

UNIVERSITY OF GHANA

COLLEGE OF HUMANITIES

**FAMILY CAREGIVING: EXPERIENCES OF CAREGIVERS AND THEIR
ELDERLY CARE RECIPIENTS IN URBAN POOR COMMUNITIES IN
ACCRA, GHANA**

BY

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ACCEPTANCE

Accepted by the College of Humanities, University of Ghana, Legon, in fulfillment of the requirement for the award of PhD Population Studies degree.

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DECLARATION

I hereby declare that, except for references to other people's work, which have been duly acknowledged, this is the result of my own research and that it has neither in part nor in whole been presented elsewhere for another degree.

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ABSTRACT

In Ghana and other sub-Saharan African countries, the family is the primary caregiver for elderly persons and provides other forms of support to them. Urbanisation and its associated consequences have weakened traditional family ties and obligation, and subsequently impaired care for the elderly, particularly in urban poor communities in sub-Saharan Africa. Against this backdrop, this study explored the experiences of family caregivers and their elderly care recipients in two urban communities (James Town and Ussher Town) in Accra. This study specifically examined the socio-demographic characteristics and health status of the general elderly population, caregivers and their elderly care recipients in Ga Mashie, caregivers' motivations for providing care, challenges faced by caregivers, strategies employed by caregivers to cope with their challenges, rewards caregivers derived from caring for the elderly and perceptions of the elderly concerning the care they receive from their caregivers. The study used qualitative and quantitative data. The socio-demographic characteristics and health conditions of 170 elderly in Ga Mashie were covered under the quantitative component while a transcendental phenomenological study was conducted among twenty elderly care recipients and thirty-one family caregivers to understand their caregiving experiences. The findings of the quantitative data show that the majority of the elderly are females aged 60 to 74 years. In addition, most households of the elderly used public toilets and charcoal for cooking. Hypertension and diabetes were the most common non-communicable diseases among the elderly. Bivariate analysis between socio-demographic characteristics of the elderly population and their tenancy arrangements show that age, marital status, ethnicity, religion, and wealth quintile were significantly associated with tenancy arrangements. The qualitative data show that family caregivers were motivated by kin relationship, reciprocity, obligation, and altruism, among others to care for their care recipients. Family caregiving to the elderly care recipients posed financial, physical, social, and psychological challenges to caregivers. Family caregivers employed strategies such as praying, adaptation, perseverance and optimism, among others to cope with their caregiving challenges. Family caregivers derived rewards from providing care to their elderly care recipients and these rewards include: gifts, blessing, honour, and asset, among others. Most elderly care recipients reported that they were satisfied with the care they received from their caregivers. However, some elderly care recipients complained that they were abused verbally and neglected. Narratives of family caregivers acknowledged that the elderly in Ga Mashie were abused verbally and physically, neglected and accused of witchcraft. The study recommended that there should be public education on both positive and negative aspects of ageing. The study also suggested that family caregivers should be counselled by health professionals about the stressful nature of caregiving, how to deal with their elderly care recipients and helped to identify effective stress coping strategies. In addition, the government should create programmes to help people prepare for old age.

DEDICATION

This work is dedicated to my mother, Beatrice Frimpomaa, and my wife, Victoria Kutorkor Kotey and our lovely son, Samuel Kwesi Kyei-Arthur.

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LIST OF ABBREVIATIONS

ADLs	Activities of Daily Living
AIDS	Acquired Immunodeficiency Syndrome
AMA	Accra Metropolitan Assembly
CHF	Cooperative Housing Foundation
EAs	Enumeration Areas
ECH	Ethics Committee for the Humanities
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
IADLs	Instrumental Activities of Daily Living
LEAP	Livelihood Empowerment Against Poverty
NHIS	National Health Insurance Scheme
RIPS	Regional Institute for Population Studies
SSNIT	Social Security and National Insurance Trust
TFR	Total Fertility Rate
UHPS	Urban Health and Poverty Survey
UN	United Nations

CHAPTER ONE

INTRODUCTION

1.1 Background

Globally, there has been an increase in the elderly population (population aged 60 years and older). Worldwide, the elderly population refers to the population aged 60 years and older (United Nations Population Fund & HelpAge International, 2012). According to United Nations Population Division (2015a), the global elderly population has increased from less than one-tenth (8.5 percent) in 1980 to a little over one-tenth (12.3 percent) in 2015. It is estimated that the global elderly population will increase to 21.5 percent in 2050 and 28.3 percent in 2100 (United Nations Population Division, 2015d). Population ageing varies across countries and regions of the world. For instance, in Europe, the elderly population had increased from 147 million (20.3 percent) in 2000 to 176.5 million (23.9 percent) in 2015. The elderly population in Europe is expected to increase to 217 million (29.6 percent) in 2030 and 242 million (34.2 percent) by 2050. In Africa, the elderly population had increased from 42 million (5.2 percent) in 2000 to 64 million (5.4 percent) in 2015. It is estimated that the elderly population in Africa will increase to 105 million (6.3 percent) in 2030 and 220 million (8.9 percent) in 2050 (United Nations Population Division, 2015c). In Ghana, the elderly population has increased from 4.5 percent in 1960 to 6.7 percent in 2010 (Ghana Statistical Service (GSS), 2013a).

The increase in the elderly population is associated with declining fertility and increased life expectancy (Schoeni & Ofstedal, 2010; United Nations Population Division, 2013, 2015d; World Health Organization, 2015). Globally, Total Fertility Rate (TFR) has declined from 4.5 children per woman in 1970-1975 to 2.5 children per woman in 2010-2015 (United Nations

Population Division, 2015b). Although fertility has declined in every region of the world, it's still high in sub-Saharan Africa. In addition, life expectancy has increased worldwide due to declining mortality (especially under-five mortality). However, it's still low in sub-Saharan Africa mainly due to HIV/AIDS, especially in Southern African countries such as Lesotho, Botswana and South Africa. Globally, life expectancy at birth has increased from 46.8 years in 1950-1955 to 70.5 years in 2010-2015 (United Nations Population Division, 2017). In sub-Saharan Africa, life expectancy at birth has increased from 36.2 years in 1990-1995 to 57.2 years in 2010-2015. Ghana's life expectancy at birth has increased from 31.9 years in 1948 to 60.2 years in 2010 for males and 34.4 years in 1948 to 63.4 years for females in 2010 (Ghana Statistical Service (GSS), 2013b).

Globally, population ageing is a topical subject for governments, demographers and policy makers due to a number of reasons. First, longer lives must be planned for. Second, ageing may affect economic growth and many other issues, including the sustainability of families, the ability of countries and communities to provide resources for older citizens, and international relations (Nagarajan, Teixeira, & Silva, 2013). Third, the increasing number of elderly population is associated with changing disease patterns (World Health Organization, 2011).

Population ageing has also attracted the interest of demographers and policy makers due to its potential impact on family caregiving to the elderly (Agree & Glaser, 2009). For example, increase in life expectancy has implications for family caregiving since elderly persons with ill health may live longer, and care for these elderly persons may be more demanding (Agree & Glaser, 2009). With the increase in the proportion of the elderly population, changes in fertility

and mortality may affect the availability of family members to provide care for the elderly (Agree & Glaser, 2009). A study on family caregiving indicated that declining fertility reduces the number of caregivers (adult children and grandchildren) elderly persons can rely on for care and support (Population Reference Bureau, 2016). Similarly, Cattell (1993) found that the HIV/AIDS epidemic in sub-Saharan Africa has reduced the number of caregivers the elderly can rely on for care and support.

Studies have linked ageing with an increased risk of illness, non-communicable diseases, frailty, impairments and disabilities (Ayernor, 2012; Mba, 2010; World Health Organization, 2015). Jacobozone et al. (1999) suggest that population ageing increases functional limitations, especially among the oldest old (85 years and older). Similarly, Ku et al. (2013) acknowledged that as population ages, the elderly may need some form of assistance. Consequently, more family members will assume caregiving roles and responsibilities to enhance the well-being and quality of life of the elderly.

Despite the challenges of population ageing such as increased demand for healthcare by the elderly and decreased labour force participation, many sub-Saharan African countries are yet to prioritise the problems associated to ageing (Aboderin & Beard, 2015; Mba, 2010). This is due to the fact that, in sub-Saharan Africa, the elderly constitute only a small proportion of the total population and the region has focused its limited resources on urgent issues such as HIV/AIDS, poverty, unemployment, and infant and under-five mortality (Aboderin, 2007; Apt, 2001; Velkoff & Kowal, 2006). In addition, the elderly often live with their adult children or extended family (Apt, 2001; Mba, 2002). However, in Ghana, the government has implemented a number of policies such as the Social Security Law (1991), the National Health Insurance Scheme

(NHIS) (2003), the Livelihood Empowerment Against Poverty (LEAP) (2008) and National Ageing Policy (2010), to promote the well-being of the elderly (Alidu, Dankyi, & Tsiboe-Darko, 2016; Kwankye, 2013; Tawiah, 2011). The elderly in Ghana and other sub-Saharan African countries encounter enormous challenges such as poor care, witchcraft accusations, loss of respect, neglect, loneliness, health problems (including barriers to healthcare), violence, and material and financial security (Aboderin & Kizito, 2010; Apt, 1993, 2001; Dsane, 2009; Mba, 2007b, 2010; Opong, 2006; van der Geest, 2002, 2004; World Health Organization, 2014).

Generally, family caregiving involves relatives, friends or neighbours providing assistance to relatives and/or non-relatives who need care (Feinberg et al., 2011). Studies on family caregiving to the elderly have shown that family caregivers perform various tasks ranging from activities of daily living (ADLs) (e.g. feeding, bathing, dressing, and toileting) to instrumental activities of daily living (IADLs) (e.g. preparing meals, managing medication, shopping, and household chores) (Apt, 1993; van der Geest, 2002).

Despite the valuable assistance provided by family caregivers to enhance the well-being of their care recipients, their caregiving roles and responsibilities can lead to negative outcomes such as poor physical health, poor psychological health, reduced productivity and social isolation (Ahmad, 2012; Chow & Ho, 2014; Schoenmakers et al., 2010). However, family caregivers may also experience positive outcomes such as satisfaction with the provision of care to the elderly (Gonyea, Paris, & de Saxe Zerden, 2008; Shim, Barroso, & Davis, 2012).

Globally, almost every country is experiencing urbanisation. Since 2008, more people have resided in urban areas compared to rural areas worldwide (UN-Habitat, 2015). According to the United Nations Population Division (2015e), the urban population of the world has increased

from about 30 percent in 1950 to about 47 percent and 52 percent in 2000 and 2010 respectively. As at 2017, a little over half (54 percent) of the global population resided in urban areas (Population Reference Bureau, 2017). It is estimated that about 56 percent of the global population will be residing in urban areas by the year 2020, and about two-thirds (66 percent) by 2050 (United Nations Population Division, 2015e).

In sub-Saharan Africa, the urban population has more than tripled over the past five decades, increasing from about 11 percent in 1950 to about 39 percent in 2017. Sub-Saharan Africa is expected to experience the fastest rate of urbanisation between 2020 and 2050. In Ghana, the urban population has increased from 23 percent in 1960 to about 44 percent in 2000 and about 55 percent in 2017 (Ghana Statistical Service (GSS), 2013b; Population Reference Bureau, 2017). The Greater Accra Region has been the most urbanised region in Ghana since 1960, and in 2010, about 95 percent of the region's population resided in urban areas (Ghana Statistical Service (GSS), 2013c).

Though urbanisation is generally a driver of economic development and poverty reduction, this has not always been the case in sub-Saharan Africa (United Nations Population Division, 2015e). Studies have documented that sub-Saharan African countries are urbanising while experiencing high levels of urban poverty (Ezeh et al., 2006; Hove et al., 2013). In Ghana, evidence from the sixth round of the Ghana Living Standard Survey shows that though poverty in Ghana has declined from about 52 percent in 1991/1992 to about 32 percent in 2005/2006 and about 24 percent in 2012/2013, poverty in coastal areas (including Ga Mashie where the study is located) have worsened from about 6 percent in 2005/2006 to about 10 percent in 2012/2013 (Ghana Statistical Service (GSS), 2014b). This implies that the living conditions of the people

residing in urban coastal areas, especially urban poor communities, has worsened compared to people residing in rural areas and this has implications for the quality of care provided to the elderly and the well-being of the elderly.

A study on the decline of family support to the elderly in Accra found that young respondents could not provide adequate material support to their elderly parents because they were not having the means to do so due to economic hardship and the high cost of living (Aboderin, 2004a). Deepening urban poverty would affect the material support family members provide to their elderly relatives and consequently, affect the well-being of the elderly. It is against this backdrop that this study seeks to explore the lived experiences of family caregivers and their elderly care recipients in urban poor Ga Mashie, Accra.

1.2 Problem statement

The proportion of the elderly population in Ghana has increased over the past five decades, from 4.5 percent in 1960 to 6.7 percent in 2010. It is estimated that the elderly population in Ghana will increase to 12.6 percent in 2050 (Ghana Statistical Service (GSS), 2013a). This indicates the increasing number of persons in the population that are attaining 60 years. The increase in the elderly population has varied consequences, including an increase in the demand for healthcare services, and demand for more family members to assume caregiving roles. The demand for healthcare services would exacerbate the already weakened health systems in Ghana which struggle to cope with both communicable and non-communicable diseases (Agyei-Mensah & de-Graft Aikins, 2010; de-Graft Aikins et al., 2012).

In addition, the elderly at advancing ages (75+ years) may need various forms of assistance due to their frailty. In Ghana, caring for the elderly is the responsibility of the family, and caregiving roles and responsibilities are traditionally assumed by women. However, studies have documented that processes such as migration, urbanisation, and modernisation have weakened the traditional role of the extended family in providing care and support to the elderly (Aboderin, 2004a, 2004b; Apt, 1993, 1996, 2001; Mba, 2004b). As a result, family support to the elderly has dwindled over time. This has implications for the quality of care provided to the elderly and the well-being of the elderly. For example, lack of adequate care and material support to the elderly would worsen the plight of the elderly who are often poor (Mba, 2004a, 2004b).

Furthermore, the inability of the extended family to care for the elderly, especially in urban areas, has led to the emergence of nursing homes and paid caregivers to complement the family sources of care. Research has acknowledged the emergence of home nursing agencies and paid caregivers in Ghana to complement the care provided by family caregivers, especially, adult children (Coe, 2016; Dsane, 2009; Sackey, 2009; van der Geest, 2016). As the Ghanaian elderly population increases, there is going to be proliferation of these home nursing agencies and paid caregivers, especially in urban areas.

A review of literature on family caregiving to the elderly from both developed and developing countries revealed four main gaps. First, studies on family caregiving to the elderly have been conducted mainly in developed countries and focused mainly on the negative outcomes of caregiving to the neglect of the positive outcomes (Bastawrous, 2013; Chappell & Funk, 2011; Vellone et al., 2011). Donorfio and Sheehan (2001, p. 39) have argued that “an

exclusive focus on the negative outcomes of caregiving does little to advance understanding of the complexity or the heterogeneity of the caregiving experience”. In other words, they are of the view that focusing only on the negative outcomes of caregiving does not give a holistic account of experiences associated with family caregiving. The negative outcomes of caregiving include financial strain, reduced labour force participation, quitting of job, conflicts in relationships, and decline in quality of life. For example, a study by Sanuade and Boatemaa (2015) among family caregivers of the elderly in Ghana found that caregivers experienced financial strain due to their caregiving roles and responsibilities. Conversely, some studies have documented that family caregivers of the elderly can experience both negative and positive aspects of caregiving (Hinrichsen et al., 1992; Lin et al., 2012; Population Reference Bureau, 2016; Shim et al., 2012; Spillman et al., 2014). Prolonged and greater involvement in caregiving influences the outcomes of caregiving. The positive outcomes of caregiving include a sense of purpose or meaning, personal growth, improved quality of relationship with their care recipients, enhanced self-esteem, and strengthened family bonds (Hinrichsen et al., 1992; Sheehan & Donorfio, 1999).

Second, a substantial proportion of studies on the negative outcomes of family caregiving (for example, caregiver burden, strain, and stress) have used quantitative measures (Bastawrous, 2013; Garner & Faucher, 2014). Most of these quantitative studies in both developed and developing countries have used instruments such as the Zarit Burden Interview (ZBI), the Role Strain Scale (RSS), and the Carer Strain Index (CSI), among others to measure the negative outcomes of caregiving (Hermanns & Mastel-Smith, 2012; Mosquera et al., 2015). For instance, Zarit Burden Scale is a 22-item scale developed to measure the level of burden experienced by family caregivers of the elderly with dementia and family caregivers respond to these 22 statements on a 5-point Likert scale ranging from “Never” to “Nearly Always”. Although

quantitative studies on family caregiving provide useful information on the prevalence and degree of these negative outcomes of caregiving (Garner & Faucher, 2014), they do not capture the cultural context of caregiving (Bastawrous, 2013). Hence, Garner and Faucher (2014) argue that qualitative studies are needed to provide an in-depth understanding of the challenges experienced by family caregivers.

Third, most studies on family caregiving to the elderly have mainly focused on the perspectives of caregivers to the neglect of the perspectives of elderly care recipients (Crist, 2005; Lyons et al., 2002). Since family caregiving involves at least two people, the caregiver and the care recipient, it is essential to study the perspectives of both caregivers and their elderly care recipients to gain a comprehensive understanding of the caregiving situation. However, few studies have focused on the perspectives of both caregivers and their elderly care recipients (Jo et al., 2007; Lyons et al., 2002).

Finally, family caregiving roles and responsibilities are often shared by family members (Checkovich & Stern, 2002; Wolf et al., 1997). Most studies on family caregiving to the elderly have focused on primary caregivers to the neglect of secondary caregivers (Adewuya, Owoeye, & Erinfolami, 2011; Dellmann-Jenkins, Blankemeyer, & Pinkard, 2000; Tomita, Lee, et al., 2010; Tomita, Sarang, et al., 2010). In other words, secondary caregivers have not been given much attention as primary caregivers. Few studies on child care has identified the role of secondary caregivers (Atobrah, 2004, 2005; Badasu, 2004). Since secondary caregivers assist primary caregivers to provide care to their care recipients, caregiving may impact their lives just like that of primary caregivers. Therefore, it is essential to study caregiving experiences of both

primary and secondary caregivers so that researchers can capture the differences and similarities of their experiences to provide evidence for policies that address their well-being.

This study addresses these research gaps by exploring the views of elderly care recipients concerning the care they receive and examining the negative and positive experiences of both primary and secondary caregivers using a qualitative assessment in a developing country setting.

The study, therefore, seeks to answer the following questions:

1. What are the socio-demographic characteristics and health status of the general elderly population, caregivers and their elderly care recipients in Ga Mashie?
2. What motivates primary and secondary caregivers in urban poor Accra to provide care to the elderly?
3. What challenges do primary and secondary caregivers face in the provision of care to the elderly in the urban poor context?
4. What strategies do primary and secondary caregivers use to cope with their caregiving challenges?
5. What rewards do primary and secondary caregivers in urban poor Accra derive from providing care to the elderly?
6. What are the perceptions of the elderly persons in urban poor Accra concerning the care they receive from their primary and secondary caregivers?

1.3 Objectives

The general objective of this study is to gain an in-depth understanding of the experiences of family caregivers and their elderly care recipients in Ga Mashie.

The specific objectives are:

1. To describe the socio-demographic characteristics and health status of the general elderly population, caregivers and their elderly care recipients in Ga Mashie
2. To explore the motivations of primary and secondary caregivers in urban poor Accra to provide care to the elderly
3. To examine the challenges faced by primary and secondary caregivers in the provision of care to the elderly in the urban poor context
4. To explore the strategies primary and secondary caregivers use to cope with their caregiving challenges
5. To examine the rewards primary and secondary caregivers in urban poor Accra derive from providing care to the elderly
6. To describe the perceptions of the elderly persons in urban poor Accra concerning the care they receive from their primary and secondary caregivers

1.4 Rationale of study

The study is important and timely for a number of reasons. The first is the acknowledgement that there is a paucity of research on the situation of elderly in Ghana and this has become a problem of national interest and concern. As a result, the 2010 National Ageing Policy of Ghana highlights the need for universities and research institutions to conduct research

on the needs of elderly persons in Ghana. This study would provide the government and policy makers research evidence on the situation of the elderly in urban poor communities in Accra which can be used for planning and designing programmes for the elderly.

This study is also important because there is a paucity of research on the positive aspects of family caregiving to the elderly in Ghana and sub-Saharan Africa at large. This study will contribute to the literature on positive aspects of family caregiving to the elderly in Ghana and sub-Saharan Africa at large. Studying the positive aspects of family caregiving would help researchers to better understand why family caregivers continue to provide care to their elderly care recipients, although it is stressful so that appropriate programmes and interventions can be designed to enhance the well-being of family caregivers and their elderly care recipients.

The study was conducted in Ga Mashie, an urban poor community. The urban poor context provides a unique opportunity to understand family caregiving to the elderly in urban areas where modernisation has influenced family care and the ability of the family to care for its elderly relatives in the urban context is weakened by limited financial resources, increased education and participation of women in the labour force, who usually perform caregiving roles and responsibilities (Apt, 1993, 2001).

1.5 Operationalisation of terms

1.5.1 Elderly

In the context of this study, an elderly person refers a person aged 60 years and older.

1.5.2 Family

In the context of this study, **family** refers to any group of individuals connected to each other by ties of consanguinity and marriage.

1.5.3 Family caregiving

In the context of this study, **family caregiving** refers to any assistance or support provided by family members, neighbours or friends to the elderly in the domestic setting to improve their well-being. Family caregiving involves all types of care provided to the elderly ranging from practical, material, emotional to medical care. Practical, material and emotional care are provided in the domestic setting. Practical care refers to daily routine activities performed for the elderly, such as cooking, feeding, bathing, dressing, toileting, cleaning the elderly when they soil themselves and running errands.

Material care refers to the provision of financial assistance for the daily upkeep of the elderly. Emotional care refers to the things caregivers do to deal with the loneliness, isolation, boredom and other psychosocial needs of the elderly such as listening and having conversations with them. Medical care comprises accompanying the elderly to the hospital and supervising or monitoring their medication.

1.5.4 Primary and secondary caregivers

This study only focused on family caregivers who were physically present at the household and were providing care to the elderly. However, the researcher acknowledges that there are other family caregivers who were not physically present at the household but were providing care to the elderly from a distance. These caregivers, who were not physically present

at the household, often provided financial assistance to support the daily upkeep and the medical expenses of the elderly. The study used the activities performed by family caregivers to categorise them into primary and secondary caregivers.

In the context of this study, **primary caregiver** refers to a family member who performs most activities for the elderly care recipient, be it practical, material, emotional or medical care. It is worth noting that there cannot be more than one primary caregiver.

Secondary caregiver, on the other hand, refers to any family member, friend or neighbour who assists the primary caregiver to provide practical, material, emotional and/or medical care to the elderly care recipient.

1.6 Organisation of study

The present study is divided into nine chapters. Chapter one is an introduction to the thesis; it provides a background to the study, states the statement of the problem and research questions, objectives, rationale of the study, operationalisation of terms and the organisation of the study. The second chapter presents a literature review and conceptual framework while chapter three focuses on the study area and methodology. Chapter four presents the socio-demographic characteristics, living arrangements and housing conditions, and health status of the elderly population in Ga Mashie, and the characteristics of study respondents and their caregivers. Chapter five describes caregiving activities of caregivers and their motivations for providing care to the elderly while chapter six examines the challenges and coping strategies of caregivers. Chapter seven describes the rewards or gains caregivers derive from caregiving. Chapter eight describes the concept of care by elderly care recipients and their caregivers, and

the perceptions of the elderly concerning the care they receive from their caregivers while the final chapter presents the summary, conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter examines the concept of caregiving, cultural norms and family caregiving, and motivations for providing care. The chapter also focuses on issues related to negative experiences of caregiving, factors associated with negative experiences of caregiving, mediators of the impact of caregiving, positive experiences of caregiving, and elderly care recipient's perception of receiving care.

In addition, the chapter discusses the Ga people, the family in the Ghanaian context, institutional care for the elderly in Africa, policies on ageing, theoretical framework and conceptual framework adapted for understating the experiences of family caregivers and their elderly care recipients.

2.2 The concept of caregiving

In the traditional setting, care is essential for the well-being of family members who are in need of it such as children, the sick and dependent elderly. Generally, caring refers to the means of responding to the needs of others (Marshall et al., 1990). Women often perform caring duties and responsibilities. Consequently, care is perceived as a feminist concept which conceptualises defining features of women's lives (Daly, 2002; Daly & Lewis, 2000). Van der Geest (2002, p. 7) acknowledged that "care, either as a concept or a practice, is highly ambiguous since people may not give an accurate account of the care they receive or give depending on the mood of the individual involved and on the context within which the

conversation takes place”. In other words, researchers must be cautious when studying the caregiving experiences of caregivers and their elderly care recipients.

Caregiving has been studied from various disciplines such as sociology, nursing and psychology. Despite the numerous studies on caregiving, there is no general definition of caregiving across studies and this sometimes makes it difficult to compare the results of studies on caregiving (Hermanns & Mastel-Smith, 2012). Hermanns and Mastel-Smith (2012, p. 15) define caregiving as “the process of helping another person who is unable to do for themselves in a “holistic” (physical, mental, emotional and social) manner”. Hermanns & Mastel-Smith’s definition of care considers the various elements of care so that the needs of the care recipient can be met comprehensively. According to Pearlin et al. (1990) caregiving refers to “the behavioural expression of commitment to protect and enhance the well-being of others”. Pearlin et al.’s definition of caregiving reflects the ultimate goal of caregiving which is to enhance the well-being of the care recipient.

Caregiving is a social activity which involves several individuals providing care to the care recipient (Barbosa et al., 2011; Margolis et al., 2014; van der Geest, 2002). Thus, caregiving is often a shared task and several family members may be engaged in providing various types of care (such as physical and emotional care) to the elderly care recipient.

Moreover, caregiving has two essential components, namely the instrumental/practical component and emotional component (Abel & Nelson, 1990; van der Geest, 2002). The instrumental/practical component refers to the concrete activities that are carried out for others while the emotional component refers to the expression of concern, dedication, and attachment to others (van der Geest, 2002). Caregivers often provide both instrumental and emotional care to

their care recipients. However, most often, instrumental/practical care is visible and as a result, it is more valued compared to emotional care (Abel & Nelson, 1990).

Furthermore, caregiving is context specific and it can consequently be understood within the specific context in which they occur (Abel & Nelson, 1990). Tronto (1993, p. 103) argued that “the activity of caring is largely defined culturally, and will vary among different cultures”.

In Ghana and among the Ga, family caregiving is viewed as communal task and as a result, caregiving duties and responsibilities are often shared among family members. A study by Atobrah (2009) among the Ga in Ghana revealed that caregivers of the chronically sick relatives conceptualised care for their sick relatives as the performance of household chores, assistance in finding treatment and cure, and providing emotional support while the care recipients (chronically sick relatives) conceptualised care as psychosocial care, assistance with treatment, medication and cure, and household chores.

2.3 Cultural norms and family caregiving

Traditional customs, norms and expectations may influence caregiving to the elderly (Bastawrous, 2013). For example, a review of the literature by Mokuau and Tomioka (2010) among Japanese caregivers providing care to elderly Japanese residing in the United States (US) found that cultural values (such as filial piety, social reputation, interdependence and patrilineal genealogy) shape the nature of caregiving and women’s role as caregivers. Patrilineal genealogy suggests that the wife of the eldest son must provide care to her elderly in-laws. Similarly, a study by Wong (2005) in Hong Kong among adult children providing care to their dependent parents and in-laws found that sexual taboos restrict the intimate personal care adult children

could provide to their elderly parents. Sexual taboos prohibit adult children of the opposite sex seeing and touching the naked bodies of their parents and this made adult children who provided intimate personal care to their parents or parents-in-law felt anxious and embarrassed seeing and touching their naked bodies. Thus, these reactions of caregivers to the provision of intimate personal care can negatively impact the quality of personal care given to the elderly.

In sub-Saharan Africa, there are taboos which forbid certain individuals to provide intimate personal care to the elderly. In Ghana, Sackey (2009) reported that among matrilineal societies, a man's wife is regarded as an "outsider" and as a result, she cannot provide intimate personal care to her mother-in-law since it is inappropriate for her to see her nakedness. Similarly, a study in Botswana by Shaibu and Wallhagen (2002) reported that in the Setswana culture, intimate personal care such as bathing, dressing and toileting are considered inappropriate or taboo for men and as a result, they must be avoided if possible. Specifically, Shaibu and Wallhagen (2002, p. 147) argued that:

"In the Setswana culture, ideally, one should wash his or her own underwear unless one is sick. If necessary, a woman can launder a man's underwear, and a mother can always launder a son's underwear. However, a man cannot launder his own mother's underwear".

Cultural norms and values influence who becomes a caregiver to the elderly. In both developed and developing countries, caregiving roles and responsibilities are usually performed by females (Cattell, 1993; Gonyea et al., 2008; van der Geest, 2002; Lin et al., 2012; Wolf, Freedman, & Soldo, 1997). This is because caregiving roles and responsibilities are viewed as a female task (Shaibu & Wallhagen, 2002; van der Geest, 2002). For example, Manuh and Quashigah (2009, p. 73) argued that:

“For many people, caregiving is viewed as an extension of women’s „natural“ functions of reproduction, child care and household work”.

Based on this perception, care provided by females are perceived to be of high quality compared to care provided by males (Manuh & Quashigah, 2009; Trujillo et al., 2012). However, in the absence of a female, a male may provide care to the elderly (Ahmad, 2012).

Family caregiving is based on the division of labour. Research has established that men usually provide financial care while women usually provide physical care (Ross-Sheriff & Swigonski, 2009; Wong, 2005). For example, van der Geest (2002) argued that among the Akan societies in Ghana (a matrilineal society), most women provide practical care (such as bathing, dressing, washing, cooking, and toileting) while men provide financial support and pay visits.

It is worth noting that the sex of the caregiver may influence the nature of the care provided to the care recipient (Manuh & Quashigah, 2009). Shaibu and Wallhagen’s (2002) study among family caregivers of the elderly in Botswana reported that male caregivers perceived their sex as a barrier to the performance of certain caregiving activities such as bathing, dressing and toileting.

However, it has been documented that cultural norms and values regarding care for the elderly have been transformed by modernisation (e.g. migration) and globalisation (Ghana Statistical Service (GSS), 2013a; United Nations Population Fund & HelpAge International, 2012). For example, a study by van der Geest, Mul, and Vermeulen (2004) which observed the linkage between migration and care for dependent elderly in Ghana, Greece, and the Netherlands revealed that due to the migration of adult children in Crete (Greece), private carers were hired to care for dependent elderly. Van der Geest’s (2002) study in Kwahu, a rural community in Ghana,

found that due to the migration of adult children in Kwahu, there are few or no adult children to provide care to their elderly parents. He, however, explained that sometimes migrant adult children are able to “care from a distance” by sending money to those providing care to their parents.

2.4 Motivations for providing care

Motivations for providing care vary from one caregiver to another. Caregiver’s motivations for providing care has implications for the quality of care provided to care recipients and the well-being of the caregiver (Feeney & Collins, 2003). Motivations for providing care can be classified into intrinsic and extrinsic motivation. Intrinsic motivation refers to personal desires to provide care while extrinsic motivation refers to external pressures to provide care (Lyonette & Yardley, 2003). Intrinsic motivations include providing care because one enjoys doing it and providing care due to concern for the well-being of the care recipient while extrinsic motivation includes providing care due to reciprocity, obligation, out of fear and one having no other choice than to provide care.

Studies in both developed and developing countries have documented that reciprocity and obligation are the primary reasons for providing care to the elderly. Reciprocity refers to the bidirectional exchange of resources (Neufeld & Harrison, 1998 cited in del-Pino-Casado et al., 2011) while obligation refers to a culturally defined attitude of duty and responsibility to care for relatives (de Valk & Schans, 2008 cited in del-Pino-Casado et al., 2011). In Africa, obligation and reciprocity to provide care to the elderly are expressed in proverbs such as “when your elders take care of you while you cut your teeth, you must in turn take care of them while they are loosing theirs” (A Ghanaian proverb) (Apt, 2001, p. 295).

In developed countries, such as the United States and the United Kingdom, researchers have identified obligation and reciprocity as motivations for providing care to the elderly. Dellmann-Jenkins et al. (2000) used both quantitative and qualitative methods to understand elderly caregiving among 22 adult children and 21 grandchildren caregivers (aged between 18 and 40 years) in the United States. They found that both adult children and grandchildren caregivers reported obligation as the main reason for providing care to their elderly parents and relatives respectively. Similarly, a qualitative study by Sheehan and Donorfio (1999) in the United States to examine the complexity of filial relationship between 11 daughters and their elderly mothers revealed that daughters provided care to their mother as an attempt to repay them for their past sacrifices.

A qualitative study by Noonan et al. (1996) among 48 family caregivers of the elderly who were part of the Massachusetts Elder Health Project¹ found that caregivers provided care to the elderly because it is a moral obligation to care for family members and to repay the elderly for their care or kindness in the past. Calderon and Tennstedt's (1998) study among African-American, Puerto Rican and White caregivers who were part of the Springfield Elder Project in Springfield, Massachusetts found that caregivers provided care to the elderly due to a sense of responsibility and obligation. Similar findings have been found in other developed countries. In the United Kingdom, a qualitative study by McGarry and Arthur (2001) in Leicestershire among 14 older caregivers (75 years and older) revealed that older caregivers viewed their caregiving role as a duty and obligation.

¹ The Massachusetts Elder Health Project is a longitudinal study of older people residing in Massachusetts.

Studies in sub-Saharan Africa have reported similar motivations for providing care to the elderly. For example, a quantitative study by Abdulraheem (2005) to examine the opinions of 426 caregivers in Ilorin metropolis, Nigeria found that tradition/customary obligation, religious teaching and personal feeling were primary reasons for providing care to the elderly. In Ghana, qualitative studies by van der Geest (1997a, 2002) in Kwahu, a rural community, found that adult children provided care to their parents because of their past deeds. He further explained that the decision of adult children to care for their elderly parents is based on „conditionality“ of filial responsibility. Elderly parents who fulfilled their parental duties in the past were assured of care in their old age. However, elderly parents who neglected their parental care were not guaranteed care in their old age. The „conditionality“ of filial responsibility to parents has been confirmed by other studies (Aboderin, 2004a, 2005; Apt, 1993).

Studies have documented that caregivers sometimes provide care because they had no choice and they feared being stigmatized as not providing care. For example, Abel and Nelson (1990) indicated that some caregivers provide care due to fear of the stigma associated with not providing care to a care recipient. Similarly, Fisher and Tronto (1990) reported that caregivers sometimes provide care because they had no choice. For example, a qualitative study by Dellmann-Jenkins et al. (2000) in the United States found that caregivers provided care to their elderly relatives because there was no one else available to care for them.

Research has established that there is a hierarchy of preference for who provides care to the elderly. Some empirical studies argued that traditionally when an elderly is married, his/her spouse is expected to be the first to provide care (Lin, Fee, & Wu, 2012; van der Geest, 2002). A possible explanation is that societal norms about spousal responsibility and reciprocity expect

spouses to be the first port of call when their partners need care since they mostly live with them. In Spain, a study by del-Pino-Casado et al., (2011) among caregivers of older persons revealed that obligation and reciprocity were higher among spouses than other types of caregivers.

In the absence of spouses, adult children are expected to provide care for their elderly parents (Lin, Fee, & Wu, 2012; van der Geest, 2002). Adult children are obliged to provide care to the elderly parents due to reciprocity (Aboderin, 2004a; van der Geest, 2002). In a situation where the elderly have more than one child, caregiving roles and responsibilities are usually shared among children of the elderly (Wolf et al., 1997).

In the absence of children, a relative is expected to provide care to the elderly (Sackey, 2009; van der Geest, 2002). Shaibu and Wallhagen (2002) indicated that in Botswana, intimate physical care is the sole responsibility of family members, preferably adult children. It is worth noting that decision about care arrangements for the elderly is a collective decision by the family rather than an individual decision (Wolf et al., 1997). In the absence of relatives, friends and neighbours may perform caregiving duties and responsibilities (Quinn, Clare, & Woods, 2010).

2.5 Negative experiences of caregiving

Studies on family caregiving have established that family caregiving to the elderly can be stressful and consequently lead to negative health consequences (Haley & Perkins, 2004; Lin, Chen, & Li, 2013). Studies in the United States and Asia have documented poorer physical and mental health among family caregivers of the elderly. For instance, in the United States, a qualitative study among 7 paid caregivers and 13 family caregivers of older Latinos by Carrion and Nedjat-Haiem (2013) revealed that family caregivers disproportionately experienced poorer

physical and emotional outcomes compared to paid caregivers. Similarly, a quantitative study by Ho et al., (2009) examining the impact of family caregiving on the quality of life and health of 246 caregivers and matched 492 non-caregiver of the elderly in Hong Kong revealed that family caregivers reported weight loss, poorer quality of life, and poorer physical and psychological health compared to non-caregivers. They also found that female caregivers reported poorer physical and psychological health compared to male caregivers. In addition, a study by Rafnsson, Shankar, and Steptoe (2015) using the English Longitudinal Study of Ageing² to investigate the impact of family caregiving transitions on emotional well-being among 6571 caregivers found that caregivers who continued to provide care reported lower levels of life satisfaction and higher levels of depression compared to non-caregivers. In addition, spousal/child caregivers reported poorer quality of life compared to non-caregivers.

Johnson and Sasso's (2006) study using the Health and Retirement Study³ to examine the impact of elderly care on labour supply found that providing care to parents reduced female labour force supply. Women who provided care to their parents for about 900 hours per year reduced their annual labour supply by 41 percent. In India, a study by Prasad and Rani (2007) among 300 family caregivers of the elderly in Visakhapatnam district, Andhra Pradesh found that female caregivers disproportionately experienced poorer health, restraint on social interaction, disruption of schedule and financial strain compared to male caregivers.

² The English Longitudinal Study of Ageing is a longitudinal study of ageing and quality of life of elderly aged 50 years and above.

³ The Health and Retirement Study is a longitudinal study funded by the National Institute on Aging.

Furthermore, studies by Capistrant et al., (2012) and Capistrant, Moon, and Glymour (2012) in the United States among spousal caregivers who had no cardiovascular disease or hypertension at the onset of the study and were followed for 8 years revealed that caregivers who provided care for 14 hours or more per week for 2 years or more doubled their risk of developing cardiovascular disease and increased their risk of developing hypertension respectively.

Drummond et al.'s (2013) study among female spousal caregivers providing care to their elderly partners in Canada revealed that caregiving roles and responsibilities had a negative impact on their sexuality and intimacy. Female spousal caregivers reported that their sexual and intimate life was no longer a priority for them due to their caregiving responsibilities.

Moreover, a study by Dellmann-Jenkins et al. (2000) among adult children and grandchildren providing care to the elderly in the United States revealed that caregivers (adult children and grandchildren) experienced difficulty establishing and/or maintain dating relationship due to their caregiving roles and responsibilities. In Hong Kong, a study by Wong (2005) among caregivers of the elderly revealed that caregivers reported a feeling of inappropriateness and embarrassment in the provision of intimate personal care such as bathing, dressing and toileting.

In Ghana, a study by Sanuade and Boatemaa (2015) using the second wave of the World Health Organization Survey on Global Ageing and Adult Health⁴ found that family caregivers experienced financial strain and lost income due to their caregiving roles and responsibilities.

⁴ The World Health Organization Survey on Global Ageing and Adult Health is a longitudinal study among the elderly aged 50 years and above.

Studies have demonstrated that family caregiving can result in conflicts in relationships (Ahmad, 2012; Ross-Sheriff & Swigonski, 2009). For example, a qualitative study by Sackey (2009) among family caregivers of the seriously sick in Cape Coast and Accra revealed a spousal caregiver (who cared for her parents and sick husband) experienced tension in her relationship with her in-laws due to the fact that she was caring for her parents while at the same time caring for her sick husband.

Research has established that characteristics of caregivers and their care recipients can influence the negative outcomes of family caregiving. These characteristics are largely socio-demographic and they have been identified in studies mainly conducted in developed countries.

Studies have established that the age of caregiver can influence the negative outcomes of caregiving. For instance, in the United States, a study by Dorfman, Holmes, and Berlin (1996) among wife caregivers providing care to their frail elderly husbands found that there is an inverse relationship between caregivers age and their level of strain. In other words, as the age of the caregivers increases, their level of strain also decreases. Similarly, in Nigeria, a study by Okoye and Asa (2011) among family caregivers of elderly relatives found that younger caregivers experience more stress compared to older caregivers. An explanation for younger caregivers disproportionately experiencing higher negative outcomes of caregiving is that younger caregivers have numerous issues to deal with in their lives and engaging in caregiving roles and responsibilities may limit their engagement in other activities which may interest them. Another explanation for this finding is that older caregivers may have engaged in family caregiving for a longer duration and may have developed a better coping strategy compared to younger caregivers (Okoye & Asa, 2011). However, some studies have documented that older

caregivers experience more negative outcome of caregiving compared to younger caregivers. In India, a study by Prasad and Rani (2007) among family caregivers to the elderly found that there is a positive correlation between caregiver's age and their level of burden. In other words, as the age of caregivers increases, their level of burden also increases. Similarly, a systematic review by Schoenmakers, Buntinx, and Delepeleire (2010) on factors influencing the impact of caregiving on the elderly revealed that older caregivers reported more depression compared to younger caregivers due to their own physical disability.

The impacts of family caregiving on caregivers differ depending on the sex of the caregiver. Gräsel (1995) indicated that caregiving influenced female caregivers differently from male caregivers. Generally, studies on family caregiving have found that female caregivers experience more negative outcomes of caregiving compared to male caregivers (Ho et al., 2009; Schoenmakers et al., 2010). For example, in the United States, a study by Rote, Angel, and Markides (2015) among caregivers of elderly Mexican-Americans found that female caregivers reported more depressive symptoms compared with their male counterparts. A study by Ahmad (2012) among caregivers of chronically ill elderly family members in Lahore (Pakistan) revealed that female caregivers experienced more burden compared to male caregivers. Similarly, Prasad and Rani's (2007) study among family caregivers in rural India found that female caregivers reported higher caregiver burden and stress than male caregivers. An explanation for higher levels of burden and stress among female caregivers is that women perform most of the caregiving roles and responsibilities compared to men (Prasad & Rani, 2007). Another explanation is that women perform caregiving tasks each and every single day while male caregivers usually choose caregiving tasks that can be performed at their own convenience (Abel, 1990).

However, other researchers have reported that male caregivers experienced more negative outcomes of caregiving compared to female caregivers. For example, a study by Okoye (2012) among family caregivers to elderly parents in Nigeria reported that male caregivers are more likely to perceive caregiving as burden compared to female caregivers. Similarly, a study by Wang et al., (2011) among family caregivers of older people with dementia in Taiwan revealed that male caregivers experienced more role strain compared to female caregivers.

The quality of the relationship between caregiver and care recipient is an essential factor that influences the negative outcomes of caregiving. Studies in North America, Europe and Asia have documented that poor quality of the relationship between family caregivers and their elderly care recipients“ impacts negatively on the outcomes of caregiving. For example, in the United States, a study by Yeh and Bull (2012) among family caregivers of older people with congestive heart failure found that poor quality of the relationship between caregivers and their care recipients was a significant predictor of caregiver burden. Similarly, Lyonette and Yardley“s (2003) study among female caregivers of the elderly in the United Kingdom reported that caregivers who had a poor quality of the relationship with their care recipients experienced more caregiver stress. In Taiwan, a study by Wang et al., (2011) among adult children providing care to their elderly parents revealed that caregivers who had a poor relationship with their care recipients (less mutuality) experienced more role strain. Another study in Taiwan by Lin, Chen, & Li (2013) among adult children providing care to elderly parents found that better parent-child relationship satisfaction moderated caregiver burden and depression.

Studies have also identified the educational level of the caregiver as an essential factor influencing outcomes of caregiving. In Taiwan, Wang et al.“s (2011) study among family

caregivers found that caregivers with lower educational level significantly experienced more role strain compared to caregivers with higher educational level. Similarly, a study by Okoye and Asa (2011) among family caregivers in Nigeria reported that caregivers with lower educational level experienced more caregiver stress. An explanation for this finding is that caregivers with lower educational level may assume more caregiving roles and responsibilities, especially providing physical care compared to caregivers with higher educational level. However, a study by Rezende, Coimbra, Costallat, and Coimbra (2010) among family caregivers of disabled elderly in Brazil found that there is a positive relationship between the educational level of caregivers and their level of burden. In other words, as the educational level of caregivers increases, their level of burden also increases and vice versa.

There is evidence that employment status of caregivers is linked to their caregiving outcomes. Studies in Asia have established that employed caregivers experience more negative outcomes. For example, in Pakistan, a study by Ahmad (2012) found that employed caregivers reported more stress compared to unemployed caregivers. Similarly, a study by Wang et al., (2011) in Taiwan found that family caregivers who were employed full-time reported more role strain compared to those employed part-time or were unemployed. An explanation for this finding is that employed caregivers must perform their work demands in addition to their caregiving roles and responsibilities and these two roles may be incompatible.

However, a study by Saunders (2010) among employed and unemployed caregivers in the United States found that employed caregivers reported better well-being compared to unemployed caregivers. Saunders (2010) stated that employed caregivers reported better well-being because they are more likely to share their caregiving roles and responsibilities with others

compared to unemployed caregivers who may be solely responsible for the care of their care recipients.

Studies in South America and Asia have linked length/duration of caregiving to negative outcomes of caregiving. In Brazil, a study by Rezende et al. (2010) among caregivers of disabled elderly found that the duration of caregiving is positively related to burden. Wang et al.'s (2011) study in Taiwan reported that caregivers who spent more time providing care to the elderly per day experienced more role strain. Similarly, a study among primary caregivers of the elderly in Saudi Arabia by Alshehri, Alohal, and Almutairi (2017) reported that longer hours of caregiving was positively associated with caregivers burden.

The literature on family caregiving has established that care recipient characteristics can negatively impact the outcomes of caregiving (such as stress, burden, and distress). Studies have found that care recipient's demographic characteristics (such as age, sex and educational level) (Goldzweig et al., 2013; Okoye & Asa, 2011), care recipients cognitive impairment (Othman et al., 2014; Tamanini et al., 2011), care recipients physical disability/functional impairment (Dorfman et al., 1996; Othman et al., 2014), care recipients level of dependency (Rezende et al., 2010; Yeh & Bull, 2012), care recipients behavioural problems (Chappell & Reid, 2002; Lin, Fee & Wu, 2012), and care recipients depression status (Rezende et al., 2010; Rote et al., 2015) are associated with negative outcomes of caregiving.

2.6 Mediators of the negative impact of caregiving

2.6.1 Social support

Studies have identified social support and coping strategies as essential factors for mitigating the negative outcomes of caregiving. Shumaker and Brownell (1984, p. 13 cited in Zimet et al., 1988) define social support as “an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient”. Social support can be derived from formal sources and informal sources.

Studies on social support have documented that caregivers receive social support from both formal sources (hospitals and clinics, health workers, and support groups) and informal sources (such as care recipient, relatives, spouse, non-relatives, and church) (Carrion & Nedjat-Haiem, 2013; Dellmann-Jenkins et al., 2000). In the United States, a study by Garner and Faucher (2014) among family caregivers of older persons found that caregivers sources of social support include; family, friends, perceived help and support from God, counting blessings and being selfless, healthcare providers, and sharing memories. Another study in the United States by Walker, Pratt, and Oppy (1992) among adult daughters caring for their elderly mothers found that elderly mothers gave love, information, advice and money to their adult daughters caring for them in exchange for the care received from them.

Studies have established that social support mitigates the negative impacts of family caregiving (Losada et al., 2010; Lin, Chen, & Li, 2013). For instance, Yeh and Bull’s (2012) study among family caregivers of older people with congestive heart failure in the United States found that lack of family support was a significant predictor of caregiver burden. Another study in the United States by Calderon and Tennstedt (1998) among family caregivers of the elderly

found that caregivers who received social support from friends and families reported that the support they received helped them to reduce their caregiving-related difficulties. Similarly, a study by Choi and Sok (2012) among family caregivers of older adults in Korea found that caregivers with higher family support reported lower caregiver burden and burnout.

2.6.2 Coping strategies

Coping strategies refer to “the specific efforts, both behavioural and psychological, that people use to tolerate, reduce, or minimise stressful events” (Taylor & Psychosocial Working Group, 1998). The literature on coping has classified coping strategies into problem-solving and emotion-focused strategies, and active and avoidant coping strategies. On one hand, problem-solving strategies involves actively doing something to mitigate stressful situations while emotion-focused strategies involve regulating the emotional consequences of stressful situations (Taylor & Psychosocial Working Group, 1998). On the other hand, active coping strategies refers to behavioural or psychological reactions that alters the nature of a stressor or how one perceives it, while avoidant coping strategies influence individuals to engage in activities or mental states to cope with their stress rather than tackling their stressful situations directly (Taylor & Psychosocial Working Group, 1998).

Research has established that coping has three main functions namely: to manage the situation from which the stressors arise, to manage the meaning of situation such that its threats are reduced, and to manage the stress symptoms (Pearlin, 1989; Pearlin, Mullan, Semple, & Skaff, 1990). Caregivers utilise different strategies to cope with their caregiving roles and responsibilities. Studies in North and South America have found that caregivers employed religious and spiritual strategies to cope with their caregiving challenges. For example, a study

by Vroman and Morency (2011) among family caregivers of the elderly in Belize reported that believing in God and participating in religious activities were the strategies family caregivers used to cope with their caregiving challenges. Dilworth-Anderson et al.'s (2002) review of the literature on family caregiving between 1980 and 2000 found that religion, having faith in God, and praying were the strategies used by family caregivers to cope with their caregiving challenges. Similarly, Dellmann-Jenkins et al.'s (2000) study among family caregivers of older relatives in the United States found that caregivers used their faith as a source of strength to cope with their caregiving difficulties.

Strategies such as perceiving caregiving as a blessing and acknowledgement of caregivers' efforts by significant others also helped caregivers to cope with difficulties. A qualitative study by Bennett, Sheridan, and Richardson (2014) among family caregivers of the elderly in the United States found that perceiving family caregiving as a blessing helped caregivers to cope with their caregiving challenges. Thornton and Hopp's (2011) study among daughters caring for their elderly parents with heart failure in the United States found that the recognition caregivers received from significant others in their community enabled them to cope with their caregiving difficulties.

Other caregivers used strategies such as denial, relaxation, and considering challenges as irrelevant to cope with their caregiving difficulties. In Canada, a qualitative study by Drummond et al. (2013) among spousal caregivers found that caregiving roles and responsibilities affected the sexuality and intimacy of caregivers, and they coped by conceptualising their sexual and intimate lives as "irrelevant". Calderon and Tennstedt's (1998) study among African-American,

Puerto Rican and White caregivers in the United States found that caregivers coped with caregiving burden by denying their caregiving situation.

In Thailand, a study by Subgranon and Lund (2000) among family caregivers caring for elderly relatives with stroke found that caregivers employed relaxation techniques to cope with their caregiving challenges.

2.7 Positive experiences of caregiving

Although studies on family caregiving mostly focused on the negative aspects of caregiving, some scholars have examined the positive aspects of caregiving (Cartwright et al., 1994; Cohen et al., 2002; López et al., 2005).

Studies have established that caregivers acquire personal gratification (Carrion & Nedjat-Haiem, 2013; Gonyea et al., 2008; Lin et al., 2012; Prasad & Rani, 2007; Sheehan & Donorfio, 1999; Shim et al., 2012), and personal growth (Sheehan & Donorfio, 1999) in the provision of care to their elderly care recipients. In the United States, a study by Dellmann-Jenkins et al. (2000) among 22 adult children and 21 grandchildren caregivers of older relatives found that the benefits caregivers derived from family caregiving include; enhanced self-respect, positive lasting memories, improved relationship with their care recipients, and financial assistance from their care recipients. Similarly, Noonan et al.'s (1996) study among 48 caregivers of frail elderly in the United States found that caregivers expressed gratification and satisfaction with their caregiving roles. In addition, caregivers reported that they experienced personal growth, improved relationship with their elderly care recipients, and enjoyed the company and friendship of their elderly care recipients.

Spillman et al.'s (2014) study using the data from the 2011 National Study of Caregiving (NSOC)⁵ found that caregiving improved the relationship between caregivers and their elderly care recipients. They also reported that caregiving taught caregivers how to deal with difficult situations.

Studies on daughter caregivers have documented that the provision of care by daughters to their mothers strengthens mother-daughter bond. For example, a study by Thornton and Hopp (2011) among daughters caring for their elderly parents with heart failure reported that caregiving has strengthened their relationship with their parents. Walker et al.'s (1990) study among daughter caregivers of their elderly mothers in Oregon, United States revealed that half of the caregivers reported that caregiving had a positive impact on their relationship with their elderly mothers. Similarly, a study by Abel (1990) among daughter caregivers found that caregiving improved the intimate contact between daughters and their elderly mothers.

In addition, studies on spousal caregivers have documented that spousal caregivers experience positive outcomes of family caregiving. For instance, Freedman et al.'s (2014) study using data from the 2009 Disability and Use of Time (DUST)⁶ among spousal caregivers in the United States found that wives who provided care to their partners with a disability reported a higher level of happiness compared to females who performed household chores. Using data from the wave 1 and 2 of the Cardiovascular Health Study (CHS)⁷, Beach et al.'s (2000) study

⁵ National Study of Caregiving (NSOC) is a national representative longitudinal study of the elderly aged 65 years and older and their family caregivers in the United States.

⁶ Disability and Use of Time (DUST) was a supplement study conducted among couples drawn from the 2009 Panel Study of Income Dynamics (PSID) study in the United States

⁷ Cardiovascular Health Study (CHS) is longitudinal study of the elderly aged 65 years and older in four American communities namely Forsyth County, Sacramento County, Washington County and Pittsburgh

among spousal caregivers providing care to their disabled partners found that increase in the level of help provided to a partner reduced depression and anxiety. Similarly, Brown et al. (2009) using data from wave 1, 2, 3 and 4 of the Asset and Health Dynamics among the oldest-old (AHEAD)⁸ found that spousal caregivers who provided care to their partners for 14 hours or more per week reported reduced mortality risk.

Moreover, an analysis of six (6) population-based studies by Roth, Fredman, and Haley (2015) found that family caregivers lived longer and experienced reduced mortality compared to non-caregivers. A meta-analysis by Pinquart and Sörensen (2004) among family caregivers of older adults revealed that positive aspects of caregiving, such as uplifts, were positively associated with subjective well-being while negatively associated with depressive symptoms.

Furthermore, a study by Tarlow et al. (2004) among family caregivers providing care to persons with dementia found that caregivers felt useful and good about themselves, learnt new skills, appreciated life more, and enhanced their relationship with care recipients and other relatives as a result of caring for their care recipients.

Finally, Vroman and Morency's (2011) study among family caregivers of the elderly in Belize found that caregivers felt special and privileged to provide care to their care recipients. In addition, caregivers reported that they felt proud that they could provide care to their care recipients.

⁸ Asset and Health Dynamics among the oldest old (AHEAD) is a national representative longitudinal study of the elderly aged 70 years and older in the United States

2.8 Elderly care recipients perception on personal care

Studies in developed countries such as the United States and Sweden have demonstrated that elderly care recipients sometimes expressed concerns with personal care since they perceived those care or assistance as loss of their autonomy and their privacy. A possible explanation for such concern is that the elderly link their independence with their autonomy (Crist, 2005). For example, in the United States, studies by Roe, Whattam, Young, and Dimond (2001a, 2001b) among 20 elderly receiving paid care and family care found that some elderly care recipients expressed concerns about receiving assistance with personal care (such as bathing) due to loss of independence and intrusion of privacy. In addition, Roe et al. (2001b) found that elderly care recipients who needed a low level of care were glad to accept assistance while elderly care recipients who needed a high level of care found it difficult to accept assistance.

Similarly, a study by Birgersson et al. (1993) among elderly women in Sweden who had urinary incontinence reported that elderly women expressed concern about assistance by nurses to change their napkins due to loss of autonomy. Conversely, Crist's (2005) study among elderly care recipients in the United States reported that elderly care recipients felt autonomous although they were receiving assistance.

It is worth noting that there is a gender difference in the acceptance of care. Roe et al.'s (2001b) study among the 20 elderly receiving paid care and family care in the United States reported that while elderly men were reasonable in asking for and accepting personal care, elderly women felt unease receiving personal care (such as bathing and dressing) due to intimacy and nudity.

Elderly care recipients sometimes perceived themselves as a burden to their household. A study by Parsons, Cox, and Kimboko (1989) among 33 elderly care recipients in Colorado, United States found that care recipients felt they were a burden to their household and as a result, they hid their troubles and feelings.

2.9 The Ga people

The Ga are traditionally the people of Accra, and they speak Ga language which belongs to the Kwa language of the Niger-Congo language family (Greenberg, 1966; Robertson, 1983). The Ga people reside in coastal towns and inland villages in Accra Plains. There are various accounts about the origin of the Ga people by various scholars. Some scholars are of the view that the Ga people migrated from Benin (Field, 1940; Henderson-Quartey, 2002; Reindorf, 2007), while others reported that they migrated from Egypt (Amartey, 1991) and moved along the Ubangi River to Congo, then through the Niger Delta Basin to Nigeria, Benin, Togo and before finally to Greater Accra in Ghana. The land area occupied by Ga people is bordered on the North by Akuapem Mountains, on the South by the Gulf of Guinea, on the East by the Tshemu lagoon and on the West by Sakumofio River (Watson-Quartey, 2011).

Traditionally, Ga women were primarily engaged in trading activities while the men were engaged in fishing and farming. However, as a result of western education, some Ga men gained some skills and were employed for clerical work (Robertson, 1977). Odotei (1991) grouped the Ga into six main States namely Ga Mashie, Osu, La, Teshie, Nungua and Tema. According to the 2010 Population and Housing Census, the Ga constitute 27.4 percent of the population in Greater Accra and 7.4 percent of the population in Ghana (Ghana Statistical Service (GSS), 2013b, 2013c).

It is worth noting that Ga Mashie which is the study area for this study have seven quarters namely Abola, Akumadze, Asere, Gbese, Ngleshie Alata, Sempe, and Otublohum. Kilson (1974) asserted that Asere, Akumadze, Gbese, and Sempe were founded by Ga indigenes while Abola, Ngleshie Alata, and Otublohum were founded by migrants.

2.9.1 Kinship of the Ga

Kinship is the foundation for the organisation of social groups and relationships in the society. Nukunya (2016, p. 21) defines kinship as “social relationships derived from consanguinity, marriage and adoption”. These social relationships are overseen by patterns of behaviour, duties and responsibilities, among others. Among the Ga, kinship is associated with concepts of blood, age and sex, and these concepts play vital roles in the Ga society (Kilson, 1974). Blood which means „*Ja*” in Ga is an important social symbol and it is conceptualised as a quantitative substance and in terms of density. The Ga are of the view that a Ga is related by blood to both paternal and maternal grandparents and through them to their kin. However, Kilson (1974) acknowledged that a Ga believe that he/she obtains a greater proportion of his/her blood from the father’s line than the mother’s line. Thus, descent in the Ga society is cognatic with emphasis on the father’s line. Regarding the conceptualisation of blood in terms of density, a child physically resembles the parent who has the „thickest” blood.

Age is another important concept in Ga society. Traditionally, seniority in social status depends on how old one is. In Ga society, age is associated with authority in social groups and consequently, older persons occupy positions with greater authority in social groups which they belong (Kilson, 1974).

Kinship is also based on the concept of sex. In Ga society, social groups are sex segregated and every male social group has its corresponding female social group. Ga families have council of men who are in charge of affairs of the males while councils of women are responsible for the females. Despite the autonomy of council of women, the council of men have control over the affairs of the family as a unit (Kilson, 1974). Therefore, men are considered superior to women in Ga society.

Apart from kinship, the concepts of blood, age and sex are also associated with inheritance, and residence patterns. Regarding inheritance, access and distribution of property is primarily based on the concept of blood, then followed by the concept of sex (Kilson, 1974). A Ga man inherits from his patrilineal kinsmen while a Ga woman inherits from the matrilineal kinwomen. As a result, a man highlights his patrilineal kin ties while a woman highlights her matrilineal kin ties (Kilson, 1974).

Among the Ga, residential arrangements are based on sex. Traditionally men and women dwell in separate houses (*wɛ*). The men dwell in male compounds (*hiiamli*) with their patrikin while the female dwell in female compounds (*yɛiamli*) with their matrikin (Azu, 1974; Field, 1940; Kilson, 1974; Nukunya, 2016). While the male compounds are dwelled by men and their son aged fifteen and older, female compounds are dwelled by women and their children (sons below the age of fifteen and daughters). The male and female compounds are usually adjacent each other and these compounds together constitute a house (*wɛ*). Reasons for this unique residential arrangement in Ga society include; the believe that menstruating women could contaminate and weaken sacred objects such as war medicine when they dwell in male compounds, to prevent women from leaking secrets and plans of their lineage to others, and to

prevent women from engaging men in quarrels (Azu, 1974; Kilson, 1974). Kalu (1981) reported that polygamous marriages were more common among Ga men and their residential arrangements enable them to continue this practice. Since husbands do not dwell in the same compounds with their wives, they are not directly exposure to conflicts from their marital relationships.

It is worth of note that when a Ga man or woman moves out of a room in the house (*wɛ*), he or she has given up their claim to the room (Azu, 1974). Although, it's only men who dwell in *hiiamli*, a wife could spend the night with her husband in his room when she is needed. Traditionally, the *hiiamli* is very important place in the Ga society since it is where lineage meetings and significant events such as outdoorings and marriage are held. Compared to *yɛiamli*, cooking activities do not occur at *hiiamli*. Children often send food to their fathers in their male compounds.

Kalu (1981) reported that societal norms prohibit females to move free in male compounds and vice versa. However, there are exceptions to this rule when there is illness, and significant traditional events such as outdoorings.

2.10 The family in the Ghanaian context

The concept of family is difficult to define due to variation in its composition and nature across societies (Nukunya, 2016). However, Nukunya (2016, p. 61) defines family as “a group of individuals related to one another by ties of consanguinity, marriage or adoption, the adult members of which are responsible for the upbringing of children”. Families can be classified into families of orientation and families of procreation. A family of orientation is the family an

individual is born into while family of procreation is the family an individual create through marriage and children are raised (Nukunya, 2016).

In Ghana, there are three main types of families namely the nuclear family, polygynous family and extended family (Gyekye, Arthur, & Dankwa, 1996; Nukunya, 2016). The nuclear family consist of a married couple and their children. Nukunya (2016) highlighted that a couple without children cannot be acknowledged as a family. Nuclear family is also known as a monogamous family.

Polygamous family consist of a man, his wives and children (polygynous) or a woman, her husbands and their children (polyandrous). Although polyandry is practiced by some societies in Asia (such as the Nayar and Tibetan) and Africa (such as the Berom, Irigwe, and Njem) (Levine & Sangree, 1980), it is not practiced among Ghanaian societies (Nukunya, 2016).

The extended family can be defined either as a residential unit or a social arrangement (Nukunya, 2016). As a residential unit, the extended family refers to “a group comprising a series of close relatives along either the male or female line, usually not along both” (Nukunya, 2016). Usually the composition of the extended family is determined by the descent system. For example, in most patrilineal societies in Ghana, a couple reside with husband’s family and the composition of the extended family is made up of the husband, his wife or wives, their never married offspring, their married sons and their offspring.

As a social arrangement, the extended family refers to “a social arrangement in which an individual has extensive reciprocal duties, obligations and responsibilities to relatives outside his immediate (nuclear) family” (Nukunya, 2016).

The functions of the family in Ghana include procreation and socialisation, among others. The family provides the socially accepted avenue to bear children. It is the duty and responsibility of parents to train their children to exhibit socially accepted behaviour. However, other relatives can assist the parents to train their children. In a nuclear family, it is the sole responsibility of parents to train their children while in extended family, other relatives assist parents to train their children. Socialisation of children is viewed as a social activity in traditional societies and consequently, it is shared by family members.

Over the past decades, the functions and structure of the family in Ghana has been transformed by demographic and modernisation processes such as migration, urbanisation, as well as increased education (Kpoor, 2015). A significant transformation of the Ghanaian family is the breakdown of the extended families which is the traditional family type in Ghana. This situation has affected the care and various forms of support provided to family members who are in need. A study by Kalu (1981) among the Ga acknowledged that urbanisation and acculturation has transformed the traditional residential arrangements of the Ga family. The author reported that the traditional family compound residential arrangements have been transformed into patrilocal nuclear residence, matrilocal kin residence, matrilocal patrilocal residence, and matrilocal residence.

2.11 Institutional care for the elderly in Africa

Across all societies in both developed and developing countries, the family plays a role in the care of the elderly. Demographic and modernisation processes (such as urbanisation, migration and monetisation of care services) have however affected family care practices, especially in sub-Saharan Africa (Aboderin, 2004a, 2004b; Apt, 1996, 2001; Badmus, Esan,

Badmus, & Arije, 2016), and consequently led to the emergence of institutions of care for the elderly and paid caregivers to complement the care provided by the family. Despite these processes, most elderly in Africa would continue to receive care and various forms of support from the family (Cattell, 1993). In Ghana, two strategies are used by the family especially in urban areas, to complement care to the elderly namely the use of distant relative and non-relatives (including domestic house helps and fostered adolescents) on one hand, and hiring a paid caregiver on the other hand (Coe, 2016, 2017, 2018; van der Geest, 2016; van der Geest et al., 2004). In both developed and developing countries, there is the coexistence of family care and institutional care for the elderly (Sijuwade, 2008). However, elderly persons and their caregivers in these countries prefer the elderly to be cared for within the family.

Generally, institutional care for the elderly is associated with developed countries. The established of institutional care for the elderly in developed countries can be traced to the 19th Century (Haber, 1977). However, studies have documented the emergence of institutional care for the elderly in developing countries such as China (Feng et al., 2011; Wu, Mao, & Xu, 2008), Nigeria (Abdulraheem, 2005; Badmus et al., 2016), South Africa (Tibbit, 1983), Zimbabwe (Tarugarira, 2015) and Ghana (Coe, 2017; van der Geest, 2016).

Despite their emergence, institutional care is viewed as “strange” in developing countries, especially in Africa where family caregiving to the elderly has been confined to the family setting. For instance, a review of literature by Mudiare (2013) in Nigeria found most Nigerians view the keeping of the elderly in institutional care as “strange”. Another study in Nigeria by Abdulraheem (2005) found that the majority (90 percent) of caregivers reported that the elderly should be cared for at home and their reasons for opting for care at home includes the elderly are

more feel comfortable at their home, it's a cultural fulfilment, adequate family support, helps spread the caregiving tasks and it is cheap. Similarly, Badmus's et al. (2016) study among 385 elderly Nigerians reported that 116 out of 385 elderly, representing 30 percent, reported that they were unwilling to retire into elderly care houses due to factors ranging from "the fear of isolation", "abandonment", "the cost involved", "inadequate care" to "it is not part of Nigerian culture to reside in elderly care houses".

In Ghana, attitudes towards institutionalisation of elderly care are mixed. For instance, a study by Sarpong (1983 cited in van der Geest et al., 2004) reported that opinion leaders denounced keeping elderly persons in institutions of care. van der Geest's (2016) study among elderly persons in Kwahu found that some elderly persons disapproved "strangers" (professionals in institutions of care) taking care of the elderly. However, the author also reported that most elderly persons approved keeping the elderly in institutions of care. Similarly, a study Coe (2018) among elderly persons in Akim, Kwahu and Akropong found that elderly persons approved keeping the elderly in institutions of care.

Manful et al.'s (2015) study among faculty members of Kwame Nkrumah University of Science Technology found that most faculty members favoured institutional care as an alternative care option for Ghanaians. However, the author also reported that some faculty members had concerns about institutional care due to the breakdown of family bonds between the elderly and their family members, the discomfort elderly would experience in order to adjust to life in the institution, stigmatization of people who send their elderly relatives to an institution of care, and fear of poor quality care by institutions of care.

According to Cattell (1993), the instructions of care for the elderly in Africa are mainly residential facilities rather than nursing homes. These instructions are often inhabited by underprivileged elderly in the society. In Ghana, institutional care for the elderly has not been considered by the government and other policymakers (Coe, 2018; Manful et al., 2015; van der Geest, 2016). However, studies have documented the establishment of a number of elderly day care centres and emergence of home nursing in Ghana, especially in urban areas (Coe, 2016; van der Geest, 2016). These institutions are operated by religious bodies, non-governmental organisations, and entrepreneurs.

Elderly persons who reside in institutions of care in Africa face several challenges. For instance, a study by Tarugarira (2015) among 7 elderly persons residing in an institutional care in Zimbabwe found that the challenges experienced by elderly persons include verbal and emotional abuse, inability to adopt to others, lack of trust in employee and other residents, lack of respect, feeling insecure at the institution, inability to accept the institution as their home, and craving for familial relations. However, the author also found that elderly persons reported positive experiences. The study found that elderly persons reported that residing in institution of care has encouraged them to manage their own affairs, made them independent, and they were content with the food, clothes and other provisions provided at the institution.

Institutions of care for the elderly in Africa also have their own challenges. For instance, a study by Tibbit (1983) in South Africa found that the challenges experienced by institutions of care for the elderly in South Africa include lack of properly trained staff to care for health needs of the elderly, shortage of beds, and lack of finance to run the institution. Similarly, Frimpong's (2015) study in Ghana found that private care homes in Accra (Adenta, Dzorwulu, Osu and

Sakumono) experienced challenges such as inadequate specialist staff, lack of finance, dispassionate staff, and lack of regulatory framework.

2.12 Policies on ageing

Policies on ageing are essential for improving the well-being of the older persons and creating an enabling environment for older persons to fully participate in societal and national development processes. This section reviewed global, regional and local policies on ageing and programmes or intervention to improve the well-being of the elderly in Ghana.

2.12.1 Global policies

Two international policies namely Vienna International Plan of Action on Ageing and Madrid International Plan of Action on Ageing are reviewed. The Vienna International Plan of Action on Ageing, adopted by the United Nations General Assembly in 1982, was the first international document on ageing and provided the framework for designing policies and programmes for ageing (United Nations, 1982). The aims of the Vienna International Plan of Action on Ageing include; strengthening the capacities of countries to deal effectively with the ageing of their population and with the special concerns and needs of their elderly and promoting an appropriate international response to issues of ageing. Its Plan of Actions is grouped under 10 thematic areas and had 62 recommendations. However, 7 out of the 10 themes concerned ageing persons, namely health and nutrition, protection of elderly consumers, housing and environment, family, social welfare, income security and employment, and education.

The Madrid International Plan of Action on Ageing was the second international document on ageing held in Madrid from 8 to 12 April 2002 (United Nations, 2002). The aim of

the Madrid International Plan of Action is to ensure that persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights. Its Plan of Actions is grouped under 3 thematic areas and had more than 100 recommendations. The three thematic areas were older people and development, advancing health and well-being into old age, and ensuring enabling and supportive environment.

2.12.2 Regional policy

Africa as a continent has adopted the African Union Policy Framework and Plan of Action on Ageing. The African Union Policy Framework and Plan of Action on Ageing were adopted in 2002 by the Assembly of Heads of States and Government. The goal of the policy framework and plan of action is to serve as a framework to guide member states in designing, implementing, monitoring and evaluating appropriate integrated national policies and programmes to meet the individual and collective needs of older people (HelpAge International Africa Regional Development Centre, 2002). The Policy Framework had 13 thematic areas and 29 recommendations. The thematic areas of the Policy Framework include rights, poverty, health, food and nutrition, housing and living environments, family, social welfare, ageing and migration, and gender.

2.12.3 Ghana policies and programmes for the elderly

Ghana approved its National Ageing Policy in July 2010. It was a revision of the draft National Ageing Policy prepared in 2002 (Ministry of Employment and Social Welfare (MESW), 2010). The overall goal of the National Ageing Policy is to achieve the social, economic and cultural reintegration of older persons into mainstream society, to enable them as

far as practicable to participate fully in the national development process. The strategies of the policy were grouped under 11 thematic areas such as rights of older persons, poverty, health and nutrition, housing and living environment, family, income security and social welfare, and gender. The Ghana National Ageing Policy was embedded in the Madrid International Plan of Action on Ageing and the African Union Policy Framework and Plan of Action on Ageing.

The National Ageing Policy recognised the family as the primary caregiver for elderly persons and acknowledged that migration and urbanisation have weakened the traditional role of the family in providing care and support to the elderly in Ghana. However, the National Ageing Policy did not acknowledge the emergence of nursing home and paid caregivers who complement the care provided by the family. There is a need to recognise the emergence of nursing home and paid caregivers.

Ghana also has implemented a number of social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and National Health Insurance Scheme (NHIS) to improve the well-being of the elderly in the country. LEAP is a social cash transfer programme which provides cash and health insurance to extremely poor households across Ghana (Handa et al., 2013). LEAP was piloted in March 2008 and as at 2015, about 145,895 households has benefited from the programme (Alidu et al., 2016). The eligibility into the programme is based on poverty and a household member must fall under any of these three categories: having an orphan or vulnerable child, elderly poor aged 65 years and older, or a member with extreme disability who cannot work. Elderly persons who are beneficiaries of LEAP enjoy free access to healthcare under the NHIS.

NHIS was established by the Government of Ghana in 2003 with the aim of providing all Ghanaians access to healthcare without paying at the point of use (Akazili et al., 2014). NHIS is a nationwide programme and the benefit package is standardised across the country (Nguyen, Rajkotia, & Wang, 2011). NHIS covers a wide range of outpatient and inpatient services including diabetes, hypertension, treatment of cervical and breast cancer, malaria, eye care, and oral health services, among others. Under the NHIS, an adult must pay an annual premium to access these benefit packages. However, Social Security and National Insurance Trust (SSNIT) contributors, SSNIT pensioners, elderly persons aged 70 and older, children under 18 years are exempted from paying an annual premium.

2.13 Theoretical framework

Several theories have been used to understand the experiences of family caregivers and their elderly care recipients. These theories include role theory, social exchange theory and stress process model.

2.13.1 Role theory

Role theory uses the “theatre” as a metaphor to explain human behaviour (Biddle, 1986; Solomon, Surprenant, Czepiel, & Gutman, 1985). According to Allen and Van de Vliert (1984) role refers to “behaviour referring to normative expectations associated with a position in a social system” (p. 3). A central concept in role theory is position. Each position an individual occupies in the social system has expectations of what one ought to do or to be (Allen & Van de Vliert, 1984). Role theory postulates that expectations are learned through experiences and occupants of these positions are aware of the expectations associated with their roles (Biddle, 1986). Other

essential concepts associated with role theory include role conflict and role overload. Role conflict occurs when an individual role expectations become incompatible while role overload occurs when an individual has to cope with too many expectations (Biddle, 1986).

Role theory has been criticised because it overemphasizes social conformity, and it does not adequately address human agency and structural constraints (Biddle, 1986; Jackson, 1998). However, role theory can be used to study the experiences of family caregivers and their elderly care recipients. Family caregivers who are often women engage in multiple roles. Research has established that family caregivers have to combine competing demands of their caregiving roles and their other roles as employees, parents and spouses (Shaibu & Wallhagen, 2002; Stephens, Townsend, Martire, & Druley, 2001). Family caregivers experience difficulty in meeting the expectations of these competing roles and this may lead to negative experiences due to role conflict. Thus, their multiple roles could result in role conflicts. In addition, lack of resources to support the family caregiver in their caregiving roles and responsibilities can also result in role overload and may lead to negative experiences.

2.13.2 Social exchange theory

Social exchange is defined as “voluntary actions of individuals that are motivated by the returns they are expected to bring and typically do in fact bring from others” (Blau, 1964, p. 91 cited in Cook & Rice, 2003). Social exchange theory postulates that humans behave rationally (Homans, 1961). In addition, social exchange theory involves the exchange of costs and rewards which could be tangible and intangible and the behaviour of an individual is based on analysis of the costs and benefits (Gefen & Ridings, 2002; Homans, 1961; Liao, 2008). Individuals as

rational beings take actions to maximize their rewards or minimise their costs (Hsu & Shyu, 2003).

Social exchange theory states that an individual will engage in social relations when he/she expects rewards from the social relations (Blau, 1994; Gefen & Ridings, 2002; Liao, 2008). Cook and Rice (2003) viewed social exchange as the basis of social relations between groups and individuals. The pioneers of social exchange include George Homans, Peter Blau, John Thibaut, Harold Kelley, and Richard Emerson (Lambe, Wittmann, & Spekman, 2001).

Social exchange theory has been used in disciplines such as economics, sociology, anthropology and social psychology (Cropanzano & Mitchell, 2005; Zafirovski, 2005). Social exchange theory has been criticised because it does not capture cultural context and cultural differences in social norms, and it creates the misconception that human beings are self-centred and reward-seeking (Zafirovski, 2005).

Social exchange theory can be utilised in the study of the experiences of family caregivers and their elderly care recipients. Family caregivers have different goals or expectations for assuming their caregiving roles and responsibilities. Family caregivers who provide care to the elderly may expect social, material or psychological benefits in return.

In addition, according to social exchange theory, costs and rewards of dyadic relationships should be examined separately (Raschick & Ingersoll-Dayton, 2004). This distinction between costs and rewards is relevant for understanding the experiences of family caregivers and their elderly care recipients. The costs of family caregiving to the caregiver

include poorer health, quitting of job and loss of income while the rewards of family caregiving to the elderly include enhanced self-esteem, personal growth, and material gifts.

2.13.3 Stress process model

Stress process model helps to explain the stress associated with caregiving (Carretero et al., 2009). Pearlin's stress process involves four components, namely the background and context of caregiving, the stressors, the mediators of stress, and the outcomes of stress (Pearlin et al., 1990). Stress process model emphasises the relationships between these components. Stress process is influenced by background and context of caregiving such as caregiver's characteristics and caregiving history (Bastawrous, 2013; Carretero et al., 2009; Pearlin, 1989).

The background and context of caregiving determine the stressors that caregivers are exposed to, the mediators they are able to organize and the stress they may experience (Pearlin, 1989). A stressor refers to the condition, experience and activity that give rise to stress. The stressors can be classified as primary and secondary. Primary stressors are the needs and demands of the care recipients such as cognitive status, problematic behaviour, and daily dependencies (Pearlin et al., 1990). These needs and demands of the care recipients lead to other problems and challenges referred to as secondary stressors such as family conflicts, difficulties at work (occupational strain) and financial difficulties (economic strain). Thus, secondary stressors are regarded as the consequences of primary stressors (Pearlin, 1989).

The mediators of stress buffer the effects of the stressors on the outcomes of stress such as depression, anxiety and burden (Bastawrous, 2013; Carretero et al., 2009; Pearlin, 1989). Research has identified coping strategies and social support as important factors (variables) that

can mitigate the stress and negative outcomes associated with family caregiving (Bastawrous, 2013; Conde-Sala et al., 2010). The stress process model has been criticised because it is challenging to label the factors that determine stress, and primary and secondary appraisals dependent on each other.

Stress process model can be applied to the study of the experiences of family caregivers and their elderly care recipients. The characteristics of caregivers (such as their sex, marital status, and employment status) and the needs and demands of the care recipients can lead to negative caregiving experiences such as burden and depression. In addition, the social support family caregivers receive from their relatives and non-relatives, and their coping strategies can mitigate their negative experiences.

2.14 Conceptual framework

The conceptual framework for the present study is a modified version of the caregiver adaptation model proposed by Kramer (1997). The caregiver adaptation model proposed by Kramer (1997) postulate that the adaption process consists of three components, namely background and context of caregiving, intervening processes and well-being outcomes (See Figure 2.1). The caregiver adaptation model is an integrated framework which synthesis different theoretical and conceptual frameworks such as stress theories (including stress process model), role theory and social exchange theory.

The caregiver adaptation model proposed by Kramer (1997) was modified based on a review of the literature for a better understanding of the experiences of family caregivers and elderly care recipients. This study was influenced by the three components (background and

context of caregiving, intervening processes and well-being outcomes) of the caregiver adaptation model. The conceptual framework for this study measured these components qualitatively. Figure 2.2 indicates the conceptual framework for this study.

The conceptual framework shows that the outcomes of caregiving are directly influenced by the background and context of caregiving and indirectly influenced through resources (intervening processes). The background and context of caregiving are made up of three components, namely care receiver characteristics, caregiver motivations for providing care, and caregiver characteristics. Elderly care recipient characteristics include sex, age, ethnicity, and needs (assistance they receive from their caregivers), among others while caregivers characteristics also include age, sex, employment status, and duration of caregiving, among others.

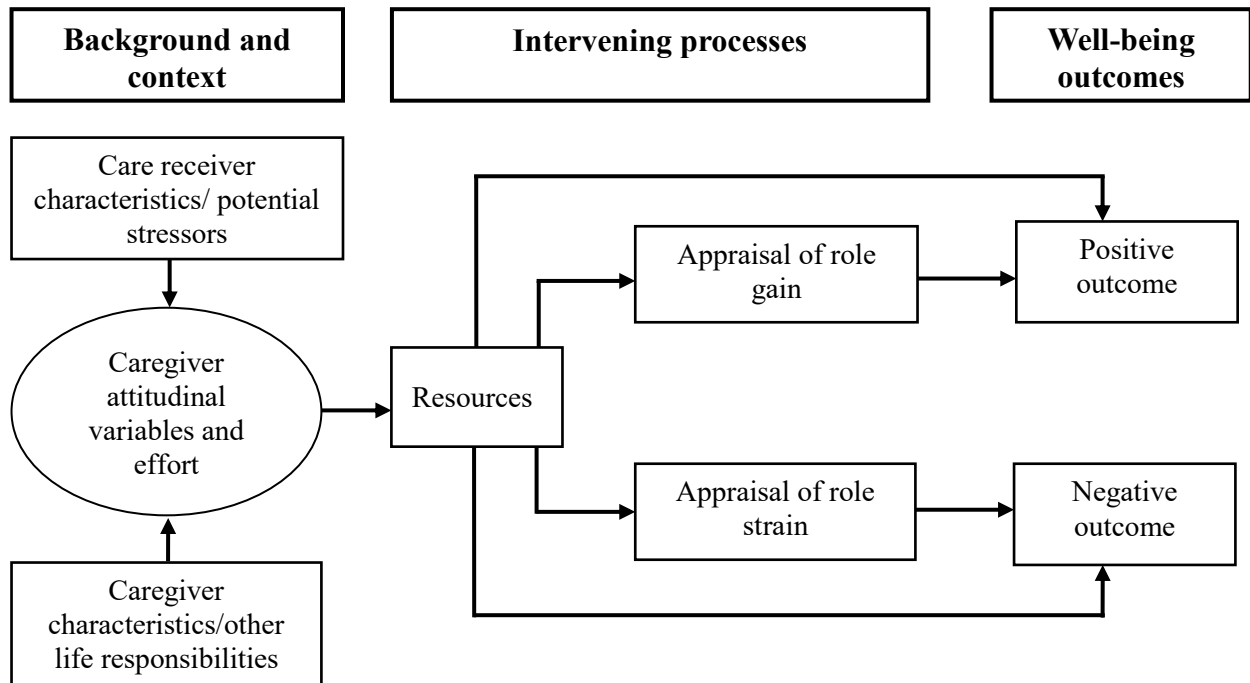
The current study conceptualised that the elderly care recipient characteristics (such as age, sex, and functional limitation) will influence who becomes a caregiver (caregiver characteristics). Caregiver characteristics and care recipient characteristics influence caregiver motivations for providing care. Folkman and Lazarus (1988 cited in Kramer, 1997) reported that attitudinal variables (such as motivations for providing care) could explain differences in the outcomes of caregiving for different caregivers. Research has established an association between caregiver attitudinal variables (such as motivation for providing care and caregiving ideology) and caregiver satisfaction (Albert, 1992; Lawton et al., 1992).

The background and context of caregiving will directly influence the outcomes of caregiving. This study conceptualised the outcomes of caregiving as care recipient experience and caregiver experience. Care recipient experience was measured as elderly care recipient

satisfaction with the care he/she receive from his/her caregivers while caregiver experience was measured as the challenge a caregiver experience and the reward a caregiver derive as a result of his/her caregiving role(s). Caregiver experience include caregivers appraisal of their roles, and their positive and negative experiences. Kramer and Kipnis (1995) argued that the background and context of caregiving are essential in understanding caregiving experiences of family caregivers. In addition, role theory, social exchange theory and stress process model recognize the importance of background and context of caregiving in the study of the experiences of family caregiving (Bastawrous, 2013; Kramer, 1997).

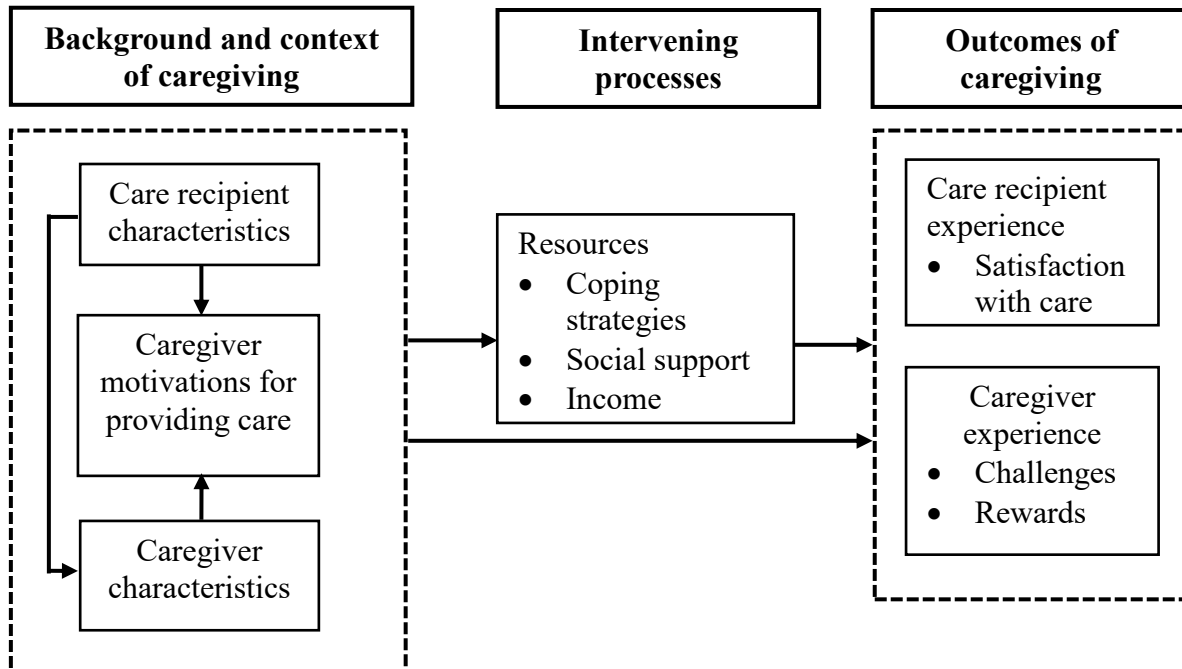
In this study, the background and context of caregiving indirectly influenced the caregiver and care recipient experiences through resources. Resources can influence the experiences of family caregivers and their elderly care recipients. Resources was conceptualised as coping strategies, social support, and income in this study. The types of coping strategies employed and social support received by caregivers can influence their caregiving challenges. A caregiver can also conceptualise the social support he/she receives as a reward. In addition, the social support elderly care recipients receive from their caregivers and significant others can influence their satisfaction with the care they receive from their caregivers. The monthly income elderly care recipient receive can also influence their satisfaction with the care they receive from their caregivers, especially material care. Although, the resources of the elderly care recipient may influence the quality of care they receive from their caregivers, it was not conceptualised in this study because information was not collected on the resources (wealth) of care recipients in the qualitative study. However, information on the monthly income of care recipients was collected. Research has identified coping strategies and social support as important resources that can help mitigate the negative impacts of family caregiving to the elderly (Carretero et al., 2009).

Figure 2. 1: A conceptual model of caregiver adaptation proposed by Kramer (1997)



Source: Kramer (1997)

Figure 2. 2: Conceptual framework showing the relationship between background and context of caregiving, intervening process and outcomes of caregiving



Source: Adapted from Kramer, 1997

2.15 Summary

This chapter examined the concept of caregiving, cultural norms and family caregiving, motivations for providing care highlighting the influence of reciprocity and filial obligation. The chapter also discussed negative experiences of caregiving, factors associated with negative outcomes of caregiving, and mediators of the impact of caregiving highlighting the influence of coping strategies and social support. Positive experiences of caregiving, and elderly care recipient's perception of the care they receive, were also discussed. The institutional care for the elderly in Africa, policies on ageing, theoretical framework and conceptual framework for the present study was also highlighted.

The review of the literature demonstrated that limited studies have explored the views of elderly care recipients in the provision of care to have a holistic understanding of the caregiving situation. In addition, few studies have explored both the negative and positive experiences of family caregivers. Hence, this study examined the challenges and gains/rewards derived with providing care to the elderly and explored the views of elderly care recipients regarding the care they receive in Ga Mashie. A holistic understanding of the caregiving situation will help in the design of programmes, and interventions to mitigate the challenges faced by family caregivers and to enhance the positive aspects of caregiving to promote the well-being of family caregivers and their elderly care recipients.

CHAPTER THREE

STUDY AREA AND METHODOLOGY

3.1 Introduction

This study used quantitative and qualitative research approaches to examine the lived experiences of family caregivers and their elderly care recipients in urban poor communities in Accra, Ghana. The third round of the Urban Health and Poverty Survey (UHPS) was used to examine the socio-demographic characteristics and health conditions of the general elderly population in Ga Mashie, and the association between socio-demographic characteristics and tenancy arrangements of the elderly. In-depth interviews and observations were the qualitative techniques used for collecting the primary data for the study. This chapter is on the methodology of the study. It is divided into two parts: the study area and the methodology.

3.2 Study area

This study was conducted in James Town and Ussher Town in Accra, Ghana (See Figure 3.3). These two communities, James Town and Ussher Town, are collectively known as Ga Mashie (CHF International and Accra Metropolitan Assembly (AMA), 2010; Owusu & Afutu-Kotey, 2010; Razzu, 2005). Ga Mashie is located on the Atlantic coast of Ghana and found in Central Accra in the Greater Accra Region (Henry & Fayorse, 2002; Mahama et al., 2011; UN-Habitat, 2011). Ga Mashie is one of the oldest communities in Accra (Dionisio et al., 2010) and it is located in Ashiedu Keteke Sub-Metropolitan District of the Accra Metropolitan Assembly (AMA) (Razzu, 2005). Ghana Statistical Service (GSS) (2012) estimates the population of James Town and Ussher Town as 16,221 and 27,624 respectively in 2010.

Ga Mashie is an indigenous community of the Ga ethnic group (Fayorsey, 1995; Quarcoopome, 1998). However, other ethnic groups reside in Ga Mashie as a result of migration. Ga Mashie is found in the Accra Metropolitan District. According to Ghana Statistical Service (GSS) (2014a), approximately 47 percent of residents in the Accra Metropolitan District are migrants. About 80 percent of the migrants in the Accra Metropolitan District are from other districts in Greater Accra while about 15 percent are from other regions in Ghana and about 5 percent are from outside Ghana respectively. Among the migrants from other regions in Ghana, most migrated from the Eastern Region (28 percent) and Volta Region (17 percent).

Fishing and petty-trading are the major occupations in Ga Mashie and Ga Mashie is one of the poorest communities in Accra (CHF International and Accra Metropolitan Assembly (AMA), 2010; Henry & Fayorsey, 2002; Mahama et al., 2011). Ga Mashie is densely populated. It has poor sanitation, poor housing conditions, inadequate space for cooking and bathing, and inadequate access to water and waste disposal.

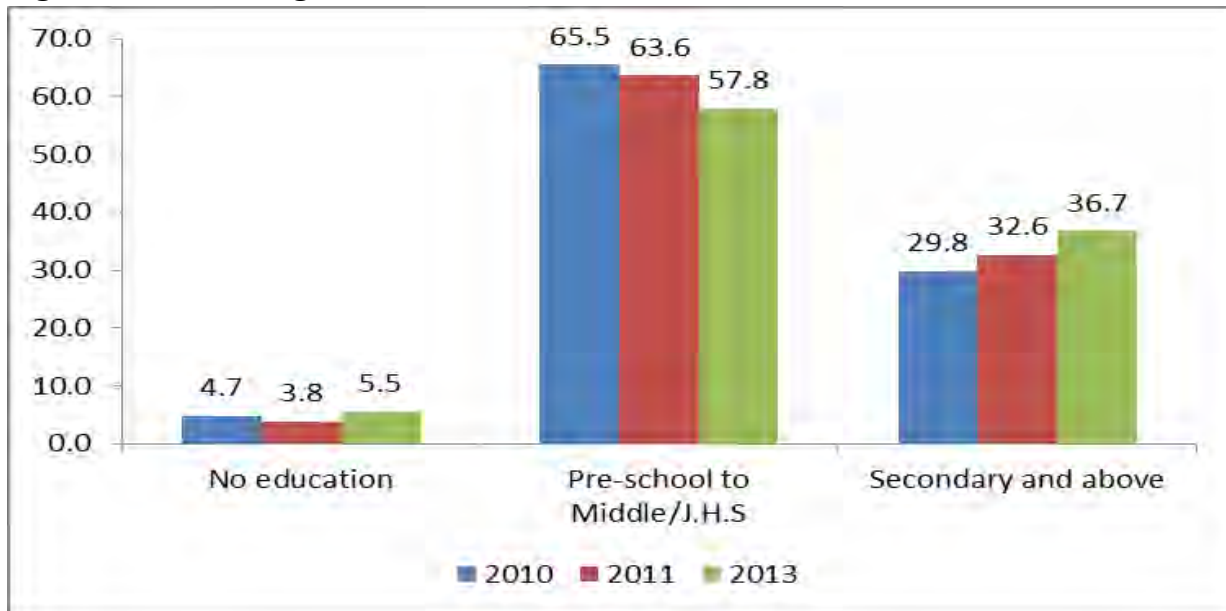
In Ga Mashie, residents often live in compound houses with other extended family members (Henry & Fayorsey, 2002). The elderly could rely on family members in the compound houses for assistance. However, traditionally, men do not live in the same compound with their wives (Kilson, 1974; Quarcoopome, 1998). Ga Mashie has a rich cultural heritage and assets such as James Fort, Ussher Fort, and Accra Lighthouse (Mahama et al., 2011; Razzu, 2005) which serve as tourist sites.

Urban poor communities, such as Ga Mashie, are characterised by low educational levels. However, preliminary analyses of the three rounds of the UHPS conducted by the Regional Institute for Population Studies (RIPS), University of Ghana shows that the majority of Ga

Mashie residents have ever attended school (See Figure 3.1). The proportion of Ga Mashie residents with secondary education and above have increased from about 30 percent to about 37 percent between 2010 and 2013 while the proportion with up to Middle School or Junior High School has declined from about 66 percent to about 58 percent over the same period. This implies that residents with secondary education and above are more likely to secure high-income jobs which could reduce their level of poverty.

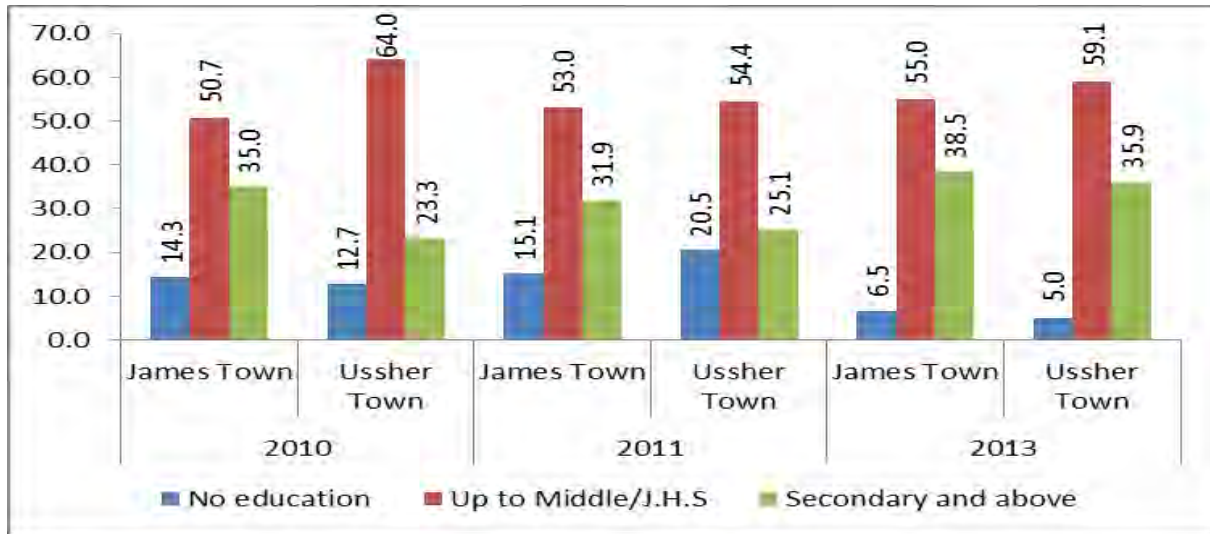
There are differences in the educational and occupational profile of residents of James Town and Ussher Town. Residents in James Town have higher levels of education and are more engaged in white-collar occupations compared to residents in Ussher Town. Figure 3.2 shows that higher proportion of residents in James Town have attained secondary education and above compared to residents of Ussher Town between 2010 and 2013.

Figure 3. 1: Percentage distribution of educational level of Ga Mashie residents



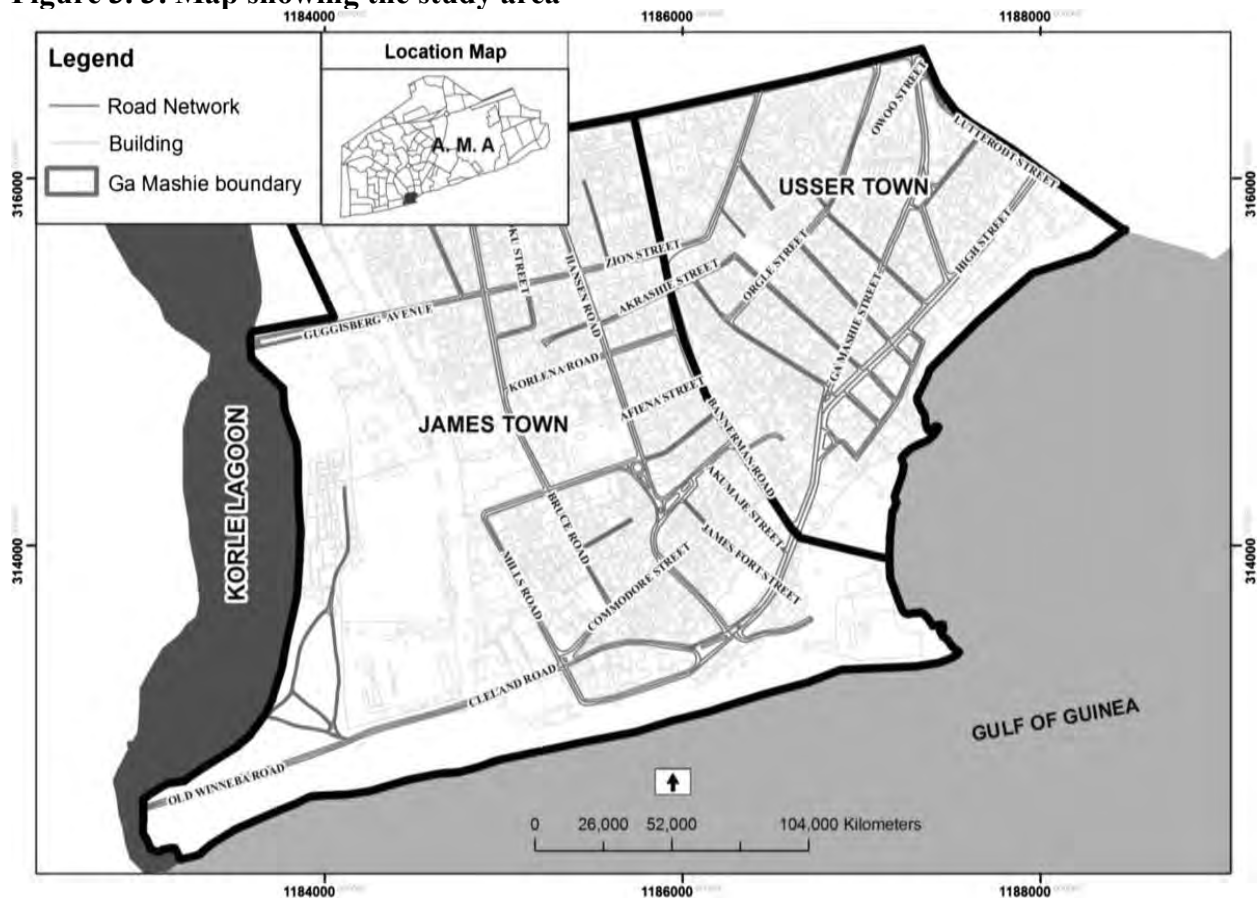
Source: Computed from UHPS, 2010, 2011 and 2013

Figure 3. 2: Percentage distribution of educational level of James Town and Ussher Town residents



Source: Computed from UHPS, 2010, 2011 and 2013

Figure 3. 3: Map showing the study area



Source: Oteng-Ababio (2014)

3.3 Methodology

3.3.1 Source of data

Data for this study are from two sources. Firstly, the third round of the UHPS conducted by RIPS, University of Ghana is used to examine the socio-demographic characteristics and health conditions of the elderly population in Ga Mashie. This data helps us to understand the situation of the elderly population in Ga Mashie.

The UHPS is a longitudinal study by RIPS, University of Ghana conducted in Ga Mashie and Agbogbloshie since 2010. The main goal of UHPS is to conduct a survey on population, health and poverty in order to gain a better understanding of the inequities in health and human welfare of the people living in urban areas. The UHPS is a collaborative project between RIPS, University of Cape Coast, University of Ibadan, University of Southampton, and the Fourah Bay College in Sierra Leone. In addition, the UHPS covers research areas such as migration, climate change, reproduction, contraception, child and maternal health, and sexual health and behaviour, among others. The questionnaire for the third round of the UHPS is attached in Appendix 18.

The third round of the UHPS was carried out between September 2013 to October 2013 and the sample for the survey was drawn from 8 Enumeration Areas (EAs) in James Town, 16 EAs in Ussher Town and 5 EAs in Agbogbloshie. The number of EAs was proportionate to the population size of the localities. These EAs in James Town, Ussher Town, and Agbogbloshie were sampled from a number of EAs used by Ghana Statistical Service for 2000 and 2010 censuses in these localities. In addition, 40 households were systematically chosen from each EA and in each household, every female aged 15 to 49 years and male aged 15 to 59 years were interviewed by trained research assistants in local languages (such as Ga and Twi). In the UHPS,

438 females aged 15 to 49 years were interviewed while 344 males aged 15 to 59 years were interviewed. In addition, individuals who were identified as household head in each household were interviewed on the research areas of the survey such as migration and climate change. In all, 782 heads of households were interviewed for the third round of the UHPS.

Ga Mashie was the study area for the present study and 675 out of the 782 individuals resided in Ga Mashie. Only 170 individuals out of the 675 residents of Ga Mashie were aged 60 years and above and they were selected for this study.

Secondly, this study used qualitative data as the primary source of data to understand the lived experiences of family caregivers and their elderly care recipients. This data was used to describe the socio-demographic characteristics of the elderly and their caregivers interviewed for the study. Transcendental phenomenology approach was employed as the qualitative method of data collection.

Transcendental phenomenology is one of the approaches of phenomenology. Phenomenology is recognized as both a philosophy and research method. As a research method, phenomenology describes the „lived experiences“ of individuals (Creswell, 2013; Moustakas, 1994; Padgett, 2012). Transcendental phenomenology was developed by Edmund Husserl and it's influenced by concepts such as epoche, eidetic reduction or phenomenological reduction, imaginative variation, and intentionality.

Epoche is a vital concept in transcendental phenomenology. Epoche is a Greek word which means “to stay away from or abstain” (Moustakas, 1994, p. 84). In transcendental phenomenology, the researcher must suspend his/her preconceived ideas, notions, biases and

beliefs about the experience of a phenomenon so that he/she can describe the experience of the phenomenon from the perspective of the individual who experienced it (Creswell, 2013; Dowling, 2007; Moustakas, 1994).

Phenomenological reduction or eidetic reduction is another important concept in transcendental phenomenology. According to Lin (2013, p. 471) eidetic reduction refers to “the process to rid the phenomenon from its surface appearances to reveal the “core”. In transcendental phenomenology, the researcher reduces individual experiences with a phenomenon to its essential elements that makes the phenomenon what it is (McLeod, 2001; Moustakas, 1994). Van Manen (1990 cited in Dowling, 2007) stated that essence is what makes a thing what it is. Thus, researchers describe the common meaning of individual experiences (Padgett, 2012).

Imaginative variation is another essential concept in transcendental phenomenology that enables researchers to seek for the possible meaning of a phenomenon, through the utilization of imagination, and approach the phenomenon from divergent perspectives (Merriam, 2009; Moustakas, 1994). According to Moustakas (1994), the aim of imaginative variation is to describe the essential structures of a phenomenon. In addition, imaginative variation helps researchers to develop structural themes.

Intentionality is another important concept in transcendental phenomenology (Moustakas, 1994). Intentionality is the idea that consciousness is directed towards the object of experience (Moustakas, 1994; Stewart & Mickunas, 1990 cited in Creswell, 2013). In transcendental phenomenology, the subject and object depend on each other since the perception of reality of an

object of experience is dependent on the experience of the individual (the subject) (McNamara, 2005; Moustakas, 1994).

The researcher applied the concept of epoche and imaginative variation in the analysis of the interview transcripts. The researcher suspended all the ideas and beliefs he has about providing care to the elderly so that he can describe the experiences of family caregivers and their elderly care recipients. The researcher also analysed the qualitative data from divergent perspectives of family caregivers and their care recipients in order to gain an in-depth understanding of the caregiving situation.

In addition, the researcher “bracketed” his caregiving experience to his father and his preconceived notion that family caregiving is stressful and associated with negative outcomes such as poor physical and mental health. The six-step method of analysing phenomenological study recommended by both Colaizzi (1978) and Moustakas (1994) was used by the researcher.

The phenomenological study employed purposive sampling. In purposive sampling, the researcher selects participants who can answer the research questions (Babbie, 2007; Teddlie & Yu, 2007). Family caregivers and their elderly care recipients were purposely selected from participants who indicated in the third round of UHPS that “during the past year, someone in the household provided help to a relative or friend (adult or child) because the person is getting old and weak”.

3.3.1.1 Inclusion criteria

The inclusion criteria for elderly care recipients were: they must be aged 60 years and above; they must be a resident of Ga Mashie; and they must have difficulty with at least one of

activities of daily living (such as feeding, bathing, dressing, and toileting) or instrument activities of daily living (such as preparing meal, and managing medication). In addition, elderly care recipient must be able to communicate; and they must consent to participate in the study and willing to share their experience. For the family caregivers, the inclusion criteria were: they must be a relative, friend or neighbour of the elderly; they must be aged 18 years and above; they must be providing care currently to the elderly; they should have provided care to the elderly for a minimum of 6 months, be willing to share their experience and they must consent to participate in the study.

Participants, who met the inclusion criteria were invited to participate in the study and those who agreed to participate were asked to give written consent. The interviews were conducted in places where the participants felt comfortable and convenient.

Out of 57 participants who reported in the third round of the UHPS that someone in the household provided help to a relative or friend because the person was getting old and weak, the researcher and the key informant were able to successfully identify 30 participants. However, the elderly care recipients of three participants had died. The households of the remaining 27 participants were not identified since the researcher and the key informant were unsuccessful in locating their household structures. In all, 20 elderly care recipients and 31 family caregivers were interviewed.

3.3.1.2 Positionality of the researcher

The researcher is a Ghanaian, a husband and a secondary caregiver to his father who is living with diabetes as indicated earlier in the source of data. The researcher mainly provides

financial care to his father who currently lives in the Central Region of Ghana. In addition, the researcher has been involved in three research projects in the study area. These projects are the third round of the UHPS; developing community-based cardiovascular disease care in Ghana: a therapeutic lifestyle approach to hypertension management in Ga Mashie, Accra; and Task-shifting program for cardiovascular risk assessment and development of dietary assessment tool in faith-based organizations in Ghana. The researcher played the role of a research assistant and his responsibilities included; recruiting participants, disseminating study findings to participants, and interviewing participants.

The participation of the researcher in these projects enabled him to establish rapport with participants and community members. It also helped the researcher to identify households of participants. The researcher didn't conduct any in-depth interviews because he is not able to speak the Ga language fluently.

3.3.2 Method of data collection

3.3.2.1 Primary data collection

The primary data collection was mainly qualitative, using in-depth interviews and observations as methods of data collection. Interviews and observations are appropriate methods for collecting data in phenomenological studies (Creswell, 2013). In-depth interviews were used because it is an appropriate method for capturing how individuals view their situations and their experiences about a phenomenon (Morris, 2015). Non-participant observations were also used because it provides opportunities for the researcher to observe the context of caregiving and understand the meaning of what family caregivers and their elderly care recipients do and say. Non-participant observations were concurrently conducted with the interviews. The researcher

observed participants gestures and other non-verbal expressions, and their environment while research assistant was conducting interviews.

Elderly care recipients were the first to be interviewed and they were asked to identify the main person and any other person who provided care to them since the study was interested in both primary and secondary caregivers. The caregivers were contacted and those available and willing to participate in the study were interviewed.

The researcher was assisted by a key informant to identify the households of participants who indicated in the third round of the UHPS that “during the past year, someone in the household provided help to a relative or friend (adult or child) because the person is getting old and weak”. Due to the inability of the researcher to speak the Ga language (a local dialect of the study community) fluently and the members of community preferring to be interviewed in Ga, three individuals (a female and two males) who had some qualitative research experience were recruited as research assistants and trained by the researcher to assist with the data collection. However, the researcher sat in some interviews conducted by the research assistants with family caregivers and elderly care recipients. During the training, the purpose and objectives of the study were introduced to the research assistants. In addition, the interview guides were reviewed with the research assistants and keywords in the interview guide were translated into the local dialects (Ga and Twi). The research assistants conducted mock interviews. Pilot interviews were conducted among family caregivers and their care recipients in Mamprobi, an indigenous Ga community close to Ga Mashie. The pilot interviews helped the researcher to revise the interview guide before the main data collection.

A semi-structured interview guide was used to collect data on the experiences of family caregivers (See Appendix 1) and their elderly care recipients (See Appendix 2). The in-depth interviews were conducted over three weeks in 2016 in Ga and English. The interviews started on the 2nd November 2016. All the interviews were tape recorded with participants' permission and lasted between 30 minutes and 55 minutes. Research assistants also took field notes and all the interviews were transcribed verbatim into English and each transcript was quality checked.

3.3.2.2 Ethical considerations

This study was reviewed and approved by the Ethics Committee for the Humanities (ECH) of the University of Ghana (ECH 009/16-17) (See Appendix 3). Participation in the study was voluntary and participants gave their consent before they participated in the study. The participants were assured of the confidentiality of the data collected from them and only individuals directly involved in the study such as the transcriber, research assistants and research supervisors may come into contact with the raw data. No personal information was used to label audio recordings and transcriptions. Identification codes were assigned to all participants. Participant names were replaced with fictitious names in the data analysis, demographic description, narrative description, and interpretation of the data in the research report. A sample of the consent forms for elderly care recipients and their caregivers are provided in Appendix 4.

3.3.3 Method of analysis

3.3.3.1 Survey data

The survey data was analysed by using univariate and bivariate analysis. Univariate descriptive statistics was used to describe the socio-demographic characteristics, living

arrangements and housing conditions, and health conditions of the elderly population in Ga Mashie. In addition, bivariate analysis was used to show the association between socio-demographic characteristics and tenancy arrangements of the elderly population in Ga Mashie.

In all, 170 respondents were aged 60 years and above in the UHPS. The survey data did not collect information on caregivers of the elderly and as a result, the qualitative study (transcendental phenomenological study) was used to collect information on the elderly and their caregivers. In all, 20 elderly care recipients and 31 caregivers were interviewed.

3.3.3.2 Primary data

Firstly, the phenomenological study was analysed using steps recommended by both Colaizzi (1978) and Moustakas (1994). In Colaizzi's method of analysis, the researcher must return to participants so that they can validate the findings of the study (Reiners, 2012). This study used NVivo software version 11 to qualitatively analyse the transcripts of family caregivers and their elderly care recipients. The use of NVivo ensured that transcripts were analysed systematically and this helped the researcher to identify significant statements in the transcripts. These significant statements were then clustered into common themes and connections between the themes were identified to describe the caregiving experiences of caregivers and their elderly care recipients.

The researcher used the six-step method to analyse the phenomenological study. In the first stage, the researcher "bracketed" his preconceived ideas and beliefs about experiences of family caregiving so that he can describe family caregiving from the perspective of family caregivers and their elderly care recipients.

In the second stage, the researcher read the interview transcripts of each elderly care recipient and their caregivers to get a general sense of their experiences. In the third stage, the researcher identified significant statements which describe the experiences of family caregivers and their elderly care recipients in each interview transcripts.

In the fourth stage, the researcher drew meaning from the significant statements by comparing the significant statements with each other and clustered these meanings into themes. In the fifth stage, the researcher used the themes to describe the experiences of family caregivers and their elderly care recipients. In the final stage, the researcher returned to participants to validate their experiences and included new and relevant data into the final description of their experiences.

3.4 Rigour

Rigour in qualitative research is very essential. Rigour basically involves ways to show integrity and competence (Holloway & Wheeler, 2002). Various strategies can be used to ensure rigour in a qualitative research such as member checks, triangulation, peer debriefing, and use of qualitative data analysis software.

To ensure rigour in this study, the researcher “bracketed” his preconceived ideas about family caregiving and described family caregiving from the perspectives of family caregivers and elderly care recipients.

Furthermore, the findings of the study were shared with family caregivers and their elderly care recipients so that they can confirm or otherwise the findings of the study. This technique is referred to as member checks and it enhances the credibility of qualitative research

(Lincoln & Guba, 1985). The researcher returned to participants in the study area to validate their experiences but only eight (8) family caregivers and three (3) elderly care recipients were available to validate their experiences after two visits.

3.5 Limitations of the study

This study has some limitations. Firstly, because the researcher may be regarded as a stranger by participants of the study, they may have been selective in their account of their caregiving experiences. However, the participants were assured of the confidentiality of the data collected from them.

Secondly, the findings of the transcendental phenomenological study cannot be generalised to other settings. This is because family caregiving is context specific and as a result the lived experiences of family caregiver and their elderly care recipients in Ga Mashie may not be applicable to the lived experiences of family caregivers and their elderly care recipients who dwell in other settings. It may require extensive replication in other settings before we can attempt to generalize to other settings.

Thirdly, this study did not include caregivers who provided care from a distance. Although the researcher acknowledged the roles played by caregivers from a distance, the study only focused on family caregivers who were physically present at the household and were providing care to the elderly.

In addition, the UHPS focused on the population aged 15 years and above. Although the survey gathered information on elderly persons aged 60 years and older, individuals aged

between 15 and 59 years were its targeted population. As a result, limited information about the elderly was collected.

Furthermore, the sample size for the quantitative data was small. The small sample size is due to the fact that the UHPS was conducted without the elderly in mind as explained earlier. The small sample size and limited information collected on the elderly limited the types of data analysis performed by the researcher. As a result, the researcher was able to perform only univariate and bivariate analysis. In addition, there were small cases for the categories of some variables due to the small sample size of the quantitative data.

Lastly, the resources (wealth) of the elderly care recipients may influence the quality of care they receive from their caregivers. However, this study did not collect information on the resources (wealth) of the elderly care recipients in the qualitative study.

3.6 Summary

This chapter described the study area and the sources of data for the present study. The chapter also provided an overview of transcendental phenomenology and its appropriateness for this study. The sampling techniques used in the study were also discussed in details. The UHPS, in-depth interviews and observations were used as instruments to collect data in the study. The chapter also discussed the methods of data analysis employed, the ethical procedures followed, the rigour and limitations of the study.

CHAPTER FOUR

CHARACTERISTICS OF THE ELDERLY AND THEIR CAREGIVERS

4.1 Introduction

The characteristics of the elderly, including their marital status, ethnicity and religious affiliation, have implications for their well-being (Ghana Statistical Service (GSS), 2013a). This chapter used univariate descriptive statistics to describe the socio-demographic characteristics, living arrangements and housing conditions, and health status of the elderly population in Ga Mashie. In addition, the association between socio-demographic characteristics and tenancy arrangements were examined.

The chapter also describes the characteristics of the elderly and their caregivers, and the activities performed by caregivers. The description of the characteristics of the elderly population and the association between socio-demographic characteristics and tenancy arrangements were based on the UHPS while the description of the characteristics of the elderly and their caregivers, and the activities performed by caregivers was based on the primary data collected.

4.2 Socio-demographic characteristics of the elderly population in Ga Mashie

Table 4.1 shows that seven out of every 10 of the elderly (71.1 percent) are young-old (60 –74 years) and 17.1 percent of them are old-old (75 – 84 years). This implies that the elderly population in Ga Mashie may need some form of assistance from their relatives and non-relatives. The majority (73.5 percent) of the elderly are females. This situation reflects the socio-demographic characteristics of the national elderly population (Ghana Statistical Service (GSS),

2013a). About one-quarter (24.7 percent) of them have no formal education and three out of every 10 of the elderly (31.2 percent) have attained Junior High School or Middle School education. In addition, 8 percent of the elderly have attained tertiary education.

With regards to marital status, approximately 6 percent of the elderly have never married and three out of every 10 of the elderly in Ga Mashie are married. In addition, 95 out of 170 elderly, representing 55.9 percent, have formerly married (separated, divorced and widowed) (Table 4.1). The majority (70.6 percent) of the elderly belonged to the Ga-Dangme ethnic group and this is not surprising since Ga Mashie is an indigenous Ga community. A little over a third (34.7 percent) of the elderly are Protestants while a little over one-fourth (28.2 percent) belonged to the Pentecostal/Charismatic denomination. In addition, one-tenth (10.0 percent) of the elderly are Muslims. About seven out of every 10 of the elderly (68.8 percent) reside in Ussher Town.

A little over half (51.2 percent) of the elderly are employed (Table 4.1) and this corroborates studies that argue that in sub-Saharan Africa, a higher proportion of the elderly remain in the labour force (Aboderin, 2009; Pillay & Maharaj, 2013; United Nations Population Division, 2012). Among the elderly who are employed, 46 percent are service and sales workers while about 9 percent are skilled/unskilled manual workers (Table 4.4 in Appendix 5). In addition, about 13 percent of the elderly are professional/technical/managerial workers. With regards to wealth quintile, 35 percent of the elderly are from poor wealth category (18.8 percent poorest and 16.5 percent poorer) while about 19 percent of the elderly are from middle wealth category (Table 4.1). In addition, about 46 percent of the elderly are from rich wealth category (18.8 percent richer and 27.1 percent richest).

Table 4. 1: Distribution of socio-demographic characteristics of the elderly population in Ga Mashie

Characteristics	Frequency (N = 170)	Percentage
Age group		
60 – 74	121	71.1
75 – 84	29	17.1
85+	20	11.8
Sex		
Male	45	26.5
Female	125	73.5
Educational level		
No education	42	24.7
Primary	37	21.8
JHS/Middle	53	31.2
SHS/Secondary	24	14.1
Higher	14	8.2
Marital status		
Never married	10	5.8
Living together	11	6.5
Married	54	31.8
Separated	13	7.6
Divorced	29	17.1
Widowed	53	31.2
Ethnicity		
Akan	38	22.4
Ga-Dangme	120	70.6
Ewe	5	2.9
Guan	3	1.8
Other	4	2.3
Religion		
No religion	11	6.5
Catholic	21	12.4
Protestant	59	34.7
Pentecostal/Charismatic	48	28.2
Other Christians	10	5.8
Islam	17	10.0
Traditional/Spiritualist	1	0.6
Other	3	1.8

Source: Computed from UHPS, 2013

Table 4.1 continued

Characteristics	Frequency (N = 170)	Percentage
Locality		
James Town	53	31.2
Ussher Town	117	68.8
Employment status		
Employed	87	51.2
Unemployed	83	48.8
Wealth quintile		
Poorest	32	18.8
Poorer	28	16.5
Middle	32	18.8
Richer	32	18.8
Richest	46	27.1

Source: Computed from UHPS, 2013

4.3 Living arrangements and housing conditions of the general elderly population in Ga Mashie

Living arrangements of the elderly are essential for their overall well-being (United Nations, 2005). Almost all (99.4 percent) of the elderly are household heads (Table 4.2) and this is due to the fact that in traditional Ghanaian societies, household headship is kept for adults (Ghana Statistical Service (GSS), 2013a). About 5 percent of the elderly reside in a household with 1 – 2 members while seven out of every 10 of the elderly reside in a household with five or more members. The household size of Ga Mashie is greater than the household size of the national elderly population. The 2010 Population and Housing Census results show that 59 percent of the elderly Ghanaian population resides in a household with five or more members (Ghana Statistical Service (GSS), 2013a). On the average, an elderly in Ga Mashie reside a household with about 7 people and this suggests that there are more household members available who could assist the elderly when they need care.

More than half (53.5 percent) of the elderly live in rent-free dwellings and one-quarter (25.3 percent) of the elderly live in rented dwellings (Table 4.2). In Ga Mashie, the proportion of the elderly living in rented dwelling is greater than the national elderly population living in rented dwelling (25.3 percent and 17.9 percent, respectively). A little over one-third (37.1 percent) of the elderly live in dwellings owned by a relative who is not a household member while about 32 percent of the elderly live in dwellings owned by a household member. The majority (75.3 percent) of the elderly live in compound houses while about 2 percent of the elderly live in separate houses. Because the elderly live in compound houses with their family members, they can depend on them when they need care.

Mba (2007b) noted that housing conditions in urban areas in Ghana are not favourable for the care of the elderly. More than half (54.1 percent) of households of the elderly use private outside standpipe/tap as their main source of drinking water while about 5 percent of households of the elderly use indoor plumbing system as their main source of drinking water (Table 4.2). The majority (72.4 percent) of households of the elderly use public toilets and about 12 percent of households of the elderly use water closets. This has implication for the well-being of the elderly, especially the oldest-old, who may have difficulty accessing these amenities because they are frail. The proportion of households using public toilets is higher in Ga Mashie than the elderly in Ghana (72.4 percent and 33.8 percent, respectively).

Regarding the main source of cooking fuel, seven out of every 10 households of the elderly use charcoal for cooking while about 12 percent of them use liquefied petroleum gas (LPG) for cooking. In addition, about 5 percent of households of the elderly use wood for cooking. The use of charcoal and wood as cooking fuel for households increases the risk of acute

respiratory infections, cataract, blindness, asthma, and tuberculosis among household members especially among the elderly (Bruce et al., 2000; Po et al., 2011).

Table 4. 2: Distribution of living arrangements and housing conditions of the general elderly population in Ga Mashie

Living arrangements and housing conditions	Frequency (N = 170)	Percentage
Relationship with household head		
Head	169	99.4
Parent	1	0.6
Household size		
1-2	8	4.7
3-4	42	24.7
5+	120	70.6
	Mean	Standard deviation
Mean household size	6.98	4.213
	Frequency	Percentage
Present holding/tenancy arrangement		
Owning	36	21.2
Renting	43	25.3
Rent-free	91	53.5
Dwelling ownership		
Owned by household member	54	31.8
Relative not household member	63	37.1
Other private individual	36	21.1
Other	17	10.0
Type of dwelling		
Separate house	4	2.4
Semi-detached house	5	2.9
Flat/apartment	5	2.9
Rooms	25	14.7
Several huts/buildings	3	1.8
Compound house	128	75.3

Source: Computed from UHPS, 2013

Table 4.2 Continued

Living arrangements and housing conditions	Frequency (N = 170)	Percentage
Source of drinking water		
Indoor plumbing	8	4.7
Private outside stand pipe/tap	92	54.1
Inside standpipe	25	14.7
Public tap/standpipe	38	22.4
Protected well	2	1.2
Pipe in neighbouring household	5	2.9
Toilet facility		
Water closet (WC/Flush toilet)	20	11.8
KVIP	22	12.9
Bucket/Pan	5	2.9
Public Toilet (WC, KVIP, Pit latrine, bucket/pan)	123	72.4
Cooking fuel		
None/no cooking	14	8.2
Wood	8	4.7
Gas	21	12.4
Kerosene	2	1.2
Charcoal	125	73.5

Source: Computed from UHPS, 2013

4.4 Health status of the general elderly population in Ga Mashie

Hypertension was the predominant chronic condition among the elderly in Ga Mashie (Table 4.3). About four out of every 10 of the elderly are diagnosed with hypertension while a little over a tenth (11.8 percent) of the elderly are diagnosed with diabetes. In addition, about 4 percent of the elderly are diagnosed with a stroke. This finding corroborates studies which found that hypertension and diabetes are prevalent non-communicable diseases among the elderly women in Greater Accra (Duda et al., 2011; Mba, 2006). Similarly, Minicuci et al. (2014)

reported that hypertension was the prevalent non-communicable disease among the elderly in Ghana.

The study also shows that the elderly in Ga Mashie are living with comorbid conditions. Table 4.3 shows that almost all (19 out of 20) of the elderly who are diagnosed with diabetes are also living with hypertension and about 4 percent of the elderly lived with both stroke and hypertension. Studies have documented that the elderly living with diabetes have a greater risk of developing hypertension (Blickle, 2005; Solini & Grossman, 2016).

Approximately 2 percent of the elderly are diagnosed with arthritis. Table 4.3 also shows that two out 170 of the elderly, representing 1.2 percent, are diagnosed with asthma. Equal proportions (0.6 percent) of the elderly are diagnosed with cancer and other chronic conditions respectively. The high incidence of chronic conditions, especially hypertension and diabetes, among the elderly suggests that there is a need for government and policy makers to invest in healthcare services since there would be an increase in the demand for healthcare services by the elderly.

It is worth noting that half (50.0 percent) of the elderly are currently enrolled in the National Health Insurance Scheme (NHIS) (Table 4.5 in Appendix 5). Therefore, they will have access to health services. However, a little less than a third (32.9 percent) of the elderly have never enrolled in the NHIS.

Table 4. 3: Distribution of health status of the general elderly population in Ga Mashie

Chronic conditions	Has been diagnosed with condition		Has not been diagnosed with condition		Total
	Frequency	Percentage	Frequency	Percentage	
Stroke	6	3.5	164	96.5	170
Hypertension	74	43.5	96	56.5	170
Diabetes	20	11.8	150	88.2	170
Stroke and hypertension	6	3.5	164	96.5	170
Diabetes and hypertension	19	11.2	151	88.8	170
Arthritis	3	1.8	167	98.2	170
Angina	3	1.8	167	98.2	170
Asthma	2	1.2	168	98.8	170
Cancer	1	0.6	169	99.4	170
Other	1	0.6	169	99.4	170

Source: Computed from UHPS, 2013

4.5 Association between socio-demographic characteristics and tenancy arrangements

Bivariate analysis was conducted to show the significant association between socio-demographic characteristics and tenancy arrangements of the elderly population in Ga Mashie. Fisher's exact test was used to test all associations at 95% confidence interval. Fisher's exact test was appropriate for the bivariate analysis because the variables of interest are categorical and some of the cells have cases less than 5. The sample size for the bivariate analysis was 170 elderly and Fisher's exact test gives accurate results when the sample size is small.

Table 4.4 shows that there is a significant association between age and tenancy arrangements. A little over half (51.6 percent) of the elderly aged between 60 and 74 live in rent free dwellings and the majority (85.0 percent) of the elderly aged 85 and older live in rent free dwellings. Equal proportions (30.8 percent) of the elderly aged between 75 and 84 live in their own dwelling and rented dwelling respectively.

With regards to marital status, a significantly higher proportion (40.0 percent) of never married elderly live in their own dwelling and more than half (56.8 percent) of formerly married (separated, divorced, and widowed) elderly live in rent free dwellings. A little over a quarter (35.4 percent) of the currently married (living together, and married) elderly live in rented dwelling.

The study also shows that more than half (55.3 percent) of the elderly who belonged to the Akan ethnic group live in rented dwelling while the majority (65.0 percent) of the elderly who belonged to the Ga-Dangme ethnic group live in rent free dwelling. A significant higher proportion (75.0 percent) of the elderly who belonged to other ethnic group category live in rented dwelling.

Furthermore, the majority (63.6 percent) of the elderly who had no religion affiliation live in rent free dwelling and a little over a quarter (26.1 percent) of the elderly who are Christians (Catholic, Protestant, Pentecostal/Charismatic, and other Christians) live in their own dwelling. The majority (70.6 percent) of the elderly who are Muslims live in rented dwelling. All the elderly who belonged to the other religion category live in rent free dwelling. The associated between religion and dwelling arrangements was statistically significant.

With regards to wealth quintile, a significant higher proportion (60.3 percent) of the elderly who belonged to rich wealth category live in rent free dwelling and two-fifth (40.6 percent) of elderly who belonged to middle wealth category live in rented dwelling. More than half (56.7 percent) of the elderly who belonged to the poor wealth category live in rent free dwelling.

The results of the bivariate analysis found no significant association between some socio-demographic characteristics and tenancy arrangements. These socio-demographic characteristics are sex, educational level, locality, and employment status.

Table 4. 4: Socio-demographic characteristics of the elderly by tenancy arrangements

Characteristics	Owning	Renting	Rent free	Fisher's exact test values
Age group				
60-74	21.0	27.4	51.6	10.95*
75-84	30.8	30.8	38.5	
85+	10.0	5.0	85.0	
Sex				
Male	22.2	26.7	51.1	0.215
Female	20.8	24.8	54.4	
Educational level				
No education	19.0	40.5	40.5	12.26
Primary	24.3	13.5	62.2	
JHS/Middle	22.6	22.6	54.7	
SHS/Secondary	20.8	33.3	45.8	
Higher	14.3	7.1	78.6	
Marital Status				
Never married	40.0	30.0	30.0	11.08*
Currently married	12.3	35.4	52.3	
Formerly married	25.3	17.9	56.8	
Ethnicity				
Akan	10.5	55.3	34.2	48.85***
Ga-Dangme	24.2	10.8	65.0	
Other	25.0	75.0	0.0	
Religion				
No religion	0.0	36.4	63.6	24.71***
Christians	26.1	19.6	54.3	
Islam	0.0	70.6	29.4	
Other	0.0	0.0	100.0	
Locality				
James Town	26.4	32.1	41.5	4.57
Ussher Town	18.8	22.2	59.0	
Employment status				
Employed	24.1	23.0	52.9	1.13
Unemployed	18.1	27.7	54.2	
Wealth quintile				
Poor	11.7	31.7	56.7	16.38**
Middle	28.1	40.6	31.3	
Rich	25.6	14.1	60.3	

Source: Computed from UHPS, 2013

*p<0.05; **p<0.01; ***p<0.001

4.6 Characteristics of study respondents and their caregivers

Table 4.5 shows that the elderly care recipients are aged between 64 and 95 years and three out of the twenty elderly care recipients are males. Nine elderly care recipients have no formal education while five of them have attained Junior High School or Middle School education. The majority of the elderly care recipients are Ga-Dangme, Christians and reside in James Town. In addition, thirteen out of the twenty elderly care recipients are widowed and all the widowed care recipients are female. An explanation for this phenomenon is that men tend to marry women who are younger than them and because women have greater life expectancy than men, men tend to die earlier than their spouse.

In addition, the number of children of the elderly care recipients ranges between 1 and 10. The average number of children of elderly care recipients was 3.75 and this implies that the elderly can rely on their children for care. The number of family caregivers interviewed for each elderly care recipient ranges between 1 and 4. The researcher was able to interview only one caregiver of eleven elderly care recipients. It must be noted that several family members provided various types of care to elderly care recipients, however, some family caregivers were not physically present at the household and others were unwilling to participate in the study. In addition, children below 18 years who provided care to the elderly were not interviewed since the study focused on adults aged 18 years and above.

Elderly care recipients in Ga Mashie are living with both communicable conditions such as fever and malaria, and non-communicable conditions such as diabetes, hypertension and stroke. With the exception of mild stroke, elderly women reported the highest prevalence of non-communicable conditions. Elderly care recipients are also living with comorbid and multimorbid

conditions. Table 4.5 also shows that four elderly care recipients are living with comorbid and multimorbid conditions namely: diabetes and hypertension; diabetes, hypertension and arthritis; stroke and hypertension; and hypertension and asthma.

Table 4.6 shows that fifteen out of the thirty-one family caregivers are primary caregivers while the remaining sixteen are secondary caregivers. Family caregivers are aged between 21 and 76 years. Secondary caregivers are older (45.9 years) than primary caregivers (44.9 years). The majority of the primary caregivers (73.3 percent) and secondary caregivers (93.7 percent) are females.

In addition, a third (33.3 percent) of primary caregivers have attained primary education while about seven out of every ten (68.7 percent) secondary caregivers have attained Junior High School or Middle School education. Eighteen out of the thirty-one family caregivers are working full-time. The majority (66.7 percent) of the primary caregivers are working full-time while half (50.0 percent) of the secondary caregivers are working full-time. Four out of the twelve employed primary caregivers worked far away from home while two out of the twelve employed secondary caregivers worked far away from home. The majority of primary caregivers (86.7 percent and 93.3 percent) and secondary caregivers (68.7 percent and 81.2 percent) are Ga-Dangme and Christians. It is worth noting that family caregivers in the study are from both the father and mother side. This is because the Ga, who constitutes the majority of caregivers, are related by blood to both paternal and maternal grandparents and through them to their kin (Kilson, 1974).

Furthermore, a little over a third (35.5 percent) of family caregivers are never married. A third of primary caregivers (33.3 percent) are married while a higher proportion of secondary

caregivers (43.7 percent) are never married. The number of children of family caregiver ranges between 0 and 11. Primary caregivers have a higher number of children (2.7 children) compared to secondary caregivers (2.5 children). The majority of primary caregivers (73.3 percent) and secondary caregivers (68.7 percent) reside in James Town.

Table 4. 5: Background characteristics of elderly care recipients in Ga Mashie

Background characteristics	Elderly care recipients (N = 20)	
	Frequency	Percentage
Age		
Range	64 – 95	
Mean	77.5	
Sex		
Male	3	15.0
Female	17	85.0
Education		
No education	9	45.0
Primary	4	20.0
J.H.S/Middle	5	25.0
Secondary	1	3.2
Tertiary	1	3.2
Employment		
Unemployed	13	65.0
Full-time	1	5.0
Part-time	6	30.0
Ethnicity		
Ga-Dangme	18	90.0
Ewe	1	5.0
Nigerian	1	5.0
Religion		
Christian	18	90.0
Islam	2	10.0
Marital status		
Never married	3	15.0
Living together	0	0.0
Married	4	20.0
Divorced/Separated	0	0.0
Widowed	13	65.0
Number of children		
Range	1 – 10	
Mean	3.75	
Locality		
James Town	15	75.0
Ussher Town	5	25.0
Number of caregivers interviewed		
1	11	55.0
2	8	40.0
4	1	5.0

Source: Author's Fieldwork, November, 2016

Table 4.5 continued

Background characteristics	Elderly care recipients (N = 20)	
	Frequency	Percentage
Health conditions		
Malaria	1	5.0
Fever	1	5.0
Swollen legs	2	10.0
Arthritis	6	30.0
Stroke	1	5.0
Hypertension	3	15.0
Asthma	1	5.0
Arthritis and glaucoma	1	5.0
Diabetes and hypertension	1	5.0
Stroke and hypertension	1	5.0
Hypertension and glaucoma	1	5.0
Hypertension and asthma	1	5.0
Diabetes, hypertension, and arthritis	1	5.0

Source: Author's Fieldwork, November, 2016

Table 4. 6: Background characteristics of family caregivers in Ga Mashie

Background characteristics	Primary caregivers (N = 15)		Secondary caregivers (N = 16)		Both (N = 31)	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Age						
Range	25 – 76		21 - 70		21 - 76	
Mean	44.9		45.9		45.4	
Sex						
Male	4	26.7	1	6.3	5	16.1
Female	11	73.3	15	93.7	26	83.9
Education						
No education	1	6.7	0	0.0	1	3.2
Primary	5	33.3	2	12.5	7	22.6
J.H.S/Middle	3	20.0	11	68.7	14	45.2
Secondary	3	20.0	2	12.5	5	16.1
Tertiary	3	20.0	1	6.3	4	12.9
Employment						
Unemployed	3	20.0	4	25.0	7	22.6
Full-time	10	66.7	8	50.0	18	58.0
Part-time	2	13.3	4	25.0	6	19.4
Place of work						
At home	2	16.7	4	33.3	6	25.0
Away from home, nearby	6	50.0	6	50.0	12	50.0
Away from home, far away	4	33.3	2	16.7	6	25.0
Ethnicity						
Ga-Dangme	13	86.7	11	68.7	24	77.4
Akan	2	13.3	2	12.5	4	12.9
Nigerian	0	0.0	3	18.8	3	9.7
Religion						
Christian	14	93.3	13	81.2	27	87.1
Islam	1	6.7	3	18.8	4	12.9
Marital status						
Never married	4	26.7	7	43.7	11	35.5
Living together	2	13.3	0	0.0	2	6.5
Married	5	33.3	2	12.5	7	22.6
Divorced/Separated	2	13.3	3	18.8	5	16.1
Widowed	2	13.3	4	25.0	6	19.4
Number of children						
Range	0 – 8		0 – 11		0 – 11	
Mean	2.7		2.5		2.6	
Locality						
James Town	11	73.3	11	68.7	22	71
Ussher Town	4	26.7	5	31.3	9	29

Source: Author's Fieldwork, November, 2016

4.7 Summary

This chapter described the socio-demographic characteristics, living arrangements and housing conditions, and health status of the elderly population in Ga Mashie. In addition, the characteristics of elderly care recipients and their caregivers interviewed are discussed in this chapter.

The results of the UHPS show that the majority of the elderly are aged 60 to 74 years (young-old) and Christians. Seven out of every ten elderly are females, belonged to the Ga-Dangme ethnic group, and reside in Ussher Town. In addition, the majority of the elderly are household heads, have high household size, and live in compound houses. This implies that the elderly can rely on household members for care and support.

The majority of the households of the elderly use private outside standpipe/tap, public toilets, and charcoal for cooking. This implies that the elderly may need assistance to access these facilities since the facilities are outside their dwelling. Hypertension was the predominant chronic condition among the elderly in the study area.

The results of the bivariate analysis of the UHPS show that some socio-demographic characteristics (such as age, marital status, ethnicity, religion, and wealth quintile) are significantly associated with tenancy arrangements.

The qualitative data show that a higher proportion of the elderly are females, Christians, reside in James Town and belonged to the Ga-Dangme ethnic group. Similarly, most family caregivers are females. Secondary caregivers are older compared to primary caregivers. The majority of primary and secondary caregivers are Christians, reside in James Town and belonged

to the Ga-Dangme ethnic group. Primary caregivers have a higher number of children compared to secondary caregivers.

CHAPTER FIVE

CAREGIVING ACTIVITIES OF CAREGIVERS AND MOTIVATIONS

FOR PROVIDING CARE TO THE ELDERLY

5.1 Introduction

This chapter is divided into two parts: caregiving activities of caregivers and motivations for providing care to the elderly. It describes the main activities of primary and secondary caregivers and their motivations to provide care to the elderly. For the purpose of this study, family caregivers are also classified into younger and older caregivers. Younger caregivers refer to family caregivers aged below sixty years while older caregivers refer to family caregivers aged sixty years and older.

5.2 Caregiving activities of primary and secondary caregivers

Family caregiving to the elderly is a communal activity which is shared among several family members to enhance the well-being of the elderly care recipients. It is sometimes difficult to distinguish between primary and secondary caregivers because family caregiving is fluid and transient. The activities performed by family members to their care recipients, which can be used to classify a caregiver as being either a primary or secondary caregiver, changes over time and a caregiver can move in and out of his role over time. In this study, most elderly care recipients didn't need any assistance with bathing, dressing and feeding.

With regards to the relationship between caregivers and their elderly care recipients, 15 children (3 sons and 12 daughters) took care of their parents while 6 nieces took care of their elderly relatives. All the 6 nieces in the study are daughters of the care recipient's sisters. In

addition, 4 grandchildren (1 grandson and 3 granddaughters) took care of their grandmother. The grandson is the son of the care recipient's daughter while all the 3 granddaughters are daughters of the recipient's daughters. The study also shows that 2 daughters-in-law took care of their mothers-in-law while a sister provided care of her elderly sister. Furthermore, 2 friends, a male and a female, provided care to an elderly male and elderly female respectively. The male friend provided only material care to his elderly care recipient while the female friend provided both material and practical care to her elderly care recipient. It was found that caregivers from both the father side and mother side provided care to their elderly care recipients. This finding is not surprising because the Ga are related by blood to both paternal and maternal grandparents and through them to their kin (Kilson, 1974), and kinsmen and kinswomen are culturally expected to assist their kin who need care and other forms of support (Aboderin, 2004a; van der Geest, 2002).

In this study, a primary caregiver is considered as a family member who performs most activities for the elderly care recipient. Primary caregivers often have ties with their care recipients before they assume the role as their primary caregivers and they often coordinate other caregivers and their caregiving activities. Fifteen out of the thirty-one family caregivers are primary caregivers (See Table 5.1). Most primary caregivers are adult children of the care recipient. Six daughters and three sons provided care to their elderly parents. Other primary caregivers of the elderly included sibling, spouse, daughter-in-law, niece, grandson and granddaughter. Eleven out of the fifteen primary caregivers are females and this finding corroborates other studies which indicate that females are often the primary caregivers of the elderly (Cattell, 1993; van der Geest, 2002).

Table 5. 1: Primary and secondary caregivers and their main caregiving activities

ID code	Relationship with elderly	Type of caregiver	Main activities performed by caregivers
C1	Son	Primary	Provision of money for feeding and payment of medicines and bills
C2	Niece	Secondary	Cooking
C3	Niece	Secondary	Cooking and fetching of water for bathing
C4	Friend	Secondary	Provision of money for feeding
C5	Daughter	Primary	Cooking, boiling water for bathing, accompanying her to the hospital, administering medicines, and having conversation with her
C6	Niece	Secondary	Accompanying her to the hospital, accompanying her to social gathering (such as funeral and family meeting), and running errands
C7	Sibling (sister)	Primary	Provision of money for feeding
C8	Son	Primary	Provision of food and dressing (wearing of clothing)
C9	Grandson	Primary	Buying her food, assisting her to the bathroom, boiling water for bathing, ironing of clothes, administering medicines, and having conversation with her
C10	Wife	Primary	Cooking, washing of clothes, cleaning him when he soil himself with stool, assisting him to the toilet, accompany him to the hospital
C11	Daughter	Primary	Provision of food, fetching of water for bathing, washing clothes and dishes, accompanying her to the hospital, administering medicines, accompanying her to places
C12	Granddaughter	Primary	Cooking, provision of money for feeding, washing clothes and dishes, fetching of water for bathing, accompanying her to the hospital and church, dressing, and administering medicines
C13	Daughter	Secondary	Provision of food and boiling water for bathing
C14	Daughter	Secondary	Provision of food
C15	Friend	Secondary	Provision of money and provision of food
C16	Daughter	Primary	Provision of food, cooking, having conversation with her, accompanying her to the hospital and payment of medicines and bills
C17	Niece	Secondary	Provision of food, fetching of water for bathing, administering medicines, having conversation with her
C18	Son	Primary	Provision of money and fetching of water for bathing
C19	Niece	Secondary	Provision of money and provision of food
C20	Daughter	Primary	Accompanying her to the hospital and assisting her to walk
C21	Daughter	Secondary	Cooking
C22	Daughter	Secondary	Cooking, and assisting him to the bathroom

Source: Author's Fieldwork, November, 2016

Table 5.1 continued

C23	Daughter	Secondary	Cooking, shopping, having conversation with her, and payment of medicines and bills
C24	Daughter	Primary	Cooking, washing of clothes, cleaning her when she soils herself with stool, and having conversation with her
C25	Daughter	Secondary	Cooking and ensuring she takes her medication
C26	Daughter	Primary	Accompany her to the hospital
C27	Daughter-in-law	Primary	Cooking, washing of clothes, and shopping
C28	Daughter-in-law	Secondary	Collect money from her debtors and washing of clothes
C29	Granddaughter	Secondary	Administering medicine and washing of clothes
C30	Granddaughter	Secondary	Accompany her to the hospital
C31	Niece	Primary	Fetching of water for bathing, drying her clothes, running errands, and having conversation with her

Source: Author's Fieldwork, November, 2016

Four out of the fifteen primary caregivers are older caregivers. Both younger and older primary caregivers provided practical, material, emotional and medical care. The primary caregivers provided material care to their care recipients. They provided financial assistance for the daily upkeep of their care recipients and also paid for their drugs and other medical expenses. Primary caregivers who provide financial assistance to the elderly often take the major decisions concerning the elderly and they are able to provide care from a distance by remitting.

Primary caregivers often spend much time with the elderly and as a result, they often provide emotional care to the elderly. The primary caregivers provided emotional care to their care recipients by having conversations with them so that they would not be feeling lonely and worried. In addition, primary caregivers provided practical care such as cooking, fetching and boiling water for bathing, dressing, and washing, drying and ironing clothes of their care recipients. They also accompanied their care recipients to church, to the hospital, and supervised and administered their medications.

There was a gender differential in the type of care provided to the elderly. Only female primary caregivers reported that they cleaned their care recipients when they soil themselves with stool. The cases of a spouse and a daughter who are the primary caregivers to their husband and mother, respectively, are presented below:

Mr. Tettey is a 69-year-old married care recipient who lives with his lovely wife, Maame Korkor, in James Town. He is a Christian, has 2 children with his wife, and has attained Senior High School education. Mr. Tettey is suffering from mild stroke and his 68-year-old wife, Maame Korkor, is the main person caring for him. Maame Korkor cooks and washes his clothes. She assists him to the bathroom since her husband, Mr. Tettey, cannot walk well due to his condition. However, Mr. Tettey is able to bath himself and use the toilet when he gets to the bathroom. Maame Korkor also cleans her husband when he occasionally soils himself with stool. She also accompanies him to the hospital and ensures that his medications do not run out.

Sister Dede is a 39-year-old primary caregiver who lives with her elderly mother and siblings in Ussher Town. She is a Christian, has never been married, has a child and has attained Senior High School education. Sister Dede, who is currently walking with clutches due to an accident, is the main person providing care to her elderly mother. Sister Dede cooks and washes the clothes of her mother. She also chats with her and cleans her when she occasionally soils herself with stool.

Only four male caregivers, three sons and one grandson, are primary caregivers to their elderly care recipients. The unavailability of other family members and siblings made male caregivers to assume the responsibility of primary caregivers of their care recipients. A 39-year-old male caregiver who provided care to his elderly mother reported that he is the main person providing care to his mother because his other three siblings are not around. He narrated that *“I am the closest one among them all, none of them is around. That is why it happened like that.”*

Four out of the five primary caregivers who provided emotional care are females. An explanation for this phenomenon is that in Ga Mashie, females dwell in female compounds with their matrikin while males dwell in male compounds with their patrikin and as a result, female primary caregivers often had conversations with their care recipients whom they live within the same compound house to make them happy.

In this study, secondary caregiver refers to any family member, friend or neighbour who assists the primary caregiver to provide practical, material, emotional and/or medical care to the elderly care recipient. Secondary caregivers are often accountable to primary caregivers. In Ga Mashie, most people live in compound houses with other extended family members and as a result, other family members assist in the care provision for the elderly.

Sixteen caregivers assisted primary caregivers to care for the elderly. Most secondary caregivers are daughters and nieces of the elderly care recipient. Six daughters and five nieces

provided care to their care recipients. Other secondary caregivers of the elderly included granddaughters, friends, and daughters-in-law. There are differences between primary and secondary caregivers in relation to their kin relationship with their care recipients. The study found that nieces, daughters, granddaughters, and daughters-in-law are primary and secondary caregivers to their care recipients. However, only friends were secondary caregivers to their care recipients while only sons, siblings (sister), grandsons, and wives were primary caregivers to their care recipients.

Secondary caregivers mostly provided practical care such as cooking, fetching water for bathing, and purchasing of groceries from the market. Secondary caregivers often cook in the morning and evening and as a result, they often purchase lunch from food vendors for their care recipients. There is an abundance of already prepared food by food vendors in the study area. Secondary caregivers also accompanied the elderly to social gatherings such as funerals and family meetings.

Secondary caregivers support primary caregivers and they are not always available to provide all types of care. Therefore, they mostly provide practical care and little or no emotional care. To provide emotional care, some level of bonding with the care recipient may be necessary. Such bonding takes place between the care recipient and the primary caregivers who are often with them.

The secondary caregivers also provided material care to the elderly. Three secondary caregivers, two friends and one niece, provided material care to their care recipients. They provide financial assistance for the daily upkeep of their care recipients. The secondary caregivers also accompanied their care recipients to the hospital and administered their

medications. In addition, only female secondary caregivers provided emotional care to their care recipients. Two female secondary caregivers often had conversations with their care recipients to make their care recipients feel happy. The company secondary caregivers provide to the elderly is essential for the mental well-being of their care recipients.

The age of caregivers influenced the types of activities they performed for their care recipients. Older secondary caregivers often provided less strenuous activities. Four out of the sixteen secondary caregivers are older caregivers and they are mainly responsible for cooking, administering medication and assisting their care recipient to the bathroom.

There is also a division of labour regarding caregiving to the elderly. The types of activities performed for the elderly are often shared among the various caregivers. The study found that siblings often share the caregiving activities among themselves based on the nature of their work and work schedules.

Naa Kwarley is a Christian, has never been married, has no children, and has attained tertiary education. Naa Kwarley, a 46-year-old secondary caregiver and currently unemployed, met with her sibling and they shared caregiving activities for their mother. Her junior sister is a fashion designer and lives with her husband. Her junior sister is responsible for accompanying their mother to the hospital while she is responsible for household chores such as washing and cooking.

Because caregiving arrangement is flexible, when a caregiver is unavailable to perform her assigned activities, other caregivers step in to perform those activities. In most cases, family caregivers who provide practical care are different from those who provide material care. Adult children who have migrated internally or internationally also engage in family caregiving from a distance by remitting cash for the daily upkeep of their elderly parents.

This study also found that children are involved in the care of the elderly. Children perform activities such as fetching water and running errands for the elderly. The following quotes from younger secondary caregivers buttressed the point that children play a role in caring for the elderly:

“We have a “small boy” around but we have sent him to school. ... When he returns from school and she [the elderly] needs something, she sends the “small boy”.” (C13; 51 year old female; Secondary caregiver; James Town)

There are two children with her. One is 12 years and the other is 16 years. They switch on the television for her and when she needs something, she will send them or send them to come for us because we do not stay here with her. (C30; 41 year old female; Secondary caregiver; Ussher Town)

5.3 Motivations for providing care to the elderly

The motivations for providing care to the elderly encompassed the reasons primary and secondary caregivers indicated for providing care to the elderly. The motivations for providing care to the elderly were classified under six major themes: kin relationship, reciprocity, obligation, altruism, egoism, and affection.

The coding frequencies for the motivations for providing care are placed in Appendix 6 while the major themes and their corresponding sub-themes and sample significant statements are presented in Appendix 7.

5.3.1 Kin relationship

Kin relationship motivated family caregivers in Ga Mashie to provide care to their care recipients. It was the prominent theme for care provision to the elderly among both primary and

secondary caregivers. Kin relationship had two sub-themes: parental relationships and non-parental relationships.

Under parental relationships, both primary and secondary caregivers decided to provide care because the care recipient was their parent. This decision by adult children to provide care to their elderly parents is underpinned by the cultural norm that children must take care of their parents in their old age. This cultural norm made caregivers to view caregiving to their parents as their duty. In this study, both younger primary and secondary caregivers in James Town and Ussher Town, and older primary caregivers in James Town respectively provided care to their elderly parents. Only one out of the six family caregivers who provided care to their elderly parents was a male. A younger male primary caregiver who resides in James Town stated that *“as he is my father by all means when he is in need, I have to help”*. A younger female secondary caregiver also indicated that *“it is our responsibility to take care of our mother to make her happy”*.

In Ghanaian culture, the eldest adult child is expected to be the main person responsible for the care of his/her elderly parent. In this study, the sex and position of the adult child in the birth order also influence the decision to provide care. A 66-year-old primary caregiver stated that:

“I am her eldest child and the only girl, so automatically I am the right person to provide care to her. No one can take care of your own mum for you”. (C16; 66 year old female; Primary caregiver; James Town)

Among the Ga in Ghana, there is an adage that *“gbɔmɔ nyɛmi dzi gbɔmɔ”* which literally means *“a human being’s sibling is a human being”* (Atobrah, 2009, p. 154). This adage implies that family members must care and be concerned about the well-being of others,

especially their kinsmen or kinswomen. In this study, being a relative also motivated both younger primary and secondary caregivers in James Town and Ussher Town, and older secondary caregivers in James Town to provide care to their care recipient.

Only one out of the nine family caregivers who provided care to their elderly relative was a male. An explanation is that caregiving roles and responsibilities are viewed as a female task and as a result, caregiving roles are often performed by women. A 39-year-old female secondary caregiver who resides in Ussher Town indicated that *“she is my grandmother so I need to take care of her”*. Another younger female secondary caregiver who resides in James Town stated that *“since he is my father’s sibling that is why I have been helping him”*.

Across all societies, adult children and family members are culturally expected to assist their kin when they need care and Ga Mashie is no exception. In Ga Mashie, parental relationship motivated adult children to provide care to their parents and this is in line with the cultural concept of intergenerational support where adult children are expected to support their elderly parents when they need assistance.

There are differences between primary and secondary caregivers in relation to kin relationship and motivations for providing care. The study found that nieces and daughters who are primary and secondary caregivers are motivated by kin relationship to provide care to their care recipient. However, only sons who are primary caregivers are motivated by kin relationship to provide care to their care recipient while only granddaughters who are secondary caregivers are motivated by kin relationship to provide care to their care recipient.

Also, in the hierarchy of preference for who provides care to the elderly, after the spouse of the elderly, adult children of the elderly are expected to provide care to their elderly parents (Lin, Fee, & Wu, 2012; van der Geest, 2002).

5.3.2 Reciprocity

In Ghanaian culture, the norm of reciprocity influences the decision of individuals to provide care to the elderly. Some studies in Ghana have documented that family members, especially female adult children, provide care to their elderly care recipients because of their past deeds (van der Geest, 1997a, 2002). Reciprocity was one of the most prominent reasons caregivers cited for providing care to the elderly. Twelve (five primary caregivers and seven secondary caregivers) out of the thirty-one caregivers mentioned that they provided care to their elderly care recipients because they want to pay back for the good deeds their care recipients did for them in the past. Three out of the twelve family caregivers who provided care to their care recipients because of past deeds were males. Nine out of the twelve family caregivers who provided care because of past deeds were younger caregivers.

Due to the past deeds of the care recipients, some caregivers had the desire to care for them until their death. The following quotes buttress this point:

“It is difficult for someone to take care of an orphan but my grandmother did it whole heartedly, so that is what motivated me to also care for her till she goes and be with the Lord Almighty.” (C12; 36 year old female; Primary caregiver; James Town)

“My mum took care of me from infancy until I became an adult, so it’s now my turn to reciprocate until the good Lord calls her.” (C23; 50 year old female; Secondary caregiver; Ussher Town)

Sometimes, caregivers provided care to their care recipients because of the past deeds of their care recipients to their (caregiver's) parents. A younger female secondary caregiver who resides in James Town narrated that she provided care to her uncle because her uncle supported her mother in the past.

“My mum used to tell us that our uncle used to be a goalkeeper for Accra Hearts of Oak and he used to support my mum in those days. So now that both he and my mum can’t afford to support themselves, we have to support him and our mum.” (C2; 23 year old female; Secondary Caregiver; James Town)

Reciprocity is underpinned by cultural norms and cultural norms influence filial responsibility to care for the elderly (Dellmann-Jenkins et al., 2000). In this study, both primary and secondary caregivers in James Town and Ussher Town provided care because they want to reciprocate past deeds of their care recipients. This finding corroborates studies in Ghana, other sub-Saharan African countries and the United States that have found reciprocity as a reason for providing care to the elderly (Abdulraheem, 2005; Sheehan & Donorfio, 1999; van der Geest, 2002). For example, studies by van der Geest (1997a, 2002) among family caregivers of elderly care recipients in Kwahu, a rural Ghanaian community, found that caregivers provided care to the elderly because they wanted to repay the elderly for the good deeds in the past. In the United States, a study by Sheehan and Donorfio (1999) among 11 daughters and their elderly mothers found that daughters provided care to their mother as an attempt to repay them for their past sacrifices.

5.3.3 Obligation

Obligation also motivated caregivers to provide care to the elderly care recipients. The cultural norm of obligation is embedded in the filial responsibility of the younger generation to

support the older generation. Both younger and older primary and secondary caregivers felt that it was their personal duty to provide care to their elderly care recipients. Obligation had two sub-themes: personal responsibility and religious obligation.

Some of the caregivers indicated that they provided care to their elderly care recipients because they perceived the provision of care to care recipients as their personal responsibility. Five caregivers, two primary caregivers and three secondary caregivers respectively, mentioned that it was their personal responsibility to care for their elderly care recipient. It is worth noting that all the five caregivers who perceived caregiving as their personal responsibility were females and this could be because family caregiving is gendered. A 50-year-old secondary caregiver stated that *“when they grow old, you have no choice than to provide care for them.”*

An older primary caregiver who resides in James Town narrated that:

“Now that she is old it is my responsibility to take care of her so that one day my children can also do the same for me.” (C11; 65 year old female; Primary caregiver; James Town)

Under religious obligations, a younger male secondary caregiver who provided financial care to an elderly care recipient stated that he provided financial care because the scriptures (in the Bible) teach him to show respect to the elderly. He perceives the provision of financial care to the elderly as showing respect to them. He stated:

“because he is an elderly. As the scripture says if you show respect to the elderly, one, it is a blessing”. (C4; 21 year old male; Secondary caregiver; James Town)

In this study, primary and secondary caregivers in James Town and Ussher Town perceived care provision to their care recipient as their personal responsibility. In addition, both

younger and older caregivers perceived care provision as their personal responsibility. This finding supports studies in other sub-Saharan countries and the United States that have found obligation as reasons for caring for the elderly (Abdulraheem, 2005; Dellmann-Jenkins et al., 2000). For example, a study by Dellmann-Jenkins et al. (2000) among 22 adult children and 21 grandchildren caregivers in the United States revealed that both adult children and grandchildren caregivers reported obligation as the main reason for providing care to their elderly parents and relatives. Noonan et al.'s (1996) study among 48 family caregivers in Massachusetts, United States found that caregivers provided care to the elderly because it is a moral obligation to provide care for family members.

5.3.4 Altruism

Generally, altruism refers to concern for the well-being of others in society. In most cultures of the world, individuals are expected to show concern for the well-being of others without expecting a reward. Altruism emerged as a theme for motivations for care provision to the elderly. In this study, only three caregivers, two in James Town and one in Ussher Town, reported that they empathised with the elderly and wanted to help them. All these three caregivers were younger female primary caregivers and secondary caregivers. A younger female secondary caregiver who provided financial assistance to her care recipient who has been neglected by her biological daughter reported:

“As you can see, her issue is pathetic, so when she wants something I should be able to help her with it so that she will also be filled with joy.” (C15; 51 year old female; Secondary caregiver; James Town)

The frailty of the elderly also motivated a younger female primary caregiver who resided in James Town to provide care to her elderly care recipient and she reported that *“I feel she is weak and she needs help in her up and down”*. Another younger female primary caregiver who resided in Ussher Town reported that *“it was because she was having difficulties in doing such chores ... so I offered to help”*.

In this study, altruistic reasons (empathy towards the elderly) motivated younger primary and secondary caregivers to provide care to the elderly. This finding revealed that only female caregivers provided care to their elderly care recipients because they wanted to assist and enhance the well-being of their care recipients.

5.3.5 Egoism

Generally, egoism refers to individuals acting in their own self-interest. In this study, caregivers were motivated egoistically to provide care to their elderly care recipients. Both younger secondary caregivers, and older primary and secondary caregivers provided care for egoistic reasons. Three caregivers, one primary caregiver and two secondary caregivers, were providing care to their elderly care recipient because of their self-interest rather than enhancing the well-being of their elderly care recipient. Egoistic had three sub-themes: self-benefit, blessing, and volition.

Self-benefit emerged as a sub-theme under egoism. A 68-year-old female primary caregiver who provided care to her husband who is living with mild stroke reported that she was caring for her husband because she did not want him to be a burden to her in the future. She noted:

“I offered to help him so that I will not suffer. If I help him and he becomes fit I will have much time to do other things but if I do not help and he collapses totally then I must sit by him without doing anything”. (C10; 68 year old female; Primary caregiver; James Town)

This finding conforms to the social exchange theory which indicates that individuals as rational beings take actions to maximize their rewards or minimise their costs and the behaviour of an individual is based on analysis of the costs and benefits. The older primary caregiver decided to provide care to her husband because she wants to minimise her cost (that is, providing adequate care to her husband can improve his condition, and the time she spends to provide care could be used for other activities when her husband recuperates from his condition).

Blessings associated with caring for the elderly also motivated caregivers to provide care to the elderly. An older female secondary caregiver who was caring for her mother noted that she was providing care because she wanted to receive the blessing associated with providing care to the elderly. She said *“I also want it. You see, it is more blessing so I also want to get it.”*

Volition also emerged as a motivation for providing care to the elderly. A younger female secondary caregiver who collects money from debtors on behalf of her elderly care recipient mentioned that she provided that assistance because she had the will to decide whether she wants to perform such a task or not.

“With her, she allows you to do it out of your own free will. If she tells you to go and you do want to or not, she wouldn’t force you.” (C28; 23 year old female; Secondary caregiver; Ussher Town)

In this study, both primary and secondary caregivers in James Town and Ussher Town indicated that they provided care to their elderly care recipients because they do not want their elderly care recipient to be a burden in the future, they want to receive the blessing associated

with care provision to the elderly and they have the will to decide whether they want to perform a caregiving responsibility or not.

5.3.6 Affection

Affection for elderly care recipients also emerged as a major theme. The affection caregivers had for their elderly care recipients motivated them to provide care. Affection for the care recipient is based on the quality of the relationship between the caregiver and care recipient prior to the assumption of the role as a caregiver of the care recipient. Two out of the fifteen primary caregivers, a younger and older primary caregiver, cited that the affection they had for their care recipient motivated them to become their caregivers. A younger female primary caregiver said *“I also provide care because of the love I have for her.”*

The study revealed that only female primary caregivers, who are daughters of the care recipient, reported that they provided care to their mother because of the love they have for them. The love female caregivers had for their elderly mothers could be attributed to the strong bond/attachment between daughters and their mothers.

5.4 Summary

The aim of this chapter was to describe the caregiving activities of primary and secondary caregivers and their motivations for providing care to the elderly. The findings of the study reveal that most primary caregivers are adult children of the care recipient while most secondary caregivers are daughters and nieces of the elderly care recipient. Both younger and older primary caregivers provided practical, material, emotional and medical care.

Secondary caregivers are not always available to provide all types of care to the elderly. Secondary caregivers mostly provided practical care such as cooking, fetching water for bathing, and purchasing of groceries from the market.

The age of caregivers influenced the types of activities they performed for their care recipients. Older caregivers often cook for their care recipients and clean their care recipients when they soil themselves with stool while younger caregivers were performing activities such as providing money for the daily upkeep of the elderly and accompanying their care recipients to the hospital.

In addition, primary and secondary caregivers have multiple reasons for providing care to the elderly. In this study, sixteen (16) caregivers reported a single reason for providing care to the elderly while eleven (11) caregivers reported multiple reasons for providing care to the elderly. The multiple reasons for providing care may be interwoven. For example, a caregiver may feel it is his/her personal responsibility to care for his/her elderly parent because of the love he/she has for his/her elderly parent. Also, a caregiver may have affection for his/her care recipient because the care recipient is his/her parent.

With the exception of affection, both primary and secondary caregivers were motivated by kin relationship, reciprocity, obligation, altruism and egoism to provide care to the elderly. Only primary caregivers were motivated by affection to provide care to the elderly.

CHAPTER SIX

CHALLENGES AND COPING STRATEGIES OF CAREGIVERS

6.1 Introduction

Family caregiving to the elderly is a demanding task for primary and secondary caregivers, as a result, they experience numerous challenges in the performance of their caregiving duties and responsibilities. This chapter examines the challenges primary and secondary caregivers face in the provision of care to the elderly and the various strategies they employ to cope with their caregiving challenges. This chapter is divided into two parts: challenges faced by caregivers in the provision of care and the strategies for coping with caregiving challenges.

6.2 Challenges faced by caregivers in the provision of care

Family caregivers experience challenges in their care provision to the elderly. Primary and secondary caregivers identified four challenges they faced in providing care to the elderly: economic burden, physical, social, and psychological challenges. The coding frequencies for caregivers' challenges are presented in Appendix 8 while the major themes and their corresponding sub-themes and sample significant statements are presented in Appendix 9.

6.2.1 Economic burden

Economic burden was a prominent challenge experienced by both younger primary and secondary caregivers and older secondary caregivers in their provision of care to the elderly. It had two sub-themes: finance and limited productivity.

Family caregiving to the elderly negatively affected the finance of both primary and secondary caregivers. One-fourth of caregivers, representing eight out of the thirty-one caregivers, reported that providing care to their elderly care recipient negatively affected their finances. Four out of the eight caregivers who experienced financial difficulty due to caregiving were males while five of them were primary caregivers. In addition, one out of the eight caregivers who experienced financial difficulty due to caregiving was an older secondary caregiver. An older female secondary caregiver who resides in James Town reported that *“seriously, it [caregiving] has really affected my finances”*.

A younger female primary caregiver who provided care to her elderly mother also explained that:

“the little money I have on me I use it in providing care for my grandmother. I am even running at a loss because the money I save for my upkeep is the same money I use to provide care for her.” (C24; 39 year old female; Primary caregiver; Ussher Town)

This finding is similar to other studies in Ghana, India and the United States (Ahmad, 2012; Carrion & Nedjat-Haiem, 2013; Prasad & Rani, 2007; Sanuade & Boatemaa, 2015). For instance, a study among family caregivers of the elderly in Ghana found that family experienced worsen financial burden due to their caregiving roles and responsibilities (Sanuade & Boatemaa, 2015). Similarly, a qualitative study by Carrion and Nedjat-Haiem (2013) among twenty Latinos providing care to terminally ill elderly Latinos in the United States found that family caregivers experienced financial strain. Ahmad’s (2012) study among family caregivers of the elderly in rural India found that caregiving had a negative impact on the finances of caregivers“, especially female caregivers.

Under limited productivity, two out of the thirty-one caregivers, a younger male primary caregiver and a younger female secondary caregiver, reported that family caregiving to their elderly care recipient has negatively affected their productivity as their number of working days reduced. This finding supports a study in the United States which found that four out of every ten adult children caregivers reported that providing care to the elderly care recipients had negatively affected their workplace attendance (Dellmann-Jenkins et al., 2000).

A younger female secondary caregiver who is a trader and accompanies her elderly grandmother to the hospital for check-up on Tuesdays and Fridays explained that due to the medical care she provides to her grandmother she is not able to trade on these days. Her inability to go to the market to sell on these two days reduces the number of days she engages in trading activities and this situation would affect the income she generates from her trading activities. She stated that:

“it affects my working days because her hospital check-ups are on Tuesdays and Fridays so I cannot go to the market and sell.” (C30; 41 year old female; Secondary caregiver; Ussher Town)

The younger female secondary caregiver in the quote above is experiencing role conflict. She is playing the role of a trader and the role of a secondary caregiver which are incompatible. As a trader, she is expected to go to the market daily to trade and as a secondary caregiver, she is expected to accompany her grandmother to the hospital for check-up. However, due to her caregiving duties and responsibilities, she is not able to go to the market on Tuesdays and Fridays. This conforms to the concept of role conflict in the role theory (Biddle, 1986).

6.2.2 Physical challenges

Providing care to the elderly is physically demanding and can pose physical challenges to caregivers. Only older female primary caregivers reported physical challenges. An explanation is that most often, primary caregivers disproportionately perform more demanding caregiving tasks compared to secondary caregivers and this makes older primary caregivers to experience more physical challenges compared to younger primary caregivers. The physical challenges included weight loss, pains in the leg, and fatigue.

A 68-year-old primary caregiver who provided care to her spouse diagnosed with stroke stated that providing care to her husband has made her lose weight. She explained that:

“Just that I have reduced in body size and weight. If I wear my old clothes I see that it is falling off but I am not bothered. People know my body size and they can tell the difference. If you do good you do for yourself and if you do bad you do for yourself.”
(C10; 68 year old female; Primary caregiver; James Town)

This finding corroborates other studies (Ho et al., 2009; Williams, 1993). For example, Ho et al.’s (2009) study among family caregivers and non-caregivers of elderly care recipients in Hong Kong reported that family caregivers are more likely to lose weight compared to non-caregivers (Ho et al., 2009). Similarly, a study by Williams (1993) among family caregivers of stroke patients in the United States found that 45 percent of caregivers experienced weight loss due to their caregiving roles and responsibilities.

Regarding pains in the leg, an older female primary caregiver who is providing care to her elderly mother and deceased father reported that she fell at the hospital while assisting her father and as a result, she has developed chronic pains in her leg. She stated that:

“... Due to my caregiving duties, I fell in the hospital and I developed some pains in my leg. My mum is aware of it. She even knows my check-up days.” (C16; 66 year old female; Primary caregiver; James Town)

Carrying out caregiving duties and responsibilities can be exhausting and lead to fatigue. An older female primary caregiver who provided physical care to her spouse diagnosed with stroke said that she sometimes break down and find it difficult to wake up from bed due to the demanding nature of her caregiving duties. Despite her fatigue, she continues to care for her spouse since the secondary caregiver (her son) who assists her is often not around.

“There are times that I break down totally and cannot wake up, but I must try and wake up because there is no one to help him.” (C10; 68 year old female; Primary caregiver; James Town)

The older female primary caregiver elaborated that she gets tired due to the practical care she provides to her husband. She reported that *“I get so tired because I wash on daily basis”*. Spousal caregivers often experience negative outcomes such fatigue because they are old, have poor health and sometimes neglect their own health needs when caring for their care recipients (Haley, 2003; Okoye & Asa, 2011; Tsai, 2003). This finding is similar to other studies (Teel & Press, 1999; Williams, 1993). For example, Williams’s (1993) study among family caregivers of stroke patients in the United States found that 48 percent of caregivers experienced constant fatigue as a result of care provision. Similarly, a study by Teel and Press (1999) among spousal caregiver and non-caregivers found that spousal caregivers experienced more fatigue compared to non-caregivers.

6.2.3 Social challenges

Family caregiving to the elderly also posed social challenges in the lives of caregivers. This was reported by younger female primary and younger secondary caregivers only. Two sub-themes emerged under social challenges namely: immobility and disruption of relationship.

Family caregiving to the elderly sometimes makes caregivers immobile since their care recipients need their constant attention and the absence of siblings to assist in the provision of care exacerbate the situation of caregivers. Only two younger female primary caregivers reported that caring for their care recipients has made them immobile. A 47-year-old primary caregiver who is caring for her mother narrated that because her siblings are not around, she is living with her mother and as a result, she is not able to move into her home which was given to her by her mother. She stated that:

“My mum has even given me a house at Mamprobi that I am even supposed to go there. ... My siblings are not here so I have to be around. ... I don't go anywhere.” (C20; 47 year old female; Primary caregiver; James Town)

Another younger primary caregiver who provides care to her mother explained that she sometimes has to cancel her appointments when her elderly mother needs her assistance. She reported that *“if I am going out and she needs my attention I will have to call and cancel my appointment”*. This finding corroborates a study by Dellmann-Jenkins et al. (2000) which found that about half of caregivers (adult children and grandchildren) of the elderly had less time to participate in social activities due to their caregiving roles and responsibilities.

Disruption of relationships also emerged as a challenge faced by caregivers in the provision of care to the elderly. A 51-year-old secondary caregiver who provides care to an

elderly care recipient narrated that the biological daughter of her care recipient is no longer talking to her because she is assisting her mother whom she accuses of being a witch. She explained as follows:

“Her child (daughter) says she has witchcraft ... Since we are in good terms with the mother, she, the daughter, is not in good terms with us.” (C15; 51 year old female; Secondary caregiver; James Town)

6.2.4 Psychological challenges

The family caregivers also experienced psychological challenges due to their caregiving roles and responsibilities. Both younger and older primary caregivers experienced two main psychological challenges: frustration and irritability.

Under frustration, two female primary caregivers (a younger and older caregiver), reported that providing care to the elderly is difficult and the behaviour of their elderly care recipients exacerbated these difficulties which made them felt dissatisfied. A 66-year-old female primary caregiver who provides care to her mother narrated:

“caring for the elderly is really difficult, while you say this she also says that. I sometimes get worried about her behaviour”. (C16; 66 year old female; Primary caregiver; James Town)

The non-cooperative behaviour of elderly care recipients sometimes makes primary caregivers feel like quitting their role as caregivers. A younger female primary caregiver stated that:

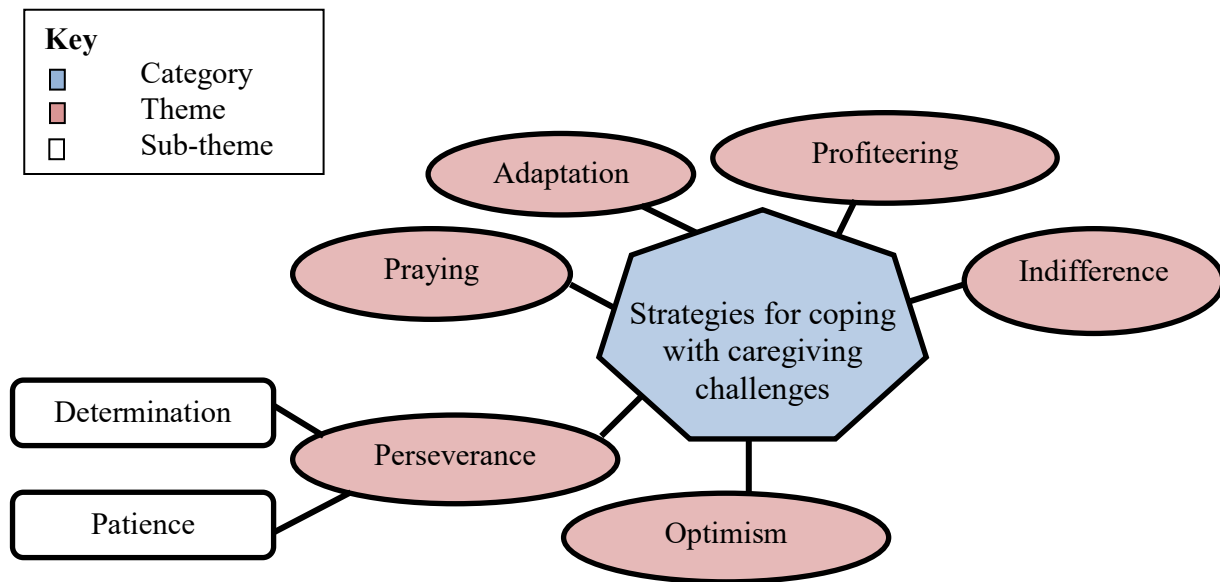
“... Sometimes providing care to the elderly is very difficult. They sometimes get angry when you are providing care to them so, at times, I feel like not providing the care again since I am not the only one she gave birth to.” (C5; 40 year old female; Primary caregiver; James Town)

In addition, the non-cooperative behaviour of elderly care recipients sometimes irritated their caregivers. A younger male primary caregiver who provides care to his grandmother explained that when he provides care to his grandmother, she sometimes accuses him of not caring for her and this makes him angry.

“When you do it, then she will tell you, you haven’t done it well. She will tell you, you know, she will even tell another person that you haven’t even done it for her and you will get pissed off.” (C9; 25 year old male; Primary caregiver; James Town)

6.3 Strategies for coping with caregiving challenges

Because family caregiving is essential for the well-being of the care recipients, the caregivers continue to provide care to the elderly despite the challenges they face. Both primary and secondary caregivers employed various strategies to cope with their caregiving challenges. This study identified six strategies employed by the family caregivers: praying, adaptation, perseverance, optimism, indifference, and profiteering. The coding frequencies for the strategies for coping with caregiving strategies are presented in appendix 10 while Figure 6.1 shows the major themes for the strategies for coping with caregiving challenges. The corresponding sub-themes and sample of significant statements of the major themes are presented in Appendix 11.

Figure 6. 1: Major themes for strategies for coping with caregiving challenges

Source: Author's Fieldwork, November, 2016

6.3.1 Praying

Praying emerged as a major theme under coping strategies. Family caregivers engage in prayers to cope with their caregiving challenges. A younger female primary caregiver and a younger male secondary caregiver indicated that they prayed to God to cope with their caregiving challenges. They prayed to God for strength to carry out their demanding caregiving responsibilities. A younger female primary caregiver who provided care to her mother in Ussher Town said *"I pray to God to give me the strength to provide care to the elderly until God calls her."* A younger male secondary caregiver who is a friend of the elderly and provided financial assistance to the elderly also noted *"hmmm, as for the challenges they will come but I pray"*.

This finding supports other studies in China and the United States (Stolley, Buckwalter, & Koenig, 1999; Sun, 2014). Sun's (2014) study among 18 family caregivers of demented elderly in Shanghai, China found that caregivers coped with their emotional problems such as

worry by praying to God. Similarly, a study by Stolley et al. (1999) among family caregivers of demented elderly in the United States found that caregivers employed prayer to cope with their caregiving challenges. In addition, a two-decade review of literature by Dilworth-Anderson et al. (2002) revealed that African Americans tend to use prayers as a coping strategy for their caregiving challenges.

6.3.2 Adaptation

Adaptation was also used as a coping strategy. In this study, a younger male primary caregiver who is a nursing student and provided care to his grandmother coped with his caregiving challenges by adopting the attitude he exhibits at school. At school, he is expected to carry out instructions without any complain and he has adapted the same attitude when providing care to his grandmother. A 25-year-old male primary caregiver explained that:

“I just say Yes Sir, Yes Sir, Yes Sir. I just pretend as if I’m into an institution where I have to salute. Because of my schooling, you know nursing, you go and they call it you have to salute in everything. You don’t have to say anything. So I have also adapted that. So in anything, what you have to do, I do it kpa kpa kpa [I do it quickly] so I don’t get tired of those things. I just do it kpa kpa kpa.” (C9; 25 year old male; Primary caregiver; James Town)

6.3.3 Perseverance

Perseverance also emerged as a coping strategy. Perseverance had two sub-themes: determination and patience. The behaviour of elderly care recipients sometimes makes caregiving very difficult and caregivers cope with these difficulties by being determined and patient. A 40-year-old female primary caregiver who provided care to her mother reported that being determined helps her to cope with the difficulty associated with caring for her mother. She

noted, *“caring for the elderly is very difficult but with determination, you can be able to provide care to them.”*

An older female secondary caregiver explained that she coped with the demanding nature of caring for the elderly by being patient with her care recipient. The secondary caregiver also acknowledged that ageing is inevitable and she will one day become old.

“Providing care to the elderly is very difficult, but as a God-fearing person I am able to cope with the challenges by having the patience for her because of her stage and I know that one day I will also get there.” (C17; 68 year of female; Secondary caregiver; James Town)

This finding supports a study among family caregivers of elderly stroke relatives in Thailand which found that caregivers employed patience to deal with their caregiving difficulties (Subgranon & Lund, 2000).

6.3.4 Optimism

Optimism also emerged as a strategy used by caregivers to cope with their financial challenges. Being optimistic about the caregiving situations enabled caregivers to cope with their caregiving challenges. A younger male secondary caregiver who provided financial care to his elderly care recipient reported that he coped with financial difficulties by being optimistic about his financial situation. He reported that:

“I say to myself that I am not broke because providing for them is a blessing, a typical blessing and a favour.” (C4; 21 year old male; Secondary caregiver; James Town)

The secondary caregiver is a religious person who perceives family caregiving as a blessing. He was hopeful that he would receive blessing and favour from God due to the

financial assistance he provides to his care recipient. As a result, he made a positive declaration that he is not broke despite his financial challenges.

6.3.5 Indifference

Indifference also emerged as a theme under coping strategies. Family caregivers sometimes cope with the behaviour of their care recipients by being unconcerned. A younger male primary caregiver whose elderly care recipient sometimes falsely accuse him of not providing care to her, coped with the situation by being unconcerned about comments made by his elderly grandmother. He stated that *“because I understand what I really want to do, I snub those things and just do it.”*

Indifference is a state in which a person is unconcerned or not interested in what happens around him/her. The primary caregiver reported that his elderly care recipient sometimes complain to others that he does not provide care to her. He copes with this situation by being unconcerned about what her care recipient tells others. In other words, he does not pay attention to those complains since they are untrue.

6.3.6 Profiteering

Provision of care to the elderly sometimes prevents family caregivers from engaging in their daily economic activities. A 41-year-old trader, who complained that she is unable to go to the market to trade on Tuesdays and Fridays because she accompanies her care recipient to the hospital, coped with this challenge by keeping the money left after paying all medical expenses. She takes advantage of the situation to make money for herself. She considers the surplus left after the payment of her care recipients medical expenses, as her daily reward.

“... When I send her to the hospital and there is a balance left, I also take it as my sales for the day. For every review, we take 100 Cedis with us.” (C 30; 41 year old female; Secondary caregiver; Ussher Town)

In traditional Ghanaian and African societies, it is believed that a person must benefit from the work he/she does. In South Africa, there is a saying “nothing for mahara” which literally meaning “nothing for free”. In addition, there is an English saying “you scratch my back, I’ll scratch yours”. People expect a reward for anything they do. The secondary caregiver reduces her economic loss by keeping the money left after paying all medical expenses. This conforms to the social exchange theory that an individual as a rational being takes action to maximize his/her rewards or minimise his/her costs (Hsu & Shyu, 2003).

6.4 Summary

This chapter focused on the challenges primary and secondary caregivers face in the provision of care to the elderly and the strategies they employ to cope with them. The findings indicate that the family caregivers experienced four types of challenges (economic, physical, social, and psychological) as a result of providing care to the elderly. Caregiving to the elderly had a negative impact on the finance and economic activities of both primary and secondary caregivers. Primary caregivers reported that care provision to the elderly made them immobile and an explanation is that primary caregivers spend most of their time with the elderly. In addition, only primary caregivers experienced physical and psychological challenges. Primary caregivers experienced physical challenges because they are old and have their own health challenges.

In this study, family caregivers tend to use problem-solving strategies (such as adaptation, perseverance, optimism, and profiteering) and emotion-focused strategies (such as praying and being indifferent) to cope with their situation. The study reveals that two out of seven caregivers employed multiple strategies to cope with their caregiving challenges.

Both primary and secondary caregivers used prayers and perseverance to cope with their caregiving challenges. Furthermore, there are differences in the coping strategies used by primary and secondary caregivers. In this study, only primary caregivers used adaptation and being indifferent to cope with their caregiving challenges while secondary caregivers used optimism and profiteering to cope with their caregiving challenges.

CHAPTER SEVEN

REWARDS DERIVED FROM PROVIDING CARE TO THE ELDERLY

7.1 Introduction

There are both advantages and disadvantages of caregiving. Although family caregiving may have negative impact on the lives of caregivers, they may also experience positive outcomes of caregiving. This chapter explores the rewards or gains primary and secondary caregivers in Ga Mashie derive from providing care to the elderly. This study identified nine rewards derived from family caregiving: gifts, blessing, skills acquisition, honour, enhanced personal attribute, asset, access to accommodation, family cohesion, and health consciousness. The coding frequencies for the rewards caregivers derived from caregiving are presented in Appendix 12 while the major themes and their corresponding significant statements about the rewards that caregivers derived from caregiving are presented in Appendix 13.

7.2 Gifts

Gifts was the most prominent reward caregivers derived from caregiving. Gifts was classified into money and in-kind. In this study, sixteen out of the thirty-one caregivers received money either from their care recipients, relatives, non-relatives or church as a result of providing care for the elderly. All the sixteen caregivers were females. Five out of the sixteen caregivers who received money as a result of providing care to the elderly were older caregivers. Two out of the five older caregivers who received money as a result of providing care to the elderly were primary caregivers. An older primary caregiver who provided care to her mother noted:

“Due to the care I provide to my mum, the church we attend sometimes give me money to motivate me to continue to provide care for my mum.” (C11; 65 years old female; Primary caregiver; James Town)

A younger primary caregiver who resides in Ussher Town explained that her care recipient assist her financially when she is not having money. She stated that *“sometimes when I am broke, my mum supports me financially.”*

In this study, some of the elderly care recipients were financially capable of giving their caregivers money as token of appreciation for the care they receive. This finding corroborates a study in the United States among adult children and grandchildren of elderly care recipients which found that caregivers received financial assistance from their care recipients (Dellmann-Jenkins et al., 2000).

Under in-kind, both primary and secondary caregivers received material gifts as a result of their caregiving roles and responsibilities. In traditional Ghanaian societies, the elderly sometimes receive material gifts from their adult children, family members and non-relatives, and their caregivers tend to benefit from these material gifts. In this study, both younger and older caregivers received material gifts such as provisions, kerosene and gifts from their care recipients, friends and relatives. Ten out of the thirty-one caregivers mentioned that they received provisions (such as bread, milk, oil and rice) as a result of providing care to their elderly care recipients. All the ten caregivers were females. More primary caregivers (6 out of 10) received material gifts compared to secondary caregivers. An older female primary caregiver who resides in James Town reported that *“I sometimes get some provisions due to the care I provide for my mum.”* A younger secondary caregiver who resides in Ussher Town also reported that *“I come for milk, provisions, bread and other stuffs. When she has food, she gives me.”* Another female primary caregiver who resides in Ussher Town reiterated that *“through the care I provide for my mum, I have received some gifts from friends and family members.”*

The benefits that the caregivers derived from caregiving also trickle down to their children. A younger primary caregiver reported that her caregiver gives her exercise books for her children. She said that “*she gives me rice, oil, biscuit and exercise books for my children.*”

7.3 Blessing

Seven out of the thirty-one caregivers (six from James Town and one from Ussher Town) received blessings as a result of providing care to the elderly care recipients. Only one out of the seven caregivers who received blessings was an older caregiver. More secondary caregivers (4 out of 7) received blessings compared to primary caregivers. A younger male secondary caregiver who provided financial care to an elderly care recipient explained that when he assists the elderly financially, it creates opportunities for him. He noted that “*at times, when I do so, a lot of things come my way, a lot of blessing.*” He further narrated that he was involved in an accident but he experienced no injury. He attributed his fortunate incident to the blessings he receives from providing care to his care recipient.

All the time, I am being delivered. Like the other time, a tragedy occurred, a serious one. The shop that you see over there, I hope you have seen a violet shop? ... We just rebuilt it. It collapsed and I was inside it. Two vehicles crushed and entered into it. It even hit me but by the grace, nothing happened to me. So you see, the good things that I do, the good that I use to do to people, you see that the blessing is following me. (C4; 21 year old male; Secondary caregiver; James Town)

A younger primary caregiver who provided care to her mother also narrated that because of the care she provides to her mother, God has blessed her and ensured that she never lacks anything.

“Since I started providing care for my mum, I have never lacked anything. The Good Lord blesses me and sees to it that we never lack anything that we need.” (C5; 40 year old female; Primary caregiver; James Town)

Some caregivers were of the view that these blessings led to increase in their daily sales. This finding is consistent with studies in the United States which found that family caregivers of the elderly perceive caregiving as a blessing (Bennett et al., 2014; Shim et al., 2013).

7.4 Skills acquisition

The provision of family care to the elderly enabled primary and secondary caregivers to acquire skills. Family caregivers acquired skills in caregiving, housekeeping, and communicating with the elderly. Four out of the thirty-one caregivers reported that providing care to the elderly has enabled them to acquire the skills of taking care of the elderly. All the four caregivers who acquired caregiving skills were younger primary caregivers. A 36-year-old secondary caregiver who provided care to her grandmother explained: *“it has helped me to know how to take care of the elderly because at first, I didn't know how to do it.”*

Some of the caregivers also learnt how to perform housekeeping chores such as cooking as a result of providing care to the elderly. Two younger caregivers (one primary caregiver and one secondary caregiver) reported that providing care has taught them how to cook. A younger secondary caregiver who resides in James Town stated that *“it has taught me how to cook and do household chores.”*

Caregiving to the elderly also enhanced the communication skills of caregivers. A younger primary caregiver who is a nursing student narrated that the care he provides to her

grandmother has improved his communication with the elderly. As a result, he is able to communicate effectively with the elderly when he goes for outreach. He stated:

“when we go on outreach and those things, when I meet the aged, I communicate with them in a way they feel like I,m their child and I believe all these things, it is because of her.” (C9; 25 year old male; Primary caregiver; James Town)

7.5 Honour

Honour emerged as a major theme under rewards derived from providing care to the elderly. The provision of care to elderly care recipients also brought honour to family caregivers. Honour had two sub-themes: appreciation and esteem. In this study, two younger caregivers and two older caregivers mentioned that they felt appreciated when significant others (such as relatives, friends and church members) recognised the good care they were providing to their elderly care recipients. Four out of the thirty-one caregivers (three primary caregivers and one secondary caregiver) reported that they felt appreciated when people recognised the adequate care they were providing care to their elderly care recipients. All the four caregivers were females. Two out of the three primary caregivers were younger caregivers. A younger primary caregiver narrated that:

“People even tell me that I have done well by taking care good care of my mum. During the Easter, we went to church and when people saw her they gave me a handshake that I have done well by taking good care of my mum. When they do that I feel appreciated.” (C5; 40 year old female; Primary caregiver; James Town)

Family caregivers felt appreciated because their relatives and significant others acknowledged their caregiving efforts. A study in the United States by Thornton and Hopp

(2011) found that family caregivers appreciated the recognition they received from others in their community for their caregiving roles and responsibilities.

With regards to esteem, a younger primary caregiver in James Town and a younger secondary caregiver in Ussher Town reported that caring for the elderly provided them the opportunity to attend family meetings and this made them feel important. This point is illustrated in the quotes below:

“... I feel I am important because I get to sit at places where I would not sit if I was alone. I get to sit at the high table when I accompany her to family meetings, if it was not because of her, I will not be sitting there because my age doesn't qualify me.” (C6; 53 year old female; Secondary caregiver; James Town)

“Because of the care I provide to the elderly, I am able to attend family meetings other than that my age would have disqualified me.” (C24; 39 year old female; Primary caregiver; Ussher Town)

Some caregivers reported that caring for their care recipients provided them with an opportunity to attend family meetings and this made them feel important. In Ga society, age is associated with authority in social groups and consequently, older persons occupy positions with greater authority in social groups which they belong (Kilson, 1974). As a result, the elderly are accorded respect and this respect is extended to people who accompany them to places. The elderly are respected because they are considered a repository of traditional knowledge and wisdom (van der Geest, 1997b, 2002).

7.6 Enhanced personal attributes

Family caregivers held the view that providing care to the elderly has enhanced their personal attributes. Enhanced personal attributes had two sub-themes: humility and patience, and

compassion. Three caregivers (two older caregivers from James Town and one younger caregiver from Ussher Town) noted that providing care to the elderly has taught them how to be humble and patient. All the three caregivers who reported that caregiving has taught them to be humble and patient were females. An older female secondary caregiver explained that *“it has taught me to be humble and patient in whatever I do.”*

With regards to compassion, a 23-year-old female secondary caregiver explained that providing care to her care recipient has taught her to be compassionate towards others and to assist others when she is capable.

“The help I give to him has helped me learn a lot of things. Some of the things that I have learnt are that if someone is in need and you are capable you should help him/her.” (C2; 23 year old female; secondary caregiver; James Town)

Care provision to the elderly taught caregivers humility, patience and compassion towards others. This finding is consistent with studies in the United States which found that family caregiving to the elderly enhanced the personal growth of caregivers (Noonan, Tennstedt, & Rebelsky, 1996; Sheehan & Donorfio, 1999).

7.7 Asset

Some caregivers reported that asset was one of the rewards they received from providing care to the elderly. A younger male primary caregiver who provided care to his father mentioned that his father has given him a piece of land to build. He narrated that:

“He has given me a place in Kokrobite to build a room. He has been forcing me to build on it but the problem is money.” (C18; 28 year old male; Primary caregiver; James Town)

The care recipient may have given the land to his caregiver as a token of appreciation for his caregiving roles and responsibilities. In traditional Ghanaian societies, there is a relationship between caregiving and inheritance. For example, adult children who provide care to their elderly parents tend to inherit the bulk of assets (such as land and houses) of their parents.

7.8 Access to accommodation

In Ga Mashie, residents often live in family houses with other extended family members. A younger male primary caregiver who provides care to his grandmother reported that he had access to accommodation in their family house due to the care he provides to his grandmother. He stated that *“I have a room and it is because of her.”*

Age is another important concept in Ga society (Kilson, 1974). In Ga societies, access to accommodation in family houses is based on seniority. When there is allocation of rooms in the family house among siblings, a priority is given to the eldest. This study found that the primary caregiver, who was aged 25 years, was given a room in their family house so that he could take good care of his care recipient.

7.9 Family cohesion

Family caregiving is a shared activity and for caregiving to be effective, it requires that family members involved in care cooperate with each other. The cooperation between family members could strengthen the bond between them. A younger female primary caregiver narrated that there used to be petty quarrels among family members, however, providing care to her mother has unified their family.

“There used to be small quarrels in the family but since I started providing care to my mum it has brought the family together.” (C5; 40 year old female; Primary caregiver; James Town)

Some previous studies have documented that family caregiving to the elderly enhanced the relationship between caregivers and their care recipients and their family members (Tarlow et al., 2004; Thornton & Hopp, 2011). In this study, a primary caregiver reported that providing care to their elderly care recipient has brought their family together. A plausible explanation is that family caregiving is often shared among family members and as a result, there is constant communication between family members and this creates a sense of togetherness among family members.

7.10 Health consciousness

Health consciousness was identified as a theme in this study. When caregivers accompany their care recipients to the hospital, they often enter the consulting room with their care recipients and this makes them privy to the condition affecting their care recipients. A younger female primary caregiver reported that accompanying her mother to the hospital has made her aware that health conditions that affect a member of her family can also affect her and as a result, she is conscious about her diet.

“Health-wise, I have learnt a lot of things that affect the family that can equally affect me so I am taking precaution every now and then to make sure I don’t fall a victim. So I check my diet.” (C26; 44 year old female; Primary caregiver; Ussher Town)

Family caregivers also interacted with health professionals when they accompany their care recipients for medical appointments and check-ups. Through these interactions, family caregivers became aware of the various hereditary conditions and their risk factors. This

information helped family caregivers to alter their diet in order to reduce their risk of developing those hereditary conditions.

7.11 Summary

The findings suggest that family caregivers simultaneously experienced challenges and derived rewards from caregiving to their elderly care recipients. Overall, 13 out of 31 caregivers derived multiple rewards from providing care to their elderly care recipients.

Both primary and secondary caregivers reported that they felt appreciated, important and blessed as a result of providing care to their care recipients. In addition, they received gifts, acquired new skills, and enhanced their personal attributes.

In this study, only primary caregivers reported that they received land, had access to accommodation, and learnt to be health conscious about diet due to the care they provided to their care recipients. Primary caregivers also reported that providing care to their elderly care recipient unified their family.

CHAPTER EIGHT

CONCEPT OF CARE AND PERCEPTIONS OF THE ELDERLY CONCERNING THE CARE THEY RECEIVE

8.1 Introduction

This chapter examines the concept of care by elderly care recipients and their caregivers, and the perception of elderly care recipients concerning the care they receive. The perception elderly care recipients have about the care they receive have implications for their well-being. This study identified two major themes for the perception of the elderly concerning the care they receive: satisfaction and dissatisfaction. The coding frequency for the perception of the elderly concerning the care they receive is presented in Appendix 16 while major themes and their corresponding sub-themes for the perception of the elderly concerning the care they receive are presented in Appendix 14.

8.2 The concept of care by elderly care recipients and their caregivers

The conceptualisation of care by elderly care recipients and their caregivers is important in the study of caregiving. This is because the conceptualisation of care by caregivers may influence the types of care they provide to their care recipients. Also, the care recipients' conceptualisation of care may also influence their attitude towards the care they receive from their caregivers.

8.2.1 Elderly care recipients' conceptualisation of care

The elderly care recipients' conceptualisation of care was influenced by the types of care they received, their needs and expectations. As a result, elderly care recipients don't include activities they perform on their own in their conceptualisation of care.

The elderly care recipients' conceptualisation of care captured the different dimensions of care such as spiritual, emotional and material care:

"It means once a while they have to pay the elderly person a visit, pray with the elderly and maybe some small parcel or money to the elderly for his or her upkeep. Also providing company to the elderly and doing things that will make the elderly always happy. That is what I understand receiving or providing with care." (E 3; 69 year old female; James Town)

"Care to me means giving the elderly money for his or her upkeep. Money that we (elderly) can use to buy food, visit the hospital and so on. Sometimes, if the elderly doesn't get support or help, it can make them to think a lot and they may even die early as a result of that. But if elderly are getting the right care, it takes their minds off certain things which can make them live longer." (E 20; 69 year old female; Ussher Town)

The elderly care recipients also conceptualised care in terms of the attributes they wanted their caregivers to exhibit. For instance, an aversion towards abusive attitudes to the elderly care recipient was an attribute care recipients wanted caregivers to exhibit.

"Care to me means that caregivers must not shout or insult an elderly person but they should have the patience and humble themselves to take good care of them." (E 16; 81 year old female; Ussher Town)

The elderly care recipients also conceptualised care in terms of caregivers meeting their needs. An elderly female who resides in James Town stated that *"care to me means my daughter taking good care of me. Whatever I need she provides for me."*

Another elderly female who resides in James Town also stated that *“receiving or providing care means when your children take good care of you by providing everything you need.”*

8.2.2 Caregivers’ conceptualisation of care

The caregivers conceptualised care as carrying out practical care which are essential for the daily living of the elderly such as feeding, washing and fetching water to the bathroom. Some of them narrated that:

“Provision of care means doing everything for my mum that is bathing, cooking, assisting her with toileting, washing her clothes, fetching water and so on.” (C11; 65 years old female; Primary caregiver; James Town)

“You will see to it that when the person is going to the bathroom, you go with her and she can bath but if she can’t you have to pour the water on her body. You will take care of her feeding.” (C14; 63 year old female; Secondary caregiver; James Town)

“Providing care means if you have an elderly person living with you, you have to provide care for them. That is their eating, assist them with toileting, bathing, dressing and so on.” (C 24; 39 year old female; Primary caregiver; Ussher Town)

The caregivers also conceptualised care as providing both practical care and medical care for their care recipients. They lay emphasis on meeting the needs of their care recipients. The following quotes buttress the point:

“Care to me is that you have to provide whatever they need, that is providing food, clothing, assist them in their bathing and you have to make sure that they are happy all the time. Also, if they are not feeling well you have to administer medicines to them in order for them to get well.” (C5; 40 year old female; Primary caregiver; James Town)

“Care to me means providing everything that the elderly needs. That is their eating, accompanying them to the hospital, fetching water for her to bath and so on.” (C16; 66 year old female; Primary caregiver; James Town)

There are differences between primary and secondary caregivers in relation to their conceptualisation of care. The study found that both primary and secondary caregivers conceptualised care as providing practical care. However, only primary caregivers conceptualised care as providing medical care.

8.3 Perceptions of the elderly concerning the care they receive

8.3.1 Satisfaction

Satisfaction was the most prominent theme regarding the perceptions of the elderly concerning the care they receive. They were content with the care they received from their caregivers.

A total of seventeen elderly, twelve from James Town and five from Ussher Town, reported that they were content with the care they received from their caregivers. Family caregivers met the basic needs of their elderly care recipients (such as food and handled them gently) and as a result, their care recipients were content with the care they received. A 69-year-old male care recipient who resides in James Town stated *“I am okay with the help they offer me. I am pleased with the gentle way they handle me.”* Another elderly female care recipient who resides in James Town also stated that *“ooo the help that he renders to me makes me feel comfortable.”*

Some elderly care recipients also narrated:

“I am happy with the care I receive from them. They treat me nicely, they don’t scold me. They give me the food I want to eat.” (E8; 95 year old female; James Town)

“The care that they are rendering is important to me. It is important to me because if you are not working and you have to eat and even buy pure water, it’s very difficult. Even if you have to eat something and even if you go to private [toilet] you have to pay. It is difficult. So here is the case that you are not working, you don’t have money.” (E1; 64 year old male; James Town)

The elderly care recipients in this study were happy to receive care from their caregivers and almost all the elderly care recipients needed little or no assistance with bathing, and dressing, as a result, they reported no concerns with the intrusion of privacy. Family caregivers only warm the water for bathing and send it to the bathroom for their elderly care recipients to take their bath. However, some studies have documented that elderly care recipients especially female care recipients sometimes have concerns with receiving personal care such as bathing and dressing due to issues of privacy (Roe et al., 2001a, 2001b).

8.3.2 Dissatisfaction

Some elderly care recipients were dissatisfied with the care they received from their caregivers. Dissatisfaction had four sub-themes: lack of financial support, lack of respect, verbal abuse and neglect.

The elderly care recipients were dissatisfied with the care they received because they received inadequate financial support from their caregivers and family members. As a result, they were not able to meet their basic needs such as food. Two elderly care recipients, a male and a female, reported that they received inadequate financial support from their caregivers. The following quotes illustrate their views:

“Hmmm, they will not even give me any money at the end of the month. I’m suffering alone. An English will say “suffer to gain”. I suffer alone and I gain.” (E10; 75 year old female; James Town)

“No, I am not satisfied. ... They should give me [money] so that I will be happy. ... As I am sitting, I am going to buy gari but I don’t have money to buy fish so I want to call my daughter to tell her that I don’t have money to buy fish.” (E12; 68 year old male; James Town)

Some elderly care recipients were also dissatisfied because their caregivers disrespected them by shouting at them. An elderly female who resides in James Town explained that her caregivers disrespect her by shouting at her when she wants them to buy her something she desires.

“Proper care is not given to me. For instance, if I see something that I like and I want them to buy it for me, they will shout at me that they don’t have money. When they do that it really have an effect on me. Today caregivers don’t have the patience for the elderly, the least thing they scold us.” (E11; 86 year old female; James Town)

The elderly care recipients also reported that they were verbally abused by their adult children and family members. Two elderly females who reside in James Town complained that they were insulted by their biological daughter and niece. A 86-year-old female care recipient explained that her sister’s eldest child insults and disgraces her in public.

“As for the first child of my sister, I don’t like her because she likes insulting me too much and disgracing me in public so I am not free with her.” (E11; 86 year old female; James Town)

Another elderly care recipients narrated that her own daughter insults her for still bearing children as she was ageing.

“She has been insulting me that “you are just giving birth as you are growing”. It is not my grandchild who insulted me. It was my child [daughter].” (E10; 75 year old female; James Town)

The elderly care recipients also reported that they were neglected by their relatives. An elderly female narrated that she was told by her sister's children to move from her room to the hall for renovation and since then, she has been prevented access to her room and as a result, she is now sleeping in the kitchen. In spite of this treatment, they continue to care for her.

"It will come to a time when you will need some further information but I will not be here. I would have moved out to hire my own apartment. This is because my sisters' children are not treating me well. My sister too is old. Her children claim my sister and I have different fathers but the same mother and since Ga we inherit patrilineal, I don't belong to this family. So I have told God to ask my mum which family I belong to. I am now sleeping in the kitchen. They told me to vacate my room to sleep in the hall and that they were renovating the place after which I will move back, but since then they have prevented me. So I don't have a sleeping abode in this house anymore." (E16; 81 year old female; Ussher Town)

The quote above highlights the emphasis on the father's line by Ga people although they are related by blood to both their paternal and maternal grandparents and through them to their kin (Kilson, 1974). The study found that the emphasis on the father's line by the nieces of the elderly care recipient made them not to recognise her (care recipient) as a member of their family.

8.3.3 Elderly abuse by caregivers, adult children, other relatives and community members

According to Mba (2007a, p. 231), elderly abuse refers to "any form of maltreatment that results in harm or loss to an older person". The National Center on Elder Abuse (NCEA) (2005) also defines elderly abuse as "intentional or negligent acts by a caregiver or trusted individual that causes harm to a vulnerable elder". Generally, abuse includes neglect, abandonment, physical abuse, psychological abuse, and financial abuse, among others.

The analyses of the qualitative data revealed that the elderly are sometimes abused by their caregivers, their adult children, other relatives and community members. The elderly reported that they are abused verbally and physically, neglected and accused of witchcraft. Appendix 17 shows the major themes and their corresponding sub-themes on elderly abuse by caregivers, adult children, other relatives and community members while the coding frequency for elderly abuse by caregivers, adult children, other relatives and community members are presented in Appendix 15.

Verbal abuse was the most cited form of elderly abuse. Six caregivers, two from James Town and four from Ussher Town, reported that the elderly in the community are sometimes insulted by their relatives and community members. Five out of the six caregivers were younger caregivers. A 51-year-old secondary caregiver who resides in James Town explained that when the elderly sometimes play with children in the community, the parents of those children sometimes insult them and call them witches. She narrated that *“sometimes, when an elderly play with children, their parents insult and call them a witch.”*

Another secondary caregiver who provided care to her grandmother narrated that her younger sister fights and insults their grandmother. She stated that *“my younger sister like this can fight and insult my grandmother telling her she will never get old like her.”*

With regards to neglect, three caregivers out of the thirty-one caregivers reported that most community members do not provide care to their elderly parents and relatives. A younger secondary caregiver stated that *“in our community, most people do not take care of their elderly parents.”*

The elderly care recipients are sometimes abused physically by their caregivers. A female caregiver who provided care to her husband diagnosed with mild stroke mentioned that she once grabbed and shook her husband but felt sorry afterwards and apologised to the husband. She narrated that *“there was a time I run out of patience and I shook him. Later I felt sorry, apologized, and prayed for forgiveness.”*

Providing care to a spouse or spousal caregiving is very challenging and stressful, and the stressful nature of spousal caregiving may have contributed to her loss of patience which subsequently led to the abuse of her husband. Research has documented that stressed family caregivers of the elderly are more likely to abuse their care recipients (Anetzberger, 2000).

The adult children of the elderly sometimes accuse their mothers of being witches. A younger female secondary caregiver who resides in James Town reported that the daughter of her care recipient has accused her care recipient of being a witch and because of the witchcraft accusation, community members refuse to sell to her care recipient.

“Her children say she is a witch. ... Mostly when she wants to buy something, people refuse to sell to her. This is because it has been said that she is a witch.” (C15; 51 year old female; Secondary caregiver; James Town)

This finding supports other studies in Ghana which have found elderly females accused of being witches (Apt, 1993; Dsane, 2009; Tawiah, 2011). For instance, Dsane’s (2009) study among childless elderly women and grandmothers in Teshie (an indigenous Ga community in Greater Accra) found that both childless elderly women and grandmothers were accused of being witches. She, however, noted that childless elderly women disproportionately experienced intense accusation compared to grandmothers. The finding of this study also supports other

studies in sub-Saharan Africa which found that elderly females are accused of being witches (Eboiyehi, 2017; Federici, 2008, 2010; Machangu, 2010; Machera, 1999).

8.4 Summary

This chapter discussed the concept of care by elderly care recipients and their caregivers, and the perceptions of the elderly care recipients concerning the care they received from their primary and secondary caregivers. The study found that different types of care were identified by the care recipients but only practical care and medical care were identified by caregivers.

The results of the study also reveal that elderly care recipients had mixed perspectives regarding the care they received from their family caregivers. Most elderly care recipients were pleased with the care they received from their caregivers. However, some elderly care recipients were dissatisfied with the care they received because they received inadequate financial support from their caregivers to meet their basic needs.

Verbal abuse was reported among elderly care recipients, and caregivers, relatives and community members were perpetrators of elderly abuse. Witchcraft accusation is one the verbal abuses experienced by the elderly female. It led to the stigmatisation of the elderly. The elderly in the community are sometimes insulted when they play with children. In addition, food vendors in the community refuse to sell food to the elderly accused of being witches.

CHAPTER NINE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

9.1 Introduction

This chapter presents a summary of the study, its findings, conclusions drawn from the study and recommendations for policy and future studies.

This study aimed at gaining an in-depth understanding of the lived experiences of family caregiver and their elderly care recipients in Ga Mashie. Specifically, this study examined the socio-demographic characteristics and health status of the general elderly population, caregivers and their elderly care recipients in Ga Mashie, caregivers motivations for providing care to the elderly, challenges faced by caregivers, strategies employed by caregivers to cope with their challenges, rewards caregivers derived from caring for the elderly and perceptions of the elderly concerning the care they receive from their caregivers. This study was conducted among family caregivers and their elderly care recipients residing in two urban poor communities (James Town and Ussher Town) in Accra, Ghana.

This study used both quantitative and qualitative data to answer the research questions. The third wave of the UHPS was used to examine the socio-demographic characteristics and health status of the elderly population in Ga Mashie while a transcendental phenomenological study was conducted among twenty elderly care recipients and thirty-one family caregivers to understand their caregiving lived experiences. The summary of key findings of the study are presented in the next section.

9.2 Summary

The analysis of the third wave of UHPS found that a higher proportion of the elderly were females and young-old (60 – 74 years); 7 out of every 10 of the elderly were females and aged 60 to 74 years. The higher proportion of the elderly females aged 60 years and older compared to elderly males could be related to high male mortality. Studies on sex differentials in mortality among the population aged 60 years and older have documented that elderly females live longer than elderly males due to risky unhealthy behaviours among males such as high consumption of alcohol and tobacco (Crimmins, Hayward, & Saito, 1996; Jacobs et al., 2014; Liang et al., 2003).

With regards to employment status, more than half (51.2 %) of the elderly were employed which is similar to the pattern of employment status observed among the young-old elderly in sub-Saharan Africa. The study also found that hypertension and diabetes were the main prevalent non-communicable diseases among the elderly in Ga Mashie: 4 out of every 10 of the elderly had been diagnosed with hypertension by a medical professional while 1 out of every 10 of the elderly had been diagnosed with diabetes. These conditions are similar to the patterns of non-communicable diseases observed among elderly in Greater Accra (Duda et al., 2011; Mba, 2006). The elderly in Ga Mashie were also diagnosed with comorbid conditions. Approximately 11 percent of the elderly were diagnosed with diabetes and hypertension. In addition, 1 out of every 2 of the elderly is currently enrolled in the National Health Insurance which could enable them to get access to basic healthcare services in National Health accredited health facilities. The majority of households of the elderly used charcoal as their main source of cooking fuel which could increase the risk of acute respiratory infections, cataract, and blindness among household members especially among the elderly.

In addition, the study found that socio-demographic characteristics (such as age, marital status, ethnicity, religion, and wealth quintile) are significantly associated with tenancy arrangements of the elderly.

This study also investigated the various caregiving activities performed by primary and secondary caregivers. The study revealed that caregiving activities varied among primary and secondary caregivers. While primary caregivers often provided practical, material, emotional and medical care to their care recipients, the secondary caregivers often provided practical care such as cooking, and fetching water for bathing.

The findings indicate that family caregivers provided care to their elderly care recipients for varied reasons. The reasons for providing care were grouped into six major themes namely: kin relationship, reciprocity, obligation, altruism, egoism, and affection. The primary and secondary caregivers had multiple reasons for providing care to their elderly care recipients. The reasons for providing care differed among primary and secondary caregivers. With the exception of affection, both primary and secondary caregivers were motivated by kin relationship, reciprocity, obligation, altruism and egoism to provide care to their care recipients. However, only primary caregivers were motivated by affection to provide care to the elderly.

The study also found that on one hand, family caregivers in James Town and Ussher Town provided care because they wanted to enhance the well-being of their care recipients. Some family caregivers provided care because they empathised with the elderly and wanted to help them.

On the other hand, other family caregivers in James Town and Ussher Town provided care because they were seeking their own interest. In this study, some family caregivers indicated that they provided care to their care recipients because they didn't want to suffer in the future, they wanted the blessings associated with providing care and they had the will to decide whether to perform such a task or not. In addition, family caregivers reported that they provided care to their elderly care recipients because of the love they had for them.

The study found that family caregivers experienced some challenges in their quest to care for their elderly care recipients. The family caregivers reported that providing care to their care recipients is difficult and as a result, they experienced economic burden, and physical, social, and psychological challenges which is similar to findings of other studies (Ho et al., 2009; Sanuade & Boatemaa, 2015). With regards to economic burden, caregivers in James Town and Ussher Town reported that providing care affected their finance and economic activities. Older family caregivers also experienced weight loss, pains in the leg, and fatigue as a result of providing care. Family caregiving to the elderly had a negative impact on the finance and economic activities of both primary and secondary caregivers. However, only primary caregivers experienced social, physical and psychological challenges.

Family caregivers employed six strategies to cope with their caregiving challenges. The strategies employed by caregivers were praying, adaptation, perseverance, optimism, indifference and profiteering. This finding is similar to previous studies which identified prayers and patience as strategies used by family caregivers of the elderly to cope with their caregiving difficulties (Dellmann-Jenkins et al., 2000; Subgranon & Lund, 2000). While some caregivers employed multiple strategies, others used single strategies to cope with their caregiving

challenges. There are differences in the coping strategies used by primary and secondary caregivers. While primary caregivers used adaptation and being indifferent to cope with their caregiving challenges, secondary caregivers used optimism and profiteering to cope with their caregiving challenges.

Despite the challenges associated with providing care, the family caregivers can also derive rewards from caring for their elderly care recipients. The family caregivers reported that they derived intrinsic and extrinsic rewards from caregiving. The intrinsic rewards derived by caregivers included: blessing, skills acquisition, honour, enhanced personal attributes, access to accommodation, family cohesion, and health consciousness while the extrinsic rewards were gifts and asset. This finding is similar to studies in the United States which found that family caregivers derived rewards such as appreciation, blessing, enhanced their relationship with their care recipients, financial rewards, and acquisition of new skills as a result of providing care to their care recipients (Tarlow et al., 2004; Thornton & Hopp, 2011).

The study further found that most elderly care recipients were satisfied with the care they received from their caregivers. The elderly care recipients in James Town and Ussher Town reported that they were content with the care they received from their caregivers. However, some elderly care recipients were dissatisfied with the care they received from their caregivers. They complained of lack of financial support and respect from their caregivers. In addition, the study found that elderly care recipients were abused verbally and neglected. The family caregivers also reported that the elderly persons in Ga Mashie were neglected, abused verbally and physically, and accused of being witches. This finding is similar to other studies which found that elderly

women are often accused of being witches (Dsane, 2009; Eboiyehi, 2017; Machangu, 2010; Tawiah, 2011).

9.3 Conclusions

Studies on family caregiving have mainly focused on the negative outcomes of caregiving and most studies on family caregiving in Ghana and other sub-Saharan African countries have focused on the elderly as caregivers to their children and grandchildren. In addition, most studies have focused on the perspectives of caregivers and neglect the perspectives of elderly care recipients. The current study addressed these research gaps by exploring the views of elderly care recipients concerning the care they receive and examining the negative and positive experiences of the family caregivers.

This study revealed that the majority of the elderly lacked access to basic social amenities such as toilet facilities and indoor plumbing in their households. Lack of these amenities has implication for the well-being of the elderly, especially the oldest-old, who may have difficulty accessing them because they are frail.

This study demonstrated that cultural norms was still influential in caregivers decision to provide care to their care recipients. Cultural norms made caregivers to perceive caregiving to their parents and relatives as their duty. In this study, motivations for providing care which were underpinned by cultural norms include kin relationship, reciprocity and obligation.

The study revealed that family members are the main caregivers of the elderly care recipients. This study found that the majority of caregivers are family members of the care recipients. Siblings, adult children, grandchildren, nieces and nephews provided care and various

forms of care to their care recipients. Majority of family caregivers were females and they performed the various types of care ranging from practical, medication, material to emotional care. Male caregivers often provided material care to their care recipients.

The study found a relationship between motivations for providing care and challenges caregivers face in the provision of care to the elderly. In this study, only caregivers who were motivated by altruistic reasons to provide care experienced social challenges. Two females (a younger primary and secondary caregiver) who experienced immobility and disruption of their relationship respectively were motivated by empathy to provide care to their elderly care recipients.

In addition, there was a relationship between motivations for providing care and rewards caregivers derived from caregiving. Only caregivers (two younger female primary caregivers and a younger female secondary caregiver) who were motivated by empathy to provide care received money and in-kind gifts from their care recipient.

The study also examined the concept of care by elderly care recipients and their caregivers, and the perceptions of the elderly concerning the care they received from their caregivers. The study found that elderly care recipients' conceptualisation of care was influenced by the types of care they received or did not receive, their needs and expectations while caregivers' conceptualisation of care was influenced by the types of care they provided.

The findings of the study conform to the theories used in this study, namely: roles theory, social exchange theory, and stress process model. The qualitative data reveal that self-employed caregivers had to provide care to their care recipients while concurrently operating their

individual businesses. Because their roles as caregivers and being self-employed were incompatible due to time conflict and different expectations, self-employed caregivers experienced role conflict which was postulated by role theorist. To resolve this role conflict, caregivers sacrificed their businesses in order to care for their elderly care recipients.

Social exchange theory postulates that an individual will engage in any social relation when he/she expects rewards from the social relation. Findings of the study reveal that on one hand, some family caregivers provided care because they wanted a reward in a form of blessings from the Lord. On the other hand, other family caregivers provided care because they wanted to enhance the well-being of their elderly care recipients rather than earn a reward. In addition, social exchange theory suggests that individuals as rational beings take actions to maximize their rewards or minimise their costs. The study also found that caregivers used their coping strategies to minimise their caregiving costs.

Stress process model postulates that the background and context of caregiving, stressors, and mediators of stress influence outcomes of stress. This study found that the characteristics of family caregivers such as their employment status, the uncooperative behaviour of elderly care recipients, coping strategies employed by caregivers and the various forms of social support caregivers received from their care recipients, relatives, non-relatives and church influence their caregiving challenges. In addition, the various forms of social support care recipients received from their caregivers and other relatives influenced their satisfaction with the care they received from their caregivers. The study also revealed that caregivers also derived rewards from providing care to their care recipients.

In a nutshell, none of the three theories was independently able to adequately explain family caregiving. However, integrating these theories in this study enabled the researcher to gain an in-depth understating of family caregiving.

9.4 Recommendations

This study examined the socio-demographic characteristics and the health status of the elderly in Ga Mashie and described the lived experiences of family caregivers and their elderly care recipients. The following recommendations on policy and future studies are made based on the findings of the study:

Financial strain was the dominant challenge experienced by family caregivers. Most caregivers were engaged in trading activities and didn't earn enough money to cater for themselves and their care recipients. In addition, elderly care recipients also complained about inadequate financial support. It is suggested that the government should broaden the Livelihood Empowerment Against Poverty (LEAP) by expanding the intervention coverage and reducing the eligibility age of the elderly beneficiaries from 65 years and older to 60 years and older so that more poor households with the elderly can benefit from the intervention.

The study found that elderly care recipients complained about lack of financial support. The government should create programmes to help people prepare for old age. These programmes should target adults working in the informal sector who are not entitled to any retirement benefits. In traditional settings in Ghana, parents view children as security against old age. Today, investments in financial and other forms of asset are available for adults, especially

those working in the informal sector, who wish to prepare for old age so that they can enhance their social and income security at old age.

The findings of the study reveal that elderly care recipients and the elderly in the study communities were abused verbally and accused of being witches. It is therefore recommended that avenues such as community durbars and town hall meetings should be used to educate community members on ageing and ageing-related issues including promoting positive aspects of ageing, elderly abuse and witchcraft. Since residents of Ga Mashie are very religious, the heads of religious bodies and traditional authorities such as chiefs, traditional rulers and family heads in the communities could be used as ambassadors to educate community members on these issues.

Family caregivers should be counselled by health professionals about the stressful nature of caregiving, how to deal with their elderly care recipients and helped them to identify effective stress coping strategies. This is because caregivers reported that providing care to their elderly care recipients was difficult and a caregiver could run out of patience and shook her care recipient which could be attributed to caregiver stress.

In addition, the elderly population should be educated and counselled by social/community workers to accept the conditions they found themselves in and the changing environment so that they can be supportive to their caregivers.

The government should explore the feasibility of using mobile clinics to provide healthcare needs for the elderly population since ageing is linked with increased risk of illness, non-communicable diseases, frailty, impairments and disabilities.

Family caregivers should be acknowledged through the media by the Department of Social Welfare and community leaders. This would enhance the self-esteem of caregivers and motivate them to continue providing care to their elderly care recipients.

In addition, Ga Mashie as a community should establish social clubs for the elderly population and involve them in some sporting activities to keep them active and reduce their level of loneliness, isolation, and boredom.

Moreover, there is a paucity of studies investigating the family caregiving from the perspectives of family caregivers and their elderly care recipients, and the positive and negative aspects of family caregiving to the elderly in Ghana and sub-Saharan Africa. It is therefore recommended that future studies should conduct ethnographic studies on family caregiving for deeper understanding of caregiving. Studying the lived experiences of family caregivers and their elderly care recipients over a period of time would enable researchers to understand the complexities of the caregiving experiences of family caregivers and their elderly care recipients.

Furthermore, future studies could investigate changes observed in the care of the elderly. In the current study, although elderly care recipients were asked about changes they have observed in the care of elderly, most care recipients didn't respond to this question. Studying changes in the care for the elderly would enable researchers to understand how modernisation and urbanisation are impacting care for the elderly for appropriate policy interventions.

Finally, future studies should investigate the nature and patterns of elderly abuse. A thorough investigation into the nature and patterns of elderly abuse will provide useful information that can be used in public education on elderly abuse.

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APPENDICES

Appendix 1

In-depth interview for family caregivers

Identification

Name: _____

Caregiver code number: _____

Elderly code number: _____

Socio-demographic background

Sex: Male [] Female []

Age: _____

Highest educational level: No education [] Primary [] JHS/Middle []
Secondary [] Tertiary []

Employment status: Unemployed [] Full-time [] Part-time []

Place of work: At home [] Away from home, nearby [] Away from home, far away []

Ethnicity: Akan [] Ga-Dangme [] Ewe [] Guan []
Mole-Dagbani [] Other []

Religion: Christian [] Islam [] Traditional/Spiritualist []
No religion []

Marital status: Never married [] Married [] Living together []
Divorced/separated [] Widowed []

Number of children: _____

Relationship with the elderly: Son [] Daughter [] Sister [] Brother []
Other relative [] Friend []

Living arrangement: Living with the elderly in the same household []
Not living with the elderly in the same household []

Locality of residence: _____

Sex of the elderly care recipient: Male [] Female []

Interview date: _____

Interviewer name: _____

Start time: _____ End time: _____

Thank you for agreeing to participate in this research on family caregiving to the elderly.

1. Please, can you tell me a little about yourself?
Probe: Life before being a caregiver, social dynamics (social activities, friends, etc.)
2. What does it mean to provide care?

Motivation for providing care

3. How did you become a caregiver to the elderly?
Probe: What happened before you became a caregiver?
Who decided that you should become a caregiver?
Did you like the idea of becoming a caregiver? **Probe:** Why?
4. What are the reasons why you provide care to the elderly?
Probe: Obligatory/no choice, Reciprocity, Benefit from someone else not care receiver etc.
5. Who do you think should provide care for the elderly? **Probe:** Why?
6. What are the cultural values or beliefs associated with caregiving for the elderly in this community?

Caregiving experience

7. Have you ever provided care to a friend or family member who needed care in the past?
Probe: If yes, who was this person?
8. Are you the main person providing care to the elderly?
Probe: Do you do it all the time?
Do other family members or friends assist you in caring for the elderly?
9. How long have you been providing care to the elderly (years and/or months)?

10. How many hours per day on average do you usually spend providing care for the elderly?

11. What types of care/support do you provide to the elderly?

Probe: Eating; Bathing; Dressing; Toileting; Household chores; Counselling; Paying for food, bills, medicine; Social support; Administering medicines, Emotional support such as company etc.

12. How do you feel about providing personal care to the elderly?

Probe: How do you feel about providing bathing to the elderly? **Why?**

How do you feel about providing dressing to the elderly? **Why?**

How do you feel about providing toileting (getting to and using the toilet) to the elderly? **Why?**

13. Kindly narrate what you do for your elderly care recipient on a typical day?

14. If you could draw a picture of you doing caregiving, what would it look like?

15. What has the experience been like providing care to the elderly? **Why?**

16. How has caregiving impacted on your everyday life?

Probe: Has caregiving affected your family life? **In what way?**

Has caregiving affected your social life? **In what way?**

Has caregiving affected your religious life? **In what way?**

Has caregiving affected your economic/financial situation? **In what way?**

Has caregiving affected your emotional/psychological problem (e.g. stress)? **In what way?**

Have you had to make lifestyle change? **In what way?**

Have you experienced any other problem (health, career, etc.) as a result of your caregiving duties and responsibilities? **In what way?**

17. Some caregivers are of the view that caregiving is beneficial to them. What do you think about it?

Probe: What makes it beneficial?

18. Have you benefited from caregiving to the elderly?

Probe: Learnt a new skill. **Kindly narrate the occasion?**

Material gifts. **Kindly narrate the occasion?**

- Feeling of Appreciation. **Kindly narrate the occasion?**
- Financial rewards. **Kindly narrate the occasion?**
- Feeling of satisfaction. **Kindly narrate the occasion?**
- Enhanced self-esteem. **Kindly narrate the occasion?**
- Enhanced relationship. **Kindly narrate the occasion?**
- Bought family together. **Kindly narrate the occasion?**
- Property inheritance. **Kindly narrate the occasion?**
- Feeling of maturity. **Kindly narrate the occasion?**
- Feeling of self-development? **Kindly narrate the occasion?**

Coping strategies

- 19. How do you cope with these challenges as an elderly caregiver?
- 20. In relation to providing care and support to the elderly, have you received any support, help or assistance?
If yes, who provided this support, help or assistance? **Probe:** What was the reason(s) for providing the support, help or assistance?
- 21. What was the type of support, help or assistance you received? **Probe:** Financial, emotional, health, physical, personal

Perception and other issues

- 22. In your community, what are people's perceptions of caregiving to the elderly?
- 23. What more do you wish you had known about while caring for the elderly?
Probe: Do you know where you can get this information?
- 24. If you were advising a relative/friend about caregiving, what advise would you give them?
- 25. Is there any other issue related to your caregiving experience that you feel is important that we have not brought up in this interview?

This is the end of the interview. Thank you for your time!

Appendix 2

In-depth interview for the elderly care recipient

Identification

Name: _____

Elderly code number: _____

Socio-demographic background

Sex: Male [] Female []

Age: _____

Highest educational level: No education [] Primary [] JHS/Middle []
Secondary [] Tertiary []

Employment status: Unemployed [] Full-time [] Part-time []

Ethnicity: Akan [] Ga-Dangme [] Ewe [] Guan []
Mole-Dagbani [] Other []

Religion: Christian [] Islam [] Traditional/Spiritualist []
No religion []

Marital status: Never married [] Married [] Living together []
Divorced/separated [] Widowed []

Number of children: _____

Whose house are you living? Own house [] Family house [] Child's house []
Spouse house [] Father's/mothers house []
Other [] Specify _____

What disease(s) have you been diagnosed with?

How many years have you lived in this community in total?

Months [] Specify _____ Years [] Specify _____ Since birth []

Are there elderly/aged facilities in the community? Yes [] No []

If Yes, the type of elderly/aged facilities available _____

Where is it located? _____

What are the sources of your income? **List all the sources of income you receive**

Remittances from children [] How much do you earn per month? (GH¢) _____

Remittances from other relatives [] How much do you earn per month? (GH¢) _____

Pension income [] How much do you earn per month? (GH¢) _____

Rental of land/house [] How much do you earn per month? (GH¢) _____

Earnings from wages or salary [] How much do you earn per month? (GH¢) _____

Business income [] How much do you earn per month? (GH¢) _____

Social protection programme (e.g. LEAP) [] How much do you earn per month? (GH¢) _____

Cash/ Non-cash gifts from friends [] How much do you earn per month? (GH¢) _____

Other (Specify) _____ How much do you earn per month? (GH¢) _____

What is the present holding/tenancy arrangement of this dwelling?

Owning [] Renting [] Rent Free [] Perching [] Squatting []

Other (Specify) _____

What type of dwelling does this household occupy? **Record observation**

Separate House [] Semi-Detached House [] Flat/Apartment []

Compound House [] Huts/ Building [] Kiosk [] Container []

Attached To Shop [] Other (Specify) _____

What is the **main source of lighting** used by your household?

Electricity [] Kerosene lamp [] Gas lamp [] Candles []

Flashlight/torch [] Other (Specify) _____

What is the **main cooking** fuel used by your household?

None/no cooking [] Fuel wood [] Charcoal [] Gas/LPG []

Kerosene [] Electricity [] Other (Specify) _____

What kind of **toilet facility** does your household use?

No Facility (Bush/Beach/Field) [] Water Closet (W.C)/Flush Toilet [] KVIP []

Pit Latrine [] Bucket/Pan [] Public Toilet (W.C, KVIP, Pit Latrine, Bucket/Pan) []

Other (Specify) _____

What is the **main source of drinking water** for the household?

Piped water [] Water truck/tanker [] Borehole [] Protected well []

Unprotected well [] Rivers/stream/spring [] Rainwater [] Dugout/pond []

Sachet/bottled water [] Other (Specify) _____

Interview date: _____

Interviewer name: _____

Start time: _____ End time: _____

**Thank you for agreeing to participate in this research on family caregiving to the elderly.
We will start by asking the first question:**

1. Please, can you tell me a little about yourself?
Probe: Life as an elderly, social dynamics (social activities, friends, etc.)
2. What does it mean to receive care or to be provided with care?
3. In your opinion, who should provide care for the elderly who are dependent? **Probe:** Why?
4. What are the cultural values or beliefs associated with caregiving for the elderly in this community?
5. Who is the main person who provides you with care?
6. Who are the other people who provide you with care?
7. What is the experience like for you to receive care from your caregiver(s)?
Probe: Why?
8. What type of care do you receive from your caregiver?
Probe: Cooking of meals. **Who provide that care?**
Assist with bathing. **Who provide that care?**
Assist with dressing. **Who provide that care?**
Fetching water. **Who provide that care?**
Assist with toileting. **Who provide that care?**
Washing clothes. **Who provide that care?**
Washing dishes. **Who provide that care?**
Escorting to hospital. **Who provide that care?**
Administering medicines, etc. **Who provide that care?**
Paying for bills, medicine etc. **Who provide that care?**

Paying for daily needs such as food, clothes, etc. **Who provide that care?**

Emotional support, provide company etc. **Who provide that care?**

Assist with going to church, mosque, etc. **Who provide that care?**

9. Do you want to be provided with personal care (bathing, dressing and toileting, etc.)?

Probe: Do you want to be bathed by your caregiver? **Why?**

Do you want to be dressed by your caregiver? **Why?**

Do you want to be sent the toilet by your caregiver? **Why?**

10. What do you expect from care?

11. Are you satisfied with the care you receive from your caregiver? **Probe:** Why?

12. What activities/hobbies do you enjoy?

Probe: Which of these activities/hobbies does your caregiver provide to you?

Which of these activities/hobbies do you want your caregiver to provide to you?

13. Have you observed any changes in the provision of care to the elderly? Why?

Probe: What do you think are the causes of changes in the provision of care to the elderly you have observed?

14. Is there any other issue related to the care you receive that you feel is important that we have not brought up in this interview?

This is the end of the interview. Thank you for your time!

End time: _____

Appendix 3



UNIVERSITY OF GHANA ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

10th October 2016

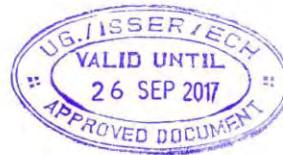
Mr. Frank Kyei-Arthur
Regional Institute for Population Studies
University of Ghana
Legon

Dear Mr. Kyei Arthur,

ECH 009/16-17: INFORMAL CAREGIVING: EXPERIENCES OF CAREGIVERS AND THEIR ELDERLY CARE RECIPIENTS IN URBAN POOR COMMUNITIES IN ACCRA, GHANA

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 26/09/17
On Agenda for: Initial Submission
Date of Submission: 29/08/17
ECH Action: Approved
Reporting: Quarterly



Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Prof. Samuel N. A. Codjoe, Regional Institute for Population Studies

Appendix 4

UNIVERSITY OF GHANA



Official Use only

ECH 009/16-17

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study:	Informal caregiving: Experiences of caregivers and their elderly care recipients in urban poor communities in Accra, Ghana
Principal Investigator:	Frank Kyei-Arthur, Regional Institute for Population Studies, P. O. Box LG 96, Legon, Mobile: 0242355075 Email: fkyeiarthur@yahoo.com
Certified Protocol Number	ECH 009/16-17

Section B- CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

The main purpose of this study is to conduct in-depth interviews with informal caregivers of the elderly in order to gain an in-depth understanding of their lived experiences. Participants in this study will be purposely selected from James Town and Ussher Town (Ga Mashie). Data collection is expected to cover a period of three month. Each in-depth interview with participants is expected to last for about 2 hours.

Benefits/Risk of the study

The issues that will be discussed with you will help us to gain a better understanding of your motivation for providing care, your caregiving experiences, coping strategies and perceptions about caregiving. This will contribute to the literature on positive and negative outcomes of caregiving in urban poor communities. Participants in the study will not be involved in any situation that will be harmful to them.

However, they may feel some discomfort while telling stories of their caregiving experiences. Apart from this, we do not think there are any other risks associated with participation in this study.

Confidentiality

The confidentiality of information provided by you in this study will be protected to the best of my ability. Typed interview transcripts and recordings will be kept securely locked up at the Regional Institute for Population Studies. Access to field notes and recorded tapes will be restricted to me and members of my thesis committee alone. Your identifiers including names and/or addresses will be removed from the transcripts and will not be mentioned in my thesis, any public communications, documents and/or reports.

Compensation

Participants will be given a token of appreciation for their time. Each participant will be given a collection of household items including a cup, a bowl and soap. The gifts will be given at the end of the interview.

Withdrawal from Study

Participation in the study will be voluntary so you are free to decide if you want to be interviewed. During the interview, you have the right to withdraw from the study or may choose not to answer a question at any time and this will not adversely affect you in any way.

Contact for Additional Information

If you have any concerns regarding this study, you may contact: Frank Kyei-Arthur, Regional Institute for Population studies, University of Ghana at fkyeiarthur@yahoo.com or 00233-242-355-075. This research has been reviewed and approved by the Ethics Committee for the Humanities, University of Ghana. If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@isser.edu.gh / ech@ug.edu.gh or 00233- 303-933-866.

Section C- VOLUNTEER AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward 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

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Name of witness

Signature of witness

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

Date

Appendix 5

Table 4.4: Distribution of type of occupation of the elderly

Type of occupation	Frequency (N = 87)	Percentage
Professional/Technical/Managerial	11	12.6
Service and sales	40	46.0
Agriculture	1	1.2
Skilled/unskilled manual	8	9.2
Other	27	31.0

Source: Computed from UHPS, 2013

Table 4.5: Distribution of health insurance enrolment status of the elderly

Health insurance status	Frequency (N = 170)	Percentage
Currently enrolled	85	50.0
Previously enrolled	25	14.7
Never enrolled	56	32.9
Different health insurance scheme	1	0.6
Missing	3	1.8

Source: Computed from UHPS, 2013

Appendix 6: Coding frequencies for motivations for providing care to the elderly

Motivations for providing care to the elderly	C 1	C 2	C 3	C 4	C 5	C 6	C 7	C 8	C 9	C 10	C 11	C 12	C 13	C 14	C 15	C 16	C 17	C 18	C 19	C 20	C 21	C 22	C 23	C 24	C 25	C 26	C 27	C 28	C 29	C 30	C 31	C 32	N
Kin relationship																																	
Parental relationships	*				*						*					*									*						*		6
Non-parental relationships		*	*			*						*	*							*	*									*			9
Reciprocity																																	
Reciprocating past deeds	*	*	*				*	*			*					*	*			*	*	*								*			12
Obligation																																	
Personal										*					*				*		*									*		5	
Religious				*																													1
Altruism																																	
Empathy													*						*							*						3	
Egoism																																	
Self-benefit										*																							1
Blessing														*																			1
Volition																											*						1
Affection																																	
Love															*																*		2

Appendix 7: Major themes for motivations for providing care to the elderly

Category	Themes	Sub-themes	Number of responses	Sample of significant statements
Motivations for providing care to the elderly	Kin relationship	Parental relationships	6	<p>“ ... As he is my father by all means when he is in need, I have to help.” (C1; 28 old male; Primary caregiver; James Town)</p> <p>“I am her eldest child and the only girl, so automatically I am the right person to provide care to her. No one can take care of your own mum for you” (C16; 66 year old female; Primary caregiver; James Town)</p> <p>“It is our responsibility to take care of our mother to make her happy” (C25; 46 year old female; Secondary caregiver; Ussher Town)</p>
		Non-parental relationships	9	<p>“Since he is my father’s sibling that is why I have been helping him” (C3; 30 year old female; Secondary caregiver; James Town)</p> <p>“She is my aunt and mother at the same time, so that is why I provide care for her” (C6; 53 year old female; Secondary caregiver; James Town)</p> <p>“She is my grandmother so I need to take care of her.” (C24; 39 year old female; Primary caregiver; Ussher Town)</p>
	Reciprocity	Reciprocating past deed	12	<p>“My mum used to tell us that our uncle used to be a goalkeeper for Accra Hearts of Oaks and he used to support my mum in those days. So now that both he and my mum can’t afford to support themselves, we have to support him and our mum.” (C2; 23 year old female; Secondary Caregiver; James Town)</p>

				<p><i>“She has done a lot for me. 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 ... that is the only thing I can use in a form of paying her back”</i> (C9; 25 year old male; Primary caregiver; James Town)</p> <p><i>“It is difficult for someone to take care of an orphan but my grandmother did it whole heartedly, so that is what motivated me to also care for her till she goes and be with the Lord Almighty”</i> (C12; 36 year old female; Primary caregiver; James Town)</p> <p><i>“My mum took care of me from infancy until I became an adult, so it’s now my turn to reciprocate until the good Lord calls her”</i> (C23; 50 year old female; Primary caregiver; Ussher Town)</p>
	Obligation	Personal	5	<p><i>“Now that she is old it is my responsibility to take care of her so that one day my children can also do the same for me.”</i> (C11; 65 year old female; Primary caregiver; James Town)</p> <p><i>“When they grow old, you have no choice than to provide care for them”</i> (C23; 50 year old female; Secondary caregiver; Ussher Town)</p>
		Religious	1	<p><i>“Because he is an elderly. As the scripture says if you show respect to the elderly, one, it is a blessing”</i> (C4; 21 year old male; Secondary caregiver; James Town)</p>
	Altruism	Empathy	3	<p><i>“As you can see her issue is pathetic, so when she wants something I should be able to help her with it so that she will also be filled with joy.”</i> (C15; 51 year old female; Secondary caregiver; James Town)</p>

				<p><i>“I feel she is weak and she needs help in her up and down” (C20; 47 year old female; Primary caregiver; James Town)</i></p> <p><i>“It was because she was having difficulties in doing such chores ... so I offered to help” (C27; 27 year old female; Primary caregiver; Ussher Town)</i></p>
	Egoism	Self-benefit	1	<p><i>“I offered to help him so that I will not suffer. If I help him and he becomes fit I will have much time to do other things but if I do not help and he collapses totally then I must sit by him without doing anything” (C10; 68 year old female; Primary caregiver; James Town)</i></p>
		Blessing	1	<p><i>“I also want it. You see, it is more blessing so I also want to get it” (C14; 63 year old female; Secondary caregiver; James Town)</i></p>
		Volition	1	<p><i>“With her, she allows you to do it out of your own free will. If she tells you to go and you do want to or not, she wouldn’t force you” (C28; 23 year old female; Secondary caregiver; Ussher Town)</i></p>
	Affection	Love	2	<p><i>“I also provide care because of the love I have for her” (C31; 45 year old female; Primary caregiver; Ussher Town)</i></p>

Appendix 8: Coding frequencies for challenges primary and secondary caregivers face in the provision of care to the elderly

Challenges caregivers face in the provision of care to the elderly	C 1	C 2	C 3	C 4	C 5	C 6	C 7	C 8	C 9	C 0	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 3	C 3	N
Economic burden																																	
Finance	*			*					*												*	*											8
Limited productivity								*																						*		2	
Physical challenges																																	
Weight loss										*																						1	
Pains in the leg															*																	1	
Fatigue									*																							1	
Social challenges																																	
Immobility																					*						*					2	
Disruption of relationship														*																		1	
Psychological challenges																																	
Frustration					*																*											2	
Irritability								*																								1	

Appendix 9: Major themes for challenges primary and secondary caregivers face in the provision of care to the elderly

Category	Themes	Sub-themes	Number of responses	Sample of significant statements
Challenges caregiver face in the provision of care to the elderly	Economic burden	Finance	8	<p><i>“Seriously, it [caregiving] has really affected my finances.”</i> (C19; 70 year old female; Secondary caregiver; James Town)</p> <p><i>“The little money I have on me I use it in providing care for my grandmother. I am even running at a loss because the money I save for my upkeep is the same money I use to provide care for her.”</i> (C24; 39 year old female; Primary caregiver; Ussher Town)</p>
		Limited productivity	2	<i>“It affects my working days because her hospital check-ups are on Tuesdays and Fridays so I cannot go to the market and sell.”</i> (C30; 41 year old female; Secondary caregiver; Ussher Town)
	Physical challenges	Weight loss	1	<i>“Just that I have reduced in body size and weight. If I wear my old clothes I see that it is falling off but I am not bothered. People know my body size and they can tell the difference. If you do good you do for yourself and if you do bad you do for yourself”</i> (C10; 68 year old female; Primary caregiver; James Town)
		Pains in the leg	1	<i>“... Due to my caregiving duties, I fell in the hospital and I developed some pains in my leg. My mum is aware of it. She even knows my check-up days”</i> (C16; 66 year old female; Primary caregiver; James Town)
		Fatigue	1	<p><i>“There are times that I break down totally and cannot wake up, but I must try and wake up because there is no one to help him”</i> (C10; 68 year old female; Primary caregiver; James Town)</p> <p><i>“I get so tired because I wash on daily basis.”</i> (C10; 68 year old female; Primary caregiver; James Town)</p>

	Social challenges	Immobility	2	<p><i>“My mum has even given me a house at Mamprobi that I am even supposed to go there. ... My siblings are not here so I have to be around. ... I don’t go anywhere.”</i> (C20; 47 year old female; Primary caregiver; James Town)</p> <p><i>“If I am going out and she needs my attention I will have to call and cancel my appointment.”</i> (C26; 44 year old female; Primary caregiver; Ussher Town)</p>
		Disruption of relationship	1	<p><i>“Her child (daughter) says she has witchcraft ... Since we are in good terms with the mother, she, the daughter, is not in good terms with us.”</i> (C15; 51 year old female; Secondary caregiver; James Town)</p>
	Psychological challenges	Frustration	2	<p><i>“... Sometimes providing care to the elderly is very difficult. They sometimes get angry when you are providing care to them so, at times, I feel like not providing the care again since I am not the only one she gave birth to.”</i> (C5; 40 year old female; Primary caregiver; James Town)</p> <p><i>“Caring for the elderly is really difficult, while you say this she also says that. I sometimes get worried about her behaviour.”</i> (C16; 66 year old female; Primary caregiver; James Town)</p>
		Irritability	1	<p><i>“When you do it, then she will tell you, you haven’t done it well. She will tell you, you know, she will even tell another person that you haven’t even done it for her and you will get pissed off.”</i> (C9; 25 year old male; Primary caregiver; James Town)</p>

Appendix 11: Major themes for strategies for coping with caregiving challenges

Category	Themes	Sub-themes	Number of responses	Sample of significant statements
Strategies for coping with caregiving challenges	Praying	Prayers	2	<p><i>"Hmmm, as for the challenges they will come but I pray"</i> (C4; 21 year old male; Secondary caregiver; James Town)</p> <p><i>"I pray to God to give me the strength to provide care to the elderly until God calls her."</i> (C24; 39 year old female; Primary caregiver; Ussher Town)</p>
	Adaptation	Adopting attitude at school	1	<i>"I just say Yes Sir, Yes Sir, Yes Sir. I just pretend as if I'm into an institution where I have to salute. Because of my schooling, you know nursing, you go and they call it you have to salute in everything. You don't have to say anything. So I have also adapted that. So in anything, what you have to do, I do it kpa kpa kpa [I do it quickly] so I don't get tired of those things. I just do it kpa kpa kpa."</i> (C9; 25 year old male; Primary caregiver; James Town)
	Perseverance	Determination	1	<i>"Caring for the elderly is very difficult but with determination, you can be able to provide care to them."</i> (C5; 40 year old female; Primary caregiver; James Town)
		Patience	1	<i>"Providing care to the elderly is very difficult, but as a God-fearing person I am able to cope with the challenges by having the patience for her because of her stage and I know that one day I will also get there."</i> (C17; 68 year of female; Secondary caregiver; James Town)
	Optimism	Being optimistic	1	<i>"I say to myself that I am not broke because providing for them is a blessing, a typical blessing, and a favour."</i> (C4; 21 year old male; Secondary caregiver; James Town)

	Indifference	Indifferent about comments	1	<i>“ ... Because I understand what I really want to do, I snub those things and just do it.” (C9; 25 year old male; Primary caregiver; James Town)</i>
	Profiteering	Profit from money left	1	<i>“... When I send her to the hospital and there is a balance left, I also take it as my sales for the day. For every review we take 100 Cedis with us.” (C30; 41 year old female; Secondary caregiver; Ussher Town)</i>

Appendix 12: Coding frequencies for rewards caregivers derived from caregiving

Rewards caregivers derived from caregiving	C 1	C 2	C 3	C 4	C 5	C 6	C 7	C 8	C 9	C 0	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 1	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 2	C 3	C 3	N	
Gifts																																
Money		*									*	*	*			*	*		*	*	*	*		*	*	*	*		*		*	16
In-kind			*		*						*				*	*	*						*			*		*		*	10	
Blessing																																
Blessing		*		*	*				*			*										*										7
Skills acquisition																																
Caregiving					*							*														*				*	4	
Housekeeping			*						*																						2	
Communicating with the elderly									*																						1	
Honour																																
Appreciation					*											*	*													*	4	
Esteem						*																	*								2	
Enhanced personal attributes																																
Humility and patience										*						*														*	3	
Compassion		*																													1	
Asset																																
Land																*															1	
Access to accommodation																																
Had accommodation									*																						1	
Family cohesion																																
Family cohesion				*																											1	
Health consciousness																																
Being health conscious																										*					1	

Appendix 13: Major themes for rewards caregivers derived from caregiving

Category	Themes	Sub-themes	Number of responses	Sample of significant statements
Rewards or gains caregivers derived from caregiving	Gifts	Money	16	<p><i>“Due to the care I provide to my mum, the church we attend sometimes give me money to motivate me to continue to provide care for my mum.”</i> (C11; 65 years old female; Primary caregiver; James Town)</p> <p><i>“I get money as a result of caring care of her.”</i> (C29; 22 year old female; Secondary caregiver; James Town)</p> <p><i>“There are times she helps me by paying my ward school fees.”</i> (C27; 27 year old female; Primary caregiver; Ussher Town)</p> <p><i>“Sometimes when I am broke, my mum supports me financially.”</i> (C31; 45 year old female; Primary caregiver; Ussher Town)</p>
		In-kind	10	<p><i>“I sometimes get some provisions due to the care I provide for my mum.”</i> (C11; 65 years old female; Primary caregiver; James Town)</p> <p><i>“Oh because of the way we relate to her, at times when she measures the kerosene and there is a little left she shares I with us.”</i> (C15; 51 year old female; Secondary caregiver; James Town)</p> <p><i>“She gives me rice, oil, biscuit and exercise books for my children.”</i> (C27; 27 year old female; Primary caregiver; Ussher Town)</p> <p><i>“I come for milk, provisions, bread and other stuffs. When she has food, she gives me.”</i> (C29; 22 year old female; Secondary</p>

				caregiver; Ussher town) <i>“Through the care I provide for my mum, I have received some gifts from friends and family members.”</i> (C31; 45 year old female; Primary caregiver; Ussher Town)
	Blessing	Blessing	7	<i>“At times, when I do so, a lot of things come my way, a lot of blessing.”</i> (C4; 21 year old male; Secondary caregiver; James Town) <i>“Since I started providing care for my mum, I have never lacked anything. The Good Lord blesses me and sees to it that we never lack anything that we need.”</i> (C5; 40 year old female; Primary caregiver; James Town)
	Skills acquisition	Caregiving	4	<i>“It has helped me to know how to take care of the elderly because at first, I didn’t know how to do it.”</i> (C12; 36 year old female; Primary caregiver; James Town)
		Housekeeping	2	<i>“It has taught me how to cook and do household chores.”</i> (C3; 30 year old female; Secondary caregiver; James Town)
		Communicating with the elderly	1	<i>“When we go on outreach and those things, when I meet the aged, I communicate with them in a way they feel like I,m their child and I believe all these things, it is because of her.”</i> (C9; 25 year old male; Primary caregiver; James Town)
	Honour	Appreciation	4	<i>“People even tell me that I have done well by taking care good care of my mum. During the Easter, we went to church and when people saw her they gave me a handshake that I have done well by taking good care of my mum. When they do that I feel appreciated.”</i> (C5; 40 year old female; Primary caregiver; James Town)
		Esteem	2	<i>“... I feel I am important because I get to sit at places where I would not sit if I was alone. I get to sit at the high table when I accompany her to family meetings, if it was not because of her, I will not be sitting there because my age doesn’t qualify me.”</i>

				(C6; 53 year old female; Secondary caregiver; James Town) <i>“Because of the care I provide to the elderly, I am able to attend family meetings other than that my age would have disqualified me.”</i> (C24; 39 year old female; Primary caregiver; Ussher Town)
	Enhanced personal attributes	Humility and patience	3	<i>“It has taught me to be humble and patient in whatever I do.”</i> (C17; 68 year old female; Secondary caregiver; James Town)
		Compassion	1	<i>“The help I give to him has helped me learn a lot of things. Some of the things that I have learnt are that if someone is in need and you are capable you should help him/her.”</i> (C2; 23 year old female; Secondary caregiver; James Town)
	Asset	Land	1	<i>“He has given me a place in Kokrobite to build a room. He has been forcing me to build on it but the problem is money.”</i> (C18; 28 year old male; Primary caregiver; James Town)
	Access to accommodation	Had accommodation	1	<i>“I have a room and it is because of her.”</i> (C9; 25 year old male; Primary caregiver; James Town)
	Family cohesion	Family cohesion	1	<i>“There used to be small quarrels in the family but since I started providing care to my mum it has brought the family together.”</i> (C5; 40 year old female; Primary caregiver; James Town)
	Health consciousness	Being health conscious	1	<i>“Health-wise, I have learnt a lot of things that affect the family that can equally affect me so I am taking precaution every now and then to make sure I don’t fall a victim. So I check my diet.”</i> (C26; 44 year old female; Primary caregiver; Ussher Town)

Appendix 14: Coding frequencies for perception of the elderly concerning the care they receive from their caregivers

Perception of the elderly concerning the care they receive	E 1	E 2	E 3	E 4	E 5	E 6	E 7	E 8	E 9	E 10	E 11	E 12	E 13	E 14	E 15	E 16	E 17	E 18	E 19	E 20	N
Satisfaction																					
Contentment	*	*		*	*	*	*	*	*		*		*	*	*	*	*	*	*	*	17
Dissatisfaction																					
Lack of financial support										*		*									2
Lack of respect											*										1
Insults									*	*											2
Neglect																*					1

Appendix 15: Coding frequencies for elderly abuse by caregivers, adult children, other relatives and community members

Elderly abuse by caregivers, adult children, other relatives and community members	C 1	C 2	C 3	C 4	C 5	C 6	C 7	C 8	C 9	C 10	C 11	C 12	C 13	C 14	C 15	C 16	C 17	C 18	C 19	C 20	C 21	C 22	C 23	C 24	C 25	C 26	C 27	C 28	C 29	C 30	C 31	C 32	N				
Verbal abuse																																					
Insults													*	*																			*		6		
Neglect																																					
Neglect																																	*		*	*	3
Physical abuse																																					
Physical abuse										*																										1	
Witchcraft accusation																																					
Witchcraft accusation																	*																			1	

Appendix 16: Major themes for perception of the elderly concerning the care they receive from their caregivers

Category	Themes	Sub-themes	Number of responses	Sample of significant statements
Perception of the elderly concerning the care they receive from their caregivers	Satisfaction	Contentment	17	<p><i>“I am happy with the care that my daughter provides for me. I don’t have any problem with it. For instance, by the time I will finish bathing my breakfast is also ready. My son said he cannot provide this kind of support that is why my daughter is here with me providing every support I need. Up till date, my daughter is the one who fetches water for me to bath.”</i> (E2; 83 year old female; James Town)</p> <p><i>“Ooo the help that he renders to me makes me feel comfortable.”</i> (E6; 85 year old female; James Town)</p> <p><i>“I am okay with the help they offer me. I am pleased with the gentle way they handle me.”</i> (E7; 69 year old male; James Town)</p> <p><i>“I am happy with the care I receive from them. They treat me nicely, they don’t scold me. They give me the food I want to eat.”</i> (E8; 95 year old female; James Town)</p> <p><i>“I am satisfied with the care my daughter provides for me.”</i> (E14; 95 year old female; James Town)</p>
	Dissatisfaction	Lack of financial support	2	<p><i>“Hmmm, they will not even give me any money at the end of the month. I’m suffering alone. An English will say “suffer to gain”. I suffer alone and I gain.”</i> (E10; 75 year old female; James Town)</p>

				<i>"No, I am not satisfied. ... They should give me [money] so that I will be happy. ... As I am sitting, I am going to buy gari but I don't have money to buy fish so I want to call my daughter to tell her that I don't have money to buy fish." (E12; 68 year old male; James Town)</i>
		Lack of respect	1	<i>"Proper care is not given to me. For instance if I see something that I like and I want them to buy it for me, they will shout at me that they don't have money. When they do that it really have an effect on me. Today caregivers don't have the patience for the elderly, the least thing they scold us." (E11; 86 year old female; James Town)</i>
		Insults	2	<i>"She has been insulting me that "you are just giving birth as you are growing". It is not my grandchild who insulted me. It was my child [daughter]." (E10; 75 year old female; James Town)</i> <i>"As for the first child of my sister, I don't like her because she likes insulting me too much and disgracing me in public so I am not free with her." (E 11; 86 year old female; James Town)</i>
		Neglect	1	<i>"It will come to a time when you will need some further information but I will not be here. I would have moved out to hire my own apartment. This is because my sisters' children are not treating me well. My sister too is old. Her children claim my sister and I have different fathers but the same mother and since Ga we inherit patrilineal, I don't belong to this family. So I have told God to ask my mum which family I belong to. I am now sleeping in the kitchen. They told me to vacate my room to sleep in the hall and that they were renovating the place after which I will move back, but since then they have</i>

				<i>prevented me. So I don't have a sleeping abode in this house anymore.” (E16; 81 year old female; Ussher Town)</i>
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Appendix 17: Major themes for elderly abuse by caregivers, adult children, other relatives and community members

Category	Themes	Sub-themes	Number of responses	Sample of significant statements
Elderly abuse by caregivers, adult children, other relatives and community members	Verbal abuse	Insults	6	<p><i>“Sometimes, when an elderly play with children, their parents insult and call them a witch.”</i> (C13; 51 year old female; Secondary caregiver; James Town)</p> <p><i>“My younger sister like this can fight and insult my grandmother telling her she will never get old like her.”</i> (C30; 41 year old female; Secondary caregiver; Ussher Town)</p>
	Neglect	Neglect	3	<i>“In our community, most people do not take care of their elderly parents.”</i> (C30; 41 year old female; Secondary caregiver; Ussher Town)
	Physical abuse	Physical abuse	1	<i>“There was a time I run out of patience and I shook him. Later I felt sorry, apologized, and prayed for forgiveness.”</i> (C10; 68 year old female; Primary caregiver; James Town)
	Witchcraft accusation	Witchcraft accusation	1	<i>“Her children say she is a witch. ... Mostly when she wants to buy something, people refuse to sell to her. This is because it has been said that she is a witch.”</i> (C15; 51 year old female; Secondary caregiver; James Town)

Appendix 18: Questionnaire of the third round of the Urban, Health and Poverty Survey (UHPS)



**POPULATION TRAINING AND RESEARCH CAPACITY
FOR DEVELOPMENT (POPTRCD)**

URBAN HEALTH AND POVERTY PROJECT

HOUSEHOLD QUESTIONNAIRE



IDENTIFICATION															
LOCALITY NAME* _____ E.A. BASE _____ NAME OF HOUSEHOLD HEAD _____ E.A. /EDL NUMBER STRUCTURE NUMBER..... HOUSEHOLD NUMBER GREATER ACCRA..... ROUND..... * CODES FOR LOCALITY NAME: 1=AGBOGBLOSHIE 2=JAMES TOWN 3=USSHER TOWN	<div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">3</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">3</td> </tr> </table>								0	3	0	3			
0	3														
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2	0	1	3												
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*RESULT CODES: 1 COMPLETED 2 PARTLY COMPLETED 3 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT THE TIME OF VISIT 4 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME 5 POSTPONED 6 REFUSED 7 DWELLING VACANT OR ADDRESS NOT A DWELLING 8 DWELLING DESTROYED 9 DWELLING NOT FOUND 10 OTHER (SPECIFY) _____				TOTAL PERSONS IN HOUSEHOLD <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> TOTAL ELIGIBLE WOMEN <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> TOTAL ELIGIBLE MEN <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> LINE NO. OF RESP. TO HOUSEHOLD QUEST. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> HH INT. IN ROUND 2 <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table>											
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LANGUAGE OF QUESTIONNAIRE: ENGLISH LANGUAGE OF INTERVIEW** _____ NATIVE LANGUAGE OF RESPONDENT** _____ WAS TRANSLATOR USED? (YES=1, NO=2) **LANGUAGE CODES: 1= ENGLISH 2 =AKAN 3= GA 4 =EWE 5 =DAGBANI 6= HAUSA 7= OTHER (SPECIFY) _____				<table style="border-collapse: collapse;"> <tr><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">1</td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr> <tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr> </table>	1										
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INFORMED CONSENT FOR HOUSEHOLD

Population, Health and Poverty in Accra

Principal Investigator: Prof. Francis Doodoo

Address: Regional Institute for Population Studies.
University of Ghana, Legon

My name is I am from the Regional Institute for Population Studies (RIPS), University of Ghana. The Institute is currently conducting a survey on urban health and poverty in Ga Mashie and Agbogbloshie in Accra. The purpose of the survey is to understand the relationship between urban health and poverty in Ghana. We will ask you questions about general characteristics of your household and members of your household: the composition, age and sex, educational attainment, etc. The information you provide would inform any future intervention programmes and teaching and learning in RIPS and other tertiary institutions.

During the interview, I will only ask you questions about you and your household. I will not be conducting any medical exams or tests; I will only be asking questions. We do not believe that there are any risks associated with participation in this study. You are free to decide if you want to be in this research. Your decision will not affect any service(s) and benefits you would normally receive. Your participation is entirely voluntary.

If you agree to be interviewed, the interview will last about 45 minutes. In the course of the discussion you may choose not to answer a question or even stop the interview altogether. If you choose to stop the discussion, all the responses you provide will be deleted from the study. However, if you consent to the interview, all the information that you give will remain confidential.

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of the Institute may sometimes look at your research records. If you agree to the interview, I will take notes of the conversation between us on paper. Have I explained everything well enough to you? Do you have any questions for me?

After our interview, if you have any concerns regarding the study you may contact any of the following persons: Prof. Francis Doodoo or Prof. Samuel Nii Ardey Codjoe (030-2500274).

This research has been reviewed and approved by the IRB of Noguchi Memorial Institute for Medical Research at the University of Ghana, Legon. An IRB is a committee that reviews research studies in order to help protect participants. If you have any questions about your rights as a research participant you may contact [Rev. Dr. Ayete-Nyampong, Chairperson, NMIMR-IRB, mobile 0208152360]

CONSENT TO PARTICIPATE IN SURVEY

Please sign/thumb print below if you agree to participate in the study.

The above document describing the benefits, risks and procedures for the Population, Health and Poverty study in Accra has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Respondent's Signature/Thumbprint.....



Date.....

Witness' Signature

Date.....

Interviewer Signature.....

Date.....

START TIME FOR INTERVIEW

HOURS MINS

210

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HOUSEHOLD SCHEDULE

I would like some information about the people who usually live in your household or who are staying with you now.										
LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HH	SEX	RESIDENCE			AGE	ELIGIBILITY		
				Does (NAME) usually live here? (6months or more)	Did (NAME) sleep here last night? YES→8	Why did (NAME) not sleep here last night? **		How old is (NAME)?	CIRCLE LINE NUMBER OF ALL CHILDREN UNDER AGE 5	CIRCLE LINE NUMBER OF ALL WOMEN AGE 15-49***
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
01		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	01	01	01
02		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	02	02	02
03		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	03	03	03
04		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	04	04	04
05		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	05	05	05
06		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	06	06	06
07		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	07	07	07
08		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	08	08	08
09		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	09	09	09
10		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	10	10	10
11		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	11	11	11
12		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	12	12	12
13		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	13	13	13
14		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	14	14	14
15		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	<input type="text"/>	IN YEARS <input type="text"/>	15	15	15
TICK HERE IF CONTINUATION SHEET USED			NUMBER OF ELIGIBLE WOMEN			NUMBER OF ELIGIBLE MEN				
<p>* CODES FOR Q3</p> <p>RELATIONSHIP TO HEAD OF HOUSEHOLD:</p> <p>01 = HEAD 02 = SPOUSE 03 = SON OR DAUGHTER 04 = SON-IN-LAW/DAUGHTER-IN-LAW 05 = GRANDCHILD 06 = PARENT 07 = PARENT-IN-LAW</p>						<p>**CODES FOR Q7</p> <p>01=AT WORK 02=NO SPACE FOR SLEEPING 03=TRAVELLED 04=BOARDING HOUSE 06=OTHER (SPECIFY)..... 98=DON'T KNOW</p>				
<p>08 = BROTHER/SISTER 09 = CO-WIFE 10 = ADOPTED/FOSTER/STEP-CHILD 11= OTHER RELATIVE (AFFINAL) 12= OTHER RELATIVE (CONSANGUINE) 13= NOT RELATED 98=DON'T KNOW</p>										

LINE NO.	EDUCATION (IF AGE 3 OR OLDER & IF ATTENDED SCHOOL)				IF AGE 15 OR OLDER MARITAL STATUS	ETHNICITY	RELIGION
	Has (NAME) ever attended school? NO→16	What is the highest level of education (NAME) attended?*	What is the highest grade (NAME) completed at that level? **	Is (NAME) still in school?	What is the marital status of (NAME)? ***	What is the ethnic group of (NAME)? ****	What is the religion of (NAME)? *****
	(12)	(13)	(14)	(15)	(16)	(17)	(18)
01	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER SPECI	<input type="checkbox"/> <input type="checkbox"/>
02	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER SPECIF	<input type="checkbox"/> <input type="checkbox"/>
03	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
04	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
05	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
06	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
07	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
08	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
09	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
10	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
11	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
12	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
13	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
14	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER	<input type="checkbox"/> <input type="checkbox"/>
15	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 96=OTHER SPECIF.	<input type="checkbox"/> <input type="checkbox"/>

Just to make sure that I have a complete listing:

- | | | | | |
|--|-----|--------------------------|---|--------------------------|
| 1) Are there any other persons such as infants or children that we have not listed? | YES | <input type="checkbox"/> | ENTER EACH IN TABLE NO | <input type="checkbox"/> |
| 2) In addition, are there any other people such as domestic servants, lodgers or friends who usually live here? | YES | <input type="checkbox"/> | → ENTER EACH IN TABLE NO | <input type="checkbox"/> |
| 3) Are there any guests or temporary visitors staying here, or anyone else who slept here last night that I have not listed? | YES | <input type="checkbox"/> | → ENTER EACH IN TABLE NO (SKIP ONE ROW) | <input type="checkbox"/> |
| 4) Are there any persons who used to live in your household but have moved out in the past 1 year? | YES | <input type="checkbox"/> | → ENTER EACH IN TABLE NO HOW MANY? | <input type="checkbox"/> |

***CODES FOR Q13**
 0=PRE-SCHOOL
 1=PRIMARY
 2=JHS/MIDDLE
 3=SHS/SECONDARY
 4=HIGHER
 8=DON'T KNOW

****EDUCATION GRADE Q14**
 00=LESS THAN 1 YEAR
 98=DON'T KNOW

*****CODES FOR Q16**
 0=NEVER MARRIED
 1= LIVING TOGETHER
 2= MARRIED
 3= SEPARATED
 4=DIVORCED
 5= WIDOWED

******CODES FOR Q17**
 01=AKAN
 02=GA-DANGME
 03=EWE
 04=GUAN
 05=GURMA
 06=MOLE-DAGBANI

07=GRUSI
 08=MANDE
 96=OTHER (SPECIFY)
RECORD ADJACENT TO TO THE CODE ABOVE.

*******CODES FOR Q18**

01= NO RELIGION 05=OTHER CHRISTIAN
 02= CATHOLIC 06=ISLAM
 03= PROTESTANTS 07=TRADITIONAL/SPIRITUALIST
 04= PENTECOSTAL/CHARISMATIC 08=EASTERN RELIGIONS (ECKANKA , HINDU)
 96=OTHER (SPECIFY).....

LINE NO.	FOR VISITORS AND USUAL RESIDENTS	VISITORS ONLY	FOR FORMER RESIDENTS/VISITORS ONLY	OCCUPATION	PopTRCD 2011
	FOR VISITORS: How long has (NAME) been staying here?*** FOR USUAL RESIDENTS How long has (NAME) lived in this household? **(USE CODES BELOW)**	Where did (NAME) come from? USE CODES BELOW)*	ONLY IF '2' IS CIRCLED IN BOTH COLS. 5 & 6 How long did (NAME) live here before moving out?***	What is (NAME) current occupation? That is what kind of work does (NAME) mainly do?	Was (NAME) a member of this household during the 2011 EDUL survey? 1=YES→ Q28 2=NO
	(19)	(20)	(21)	(22)	(23)
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
07	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*CODES FOR Q20 1= WITHIN THE SAME COMMUNITY 2= ANOTHER COMMUNITY IN ACCRA 3= ANOTHER TOWN 4= RURAL 5= BOARDING SCHOOL 8=DON'T KNOW	**CODES FOR Q19 AND Q21 1= DAY 2= WEEKS 3=MONTHS 4= YEARS 5=SINCE BIRTH 8=DON'T KNOW	***CODES FOR Q22 01=NO OCCUPATION 02=PROFESSIONAL/TECHNICAL 03=MANAGEMENT 04=CLERICAL 05=SALES 06=AGRICULTURE- SELF EMPLOYED 98=DON'T KNOW	07=AGRICULTURE 08=HOUSEHOLD AND DOMESTIC 09=SERVICE 10=SKILLED MANUAL 11=UNSKILLED MANUAL 12=STUDENT 96=OTHER (SPECIFY).....
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	(24)	(25)	(26)	(27)
	Was there any person(s) who was a member of your household during 2011 PopTRCD (EDULINK) survey but currently not a member now? 1=YES 2=NO → SKIP TO Q28	Please give me the name(s) of that person(s) a. b. c.	What is the reason for [NAME]'s absence?****	Where did [NAME] go to?*****

		d.			
****CODES FOR Q26 01 = EMPLOYMENT 02 = LOOKING FOR WORK 03 = SCHOOL 04 = VISIT FAMILY 05 = VISIT FRIENDS 06 = MARRIAGE/COHABITATION		07 = PERSONAL REASONS 08 = ESCAPE VIOLENCE OR POLITICAL PROBLEMS 09 = PRISON 10 = HOSPITAL /CLINIC 11 = NURSING HOME/OLD PERSONS HOME 12 = DIED _ go to Next HH member 96= OTHER (SPECIFY).....	****CODES FOR Q27 1 = DIFFERENT HOUSEHOLD IN SAME COMMUNITY/LOCALITY/ NEIGHBOURHOOD 2 = RURAL AREA IN DIFFERENT PART OF THE COUNTRY 3 = CITY/URBAN AREA IN DIFFERENT PART OF THE COUNTRY 4 = ANOTHER COUNTRY 8 = DON'T KNOW		

CHRONIC NON-COMMUNICABLE DISEASE CONDITIONS						
LINE NO.	Has (Name) ever been told by a health professional that he/she has had a stroke ? 1. YES 2. NO → Q35	Has (Name) been taking any medications or other treatment for it during the last 2 weeks ? 1. YES 2. NO	Has (Name) been taking any medications or other treatment for it during the last 12 months ? 1. YES 2. NO	Has (Name) ever been diagnosed with high blood pressure (hypertension)? 1. YES 2. NO → Q38	Has (Name) been taking any medications or other treatment for it during the last 2 weeks ? 1. YES 2. NO (Other treatment might include weight loss program or change in eating habits.)	Has (Name) been taking any medications or other treatment for it during the last 12 months ? 1. YES 2. NO (Other treatment might include weight loss program or change in eating habits.)
	(32)	(33)	(34)	(35)	(36)	(37)
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
07	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
08	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
09	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHRONIC NON-COMMUNICABLE DISEASE CONDITIONS							
LINE NO.	Has (Name) ever been diagnosed with diabetes (high blood sugar)? (Not including diabetes associated with a pregnancy) 1. YES 2. NO → Q41	Has (Name) been taking insulin or other blood sugar lowering medications during the last 2 weeks? 1. YES 2. NO	Has (Name) been taking insulin or other blood sugar lowering medications during the last 12 months? 1. YES 2. NO	Has (Name) ever been diagnosed with any other chronic non-communicable disease apart from conditions mentioned in (Q32, Q35, and Q38 - Stroke, hypertension and diabetes) 1. YES 2. NO → Q45	If Yes in Q41, please specify: <i>(Interviewer, record all mentioned)*</i>	Has (Name) been taking any medication or therapy for the condition during the last 2 weeks? 1. YES 2. NO	Has (Name) been taking any medication or therapy for the condition during the last 12 months? 1. YES 2. NO
	(38)	(39)	(40)	(41)	(42)	(43)	(44)
01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
06	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
07	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
08	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
09	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Code For Q42*
 1=ARTHRITIS
 2=ANGINA (coronary heart disease)
 3=ASTHMA
 4=CANCER
 5=DEPRESSION
 6= OTHER (SPECIFY).....

	neighbouring standpipe, or any other source in the last 2 weeks				
53.	Did your household sell any water to someone else? 1=YES 2=NO		<input type="checkbox"/>		If code 2, skip to 55
54	How much did your household receive from the water sold in the last 2 weeks? Don't know=999.98	Amount in GH¢			
55	Do you store water in your house so as to use it for more than one day? 1=YES 2=NO		<input type="checkbox"/>		If code 2, skip to 61
NO	Question	Response		SKIP	
56	How do you mainly store your drinking water? <i>Codes below</i>		<input type="checkbox"/>		IF CODE , 1,3,5,7,8 9 SKIP to 59
57	If container has a lid, does the lid screw on or attach tightly to the container? 1=YES 2=NO		<input type="checkbox"/>		
58	Does the container have a spigot or small mouth or tap for dispensing water? =YES 2=NO		<input type="checkbox"/>		
59	Do you do anything to make this water safe to drink? 1=YES 2=NO 8=DON'T KNOW		<input type="checkbox"/>		IF CODE 2 OR 8, SKIP to 61
60	What do you usually do to make the water safe to drink? <i>Codes below</i>		<input type="checkbox"/>		
61	What kind of toilet facility does your household use? <i>Codes below</i>		<input type="checkbox"/>		
62	Do you share the above mentioned toilet facility with other households? 1=YES 2=NO		<input type="checkbox"/>		
63	Do you have a refuse bin in your household? 1=YES 2=NO		<input type="checkbox"/>		
64	Who usually disposes of the household solid waste? 1=ADULT WOMAN 2=ADULT MAN 3=FEMALE CHILD (UNDER 15 YEARS) 4=MALE CHILD (UNDER 15 YEARS)		<input type="checkbox"/>		
65	Where do you dispose of household solid waste? 1=COLLECTED AT HOME BY A PRIVATE COMPANY 4=COMMUNITY DRAIN 2=COLLECTED AT HOME BY A GOVERNMENT AGENCY 5=TRUCK PUSHERS (KAYA BOLA) 3=REFUSE CONTAINER 6=INDISCRIMINATELY 7=OTHER.....		<input type="checkbox"/>		
66	Do you pay for disposing of household solid waste? 1=YES 2=NO		<input type="checkbox"/>		IF CODE 2, SKIP to 68
67	How much do you pay monthly?				
68	How do you dispose household liquid waste (waste water from bathing, preparation of food, cooking and other personal and domestic activities)? 1=SEPTIC TANK 2=COMMUNITY DRAIN 3=BACK OF HOUSE 4=INDISCRIMINATELY 5=OTHER (SPECIFY).....		<input type="checkbox"/>		
69	What is the main source of cooking fuel for this household? <i>codes below</i>		<input type="checkbox"/>		
70	Does your household have.....?	1=YES 2=NO		1=YES 2=NO	
	CAR			WASHING MACHINE	
	BICYCLE			TELEVISION	
	BOAT/CANOE			RADIO	
	TRUCK			TELEPHONE	

		AN OUTBOARD MOTOR		CLOCK	
		REFRIGERATOR		ELECTRIC/GAS STOVE	
		FREEZER		SOFA	
		GENERATOR		SEWING MACHINE	
		IRON		ELECTRIC FAN	
		COMPUTER		FISHING NET	
Codes: Question 56		Codes: Question60:		Codes: Ques.61	
1=OVERHEAD TANK		01=BOIL		1=NO FACILITY	
2=PLASTIC/STEEL CONTAINER WITH LID		02=ADD BLEACH, CHLORINE, OR		(BUSH/BEACH/FIELD)	
3=PLASTIC/STEEL CONTAINER WITHOUT LID		ALLOY		2=WATER CLOSET	
4=EARTHEN WARE POT WITH LID		03=STRAIN THROUGH A CLOTH		(W.C)/FLUSH TOILET	
5=EARTHEN WARE POT WITHOUT LID		04=SOLAR DISINFECTION		3= KVIP	
6=ALUMINIUM BUCKET WITH LID		05=LET IT STAND TO SETTLE		4= PIT LATRINE	
7=ALUMINIUM BUCKET WITHOUT LID		06=WATER TABLETS		5=BUCKET/PAN	
8=BASIN(PLASTIC/ALUMINIUM/ENAMEL		07=ALUM		6=PUBLIC TOILET (W.C,KVIP,	
9=SACHET		08=CAMPHOR		PIT LATRINE,BUCKET/PAN)	
10=OTHER		09=OTHER (SPECIFY).....		96=OTHER	
		98= DON'T KNOW		(SPECIFY).....	
				01=NONE/NO	
				COOKING	
				06=CHARCOAL	
				02= WOOD	
				07=CROP RESIDUE	
				03=GAS	
				08=SAW DUST	
				04=ELECTRICITY	
				09=ANIMAL WASTE	
				05=KEROSENE	
				96=OTHER	
				(SPECIFY).....	
71	How many rooms does this household occupy? (<i>count living, dining, bedrooms but not bathrooms ,toilet & kitchen</i>)				<input type="text"/>
72	How many of the rooms are designed primarily for sleeping?				<input type="text"/>
73	How many household members sleep outside the designated sleeping rooms? CODE 00 IF NO HOUSEHOLD MEMBER SLEEPS OUTSIDE				<input type="text"/>
74	Who owns this dwelling? 1=OWNED BY HH MEMBER 5=PRIVATE EMPLOYER 2=BEING PURCHASED (e.g., Mortgage) 6=OTHER PRIVATE AGENCY 3=RELATIVE NOT HH MEMBER 7=PUBLIC/GOVERNMENT OWNERSHIP 4=OTHER PRIVATE INDIVIDUAL 96=OTHER (SPECIFY)_____				<input type="text"/>
75	What is the present holding/tenancy arrangement of this dwelling? 1=OWNING 2=RENTING 3=RENT FREE 4=PERCHING 5=SQUATTING 6=OTHER (SPECIFY)_____				<input type="text"/>
HOUSEHOLD OBSERVATION					
76	What type of dwelling does this household occupy? Record observation 01=SEPARATE HOUSE 04=ROOMS 07=KIOSK 02=SEMI-DETACHED HOUSE 05=SEVERAL HUTS/ BUILDING 08= CONTAINER 03=FLAT/APARTMENT 06=TENT 09= ATTACHED TO SHOP 10= COMPOUND HOUSE 96=OTHER (SPECIFY)_____				<input type="text"/>
77	What is the main material of the floor? Record observation 01=EARTH/SAND 04=WOOD 10=VINYL TILES 07=WOOLEN CARPET 02=BURNT BRICKS 05=WOOD PLANKS 08=LINOLEUM/RUBBER CARPET 03=CEMENT/CONCRETE 06=TERRAZO 09=CERAMIC TILES/PORCELAIN GRANITE/MARBLE 10=VINYL TILES 11=STONE				<input type="text"/>
77	What is the main material of the roof? RECORD OBSERVATION 01=THATCH/PALM LEAF/SOD 06=ROOFING SHINGLES 02=RUSTIC MAT 07=ASBESTOS/SLATE ROOFING SHEETS 03=CARDBOARD 08=PALM/BAMBOO 04=METAL SHEETS 09=WOOD 05=BRICK TILES 10=CEMENT 96=OTHER (SPECIFY)....				<input type="text"/>
78	What is the main material of the wall? RECORD OBSERVATION 01=CANE/PALM/TRUNKS 08=MUD BRICKS 02=BAMBOO WITH MUD 09=STONE WITH MUD 03= WOOD 10= PLYWOOD				<input type="text"/>

	04=CARDBOARD 05=LANDCRETE 06=BURNT BRICKS 07=METAL SHEETS/SLATE/ASBESTOS	11=BAMBOO 12=CEMENT BLOCKS/CONCRETE 96=OTHER (SPECIFY).....		
79	INCOME EVALUATION QUESTION (IEQ) Taking into account your own situation with respect to the physical characteristics of your family and job you would call your net-income (including gifts from family and friends, and tips) per year			
			GHANA CEDIS	
	MORE THAN WHAT YOU NEED (IF IT WERE ABOVE)			
	JUST WHAT YOU NEED (IF IT WERE BETWEEN)			
	BARELY WHAT YOU NEED (IF IT WERE BETWEEN)			
	LESS THAN WHAT YOU NEED (IF IT WERE BETWEEN)			
	MUCH LESS THAN WHAT YOU NEED (IF IT WERE BELOW)			
80	Who is the primary source of income for this household? 1=HEAD OF HOUSEHOLD 2=PARTNER/SPOUSE 6=OTHER(SPECIFY).....		<input type="checkbox"/>	
	3=BOTH SHARED EQUALLY (HEAD AND SPOUSE) 4= A DIFFERENT MEMBER OF THE HOUSEHOLD			
81	How much can you rely on relatives outside of your household or friends for financial support if you need it? 1=A LOT 2=SOMETIMES 3=A LITTLE 4=NOT AT ALL		<input type="checkbox"/>	
NO	Question		Response	
82	Who manages sanitation resources in your community?		YES	NO
	AMA/SUB-METRO		1	2
	UNIT COMMITTEE		1	2
	LOCAL WATER/SANITATION COMMITTEE		1	2
	COMMUNITY DEVELOPMENT COMMITTEE		1	2
	NGO		1	2
	TRADITIONAL LEADER(S)		1	2
	RELIGIOUS ORGANISATION(S)		1	2
	PRIVATE INDIVIDUAL(S)		1	2
	PRIVATE ORGANISATION		1	2
	OTHER.....		1	2
	DON'T KNOW		1	2
83	What are the major environmental challenges that you face in this community		YES	NO
	1. FLOODING		1	2
	2. POOR SANITATION		1	2
	3. POLLUTION		1	2
	4. HIGH TEMPERATURE (HEAT)		1	2
	5. SEA LEVEL RISE		1	2
	6. OTHER (SPECIFY).....		1	2
84	Which is the most challenges environmental issue mentioned in Ques.78 above?			<input type="checkbox"/>
85	What are the most common diseases in this community that are associated with these environmental challenges?		YES	NO
	1. DIARRHOEA		1	2
	2. MALARIA		1	2
	3. CEREBRO-SPINAL MENINGITIS		1	2
	4. SKIN RASH		1	2
	5. COUGH/DIPHThERIA		1	2
	6. OTHER (SPECIFY)		1	2
			1	2

86	What is the most common disease mentioned in Ques.80 in this community that is associated with environmental challenges?	<input type="checkbox"/>
87	What is the distance from your house to the nearest standing water or open gutter? <i>Distance in meter</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
88	When was the last time you or any member of your household had diarrhoea? 1=LESS THAN A WEEK AGO 2=A WEEK AGO 3=TWO WEEKS AGO 4=THREE WEEKS AGO 5=A MONTH AGO 6=MORE THAN A MONTH AGO	<input type="checkbox"/>
89	How many times did you or any member of your household have diarrhoea within the past month?	<input type="text"/> <input type="text"/>
90	Did you or the member of your household seek advice or treatment for the diarrhoea (from any source)? 1=YES 2=NO	<input type="checkbox"/> If code 2 SKIP to Q.93
91	Where did you first seek advice or treatment for the diarrhoea? 1=HOSPITAL/CLINIC 2=PHARMACY/DRUG STORE 3= HERBAL MEDICINE (SELF PRESCRIPTION)	<input type="checkbox"/>
92	How many days after the diarrhoea began did you first seek advice or treatment?	<input type="text"/> <input type="text"/>
93	The last time the youngest child (under 5 years) passed stool, what was done to dispose of the stool? CHECK HH ROSTER IF THERE IS A CHILD UNDER 5 YEARS 1=CHILD USED TOILET/LATRINE 5=BURIED 2=PUT/RINSED INTO TOILET OR LATRINE 6=LEFT IN THE OPEN 3=PUT/RINSED INTO DRAIN OR DITCH 7=OTHER (SPECIFY)..... 4=THROWN INTO GARBAGE 8=DON'T KNOW	<input type="checkbox"/>

Household level conditions and adaptive capacity																
94	Have you noticed any change in climate (Rainfall and Temperature) for past 30 years? 1=YES 2= NO	<input type="checkbox"/> IF CODE 2 SKIP TO Q99														
95	What changes have you noticed? <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 50%; text-align: center;">1=YES 2=NO</th> </tr> </thead> <tbody> <tr> <td>Getting more rainfall than before</td> <td><input type="text"/></td> </tr> <tr> <td>Less rainfall than before</td> <td><input type="text"/></td> </tr> <tr> <td>Rainfall becoming erratic/unpredictable</td> <td><input type="text"/></td> </tr> <tr> <td>Increased in temperature</td> <td><input type="text"/></td> </tr> <tr> <td>Decrease in temperature</td> <td><input type="text"/></td> </tr> <tr> <td>Don't know</td> <td><input type="text"/></td> </tr> </tbody> </table>		1=YES 2=NO	Getting more rainfall than before	<input type="text"/>	Less rainfall than before	<input type="text"/>	Rainfall becoming erratic/unpredictable	<input type="text"/>	Increased in temperature	<input type="text"/>	Decrease in temperature	<input type="text"/>	Don't know	<input type="text"/>	<input type="checkbox"/>
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Increased in temperature	<input type="text"/>															
Decrease in temperature	<input type="text"/>															
Don't know	<input type="text"/>															
93	how sure are you that the pattern of rainfall and temperature are changing? 1=Extremely sure 2=Sure 3=Somewhat sure 4=Not at all sure	<input type="checkbox"/>														
94	How worried are you about the changing pattern of rainfall and temperature? 1=Very worried 2=Somewhat worried 3=Not worried 4=Not at all worried	<input type="checkbox"/>														
95	What in your opinion causes these changes in rainfall and temperature? 1=Cars and trucks 4=Toxic wastes 2=Burning fuel for heat and electricity 5=Aerosol spray cans 3=Deforestation 6=Volcanic eruptions 7=Cow rearing	<input type="checkbox"/>														
96	Which of the above mentioned factors contribute most to changes in rainfall and	<input type="checkbox"/>														

	2=It increases one's chances of getting malaria 3=It does not affect incidence of malaria 4=Other, specify.....				
105	If flooding occurred in your community during the last season, how many days did it take for the area to completely dry up?	<input type="text"/>			
106	If flooding occurred in your community during the last season, how would you rate it: 1= MILD 2= MODERATE 3=SEVERE	<input type="text"/>			
107	How often is your house affected by flooding in a year? 1=Once a year 2=Two or more times a year 3=Not affected at all	<input type="text"/>			
108	What in your opinion causes malaria? (<i>tick those mentioned</i>)				
	1. Bites from infected mosquitoes	<input type="checkbox"/>			
	2. Dirty environment	<input type="checkbox"/>			
	3. Too much exposure to sunlight	<input type="checkbox"/>			
	4. Eating oil rice	<input type="checkbox"/>			
	5. Bites from mosquitoes	<input type="checkbox"/>			
	6. Other specify	<input type="checkbox"/>			
109	On the average how much do you spend on the treatment of each episode of malaria?	Amount in GHC <input type="text"/>			
110	The last time you or any member of your household was sick of malaria, how much did you or the person spend on malaria medication?	Amount in GHC <input type="text"/>			
111	Are the windows in the house covered with mosquito-proof screens/net? 1 = YES 2 = NO	<input type="text"/>			
112	On average, how much does your household spend on the following each month? 1=MOSQUITO COILS 2=MOSQUITO SPRAY 3=MOSQUITO REPELLING CREAM	Amount in GHC <input type="text"/>			
113	What is the total amount of money you and the members of your household spend on health related issues each month, on the average?	Amount in GHC <input type="text"/>			
114	How often do you receive health related information or assistance in this community? (from any source) 1=At least once a year 2=More than once a year 3=Not at all	<input type="text"/> IF CODE 3 SKIP TO Q116			
115	What is the main source of the information? 1=TV 2=RADIO 3=NEWSPAPER 4=PAMPLETS/POSTERS 5=MOSQUES/CHURCHES 6=SCHOOLS/TEACHES 7=COMMUNITY MEETING 8=FRIENDS/ RELATIVES 9=WORK PLACE 10=DRAMA /PERFORMANCE 11=OTHER (SPECIFY _____)	<input type="text"/>			
	Is there any institution you turn to for help when you have health related problems in this	Mention the kind of support received. <i>Codes</i>	Specify amount in monetary terms or specify type of	Have you received any support from organisation in the past one	How would you rate the support received? <i>Codes below**</i>

	community? (Tick all that apply)	below*	kind	year?	
	(116)	(117)	(118)	(119)	(120)
Community based organization					
Private organization					
Government agency					
Other					

Codes for Q117	Codes Q120
1=Monetary	1=Able to meet all the need of household at the time
2=In kind	2=Somewhat able to meet the need of household?
3=Moral/psychological	3=Not helpful at all

HOUSEHOLD AND FAMILY SUPPORT NETWORKS AND TRANSFERS

The next questions are about your family and friends, specifically those not living with you in this household. Families and friends sometimes help one another in a variety of ways, and each type of help or support can be important. Part of our survey involves finding out how they do that. We would now like to ask some questions about your family and friends who do not live with you, and the different ways in which you help or support each other. The next questions are about help received by your household in the last 12 months.

121.	Has any member of the household received any financial credit/loan within the past one year? 1 = YES 2 = NO	<input type="checkbox"/>	
122.	In the last 12 months, has anyone in the household received any financial or in-kind support from your family (children, siblings or parents), relatives (other kin) and friends who do not live with you? 1=YES 2=NO 8=DON'T KNOW	<input type="checkbox"/>	IF CODE 2 OR 8 SKIP TO Q126
123.	What type of assistance did your household receive? 1=MONEY ONLY 2=KIND ONLY (Specify)..... 3=BOTH MONEY AND KIND	<input type="checkbox"/>	
124.	What is/are the main purpose(s) of the support? a. General and household upkeep b. Education c. Medical care d. Business and work related e. Social events f. Other	<input type="checkbox"/>	
125.	About how much would this assistance amount to over the last 12 months in Ghana Cedi (GHC) (if in kind impute and estimate the value)	GHC	<input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="0"/>
126.	In the last 12 months, has your household provided any financial aid or in-kind support to any of your children, grandchildren and/or other family (and those of your spouse) who do not live in this household? 01=YES 02=NO 8=DON'T KNOW	<input type="checkbox"/>	IF CODE 2 OR 8 SKIP TO Q130
127.	What type of assistance did your household provide? 1=MONEY ONLY 2=KIND ONLY (Specify)..... 3=BOTH MONEY AND KIND	<input type="checkbox"/>	

128.	What is/are the main purpose(s) of the support provide? a. General and household upkeep b. Education c. Medical care d. Business and work related e. Social events f. Other	<table border="1"> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>																																
129.	Can you give an approximate total amount for this for the last 12 months in Ghana Cedis (GHC) <i>(if in kind impute and estimate the value)</i>	<table border="1"> <tr> <td>GHC</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> </table>	GHC	0	0	0	0	0	0																									
GHC	0	0	0	0	0	0																												
130.	During the past year, did you or someone in your household provide help to a relative or friend (adult or child), because this person has a long-term physical, or mental illness, or disability, or is getting old and weak? 1=YES, physical illness 2=YES, mental illness 3= YES, DISABILITY 4= YES, GETTING OLD AND WEAK 3=NO	<table border="1"> <tr> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/>																															
<input type="checkbox"/>																																		
FOOD SITUATION AND EXPENDITURE																																		
	Was there a day in the previous 30 days when you or any member of the household did not have enough food to eat? 0=No 1=Between 1-5 days 2=Between 6-10 days 3=More than 10 days	<input type="checkbox"/>																																
	Please indicate whether your household bought cooked food (breakfast, lunch and dinner) from street vendors for each of the days within the past week. <table border="1" data-bbox="321 974 1349 1276"> <thead> <tr> <th>DAY</th> <th>BREAKFAST</th> <th>LUNCH</th> <th>DINNER</th> </tr> </thead> <tbody> <tr><td>Monday</td><td></td><td></td><td></td></tr> <tr><td>Tuesday</td><td></td><td></td><td></td></tr> <tr><td>Wednesday</td><td></td><td></td><td></td></tr> <tr><td>Thursday</td><td></td><td></td><td></td></tr> <tr><td>Friday</td><td></td><td></td><td></td></tr> <tr><td>Saturday</td><td></td><td></td><td></td></tr> <tr><td>Sunday</td><td></td><td></td><td></td></tr> </tbody> </table>	DAY	BREAKFAST	LUNCH	DINNER	Monday				Tuesday				Wednesday				Thursday				Friday				Saturday				Sunday				
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