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Frank Kyei-Arthur & Deborah Atobrah

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Exploring the Motivations of Family Caregivers Caring for Older Persons in Urban Poor Accra, Ghana

Frank Kyei-Arthur [a] and Deborah Atobrah [b]

[a]Department of Environment and Public Health, University of Environment and Sustainable Development, Somanya, Ghana; [b]Institute of African Studies, University of Ghana, Legon, Ghana

ABSTRACT

There is a general paucity of studies on family caregivers' motivations for providing care to older persons in the urban poor context in Ghana. This study seeks to explore family caregivers' motivations for providing care to older persons in urban poor Accra, Ghana. A qualitative descriptive design was used and in-depth interviews were conducted with thirty-one family caregivers. The QSR NVivo 10 software was used to analyze the data thematically. We found that autonomous motivation inspired family caregivers to provide care. Empathy and affection intrinsically motivated some caregivers to provide care to their care recipients, while others were extrinsically motivated by filial responsibility, reciprocity, and obligation to provide care. These findings showed that family caregivers were autonomously motivated to provide care to older persons. We recommend the need for future studies to explore changes in family caregivers' motivations to provide care over time.

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Introduction

Globally, care for older persons has become a topical issue due to an increase in the proportion of older persons (60 years and older). The increased proportion of older persons is primarily due to an increase in life expectancy and a decline in fertility (United Nations Population Division, 2020). The family is most often responsible for caregiving, although institutionalized care is more common in high-income countries (Lloyd-Sherlock, 2014; van der Geest, 2016). Family caregivers generally refer to individuals who provide unpaid assistance to family members or friends who need care and support due to physical, emotional, or cognitive impairments (Schulz et al., 2020). Family caregivers are often women, and family caregiving is commonly perceived as a female task (Eriksson et al., 2013; Kusi et al., 2020; Manuh & Quashigah, 2009). In a Ghanaian and African context, women often provide practical care while men provide financial care (Agyemang-Duah, Mensah et al., 2019).

CONTACT Frank Kyei-Arthur fkyei-arthur@uesd.edu.gh Department of Environment and Public Health, University of Environment and Sustainable Development, Somanya, Eastern Region, Ghana

There is often a hierarchical ordering of informal care provision. First, spouses are the first persons expected to provide informal care. Second, adult children assume caregiving responsibilities when a spouse is unavailable or unable to provide informal care. Third, relatives provide informal care when adult children are unavailable. Finally, friends assume caregiving responsibilities when relatives are unavailable (Kusi et al., 2020; Lin et al., 2012; Quinn et al., 2010).

Research has established that family caregivers are motivated by diverse reasons to care for older persons. These motivations include filial responsibility (Kusi et al., 2020; Wallroth, 2016), reciprocity (Faronbi et al., 2019; van der Geest, 2016), financial motives (Zahed et al., 2019), obligation (Gurayah, 2015; Zahed et al., 2019), religious and spiritual rewards (Zahed et al., 2019).

In Ghana, however, most studies have focused on the impact of family caregiving on caregivers (Agyemang-Duah, Abdullah et al., 2020, Agyemang-Duah, Mensah et al., 2019; Nortey et al., 2017; Sanuade & Boatemaa, 2015). Few studies in Ghana have investigated family caregivers' motivations for providing care to older persons (60 years and older), especially in urban settings (van der Geest, 2016). This could be attributed to the assumption that care is perfunctory within the family setting (van der Geest, 2016). Also, a plausible explanation for a limited focus on family caregivers' motivations for providing care to older persons in urban settings is that a higher proportion of older persons in Ghana reside in rural areas (Ghana Statistical Service [GSS], 2013). Thus, there is a general paucity of studies on family caregivers' motivations for providing care to older persons (60 years and older) in the urban poor context in Ghana.

Research has established that family caregivers' motivation for providing care affects their caregiving roles, behavior, outcomes, and well-being, which consequently impact the quality of care they provide to their care recipients (Quinn et al., 2010, 2012, 2015). For instance, family caregivers who are motivated to provide care due to feelings of social pressures (extrinsic motivations) are more likely to experience higher caregiver burden which may negatively impact the quality of care they provide to their care recipients (Quinn et al., 2012).

Also, family caregivers' motivations for providing care are not mutually exclusive and discrete. They are sometimes interrelated, and thus, they can influence each other. For instance, Quinn et al. (2010) highlighted that the desire by family caregivers to pay back past deeds of older persons could influence caregivers to feel obliged to provide care. Also, Marks and Kang (2016) explained that affection for care recipients could influence filial responsibility by making family caregivers feel obliged to provide care.

Understanding family caregivers' motivations for providing care is critical since it will guide researchers, gerontological social workers, and policymakers in Ghana to design appropriate interventions to improve the quality of care provided to older persons, and also help to provide support to family caregivers who need assistance with their caregiving roles and responsibilities.

This study, therefore, seeks to bridge the knowledge gap by exploring family caregivers' motivations for providing care to older persons (60 years and older) in urban poor Accra, Ghana. The main research question is: What motivates caregivers to provide care to older persons (60 years and older) in urban poor Accra, Ghana.

Theoretical framework

This study was guided by the Self-Determination Theory (SDT). SDT postulates that different types of motivation influence the behavior or activities of people. SDT uses three psychological needs to explain human motivation: competence, autonomy, and relatedness. An individual's performance of an activity depends on their perceived competence (feeling effective), autonomy (feeling of volition), and relatedness (feeling understood and cared for by others) (J. Y. Y Ng et al., 2012).

SDT identifies two types of motivations, namely autonomous motivation and controlled motivation. SDT has been used to study issues such as psychological needs, aspirations and life goals, personal development, and self-regulation (Deci & Ryan, 2012). Autonomous motivation refers to intrinsic and extrinsic motivations that individuals have identified and integrated into their sense of self. With intrinsic motivation, an individual performs an activity because it is interesting and satisfying, while with extrinsic motivation an individual performs an activity because it leads to separate consequences (Deci & Ryan, 2012). Social contextual events, such as feedback and reward, can influence an individual's perceived competence, which can impact their motivation. Also, an individual's feeling of autonomy can influence their perceived competence, which may influence their motivation (Ryan & Deci, 2000). Regarding relatedness, an individual is more likely to act intrinsically when they feel secured and cared for. Individuals motivated intrinsically are more autonomous compared to individuals motivated extrinsically (Ryan & Deci, 2000).

It is also postulated that motivation to perform an activity could be both intrinsic and extrinsic. Individuals who are autonomously motivated act based on their own will (Deci & Ryan, 2012). Studies have linked autonomous motivation to enhanced quality of care, improved quality of life of care recipients, and better caregiver psychological well-being (Dombestein et al., 2019; Kim et al., 2008, 2015). Controlled motivation generally refers to individuals acting/behaving due to external and introjected regulations such as rewards or punishments, avoidance of shame, approved motive, and ego-involvement, among others (Deci & Ryan, 2012). Individuals who experience controlled motivation act or behave due to feelings of social pressure.

According to SDT, the motivation for an activity could be influenced by autonomous motives and/or controlled motives. In this study, we used SDT to describe family caregivers' motivations for providing care to older persons in urban poor Accra, Ghana. Using SDT, we theorized that family caregivers would be motivated to provide care to older persons due to both autonomous motives and controlled motives. Based on autonomous motives, the needs of older persons, provision of care being enjoyable, and affection could intrinsically motivate family caregivers to provide care. Also, family caregivers could be extrinsically motivated by obligation, filial responsibility, and reciprocity to provide care. Regarding controlled motives, family caregivers could be motivated by financial gains/rewards, and family/social pressure to provide care to older persons.

Methods

Design and study setting

This study used a qualitative descriptive design to examine family caregivers' motivations for providing care to older persons in the urban poor context. A qualitative descriptive design comprehensively summarizes the experiences of an individual or group of individuals and it is not aligned with any particular theoretical and philosophical orientation (Lambert & Lambert, 2012). A qualitative descriptive design is simple and flexible to use (Doyle et al., 2020), and it was selected because it helps researchers to provide rich detail regarding the experiences and perceptions of their participants (Sandelowski, 2010).

The study was conducted in James Town and Ussher Town being urban poor communities in Greater Accra, the capital town of Ghana. James Town and Ussher Town are neighboring coastal communities on the Atlantic coast of Ghana, collectively referred to as Ga Mashie (Mahama et al., 2011). Fishing and petty trading are the main occupations of residents. Ga Mashie is an indigenous Ga community and residents live in compound houses with other extended family members (Dake et al., 2016) who serve as potential family caregivers for older relatives. Although it is an indigenous Ga community, migrants from other parts of the country, especially those from other districts in Greater Accra, have moved to settle there due to its proximity to the Central Business District of Accra. Ga Mashie is characterized by poor housing and sanitation conditions, and lower educational attainment. As of 2010, James Town had an estimated population of 16,221 while Ussher Town had a population of 27,624 (Ghana Statistical Service [GSS], 2012). Ga Mashie has several tourist sites including Accra Lighthouse, James Fort, and Ussher Fort.

Sample and procedure

Family caregivers were purposely sampled from a list of participants who indicated in the third wave of the Urban Health and Poverty Survey (UPHS) that they or a member of their household provided care because the care recipient was an older person and needed assistance with at least one activity of daily living or substantial activity of daily living. The third wave of the UPHS was conducted in September 2013. The UPHS is a longitudinal survey that examines the link between health, poverty, and development. The UPHS has three research sites namely James Town, Ussher Town, and Agbogbloshie. The UPHS used systematic sampling to select households from 29 Enumeration Areas (EAs) in the three research sites. EAs are the smallest geographical areas assigned to enumerators during data collection. The selection of EAs was proportionate to the size of the research sites. Women aged 15 to 49 years and men aged 15 to 59 years were interviewed for the UPHS. In total, 1,160 households were interviewed for the third wave of UPHS. Out of the 1,160 households, 320 households were from James Town while 640 households were from Ussher Town. The UPHS was approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research (NMMR), University of Ghana. The Principal Investigators of the UPHS granted permission to the first author to use the UPHS data.

The data collection for this study involved two stages. In the first stage, family caregivers who took part in the third wave of the UPHS were identified. In the third wave of the UPHS, 57 participants indicated that they or a member of their household provided care because the care recipient was an older person and needed help. The first author and research assistants were successfully able to contact 30 out of the 57 participants. Care recipients for three of the 30 participants had passed away. In the second stage, care recipients were contacted to help connect with their caregivers. Family caregivers voluntarily mentioned by care recipients were contacted and interviewed. In total, 31 family caregivers who provided care to 20 care recipients were interviewed. Family caregivers who met the following inclusion criteria were interviewed: aged 18 years and older, providing unpaid care to a person aged 60 years or older who needs assistance with at least an activity of daily living or substantial activity of daily living, currently providing care for a minimum of 6 months. The exclusion criteria were family caregivers who had provided care to an older person less than 6 months preceding the data collection.

Data collection

The study is part of a broader doctoral thesis on the experiences of family caregivers and their elderly care recipients (Kyei-Arthur, 2017). The broader doctoral thesis explored family caregivers' motivations for providing care,

Table 1. Sample questions from the interview guide.

Sections	Main questions	Probes
Motivation for providing care	How did you become a caregiver to the elderly?	What happened before you became a caregiver? Who decided that you should become a caregiver? Did you like the idea of becoming a caregiver?
	What are the reasons why you provide care to the elderly?	
	Who do you think should provide care for the elderly?	Why?
	What are the cultural values or beliefs associated with caregiving for the elderly in this community?	
Caregiving experience	What types of care/support do you provide to the elderly?	
	What has the experience been like providing care to the elderly?	
	How has caregiving impacted on your everyday life?	
	Some caregivers are of the view that caregiving is beneficial to them. What do you think about it?	What makes it beneficial?
Coping strategies	How do you cope with these challenges as an elderly caregiver?	
Perception and other issues	In your community, what are people's perceptions of caregiving to the elderly?	

caregiving challenges experienced by caregivers and their coping strategies, rewards for providing care, and perception of older adult care recipients concerning the care they received. This study focused on family caregivers' motivation for providing care. Data collection took place over three weeks in November 2016. In total, in-depth interviews were conducted with 31 family caregivers. Table 1 is a summary of questions and probes participants were asked during the data collection.

Due to the language differences, the first author recruited and trained three research assistants who translated the interview guide from English to the *Ga* Language.[1] The three trained research assistants were selected because they could speak and understand the *Ga* language. Also, they had prior experience in data collection in Ga Mashie. The interviews were conducted in the *Ga* language. The interview guide was piloted in Mamprobi, a neighboring locality that has a similar culture and characteristics to Ga Mashie, which provided the opportunity to revise the questions and probes in the interview guide. For instance, after piloting the interview guide, some participants had difficulty understanding the question and probes on how participants became caregivers to their care recipients. Consequently, the question and probes were modified to ensure participants understood them without difficulty.

Ethical approval was obtained from the Ethics Committee for the Humanities, University of Ghana. Participation in the study was voluntary and participants gave their consent before they were interviewed. Each participant received compensation worth less than two American dollars after they

[1] *Ga* language is one of the Kwa languages spoken among the Ga people in Accra, Ghana.

were interviewed in appreciation of their time. Compensation was given after the interviews in order not to influence participants' decision to participate in the study.

Data analysis

All interviews were audio-recorded and transcribed verbatim from the *Ga* language to English. Field notes were also taken during interviews. Transcripts of interviews and field notes were quality checked and entered into the QSR NVivo 10 Software. The QSR NVivo software is suitable for most research designs and analytical approaches including the thematic analysis approach (Zamawe, 2015). The interviews were analyzed using the thematic network approach (Attride-Stirling, 2001). The following recommended steps by Attride-Stirling (2001) were followed to facilitate thematic analysis with the aid of the QSR NVivo 10 Software. First, all transcripts and field notes were read to get a general sense of family caregivers' motivation for providing care. Second, significant statements/texts from transcripts and field notes were identified and codes were assigned to them. Similar significant statements/texts across transcripts and field notes were assigned the same codes. Overall, 41 significant statements/texts were assigned codes. The QSR NVivo 10 Software was used to create nodes for each code identified. Third, similar codes were clustered to form themes. Fourth, the themes were used to describe family caregivers' motivations for providing care to older persons.

Trustworthiness or rigor of findings is critical in qualitative research (Connelly, 2016). To ensure the rigor of our findings, the transcribed interviews were shared with family caregivers to authenticate whether they reflected their accounts. Also, the researchers had peer briefing sessions with colleagues and supervisors to discuss the data analysis process and review themes that emerged from the transcripts. Supervisors belonged to the Ga ethnic group and they understood the culture and language of participants. In addition, all decisions made during the data analysis were documented. Member checking, peer debriefing, and audit trail are strategies to ensure trustworthiness or rigor in qualitative research (Gunawan, 2015; Hadi & Closs, 2016).

Results

Background characteristics of participants

The socio-demographic characteristics of family caregivers are presented in Table 2. In total, 31 family caregivers aged between 21 and 76 years were interviewed. The majority of family caregivers were female, Christians, belonged to the Ga-Dangme ethnic group, and had formal education. Also,

the majority of family caregivers were employed full-time and half of them worked near their home. The majority of family caregivers had ever married. Furthermore, the majority of family caregivers resided in James Town, lived with their elderly care recipients in the same house, and were adult children of their care recipients.

Family caregivers' motivations for providing care

The findings on family caregivers' motivations for providing care are grouped under two themes: (i) intrinsic motivations, and (ii) extrinsic motivations. In terms of SDT, intrinsic and extrinsic motivations are classified under autonomous motivation.

Table 2. Socio-demographic characteristics of family caregivers.

	Number (n = 31)	Percentage
Age		
Range	21 - 76	
Mean (years)	45.4	
Sex		
Male	5	16.1
Female	26	83.9
Ethnicity		
Ga-Dangme	24	77.4
Akan	4	12.9
Other	3	9.7
Education		
No education	1	3.2
Primary	7	22.6
Junior High School/Middle	14	45.2
Secondary/Senior High School	5	16.1
Higher	4	12.9
Employment		
Unemployed	7	22.6
Full-time	18	58
Part-time	6	19.4
Place of Work	**(n = 24)**	
At home	6	25
Away from home, nearby	12	50
Away from home, far away	6	25
Religion		
Christian	27	87.1
Muslim	4	12.9
Marital Status		
Never married	11	35.5
Married	9	29
Formerly married	11	35.5
Locality		
James Town	22	71
Ussher Town	9	29
Relationship with the care recipient		
Spouse	1	3.2
Son/daughter	15	48.4
Other relatives	13	41.9
Friend	2	6.5
Living arrangement		
Living with care recipient in the same house	23	74.2
Not living with care recipient in the same house	8	25.8

Intrinsic motivations

Intrinsic motivations had two subthemes: empathy, and affection.

Empathy. In this study, empathy means recognizing the caregiving needs of older persons and providing care to meet those needs. Caregivers highlighted that they recognized their care recipients needed financial, practical, and health-related care so that motivated them to provide such care to meet the needs of their care recipients. These family caregivers provided financial care, in a form of a loan to supplement the working capital of their care recipients, accompanied their care recipient to the hospital, and assisted with practical care such as washing, cooking, and running errands. Most caregivers who empathized with their care recipients were middle-aged. The following quotes reflect the theme:

> I have taken her [care recipient] as my mother. As you can see, her issue is pathetic so when she wants something, I should be able to help her so that she will also be happy. Do you get me? If not, when she asks you for something and you are not able to give it to her, she tends to think about it when she seats alone. *(Female, 51 years; James Town)*

> I felt she is weak and she needs help in her errands. *(Female; 47 years; James Town)*

Interviewer: How did it all start, providing care to her?

Participant: She is a fat person so there are a lot of things that she cannot do.

Interviewer: Why did you choose to help her?

Participant: It was because she was having difficulties in doing such chores [washing and cooking]

Interviewer: So, you decided to help her?

Participant: I realized she was having difficulties so I offered to help. (Female; 27 years; Ussher Town)

Affection. Affection was contextualized as love for care recipients. Affection for parents, especially mothers, motivated adult children to provide care. Affection for parents could be attributed to a prior positive parent-child relationship between adult children and their parents. For instance, mothers spend much time with their children due to their reproduction activities, such as child upbringing, which enhance their relationship with their adult children. A middle-aged primary caregiver who provided personal and emotional care to her mother reported that she was motivated by love to provide care. She narrated that:

> I provide her [mother] care because of the love I have for her.
> *(Female; 45 years; Ussher Town)*

> The love for my mother motivated me to provide care to her.
>
> *(Female; 66 years; James Town)*

Extrinsic motivation

Extrinsic motivation had three subthemes: filial responsibility, reciprocity, and obligation.

Filial responsibility. Filial responsibility refers to feeling obliged to provide care and support to an older person because he/she is a parent. Filial responsibility emerged as a dominant motivation for providing care to older persons. Most family caregivers stated that they provided financial (i.e. cash, and payment for food, medicines, and bills), practical, emotional (chatting with the elderly) and health-related (i.e. accompanying elderly to the hospital, and administering medication) care to their care recipients because their care recipients were their parents and relatives. The majority of adult children, especially females, were motivated by filial responsibility to care for their parents. Family caregivers narrated that:

> . . . As he is my father by all means when he is in need [financial support], I have to assist him. *(Male; 28 years; James Town)*

> She is my aunt and mother [socially recognized mother] at the same time, so that is why I provide care to her. *(Female; 53 years; James Town)*

Furthermore, a 66-year-old female adult child explained that being the eldest child and the only female among her siblings made her the appropriate adult child to provide care to her mother.

> I am her eldest child and the only girl, so automatically I am the right person to provide care to her [mother]. No one can take care of your mother for you.
>
> *(Female; 66 years; James Town)*

Reciprocity. In this study, reciprocity means providing care to pay care recipients back for good deeds in the past. The desire to pay back the past good deeds of the elderly motivated family caregivers to provide care. Twelve family caregivers narrated that the past good deeds of their elderly care recipients motivated their care provision. In some instances, family caregivers were not the direct beneficiary of those past deeds. The following quotes highlight this point:

> It is difficult for someone to take care of an orphan but my grandmother did it wholeheartedly, so that is what motivated me to also care for her.
>
> *(Female; 36 years; James Town)*

> My mother used to tell us that our uncle used to be a goalkeeper for Accra Hearts of Oak and he used to support her in those days. So now that both he and my mother cannot afford to support themselves, we have to support them. *(Female; 23 years; James Town)*

Also, a male student nurse who provided practical and health-related care to his grandmother explained that:

> She [grandmother] has done a lot for me. During my childhood, even though my mother was there, she had been the closest person I have ever known. She has done a lot for me so I feel in my small way even though I don't have money, I massage her knees because she complains a lot of knee pains . . . and I make sure I check her blood pressure regularly any time I'm home. Those are the only things I can do in paying her back.
>
> *(Male; 25 years; James Town)*

An adult child provided care to her mother because she wanted to reciprocate the love her mother showed toward her during childhood. She explained that:

> The kind of love she [mother] gave to me when I was young is why I provide care to her.
>
> *(Female; 66 years; James Town)*

Obligation. Obligation means perceiving care to older persons as a duty or responsibility. Family caregivers were also motivated to provide care due to personal responsibility. Some caregivers reported that they felt it was their responsibility to take care of their care recipients. A 65-year-old family caregiver explained that it was her responsibility to care for her mother and she anticipates that in the future her children would also care for her.

> Now that she is old, it's my responsibility to take care of her [mother] so that one day my children can also do the same for me. *(Female; 65 years; James Town)*

Also, a male family caregiver explained that he was obliged to provide financial care to his care recipient because he wanted to show him respect.

Interviewer: What are the reasons why you provide care to him?

Participant: Because he is elderly. As the Scripture says if you show respect to the elderly, it is a blessing. (Male; 21 years; James Town)

Discussion

This study explored family caregivers' motivation for providing care to their care recipients in the urban poor context. The study revealed that family caregivers observed some older persons could not perform certain activities of daily living such as cooking and washing, and this motivated them to provide care to these older persons. This finding is similar to that of Stols's (2014) study in South Africa which found that adolescents were motivated to provide care to older persons when they observed that older persons were struggling with physical activities such as carrying heavy loads, washing, and bathing.

The findings also showed that affection motivated family caregivers to provide care to their care recipients. This finding is supported by other studies in Ireland, the United Kingdom, and the United States which found that affection motivated caregivers to provide care to older persons (Kim, 2009; Lin et al., 2011; McDonnell & Ryan, 2014). For instance, Lin's et al. (2011) study in the United Kingdom revealed that some caregivers were motivated by affection for their spouse to provide care. Likewise, Kim's (2009) study in the United States reported that caregivers were motivated by love to care for their spouses. McDonnell and Ryan's (2014) study in Ireland found that sons were motivated by affection for their parents to provide care.

The findings of the study further revealed that family caregivers were motivated by filial responsibility to provide care to their care recipients. Traditionally, kinsfolks are expected to assist each other in times of crisis such as the need for care and support (Seekings, 2008; van der Geest, 2016). This finding is similar to other studies conducted in Ghana, Singapore, and Sweden which found that filial responsibility motivated family caregivers to assume elderly caregiving (Kusi et al., 2020; H. Y. Ng et al., 2016; Wallroth, 2016). A caregiver mentioned that being a female made her the appropriate person to provide care and she has this perception because family caregiving is perceived as a female task and this finding corroborates with other studies that highlighted caregiving as a female responsibility (Bainbridge et al., 2021; Bertogg & Strauss, 2020; Esplen, 2009; Kusi et al., 2020).

Family caregivers mentioned that the principle of reciprocity motivated them to provide care to their care recipients. Family caregivers provided care to pay back the past deeds of their care recipients and this finding is supported by other studies in Ghana, Nigeria, Hong Kong, Japan, and Ireland which found that past deeds motivated family caregivers to provide care to their care recipients (Faronbi et al., 2019; McDonnell & Ryan, 2014; Pang & Lee, 2019; van der Geest, 2016; Yamaguchi et al., 2016).

Family caregivers also mentioned that they felt obliged to provide care to older persons and this perception could partly be explained by cultural norms that expect the younger generation to take care of the older generation. This finding corroborates with other studies in South Africa, Pakistan, Iran, Ireland, and the United Kingdom which found that obligation made family caregivers provide care to their care recipients (Gurayah, 2015; Lin et al., 2011; McDonnell & Ryan, 2014; Qadir et al., 2013; Zahed et al., 2019). It is worth noting that one caregiver highlighted that respect for older persons made him obliged to provide care to his care recipient. Traditionally, older persons are respected since they serve as a repertoire of wisdom and indigenous knowledge (van der Geest, 2016).

Limitations

The main limitation of this study is that it was conducted in James Town and Ussher Town in Accra and therefore the findings of the study cannot be generalized to entire urban poor communities in Ghana. Despite this limitation, the study provides an in-depth understanding of family caregivers' motivations and contributes to the literature of family caregivers' motivations for elderly care in Ghana and sub-Saharan Africa at large.

Implications for social work

Caregiving responsibilities are multifaceted and demanding. Therefore, the motivations of family caregivers are essential since they can influence the quality of care they provide to older persons. This study found that family caregivers are motivated by both intrinsic and extrinsic motives to provide care. Previous studies have found that caregivers motivated by intrinsic motives provide adequate care to their care recipients than those motivated by extrinsic motives (Feeney & Collins, 2003). This finding has implications for social work practice. Gerontological social workers should target and provide tailor-made support to assist family caregivers motivated by extrinsic motives since they are more likely to provide inadequate care. For instance, gerontological social workers can provide emotional support and counseling to caregivers to enhance their quality of care.

Also, family caregivers' motivations for providing care can change during their caregiving trajectory. However, this study investigated family caregivers' initial motives for providing care to older persons. Future studies should longitudinally explore changes in family caregivers' motivations since it will help researchers and social workers understand family caregivers' motivations to design appropriate interventions to enhance the quality of care and quality of care life of older persons.

Conclusions

The study's findings demonstrate that family caregivers were only motivated by autonomous motivations to care for older persons. Intrinsically, empathy and affection motivated some family caregivers to provide care, while others were inspired by extrinsic motives; filial responsibility, reciprocity, and obligation. Furthermore, family caregivers motivated by extrinsic motives are more likely to provide poor quality of care than those motivated by intrinsic motives. Therefore, gerontological social work interventions to enhance the quality of care provided to older persons should target family caregivers motivated by extrinsic motives.

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ORCID

Frank Kyei-Arthur http://orcid.org/0000-0001-9794-8524
Deborah Atobrah http://orcid.org/0000-0002-4257-7508

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