the systematic thematic analysis process we adopted:

**Table 1. Thematic Network Analysis of the data-set**

| Codes  | Basic themes   | Organizing themes                                       | Global themes  |
|--|--|---|--|
| <p>...dormitory style means too many children per caregiver<br/>                     ...being in charge of a house means taking care of 40 children<br/>                     ...It's difficult with this style, you get overwhelmed with work<br/>                     ...your role shifts from being a caregiver to so many other things</p>    | Dormitory-style increases work demands on caregiver          | Impacts of organizational structure on caregiving work  | Impacts of organizational structure & funding sources on caregiver work and health |
| <p>...this style of care doesn't make us parents<br/>                     ...the children don't have a bond with you, they only see a worker<br/>                     ...this style makes it look like a boarding school instead of home<br/>                     ...we close from our parenting duties, so it's difficult to bond</p>           | Dormitory-style makes bonding difficult                      |   |  |
| <p>...with our family style, there are no starting and closing times for us<br/>                     ...with this family style there are no working days and weekends for us<br/>                     ...the pay does not match the hours we work<br/>                     ...the difficulty with this style is that you are on the job 24/7</p> | Family-style is physically demanding                         |   |  |
| <p>...the children easily bond with each other with this family style<br/>                     ...the caregiver is seen as a parent figure in the family home<br/>                     ...The children get a sense of family<br/>                     ...the number of children is smaller with this style</p>                                   | Family style makes work outcomes better for the children     |   |  |
| <p>...Slips and falls are common with dorm style because of work pressure<br/>                     ...At the end of your shift, you go home with body ache all over<br/>                     ...despite everything, you close and go home to rest<br/>                     ...that sense of relief when you finally close feels so good</p>      | Dormitory-style impacts physical health                      | Impacts of organizational structure on caregiver health |  |
| <p>...one mother with 10 kids in family home, you develop blood pressure<br/>                     ...we work non-stop with family style, you get exhausted everyday<br/>                     ...with this family style, you have no rest</p>   | Family style impacts physical health                         |   |  |
| <p>...we don't get to be with our own families often<br/>                     ...you lose all your friends because your life is in the CH family home<br/>                     ...you can't attend family social gatherings, you become a stranger</p>   | Family-style impacts social well-being                       |   |  |
| <p>...with this style, if your child is not doing well in school, you bear the guilt<br/>                     ... to understand and respond to 10 different kids drains you mentally<br/>                     ... the separation from your own biological family is mentally challenging</p>   | Family-style affects caregiver mental health                 | Impacts of funding sources on caregiving work           |  |
| <p>...foreign funders expect foreign parenting with child rights<br/>                     ...sometimes what they expect you to do is confusing<br/>                     ...They pay, so they expect you to obey without complain<br/>                     ...foreign funding comes with confusing child rights</p>                               | Foreign funding comes with confusing work demands            |   |  |
| <p>...we are funded mainly by government, so we don't have much<br/>                     ...the government never brings the money on time<br/>                     ...if local sources fund you, you can parent like a Ghanaian<br/>                     ...you don't get much training with local funding</p>                                   | Government/ local funding affects work performance           | Impacts of funding sources on caregiver health          |  |
| <p>...foreign funding enables CHs to support caregiver health costs<br/>                     ...foreign funders provide much more work resources easing work stress<br/>                     ...with foreign funding we train a lot which helps us do the work in healthy ways</p>   | Foreign funding supports caregiver health                    |   |  |
| <p>...foreigners fund you, so you parent like them and your own conscience judges you<br/>                     ...the local community sees you as only spoiling the children not parenting them<br/>                     ...foreign funders brings foreign rules which conflict with our parenting values and make us feel guilty</p>            | Foreign funding affects caregiver mental & social well-being |   |  |
| <p>...we bear our own health care costs because we are funded locally<br/>                     ...local funding means less resources, which means more work stress<br/>                     ...We don't train much so we don't know much about healthy work practices</p>  | Local funding impacts caregiver health on the job            |   |  |

**Results**

Themes that emerged from our systematic analysis process describe the experiences and accounts of employees regarding what the organizational structure of their institutions and the sources of funding and resources mean for their work and health. They also capture how

expectations and conditions from funders influence their work as caregivers. We present these results here under the main organizing themes that emerged:

### ***Impacts of organizational structure on caregiving work***

Caregiver accounts and field observations revealed various ways (positive and negative) in which the organizational structure of CHs impact on the phenomenon of care and what this means for those employed to provide it in that sector. In some cases, the different structures had similar implications for the demands made on caregivers although through different pathways. For example, the dormitory-style of organizing care implied that the workload for caregivers was high as few caregivers were placed in charge of large numbers of children in large accommodations increasing the work stress level on the caregivers:

“...because of the style we operate, we have too many children under sometimes just two caregivers...that brings overwhelming stress to them as employees. The work demands become just too much for the caregivers” (Resident nurse, dormitory style CH)

An assistant house mother shared this experience:

“...there are too many children under one house mother and sometimes just one assistant on duty because this place is more like a dormitory...there was a time I had to feed 40 children all by myself...it’s too stressful...”(Assistant house mother, dormitory-style CH)

Similarly, caregivers in the family-style CH structure also felt their work was too demanding and stressful not because of high child-caregiver ratio but because they are required to live permanently with the children in the family homes and never ‘close from work’:

“...with our style, we don’t have a time to go to work and a time to close...we live here permanently with the children and we work practically every day, every minute...the demands are just too much sometimes...”(Mother, family-style CH)”

In other cases, there were differences in the impacts that the organizational structure had on the caregiving work. This mainly had to do with caregiver relations with the children which caregivers felt was crucial for effective work performance. Caregivers in the dormitory-style CH for instance, felt that their organizational structure made bonding with the children difficult because of the near impossibility to pay individual attention to each child and also because of the shift work system that comes with that design. This perception was common during focus group discussions:

“...because of the way the care service here is organized, we struggle to build bonds with the children so they (the children) treat us just as we are - workers not parents...you can’t really care for them like you would do for your own child, and yet, that is what we are employed to do...” (House mother, dormitory-style unit)

During an interview, another caregiver said:

“...I would say this style of caregiving is not the best for the children because of the shifts we run...there is no continuity in the parenting they receive so it is difficult for the children to bond as siblings and then to bond with caregivers...this affects our work a lot...”(House mother, dormitory-style CH)



Caregivers in the family-style organizational structure rather felt that the structure impacts their work by facilitating bonding between the children and between the children and caregivers. They thought this was positive as it made work performance relatively easier:

“...I think this family unit form of organizing care is better for the children compared to those other styles like the dormitory styles...here the children live together in smaller family units with a mother...so they see themselves as siblings and handling them is easier for us...” (Mother, family-style CH)

A social worker in a family-style organizational structure shared a similar opinion:

“...From the way we organize the care service here, it’s not possible to cram many children into one family home...so the children actually do have a sense of family and belonging...the caregivers have relatively smaller numbers of children...” (Social worker, family-style CH)

Caregivers in the dormitory-style CHs agreed with the thoughts of those in the family-style CH workers on this:

“...The way we are organized here makes the job more stressful for us... and does not provide the children with optimum care...it is not like those family-style CHs where they look like real families...that is better for the children...” (Assistant house mother, dormitory-style CH).

Thus while the structures of the CHs presented high levels of work stress to caregivers (albeit through different pathways), the family-style organization had some positive impacts on caregiver work performance and children’s growth while the dormitory-style organization largely impacted negatively on these.

### ***Impacts of Organizational structure on caregiver health***

Some of the impacts that the structures of the CHs have on caregiver work performance also tended to hold implications for their health and safety on the job. Here again, similarities and differences emerged in the nature of the health impacts. For example negative impacts on physical health of caregivers were shared across the two organizational structures attributed largely to the work demands and high stress levels. While a caregiver in a dormitory-style CH said:

“...slips and falls are a part of the job in this place...especially in the mornings on weekdays when we have to get all of them ready for school...it can get crazy I tell you...”(Assistant house mother, dormitory-style CH)

another in a family-style CH said:

“...well, I if you work permanently 24/7 without break or without a sense of closing time, obviously that’s not good for your health, is it?... exhaustion can kill...(Auntie, family-style CH)

Also there were complaints of high blood pressure which caregivers attributed to the work demands brought on by the nature of organization across both organizational structures:

“...I am aware that some of my colleagues have become ill with hypertension and other things after they joined this job here...I mean, from the way the whole care is arranged, why wouldn’t they get hypertension after working in this set-up for a long time...” (Mother, dormitory style CH)

From the family-style organization, a caregiver said:

“...Since I joined this home, I have developed high blood pressure...I am often alone with 10 children... I have to cook, wash and clean...what kills me is the talking...sometimes you practically have to scream before they listen to you...and if anything goes wrong, the office blames you the mother...” (Mother, family-style CH)

Aside from the shared concerns for physical health of caregivers across organizations, the family-style organization in particular seemed to have additional negative impacts on caregiver mental health:

“...This organizational form is good, but only for the children...for us, it means you hardly see your own family...you are left longing for them and wondering what’s happening with them...that drains you mentally...it’s hard to deal with” (Mother, family-style CH)

Another caregiver shared this experience:

“...my teenage daughter is now pregnant and we don’t even know who made her pregnant...because I left her in somebody’s care while I came here to care for other people’s children. I can’t stop blaming myself...the guilt is heavy...sometimes I just lock myself up and cry...”(Mother, Family-style CH)

Some caregivers in the dormitory-style CHs seemed aware of the inherent mental health implications of the family-style CHs and preferred to work where they are:

“...I would rather work here than in those family unit organizational styles. At least here, we close and go home to see our own children...you look forward to closing time to get away from all this...in those family style homes, there is no escape...longing for your family can mess up your mind... (Mother, dormitory-style CH).

There were also social costs of the family-style organization for the caregiver:

“...you become a stranger to your community...they don’t see you at community gatherings...you don’t attend funerals...your excuse is work...if something happens to you, people will say they are also going to work...who will help you?...”(Mother, family-style CH)

Other staff including institutional gatekeepers and educational workers agreed to the health implications of the family-style for caregivers:

“... I guess when this style was adopted, the authorities were probably thinking of what’s best for the children, not so much the employee...the children are vulnerable and need complex care, so they probably forgot to think about what this would mean for the health of people who sign up as caregivers...” (Educational worker, family-style CH.)

An institutional director said:

“...I don’t think our policy caters well for the people we have employed as caregivers...everything is about the children...I admit the children should be our first priority...but we can’t achieve our goals if we don’t take good care of the people in whose care we entrust them...”(Director, family-style CH).

### ***Impacts of Funding sources on caregiving work***

The ownership and sources of funds and other resources to run the CHs also had a variety of impacts on how caregivers performed their work roles in the organizations. Again, there were similarities and differences in these impacts with the differences observed mainly in the extent of the impacts. For example caregivers in both privately funded and locally funded CHs expressed frustrations regarding the rules that they are expected to follow in carrying out their parenting work. Participant caregivers felt frustrated with the requirement to use the UNCRC as they thought the rules are foreign and conflict with their own local values of parenting. Interestingly, the severity of the frustration seemed higher on the part of the caregivers in locally funded CHs while the degree of enforcement of these provisions seemed higher in the privately funded CHs:

“...Sometimes you are just confused...all these rules from foreigners...how do they expect me to raise a child like how white people raise their children...you can't discipline them... you just watch them get spoiled...it's just frustrating...” (Mother, government-funded CH)

A caregiver from a privately-funded CH however said:

“...well, they train us here to obey the rules of child rights...over time we have learnt to accept them and just work with them...you convince yourself that it is not your fault that the children are getting spoilt...” (Mother, private funded CH)

Stark differences were observed in how child rights regulations were enforced in the government versus private funded CHs. In informal conversations during participant observations, caregivers revealed these differences:

Caregiver from government funded CH:

“...here, we are funded by the government and the government knows the local norms, so yes they make sure that we adhere to child rights, but sometimes they understand if we have to go the local way...”(Mother, government-funded CH)

Caregiver from privately-funded CH:

“...you can lose your job or even face prosecution if you breach those child rights rules here...the money for this place comes from white people and some rich people who have lived abroad so they are very strict with those rules...you just leave the children alone if you don't want trouble...” (Auntie, private-funded CH).

Funding sources also impacted caregiver work performance by influencing the frequency of training caregivers received. Caregivers unanimously agreed that training was important in helping them understand their roles and handle the stress in the work better. In this sense caregivers felt that those working in private-funded homes perform better on the job than those in government-funded ones:

“...you see, we here are funded by foreign, western donors, so they run this place almost like how other homes in Europe and America are run...training is frequent and that helps us deal with the stressors in this job...” (Mother, Private CH)

A government –funded CH caregiver said:

“...I can say that in my 15 years of service in this institution I have attended training only twice...the government never has money ...so obviously those rich private home workers do better on the job than us...” (Mother, government CH)

The funding sources again impacted caregiver work performance by determining the quantity and availability of material resources available to caregivers for the performance of their work roles. Again the odds were in favour of privately-funded homes:

“...I can’t remember a time when school has re-opened and even one child here lacks anything to go to school...they are superb with releasing materials and money for the children... you have to commend them for that...” (Aunty, Private-funded CH)

A volunteer in the government CH said:

“...On several occasions some mothers here have had to use their own small salaries to purchase items needed for the children’s upkeep because the government money does not come on time...” (Volunteer, government funded CH)

Institutional heads in the private organizations expressed awareness of the influence that funding sources were having on the caregivers’ ability to perform the tasks required of them:

“...here, we give them everything they need...so they keep the children neat, feed them and all...it is not like the locally-funded homes where the children look dirty because their caregivers don’t have the needed materials...” (Director, private-funded CH)

### ***Impacts of Funding sources on caregiver health***

Like the organizational structures, the funding sources also had implications for the health and wellbeing of the caregivers at work. One key area where funding impact on caregiver health was observed concerned issues of institutional support systems for employee health care costs. Privately funded CH workers testified that their institutions support their health care costs because they receive funding from abroad:

“...As for our health issues, we receive some help from our employers with, for example, health bills...we get money from abroad so they pay like 50% of the total cost for us and we also pay the other 50%...” (mother, private-owned CH)

Government CH workers rather lamented about the total lack of support for their health costs:

“...We go through all this stress and when we fall ill, who is there to support us?...we have to use that small salary they pay us to pay our hospital bills...it makes you feel so unappreciated...” (mother, government CH).

A social worker in one of the institutions summarized the impact of funding on employee health issues in an informal conversation during participant observation:

“...it’s simple, how your health matters are handled as an employee in an organization like this depends very much on who owns the organization and how it obtains funds to run the place...if your institution is funded by foreign donors, like Europeans or Americans, you can be sure they will pay for your health, but if it is owned by the government here, forget it, you are on your own...” (Social worker, private-owned CH).

Other impacts that funding sources had on employee health were in a way, chain effects of impacts brought on by the funder impacts on work responsibilities. Caregivers from across the organizations agreed that the funding sources influence the rules of the job (child rights) which in turn brings them a sense of guilt and confusion making the job mentally stressful:

“...you see, we are parents ourselves so we know how to raise children...so when they ask us to follow rules that only end up spoiling the children’s behavior, we as parents, have a sense of guilt...that is not mentally healthy for us...(Mother private funded CH)

A caregiver from the government CH said:

“...there are times when I have arguments with myself in my head especially when the big children stand up to you and say things to you and you can’t do anything because of child rights...you feel sad and depressed...”(Mother, government-funded CH).

The funder expectations of caregivers to adhere strictly to child rights provisions, seems not only to bring mental challenges to caregivers, but also social costs:

“...the local community don’t think anything good of us...they think we are adults who have sold our values for money and just spoil people’s children...” (Mother, private funded CH)

During focus group discussion a caregiver shared this experience:

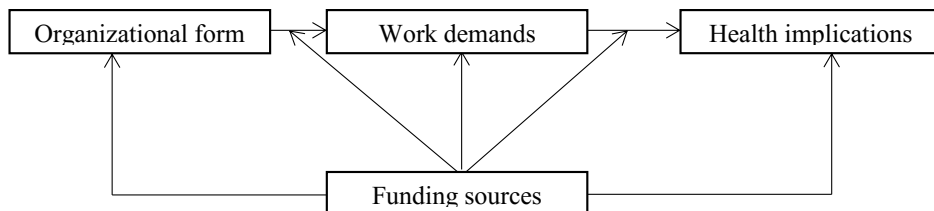
“...once I tried to advice a local woman to stop beating her child... she yelled at me and told me that if I know how to raise children I should teach the children in my care to show some respect to elders instead of just following white people and spoiling them...”(Mother, private-funded CH)

For the government-funded CH, much of the chain effect impacts had to do with the funder inability to provide adequate work resources, which in turn increases the stress levels in the job and through that impact their health:

“...Because we don’t have much resources here, we are always stretched tight...if the home vehicle does not have fuel, we caregivers have to walk long distances to buy materials and carry them on our heads into this compound...in no time, you develop back pain and chronic body pain...it is not easy here...( assistant mother, government-funded CH)

In essence, our findings seem to reveal a peculiar impact pattern where organizational forms present certain work demands which then present certain physical and psychosocial health risk factors to caregivers with the nature and level of demands as well as the severity of risk factors influenced by funding sources. Figure 1 gives diagrammatic presentation of this pattern. It must be noted that this figure represents what was found in this particular study and might need further testing in subsequent research:

**Fig 1. Impact pattern between organizational forms, funding sources, work demands and health implications for caregivers in CHs**



## Discussion

In this study we explored the impacts of organizational structures (traditional dormitory style vs family unit style) and funding sources (government funding vs private funding) of children's homes in Ghana on the work and health of employed caregivers.

We found that both organizational structures, as they were practiced in the CHs involved in this study, increased the amount of workload on caregivers, which they felt limited their ability to carry out their work duties of providing adequate care. In the dormitory-style CHs this was attributed to high child-caregiver ratio, while in the family-style CHs it was attributed to the requirement for the mother to live full time with the children and be constantly working to provide care without break or 'closing from work'. This finding holds important implications. First, it confirms earlier perceptions that dormitory-style institutional arrangement for CWPC is not beneficial for the caregivers' work and the growth of the children in residence (Delap, 2011). However it also reveals that the general perception that the family-style of organizing care is better than the traditional dormitory style (- see Delap, 2011; DSW, 2008; Frimpong-Manso, 2016; Whetten et al, 2009; Yendork & Somhlaba, 2015) may only be true for the children but not so much for the employees. Dormitory style CHs had additional negative impacts on caregivers' work through the shift work systems; caregivers found this disrupted continuity of care and hindered their ability to build their role as 'parents' to the children. Existing research into child care confirms these caregiver perceptions as it demonstrates that the changing of core-caregivers through such means as shift-work schedules disturbs continuity and stability in the care relationship between caregivers and children and orchestrates behavioural problems in children (Browne, 2009; Han, 2008).

We found that the organizational structures of CHs impact the physical, mental and social health of caregivers at work. Physically, the heavy workload in both structures contributed to caregiver feelings of exhaustion and overwhelming work stress. Existing literature demonstrates that such employee perceptions whether actual or imagined have an impact on satisfaction, commitment and productivity (Patterson, Warr & West, 2004; Raziq & Maulabakhsha, 2015). Concerning caregiver mental health, we found the dormitory style organizational structure to be better than the family-style arrangement. The full time commitment required of mothers in the family-style structure significantly limited the amount of time they were able to spend with their own families. Caregivers in the dormitory style arrangement perceived that having an end to the work day is positive for their mental health as it offers them an "escape" opportunity from their often stressful work environment and a chance to spend time with their own families. There is overwhelming research evidence that an employee's negative mental state affects their work behaviour (Chen et al, 2017; Rajgopal, 2010; Sahler & Dubois, 2009). Given the fact that caregiver work behaviours have frequently been called into question in the Ghanaian residential child care contexts (Anas, 2010, 2015; Frimpong-Manso, 2016; Smith-Asante, 2014) the need for debate and reconsideration of the current states of the organizational structures could not be more urgent. Caregiver absence from the lives of their own families and local communities also seemed to come with social costs for the caregivers in the family-style CHs. Our findings show that caregivers felt alienated from their communities and feared losing their social networks and receiving social

support as a result of the requirements of their organizational structures. Analyzing the family-style structure in its present state inside the Ghanaian social context, the caregivers fears hold merit as Ghanaian traditional social relations are organized by the principle of reciprocity reflected in traditional sayings such as “one shows benevolence to the child of his benefactor” (Fenenga et al, 2015; Ferrara, 2003:1; Yidana, 2014). The prospect of losing social capital or social support as a result of their organization’s strategy is a cause for concern as previous research shows social capital and social support are crucial for individual social and mental health (Berkman & Glass, 2000). Going by our findings, we argue that modifications need to be considered to make the care system more supportive of employee health.

The impacts of the funding sources on caregiver work performance varied in nature and severity. We found that funding sources were connected to the nature and frequency of on-the-job training that caregivers received. The CHs funded by private, often western sources, tended to undergo frequent training which, helped increase caregivers skill in handling their work roles better. CHs funded by local government had less frequent training. The implication here is that caregivers in the private homes had the knowledge to interpret their work roles better, and stood a better chance of adopting more effective ways of handling the work demands as compared to those in government-funded CHs. Consequently, work outcomes are likely to be better in the privately funded homes (and this has been observed in earlier research, see Colburn, 2010) while perceived stress and inability to provide adequate care would be more likely in the government-funded homes. Funding sources also influenced the extent to which stipulated laws and regulations, in particular, child rights that residential child-care institutions in Ghana are required to follow in carrying out their duties are enforced. There have been challenges in enforcing this law in general Ghanaian society (see Darkwah, Daniel & Yendork, 2018; Kyei- Gyamfi, 2011) but our findings reveal that in the CH context the extent of enforcement is related to who is paying. The strict application of UNCRC principles in raising children in the privately-funded CHs seemed to however be a point of conflict between institutional authorities who were more concerned about meeting funder expectations, and core-caregivers who were more concerned about meeting local community expectations of raising children the ‘Ghanaian way’. The implication is that the privately-funded CH work environment likely has more tension due to the disagreements between institutional authorities and core-caregivers on this matter. These tensions, as observed in earlier workplace research (Castro & Martins, 2010; Carter, Armenakis, Field, & Mos, 2013) may hold negative implications for work performance in the CH. While this finding suggests a need for more attention to be paid to education and training of both institutional authorities and caregivers on more positive and cooperative ways of discussing and utilizing children’s rights principles for the benefit of their work, it also exposes a possible weakness in the enforcement strategies adopted by the local Ghana government regarding the UNCRC. Beyond the Ghanaian context, this finding highlights the complexities in universal applications of international laws and principles in different social and cultural contexts (Welbourne & Dixon, 2015) and the need for continuous debate aimed at developing more effective ways of encouraging acceptance of such laws in local contexts.

Generally, the impact that funding source has on caregiver health manifests through the impact it has on their work performance, with the exception of impact on support for caregiver health care costs. In essence, the health implications of the funding sources for caregivers in this regard were more negative for government-funded CH workers than private, western funded CH workers. The simple implication here is that funding strategies for government CHs need to be reviewed with more budgetary considerations given to CHs as this finding, together with findings of earlier research, demonstrate how inadequate funding undermines caregivers' work in government CHs in Africa (Ntukidem, 2011; Hearle & Ruwanpura, 2009). We found funding sources to also impact social and mental well-being of caregivers through their role in adherence to children's rights principles. The local communities' negative perceptions regarding using these principles to raise children means that the foreign funders' insistence on using children's rights principles, put the private CH workers in particular on a sort of a 'collision course' with the local communities where they work. Our findings demonstrate this as caregivers recounted experiencing hostile attitudes from local community folk due to their approach to raising the children in their care. Thus while caregivers faced friction on the issue of child rights with their superior officers on the one hand, they faced hostile reactions from the local community on the other on the same issue. The implication is that the social environment of caregivers within and outside the walls of their institutions is quite unsupportive. This kind of social situation in itself is a potential mental health risk factor for individuals in any context (Kawachi & Berkman, 2001; Rutter, 2005). We suggest that stakeholder consideration of interventions aimed at addressing these human relations issues in the CH should also target wider community education to increase understanding of children's rights principles. This would help change local community attitudes towards children's rights principles and caregivers eventually.

Funding sources also had quite a significant impact on employee health issues by being a key determinant of the amount of financial support caregivers received for their own health care costs. Our findings show that caregivers in the private, western funded CHs received some support with their health care costs while local government funded CH workers received no such support. Thus even though caregivers in the private funded CHs still complained about the institution's lack of urgency in providing this financial support compared to when such support is required for the children, this finding still implies that caregivers in the private CHs had better conditions of service and could approach their work duties more confidently. With no guarantee that their institutions would support them financially should any health consequence arise while performing their work duties, research suggests that employees' motivation, work engagement and commitment would likely be negatively affected (Arshadi, 2011; Setti & Argentero, 2011; Gillispie, 2012). The eventual implied outcome in this situation is that private CHs are likely to perform better in providing care for CWPC than government CHs.

The observed impact of organizational structure and funding source on the work performance and health of caregivers in CHs, also has implications for the growth and welfare of the children (Gray et al. 2017). Our findings show the care quality children in the CHs receive is likely to differ with children in the private-funded CHs standing a better chance of receiving



good quality care. High child-caregiver ratio and increased work load imply that caregivers are even less able to carry out the duties expected of them (Bass et al 2016). Caregiver training can significantly improve the situation and dramatically improve bonding and relationships between children and caregivers (Hermeu et al., 2015; Hermeu et al, 2017). Thus while we confirm that the small group family-style organizational form is a better option for the children, we also recommend that more has to be done in order for it to better support caregiver work performance and health.

### **Limitations**

This study was qualitative in approach and design as our aim was to generate information regarding lived experiences and meaning making of people who work as caregivers in children's homes in the Ghanaian context. This means that our methods primarily concentrated on obtaining subjective views and experiences of care workers in this unique work context. Our findings therefore best apply to the context of study as cross-context generalization may not be best practice. However our findings do provide grounds for similar studies to be conducted in contexts similar to Ghana where such institutions are in use. The limited numbers of participants and geographical scope of this study also means that within Ghana, further studies may be needed to obtain a complete picture of the entire CWPC caregiving work scene. The use of techniques such as participant observation also means that the lead author stayed with participants and interacted with them on regular basis to make observations. Reflexively, author biases in interpreting findings and possible influences on participant willingness and candidness in giving information can therefore not be completely ruled out. It should however be noted that we took conscious steps to limit author subjectivity and bias in the data and this final report. The lead author (who collected the data) maintained awareness of possibility of bias (as recommended in qualitative research) and ensured he only played the role of facilitator during focus groups and conducted interviews in an open, non-threatening environment where participants were free to share experiences. Our use of a coding team to ensure inter-coder validity during data analyses also helped limit subjectivity.

### **Conclusion and recommendations**

This study was conducted to investigate how the organizational structures and funding sources of children's homes in Ghana impact the work and health of employee caregivers. We had two research questions. First, we wanted to know how the organizational structure of a children's home influences work performance and health of employee caregivers and second, to find out how funding sources and funder expectations affect caregivers. We found that the impacts that these two factors have for employed caregivers varied and followed a peculiar pattern: organizational structures present certain work demands (eg. high workloads, long duration on the job) which in turn present certain physical and psychosocial risk factors (eg. work stress & exhaustion, separation from family) the severity of which is connected to funding sources. Funding sources impacted the level or severity of work demands and health risk factors as it was connected to the availability of materials and logistics needed for the job, frequency of caregiver training, support for caregiver health care costs, and the extent of adherence to children's rights regulations (which tended to affect caregiver relations with

local community folk). In the light of our findings, we argue that there may be the need for stakeholder discussion and review of the current strategies adopted for organizing care for CWPC in residential institutions in Ghana and beyond as our findings reveal the possible limitations that are placed on caregiver ability to perform the duties expected of them with these current structures. The caregiver's position, health and wellbeing should be a focal point in such interventions as the health and wellbeing of the vulnerable children in this context significantly depends on the caregivers' health and wellbeing.

### **Conflict of interest statement**

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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## Appendix 1.

### Focus Group / Interview Guide

#### SECTION A: Demographic Information

Age: .....

Sex : Male  Female

Education level: Primary  Secondary  Tertiary  Vocational  (Please specify).....

Marital Status: Married  Single  Separated  Divorced

Number of own Children.....

Place of work / Organization:.....

Work role/position:.....

Length of service.....

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#### SECTION B: Guide questions

##### 1. Perceptions of CWPC and institutional care work

- i. What kinds of children are normally brought here in this institution?
- ii. What specific kinds of care do the children often need?
- iii. What is it like to provide this kind of care?
- iv. How do you perceive / see the children placed in your care?
- v. What motivates you / others to take up employment/ keep working as caregivers for these children?

##### Stressors and Resources

1. A. As a..... (Interviewer to mention participant's position), what are your work roles?
- B. What causes stress in this job? Could you explain a bit more on how these things stress you?

*Probes: Organizational, social/family, material, personal, the children*

- i. How do these stressors affect your health and wellbeing?
- ii. How do you deal with unpleasant situations in your job? Move on?, dwell on them?  
*Probes: know what to do, people you can count on, ideas of possible solutions (Manageability)*

- C. What helps you to carry out your duties well? Are there any such things?

*Probes: motivations (why this job and what keeps you going?), resources and support/assistance (institutional, material, social/family, community, church etc.),*

- i. What does this job mean to you? (Meaningfulness).
- ii. What training have you received for this job? Did it prepare you well for these duties?

- iii. When thinking of difficulties, do you feel you will succeed in overcoming them? Why? (Comprehensibility)  
*Probes: Know the people around you/ the environment, what to do, how to handle problems*

**Organizational forms and funding sources**

- 2. A. Your institution is like a boarding school/ family home (interviewer to describe what has been observed about the organizational form of the institution), how has this influenced your work roles?
  - i. What characteristics about this (Organizational form) cause stress?
  - ii. What would relieve the stress /help you to do a better job?
  - iii. If you compare this form to other forms (interviewer to describe forms alternative to the interviewee's organization), which one would you say could make the job of a caregiver like you enjoyable/better?
  - iv. Does working in this organizational form affect your health?
  
- B. Which sources does this institution get its funding from?
  - i. Is this institution adequately funded? Why do you think this is the case?
  - ii. How does the status of funding impact on your work as a caregiver?
  - iii. What expectations do the funders of your institution have concerning your work role?
  
- 3. A. What are the perspectives of the local community here concerning how to properly raise a child?  
*Probes: communication between adult and child, discipline/correction, morals, values, self-concept/perception?*
- B. In your own view, what do you think are the proper ways of raising a child?
- C. What are the specific rules from your institution concerning how you are to raise the children in your care?
- D. How do these rules compare to your own opinion of proper child up-bringing?  
*Probes: if participant mentions differences, then ask: how do these differences make you feel? (do you feel you are being a good parent to the children in your care?)*
- E. How do the rules also compare to the community perceptions of proper child upbringing?
  
- F. How does the community here perceive the children you are raising as compared to the children in the open community?

Is there any other thing you would like to talk about relating to your job and how it affects your life, health or wellbeing?

*Thank you very much.*





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Ernest Darkwah  
HEMIL-senteret Universitetet i Bergen  
Christiesgt. 13  
5015 BERGEN

Vår dato: 05.06.2015

Vår ref: 43218 / 3 / MHM

Deres dato:

Deres ref:

## TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 22.04.2015. Meldingen gjelder prosjektet:

43218                      *Caring for 'parentless' children - A salutogenic exploration of the experiences of workers in children's homes in Ghana*  
*Behandlingsansvarlig*    *Universitetet i Bergen, ved institusjonens øverste leder*  
*Daglig ansvarlig*        *Ernest Darkwah*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.07.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Marianne Høgetveit Myhren

Kontaktperson: Marianne Høgetveit Myhren tlf: 55 58 25 29

Vedlegg: Prosjektvurdering

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

Avdelingskontorer / District Offices

OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no

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## Prosjektvurdering - Kommentar

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Prosjektnr: 43218

The purpose of the project is to explore job-related experiences of workers in children's homes in Ghana.

The sample will receive written and oral information about the project, and give their consent to participate. The letter of information and consent form are somewhat incomplete, and we ask that the following is changed/added:

- When the project will be completed and information about what is going to happen with personal data at that point; whether it will be erased, anonymized or stored
- If the supervisor in Norway will have access to the personal data as stated in the notification form, the information regarding this matter must be changed in the consent form under "Confidentiality" (now it says that supervisors will have access to anonymized data only).

We ask that the revised letter of information is sent to [personvernombudet@nsd.uib.no](mailto:personvernombudet@nsd.uib.no) before contact with the sample is established.

The Data Protection Official assumes that there will be registered sensitive information relating to health.

The Data Protection Official presupposes that the researcher follows internal routines of University of Bergen regarding data security. If personal data is to be stored on a private computer /portable storage devices, the information should be adequately encrypted.

Estimated end date of the project is 31.07.2018. According to the notification form all collected data will be made anonymous by this date. Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)

*In case of reply the  
Number and date of this  
Letter should be quoted*

Our Ref. No.  
Your Ref. No: ... ..



REPUBLIC OF GHANA

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29<sup>th</sup> June, 2015

TO WHOM IT MAY CONCERN

**PERMISSION TO COLLECT RESEARCH DATA AT SELECTED CHILDREN'S  
HOMES IN GHANA**

Research Title: Caring for 'Parentless' children: A salutogenic exploration of work experiences of caregivers in Children's Homes in Ghana.

Primary Researcher: Ernest Darkwah

Researcher Institution: University of Bergen, Bergen Norway.

Permission is hereby granted to the above-mentioned student researcher to collect research data at the [REDACTED]

**This permission is subject to approval from the authorities directly in charge of the specific institutions involved.**

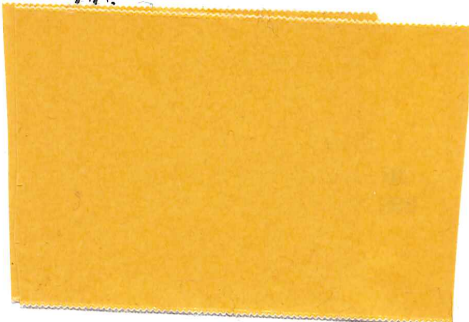
The Department has reviewed the research proposal and ethical clearance for the research provided by the researcher's affiliated institution and deems them sufficient enough for the research to be conducted. The Department has no objection to the conduct of the research.

Thank you.

**YVONNE NORMAN  
CRI COORDINATOR**

**FOR: AG. DIRECTOR OF SOCIAL WELFARE**

Note: For ethical reasons, the names of the specific institutions have been covered in this document.



## Appendix 4.

### Informed Consent Form

#### SECTION A: Background Information

|                               |   |
|-------------------------------|---|
| <b>Title of Study</b>         | Caring for “parentless” children: An exploration of work-related experiences of caregivers in children’s homes in Ghana                       |
| <b>Principal Investigator</b> | Ernest Darkwah , PhD Candidate, University of Bergen, Bergen, Norway  |
| <b>Supervisors:</b>           | 1. Marguerite Daniel (PhD). Principal Supervisor (University of Bergen)<br>2. Maxwell, A. Asumeng (PhD). Co –Supervisor (University of Ghana) |

#### SECTION B: Consent to Participate in the Research

##### 1. General Information about the Research

You are invited to participate in an academic research project aimed at exploring the work-related experiences of people who work in children’s homes in Ghana. The purpose of this study is to gain understanding and develop empirical knowledge of factors that impact, both negatively and positively, on the work, health and wellbeing of caregivers in children’s homes. It is the researcher’s belief that generating this knowledge will help provide empirical grounds for policy and stakeholder action towards improving the condition of people who care for children in these homes. Should you volunteer to be part of the study, you will be invited to participate in a two –hour focus group discussion after which you may be interviewed for one-hour on a different day and time of your choosing. During the focus group discussion, you will join other colleagues who are also caregivers to discuss issues about your job and how it affects you. If you volunteer for interview, you will be asked to talk about aspects of your job that stresses you or gives you motivation to keep working. Your participation in the study ends as soon as you complete these activities. Please feel free to ask questions if you do not understand anything. Thank You.

##### 2. Benefits/Risks of the study

This study is not intended to benefit you directly. Nonetheless, your participation in the research will help provide important insight into the work situation of caregivers in children’s homes in Ghana. You may experience fatigue as a result of taking part in the activities outlined in point 1. Aside from this, there are no foreseeable risks or consequences for taking part in the research. Your participation in activities for which you volunteer will be at times and venues convenient to you.

##### 3. Confidentiality

You are assured of the highest possible confidentiality and anonymity of any information you provide. Only the researcher will have complete access to your information. Supervisors and approved research assistants will have **restricted** access to the data you will provide. By signing this form you agree to give such access. The results will be reported in an aggregated format and under no circumstances will any individual participant be identified by name or any means to supervisors and assistants or in any publication or presentation describing this study.

4. *Compensation*

You will receive no compensation for taking part in this study.

5. *Withdrawal from the research*

Your participation is voluntary and you may withdraw at any time without penalty. You will not be adversely affected if you decline to participate or later stop participating. You will be informed in a timely manner if information becomes available that may be relevant to your willingness to continue participation or withdraw.

6. *Contact for Additional Information*

The following persons can be contacted in case of any discomfort, explanation or further information:

- **Ernest Darkwah** (Investigator): Department of Health promotion and Development, University of Bergen, Norway -Phone: +47 969 91864; +233 246 774671, e-mail: [ernest.darkwah@student.uib.no](mailto:ernest.darkwah@student.uib.no)
- **Marguerite Daniel** (Principal Supervisor): Department of Health promotion and Development, University of Bergen, Norway.
- **Maxwell A. Asumeng** (Co-Supervisor) Department of Psychology, University of Ghana, Legon, Accra-Ghana.

**SECTION C- Volunteer Agreement**

**"I have read or have had someone read all of the above to me, asked questions, received answers regarding participation in this study, and am willing to give my consent to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."**

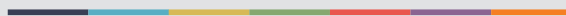
**Name of Volunteer**-----

**Signature or Mark of Volunteer**-----

**Date:**-----



Graphic design: Communication Division, UIB / Print: Skjipes Kommunikasjon AS



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ISBN: 978-82-308-3626-2