Experiences of burn patients in Ghana: A qualitative study at the Korle-Bu Teaching Hospital in Accra

ABSTRACT

Background: Statistics on the trends of burn injuries in Ghana, Africa, and the world at large indicate unacceptable number of lives lost through burns. Aside these deaths, individuals who survive suffer lots of physical and psychological burdens as a result of long hospitalization and pain from the regular wound dressing, and physical deformities in severe cases. This study focused on the sources of burns, types of burns, how burns are managed, and the effects of burns on victims to enable an empirical basis for formulating preventive educational materials for awareness creation and preventive education.

Methodology: We employed a case study design and purposively selected 20 participants made up of 15 adults and 5 caregivers of children with burns who were receiving treatment at the Reconstructive, Plastic Surgery, and Burns Centre of the Korle-Bu Teaching Hospital in Accra for the study. In-depth interviews were conducted with participants to ascertain the type and sources of burns incurred, and their experiences with the study facility and living with the consequences of burns. Recorded interviews were transcribed and analyzed based on themes with the study objectives as a guide.

Results: The majority of participants had third-degree burns from explosive sources either at their place of residence or the work-place. The physical and psychological effects of burns have been unbearable. Their encounter with the study facility has been pleasant with few challenges related to the cost of treatment, some personnel, and waiting time.

Conclusion: Massive education on burns and the prevention of accidental burns in Ghana is needed. Training of more personnel to handle patients in a professional manner and cost of care of burn patients should be placed on the agenda of all relevant stakeholders in the country.

Keywords: Burn patients, experiences, Ghana

INTRODUCTION

A burn is any injury to the skin or tissue instigated by heat (thermal), electricity, chemicals, or radiation (Temu-Justin et al., 2008). There are various types of burns dependent on what caused the burn injury. They may include thermal burn, chemical burn, electrical burn, and radiation burn. A thermal burn is any damage that occurs when the skin comes into contact with hot items, such as boiling water, steam, or hot cooking. When a corroding substance such as a strong acid comes into contact with the body’s tissue, a chemical burn occurs. An electrical burn occurs when an electrical current passes through the body. A radiation burn is injury to the skin or tissue caused by exposure to radiation. It is noted that the most common causes of burns are fire or flame damages and burns from hot liquids and steam (American Burns Association, 2011).

The human skin plays very important roles including maintaining and supporting thermoregulation such as

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ensuring fluid balance. It is made up of layers: epidermis, dermis, and tissues (Kolarsick et al. 2011). The epidermis is the outermost cover of the skin. It serves as the water-resistant and protective wrap over the body’s surface (Sanderson et al., 1995). The dermis is the cover of the skin underneath the epidermis. It is made up of connective tissue and helps the body withstand stress and strain. The basement membrane firmly joins the dermis to the epidermis (Kolarsick et al., 2011). Anatomically, it has two parts: the papillary region, which is shallow and adjacent to the epidermis and a deep, thicker area called the reticular region (James et al., 2005).

The hypodermis lies below the dermis, and though it is not part of the skin, it is usually not separated from the dermis and the epidermis when discussing. In addition to supplying the skin with nerves and blood vessels, it also fastens the skin to underlying bone and muscle (Huckfeldt et al., 2015). Below the hypodermis lie muscle, fascia, tendons, ligaments, and bone. Muscle aids the body to move and also protects the nerve cells. Fascia, tendons, and ligaments make up the body’s “connectors.” These connector tissues are all made of collagen but help to join different parts of the body. The ligaments join bone to bone, tendons link muscle to bone, and fascia protects muscle and separates internal organs of the body. Bone tissue plays protective roles, serves as a structure, and aids in movement (Huckfeldt et al., 2015).

Burns can result in minor damages or can lead to a dangerous emergency, depending on the concentration of the heat, the expanse of tissues burned, and how long the skin had been exposed to the heat. A lot of individuals suffer from infirmities and deformities as a result of burns (Van Hasselt, 2008). When categorizing the thickness of a burn, a system of classification that is mostly adapted involves assigning a degree to the injury, from first degree through fourth degree (Reed and Pomerantz, 2005). A superficial or first-degree burn is a painful damage, typically confined to the epidermis. Thus, it involves only the top layer of the skin (Hettiaratchy and Dziewulski, 2004). Usually, first-degree burns are not severe and affect only the superficial epidermis. They are hardly reported to hospitals for treatment/management (Reed and Pomerantz, 2005).

Another type is a superficial partial-thickness burn, which may also be classified as a first or second degree. This kind of injury mostly spreads into the epidermis, and perhaps the papillary layer of dermis, and normally heals without leaving scars. It is usually painful with the skin becoming pink (Mertens et al., 1997). According to Temu-Justin et al. (2008), in the second-degree burns the skin is light, red and blisterly, swollen to some extent with moistly discharge and severe pain. For a deep partial thickness burns, tissue damage encompasses the epidermis, papillary dermis, and reticular dermis. The portion of dermis might still be undamaged, which may provide some amount of protection through the healing process. The color of the skin is red to pale pink (Bessy, 2007). According to Huckfeldt (2013), if the majority of the dermis is injured, this damage could lead to scarring which might lead to functional and motor problems, particularly if the damage involves a joint area.

Sterling, Heimbach and Gibran (2010) explained full-thickness or a third-degree burn to include the epidermis, the two layers of dermis across the basement membrane into subcutaneous tissue. Here, the immediate region of damage differs in deepness, causing changes in skin color which could range from a dark waxy red to waxy white or black (Mertens et al., 1997). According to Temu-Justin et al. (2008), this kind of injury causes nerves and blood vessels damages. The initial pain may be little or there may have no sensation, dependent on which nerve tissue is damaged. The burn area is yellow, cherry red and becomes dry and leathery (Mazzeo et al., 2014). Even after appropriate treatment and care, scarring is very common (Huckfeldt, 2013). In fourth degree or deep full-thickness burns, there is a lot of tissue damage. The damages outspread the covers of the skin and the intravenous tissue. They may comprise the destruction of muscle, tendon, and perhaps bone. Tissue damage is evident, and the color of the skin is frequently black (Huckfeldt, 2013). Often, extensive debridement and considerable tissue reconstruction, like muscle flaps are necessary to aid healing.

Burn injuries cause distress to lots of people worldwide, and they present with both physical and psychological stressful forms of trauma. This is because of the extensive hospitalizations they implicate and the likelihood of resulting in serious physical as well as psychological sequelae. Again WHO (2008), emphasized that burn injuries may come with prolonged or even permanent trauma. Burns constitute one of the most common household injuries and thus, a major cause of morbidity and mortality. Burn injuries are very complex and distressing; thus, caring for patients who have suffered serious damages from burns necessitates a holistic way of treatment with effort from a multidisciplinary team which may include physicians, surgeons, nurses, psychologists, and dieticians, just to mention few.

The World Health Organization statistics in the year 2000, reported that about 833, 773 children in Africa <5 years old suffered fire-related injuries/deaths. In 2002 estimated...
death rates of fire-related burns worldwide were 322,000, of this number, 40,000 of them occurred in sub-Saharan Africa (WHO, 2002). In Africa, fire-related mortality rates are more common compared with recorded rates in high-income countries (i.e., about 6 of every 100,000 people in the African population as compared to about 1 death in every 100,000 people in high-income countries) (Mock et al., 2008). These statistics are highly unacceptable considering the fact that most burn injuries are preventable.

In Ghana, the Reconstructive Plastic Surgery and Burns Centre (RPSBC) at Korle Bu Teaching Hospital (KBTH) is only one of its kind in the country and the West African Sub-Region. Statistics from the RPSBC at Korle Bu show that in the year 2013, 302 people (181 males and 121 females) who suffered burn injuries were admitted to the unit. Of this number, 162 were children and 140 were adults. A total of 66 people died constituting 21.9% of the total number of burn cases that were recorded at the unit (RPSBC- Korle Bu Teaching Hospital, 2013). In 2014, a total of 283 people (130 males and 153 females) were brought to the unit. Children constituted 51.6% (146 of 283) and adults constituted 48.4% (137 of 283). The rate of mortality recorded in 2014 was 24% (i.e., 68 deaths). Furthermore in 2015, a total of 248 people who have suffered burn injuries (138 males and 110 females) reported to the unit, with 145 being children and 103 being adults. As of September 2015, a total of 41 deaths had been recorded at the unit (Reconstructive Plastic Surgery and Burns Centre - Korle Bu Teaching Hospital, 2016). A major percentage of the workload for the Plastic Surgery and Burns Units are burns cases, and children make up about 45% of these burns cases recorded.

Burns remain a common public health problem in Ghana, this is because a growing number of both the urban and rural Ghanaian populations now depend on gas cylinders for cooking. These cylinders are mostly kept indoors for security reasons. In addition, there are incidences of roadside cooking over open flames. These practices have the tendency to cause accidental burn injuries both in children and adults. Statistics on the trends of burn injuries in Ghana, Africa, and the world at large indicate the number of lives lost through burns. Aside these deaths, individuals who survive suffer lots of psychological burden as a result of long hospitalization and pain from the regular wound dressing.

Most studies done in the area of burns are focused on the prevalence rate of burns, chronic pain associated with burns in general, pain beliefs, caregivers’ well-being, coping, and quality of life. This study focused on the sources of burns, types of burns, how burns are managed, and the effects of complications of burns on victims to enable an empirical basis for formulating preventive educational materials for awareness creation and preventive education aimed at reducing the incidence of burns, especially in children and its related complications in Ghana.

**METHODOLOGY**

**Study design, population, sampling, and sample size**

We employed a case study design to uncover the experiences of burns patients, the management and effects of burns on their lives. A case study design was used so we could study holistically the effects of burns and care for burn patients in the study facility from the perspectives of patients and caregivers of burn patients (Creswell, 2013). The population of interest for the study was all burn patients receiving treatment at the RPSBC of the Korle-Bu Teaching Hospital in Accra, their caregivers, and their health-care providers.

Purposive sampling technique was employed throughout the study. The RPSBC of the Korle-Bu Teaching Hospital in Accra was purposively selected because it serves as the central referral point for most burn cases in the metropolis and in Ghana as a whole where specialist services such as reconstructive and plastic surgery are required. In addition, the RPSBC is where burn patients and their caregivers could easily be located for the study. Accra is highly populated and made up of diverse ethnic groups (AMA, 2011); hence, it is more representative of the Ghanaian society than other cities and towns of Ghana.

Fifteen burn patients five caregivers of children with burns, totaling twenty participants were purposively selected for the study. Burn patients selected were those who had been diagnosed with having the first, second, or third-degree burns by a qualified medical officer, was receiving treatment at the RPSBC, was 18 years and above, and was willing to participate in the study. Caregivers were also purposively selected based on the fact that they care for burn patients who were children, and were willing to be part of the study.

**Data collection methods, instruments**

The study employed qualitative methods of data collection. Thus, the qualitative data were made up of responses from in-depth interviews using in-depth interview guide. The instrument for collecting the data for the study were pretested in a hospital in Accra to determine their appropriateness in collecting the desired data in English or in the local Twi language, which is spoken by most Ghanaian.

The in-depth interviews with patients and caregivers were conducted at their convenience in a location at the hospital.
or in the comfort of their homes. This was determined by the interviewees. All the interviews were conducted by the second and third authors who are MPhil degree holders in the Social Sciences and have enormous experience in qualitative data collection.

**Ethical clearance**

Before the start of the study in 2018, ethical approval was obtained from the Ethics Committee of Humanities, University of Ghana with the study protocol. All participants were provided with written informed consent before they participated in the study. Following information and explanation on the rationale, purpose, procedures, confidentiality, participation and rights, risks and benefits, voluntary, and right to withdrawal at any point without prejudice to participants, participants were given the opportunity to choose between signing or thumb printing the written consent form before their involvement in the study. Permission was also sought from participants to publish the findings of the study with anonymous quotes. This was done by asking participants to also sign or thumbprint another portion on the written informed consent form.

**Data analysis**

The data were recorded using electronic recorder during the interview sessions with the interviewees; in addition, handwritten notes were also taken during the interviews. The audio recorded responses and notes taken from the interviews were translated verbatim in the English language separately by two data entry experts and transcribed in a word processing application. The experts then came together for consensus building by reviewing their transcripts and the original recordings, the transcripts and field notes were stored as files. Manual coding was then be used to select themes based on the research tools and objectives. Information on the themes were compared using similarities and differences in views of participants and quotes were selected to instantiate the themes using pseudo-names to maintain anonymity. Thus, PR, and CG-R were used to represent patient respondent (PR) and caregiver respondents (CG-R), respectively.

**RESULTS**

The findings from the study have been presented and discussed under five main sub-headings, namely sociodemographic characteristics of respondents, type of burns, sources of burns and area of the body affected, effects of burns, and management of burns.

**Sociodemographic characteristics of burn-patient participants**

Fifteen burns patients whose ages ranged from 25 to 62 years participated in the study. The majority, that is, 13 of them were between the age group of 25 and 40 years, and the remaining two were 50 and 62 years old. Thirteen of them were male and only 2 were female. More than 50% (8/15) of these burns-patient respondents had tertiary education, while the remaining 7 had either primary or secondary education. Two of the respondents were tertiary level students, and 13 were either employed in the formal sector or the informal sector. Thirteen of these participants hail from the Greater-Accra Region with the remaining two from the Bono-East and Central Regions of the country [Table 1].

The caregiver respondents were all mothers of children with burns who were aged between 19 and 38 years. Two of them had no formal education, two had primary education, and one had secondary education. Three were unemployed, and two were traders [Table 2].

**Types and sources of burns presented at the facility**

The majority of respondents (8 of 15 adults and 3 of 5 children) had suffered third-degree burns, 3 adults and 2 children had second degree burns, and the remaining 4 adult participants could not tell of the degree of burns they had.

The sources of burns as reported by participants included mainly gas explosion either at home/hostel or the workplace, melting metals at the workplace, home fire outbreak with unknown source, explosion in the car while driving and electricity in the home/hostel or workplace.

“My burns occurred at the work place, we were melting the metals and it accidentally poured on us.” ……PR1.

“…..It was electrical burns. My kettle got spoil and I had to use heater to heat water for something. I don’t really know what happened I tripped and pushed the bucket I was heating the water in and sat in the water but because the heater was still in the socket I got electrocuted and got burnt……PR11.

“I had a third degree burn as a result of gas explosion in the course of my working for a school as a welder”……..PR9.

**Area of body affected**

The majority of participants had their whole body affected by burns (especially those with gas explosion sources). Others had their faces, upper and lower limbs, and hand and waist down affected.

“……My whole body, from head to toe was affected, but the most serious parts are my face, chest and my hands …….. PR 8.
Table 1: Demographic characteristic of burn patient respondents

| Respondent | Age (years) | Gender | Level of education | Employment status | Area of residence (region) |
|------------|-------------|--------|--------------------|-------------------|---------------------------|
| PR1        | 31          | Male   | Secondary          | Factory hand      | Greater Accra             |
| PR2        | 30          | Male   | Secondary          | Self employed     | Greater Accra             |
| PR3        | 25          | Female | Secondary          | Secretary         | Greater Accra             |
| PR4        | 50          | Male   | Tertiary           | Banker            | Greater Accra             |
| PR5        | 40          | Male   | Tertiary           | Welder            | Greater Accra             |
| PR6        | 29          | Male   | Tertiary           | Internet installer| Greater Accra             |
| PR7        | 30          | Male   | Secondary          | Self employed     | Greater Accra             |
| PR8        | 30          | Male   | Primary            | Welder            | Greater Accra             |
| PR9        | 25          | Male   | Tertiary           | Student           | Greater Accra             |
| PR10       | 62          | Male   | Tertiary           | Engineer          | Bono-East                 |
| PR11       | 40          | Female | Primary            | Seamstress        | Greater Accra             |
| PR12       | 29          | Male   | Primary            | Unemployed        | Greater Accra             |
| PR13       | 26          | Female | Tertiary           | Student           | Central                   |
| PR14       | 40          | Male   | Tertiary           | Businessman       | Greater Accra             |
| PR15       | 27          | Male   | Tertiary           | Businessman       | Greater Accra             |

Table 2: Demographic characteristic of care givers of burn patients

| Caregiver | Age (years) | Gender | Level of education | Employment status | Relationship to patient |
|-----------|-------------|--------|--------------------|-------------------|-------------------------|
| CG-R1     | 35          | Female | Primary            | Unemployed        | Mother                  |
| CG-R2     | 19          | Female | Primary            | Unemployed        | Mother                  |
| CG-R3     | 30          | Female | None               | Trader            | Mother                  |
| CG-R4     | 30          | Female | None               | Unemployed        | Mother                  |
| CG-R5     | 38          | Female | Secondary          | Trader            | Mother                  |

Effects of burns on participants

**Physiological and physical effects**

All adult patient participants lamented that excruciating pain and discomfort was the first effect of burn they had to battle with. They reported of sleeplessness at night for several days after burns resulting from pain at the affected parts of their bodies. Some complained of severe and unbearable pain with itching all over the body that they thought they would not survive the burns. Participants also reported of wounds, skin discoloration, scars, keloids, amputation of toes, and arm, deformed ear, impaired vision in the afternoons, and total blindness as the consequences of their encounter with burns. These physiological and physical effects of burns were described by all participants as very uncomfortable and unbearable.

"…… as you can see, I have scars all over my body with a deformed ear, very sad". PR1

"I have several problems after my burns. I still have pains, my skin's colour is changed and become partially darker with itching sensation most of the time, and to crown it all I have difficulty seeing anything clearly especially in the afternoons".….PR3.

"My biggest problem is the keloids on my body after the burns, I don't know if I can ever recover and have my beautiful skin back, hmmm."……….PR4.

For those participants who have had physical deformities from burns, some reported that they have difficulty performing daily personal routine activities and need assistance everyday, others reported they cannot work anymore.

"I have distracted activities and school attendance is poor. I depend mostly on my family members especially my mother for assistance in almost everything I do".……..PR13.

"Going about my daily routine has now come to halt. I just have to sit and ask that it be done for me. Am helpless without my hands".……..PR14.

"Hmm, I don't engage in any activity I just watch it being done for me".……..PR11.

"……It's very difficult for me, I can't work anymore and I'm a burden for my family”……..PR4.

**Psychological effects of burns on participants**

Participants reported mixed feelings of the psychological impact of burns on their lives. Some respondents feel stigmatized against in various ways, especially being described and tagged by their deformity. They also expressed that they are stigmatized and looked at in very uncomfortable ways. This has led to some of them staying indoors most of
the time, and hence, complained of loneliness. Some reported to have been assigned new jobs because of the discolorations they have suffered as a result of burns, while others indicated that they lost some jobs from their customers because they are deformed, and some even expressed fear of losing their spouses. Thus:

“It’s not been easy at all for me after my burns, this is because I used to be Teller at the bank where I work and was interacting with a lot of people, but now I’m no more a teller I work in the back office”………PR4.

“I lost a lot of jobs from my customers after my burns, though I can still do the jobs, and I believe it’s because of the way I look, in fact, I have changed a lot physically”……PR 6.

“………… you see, I’m very young, and afraid of losing my wife because of my deformity”….PR7.

Some participants, however, reported that they had not really experienced any form of stigma or discrimination resulting from their deformity.

“I have not faced any yet because I see that everybody is okay with me and I get along well with my family and friends”………PR 12.

For the caregiver participants, this is what one of them had to say:

“He plays with the children around all the time. You see he is young so I do everything for him. But the small right finger the doctors say they have to do another surgery to make it straight. But there is no money”………CG-R2.

Management of burns

General management of burns prior to being transported to study facility

Some of the participants indicated that they had water or oil poured on their affected parts before transporting them to the study facility; however, these interventions did not help much in alleviating the pain and other effects of their burns.

Participants’ experience with the health facility and personnel

Most of the participants reported satisfaction with the medical management of their condition at the study facility and the constant counselling and psychological therapy they receive. They were however, not happy with the charges at the facility, almost all participants complained about the exorbitant fees of medications and consumables. They reported that drugs and consumables were more expensive at the facility than at the pharmacy shops outside of the facility. Some participants recommended that the burns centre should introduce the National Health Insurance Scheme, to subsidize for some of the costs of treatment of burns at the centre.

“What I don’t like about them is their fees. It is too expensive. When I was discharged it took about a month for my mother to raise the money to settle the bills.

“I think they should use health insurance more and it will help reduce the bills that people pay at the centre”…….PR1.

“I was thinking about how I was going to raise the money for his bills because I was not able to go to the market. But God being so good I had someone to pay for his bills for free. Some company came to pay for the children at the ward and I was fortunate”…… CG-R3.

“Initially it wasn’t easy but with the help of the psychologist and some of the student doctors I got to know that that is not the end of my life and I can do something beneficial with my life with one hand ………PR3.

“The only problem I have with them is that medicine at the pharmacy is more expensive than the one across the street”…… PR10.

Some participants specifically mentioned that some of the nurses are not professional and empathetic in their dealings with them (during dressing of their wounds). They reported that some of the nurses were rude, especially toward patients who could not pay their bills promptly.

“…in this centre, some of the nurses are rude and they like dealing with those who can afford to give them tips. They are always nice to and attending to those who can give them something…PR15.

“With the facility I don’t have issues, with the exception of some of the nurses being rude and insulting patients….PR11.

Some patients also raised concerns about the long queues they have to join to see a doctor. They explained that they have to wait for long hours before they have access to the consulting room of a doctor. They reported that this sometimes takes about seven long hours of wait in their painful state, this, patients reported as very uncomfortable.

“I think the waiting time at the OPD and where they do the dressing should be reduced. There are instances that you will sit there from morning to afternoon before it gets to your turn to see a doctor or to have your wounds dressed…….”PR12.
Experience with home and community care
The majority of participants reported that their families are very supportive and very friendly. They explained that even though some friends have abandoned them, they receive a lot of love from their family and close loyal friends. Some reported that their family members and caregivers have taken over some of their chores. Some self-employed burns patients also reported to have hired assistants in their shops to help in the daily running of their businesses.

“I have to employ someone to assist me at work because of my new condition. I can’t do everything on my own…………” PR7.

“…….My friends have been very helpful in my recovery which helps me maintain my sense of belongingness…….” PR 15.

One caregiver had this to say
“This is the first time and I’m really praying that I don’t go through this trauma again with my children. My sister is not easy to go through this, the ups and downs are too much that if care is not taken you will fall ill alongside”…….. CG-R1.

DISCUSSION

Burn injuries represent a major cause of morbidity and mortality globally and its occurrence is not specific to any age group or population. Although the incidence of burn injury has been noted to be decreasing in the Western Countries, the rate of reduction is slower than other diseases. However, Rybarczyk et. al., (2017)\(^{[21]}\) indicated that the burden of burns remains high in the sub-Saharan African regions. Tripathee and Basnet for example in a study identified that majority of burn associated deaths occur in low-middle-income countries and specifies the need for public health interventions. In Ghana, the rate of mortality recorded in 2014 was 24% (68 deaths). Currently, a total of 248 people who have suffered burn injuries (138 males and 110 females) reported to the unit, with 145 being children (KBTH, annual report, 2017).\(^{[22]}\)

From the findings, burn injuries of varying degrees are common in Ghana. Despite this fact, the country lacks a National Burn Repository, which makes it difficult to assess the actual care and rehabilitation needed by survivors. Such a facility would help in the measures in place to handle burns survivors effectively.

Burn injuries perhaps represent the widest range of any form of trauma. From the interviews with participants of the study, respondents experience a lot of pain and feelings of itching. The burden of burn injuries and lack of adequate epidemiological data makes it challenging for the policymakers to implement a proper strategic plan for effective therapeutic care and burn prevention.

Although the house is considered to be a safe place, it was cited as the setting for the occurrence of burn injuries. The use of open fire for cooking, wearing loose-fitting clothes, and poorly regulated liquefied petroleum gas (LPG) cylinders increase the risk of burn.

Similarly, with the narratives, the use of traditional open fire (coal pot) and LPG cylinders have been reported, which predispose the household to burns. Usually, LPG cylinders are kept indoors for fear of being stolen and this makes it easy for the cylinder to leak its content within the kitchen. In addition, most households may avoid reporting problems associated with their cylinders at the earliest possible time and instead use heavy stones or wet clothes on the regulator. These activities increase the occurrence of burns within the home setting. Hence, education by the mass media on safety tips will be helpful and can reduce the incidence of fire in homes.

More worrying is the fact that some burn patients experience stigma and discrimination. Efforts should be made to incorporate psycho-therapy into the treatments of burns patients. There is a need to educate the public to accept and love patients despite their deformity. Religious bodies can help with all-inclusive activities, which will increase the morale of survivors and also have a sense of belonging. This will help patients with suicidal ideations to at least think twice about their condition.

Home caregiving and support is a major component of the management of burn patients and survivors’ disease as the study has shown. It is thus, important that family members and caregivers show love, compassion, and empathy as well as provide psychological support to their family members throughout their lives, for home caregivers who pass negative comments on the condition to unintentionally demoralize patients, special education plans should be targeted at them, for behavior change.

At the management level, it is suggested that health-care providers, especially nurses be trained on emotional intelligence, customer care, and relations and professionalism to improve on their relations with clients. Management of the hospital must also act on complaints brought in by patients. In addition, the government must consider enrolling the burns centre unto the national insurance scheme, to ensure affordability and equal access to health for all, since a lot of patients complained about the expensive services at the center.
The study has revealed that burn patients in Ghana live with a lot of distress, pain, low self-worth stigma and loneliness and therefore, much attention should be given to them. The establishment of an effective National Burns Repository will go a long way to help these survivors.

CONCLUSION

Burns represent a significant public health problem in Ghana considering our limited resources. Although Ghana shares a huge burden of burn injury, studies concerning the experience of burn patients are limited. The experience of these burn survivors has been neglected. There is, therefore, a need for clear policy interventions for the inclusion of burn patients into the society.

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Conflicts of interest

There are no conflicts of interest.

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