Exploring Elder Care in Two Communities in Ghana, West Africa, within the Context of the Current State of Social, Economic and Environmental Influences:

A Constructivist Grounded Theory Study

By

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Abstract

Researchers increasingly emphasize the importance of providing high-quality, accessible care to meet the needs of a rapidly growing ageing population. Although low- and middle-income countries (LMICs) remain in the early stages of demographic transition, evidence indicates that these changes are accelerating at an unprecedented pace. This rapid shift presents significant challenges, especially in Ghana, where society continues to frame caregiving as a private responsibility. Guided by a feminist gerontological perspective, this study explored the social, economic, and environmental factors influencing elder care, including the effects of COVID-19, by drawing on the experiences of older adults, family caregivers, and service providers such as government officials, community leaders, and not-for-profit representatives.

I employed a constructivist grounded theory approach and conducted thirty-three face-to-face semi-structured interviews and three focus group discussions between November and December 2023 in Akuapem-Mampong and Akuapem-Akropong, located in the Akuapim-North Municipality of Ghana's Eastern Region. I audio-recorded the interviews with participants' consent, transcribed them verbatim, and coded them using NVivo 12. Through iterative analysis, constant comparison, systematic coding, and detailed field notes, I developed a substantive theory grounded in participants' lived experiences.

Findings revealed that traditional, culturally rooted caregiving norms face considerable challenges. Participants highlighted the inadequacy of government programs, the lack of formal care services, and the heavy physical and mental burdens carried by elderly individuals and their caregivers. They also pointed out environmental barriers that limit access to care. In response, participants called for urgent reforms in government programs, increased financial and in-kind

support, and the integration of community- and faith-based support into formal caregiving systems.

This study developed the emergent theory, “Drive to Negotiate,” which illustrates how elderly individuals, caregivers, community leaders, and service providers actively adapt, improvise, and sustain care amidst systemic shortcomings. Despite resource constraints, declining kinship-based caregiving, and inadequate institutional support, participants negotiated solutions through interdependence and adaptability. Their resilience demonstrates how social relations and collective strategies sustain the availability and quality of elder care in Ghanaian communities under changing social, economic, and environmental pressures.

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Dedication

I dedicate this dissertation to my late maternal grandmother and to my family.

To the Late Mary Yaa Fosuah Owusu, “Grandma Small.”

Your resilience in old age inspired me to pursue and complete this journey.

My parents,

Mr. and Mrs. William & Barbra Boateng.

My siblings,

Kwasi, Kwadwo, and Kwamero.

Thank you for your love, support, and ongoing inspiration that motivate me never to give up.

It is all because of the Covenant-Keeping God (CKG).

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Glossary of Key Terms

ACP	Advance Care Planning: Discussion of values, goals and preferences of individuals requiring long term and end of life care. This is not a formal legal document but a means of documenting preferences of care.
DSW	Department of Social Welfare and Community Development (Known as DSW)
Elder/Elderly/Older Adults	Individuals aged 60 years and above
Elder Care	The instrumental and emotional care provided to elderly individuals who cannot perform them on their own
Elderly Caregiver/ Informal Caregiver	An individual providing care for an elderly
Formal Caregiving	Caregiving provided by a hired individual/ professional and they are paid.
Informal Caregiving	Caregiving provided by a family member or close relatives/ neighbours without pay
GoG	Government of Ghana
GHS	Ghana Health Service
GSS	Ghana Statistical Service
LEAP	The Livelihood Empowerment Against Poverty: A cash transfer program established in 2008 to alleviate extremely poor households including poor persons 65 years and above.
MoGCSP	Ministry of Gender, Children and Social Protection
National Ageing Policy (NAP)	The National Ageing Policy was launched in December 2011 with overarching goal "to achieve an the overall social, economic and cultural re-integration of older persons into mainstream society, to enable them as far as practicable to participate fully in the national development process." It was to include a national coordinating body (National Council on Ageing [NCA]) and an Active Ageing Fund to implement the goals. But it is yet to be passed and implemented.
NHIS	The National Health Insurance Scheme: Introduced in 2004 accessible to the poor including older adults. Eligible age for exemption from payment of monthly installment is 70 years and above which omits 60–69-year-olds.
NPOs	Not-For-Profit Organizations or formerly known as Non-Profit Organizations
Remittance	Money received by emigrants or immigrant families and friends
SSNIT	The Social Security National Insurance: Agency established in 1965 to provide pension income security (first tier) for workers (Formal sector). In 2006, tier three was introduced for voluntary contributions.
WHO	World Health Organization

Chapter 1: Introduction

Older adults worldwide are experiencing an unprecedented increase that demands attention to ensure their long-term care needs. Many countries struggle to address this challenge, leading to a decline in the quality of care for older citizens, particularly in low- and middle-income countries (LMICs) (WHO, 2020). Ghana's population stood at 33.79 million in 2023, an increase from 31 million in the 2021 census, ranking it 46th among countries by population size (GSS, 2023; UN DESA, 2020). Although the population is generally young (Darkwa, 2000; GSS, 2013a), the proportion of the elderly in Ghana is one of the highest in sub-Saharan Africa and continues to increase rapidly (WHO, 2014; 2020). This trend raises particular concern for the country, where families and communities serve as the main support for these vulnerable groups. Research shows that socio-economic and environmental changes have gradually influenced Ghana's traditional care arrangements for its elderly population (Apt, 2012).

To address these changes, the government of Ghana introduced some programs, including the NHIS and LEAP, to mitigate some of the struggles of the vulnerable, including older adults. Unfortunately, these responses are inadequate to meet the needs of this rapidly evolving demographic transition and the societal changes transforming the Ghanaian community. Several studies (e.g., Apt, 2012; Atobrah, 2016; Dovie, 2019; He et al., 2020) have found that factors such as economic and social struggles in developing countries like Ghana underscore the importance and opportunities inherent in recognizing ageing as a developmental issue. With the impact of the COVID-19 pandemic, a continued exploration is necessary to understand the current challenges and evidence-based interventions that address the unique needs of this target population, informing practice, policy, and research and reducing the long-term burden on families.

This chapter articulates the study's rationale by identifying gaps in the existing literature and outlining the researcher's personal and professional motivations that informed the study's aims. It also delineates the research objectives, thus establishing a coherent framework for the subsequent chapters.

1.2 Rationale for the Study

Population ageing represents a human success story that showcases advancements in public health, medicine, and economic and social development. However, studies (e.g. Apt, 2012; GSS, 2013; UN DESA, 2020) link it to increased risks of disabilities, chronic diseases, falls, fall-related injuries, and mental health issues (WHO, 2015). Reports from GSS indicate that the proportion of older adults in Ghana increased by 2 percent from 4.5 percent in 1960 to 6.5 percent in 2021. Notably, older women made up approximately 56 percent of this demographic in 2021, reflecting their longer life expectancy and highlighting the health and gender-specific challenges associated with ageing. Much of the concern regarding elder care for this population centers on those in rural areas, towns and semi-urban communities, where inadequate infrastructure and other essential amenities are often lacking (Hanrahan, 2018).

Historically, families managed informal care arrangements for older adults based on the traditional norms of reciprocity and filial obligations (Darkwa, 2000; Owusu-Ansah, 2015). But previous research suggests that socioeconomic and environmental changes have dramatically shifted this trajectory (e.g., Aboderin, 2006; van der Geest, 2016; Kyei-Arthur, 2017). For example, Mba (2010) and Mensah & Amissah (2016) highlight how social transformations, such as rural-urban migration and economic restructuring, erode families' reliability as caregiving units, especially for the elderly in rural and underdeveloped communities. Sadly, limited formal

elder care services and inconsistent government programs worsen the inadequacies of these support structures, increasing the risk of neglect among older adults (Kpessa-Whyte, 2018).

The COVID-19 pandemic further intensified several structural vulnerabilities across countries. Older adults suffered disproportionately during the pandemic because they were considered more susceptible to severe complications and faced higher mortality rates. They and their families experienced the health, emotional, financial, and social consequences of this global crisis (Vahia et al., 2020; Deku et al., 2021), in addition to the existing issues in elder care. For example, lockdowns, rising living costs, and overstretched health systems widened the care gap (Kyei-Arthur & Codjoe, 2021), especially in underdeveloped areas in Ghana, during this period. Therefore, there is a need to gain an in-depth understanding of the current state of elder care in these underdeveloped towns in Ghana.

Research on elder care in Ghana mainly focuses on family caregivers, the impact of informal caregiving, and coping strategies employed by caregivers (e.g., Agyemang-Duah et al., 2019; Martey, 2022; Sanuade & Boatemaa, 2015). Other studies have explored rural-urban migration, emigration, and health-related issues affecting the elderly (e.g., Badolo, 2020; Enu, 2015; Kodwo-Nyameazea & Nguyen, 2008). However, only a few studies capture the lived experiences of older adults, particularly those of older women (e.g., Awuviry-Newton et al., 2020; Braimah & Rosenberg, 2021). Additionally, literature on stakeholders, including community leaders and social or healthcare providers, remains limited, with only a handful of studies (e.g., Awuviry-Newton et al., 2021; Dovie, 2019) that highlight their perspectives. These gaps in the literature highlight the need to investigate how socioeconomic and environmental transformations are reshaping elder care in Ghanaian communities. Aboh et al. (2019) suggest in their scoping review that future research should focus on the welfare of the elderly and how they

thrive in their communities. Such research focus informs need-based interventions for practice that can enhance their overall well-being.

Using a qualitative design in elder care research helps us understand how the elderly population sustains and adapts to their care needs as the traditional model rapidly deteriorates. Yet, most existing studies on elder care focus primarily on the elderly and caregivers; therefore, researchers must integrate insights from various stakeholders, including community leaders and organizational representatives. Particularly, older women in Ghana face unique, intersecting challenges across their life course, which become especially pronounced in later years. These individuals experience the intersectionality of social, economic, and environmental changes simultaneously in their communities. Capturing their lived experiences through a feminist gerontological lens highlights

1.2.1 Personal and Professional Motivation

This study was personally motivated by my maternal grandmother's early dementia diagnosis and the minimal support she received beyond that provided by her children. My mother, who served as her primary caregiver while managing a career and other family responsibilities, relied solely on hospital visits to address sudden changes in my grandmother's condition. Although additional help could be hired, our family lacked the specialized knowledge and skills needed to provide adequate care for someone with cognitive decline. Despite these challenges, my mother ensured that my grandmother received continuous emotional and psychological support until her passing.

This experience prompted me to question the availability of governmental or agency support for families in similar circumstances. Although my grandmother lived with one of her daughters and was occasionally visited by relatives, I wondered how other grandmothers in the

village, particularly those with less familial support, were managing. Visits to my hometown of Akuapem-Akropong, a key research setting, revealed that many elderly individuals, especially women, engaged in activities such as roadside hawking, raising questions about the adequacy of familial and state support.

As a coordinator collaborating with the Department of Social Welfare (DSW) in deprived communities, I observed the dedication of DSW staff in serving their clients despite limited resources under challenging circumstances. In reviewing various literature on elder care in Ghana, I observed several findings that revealed some of these issues. Yet, I questioned whether these ongoing social, economic, and environmental changes had altered the persistent challenges in this area. I also considered whether the government and other service providers had adopted diverse approaches to support older adults and their caregivers.

Guided by self-determination, advocacy, and social justice values, I pursued interviews with stakeholders involved in elder caregiving. I sought perspectives from service providers, including traditional and political leaders, social and health professionals, and ageing organizations whose voices are often underrepresented in the literature. Accordingly, this study explored the current state of elder care within social, economic, and environmental influences, drawing on diverse perspectives from care recipients and providers in the post-COVID-19 era.

1.3 Research Objectives

The purpose of this constructivist grounded theory study was to provide an in-depth understanding of the current state of elder caregiving experiences within the context of social, economic, and environmental influences in Akuapem-Mampong and Akuapem-Akropong communities in the Akuapim-North Municipality of the Eastern Region of Ghana.

The specific objectives are to:

1. To describe how older adults, family caregivers, and service providers define the concept of elder care based on their experiences in traditional Ghanaian settings.
2. To investigate the recent factors that influence the quality and availability of elder caregiving in their homes, communities, and service centers.
3. To comprehend the extent of the impact of COVID-19 on caregiving in the two communities in Ghana.
4. To explore the recommended approaches from service users and providers to address the care needs of elder caregiving in the Ghanaian community more effectively.

A detailed account of the elderly and the inequalities they face is provided in subsequent chapters. Chapter Two presents a literature review that focuses on the demographic trends of ageing, conceptualizations of elder care, the social, economic, and environmental driving factors, and the impact of COVID-19 on caregiving practices. Chapter Three outlines the qualitative research design and ethical considerations for working with older adults and their service providers. It details the data collection and analysis processes. Chapters Four present the findings, highlighting the diverse perspectives of older adults, caregivers, and service providers. Chapter Five discusses and interprets these findings in the context of the identified social, economic, and environmental influences on elder care. It also evaluates the study's strengths and limitations, examining the implications for social work and offering recommendations for future research. Finally, Chapter Six allows the researcher to reflect on the study's limitations and draw conclusions.

Chapter 2: Literature Review and Theoretical Frameworks

2.1 Introduction

The first section of this chapter reviews the literature on the definition of caregiving, the concept of care in Ghana, demographic trends of ageing, and the social, economic, and environmental driving factors amid the impact of COVID-19. The second section utilizes a feminist gerontological lens to understand ageing and elder care throughout the life course. Charmaz (2006) suggests that conducting the literature review at an early stage facilitates the clarification of ideas and demonstrates an understanding of the research context.

2.2 Defining Caregiving

Caring for elderly dependents greatly influences their well-being and promotes a more fulfilling end-of-life experience. Caregiving intersects with ageing and intergenerational relationships, which helps secure a safety net for older adults (Bozaleck & Hooyman, 2013). In their early work, Van der Geest (2002) defined care as "a concept or practice" involving concrete activities for others who cannot manage them independently. Similarly, Pearlin et al. (1990) distinguished between "caring" and "caregiving" in their influential work on *"Caregiving and the Stress Process: An Overview of Concepts and their Measures."* The authors describe caring as the affective component of an individual's commitment to another's welfare, while defining caregiving as the behavioural expression of this commitment aimed at ensuring the well-being of the care recipient.

Although no standard definition of caregiving exists (Hermanns & Mastel-Smith, 2012), Bowers (1987) proposed a model to understand the caregiving process. He identified five roles that guide caregivers: anticipatory, preventive, supervisory, instrumental, and protective. Through this framework, Bowers emphasized that caregivers engage in a dynamic process rather

than a static activity. They anticipate potential crises, adopt measures to prevent or minimize risks, oversee care needs, perform practical instrumental care tasks, and protect the physical, emotional, and social well-being of the elderly. Hermanns and Mastel-Smith (2012) conducted a qualitative analysis with six participants to define caregiving. They described caregiving as the process of helping someone who cannot care for themselves in a holistic manner, addressing their physical, mental, emotional, and social needs. Although Bowers (1987), Pearlin et al. (1990), and Hermanns and Mastel-Smith (2012) approach caregiving from different perspectives, they all agree on the importance of addressing both the physical and emotional needs of the elderly during the caregiving process.

Literature describes elder care and caregiving as a wide range of institutional and home-based services that support older people who cannot care for themselves (Kodwo, 2009). Although GSS does not formally define elder care, it broadly refers to services that promote healthy and independent living among the elderly (2013b). This conceptualization emerged from demographic analyses and policy considerations outlined in its monograph, "*The Elderly in Ghana*" (GSS, 2013b). The GSS emphasizes the importance of developing policies and programs that address the health, economic, and social needs of older adults, particularly in terms of healthcare access, social protection, and community-based support structures. These institutional definitions primarily reflect the types of care provided rather than how older adults understand or experience care. Consequently, this study seeks to bring to the forefront the perspectives of older adults in defining elder care and caregiving, thereby addressing a critical gap in the literature.

2.2.1 Concept of caregiving in Ghana

Elder care in Ghana encompasses both instrumental and emotional components. Caregivers actively assist older adults with activities of daily living (ADLs) such as feeding,

bathing, dressing, and toileting, and they also help with instrumental ADLs like managing medications, shopping, and maintaining the household (Qualls, 2016; van der Geest, 2002). While these tasks fulfill physical needs, caregivers provide emotional reassurance and companionship. Van der Geest (2016) emphasizes that strong bonds of attachment and duty underpin caregiving. Qualls (2016) notes that caregivers often start with practical support but gradually become the emotional anchor for older adults who increasingly depend on them for reassurance, presence, and affirmation.

Like other countries, Ghana recognizes two caregiving models: the informal family-based care and the formal institutional support (van der Geest, 2002; Sanuade & Boatemaa, 2015). Families, broadly defined as kin, foster relations, and marriage ties, form the foundation of elder care and are guided by communal values and reciprocity (Ardayfio-Schandorf, 2006; Hanrahan, 2018). Informal care, involving no payment, provides physical assistance and emotional support to their ageing relatives (Pearlin et al., 1990). In contrast, though limited in these communities, formal care involves paid professionals such as nurses, personal support workers, and physicians who help elderly individuals with functional limitations (Awuviry-Newton et al., 2020; Diameta et al., 2018). Yet, families remain responsible for initiating and financing this form of care (Coe, 2017; Dovie, 2019).

In *"Ageing in Africa: Past experiences and strategic directions*," Apt (2012) asserts that Ghanaian society values the respect and care for relatives, particularly the elderly. Children care for their ageing parents as a form of reciprocity and social obligation (Dosu, 2014; Lowenstein & Katz, 2012). This practice provides "welfare security" in old age (Atobrah, 2016). Apt (2012) emphasizes that respect and care for elders remain central to Ghanaian moral values. Notably, women disproportionately bear caregiving responsibilities, which society labels as a "feminine

quality" (Hanrahan, 2018). Traditional norms link care to women's domestic roles, assigning tasks like cooking and bathing to wives, daughters, and grandmothers (van der Geest, 2002; Blum & Sherman, 2010). Although men are indirectly involved, they provide financial support or take on secondary caregiving and occasional primary care roles, especially when women are absent (Kusi et al., 2020; Kyei-Arthur, 2017). This gendered division reflects longstanding societal expectations while also demonstrating evolving participation in elder care within Ghanaian society.

Existing studies on elder care warn that demographic changes, such as increased life expectancy and the prevalence of chronic illnesses among older adults, will heighten demands on caregiving systems (WHO, 2020; de-Graft Aikins et al., 2012). Literature also shows that socioeconomic factors disrupt traditional support networks and strain informal care (Aboderin, 2006; van der Geest, 2016). Therefore, understanding how these changes reshape access to and availability of elder care in Ghana can inform further research and guide responsive policy interventions for this population.

2.3 Ageing Trends in Ghana

Many countries, particularly in developed regions, define older adults as individuals aged 65 and above because of higher life expectancy and health standards (WHO, 2020). However, the United Nations considers anyone aged 60 years and above as an "Older adult." Ghana adopts this definition of "Elderly/ Older adult" because it aligns with retirement and elder care policies in many developing countries, where life expectancy tends to be lower (GSS, 2021; UN, 2019). The WHO views ageing as a gradual, complex process influenced by genetic, environmental, and lifestyle factors. Its "Decade of Healthy Ageing" initiative emphasizes maintaining functional ability, independence, and quality of life, while promoting supportive environments and

adaptable healthcare systems to reduce ageism and address diverse health needs (WHO, 2020). In Ghana, the elderly within this category display social, economic, and environmental indicators that highlight their needs and vulnerabilities, aligning with the objectives of this study.

This section explores the demographic patterns of the older Ghanaian population. It focuses on the evolving characteristics of the elderly population over time to examine the ageing demographic trend. These trends include socio-demographic factors (age, gender, marital status, religion, and disability), socio-economic factors (education, employment, and income levels), and socio-environmental factors (geographical location and living arrangements).

2.3.1 Socio-demographic trends of ageing

Since gaining independence in 1957, Ghana has undergone substantial demographic transformations that continue to shape the landscape of elder care. The population structure shows a steady increase in adolescents and young adults, with the number of individuals aged 15–24 growing from 1.1 million in 1960 to 4.9 million in 2010. This age group consistently accounts for approximately 20 percent of the total population (GSS, 2013a). Adults aged 25 to 59 have also increased their share, rising from 30.6 percent in 1970 to 35 percent by 2010 (GSS, 2013a). Meanwhile, children under 15 accounted for 40 percent of the population in 2010, but projections show a decline to 22.3 percent by 2050. Conversely, the elderly population (aged 60 and above) is expected to more than double, reaching 14.1 percent by 2050 (GSS, 2013a; GSS, 2021).

Recent figures affirm this trajectory. The 2021 Ghana census reports that the elderly population has grown nearly tenfold in sixty years, increasing from just over 213,000 in 1960 to nearly 2 million (GSS, 2021). In 2023, Statista estimates that approximately 1.22 million people aged 65 and older lived in Ghana (Sasu, 2023). While older adults constituted only 4.6 percent of

the population in 1960, this figure rose steadily to 7.2 percent by 2000, though it slightly declined to 6.7 percent in 2010. Notably, the absolute numbers surged from 215,258 in 1960 to over 1.6 million in 2010, marking a 770 percent increase (GSS, 2013a; 2013b). Projections estimate that by 2050, Ghana will host approximately 6.3 million elderly individuals (GSS, 2013a).

Ageing increases the risk of disabilities and chronic diseases. Research by the WHO (2003, 2017) links non-communicable diseases (NCDs) such as diabetes, hypertension, and stroke to older age, highlighting the roles of genetic, lifestyle, and environmental factors. Data from the GSS (2013b) shows that 12 percent of older adults experience one or more disabilities, while only 2 percent of people under 60 face the same issue. As people age, their likelihood of experiencing disabilities increases, affecting 18.5 percent of individuals aged 80 and older. The most common disabilities include sight impairment (29%), physical limitations (18.4%), and emotional and cognitive challenges (13.4% and 11%, respectively). Older adults living in rural areas report slightly higher rates of disability (13%) than their urban counterparts (11.5%), likely due to unequal access to healthcare (GSS, 2013b).

Health improvements, along with declining fertility and mortality rates, have transformed the demographic landscape (Mba, 2010; GSS, 2021). In 2021, 60.4 percent of Ghanaians were in the 15–64 age group, while 4.3 percent were aged 65 or older. Data from GSS (2013b) show that the elderly population increasingly comprises individuals aged 60–74 (68.2 percent), with women living significantly longer than men. Census data indicated that in 2021, females (50.7%) outnumbered males (49.3%) by 0.4 million. These trends in life expectancy and declining fertility rates, which dropped from 6.7 births per woman in 1960 to 3.75 in 2021, suggest a

steadily ageing population (GSS, 2021; WHO, 2017), highlighting the importance of exploring social, economic, and environmental strategies to effectively support these individuals.

Marriage and fertility practices significantly influence access to elder care. While 83.6 percent of men marry, only 30.1 percent of women do so, mainly because women outlive their spouses and have lower remarriage rates (GSS, 2013b; WHO, 2014). These patterns stem from gendered norms; men tend to marry younger women and remarry more often after losing their wives. In Ghanaian society, women are judged by their ability to bear children, while men boost their social status through the number of wives and children they have (Kpessa-Whyte, 2018). Proverbs like "There's no wealth where there are no children" reinforce the importance of reproduction and family continuity (Dosu, 2014). As a result, nonreproductive women often resort to fostering to meet social expectations and secure care in old age (Drah, 2014).

Ghanaian families have historically regarded social reproduction as a crucial investment strategy for the future. For instance, most households engaged in agriculture and relied on their children to maintain these livelihoods and care for ageing parents (Mensah & Amissah, 2016). However, these expectations reinforce structural and gender inequalities in communities. Scholars such as Randriamaro (2013) and Kpessa-Whyte (2018) show that nonreproductive or unmarried women often face neglect and marginalization, which limits their support in later life. Therefore, these institutional and cultural practices influence the ageing process and determine older adults' long-term access to care (Bengtson et al., 1997).

Religion remains a pivotal institution in the lives of Ghana's elderly. The 2013 census revealed that 95 percent of elderly women and 91 percent of elderly men identified with a religious affiliation, primarily through churches, mosques, and local spiritual communities (GSS, 2013b). Especially in rural areas, older adults in Ghana often draw strength from prayer and

communal faith-based engagement (Owusu-Ansah, 2015; GDHS, 2019). Such religious ties offer both psychological support and informal social protection, thereby enhancing well-being and facilitating access to care (Brown, 2015; Kyei-Arthur & Codjoe, 2021). Yet, the sustainability of these supports under shifting socioeconomic conditions remains uncertain.

2.3.2 Socio-economic trends of ageing

Educational attainment plays a crucial role in shaping an individual's lifelong socio-economic status and has profound implications for economic security in old age. In Ghana, persistent gender disparities in education have disadvantaged women for decades. The 2010 Population and Housing Census showed that 33.6 percent of elderly women had never received formal education, compared to 23.6 percent of elderly men (Biritwum et al., 2013). Tertiary education data further exposed this gap, with only 4.8 percent of men and 1.9 percent of women completing university education (GSS, 2013b). These disparities underscore entrenched gender biases in access to education, which were noted as early as 1987 when just one girl was enrolled for every eleven boys (GoG, 1997). Although the Government of Ghana enacted the Girl-Child Education Policy in 1997 to address these inequalities, the disadvantages continue to affect older women today.

Geographic location further exacerbates educational inequality. The 2010 and 2021 censuses consistently revealed that nearly two-thirds of rural residents had never attended school, compared to just under half (49%) of urban dwellers (GSS, 2013b; 2021). These disparities influence literacy levels, economic opportunities, and access to social resources in older age. Education strongly determines access to employment opportunities, income stability, and social mobility throughout the life course (GhanaWeb, 2024; Kpessa-Whyte, 2018). Low educational

attainment limits older adults, especially women, from engaging in the formal labour market and increases their vulnerability to poverty in later life (Apt, 2012; GSS, 2013b).

Additionally, the labour-force data reveal persistent structural inequalities. In 2021, over one-third (37.6%) of the elderly population engaged in employment. Although Ghana's statutory retirement age is 60, many continue to work in the informal economy well into old age. GSS (2021) shows that 90.1 percent of older adults work in informal sectors (e.g., market traders), while only 7.1 percent hold positions in the private formal sector (GSS, 2013b; 2024). Most of these individuals rely on informal work, which leaves them without access to work benefits like pensions or healthcare (GSS, 2013b; WHO, 2014). These patterns highlight the urgent need to safeguard the well-being of older adults, especially as more than half (53.2%) of those employed remain in vulnerable forms of work (GSS, 2021).

The gendered dimension of economic vulnerability among the elderly remains prominent. In 2010, older adults made up 8.8 percent of Ghana's total labour force, with men (9.2%) participating at a slightly higher rate than women (8.6%) (GSS, 2013b). By 2021, 47 percent of older women participated in employment, compared to 30.4 percent of older men. At the same time, a higher proportion of women remained outside the labour force, often acting as homemakers, retirees, or individuals living with disabilities (GSS, 2021). Women's lower participation reflects the enduring impact of reproductive roles and informal care responsibilities that constrain their economic engagement (GSS, 2013b; Baah-Boateng, 2014). Among those employed, most elderly women work in the private informal sector as market traders, street vendors, or domestic workers (Baah-Boateng & Vanek, 2020). As a result, many women retire at an old age without access to formal social security (Kwankye 2013).

Limited financial protection for informal workers disadvantages older adults. Despite the high labour participation rate among elderly Ghanaians, reliable income level data remains scarce (Darkwa, 2000; WHO, 2017). According to the SSNIT program, public sector employees receive relatively stable pensions due to employer contributions, while informal sector workers often retire without any formal retirement income (GSS, 2013b; Oteng et al., 2022). This disparity in pension access deepens financial insecurity. In 2021, 395,693 older adults, which is more than half of the working older population, engaged in vulnerable employment (GSS). Such precarious conditions foster chronic dependency on family members, which undermines the autonomy and dignity of older adults living in poverty (Nortey et al., 2017).

2.3.3 Socio-environmental trends of ageing

Historically, a larger proportion of Ghana's elderly population lived in rural areas. In 2010, 54 percent of older adults resided in rural communities, despite the country's overall trend toward urbanization (Darkwa, 2000; GSS, 2013a). The 2021 Population and Housing Census revealed a demographic shift: 53 percent of older adults now reside in urban areas, while 47 percent remain in rural regions (GSS, 2021). This change reflects broader urban migration patterns and highlights uneven regional distribution. Older adults in Greater Accra and four other regions are concentrated in urban centres, whereas 11 regions, such as the Eastern Region (52%), remain predominantly rural (GSS, 2021).

This rural concentration faces critical challenges. Ghana's rural areas continue to lack adequate infrastructure, including water, sanitation, transportation, and healthcare facilities, which exacerbate accessibility issues for the elderly and their caregivers (GSS, 2010b; 2021). These environmental constraints hinder service provision and diminish the quality of life. Many

older Ghanaians do not own homes and instead live in compounds or extended family houses, often without secure tenure (GSS, 2013b).

Household composition significantly influences access to resources, emotional support, and caregiving (WHO, 2017). Younger cohorts of older adults (ages 60–64) are more likely to serve as household heads (74%), due to higher economic activity compared to older age groups (Kpessa-Whyte, 2018). However, as age increases, the proportion of elderly living alone also increases; in 2021, 341,960 older adults lived alone, including 62,480 individuals aged 80 and above (GSS, 2021). Migration and the growing preference for nuclear family structures intensify this isolation, as younger relatives relocate for education or work, leaving older family members behind (van der Geest, 2016).

Three-generation households, which include grandparents, parents, and children, remain the most common living arrangements in Ghana, accounting for 44 percent of households (Biritwum et al., 2013). Yet changing family dynamics are introducing new caregiving configurations. In many rural areas, people are increasingly forming "skipped generation" households, where grandparents live with grandchildren in the absence of parents, due to migration and parental absence (He et al., 2020). Despite cultural ideals of family support, fewer than one in ten (8.3%) older adults report receiving care from extended family members within their households. Data also show that the share of older adults living alone increases from 9 percent among those aged 65–69 to 11.4 percent among those aged 75–79 (GSS, 2013b), underscoring their reduced household authority and decision-making power.

Although multigenerational co-residence has traditionally served as a social safety net, current literature shows its fragility. In some cases, older adults provide childcare for grandchildren and support for younger relatives in exchange for informal care (Kpessa-Whyte,

2018). However, this reciprocity weakens. Social transformations, including migration, urbanization, and shifting household priorities, erode intergenerational interdependence, leaving many older adults without reliable family-based support (Apt, 2012).

In summary, policymakers must urgently address Ghana's ageing population by developing policies that cater to the intertwined social, economic, and health needs of older adults. Declining fertility rates reduce the number of family members available to provide care, while urbanization, economic constraints, and changing gender roles undermine traditional caregiving systems. Research (e.g., Dovie, 2019) indicates that elder care in Ghana cannot rely solely on informal systems or cultural norms. Instead, they need to create sustainable and inclusive care systems that adapt to demographic changes and protect vulnerable elderly populations across rural and urban settings.

2.4 Social, Economic and Environmental Driving Factors

To understand the driving factors influencing elder caregiving in Ghana, one must conceptualize and explore the culture of care, along with the challenges that affect the sustainability of quality care for older adults in these communities. This section examines how social changes, economic factors, and physical barriers influence elder care in Ghana.

2.4.1 Cultural influences of caregiving

Culture plays a crucial role in shaping caregiving norms for older adults in Ghana, influencing both who provides care and how it is delivered (Atobrah, 2016; Kyei-Arthur, 2017). Atobrah (2016) emphasizes that traditional Ghanaian culture embeds caregiving within communal life, ensuring that society supports elderly individuals who are revered as educators, spiritual leaders, and arbitrators. Similarly, Mensah and Amissah (2016) argue that these socially

recognized roles compel communities to respect and care for older adults, primarily through intergenerational reciprocity.

Over the years, modern norms have eroded the cultural structures that previously guaranteed elder care. Aboderin (2004) notes that the shift from extended to nuclear family orientation weakens intergenerational caregiving. While older adults continue to foster social cohesion by transmitting indigenous customs, digital technologies and modern influences have reduced their leadership opportunities (GSS, 2013b). A growing body of literature, including Aboderin and Hoffman (2015) in *"Care for the Elderly in Sub-Saharan Africa: Issues, Challenges and Future Directions,"* further contends that this cultural shift undermines both the symbolic status of older adults and the caregiving structures they rely upon. Van der Geest's (2016) ethnographic study echoes this, showing that even where respect for elders persists, it seldom translates into tangible care or emotional support.

As cultural norms shift, families resist formal alternatives. Coe (2017) observes that many Ghanaians reject institutional elder care, considering it "un-African," and equate it with abandonment. Families often see formal care as incompatible with cultural values of filial piety (van der Geest, 2016). Ng and Indran (2021) confirm that these social perceptions strongly influence caregiving choices, which limits families' willingness to explore external support. Essuman et al. (2018) add that traditional values create a false dichotomy, implying only family members can provide genuine care. Such stigmas against formal care deepen the care deficit and restrict options for vulnerable older adults.

Harmful cultural beliefs also exacerbate elder vulnerability, particularly for women. In "*Condemned Without Trial: Women Accused of Witchcraft in Ghana,*" ActionAid (2013) documents how accusations of witchcraft in northern Ghana isolate and endanger older women.

In one widely reported case, community members tortured and killed a 90-year-old woman in the Savannah region after she refused to confess to causing local misfortunes (MyJoyOnline, 2020). Mental health experts link such accusations to untreated conditions like dementia or schizophrenia (ActionAid, 2013; Adom Online, 2017). Coe (2021) argues that these beliefs stretch family-based care systems to unsustainable levels.

Although both men and women face ageism, women disproportionately bear the burden of its gendered forms (ActionAid, 2013). For instance, Kpessa-Whyte (2018) explains that communities often accuse older women of witchcraft and forcibly banish them under the guise of traditional practices. Despite minor interventions (Sossou & Yogtiba, 2015), accused women are frequently confined in "witch camps" without access to instrumental or emotional care, which compounds their isolation. These practices, deeply rooted in traditional ideologies, heighten women's vulnerability and undermine their well-being. Addressing these cultural barriers is therefore essential for building inclusive caregiving models that protect the dignity, safety, and welfare of the elderly in Ghana.

2.4.2 Social changes on elder care

Literature shows that structural changes, particularly those that modify gender roles, strongly influence family members' availability and willingness, especially women, to provide elder care (Mba, 2010). Hanrahan (2018) emphasizes that society has historically constructed caregiving as a feminine duty, expecting women to remain in the domestic sphere to manage child-rearing and elder care. However, increased educational and employment opportunities have shifted these expectations, decreasing women's time and willingness for unpaid caregiving (Ng & Indran, 2021). Mensah and Amissah (2016) found through a descriptive survey that women increasingly gain formal education and participate in the formal sector, resulting in less

involvement in traditional caregiving roles. Their findings align with the National Population Council (2011), which reports that women's education significantly influences decisions related to reproductive health, marriage, and labour participation, thus influencing their capacity to assume elder care responsibilities.

The feminization of care work and women's evolving socio-economic roles highlight the inadequacy of family-based caregiving models for addressing Ghana's growing elder care needs (Dovie, 2019; Ng & Indran, 2021). Randriamaro (2013) documents how families relocated girls between households to provide care in exchange for financial or in-kind compensation. However, as women increasingly pursued educational and vocational opportunities, this care practice declined (Sanuade & Boatemaa, 2015), resulting in fewer family members available to provide care.

Research reveals how past family dynamics shape caregiving in later life. Aboderin (2004) and Kodwo (2009) note that some adult children refuse to care for elderly parents who neglected them in their formative years. These findings challenge the assumption of automatic filial obligation and show that emotional and social investments throughout life critically affect later-life care (Martey, 2022). While collective values continue to guide care expectations, modernization, individualism, and shifting intergenerational commitments weaken these social contracts (van der Geest, 2016; Sanuade and Boatemaa, 2015). Traditional practices like communal eating, storytelling, and household rituals increasingly give way to digital entertainment and virtual communication, eroding family cohesion and proximity-based caregiving.

The COVID-19 pandemic further disrupted caregiving norms. Studies reveal that lockdowns and social distancing eroded vital interpersonal connections necessary for older

adults' well-being (WHO, 2020; Asante & Awuviry-Newton, 2021). However, much research overlooks the perspectives and burdens of informal caregiving, particularly in rural areas during this period. Dovie (2021, p. 118) observed that "the COVID-19 virus is the cruellest stress test on institutional and individual health and social care activities." These realities highlight the need to examine how older adults, and their families adapt to shifting caregiving norms as elder care systems continue to decline.

2.4.3 Economic constraints at different levels

A growing body of literature on Ghana's rapidly ageing population highlights that caregiving crisis stems from economic injustice and institutional neglect. Nortey et al. (2017) in "*Economic Burden of Family Caregiving for Elderly Population in Southern Ghana: The Case of a Peri-urban District*" argue that the country's economic policies and labour market structures perpetuate inequalities that disadvantage older adults requiring care. Despite policy commitments and international obligations, Ghana still lacks a sustainable, rights-based long-term care system that guarantees affordable and accessible support (WHO, 2017). Research into government initiatives shows that Ghana is one of the few sub-Saharan countries to adopt pro-poor programs such as the NHIS and the LEAP program (Kpessa-Whyte, 2018; Agyemang-Duah et al., 2020). While these programs provide some support, scholars call for further evaluation of their effectiveness, particularly in rural and underdeveloped settings.

Poverty worsens these challenges. In 2021, Ghana's poverty rate was 26.8 percent, meaning one quarter of the population lived on less than $3.20 a day (Sasu, 2022). Older adults experience multidimensional poverty, with deprivations in health, housing, and living standards. Because family care heavily relies on younger relatives, rising youth unemployment further weakens these support systems. Ghana's unemployment rate increased from 3.52 percent in 2022

to 3.56 percent in 2023 (World Bank, 2025), leaving many young adults unable to support their ageing relatives financially. Limited rural job opportunities also drive chain migration (GSS, 2013b; Nkansah et al., 2021), which reduces the availability of caregivers in local communities.

The formal care sector has not adequately addressed these gaps. For instance, Coe (2017), in "*Transnational Migration and the Commodification of Eldercare in Urban Ghana*," critiques the sector as commercialized and inaccessible, noting that "Unlike western countries where public eldercare is subsidized, Ghanaian families must navigate a privatized system with little to no state intervention." Dovie (2019) similarly explains that the few private elder care facilities available operate almost exclusively in urban centres and require families to shoulder the costs. Without government subsidies, access to quality formal care depends on private wealth or remittances (Kodwo, 2009; van der Geest, 2016). Dovie (2021) further criticizes the failed implementation of Ghana's 2010 National Ageing Policy, highlighting inadequate government support, untrained care workers, under-resourced social welfare services, and a lack of geriatric professionals. Coe (2021) and Awuviry-Newton et al. (2021) add that most nursing programs still lack geriatric training, leaving the physical and institutional environments unable to support the ageing population.

Research underscores the financial strains of caregiving. Martey (2022), using quantitative economic modelling, found that households with an elderly member experience an overall welfare decline of about 4 percent. Nortey et al. (2017) quantified the direct and indirect costs of caregiving, showing that many families, especially women, must forgo employment or educational opportunities to care for their older relatives. Agyemang-Duah et al. (2024), using HRQoL instruments, found that increased caregiving demands negatively affect caregivers' health and quality of life.

The COVID-19 pandemic further exacerbated these economic pressures. Lockdowns and global downturns triggered job losses and reduced earnings, which undermined the financial capacity of family caregivers to provide consistent support (World Bank, 2022; Oti-Boadi & Andoh-Arthur, 2024). These findings underscore the importance of investigating how older adults and their families navigate intersecting economic, institutional, and caregiving challenges in marginalized communities (Nortey et al., 2017).

2.4.4 Physical barriers to elder care

Urbanization and related environmental shifts are rapidly reshaping the landscape of elder care in Ghana, accelerating the decline of traditional family-based caregiving structures. As more people migrate for economic opportunities, rural-urban disparities intensify, weakening the intergenerational support systems that once sustained elder care (Crookes, 2015; Dosu, 2014). This shift has reduced extended family co-residence, fostered nuclear family structures, and promoted individualism at the expense of collective caregiving traditions (Mba, 2007; GSS, 2013b).

Owusu-Ansah (2015) observes that the declining presence of extended family members within the same household or community has restricted both physical and emotional support for older adults. In the Bono Region, for example, youth outmigration has left many older adults living alone without support (Adjomah, 2021). One elderly participant shared: *"I wish that at least one of my children was physically here with me, but that is not the case, and it's a pity"* (Adjomah, 2021). Such sentiments illustrate the emotional and physical vulnerabilities of elderly individuals amid shifting household and environmental dynamics.

Literature also highlights an infrastructural gap that further diminishes the quality of life for older adults, particularly in rural areas. Hanrahan (2018) argues that caregiving in rural

Ghana is especially challenging due to the absence of social amenities and health infrastructure compared to urban centres. While private care institutions have emerged in some cities, rural communities lack formal care systems such as nursing homes or community-based services (Dovie, 2019; Kpessa-Whyte, 2018). This gap forces families to assume the full burden of elder care, even when they lack the resources or willingness to do so (Dovie, 2019; Kusi et al., 2020).

COVID-19 further widened these spatial inequalities by exposing weaknesses in healthcare and caregiving infrastructure. Lockdowns limited access to medical treatment and travel, while fear of infection discouraged many older adults from seeking routine health services (GHS, 2021; Tagoe & Nonvignon, 2023). These dynamics underscore the need to investigate how environmental change affects elder care and the strategies that the elderly and care providers adopt to mitigate these challenges.

In conclusion, the literature portrays the complex and evolving landscape of elder care in Ghana, shaped by economic strain, limited government support, household dynamics, and shifting caregiving norms. These gaps call for further research into how middle- and low-income households adapt care strategies in these circumstances in underdeveloped settings. Such work is essential for building sustainable, culturally aligned approaches to support ageing populations amid intensifying social, economic, and environmental change.

2.8 Theoretical Framework

This study adopts Hooyman and Gonyea's (1995) feminist gerontological perspective, grounded in feminist theory and critical gerontology. Their work integrates feminist theory, gerontology, and social work, emphasizing the need for gender-sensitive, justice-oriented approaches to elder care.

2.8.1 Feminist gerontological perspective

Grounded in feminist theory and critical gerontology (Wollstonecraft, 1759-1797; Katz, 2019; Minkler & Estes, 1999), feminist gerontology emerged in the late 20th century as a response to traditional theories that often neglected the gendered dimensions of ageing. Classic frameworks such as disengagement theory (Cumming & Henry, 1961) or continuity theory (Atchley, 1989) treat ageing as a gender-neutral process, overlooking how gender, power relations, and other intersecting inequalities uniquely shape the experiences of older women and men. Earlier scholars such as Abel (1991) and Calasanti (1991, 2004) argue that the invisibility of gender in mainstream gerontology obscures the different ways men's and women's lives are structured across the life course.

The feminist perspective broadens our understanding of ageing by moving beyond a singular focus on gender to include privilege, inequality, diversity, and interdependence that impact both men and women (Hooyman et al., 2012). It frames gender not as an inherent trait but as a social construction produced through structural, relational, and symbolic uses of privilege between men and women in both public and private spheres. Critical gerontology reinforces this view by emphasizing that social and economic processes produce experiences of aging, creating power imbalances and inequalities in the lives of the elderly (Baars et al., 2006). Drawing on these perspectives, Hooyman and Gonyea's (1995) *Feminist Perspectives on Family Care: Policies for Gender Justice* systematically apply feminist theory to ageing and caregiving, laying a foundation that directly aligns with this study's objectives.

Hooyman and Gonyea (1995) developed a feminist gerontological theory that incorporates gender analysis into the study of aging, caregiving, and social policies. Hooyman et al. (2002; 2012) expanded the framework to include broader intersectional analyses,

demonstrating how caregiving responsibilities, workforce participation, and social policies intersect with gender and age. The framework rests on five key tenets: caregiving as gendered labour, cumulative life course inequality, critique of policy or institutional structures, intersectionality, and the promotion of empowerment and social justice (Hooyman & Gonyea, 1995; Hooyman et al., 2002; 2012).

The framework highlights how disadvantages accumulate over the life course, intensifying vulnerabilities in later life. Hooyman and Gonyea (1995) argue that gender fundamentally shapes life course trajectories, influencing education, employment, caregiving roles, and retirement outcomes. Kpessa-White (2018) shows that limited access to girl-child education has historically prevented women's access to formal job markets, which leads to poverty and financial insecurity in old age. Hooyman and Gonyea (1995) further argue that women often leave the labour force for children or older parents, which reduces their access to pensions and benefits compared to men who enjoy uninterrupted careers. In Ghana, Baah-Boateng & Vanek (2020) demonstrate that older women spend most of their lives in the informal sector, primarily engaging in trading, often as self-employed individuals without benefits to secure their future. Many of these women continue to provide unpaid care into old age for spouses, grandchildren, or dependents without any form of financial protection, which leads to economic insecurity dependent on the family.

The theory also recognizes that women do not age uniformly. Various factors such as gender, age, class, ethnicity, cultural background, education, geographical location, and socio-economic background intersect to compound inequalities (Hooyman et al., 2002). These intersections influence how older women access opportunities and resources. For example, reproductive and social roles, combined with low educational backgrounds and employment in

the private informal sector in Ghanaian society, increase the likelihood that older women will experience poverty or fall under low socio-economic status (GSS, 2013b). Disparities in education, employment, and residential status marginalize these older women, pushing them into poverty.

The framework acknowledges that caregiving is not a neutral work but rather labour that societal norms have historically assigned to women. These norms portray women as inherently nurturing and responsible for dependent family members, while the community devalues such roles (Hooyman & Gonyea, 1995). Society constructs caregiving as women's work, unpaid and excluded from policy protections, which has long-term consequences for women's health and economic security. In most communities, families typically assign daughters, daughters-in-law, wives, and other female relatives the task of hands-on elder care, while praising sons for minimal involvement (Hooyman et al., 2002). This reinforces the idea that caregiving is a woman's moral obligation rather than a shared family responsibility. In Ghana, Agyemang-Duah et al. (2024) found that more than 60 percent of primary caregivers in rural communities are women, many of whom abandon income-generating activities to care for ageing relatives. This gendered division of labour deepens women's economic dependence and prevents them from accumulating pensions or savings for their own old age.

Feminist gerontology critiques policies and institutions that disregard these realities, including caregiving as essential labour (Hooyman & Gonyea, 1995; Hooyman et al., 2012). In Ghana, the National Ageing Policy, social programs, and employment-related retirement benefits remain fragmented and inadequate (Kpessa-Whyte, 2018; Dovie, 2019). The absence of infrastructures such as elder care facilities, trained geriatric professionals, and adequate social work systems affects the social and economic well-being of older adults in old age.

Feminist gerontology emphasizes transforming social structures through advocacy, empowerment, and justice-oriented practices (Hooyman & Gonyea, 1995; Hooyman et al., 2012). In Ghana, older women serve as caregivers and community leaders, playing vital roles in socialization, spiritual leadership, and conflict resolution within traditional settings (Odotei, 2006; GSS, 2013b). Hooyman and Gonyea (1995) argue that describing inequalities alone is insufficient; instead, scholars, social workers, and policymakers must advocate for reforms that elevate the rights of ageing individuals. To achieve this in Ghana, stakeholders need to expand social protection, strengthen inclusive care systems, and support culturally aligned care initiatives that uphold older women's dignity and well-being.

2.6.2 Relevance of the theory to the study

Feminist gerontology shapes our understanding of elder care, especially informal care. Social, political, and economic issues affecting women play a vital role in this analysis (Hooyman et al, 2002). In LMICs like Ghana, factors such as poverty, limited support, and traditional expectations intensify these dynamics. Feminist gerontological theory aligns with Charmaz's (2006, 2014) constructivist grounded theory (CGT), which constructs meaning from participants' lived experiences through an interpretive and reflexive lens. Charmaz (2014) describes knowledge as socially constructed, emerging from interaction and context. Combining feminist gerontology and CGT enables scholars to develop theories grounded in gendered experiences of ageing and care. For example, analyzing interview data from older Ghanaian women and caregivers with CGT reveals how caregiving roles are negotiated amid poverty, gender norms, and weakened kin networks. This process produces a grounded theory that explains how gender, power, and socio-economic conditions shape care experiences while addressing the objectives of the study.

Chapter 3: Research Methodology

3.1 Introduction

The philosophy underpinning this qualitative research rests on the idea that individuals perceive reality subjectively and socially construct it within specific contexts (Creswell & Creswell, 2018; Glaser & Strauss, 1967). Methodologically, qualitative research offers a framework that shows how each component of the research process, such as formulating research questions, selecting appropriate methods, and interpreting results, works together to address a broader research problem (Saunders et al., 2019). In this case, I seek to understand the current state of elder care through participants' shared experiences. Guided by the research objectives, potential gaps in the literature review, and my motivation and perspective on knowledge creation, I chose constructivist grounded theory (CGT) for this study. This chapter describes how I applied the CGT epistemological stance and how it influenced participant recruitment, data collection, analysis, and findings. Throughout the study, I emphasize reflexivity, which I incorporate into every stage of the research.

3.2 Research Design of the Study

Research design provides the framework that guides the collection, measurement, and analysis of data in a study (Creswell & Creswell, 2018). It serves as a blueprint that specifies how each part of the research process, including formulating research questions, selecting appropriate methods, and interpreting results, fits together coherently to address the overarching research problem (Saunders et al., 2019).

3.2.1 Research paradigm

According to Guba & Lincoln (1994), research paradigms differ because of their underlying philosophical assumptions: ontology, epistemology, axiology, and methodology.

These assumptions guide how researchers understand and address problems. Recognizing that experiences of a phenomenon change across social contexts, I positioned my study within the constructivist paradigm. This paradigm acknowledges that "truth or meaning comes into existence in and out of our engagement with the realities in our world" (Crotty, 1998, p. 8; Lever, 2013). Constructivists interpret meanings beyond mere description, making their insights relevant for social and healthcare decisions (Burns et al., 2022; Lincoln et al., 2018).

Ontology. Charmaz (2014) adopts a relativist ontology, arguing that multiple subjective realities emerge through social interactions. Reality draws from local knowledge and depends on those who hold it, resulting in diverse and co-constructed understandings (Burns et al., 2022; Guba & Lincoln, 1998, p.206). Constructivists therefore reject the notion of a single, objective truth (Caton, 2013). From this perspective, elder care is context-specific, shaped by relationships, values, and cultural expectations. Individuals actively construct knowledge through their experiences within social and cultural settings (Schreiber & Valle, 2013). This stance enables researchers to examine how older adults and care providers define care and ageing within their communities.

Epistemology. Constructivists pursue inter-subjectivity and shared understanding, viewing knowledge as co-created through ongoing researcher-participant interaction (Burns et al., 2022; Creswell & Creswell, 2018). Researchers use methods such as in-depth interviews or focus groups (Caton, 2013; Charmaz et al., 2018) to allow participants to articulate their perspectives on care. During the process, researchers interpret and refine emerging data, co-constructing insights that reveal the beliefs and practices underlying elder care in Ghanaian communities.

Axiology. Constructivist inquiry embeds values within the research process, acknowledging that both researchers' beliefs and participants' perspectives shape the study (Guba & Lincoln, 1994). Ethical engagement requires respect for cultural norms and participants' preferences (Chilisa & Kawulich, 2012). I recognize the value-laden nature of this study and disclose my positionality and biases (Chilisa & Kawulich, 2012; Lincoln & Guba, 2013). This stance supports amplifying the voices of older adults, caregivers, and service providers often excluded from policy debates, while upholding reflexivity. Constructivist grounded theory (CGT) aligns with this orientation by advancing action-oriented research that informs social work practice, policy reforms and community interventions.

Charmaz and Thornberg (2021) argue that ontology and epistemology together determine research quality. Constructivist approaches focus on lived experiences while recognizing the contextual and co-constructed nature of care. Their emphasis on reflexivity, empowerment, and creativity makes CGT valuable for addressing complex realities in Ghanaian elder care. Braimah and Rosenberg (2021) highlight the heterogeneity of older adults and care providers, whose experiences are shaped by social and structural conditions. As a Ghanaian, I attest to this diversity, shaped by socio-cultural values, economic pressures, and environmental factors. My own background informs my stance, making reflexivity essential for capturing the multiple truths embedded in participants' lived experiences.

3.2.2 *Perspectives of CGT methodology*

Strauss and Corbin (1998) developed the initial version of grounded theory within the post-positivist paradigm. It reflected a realist ontology (an independent reality) and a modified objectivist epistemology, where researchers sought to represent reality through a practical and objective stance. Under an objectivist epistemology, researchers must let the data "speak for

itself" by maintaining distance from both data and abstraction (Glaser & Strauss, 1967; Singh & Estefan, 2018). By contrast, constructivist grounded theory (CGT) gained recognition when Charmaz revised Glaser and Strauss's approach to incorporate the subjective nature of individual realities (Charmaz, 2005, 2006, 2014; Charmaz et al., 2018). CGT encourages researchers to recognize values and cultivate relationships with participants.

Charmaz's grounded theory highlights the researcher's active role in shaping findings, acknowledging their perspective, values, privileges, interactions, and positionality. In defending the role of literature reviews, Charmaz (2014) argued that researchers need prior knowledge to secure study proposals and funding. Reviewing literature both before and after data collection strengthens theoretical sensitivity and ensures the study contributes to existing scholarship (Charmaz, 2014; Thornberg, 2012). In this process, theoretical sensitivity grows as researchers engage prior knowledge alongside emerging data. Charmaz (2014) also used constructivism and social constructionism interchangeably when describing their evolved grounded theory method (GTM).

Methodologically, CGT is robust, employing inductive, deductive, and abductive reasoning in a flexible and iterative manner (Charmaz, 2014). Inductive reasoning anchors initial and focused coding, while iterative analysis continually refines categories and concepts. CGT analysis unfolds in a nonlinear and cyclical way, following Charmaz's (2006) principle of constant comparative analysis. Each round of coding informs subsequent data collection, leading to theoretical sampling. Memo writing extends this process, deepening interpretation, supporting reflexivity, and shaping an interpretative framework that resonates with social meanings.

CGT also draws from symbolic interactionism, which emphasizes the interpretation and construction of meaning in social interactions (Blumer, 1969). This perspective views individuals

as using symbols, roles, and cultural expectations to negotiate identities and relationships. In elder care, such meanings appear in ideas of "being a good daughter" or "dying with dignity." CGT, therefore, requires researchers to reflect on their biases and social positions during data collection and analysis, contrasting sharply with classic grounded theory's claim of neutrality (Glaser & Strauss, 1967).

The methodology selected for this study reflects my worldview, personal experience, and the aim of the research. I recognize that phenomena continuously evolve within their social contexts. Understandings of truth and reality remain subjective, shifting with sociocultural conditions. Thus, caregiving practices that are acceptable in advanced cities, such as hiring external help, may be inappropriate in smaller towns due to differing beliefs and values. While engaging participants, I understood that I was not only collecting data but also co-constructing theory with them. This approach fostered active engagement and flexibility to pursue unexpected findings with participants' historical, social, and cultural contexts (Charmaz, 2020; Creswell & Poth, 2016).

CGT permits data collection from diverse sources, including interviews, field notes, and participant observations, to capture a rich picture of the phenomenon (Charmaz, 2014). In this study, triangulating sources provided multiple perspectives and supported validation. Interpreting the narratives of older adults, caregivers and service providers, while situating my own interpretative role, helped clarify the emerging substantive theory.

3.3 Methods

The initial phase of the study involved a literature review that informed the draft proposal and guided discussions about the perceptions and experiences of care recipients and service

providers. This process aimed to capture the multiple realities of elder care within the Ghanaian context.

To begin the method, these questions guided the study's aim:

1. How do the elderly, their caregivers and service providers define elder caregiving from their perspective?
2. What are the key contextual factors contributing to the current state of elder caregiving as understood from the perspectives of the elderly, their caregivers, and service providers?
3. How has the COVID-19 pandemic contributed to elder caregiving in the community as understood from the perspectives of the elderly, their caregivers, and service providers?
4. What are the formal and informal support systems for service users (elders and caregivers) and service providers to manage care deficits in their community, as understood from the perspectives of the elderly, their caregivers, and service providers?

3.3.1 Research setting

The research took place in two communities in the Eastern Region of Ghana, selected for their high proportion of elderly residents, increasing migration rates, and strong cultural commitments to filial obligations and reciprocity in caregiving. Nationally, 4.3 percent of the population in 2021 was 65 years and older. The Eastern region ranked third out of sixteen regions, with a higher proportion of older adults at 5.7 percent (GSS, 2021), exceeding the national average. Although 51.5 percent of the region is urban, its infrastructure and socio-economic conditions remain inadequate, making it a crucial site for examining elder care. Within this context, I purposively selected Akuapem-Mampong and Akuapem-Akropong to explore the experiences of the growing ageing population. Akuapem-Akropong serves as the semi-urban

capital of the Akuapim-North district, while Akuapem-Mampong is a town (GSS, 2013; 2021 Alhassan & Kwakwa, 2013).

The municipality's landscape features the Akuapem Range, a prominent hill formation with elevations between 381 and 488 metres, and peaks that reach 500 metres. Its lowest point lies at about 152 metres (GSS, 2010). Growing up in Akuapem-Akropong, I often heard both locals and visitors refer to this area as "The Mountains." Walking and connecting with the land during the fieldwork reaffirmed why this description resonated so strongly.

Akuapem-Twi is the most widely spoken language in these communities, representing 51.6 percent of the population (GSS, 2010). I used Akuapem-Twi as the primary language of communication with most participants, relying on my basic fluency. Being from one of the study communities and speaking the local dialect helped me build rapport and trust more easily than anticipated.

The Akuapem-North Municipal Assembly operates as a decentralized political and administrative unit under the Local Government Act of 1993. It oversees planning, budgeting, and development programs for the district. The Social Welfare and Community Development Department (DSW) supports the Assembly by designing and implementing social policies for vulnerable populations, including older adults. My engagement with the department deepened my understanding of their programs and revealed their collaboration with traditional and religious leaders, who play key roles in advancing the Assembly's objectives.

3.3.2 Population (Who are the participants of the focused study?)

The elderly population in the Akuapim-North Municipality, which includes Akuapem-Mampong and Akuapem-Akropong, grew significantly between 2010 and 2021. According to the 2021 Ghana Population and Housing Census, the municipality's total population increased

from 75,771 in 2010 to 105,315 in 2021, with a higher proportion of females (53%) than males (47%). During this period, the number of older adults also increased: 7,241 individuals were aged 65 and over, contributing a total of 10,347 people aged 60 years and above. This trend reflects broader demographic changes in Ghana, where ageing populations are expanding due to increased life expectancy and declining birth rates (GSS, 2021; Cambridge Core, 2021). For this study, the terms *elderly* or *older adult* are used interchangeably for individuals aged 60 years and above in these two communities.

3.4 Sampling Techniques and Procedure

Participants were recruited from the Mampong and Akropong communities in the Akuapim-North Municipal Assembly of Ghana's Eastern Region through purposive, snowball, and theoretical sampling (Charmaz, 2006). Purposive sampling served as the primary method, as it allowed for the selection of knowledgeable participants who could provide rich data and spark multiple lines of inquiry (Charmaz, 2014). Snowball sampling complemented this strategy at the start of data collection and during theoretical sampling by helping to identify additional participants who met the criteria (Nikolopoulou, 2023). These qualitative research methods aimed to achieve a deeper understanding of the phenomenon through the knowledge and experiences of these informants (Palinkas et al., 2013).

Older adults aged 60 years and above who received formal and/or informal assistance with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) and who resided in either community were purposively recruited. Caregivers providing ADL and IADL support were included using the same criteria. Community leaders were intentionally selected for their influence on the well-being of the elderly, while health professionals, including doctors and nurses, were recruited based on their direct role in elder care within the district. As

Tindana et al. (2006) emphasize, community leaders in Ghana function as "gatekeepers" of cultural norms and values, holding knowledge and influence that shape social development. Including these leaders and health professionals ensured multiple perspectives on formal and informal support systems.

Before recruitment, I contacted the Akuapim-North Municipal DSW, the government agency responsible for implementing social welfare and development programs (MoGCSP, 2023). Having previously collaborated with staff from this office, I obtained the director's contact information and initiated an encrypted WhatsApp call on August 29, 2023. During this call, I introduced the study and subsequently followed up with an email (Appendix B) on October 2, 2023, providing detailed information and securing initial approval for collaboration.

Face-to-face meetings further solidified rapport with both the DSW director and community leaders before data collection, in line with Horsfall et al.'s (2021) recommendation that culturally grounded introductions strengthen community support. Upon arrival in Ghana, I met the director in person at the departmental office in Akuapem-Akropong on November 3, 2023. While awaiting ethics approval, I submitted a demographic profile and draft participant criteria for review. After receiving formal approval on November 28, 2023, posters outlining the study's purpose and inclusion/exclusion criteria (Appendices A1, A2, A3) were distributed through the DSW and displayed on the community bulletin boards. Recruitment also relied heavily on word of mouth, with the DSW director introducing me to community leaders, religious leaders and agencies in these communities.

Through these introductions, I learned that several potential participants were unable to read. This insight required adapting strategies, such as using formal introductions by community leaders rather than relying solely on recruitment flyers. For example, the DSW introduced me to

a local pastor who then facilitated traditional introductions to some elderly individuals in his community. Out of seven initial introductions, I successfully contacted four individuals to schedule interviews. This iterative and flexible recruitment process reflected the need to adapt to each community's communication practices.

As both participant and observer, I navigated insider-outsider dynamics throughout recruitment (Creswell, 2003). Some referrals did not meet the criteria, for instance, caregivers who cared for children rather than older adults. These experiences underscored the importance of continual negotiation and reflexive assessment rather than accepting all referrals uncritically. By balancing rapport with gatekeepers and critical evaluation of eligibility, I maintained methodological rigour while respecting community norms.

Seventeen older adults participated in the individual interviews, eight of whom were recruited through referrals and nine through community leader introductions. Five elder caregivers were referred directly by older adult participants, and four through community leader introductions. Seven community leaders were recruited: two through the DSW, three through elderly participants, and two through referrals from already engaged leaders. Nine government and not-for-profit representatives joined the study: six from the DSW, one referred by an older adult, and two through community leaders.

Theoretical sampling refined recruitment as data analysis progressed (Charmaz & Belgrave, 2012). For example, early interviews highlighted an ageing centre affiliated with Christ Presbyterian Church in Akropong. This insight led me to recruit staff and a church leader from the centre's committee. Similarly, participants' reflections on care homes shaped later probing questions, allowing me to compare differing perspectives on institutional and home-based care. For instance, in earlier interviews, I assumed that participants, particularly the elderly

and caregivers, understood "home care." However, as I listened to these recordings and reflections to explore the data, I realized this was not necessarily the case. In later interviews, I needed to probe using different wording and paraphrasing with these participants to capture their understanding and perspectives of home care and their community. By cycling between data collection and constant comparative analysis (Charmaz and Thornberg, 2021), I refined categories and extended sampling to address emerging concepts.

3.4.1 Sample size

The study sample included perspectives from older adults, family caregivers, community leaders, and organizational representatives in Akuapem-Mampong and Akuapem-Akropong. In total, 36 interviews were conducted. Seventeen older adults, five caregivers, seven community leaders, and four organizational representatives participated in semi-structured individual interviews. In addition, three focus groups were held: one with older adults (eight members), one with caregivers (four members), and one with organizational representatives (five members).

Community leaders consisted of Abusuapanin (Family Clan Head), a church leader, a pastor, two assemblymen (one from each community), a queen mother, and an Islamic leader. Organizational representatives included a director, two nurses (one private and one public), a doctor, and five officers from DSW occupying different positions. Including these diverse voices ensured that the study captured not only the lived experiences of older adults and caregivers but also the perspectives of service providers, who remain underrepresented in elder care research (Dovie, 2019).

Engaging participants from different demographics facilitated robust discussions and enriched the analysis with divergent perspectives. Charmaz (2014), theoretical saturation occurs when no new properties of categories emerge and when sufficient data have been collected to

explain participants' actions, views, and processes. In this study, the range of participant perspectives provided analytic depth, enabled comparisons across roles, and helped refine conceptual categories.

Data collection spanned two months and took place in participants' homes or other safe spaces. Reflective notes were extensively used throughout the process to support originality, resonance, and usefulness in accordance with CGT criteria (Charmaz, 2014; Charmaz & Thornberg, 2021). Table 1 represents the sample attained in this study.

Table 1: Sample Size Design Construct

Participants	Composition	Data collection method	Sample size (N=50)
Elderly (ED/FGED)	Elderly receiving care in the two communities	Semi-structured Interviews	17
		One (1) focus group discussion	8
Caregivers	Children/Relatives Non-relatives (role of a caregiver)	Semi-structured Interviews	5
		One (1) focus group discussion	4
Community Leaders (Service providers: CL)	Traditional/ Religious/ Political leaders in the townships	Semi-structured Interviews	7
Organizations Representatives (OR/FGOR)	Government (DSW, GHS)/ Not-for profit agencies (Geriatric/ formal care centres)	One (1) focus group discussion	5
		Semi-structured Interviews	4

Source: Author (2023)

3.5 Data Collection

To capture and analyze participants' perspectives, I conducted fieldwork aimed at uncovering the meaning of their experiences and co-constructing a theory grounded in their situation in the Akuapim-North Municipality. To ensure credibility and rigour, I used semi-

structured individual and focus group interviews, complemented by field notes and observations from interactions and the physical settings of the two communities (Charmaz, 2014; Charmaz & Thornberg, 2021). All interviews and discussions in either Akuapem-Twi or English, depending on participants' preferences.

3.5.1 Individual interviews

Before each interview, I explained the study and administered consent forms (Appendix C1), addressing participants' questions and collecting signatures. Participants who could read received the forms in advance, with time to review them before signing. For example, I left forms with government agency representatives ahead of their scheduled interviews. On the interview day, I reviewed the forms again before beginning. Interviews were guided by a flexible questionnaire (Appendices E1, E2, E3), which encouraged participants to share their experiences in detail.

Most interviews (23 of 27) were conducted in participants' residences, while the remaining took place in workplaces to accommodate scheduling constraints. Conducting interviews in familiar environments provided participants a sense of safety and convenience and allowed me to observe behaviours and daily interactions. Interruptions occasionally occurred, such as pausing to allow a caregiver to attend to a care recipient or to take breaks for elderly participants experiencing fatigue. Interviews generally lasted about one hour, and I arranged follow-ups if necessary.

I assured participants of anonymity and confidentiality through pseudonyms and composite profiles (Creswell & Poth, 2016). Identities included elderly (ED-P1, ED-P2, etc.), caregivers (CG-P1, CG-P2, etc.), community leaders (CL-P1, CL-P2, etc.), and organizational representatives (OR-P1, OR-P2, etc.). I also explained limitations to confidentiality during and

after the interview process. I collected demographic information through a questionnaire (Appendix D) from elderly and caregiver participants. With participants' permission, I audio-recorded all interviews, which allowed me to focus on the conversation and ensure accurate transcription (Biaggi & Wa-Mbaleka, 2018).

3.5.2 Focus group interviews

I conducted focus group discussions with elderly participants, caregivers, and organizational representatives in the community, using semi-structured interview guides (Appendices F1 and F2). Before each session, I administered consent forms (Appendix C2), addressed participants' questions, and collected their signatures. Participants who could read received the forms in advance, reviewed them before signing, and I revisited the forms at the start of the group discussions. I collected demographic information through a questionnaire (Appendix D) from elderly and caregiver participants. I guided the interviews with a flexible questionnaire (Appendices F1, F2), which allowed participants to share their experiences in detail and freely.

The elderly group discussion took place in the family home of one participant, conveniently located near the marketplace and many participants' businesses, including those of caregivers. Organizational representatives met in a private office at the Municipal Building, where the setting minimized distractions. After the interviews, I observed participants in their workplaces. For instance, one elderly participant brought her goods to the discussion and, as soon as it ended, she carried them on her head to continue hawking. The focus group discussions lasted 30 minutes to one hour, with opportunities for follow-up when necessary.

3.5.3 Field notes and memo

I maintained field notes throughout data collection, which proved helpful during the analysis phase of the study. At the end of each day's interviews, I documented my reactions and observations in a journal. During the analysis, I recorded reflections on standout responses. Charmaz (2006) emphasizes that field notes and memos not only aid in writing but also help researchers explore how categories develop and refine. This process ensures that analysis remains grounded in the data and provides a transparent record of analytic progress and thinking (p.94). An extract from my field notes is included in Appendix G.

3.5.4. Data handling

I collected data using an audio recorder and field notes. After each interview, I transferred the recordings to my computer, deleted them from the recorder, and securely stored them on a password-protected University of Manitoba OneDrive account. The University recommends Microsoft Teams and OneDrive as official platforms for data storage and sharing. I recorded field notes and memos in a private journal accessible only to me.

Before individual interviews or group discussions, I provided participants with information sheets and consent forms to read, discuss, and sign. I scanned and stored these documents electronically, while hard copies were kept in a sealed folder and locked in my home filing cabinet to ensure confidentiality and anonymity.

3.6. Data Analysis

This section describes the data analysis with the coding process guided by the CGT coding.

3.6.1 Transcription

I digitally recorded and transcribed all interviews verbatim, except for one focus group discussion and one individual interview conducted in English, which I transcribed using Otter.ai.

I anonymized all data and digitally filed notes written in my journal. I began transcription alongside data collection, which allowed me to refine and guide subsequent interviews. I personally transcribed and translated all remaining interviews from Akuapem Twi into English, carefully considering the cultural contexts and participants' communication styles.

Transcription itself acted as a form of translation. As Braun and Clarke (2013) and Michelle & Kiyimba (2015) note, transcription shapes findings by determining which details to include, such as pauses, tone, or non-verbal expressions, which in turn influences interpretation. During transcription and journaling, I documented silences, pauses, and emphases. For example. I noticed hesitations when participants were asked about finances, which I later understood as cultural reluctance to discuss money openly. Similarly, I observed fatigue in some elderly participants' voices and suggested breaks, while in other cases, phrases such as "Hmm, hmm, hmm" signaled unresolved concerns. In follow-up interviews, I encouraged participants to voice their concerns, using targeted questions to capture their perspectives.

I reviewed each recording multiple times while transcribing to manage poor audio quality and overlapping speech. I first produced literal English translations and later refined the wording to clarify meaning while preserving cultural authenticity. As Berman and Tyyskä (2011) emphasize, translating culturally specific terms is time-consuming and risks losing nuance. To address this, I researched the contextual meaning of certain native expressions and added explanatory notes in my memos. This process ensured that participants' voices were conveyed as authentically as possible.

3.6.2 Coding

In the CGT approach, I coded transcripts by labelling sentences, phrases, objects, and categories or properties after repeatedly reading the data until a substantive theory began to

emerge (Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 2002). I coded each data set (Elderly, caregiver, community leader, organizational representatives) in a separate NVivo database and analyzed them individually. I then used diagramming and mapping throughout the process to triangulate perspectives across groups during the analysis. These processes, together with memo writing, contributed to the development of the emerging theory: "Drive To Negotiate," which reflects the current state of elder care in the context of social, economic, and environmental influences.

The initial coding phase involved line-by-line open coding performed with each transcript (Table 2). Charmaz (2014) outlines two main stages of CGT coding: the "*initial phase*," which names each word, line, or segment of the data, and the "*focused phase*," which sorts, organizes, and synthesizes larger amounts of data by using clustering, the most significant or frequent initial codes. I imported the transcripts into QSR-NVivo 12 plus (Appendix I) and created open codes as nodes. As Jackson and Bazeley (2019) highlight, NVivo is particularly valuable for managing large datasets, which allows researchers to organize and analyze data systematically. However, Charmaz (2014) cautions against relying too heavily on software tools that encourage mechanical rather than theoretical coding.

To maintain theoretical depth, I engaged deeply with the data, focusing on the interviews and used the software as a supportive tool throughout the analysis. I reorganized and examined similarities and differences in coding. While NVivo can manage memos, I wrote reflections in my field journals, documented them in Microsoft Word, and stored them securely on my University of Manitoba OneDrive account. Table 2 presents a sample of the initial coding used in this study.

Table 2: Sample of Open Coding

Open Coding	Text
Defining what elder care is to them	I think when someone is sick, and you take care of them. Also, when they give you money and provide you with food to eat then that is also taking care of you.
	Oh, my children are the ones that take care of me. Oh, when I am sick, they take care of me.
Depend on family/children for support	When they get to hear that I am sick they come down and take care of me.
	Also, they send something every end of the month. But now they are going to school so if one of them cannot send me something then
Experience economic struggles with occasional family support	another person will do that. And not it is not every month. Sometimes it is twice or three months before they send me something.
	Oh, I took care of them all by myself so I think they also remember what I did for them when they were young and so they care for me. Oh, sometimes too they can call and just check up on me and see how I am doing and not just send me money or coming over when I am sick.
	Oh, I think some older adults don't have children at all. They never had children, or they have lost all their children through untimely death, so they are all alone. So, they don't have any help or support from anywhere and it is sad. Oh, that is true. When my father
Cultural expectations are shifting	became ill, I took care of him, and I did the same for my mother all here in Mampong. But now a days, when a father or a mother falls ill, it is by choice if the children decide to care for that elderly parent.
	Not all of us have people to provide care or support for me. And there is nothing like a care home here.
No formal institutions for the elderly	So, if there is someone or a place for that support then it will be helpful for such people.

In this study, I conducted focused coding by selecting the most significant, frequent, and conceptually similar initial codes and organizing data into coherent, higher-level categories

(Charmaz, 2014). As the analysis progressed, I grouped the initial codes with related meanings to refine these categories, which are more abstract than the open codes developed earlier (Charmaz, 2006). I employed constant comparative analysis by examining data segments, codes, and categories against one another to identify patterns and sharpen conceptual boundaries. Charmaz (2014) and Glaser & Strauss (1967) agree that such an approach ensures that categories are consistently grounded in the data.

Whereas initial coding enabled open-ended exploration, focused coding required more analytical and deliberate decisions to identify the core themes underpinning the phenomenon. Charmaz (2014) emphasizes that focused coding requires flexibility and reflexivity, as researchers must continually test whether the emerging categories resonate with the participants' accounts. For example, initial coding identified broad concerns within each data set, including the high cost of commodities, weak social support, and job instability. Focused coding distilled these into more precise categories, such as financial constraints, inflexibility of government support, and rising unemployment.

Building on focused coding, I moved towards theoretical coding to articulate relationships between categories, identify a core category, and construct a framework that extended beyond thematic description. Glaser (1978) introduced theoretical coding to conceptualize latent patterns, while Charmaz (2014) reframed it as an interpretive process of weaving categories into theoretical narratives. In this study, categories such as *resource constraints, understanding elder care,* and *transforming care* were integrated into a substantive framework that informed the emergent theory.

The constant comparative analysis grounded categories in the data across diverse participants. I distilled broad issues into more precise categories, generating fresh insights into

elder care beyond mere descriptions. By refining these categories, I captured participants' struggles and strategies, interpreting their lived realities in these communities. This process led to the emergence of a theory that can inform policy, practice, and interventions.

3.6.3 Data Analysis: Field notes and memoing

Researchers adopt different strategies for recording field notes and memos. For example, Hutchison et al. (2010) systematically recorded and stored memos in NVivo, attaching them to nodes, categories and interview reflections. In contrast, I relied on a personal filing system, a journal, and interview reflections to trace connections between the categories and codes and to capture the underlying themes that informed the substantive grounded theory.

I engaged with earlier literature throughout the data collection process and used it to frame reflections that emerged in the field. These strategies helped me stay focused on the data rather than get absorbed in the technicalities of database management. I revisited the original interview recordings and transcripts to verify that my coding accurately reflected participants' meanings. Before heading to the field, I documented relevant literature and the data collection process in my research journal. This included email correspondence, personal reflections on observations, realizations, and concerns about ethical challenges. I critically examined whether the codes I developed adequately represented the meanings and nuances of the data.

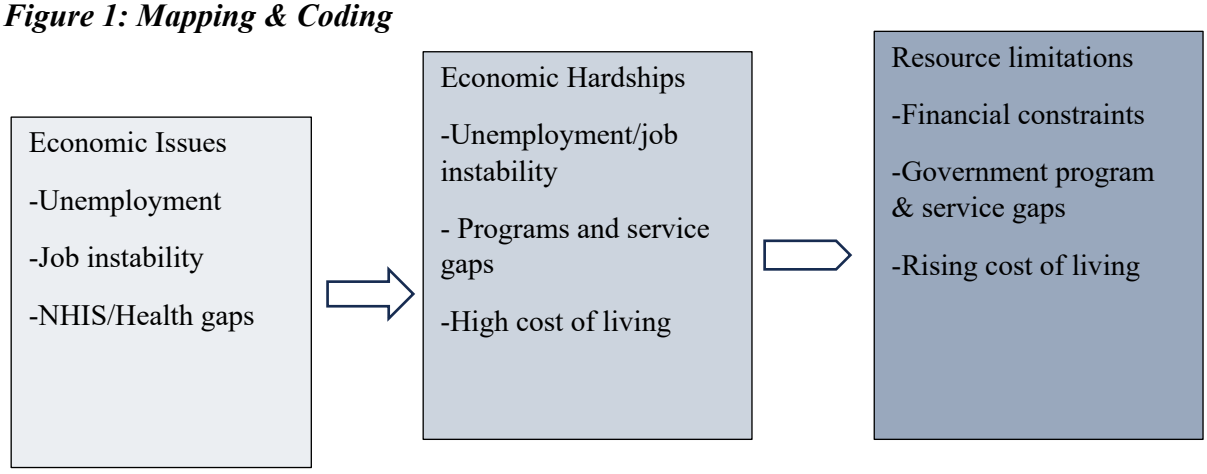
This reflective approach aligns with Charmaz's (2014) criteria for evaluating grounded theory. By recording memos and revisiting transcripts, I ensured that my categories remained closely tied to the data. Documenting reflections on emerging patterns encouraged me to stay attentive to insights that extended beyond existing literature. By situating codes within participants' socio-cultural contexts, I produced interpretations that reflected their lived experiences.

3.6.4 Data Analysis: Mapping

Recent methodological writings provide practical guidance for implementing mapping techniques in CGT. Urquhart (2022), for instance, highlights the value of digital tools and visual platforms for organizing large datasets and iterating conceptual diagrams. Similarly, Thornberg (2017) offers step-by-step instructions for mapping categories during focused coding, encouraging researchers to experiment with different visual formats such as hierarchical trees and radial diagrams to represent conceptual logic.

In this study, mapping served as a valuable tool for guiding data exploration and category development. Figure 1 illustrates an early map that traces the category from *Economic Issues* to *Economic Hardships* to *Resource Limitations*, while also identifying sub-themes aligned with the category. This approach made the analytic decisions visible, clarified participants' experiences, and revealed connections among themes that extended beyond descriptive accounts to understanding challenges and strategies in elder care.

Figure 1: Mapping & Coding



3.6.5 Data Analysis: Theoretical Saturation

In this study, I collected sufficient data to support the in-depth exploration of core categories, which led me to conclude data collection. I decided to cease further recruitment after consistently recognizing patterns and themes that addressed the study's objectives and provided conceptual depth. Some scholars caution that placing too much emphasis on saturation may prematurely limit the exploration of complex social phenomena, potentially oversimplifying the intricate nature of the data (Fassinger, 2005). Nonetheless, other researchers argue that saturation provides a methodological stopping point that signals both the depth and comprehensiveness of the analysis, ultimately enhancing the credibility and trustworthiness of the resulting theory (Charmaz, 2014). In this study, achieving saturation ensured that the substantive theory remains firmly grounded in participants' experiences and reflects the complexity of elder care in Ghanaian communities.

3.7. Researcher Reflexivity

Reflexivity and researcher positionality are central to CGT. Charmaz (2007, p.15) emphasizes that researchers and participants make assumptions about reality, and their "respective views and actions influence each other." My position in this study partly echoed the insider/outsider dynamics. By engaging in continual self-scrutiny, I sought to strengthen the credibility and trustworthiness of the research while safeguarding participants' rights and dignity (Berger, 2015).

As an insider native to the community, I assumed my background would facilitate rapport and trust. Ghanaian communities are widely known for their hospitality, and the research setting was no exception. An initial meeting with DSW in Akuapim-North Municipality created a

supportive environment that also ensured counselling support was available if needed. Although I anticipated that health and family-related questions could be sensitive, I had not anticipated the intensity of other challenges participants revealed, including financial struggles and the loss of children or caregivers.

Most interviews took place in participants' homes at mutually agreed-upon times. Access was facilitated by introductions from DSW to community leaders, such as an assemblyman and a pastor. Although recruitment flyers were distributed, the DSW's direct involvement made in-person introductions more effective. This process allowed me to meet participants, introduce the study, collect contact information, and arrange interviews at their convenience. Focus group discussions proved more challenging to organize, but with advice from community leaders, the local community centre emerged as the most suitable meeting point. This arrangement allowed participants and me to agree on logistics without barriers, reinforcing the collaborative spirit of co-constructing knowledge.

Some of the most vivid and painful stories emerged in private homes. For example, I interviewed an elderly participant recovering from a stroke who had lost the ability to farm cocoa and care for her family. While she could eat independently and stroll, she was distressed by her inability to manage continence, a condition that brought her tears. She felt powerless despite trying every remedy available, including herbal medicine. Reflecting on this interview reminded me of my maternal grandmother, who faced similar struggles with losing aspects of herself that once shaped her identity. These moments underscored the emotional depth of the fieldwork and the importance of reflexivity in acknowledging how participants' experiences intersected with my own memories and positionality.

3.8 Leaving the Field

Before leaving the field, several participants invited me to attend a church service at Christ Church, where the Ageing Centre is located. I accepted and joined the congregation on December 17, 2023, to honour the cultural expectation and as a way to share in the participants' experiences within their organization. By that time, data collection had concluded, which was fortunate, as first-time visitors were expected to introduce themselves and their reasons for attending before the entire congregation.

Honouring this invitation provided necessary closure. I observed participants' excitement at my presence and their active engagement during the service. Despite physical and emotional challenges, they sang, clapped, and danced with visible joy. Their dedication was striking, especially considering the effort required to travel from their homes to the roadside to catch transportation to attend church in that part of the community. Participating in the service allowed me to say goodbye in a meaningful way, ensuring I did not leave the impression that I came solely to extract information. I also visited community leaders and organizational representatives to inform them of my departure and thank them for their support. This farewell engagement reinforced and affirmed participants' lived experiences within their own cultural and spiritual practices. It highlighted a study grounded in reciprocal relationships, where participants and researchers co-construct knowledge with respect for community values and ongoing connections beyond the formal end of data collection.

3.9 Ethical Considerations

Before distributing any study protocols, I obtained approval from the University of Manitoba Research Ethics Board at the Fort Garry Campus, which operates under the Tri-

Council Policy Statement. I ensured that potential participants had sufficient time to review the study information, ask questions, and decide whether to participate, while safeguarding their privacy and anonymity (Creswell & Poth, 2016). I anticipated minimal risk but took precautions to avoid potential triggers that could cause physical or psychological distress. All individual and focus group interviews proceeded without concern, but the DSW in the municipality remained available to provide counselling support if needed. During the consent process, I informed participants that they could withdraw from the interviews or retract any personal statements at any stage before the findings were finalized.

To recognize participants' time and expenses, I provided compensation for their contributions. Each participant received GH70 cedis for time and GH30 cedis for transportation, totalling GH100 cedis (approximately CAD 12.40). This gesture acknowledged their involvement and commemorated their contributions to the study.

To further benefit the communities, I intend to share a summary report with key stakeholders, including social and healthcare professionals and community leaders. This report will include participants' recommendations and serve as a basis for dialogue on elder caregiving. By sharing the findings locally, I aim to promote advocacy and empower community-driven change in support of older adults in Akuapem-Mampong and Akuapem-Akropong.

3.10 Summary

This study examined elder care in Ghanaian communities and revealed significant gaps that have reshaped traditional caregiving practices. The literature review underscored these gaps, highlighting the extensive social, economic, and environmental influences, particularly in the post-pandemic context, on how older adults receive care and how caregivers provide it. To address these issues, I employed a CGT methodology, enabling an in-depth exploration of the

experiences of older adults, caregivers, organizational representatives, and community leaders. Through this approach, I co-constructed themes with participants that illuminate the realities of elder care, identify the factors driving changes in caregiving, and propose strategies for improving the quality of care in Ghanaian communities.

The next chapter presents the findings of this study, organized around the emergent themes and the substantive theory, which together illustrate how older adults, caregivers, and service providers experience and navigate the realities of elder care in Akuapem-Mampong and Akuapem-Akropong in the Akuapim-North Municipality of the Eastern Region of Ghana.

Chapter 4: Research Findings

4.1 Introduction

This chapter presents findings from older adults, family caregivers, and service providers about the current state of elder care in their communities. Their perspectives offer insights into how social, economic, and environmental changes affect caregiving. These insights reveal the challenges faced and strategies used in elder care today. The chapter begins with a demographic profile of participants, followed by a thematic presentation of the findings. These themes illustrate both the underlying challenges of elder care and the ways communities are developing new approaches to sustain and improve its quality.

4.2 Demographic Profiles

4.2.1 Elderly Demographic Profile

Seventeen older adults participated in one-on-one semi-structured interviews, while eight joined a focus group discussion. A summary of participant characteristics is provided in Table 3, with additional demographic details in Appendix G. As noted, the study focused specifically on older women in these two communities. Participants ranged in age from 60 to 94. Most were widowed (16), with six separated, two married, and one cohabiting. All participants identified as religious; the majority were Christian, with only one Muslim participant, reflecting the dominance of churches in the municipality compared to a single mosque in a neighbouring town. Educational backgrounds varied: most had completed only primary or junior high school, three had finished secondary school, and five had attained college or tertiary-level degrees.

Employment status further reflected participants' diverse circumstances. Seven were employed full-time in the private informal sector, primarily as traders, four worked part-time,

and the remainder were unemployed or retired. Some retired participants with secondary or tertiary education received monthly pensions, although these were often modest and supplemented by other sources of income. Reported monthly earnings ranged from GHC50 to GHC800, depending on the type of work., Only three participants relied solely on their businesses for income, while the majority received remittances from children and other family members. Notably, all participants had at least one child, except for one woman who had neither children nor external support beyond her own business.

Living arrangements offered a degree of stability. Nineteen of the twenty-five participants lived in extended family houses, while the others resided in their own homes. These arrangements ensured shelter regardless of marital status, employment or income. Six participants managed their daily care independently but relied on relatives in the family house when needed. Most others had a family member providing regular caregiving support, and only two reported living with hired help. As one participant explained, “Taking care of her, including sending her to school or learning a trade” (ED-P11; ED-P17).

Health challenges appeared consistently among participants. Each participant reported at least one chronic illness, including high blood pressure, diabetes, high cholesterol, arthritis, hypertension, cataracts and other eye problems, insomnia, stomach pain, heart disease, and mobility issues such as knee or waist pain. Many attempted to manage their personal care independently, but tasks like fetching water or running errands often required assistance. Caregivers provided crucial financial and emotional support, significantly contributing to participants’ overall well-being.

Table 3: Elderly Characteristics

Background characteristics	**Elderly care recipients = (N: 25)**	
	Frequency	Percentage
Age		
Range (years)	60-94 years	
Education		
No education	1	4
Primary/Junior/Secondary	19	76
Tertiary/College	5	20
Employment		
Unemployed	14	56
Employed	11	44
Marital Status		
Never married/Cohabiting	1	4
Married	2	8
Separated/Divorced	6	24
Widowed	16	64
Number of Children		
Range (number of children)	1-12	
No children	-	
Income (Monthly)		
Range (Income per month)	25-800ghc	
No income	13	52
Other Sources of Income		
Remittance from family	16	64
Pension Income	5	20
Other (e.g., Prefer not to answer/ None)	4	16
Health Status		
Communicable disease (e.g., malaria)	2	8
Non-communicable disease (e.g., stroke, arthritis, diabetes, cataract)	23	92
Relationship with Caregiver		
Spouse	1	4
Children	10	40
Other family members (e.g., grandchildren)	12	48
Formal	2	8

4.2.2 Caregiver Demographic Profile

Nine informal caregivers participated in the study. Five took part in one-on-one semi-structured interviews, while four joined a focus group discussion. Table 4 summarizes caregiver characteristics, and Appendix I provides the complete demographic profile. All participants were

women, aged between 44 and 82. Three were married, two had never married, two cohabited, and one was separated. All identified as Christian. Educational backgrounds varied: four had completed primary school, four had junior high (middle school), and one reported no formal education.

Employment status reflected both precarious and informal work. Three caregivers were employed full-time in the private informal sector, primarily as traders; two worked part-time, and the remaining participants were unemployed. Monthly incomes ranged from as low as GHC20 to as high as GHC800. Only one caregiver relied solely on her business to support herself and the care recipient. Two received occasional remittances from family members, and three depended on government support such as disability benefits, pensions, or LEAP payments for their recipients. One participant reported receiving spousal support, while another declined to answer. All participants had at least two children, except for one caregiver who explained, "*If I were married, I would have to move back, leaving my mother alone. Because of my tenacity in caring for her, I never had the time to court anyone when I moved here to be with her*" (CG-P5).

Most caregivers (six) lived in extended family houses; one lived in her children's home, and two rented accommodations. All provided care for family members, including mothers, husbands, and siblings, or grandfathers. Although most supported one person, one caregiver looked after both her mother and maternal aunt, explaining: "*My aunt gave birth to all boys, so I had to take on that additional role. However, I would not have undertaken that extra task if she had had a daughter or daughter-in-law nearby*" (CG-P4).

Caregivers also faced health challenges of their own. While two reported no health concerns, the others described conditions such as headaches, dizziness, high blood pressure, diabetes, ulcers, eye problems, and chronic body pain. Despite these health issues, caregivers

supported their elderly relatives with personal care (cooking, bathing, dressing, and feeding), financial care (groceries, utilities, hospital bills, and medications), and emotional care (companionship and outings to meet social or spiritual needs).

Table 4: Caregiver Characteristics

Background characteristics	**Informal Caregiver (N: 9)**	
	Frequency	Percentage
Age		
Range (years)	44-82 years	
Education		
No education	1	11.1
Primary/Junior/Secondary	8	88.9
Tertiary/College	-	
Employment		
Unemployed	4	44.4
Employed	5	55.6
Marital Status		
Never married/Cohabiting	4	44.44
Married	3	33.33
Separated/Divorced	1	11.11
Widowed	1	11.11
Number of Children		
Range (number of children)	2-12	
No children	1	11.1
Income (Monthly)		
Range (Income per month)	20-800ghc	
No income	4	44.4
Other Sources of Income		
Remittance from family	5	55.55
Pension Income (from recipient)	1	11.11
Other Social Programs (e.g., disability benefits for recipient)	3	33.33
Health Status		
Communicable disease (e.g., malaria)/ none	5	55.6
Non-communicable disease (e.g., stroke, arthritis, diabetes, cataract)	4	44.4
Relationship with Care Recipient		
Spouse	3	33.3
Parent	4	44.4
Other relatives (e.g., grandchildren)	2	22.2
Formal	-	

4.2.3 Service Providers Demographic Profile

In this study, service providers referred to community leaders, government representatives, and representatives from not-for-profit agencies. Specifically, participants included social welfare officers, a director, two nurses, a family physician, a Christian Church leader, an Islamic leader, assemblymen, an Abusuapanyin (family head), and a Queen Mother. Their perspectives reflect their roles in providing or facilitating care and services that respond to the needs of the elderly and their caregivers within the current social, economic, and environmental context.

4.3 Underlying Challenges of Elder Care

This section examines two broad but interconnected factors that define the struggles of elder care in the two Ghanaian communities: *Understanding Elder Care* and *Resource Limitations*. The first theme highlights how diminishing kinship support, rural- urban migration, social isolation, and the COVID-19 pandemic has destabilized traditional caregiving structures, leaving many older adults and caregivers emotionally and physically vulnerable. The second theme addresses resource limitations, capturing the financial and emotional burdens that undermine the quality of care and place participants in a state of economic insecurity and stress as they strive to maintain the dignity of older adults. By presenting the lived experiences of the elderly and care providers within these dual themes, this section highlights the systematic and deeply rooted challenges that shape everyday caregiving realities. At the same time, these challenges created the conditions that prompted participants to develop adaptive strategies and reimagine support systems, which are explored in the following section on *Transforming care*.

4.3.1 Understanding Elder Care: The Changing Norms of Caregiving

Diminishing Kinship Ties. Across all participant groups, there was agreement that the cultural expectation of elder care continues to revolve around *reciprocity*. However, participants consistently emphasized that kinship ties, once a cornerstone of elderly care in the Ghanaian society, have significantly weakened. The elderly and caregivers described how the expectation that adult children would reciprocate the care once provided to them is no longer consistently upheld. As one older adult explained: "In the past, our elderly cared for us, so we care for them when we get old… But it is not the same anymore because not all children care for their elderly parents" (ED-P6).

Participants with adult children living at home often receive physical and emotional support, while those living alone or in extended family homes mainly rely on remittances. Yet, these older adults emphasize that such support remains voluntary, especially in today's unstable economic environment. They express disappointment with the economy; one elder noted, "You only hope that they make it in life to come back and take care of you. But if they don't, there is no requirement that forces them to care for you" (ED-P3). When asked about advanced conversations, these older women admit that they have never had formal discussions about their care due to the cultural norm of reciprocity in their communities. This breakdown and overreliance on traditional expectations cause many older adults to feel abandoned and burdened.

Caregivers echoed this norm of reciprocity as both a duty and a burden: "They are family, so if you don't take care of them, then who will?" (CG-P5). Several (six) reported stepping into this role unexpectedly, without consultation or family consensus. For example, one caregiver explained that she assumed responsibility for her maternal aunt only because there were no daughters in the family to do so, which forced her to step up. Her cousins support her by sending

remittances from time to time as part of their contributions to their mother's care (CG-P4). Another caregiver, a 73-year-old woman caring for her spouse (CG-P1), said that no initial conversations or plans took place before these responsibilities unexpectedly fell on her. She is the spouse. With her four children absent, she considers this an unspoken expectation and a matter of willingness, since no one else is prepared to take on this role.

Caregivers, despite a strong sense of duty and sacrifice, report that the lack of collective family participation causes significant physical, emotional, and financial burdens. One participant expressed frustration, saying, "My mother has other children living outside the community, but none of them support her in any way" (CG-P3). When caregivers have children living in the community, they often receive extra support. However, for some of these women, that support is occasional, and community help is almost non-existent. With connections weakening, only a few caregivers remain available to care for the elderly.

Service providers confirmed that kinship obligations have eroded, attributing the decline to the decrease of extended family households and the rise of nuclear living arrangements. One community leader observed, "In the past, relatives filled grandparents' houses… now, elderly individuals live alone because each married child desires a separate home" (OR−P1). Another added, "A single daughter is expected to do everything for her frail father while working and raising her children. How can she manage it alone?" (CL−P3). These accounts illustrate how economic hardship and social shifts, such as the rise of individualism, have transformed caregiving from a communal obligation into a personal sacrifice, often without planning or shared responsibility.

> "…the moment an elderly person cannot do things for themselves, people begin to ask, where are their children?" (CG-P5)

Service providers observed that older adults often complain about their economic situations because their children cannot find jobs to meet their needs. A community leader remarked, “The traditional norm of reciprocity: ‘If you care for your children, when they grow up, they care for you,’ no longer guarantees support in later life due to such situations” (CL-P4). Meanwhile, professional elder care settings rarely engage in advanced conversations. Only one participant (OR-P3) mentioned that they occasionally initiated such discussions with their clients. The absence of advance care planning conversations, reliance on unspoken expectations, and limited public awareness of elder care challenges contribute to this breakdown.

All participants reported that the “positive aspect” of the cultural expectation is that it guarantees “shelter” (the family house) for the elderly, although it does not ensure care. Each group of participants defined elder care in a way that reflects their unique lived experiences. Older adults defined elder care as:

> “It is when an elderly person gets to a stage of life where they receive some help regarding feeding, bathing, and even money, and someone (children) has to care for them.”

Family caregivers defined elder care as:

> “It is having the patience to provide care for an older adult who cannot care for themselves, in terms of their bathing, dressing, eating, among other things.”

Service providers defined elder care as:

> “Elder care involves individuals aged 60 and above who have retired from active duty and require care and support from younger generations, often with some formal arrangements.”

Migration of Younger Generations. Migration emerged as a central concern for all groups. Participants explained that youth migration, driven by unemployment and precarious jobs, destabilizes caregiving structures. One elder stated, “My children are all over the place…

one in Accra, Dunkwa, and another in the Ivory Coast" (ED-P16). Traditionally, multigenerational households ensured daily assistance, from cooking to personal hygiene, readily available for older adults. But with the shift towards single-generation homes, care is increasingly reduced to monthly or occasional remittances. While remittances provide some relief, they are no substitute for physical and emotional presence.

> "When we were younger, all the generations lived together. Now, nobody is home" (ED-P13).

Participants acknowledged the community's current employment and economic hardships. They recognized that if the younger generation does not migrate, they will encounter greater difficulties and could become a burden on their ageing parents (FGED-P5). Additionally, parents have become aware of the importance of education; therefore, they are sending their children to school (FGED-P3), with only a few caregivers available.

Caregivers assumed responsibility by "default" when siblings or relatives migrated. One caregiver explained, "I am taking care of my aunt because her children are not around. If they were here, I would concentrate on my family" (FGCG-P3). Younger relatives have "disappeared" to urban cities or abroad, leaving older relatives behind. Although some provide financial support from afar, the physical burden falls unevenly on those left behind, often stretching their own health and family resources.

Caregivers shared that living arrangements that allow for additional support from those residing in a family home are no longer sustainable for care. Participants said that the young are rarely home due to school, job locations, and busy schedules. They lamented that most leave home early and return late at night, including schools that close as late as 6 or 7 in the evening due to extracurricular activities. According to these participants, the few family caregivers

ultimately experience increased burdens while supporting their families and ageing relatives. One caregiver shared, "…my daughter, who is in university, can only help during vacations; all other responsibilities fall on me" (CG-P4). This demonstrates how caregiving responsibilities fall unevenly across family lines.

> "When the best job prospects are in Accra, our youth vanish. An older mother is left alone. She can't rely on phone calls for everything" (FGOR−P2).

Service providers described migration as both a survival strategy and a disruption to traditional caregiving. They observed that many young people never return, and those who do often lack the capacity or willingness to assume caregiving roles. A community leader (CL-P4) stated that modern urbanization has led many younger generations to avoid jobs like farming and instead travel in search of other opportunities. As a result, many people travel to urban areas and other countries, leaving their parents isolated and without physical care. This situation is common in these communities (CL-P7). A leader confirmed this, saying, "When children complete their secondary education, they leave. I did the same when I moved to Accra" (CL-P2). Consequently, the elderly face isolation, hunger, and medical neglect, as they receive insufficient remittances to cope with economic hardships (FGOR−P2).

Concerns of Isolation and Burden. All participants clearly expressed that elder care involves feelings of isolation or burden, although their experiences differ. Older adults described experiencing emotional isolation, neglect, and stigmatization. Participants observed that ageing often distances many individuals from society, leading to neglect and a lack of support. Two elderly participants who shared similar sentiments recounted how growing old creates a "marginalization in community activities," making them feel "isolated and irrelevant" (ED-16). Others recalled being stigmatized, with one saying, "When you reach a certain age, they declare

you evil or a witch… so, people isolate themselves from you" (ED-P1). Women without children are viewed as particularly vulnerable. This stigmatization results in a decline in communal support. One participant noted, "There was a time, someone would cook and share food with the elderly in the house… now, no one cares" (ED-P1). Consequently, these older women experience feelings of abandonment, marginalization, and social disengagement that impact their overall well-being.

> "Oh, older women in this community struggle a lot. And it is an eyesore when you meet them in the community. And that is especially true for those who don't have children. If you don't have anyone, it is hard. They struggle with their health issues, so you can imagine how they are even coping to get food to eat" (ED-10).

Caregivers experience isolation due to role exhaustion and personal sacrifice. One caregiver said, "I'm always stuck at home with my father because if something happens, who else will be here?" (FGCG-P1). The caregivers noted that they had not recognized how demanding their caregiving roles were and admitted that these responsibilities influence every aspect of their lives. Many caregivers, especially older ones, manage elder care while dealing with their own health challenges. Six out of nine caregivers in the study are older adults who care for spouses or relatives while facing age-related ailments. One caregiver shared, "I am also experiencing some back pain" (CG-P1).

Participants describe how their life choices gradually change because of their roles as caregivers. Some have had their marital status dissolved or never pursued marriage because, as one explained, "It would conflict with the responsibilities for their older relatives" (CG-P5). Without community programs to support them, their social lives diminish as they forgo community involvement and personal care to focus on caregiving. One participant reflected,

“Whenever I go out, I am self-conscious thinking about home... it is like she is an addition to my children that I think about while away” (CG-P3).

Participants expressed feelings of isolation and the heavy burden of elder care due to limited external support from families or the community. The physical and emotional demands of caregiving for loved ones often lead to burnout. An 82-year-old caregiver, who looks after herself and her older sister, acknowledged that overthinking affects her overall well-being. She echoes the sentiments of other caregivers in the focus group, stating, “You go to bed and struggle to sleep, only to wake up with the dawn feeling even weaker than the previous day” (FGCG-P4).

Service providers corroborated these accounts, noting how poverty, stigma, and lack of programs intensify isolation and caregiver stress. One leader remarked, “Cultural beliefs such as witchcraft prevent people from engaging with the aged, even from the same household” (CL-P1). They described an increasing number of elderly clients living alone who often lack basic food or companionship. As traditional extended families continue to disband, many community and organizational representatives are concerned about the growing isolation of older adults in the community.

> “Some of them always come to the hospital with high blood pressure (BP), and we frequently prescribe medication. I have consistently asserted that there is more to it. Upon further investigation, it became clear that even finding food was a problem, and no one was around to assist with basic needs” (OR-P3).

Caregivers’ emotional fatigue was clearly visible to service providers. “Older adults feel guilty about being a burden... and caregivers experience stress and despair” (OR-P1). Participants observed that family members often become exhausted from managing multiple responsibilities, including jobs, parenting, and finances, while caring for frail elderly relatives. They noted that this exhaustion leads to burnout and sometimes resentment, which manifests as

partial neglect or emotional distancing in these communities. One organizational representative expressed concern: “Caring for the elderly in Ghana is not easy. We categorize the elderly, especially those who are bedridden, as particularly difficult to care for” (OR-P4).

Service providers experience emotional strain when they observe repetitive patterns. Organizational representatives report feeling “outnumbered, lacking manpower and funds” (OR-P4), which limits their capacity to support the elderly and informal caregivers. During home visits, two participants expressed frustration, saying, “Although resources are thin, I cannot support one elderly person and ignore another I encounter in the community” (OR-P1; CL-P3). They acknowledged experiencing secondary strain themselves when faced with widespread unmet needs for their elderly and caregiver clients in their communities.

> “I sometimes visit an older woman who can barely pay her hospital bills. She cries about it, and I always leave with a heavy heart too. We keep wondering, ‘Where can we find help for her next time?” (FGOR-P2)

Impact of COVID-19. Participants from all groups described the COVID-19 pandemic as a turning point that worsened elder care vulnerabilities. Elderly individuals expressed that restrictions deepened their isolation and severed their last remaining ties to community life. “The church prevented the elderly from coming for our health and well-being,” said one participant (ED-P1). The lockdown period stopped all forms of social interaction, with religious groups often being the only source of emotional and material support. Even after restrictions were lifted, many reported fear of socializing. A 69-year-old participant recounted, “I was ill during that time, and even after recovery, I isolated myself out of fear” (ED-P12), worried about contracting the virus. This pandemic further increased the already existing physical isolation due to the migration of children, leading to fewer physical visits from children.

Caregivers felt overwhelmed and viewed the COVID-19 period as a difficult time. They feared catching the virus whenever they left the house, constantly worrying about infection and the risk of passing it to elderly relatives with underlying health issues (CG-P5). Getting the disease would mean they couldn't care for their loved ones, which would indirectly affect the well-being of their elderly relatives, something they couldn't afford. Even though most caregivers followed precautions like “Consistent hand-washing and maintaining hygiene,” the lingering uncertainty caused ongoing concerns, because “You don’t know which family member from this house will bring it in” (CG-P4).

Service providers faced similar constraints. They expressed frustration over restricted mobility and disrupted support for the elderly in the communities. Some community members voiced concerns about the disruption of regular home visits to their ageing members in the community. Several participants mentioned that this situation posed significant challenges for both them and the community as a whole. Religious leaders highlighted that communal giving and support stopped due to the mandatory restrictions. Although some providers managed to distribute food and hygiene items, they found these efforts unsustainable, especially since older adults also rely on these organizations for social engagements that promote their emotional well-being.

> “Being confined to our homes during that time was really challenging for us, as our main source of support and socialization was at church. On certain Sundays, people would see the elderly members and choose to give them some money out of kindness. It wasn’t only the elderly; even the unemployed youth in the church benefited from this generosity shown by the congregation. But now, what will they do?” (CL-P5)

Despite the challenges, faith-based organizations served as temporary lifelines for participants from all groups. Their churches provided groceries and occasional health check-ups

to elderly participants (ED-P15), and caregivers recognized these contributions: “My mother’s church gave us rice and oil, which eased some of our burdens” (CG-P2). Service providers also relied on church networks and private donors to fill the care gap during this period.

In summary, participants across groups revealed that the cultural expectation of reciprocity no longer guaranteed care migration, isolation, and caregiving burdens intersect with poverty and stigma to erode the traditional safety net. The COVID-19 pandemic further disrupted social ties, leaving elders and caregivers vulnerable. These findings illustrate how deeply rooted socio-economic and cultural changes have destabilized elder care in rural communities.

4.3.2 Resource Limitations

Most older adults report having little to no stable income to sustain themselves, instead relying on their families for financial support. Participants emphasize that financial resources matter more than any other form of care because they determine access to essential services that ensure overall well-being. An elderly woman stated, “Even the money for porridge is sometimes hard to come by in this economic hardship” (FGED-P5). For these participants, even if caregivers are not physically present, access to resources can still ensure some basic needs.

Participants lament that unstable jobs and persistent unemployment undermine the quality of elder care. Elderly participants who still work in old age explain that they can no longer rely on subsistence agriculture because “We must purchase everything from the market” (ED-P5). These older women continue working in the informal sector to support themselves and contribute to caregiving. Still, their ability to provide care depends on the resources they earn from each day’s sales.

> “If you don’t have a job, that will also be another issue that will make it challenging to care for someone” (ED-P6).

Caregivers agreed that a lack of financial resources makes it difficult to care for their loved ones. One caregiver remarked, "…If my father is lying there hungry, and I don't have money, then I cannot care for him" (FGCG-P1). Caregivers explained that supporting older adults requires essentials such as food, medication, regular check-ups, and personal care products (CG-P3). Unlike older adults who seek work to support themselves, caregivers described making daily trade-offs between caregiving duties and income-generating activities. Several caregivers, including CG-P2 and CG-P3, moved their businesses to their homes to stay available, even though this shift lowered their earnings.

One participant explained during her home interview that she operated a convenience store on her premises because of her caregiving responsibilities. She noted that the shop's location limited customer traffic and reduced her daily profits. High unemployment and unstable jobs in these communities further challenged caregivers' ability to provide sufficient care for their elderly relatives. Caregivers emphasized that their responsibilities became even more difficult when they faced additional financial obligations, such as "Taking care of my children's needs like paying their tuition" (CG-P4). These circumstances intensified their financial burdens amid ongoing economic hardships.

> "Our sources of income commonly yield unpredictable earnings that are insufficient to maintain the household's needs during the current economic crisis" (CG-P2, CG-P5).

Service providers reinforced these concerns and noted that community-wide economic hardship limited both informal and formal care provision. They observed widespread unemployment and unstable income among adult children, which constrained remittances and reduced caregivers' ability to provide consistent support. One participant summarized, "If adult children are jobless… how do they send money home for their parents' upkeep?" (OR−P1).

> "Older adults always complain about the economic situation because their children… cannot afford to find a job to do the needful" (CL-P4).

Agencies such as the DSW also faced financial strain. There are limited funding and resources for programs like LEAP, which constrain service delivery even when the elderly qualify. Officers disclosed that "*Inadequate budgetary"* hindered their ability to organize health outreach or distribute resources and sometimes compelled them to use personal funds. Agencies reported lacking basic operational resources, including vehicles needed to fulfill their duties. A community leader explained, "For our screening program, we receive a small grant annually. Beyond that, it's all on us, personal funds, small contributions from friends" (CL−P1).

Faith-based organizations faced challenges as well. These organizations often secure donations from community members or approach not-for-profit entities, but the unpredictability of external funds creates operational instability. These increasing job instabilities and the general economic hardships have affected the capacity of individuals and entities to be benevolent. One religious leader expressed disappointment that limited funding reduced the number of events and donations for elderly congregants (CL-P2).

These financial constraints revealed how the system is under-resourced, both for families providing care and the institutions meant to support them. Caregivers and older adults bore the day-to-day burden, while service providers confronted policy-level inadequacies that restricted their capacity to intervene meaningfully. Together, family hardship and institutional insufficiency reinforced cycles of deprivation in elder care within these communities.

Rising Cost of Living. Participants emphasized that the rising cost of living worsened the struggles of elder care. Elderly individuals shared how even basic sustenance had become tough. An 85-year-old woman, a long-time resident of one of the towns, explained that

increasing costs had made life difficult for many elderly individuals (ED-P16). Older adults valued remittances from relatives but emphasized that the high prices of necessities in their communities make long-term survival difficult. When adult children, relatives, or the elderly themselves lacked stable financial resources, the high cost of living forced them to delay or avoid urgent expenses such as hospital visits and medications.

> "I receive monthly stipends, so until the month ends, I don't receive anything. So, if the money runs out before the end of the month, then so be it because you cannot call in the middle of the month" (ED- P9).

Caregivers lamented that elderly relatives faced constant health issues, which required frequent trips to clinics and pharmacies. "Today, kenkey and fish cost about 10 GHC… and older adults need proper food and medication" (FGCG-P2). They stressed that the rising costs of food, medication, and transportation directly undermine the quality of care they could provide. A caregiver shared that, "Just the cost of Dettol is no longer a small joke" (CG-P4), implying that even the cost of sanitary products for elderly parents was high. Many admitted that the rising cost of living forced them to downgrade care, offering meals that were less nutritious but more affordable.

> "You step out to get a simple medication, and it costs between 500ghc and 1000ghc," a caregiver explained, "which I do not have" (CG-P2)… "Sometimes, the cost of transportation alone can prevent us from going to appointments (ED-P13).

Service providers described similar trends and noted that "Markets in these semi-urban communities mirror city prices…the same as that of the capital city, Accra" (OR-P4), making it difficult for families to maintain consistent care. They explained that escalating costs of essentials caused elder care to suffer first, especially when caregivers prioritized funds for younger dependents. They added that small remittances of GHC200–300 from children often

proved insufficient. Service providers also acknowledged that inflation limited their own capacity to offer consistent support. For instance, an agency representative revealed that "The high cost of expenses, such as transportation, limits previously extensive outreach efforts" (FGOR-P1) to support their clients. Both caregivers and facilitators confirmed that their inability to cover essential costs stifled individual and institutional capacity to provide dignified elder care.

> "If adult children are jobless or stuck in unstable jobs, how do they send money home for their parents' upkeep?... especially with everything expensive these days. We end up handling cases of hunger or untreated illness almost daily" (OR−P1).

Government and Institutional Gaps. Participants expressed significant dissatisfaction with state programs and services, especially the NHIS and LEAP. Older adults and caregivers criticized these programs for their lack of accessibility and limited coverage. Of the 18 interviews, 10 participants said they knew about the LEAP program or knew someone who had benefited from it. However, none reported receiving assistance due to eligibility issues or a lack of knowledge about the application process. All participants confirmed they had registered with NHIS, but they explained that the program's inflexibility left many medical needs unmet. One older adult explained, "They will write medications for you to pay for them, or they can write it down so you can buy it elsewhere because NHIS does not cover the cost" (ED-P3).

> "We hear it all the time on the radio about older people like me and my husband not paying for anything if you have the NHIS, but unfortunately, we do" (ED-P11).

Regarding the SSNIT pension program, only five elderly participants out of 18 interviews reported receiving benefits. Some women explained that they qualified because they had worked as teachers, nurses, or in other formal sector jobs that guaranteed pensions at retirement.

Participants without these benefits said they had to provide for themselves or rely entirely on their families.

One caregiver explained that although her mother receives support from the LEAP program, the government sometimes takes three to six months or longer to distribute stipends. Another caregiver (CG-P4), whose elderly relative registered with NHIS, expressed concern that medication, laboratory tests, and specialist care still required out-of-pocket expenses when she sought healthcare for her ageing mother and maternal aunt. A third caregiver reiterated that, "The hospital she goes to does not accept NHIS. You would have to pay directly from your pocket" (CG-P3). Meanwhile, two caregivers (CG-P1; CG-P2) who supported their elderly spouses cited disability benefits and pension plans as essential income sources that supplemented their limited funds. Participants emphasized that the gap between policy promises and actual coverage led to disappointment, depleting already-strained household budgets.

Service providers affirmed that NHIS does not cover many prescriptions for chronic conditions. They also confirmed inconsistencies in LEAP eligibility and disbursement. The LEAP program, for instance, is limited to those 65 years and above, while the NHIS is effective for some individuals aged 70 years and above. Many of the elderly are from indigent households, including those living with disabilities. Yet, not everyone receives it, and as one participant stated, "The amount of money is insufficient, and not everyone who qualifies receives it" (FGOR-P5). A community leader (CL-P4) emphasized that there was always "Limited money in the common fund" for the community. He added that people could not blame the DSW for the lack of support because the department could only do so much with the limited resources available.

> "They show us their insurance cards, but half of the prescriptions… aren't on the coverage list" (CL−P3).

The gaps extended beyond financial programs to include physical infrastructure. Elderly individuals and caregivers reported the lack of formal aged care centres. Participants acknowledged the emergence of care homes in larger cities but had mixed feelings about access to them if they were available in the community. Family caregivers shared similar sentiments with the elderly regarding care institutions. One caregiver commented, “I doubt my siblings or even myself would agree to such a thing” (CG-P5). Instead, almost all participants recommended the need for such programs for older adults without any form of support, including physical support. However, both older adults and caregivers admitted they would accept “hired help” as a last resort if family members were unavailable. Unfortunately, traditional council structures and local governance offer little or no support in these communities, leaving many destitute in the hands of their families for occasional support.

Fortunately, a Presbyterian Church in Akropong has a geriatric centre that provides some support for its elderly congregants. An elderly recipient shared, “ We get food items, healthcare talks from experts, occasional check-ups, and socialize with other older colleagues with music and dance at least every 3 months” (ED-P15). But due to financial constraints and limited external support, the centre, these events and supplementary support of their members are not guaranteed (CL-P2).

Participants also highlighted environmental barriers such as hilly terrain, shared outdoor toilets, staircases in nearly every home, and poor road access, which exacerbate mobility challenges for older adults in these communities. One representative observed, “The topography, by itself, is quite challenging for older persons” (OR-P3). A community leader raised similar concerns, remarking, “Most homes... have access to only one public washroom. What happens to

the elderly who are immobile?" (CL-P7). These obstacles increase their health issues and delay their healing process, especially those with knee and hip issues (OR-P3; OR-P1).

Both caregivers and service providers expressed the lack of training and preparedness in elder care. One caregiver lamented, "Nobody teaches you anything. If you wait, their health can worsen" (CG-P4). Service providers acknowledged that many staff lack geriatric training, and agencies such as the DSW do not have targeted geriatric programs for the elderly. A representative admitted, "We need training ourselves on how to work with the aged. But we also need training resources for caregivers" (FGOR-P5). These gaps expose institutional fragility at every level, from policy planning to service delivery, leaving caregivers unsupported and older adults underserved.

Mental Strain from Economic Burden. All groups described feeling a heavy psychological burden from elder care, mainly because of financial uncertainty and caregiving responsibilities. Older adults recounted sleepless nights and anxiety over securing basic needs. One participant said, "You cannot even sleep when you go to bed," (FGED-P7). Others explained the toll of worrying about meals and medication: "The more you think about it, the more your BP goes high" (ED-P1). Some reported that prolonged mental stress left them physically unwell. One older woman shared, "Now I don't have the strength to work… and it has not been easy for me" (ED-P1).

Most of these elderly participants explained that their current health conditions prevented them from engaging in previous activities that once provided financial stability. One woman reflected, "Oh, I used to farm to care for myself, but now I don't have the strength to do any of those things. I have BP and diabetes as well, and it has not been easy for me" (ED-P4).

Participants added that worries intensified for those without anyone to support their needs. They revealed that stress weighed especially heavily on older women without family or community support, particularly those without children. These women said they relied on the kindness of friends, neighbours, or faith organizations for support, but acknowledged that this reliance remained unsustainable.

> "You always need to eat too, so that you can take medication, but there is no money or food at home, and then what do you do? It increases your worries even more" (ED-P17).

Caregivers reported experiencing unique emotional exhaustion, which intensified with juggling childcare, elder care and insecure employment. Participants who serve as the sole providers or breadwinners for their nuclear families while caring for aged relatives or parents experience the strongest stress and anxiety. One caregiver noted, "I worry about my business, paying tuition and loans. At all times, I have something on my mind" (CG-P4). Participants shared that they often cannot meet an ideal standard of care due to scarce resources and support, which takes a heavy emotional toll on them. They noted that caregiving usually led them to neglect their health, with physical pain, fatigue, and emotional withdrawal becoming common. Caregivers admitted that getting physically unfit can hinder their ability to provide care, saying, "...And we don't have that luxury" (FGCG-P4).

Caregivers further reported that the absence of programs left them unsupported, both financially and institutionally. Adult children emphasized the constant anxiety about the unknown, especially whether business would succeed or fail, an uncertainty that loomed over each day's demands and carried into tomorrow's burdens.

> "With no additional support, you begin to overthink and worry about how to provide that needed care. You will end up sick because of all these worries…it is so many issues and boils down to money." (FGCG-P3)

Service providers confirmed that community members face significant mental strain. They explained that poverty, unemployment, and difficulties in accessing essentials like healthcare often trigger persistent anxiety among older adults and their families. They added that this anxiety often spilled over onto the professionals who support them. Service providers reported feeling emotional burnout and vicarious trauma from repeatedly confronting the challenges faced by elderly individuals and their caregivers in these communities. They are worried that, without regular interventions, “Things might fall apart” for these vulnerable seniors (FGOR-P2). Several community and religious leaders voiced the ongoing mental and emotional burdens they bear, especially when they have limited resources to support their elderly congregants or Islamic members.

These service providers lamented, “We have no formal counselling for ourselves, so we share our feelings among colleagues. If not, every heartbreak story from the elderly will weigh us down” (CL−P4). They highlighted that the lack of mental health support for service providers underscores how deeply the caregiving crisis affects institutions. Participants also explained that limited resources cause mental strain, which disrupts their daily caregiving routines.

Impact of COVID-19. The COVID-19 pandemic exposed and worsened existing vulnerabilities in the elder care system. It disrupted numerous businesses and financial support networks for older adults and caregivers in both communities. The pandemic impacted both primary caregivers and secondary providers, both inside and outside the communities. One elderly woman explained that her child lost a job, which reduced the financial support she received during that period. Most participants who worked as part-time or full-time traders said the pandemic severely affected their trading and small-scale businesses. Prices were already high, but COVID-19 further intensified the economic challenges faced by participants.

Caregivers reported heightened anxiety and income loss during this period. Informal sector workers described how business closures triggered food insecurity. One caregiver asked, "What food will you eat when you haven't gone to work for months?" (FGCG-P2). They stressed that these economic disruptions undermined their ability to meet even basic caregiving needs. Most of the caregivers lamented that "They (government) did not allow us to sell even when schools reopened close to a year"(CG-P2), impacting their source of income.

Service providers, already constrained by limited funding, said the pandemic created additional challenges. Many reported halting community outreach, receiving fewer donations, and restricting physical visits because of safety concerns. One community leader explained, "We tried to help, but we had to balance care and not transmitting the virus ourselves" (CL-P7). Even so, some faith-based groups intervened, providing food and small gifts: "We ensured every vulnerable person had something during that period" (CL-P6).

Despite these efforts, all groups agreed that the formal government response during the pandemic was inadequate. Sharing the sentiments of all participants, one elderly woman lamented, "We were stuck with no money"(FGED-P3). Just a fraction of the government and other agency relief items (food, sanitizers) reached a fraction of the population in these communities. Most participants reported never hearing or receiving any form of support during the lockdown period.

Participants acknowledged that the church and informal networks offered essential help but emphasized that these measures remained temporary substitutes for a permanent, structured response. They agreed that the pandemic highlighted the urgent need for resilient, integrated support systems for elders across financial, emotional, medical, and communal domains.

In conclusion, participants highlighted how unstable employment and inadequate financial support systems undermined the provision of quality and consistent care in their communities. They explained that financial constraints and the rising cost of living depleted their savings and resources, reducing their ability to provide and sustain care. They further emphasized that government programs and services for the elderly remained inflexible, while support mechanisms for family caregivers were virtually nonexistent. Participants added that the COVID-19 pandemic disrupted the businesses of both primary and secondary caregivers. Ultimately, they stressed that these economic hardships, combined with insufficient governmental support, created significant mental strain and harmed the well-being of both the elderly and their caregivers.

4.4 Transforming Care

Participants in this study shared experiences regarding the current state of caregiving challenges in their communities, articulating their "Drive to Negotiate," which is also the title of the emergent theory. This theory reflects how they transform elder care through interdependence and adaptability to meet pressing needs. Through these evolving care strategies, participants also recommended reforms to government programs and services and called for community-based support to enhance quality elder care in these areas.

4.4.1 Interdependency

Confronted with economic hardship, social transformation, and institutional gaps, participants developed dynamic strategies by building support networks to sustain elder care in their communities. They drew on relationships within families and the broader community to compensate for the erosion of traditional care structures. Interdependency exemplified the deep-

rooted reciprocity connecting older adults to kin and community networks in Ghanaian society. In the absence of close relatives, they relied on extended family, neighbours, and religious organizations. A 94-year-old widow described her informal support system, saying, “Some relatives run errands for me when my children are away” (FGED-P6). Religious groups played a central role. One elder shared, “The church usually organizes programs to feed the elderly members and gives them food items. And they even put something small into an envelope for some of them as well” (ED-P11). These relational strategies reflected negotiated interdependence, rooted in communal reciprocity and moral obligation.

Family caregivers sustained elder care by relying on interdependence among kin, faith communities, and informal networks. Although many faced economic hardship and limited institutional support, they actively mobilized extended family assistance during crises. One caregiver noted, “During emergencies, we call family outside the community for remittances” (FGCG-P3). In addition to financial aid, community initiatives like health outreach days provided essential relief. “At Christ Presby, they do check-ups and feed them. It helps us a lot” (CG-P5). While not directly aimed at caregivers, these organizations indirectly eased caregivers’ burden by helping their older relatives. Such partnerships created occasional shared caregiving models that redistributed responsibility, underscoring resilience through communal negotiation.

Service providers, including local government officials, religious leaders, and health professionals, exemplified interdependency by forming alliances to extend care beyond institutional limits. One leader acknowledged, “Our social programs, while helpful, are only scratching the surface” (OR-P4). Providers collaborated with churches, radio stations, and local businesses. “We have collaborated with local businesses and churches to obtain donations and volunteer support. While it’s not sufficient, every contribution helps us extend our limited funds

further" (CL-P5). Despite persistent limitations, these partnerships sought to fill systemic gaps through improvisation, advocacy, and community-based support.

4.4.2 Adaptability

Adaptability, the second key factor in negotiation, shaped participants' responses to caregiving challenges. Older adults addressed limited resources and inadequate services, such as health coverage, by adjusting their approaches. Some adopted cost-saving strategies: "I take my prescription to another pharmacy to purchase cheaper alternatives. Because what can you do; the money is not there?" (FGED-P5). Others borrowed to manage urgent needs: "Yes, sometimes, the person sending the money might not have it immediately. So, you tend to borrow and use that for the emergency while you wait" (ED-P6). Many continued part-time or full-time informal work to sustain financial independence, often purchasing goods on credit and reselling them to support their care needs (ED-P6). They also relied on spirituality as a source of resilience to cope with the mental strain caused by socio-economic uncertainties. One woman remarked, "I realized I will not benefit from it (worrying)" (ED-P5). These strategies demonstrated tactical flexibility, where these individuals viewed scarcity as manageable rather than as suffering.

Caregivers demonstrated adaptability by adjusting daily routines to manage economic and emotional responsibilities. They balanced roles as breadwinners, childcare providers, and health aides without professional training or compensation. One caregiver said, "It's tough when my father needs constant attention, but I also need to work part-time to buy his medicine" (FGCG-P1). Another admitted, "I had to train myself on the job" (CG-P4), implying she developed a strategic approach to care for her bedridden aunt. Many rely on faith as emotional support: "God is my strength" and "By the grace of God" were common phrases. Despite these overwhelming responsibilities, caregivers viewed their roles as moral commitments rather than

burdens. “I wouldn’t abandon him because of his predicament. If I do, I have sinned; I just pray for God’s strength to care for him” (CG-P1). Their tactics of borrowing, sharing duties, and holding on to their faith demonstrate a multidimensional adaptability that is both practical and flexible in response to the changing social, economic, and environmental challenges they face daily.

Service providers also modified their service delivery to address their challenges. Recognizing that not all older adults attended clinics or meetings, they shifted to mobile outreach and decentralized education: “We go to churches and participate in radio discussions” (OR-P4). Some professionals acted beyond their job descriptions: “At times, we use our own money to feed them… every time I make home visits, I wear gloves in case I need to attend to an elderly person in the home” (FGOR-P5; OR-P1). Others culturally adapted by supporting as alternative caregiving structures, such as churches involved in home visits, and providing occasional in-kind or cash support: “It is about creating a communal support system that can supplement what families can no longer provide” (CL-P3). By redefining care as a shared social duty, providers bridged traditional values with modern realities through adaptable, community-based frameworks.

All in all, the elderly, family caregivers, and service providers navigated caregiving challenges shaped by social, economic and environmental changes amid unforeseen crises such as COVID-19. In their own ways, they borrowed, compromised, and managed scarce resources to ensure elder care in their communities.

4.4.3. Recommendations

Reforms to Government Programs and Services. Participants across all groups expressed frustration with the limitations of state-run programs like NHIS and LEAP. Older

adults called for immediate reforms, including lowering the NHIS eligibility age from 70 to 60 and expanding medication coverage. “They need to change it and add those from 60 years going… and put all the drugs on the insurance card for us” (FGED-P6). They emphasized the importance of direct financial support to encourage independence and self-reliance. Most have worked in the informal sector, and many suggested a financial assistance programme specifically for older adults. Such measures would help sustain their trading businesses in these communities.

Caregivers similarly requested financial support tailored to their dual roles as caregivers and breadwinners for their families. “If I get some monthly stipend of at least GHC300 to support myself and the children, I would be glad” (FGCG-P2). They recommended stipends or in-kind contributions, such as diapers, toiletries, and groceries, to ease their economic burden. Both the elderly and caregivers argued that expanding benefits would reduce hardship and enhance their well-being.

Service providers echoed these calls, emphasizing interdepartmental collaboration. “If the systems could work holistically across all departments, many issues affecting the elderly in the community could be minimized” (OR-P3). For example, some representatives recommended better coordination between health and social sectors, where hospitals refer elderly patients to social workers for support, and welfare agencies gather relevant information to address the responsive health needs of these individuals. A leader noted, “We are doing the same things in the same manner when, in fact, things are evolving around us” (CL-P4). Providers also requested operational resources, including official vehicles for field officers and investment in geriatric training for health and social workers. One officer emphasized, “Caregivers themselves are not knowledgeable enough in the appropriate way to provide support, such as medication

administration" (OR-P3). They argued that proper training and reforms would enhance care quality while alleviating the strain on caregivers and frontline staff.

Service providers further urged infrastructural upgrades to create age-friendly environments. "Because the community is ageing, the environment and its infrastructure also need to change to meet these needs" (OR-P3). All participants agreed that effective elder care requires responsive, context-specific, and inclusive policy reform. One elderly woman expressed that, "If they (service providers) could support us to ensure that we live a good life in our old age, that would be helpful" (ED-P2). A caregiver added, "Yes, caring for our elderly involves challenges, and if the government can support us, we will be happy" (CG-P1). Collectively, these appeals reflect an urgent call to prioritize elder care as a national development goal rather than a private family responsibility.

Community-Based Support. Although participants appreciated family-based caregiving traditions, they recognized their decreasing practicality. Older adults, caregivers, and service providers saw community-based care as an essential addition to the diminishing extended family system. The elderly, particularly those without nearby children, showed openness to support centres. "Those without caregivers, the government should support them… Such services will give them somewhere to interact and play games and giving them one hot meal would be good" (ED-P17). Some recipients spoke positively about the religiously affiliated day centre in Akropong, admitting that, "When we go there, we meet friends, engage with each other, sing songs and dance. We enjoy ourselves" (ED-P10). The Christ Presbyterian Ageing Centre stood out as an example of limited but crucial community support, especially for elderly individuals without family care.

Family caregivers called on the government to support trusted community institutions already involved in elder care. One caregiver said, “The government should support religious organizations so they can do more for our elderly relatives” (CG-P3). Service providers agreed, highlighting their partnerships with churches, mosques, and NGOs to offer food, health checks, and social activities for older adults in these communities. Though initially hesitant about institutional care homes, caregivers strongly supported day centres and trained home aides. “…a day centre like those for children would be helpful” (CG-P5). Another mentioned, “If such services become available and the providers are professionally trained, we are more likely to use them” (FGCG-P4). They see these services not as replacements but as supplements to help manage and reduce their daily challenges.

Service providers played a crucial role in advocating for structured interventions. They described pilot programs in nearby towns offering social activities, meals, and health screenings. “The leaders there heard older people expressing concerns about being left alone. So, they established a day program at Osabene…” (FGOR-P1). They emphasized cross-sector collaboration: “Government programs for vulnerable populations… are designed with a family-oriented approach. But we must also partner with faith-based organizations, philanthropic entities, or local volunteer groups to pool resources” (OR-P4). Participants suggested cross-training models where nurses offered geriatric advice, and pastors provided emotional counselling while minimizing redundancy (FGOR-P1).

All three groups identified public education and awareness as essential. Older adults called for destigmatizing care homes or centres. An older woman shared, “Letting them know there is no shame to be in such places” (ED-P2). Service providers agreed, noting that cultural stigma often deters families from seeking support. “Because of what people may say, families

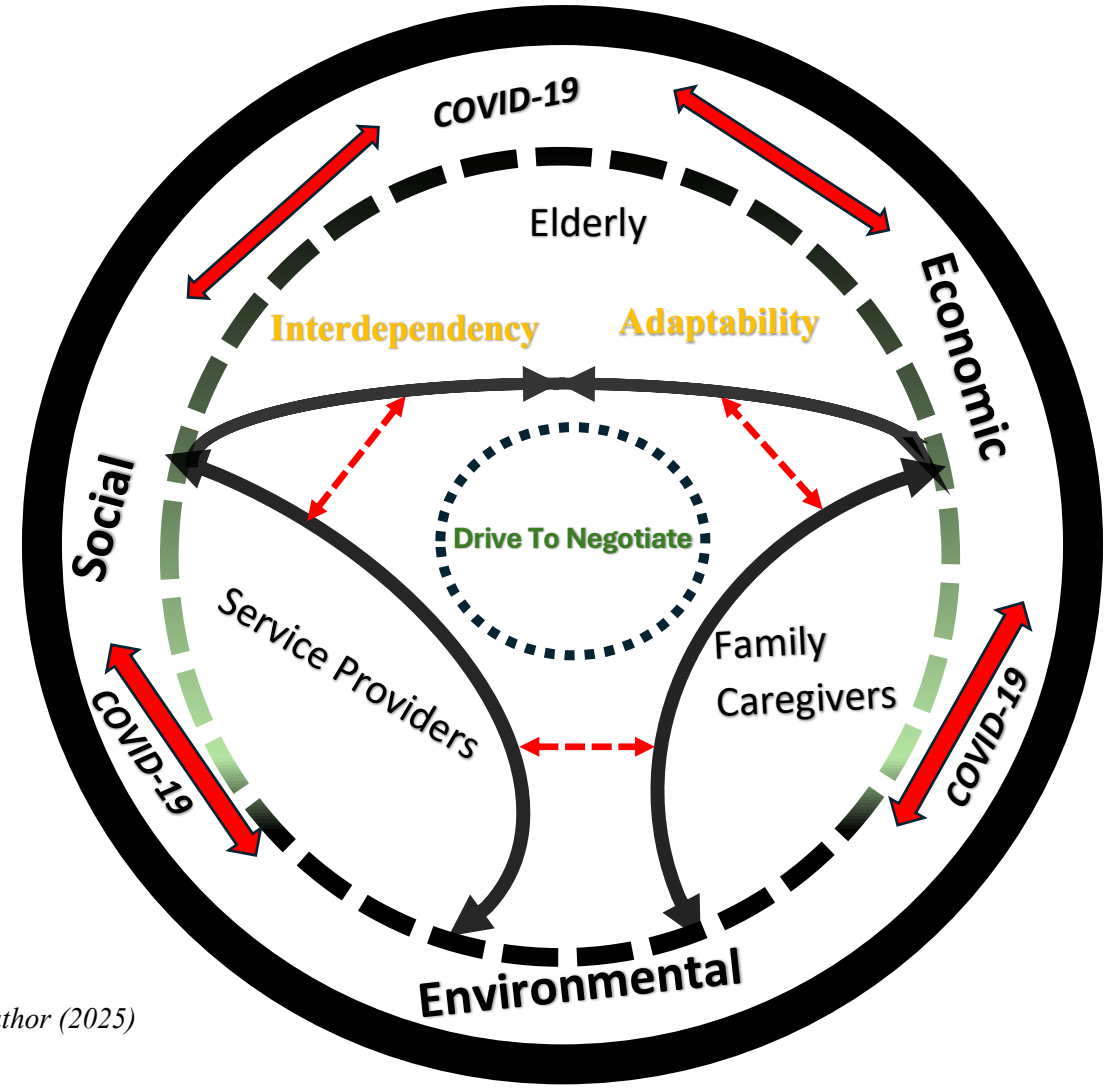
often prefer to leave older adults at home without proper care. However, if we could destigmatize these mindsets, it would help in supporting the elderly more effectively" (OR-P1). They also emphasized the importance of promoting preventive geriatric health measures (OR-P3), such as regular health screening events to identify early health issues among this ageing population.

Taken together, the findings highlighted that participants assert that interdepartmental care approaches, community-based services, and improved infrastructure can significantly enhance well-being. They emphasize that awareness, institutionalized care, and alternative support models must address cultural misconceptions while adapting to socio-economic realities. The collective call for community-based care reflects not a rejection of family caregiving but a pragmatic adaptation to changing conditions. The shift toward integrated, culturally rooted, and professionally managed elder care marks a hopeful move from private toward shared public responsibility.

4.5 Summary of Emerging Theory: Drive to Negotiate

The study's findings are shown in the following model. Figure 2 highlights the main results within the social context of the emerging substantive theory on changing elder care in the two communities. Shifting norms of traditional caregiving and resource limitations emerged as the central challenges faced by older adults, family caregivers, and service providers. To address these challenges, participants engaged in mutual exchanges of support that helped them adapt and stay resilient amid social, economic, and environmental pressures.

Figure 2: The Substantive Theory: Drive To Negotiate



Source: Author (2025)

The emergent substantive theory in Figure 2 is depicted as a steering wheel, emphasizing the interdependent relationships among older adults, family caregivers, and service providers, along with their ability to adapt within Ghana's evolving elder care landscape. The broken circular design represents a community influenced by external social, economic, and environmental pressures. At its centre, the broken hub, *"Drive to Negotiate,"* links three spokes: Elderly, Family Caregivers, and Service Providers, illustrating the dynamic balance needed to

sustain caregiving under strain. Double arrows show the ongoing refinement of care through interdependence and adaptability, underscoring the continuous effort to maintain accessible and available elder care.

At the core of the model is the central principle, “Drive to Negotiate.” This concept captures the strategies, compromises, and adaptable methods that participants use daily. Instead of viewing caregiving as static or linear, it highlights ongoing negotiation marked by fluidity and resilience. Older adults negotiate their dignity and independence; caregivers oversee family duties alongside economic survival; and service providers navigate systemic gaps by developing strategic alternatives. Therefore, the steering wheel metaphor suggests that the progress of elder care in these communities relies on active participation from all groups, who collectively steer toward accessible and quality care for the ageing population.

Elderly women occupy the top spoke of the wheel. Their experiences reveal the emotional, physical, and financial complexities of ageing in under-resourced settings. Once caregivers themselves, many now require support but lack reliable access to family or institutional assistance. This shift becomes more acute as reciprocity weakens and COVID-19 amplifies vulnerabilities. Older adults negotiate by depending on available kin, accessing limited institutional services, and drawing on community resources when possible. They adapt their strategies based on existing resources, continuously negotiating to meet essential needs.

The right-side spoke represents family caregivers, most of whom are women. They shoulder unpaid labour, balancing childcare, employment, and elder care with little institutional support. The COVID-19 pandemic magnified their struggles by disrupting income, mobility, and access to networks. Their inclusion in the model highlights their indispensable yet undervalued role, often sustained through personal sacrifice. Caregivers negotiate by mobilizing relatives,

using scarce services, and sacrificing time and income to maintain older adults' well-being. Without their efforts, many elders would face isolation.

The left-side spoke represents service providers, including social workers, religious leaders, healthcare professionals, and community leaders. They operate in constrained environments with minimal resources, limited training, and underfunded programs. Despite these barriers, they advocate for reforms, form partnerships, and improvise community-based solutions to support older adults and caregivers. Their position in the model reflects their role in strengthening caregiving infrastructures and pressing for systemic change.

These insights collectively reinforce the central argument that the steering wheel metaphor provides layered understanding of elder care. It symbolizes movement, highlighting that caregiving is dynamic and future-focused. Its circular design reflects interdependence: when one spoke weakens or disengages, the system struggles. Above all, the model emphasizes the need for balance and shared responsibility among older adults, caregivers, and service providers to maintain quality care.

Chapter 5: Discussion

5.1 Introduction

Using a constructivist grounded theory approach, this chapter synthesizes the research findings, relevant literature, and my interpretive perspectives (Charmaz, 2014). I acknowledge earlier theoretical contributions and employ feminist gerontological theory to situate the new substantive theory within existing scholarship, demonstrating how this study both contributes to and extends the literature (see Chapter 2). The literature shows that socio-demographic, cultural, economic, and environmental pressures increasingly strain elder care systems. These pressures influence later life and negatively impact older adults' well-being throughout the life course. The findings have implications for practice, policy, and future research, which I discuss in the final chapter. In line with SCGT, I also reflect on my positionality as a researcher.

5.2 Discussion of Findings

In Akuapem-Mampong and Akuapem-Akropong, within the Akuapim-North municipality, elder care is changing in response to shifting cultural norms, economic struggles, and changing family dynamics. The emerging theory, "Drive to Negotiate," explains how caregivers operate amidst social, economic, and environmental pressures. This section presents findings from these two communities alongside existing literature on elder care, highlighting both similarities and differences. By framing local insights within broader academic discourse, the study underscores both universal and context-specific aspects of caregiving for the ageing population.

Drawing on participants' lived experiences influenced by these intersecting pressures, this study defines elder care as: *"The supportive practices provided to individuals aged 60 and above*

who experience difficulties in performing some or all activities of daily living and instrumental activities of daily living, such as bathing, dressing, eating, and managing finances. It involves the emotional commitment and practical assistance from designated caregivers and community care providers, often within informal family networks or formal caregiving arrangements."

5.2.1 Demographic Trends of Ageing

The findings confirm an expanding older population in Ghana's Eastern Region and the two selected communities, highlighting a demographic shift that mirrors global projections (GSS, 2021; WHO, 2011). Unlike high-income countries that had decades to prepare, Ghana has experienced this transition within a single generation, often outpacing economic growth and social welfare development (WHO, 2014). This demographic pressure exposes the inadequacy of existing social care systems, particularly for older women, whose ageing experiences reflect a lifetime of gendered disadvantage.

From a feminist gerontological perspective, ageing must be understood through the intersections of gender, class, race, and other social contexts across the life course. Hooyman and Gonyea (1995) argue that gender serves as a central organizing principle, shaping education, employment, income, and caregiving roles that accumulate in old age. This study confirms this pattern, with many older women reporting they are widowed, separated, or married; marital status directly influences their access to care and social support. For example, married women cite pension or disability benefits from their spouses as their primary income sources to support their families. This finding aligns with research in Portugal, which identifies marital status as a determinant of elderly well-being (Mota-Pinto et al., 2011). In Ghana, social roles such as spouse, in-laws, adult children, neighbours, and friends remain embedded in social networks that sustain intergenerational relationships and secure care for the elderly. Most of the elderly

mothers in this study also reported remittances from family members, including their children, a role that ensures support for their well-being.

Arber and Ginn (1991) emphasize that gendered divisions of labour and care in earlier life create cumulative disadvantages for women. Most older women in the study report limited education and employment histories rooted in informal work such as subsistence farming and petty trading, consistent with this claim. Mota-Pinto et al. (2011) similarly found that illiteracy among the elderly narrows their occupational choices. According to GSS (2013b; 2021), a large proportion of elderly Ghanaians work in the private informal economy, reflecting their educational background. Women with low education typically face limited employment, earn low wages, and find few opportunities for advancement (Blau & Kahn, 2013).

These findings align with Calasanti's (2004) argument that aging is influenced by social structures that put women at a disadvantage. Gendered gaps in education and employment, often seen as natural, shape long-term economic insecurity and health outcomes. Dosu (2014) noted that older adults engaged in small-scale farming and petty trading lack the resources to switch to commercial methods that could improve their living standards. Many of the older women in this study were petty traders, with many still working in this sector in old age to maintain their well-being. Feminist gerontologists (e.g., Hooyman et al., 2012; Katz, 2019) critique societal views of ageing that ignore how institutional and cultural systems marginalize older women, expecting them to be self-reliant without equal access to resources throughout their lives.

In contrast, older women who attained tertiary education secured employment in the formal sector, reflecting some financial security in old age. Previous studies (e.g., Darkwa, 2000) confirm that Ghanaian men have historically had greater access to education, employment, and income. However, research also shows that women with higher education often gain entry to

professional and managerial roles with higher pay, stability, and benefits (Goldin, 2014). This was evident among study participants who retired from professions such as teaching and nursing and now benefit from the SSNIT pension scheme. Feminist gerontologists argue that when women attain higher socio-economic status, they not only access better opportunities during midlife but also enter old age with greater security and caregiving options (Bozaleck & Hooyman, 2013; Fassin, 2005).

Early structural disadvantages, such as limited education, trap many older adults in poverty and restrict their access to healthcare. For women, restricted access to education and certain occupations historically reinforced gender inequality, resulting in unfavourable socio-economic conditions and lower wages compared to men (Nkansah et al., 2021; Sossou & Yogtiba, 2015). The Ghanaian phrase "The place of a girl is in the kitchen" reflects the deeply rooted cultural norms that marginalized women and lowered their long-term economic prospects. Many participants recalled these restrictions. One elderly woman explained, "We didn't see the essence of education then compared to our other counterparts in the neighbouring towns" (FGED-3). While boys gained access to education, many girls assumed homemaking roles, a pattern that diminished their socio-economic opportunities later in life. Hicks and Stokes (2017) argue that analyzing women's lived experiences and gender relations offers more profound insight into their current well-being. Consequently, many older women now face poverty and dependency due to unequal opportunities across the life course.

Taken together, the study underscores the lived experiences of older Ghanaian women characterized by limited education, informal work, and restricted caregiving options in both communities. Framing elder care within the feminist gerontological perspective, the study stresses that structural inequalities, rather than just individual choices, influence women's

vulnerability in later life. Addressing these disparities requires shifting caregiving from a private, gendered duty to a shared social responsibility.

5.2.2 Economic Driving Factors

Participants in this study predominantly identified financial constraints as the most significant barrier to providing quality elder care. Stakeholders highlighted that the availability, reach, and effectiveness of services for older adults. Ongoing resource limitations and the rising cost of living have intensified financial pressures on older adults and caregivers. Older adults and their caregivers increasingly find basic needs such as food and medication unaffordable, often having to "scrape together whatever little money is available." These findings reflect broader regional patterns across LMICs, where caregiving remains informal, under-resourced, and lacks robust welfare support (Ae-Ngibise et al., 2015).

Among those still employed, data showed that both the elderly and their caregivers earned as little as GHC 50 per month (around CAD 4). This finding aligns with Ahadzie and Doh's (2009) research, which reported that elderly individuals working in the informal sector earned about GHC 50 monthly, nearly sixteen times lower than the extreme poverty threshold of GH₵ 792.05 per adult equivalent per year. With a large percentage of this target population in the informal sector of the economy (Kpessa-White & Tsekpo, 2020), most of these women are already in their old age without any form of stable income. These financial difficulties are not gender-neutral but reflect structural inequalities that marginalize women throughout their lives (Hooyman & Gonyea, 1995).

Notably, all caregivers, including about 80 percent of older women interviewed in this study, had low levels of education and worked in the informal sector as small-scale traders, which directly affected their low-income levels. These findings align with Agyemang-Duah et al.

(2024), who reported that lower educational attainment among caregivers in Ghana's Ashanti Region was associated with informal employment and low incomes. Studies confirm that financial strain is the primary challenge for caregivers (Ae-Ngibise et al., 2015). In this study, caregivers supported both ageing parents and their nuclear families, further increasing their financial burdens, which puts them at increasing risk of also ageing in poverty if they lack appropriate system support.

Similar financial stresses impact caregivers in high-income countries (HICs), although mitigation strategies vary. For instance, in Canada, informal caregivers often reduce their work hours or leave employment to meet caregiving demands, resulting in lost wages, diminished career prospects, and future pension deficits (Fast et al., 2013). Women, especially those in low-income brackets, bear the brunt of these sacrifices. Unlike Ghana and many LMICs, HICs often provide institutional supports such as paid caregiving leave, tax credits, and respite services to offset economic costs (Rocard et al., 2021). Caregivers in this study report adjusting work hours, relocating businesses closer to home, or abandoning income-generating activities to prioritize caregiving. However, as Katz (2019) argues, even in HICs, policies increasingly shift elder care from the state to private households, reflecting a global trend of care privatization that continues to marginalize women's unpaid labour.

In LMICs like Ghana, family and community members serve as the primary providers of geriatric care due to limited public funding and under-resourced social and health infrastructures. Aboderin and Beard (2015) highlight that many sub-Saharan African countries face rapid population ageing amid constrained health systems, creating significant gaps in formal elder care. Participants in this study note that public programs such as NHIS and LEAP offer minimal relief, leaving many elderly individuals and family caregivers with unmet needs. One caregiver

states, “Even the LEAP is too small, and sometimes even that doesn’t cover all her needs” (CG-P1). This finding echoes Kpessa-Whyte and Tsekpo’s (2020) observation that Ghana’s state provisions do not fully address older adults’ socio-economic and health needs, reflecting a broader trend in LMICs where governments prioritize macroeconomic goals over social welfare (Scott, 2017; WHO, 2015).

Findings show that government programs remain insufficient for older adults and offer even less support for informal caregivers. Conversely, countries like Japan have implemented a publicly funded long-term care insurance system that alleviates family burdens through home care, institutional services, and professional care workers (Rocard et al., 2021). Meanwhile, Ghana’s DSW lacks a geriatric program, as well as training and resources to assist family caregivers in delivering quality care. The WHO’s (2015) *World Report on Ageing and Health* emphasizes that LMICs face disparities in access to and quality of care due to inadequate funding and policy support. While enrolling an elderly parent in private institutional care homes is extremely costly (Dovie, 2019), such options are not available in these two communities.

Sanuade and Boatemaa (2015) argue that limited access to social services significantly burdens informal caregivers. Dovie’s (2021) findings show that weak government support, a shortage of trained care workers, and fragmented caregiving approaches hinder elder care in Ghana. Participants confirmed the absence of government-funded day care centres or community-based programs that could ease family pressures. Countries like Mauritius and the United States manage and finance numerous aspects of elder care, including day centres, recreational programs, and home health visits (WHO, 2017). The experiences of recipients at the Christ Presbyterian Church Aged Centre in Akropong, Ghana, highlight the positive impact of

such programs on the well-being of older adults and their caregivers, even when events are occasional.

Overall, the findings demonstrate that although caregiving challenges manifest differently across contexts, the gendered dynamics of elder care remain global and persistent. Feminist gerontologists argue that care must be reframed as a collective societal responsibility rather than a private burden. Achieving this requires policy reforms that prioritize gender equity, caregiver support, geriatric training, and expanded public elder care infrastructure.

5.2.3 Social Driving Factors

This study found that reciprocity and cultural norms of filial obligation continue to support elder caregiving. Similar patterns appear among African Americans, Asian Americans, and Latin Americans, as caregiving involvement reflects socio-cultural beliefs about reciprocity within families (Dilworth-Anderson et al., 2005). Across these contexts, values of family cohesion and interdependence sustain care, with a strong desire to maintain harmonious relationships shaping motivations to support aging relatives (Pharr et al., 2014).

Findings revealed that reciprocal relationships between parents and adult children foster strong intergenerational bonds and caregiving obligations in old age. Informal caregivers often frame their care as an obligation and moral continuity; as one explained, “They raised me, so now it is my turn.” Logan (2019) argues that morals and motivations critically shape caregiving decisions. This reciprocity aligns with Hooyman and Gonyea’s (1995) feminist gerontological insight that caregiving reflects affective ties and emotional labour, particularly for women.

This study demonstrates that reciprocity is not always a reliable measure. Van der Geest (2016) argues that poverty, social fragmentation, and migration weaken reciprocity. The study confirms that many older adults no longer receive consistent care from their adult children,

illustrating the decline of kinship roles in Ghana's caregiving landscape. Economic hardship, migration, and shifting values increasingly undermine family-based care (Kisi et al., 2020). He et al. (2020) note that adult children's migration may lead to older adults receiving support through remittances or experiencing neglect, depending on economic circumstances and intergenerational ties. Participants describe remittances as unreliable and insufficient, as they only partially replace physical care with financial support, echoing Coe's (2017) findings. These dynamics indicate that care is shaped by both interpersonal relationships and broader structural and cultural forces (Bengtson et al., 1997; Calasanti, 2010).

Evidence also showed that while caregiving is rooted in the family unit, women overwhelmingly bear the instrumental and physical responsibilities. These gendered divisions reflect socio-cultural norms seen worldwide. For example, in Latin America, North America, South Asia, and African contexts, women provide direct care (Coe, 2017; Oppong, 2006; WHO, 2017). By contrast, in Chinese culture, adult sons more often co-reside with parents and offer financial support, while daughters "marry out" (Deutsch, 2006).

Several elderly women in this study reported caring for their own parents earlier in life, reflecting what feminist gerontologists describe as unchallenged and normalized gender expectations embedded in daily practices that perpetuate inequalities (Calasanti, 2010). For older adults who live with adult children, reciprocal exchanges, such as caring for grandchildren, remain a practical way to secure care in old age (Aboderin, 2004; van der Geest, 2002, 2016). However, migration and social change have disrupted these patterns, leaving many older adults without nearby family support.

Family caregivers described the emotional and physical toll of their roles, reporting limited social participation, decreased earnings, fatigue, and exhaustion. These findings align

with Taylor and Quesnel-Vallée (2017), who argue that caregiving, while sometimes rewarding, is more often associated with adverse physical and mental health outcomes when support is lacking. Ae-Ngibise et al. (2015) also found that Ghanaian caregivers in rural areas felt overwhelmed by tasks that undermined their social and emotional well-being.

Caregivers in this study emphasized that stress stems from a lack of support from family, community, and government. In Ghana, elder care remains a private and undervalued sector, which renders women invisible in policy frameworks (Dovie, 2019; Kpessa-Whyte, 2018). Without government assistance, caregivers face increased risks of poverty later in life (Bozaleck & Hooyman, 2013; Randriamaro, 2013). None of the elderly women discussed advance care planning (ACP) with their families, saying that "Children should already know." These unspoken expectations reflect a cultural norm of assumed reciprocity. Although ACP conversations are considered difficult, experts highly recommend and consider them necessary (Scott et al., 2013) to protect values, beliefs, and ensure some form of care for the elderly in the Ghanaian community.

Overall, this study shows that elder caregiving in Ghana is still influenced by norms of reciprocity and filial duty, but it is increasingly challenged by economic and social changes. As the extended family system weakens and formal supports remain insufficient, the burden mainly falls on women. A feminist gerontological perspective highlights that effective responses need to reframe elder care as a collective, gender-equitable responsibility shared by families, communities, and the government.

5.2.4 Environmental driving factors

This study found that the migration of younger generations weakens kinship roles and disrupts traditional physical arrangements for care. Many older participants described feeling

"abandoned" when their children moved to Accra or other urban centres for work or education. Findings indicated that older adults can no longer rely solely on younger generations due to economic crises, social shifts, and the physical absence of potential caregivers. Migration significantly reshaped family roles, living arrangements, and the availability of elder care in the two communities. Unemployment and unstable incomes compel many younger people to move to cities or abroad (Braimah & Rosenberg, 2021), leaving elderly relatives with minimal and inconsistent care.

Evidence from other contexts supports these findings. For example, in Bangladesh, adult children's migration often leaves elderly parents lonely and inadequately supported (Khan & Leeson, 2006). Likewise, older women in this study said that although they lived in family houses, the support they received was limited because "Everyone is minding their business." The once-reliable extended family systems have declined under the pressures of modern education and employment demands. While accommodation was not an issue, the physical absence of younger family members, due to busy schedules, caused many older adults to feel isolated.

Similar patterns emerged in Kenya, where urbanization and individualism led to a shift in caregiving responsibilities toward nuclear families, thereby decreasing the availability of kin-based care (Nyangweso, 1998). This change mirrors the feelings of isolation and neglect reported by participants in this study. Providing companionship, especially for elders who are homebound, remains essential for their well-being (van der Geest, 2016). However, when migration shrinks the pool of available caregivers, the stress of offering both practical and emotional support falls disproportionately on a few family members (Mba, 2007; Kpessa-Whyte & Tsekpo, 2020; van der Geest, 2002).

This study also confirmed that communities lack geriatric care homes, which further increases elders' loneliness and caregivers' burden. Similar findings appear in other rural Ghanaian settings, where the absence of nursing homes or home-based care widens the care gap (Dovie, 2019; Kpessa-Whyte, 2018). Participants also recognized that cultural stigma hinders the development of such facilities, echoing observations from Japan and Hong Kong, where relying on professional caregivers is stigmatized as “negligence” (Hanssen & Tran, 2019). Notably, many older women in this study shared similar views but expressed interest in senior day centres rather than institutional-based care, especially for elderly individuals in communities without children or physical family support.

Rural areas or underdeveloped communities exacerbate these challenges due to poor infrastructure and limited social amenities compared to urban centres (Myjoyonline, 2014). In this study, inadequate access to potable water and sanitation services, combined with steep terrain, increased the risks faced by older adults. Most homes lacked toilets, forcing elderly individuals to use public facilities despite mobility issues. Inaccessible environments not only increase the risk of falls but also worsen the health and well-being of both elders and caregivers.

The absence of basic amenities ultimately undermines the quality of life and care in these communities (Nkansah et al., 2021). The compounded effects of inadequate housing, inaccessible infrastructure, and entrenched caregiving expectations illustrate how space, gender, and policy intersect to shape ageing experiences. As Bozaleck and Hooyman (2012) argue, equitable care necessitates the redistribution of responsibility and the establishment of supportive institutional and environmental structures.

5.2.5 Impact of COVID-19

The findings revealed that resource limitations, such as financial constraints, rising living costs, inadequate government support, and the disruptive effects of COVID-19, significantly challenge elder caregiving. The pandemic intensified these pressures. Participants in the study reported increased financial hardship caused by disrupted income sources and reduced access to services. One caregiver stated, “During COVID, our food supplies dwindled because the children who used to send money were struggling themselves.” Many primary and secondary caregivers lost jobs or income opportunities as mandatory lockdowns forced traders and small business owners to suspend operations (Oti-Boadu & Andoh-Arthur, 2024). These restrictions caused financial and emotional strain, which indirectly affected their dependent relatives.

International studies confirm that the pandemic disproportionately impacted elderly populations by restricting access to resources, reducing social support, and increasing isolation, which worsened existing vulnerabilities (WHO, 2021). Participants in this study expressed deep uncertainty and fear about COVID-19. Care providers, in particular, described ongoing anxiety about contracting the virus and passing it to elderly individuals, especially those with underlying health issues. Feminist gerontologists (e.g., Hooyman & Gonyea, 1990, 1999; Calasanti, 2010) argue that crises like COVID-19 consistently reveal the gendered fragility of caregiving systems, where women’s unpaid labour remains feminized, undervalued, and invisible in policy.

The pandemic also limited older adults’ ability to socialize with friends and neighbours. Social distancing measures and perceptions of older adults as highly vulnerable restricted important ways of connecting, such as church services, which forced many to stay at home. Asante et al. (2021) found that COVID-19 disrupted social networks for older adults, leading to increased feelings of loneliness. Van der Geest (2016) emphasizes that older adults depend on

gatherings like funerals and church to fulfill social roles and build ties. The loss of these spaces intensified feelings of isolation and loneliness, especially among those without close family support in the community.

Lockdown restrictions also led to emotional and physical distancing within families. One participant shared, “They used to visit once a month with food supplies, but COVID-19 made it impossible, so I went months without seeing anyone.” During this time, government support remained limited. Although the DSW oversees welfare for vulnerable populations, it lacked resources to provide consistent intervention programs for the elderly and their caregivers. In contrast, developed countries like Canada experienced widespread isolation among older adults but responded more effectively. They implemented financial subsidies, digital outreach for social support, and public health education campaigns (Rocard et al., 2021). While efforts to educate and raise awareness occurred during this period, financial and in-kind support from the government fell short in these communities.

The pandemic comprehensively exposed the structural and cultural vulnerabilities of elder caregiving systems in Ghana and other LMICs, where informal networks and women’s unpaid labour dominate. It also underscored a global caregiving crisis, revealing that even well-resourced contexts find elder care to be fragile and dependent on systemic reform to ensure quality and equitable support for ageing populations.

5.3 The Emergent Theory: “Drive to Negotiate”

The emergent theory of *“Drive to Negotiate”* captures how older adults, caregivers, and service providers in Ghanaian communities actively engage in continuous, resilience-driven negotiations to sustain elder care amid social, economic, and environmental hardships. Negotiation is not a one-sided process. These individuals and groups respond to adversity by

mobilizing resources, adjusting strategies, and reshaping expectations. Instead of passively enduring systemic deficiencies, participants turn challenges into opportunities for improvisation and collaboration.

This theory aligns with contemporary resilience perspectives that move beyond individual coping traits to emphasize relational, ecological, and structural dimensions (Ungar, 2011). People collectively navigate toward and negotiate for resources in ways that are socially and culturally meaningful, leading to resilience. Interdependence and adaptability serve as the twin mechanisms of this negotiation. They do not function in isolation; instead, they complement and reinforce each other, producing a caregiving system that bends under pressure but does not collapse. Wiles et al. (2012) assert that resilience involves dynamic realignment to shifting circumstances.

Interdependence grounds caregiving in reciprocal ties across families, communities, and faith-based networks. Older adults depend on remittances, neighbours, and church groups to maintain their daily well-being. Caregivers turn to relatives or community members during emergencies, sometimes even accessing resources on "credit." Service providers build networks by linking government programs with local religious and social groups. However, these networks alone cannot ensure stability, especially during economic hardship, migration, or pandemics. Participants actively adapt by extending resources, creating new caregiving routines, and adjusting practices to changing circumstances. For example, as elderly needs evolve (such as new illnesses or increased frailty), caregivers modify their approaches. Some learn basic wound care, research affordable medications or essential supplies, or coordinate rotating shifts with neighbours to care for their older relatives. Meanwhile, religious groups step in with occasional food donations or communal outreaches when government support is lacking. These practical

efforts demonstrate self-determination, perseverance, and the use of social networks to thrive within their communities.

In reality, the sustainability of adaptability depends on interdependence. Supportive networks minimize individuals' burden, especially women who shoulder disproportionate caregiving responsibilities, from becoming exhausted. Caregivers who relocate their businesses home to stay close to frail relatives demonstrate this dynamic: they can adapt and rely on remittances or occasional church programs to fill the gaps. Similarly, service providers occasionally rely on personal funds to improvise and depend on partnerships with local businesses, individual donations and congregations to expand their reach. Interdependence stabilizes these forms of adaptability, while adaptability keeps interdependence responsive to new social, economic and environmental pressures in these societies.

From a feminist gerontological perspective, these negotiations emphasize empowerment and collective action as essential to maintaining elder care (Bozalek & Hooyman, 2013). Older adults assert their dignity through small acts of independence; caregivers sustain themselves by reframing sacrifice as moral duty; and service providers navigate systemic constraints by forming unconventional alliances. Contrary to popular narratives that portray resilience as a solitary, heroic trait, research increasingly emphasizes its social and relational dimensions. Windle (2011) defines resilience in later life as the ability to "maintain or regain well-being in the face of adversity," underscoring the importance of not just individual capabilities but also the availability of supportive social environments and networks. Together, these practices demonstrate resilience as a socially constructed process that relies on shared responsibility and creative adjustments.

Although cultural norms often stigmatize institutional elder care, communities demonstrate resilience by combining public awareness with cultural sensitivity to overcome resistance. Van Hook (2019) notes that resilient families draw on cultural values, mutual support, and flexible problem-solving strategies, as evidenced in this study. For example, leaders promote middle-ground solutions such as day centres where older adults can socialize, receive care, and return home, balancing tradition with modern needs. Despite limited resources, they coordinate health outreach, connect families with government programs like LEAP and NHIS, and organize communal support, reinforcing interdependency and adaptability.

Participants relied on faith-based reassurance and reciprocity to cope with resource scarcity. Religion, which is central to Ghanaian life (Braimah & Rosenberg, 2021; GSS, 2021), shaped caregiving as an act of respect and mutual obligation. For many of these individuals, it is not solely about *"Trusting God" or "Believing in God's blessings"* through their acts of elder care; it is also deeply rooted in the traditional religious principles of *"Respect and Reciprocity"* within their communities to support each other in times of crisis.

According to Ofori-Dua (2014), the accessibility of care for the elderly depends on the quality of their social networks and their level of connectedness to their environment. Luo (2015) found that social capital, formed through social networks and support, has a positive relationship with the mental health of Chinese women. Evidently, the social groups in these communities offer practical help, including food donations, companionship, and emotional support through prayer meetings and social outings, which positively impact the well-being of these elderly women and their caregivers, empowering them to keep overcoming their challenges. Several other studies, such as van der Geest (2016), confirm that reciprocity is a crucial catalyst for elder care. It facilitates negotiation among all stakeholders to ensure quality care.

In conclusion, Drive to Negotiate shows that elder care in these communities is dynamic and constantly co-created through the interplay of interdependence and adaptability. One cannot succeed without the other: interdependence offers relational support, while adaptability provides the flexibility to manage crises and changes. Their partnership forms a caregiving system that, although underfunded and fragile, keeps supporting older adults.

5.4 Recommendations for Social Work Practice

This study highlights demographic trends in ageing and shows how traditional family-based care evolves. It demonstrates how age, gender, marital status, and geographical location intersect with social and cultural traditions that influence older adults' social, economic, and environmental status throughout their lives, impacting caregiving arrangements in old age. It also reveals that social transformations such as migration and urbanization shape factors that alter familial caregiving arrangements for the elderly in Ghana. Therefore, research, policies, and social and health interventions should focus on enhancing the quality of life for the elderly and addressing the growing care deficit in elder caregiving within the country.

5.4.1 Practice

Social workers in Ghana operate in environments where traditional kinship obligations are challenged by unique issues (Baffoe and Dako-Gyeke, 2013), such as migration, economic difficulties, and declining reciprocity. The Drive to Negotiate framework emphasizes how caregivers, older adults, and service providers actively build support networks through interdependence and flexibility, often outside formal institutions. Social work practice must therefore acknowledge, support, and reinforce these community-led strategies.

For example, caregivers in this study moved businesses to their homes to stay close to their elderly relatives, sacrificing income for proximity and security. Social workers can expand

on such adaptive practices by offering microfinance opportunities or connecting caregivers with targeted livelihood programs. This aligns with feminist gerontology's focus on recognizing and redistributing unpaid caregiving labour, which has historically been borne by women and reinforced cycles of disadvantage (Hooyman et al., 2012).

Furthermore, social workers must advocate for the inclusion of caregivers in state welfare programs. In countries like Canada, Ireland, and Australia, family caregivers receive stipends or tax credits as acknowledgment of their unpaid labour (Gardiner et al., 2019). Ghana's LEAP program could be expanded to include caregivers, especially women whose caregiving work makes them economically vulnerable. By framing caregiving as a societal responsibility rather than a private burden, social workers can promote interventions aligned with feminist principles of equity and social justice (Bozalek & Hooyman, 2013).

Community leaders and associations, already central to caregiving resilience, serve as vital partners for social workers. Faith-based groups like the Christ Presby Ageing Centre demonstrate how collective interdependence supports older adults through food, check-ups, and companionship. Social workers can strengthen these networks by formalizing partnerships, offering training for volunteers, and advocating for similar centres across diverse religious and cultural communities. This approach aligns with the adaptability dimension of Drive to Negotiate, illustrating how social workers can operate within cultural frameworks while raising standards of elder care. For example, in Canada, social work facilitators are integrating the Canadian Indigenous Medicine Wheel, Indigenous customs, and rites into their social programs (Lane et al., 2012) to align with the needs of their Indigenous clients.

5.4.2 Education

The study revealed a critical lack of knowledge and training in geriatrics among caregivers, social, and healthcare professionals. Most social welfare officers lack specialized skills in geriatric care, leaving them underprepared to meet the multidimensional needs of older adults. This gap highlights the structural neglect of ageing in professional curricula, a problem consistent with feminist gerontological critiques of how institutions marginalize the caregiving system by failing to provide adequate educational and professional resources (Calasanti, 2004; Sossou & Yogatiba, 2015).

Educational reforms should incorporate gerontology and caregiving into vocational, social work, and medical curricula. For example, the Department of Social Welfare could work with the Ghana Health Service to develop interdisciplinary training modules in geriatric care, concentrating on chronic illness management, caregiver support, and culturally sensitive interventions. Feminist gerontological perspectives emphasize that such training must also prioritize gender equity, ensuring that professionals acknowledge the specific burdens faced by women caregivers and the accumulated disadvantages experienced by older women (Arber & Ginn, 1991; Hooyman & Gonyea, 1995).

Encouragingly, Ghana has taken initial steps. The Ghana College of Physicians and Surgeons introduced a fellowship in Geriatric Medicine (Essuman et al., 2019), and the University of Ghana established the Centre for Ageing Studies in 2016 (Centre for Ageing Studies, 2024). In 2022, the first trained Geriatrician graduated from the college mentioned above (Graphic Online, 2022). These initiatives are milestones, but they remain underutilized unless systematically integrated into social work and community development training. Social

workers must advocate for the expansion of such programs and push for the inclusion of geriatric modules in seminar trainings, as well as diploma or certificate courses in social work.

Beyond professionals, communities must also receive education. Misconceptions that link old age with witchcraft or social irrelevance continue to perpetuate stigma and isolation. Social workers can lead sensitization campaigns through churches, mosques, and traditional councils to promote awareness of healthy aging, caregiving responsibilities, and advance care planning. Feminist gerontology emphasizes dismantling ageist and gendered stereotypes to promote social inclusion and dignity in later life (Katz, 2019). DSW and GHS in these communities use local and town radio stations to educate individuals, although many elderly and caregivers are unaware of such support channels. By embedding gerontological knowledge into community education, social workers can empower both families and caregivers to recognize elder care as a shared responsibility.

5.4.3 Policy

The Drive to Negotiate framework exposes the systemic inadequacies of Ghana's elder care infrastructure. While families and communities negotiate solutions through interdependence and adaptability, they remain constrained by rigid and underfunded state programs. Social workers must therefore advocate for policy reforms that strengthen and expand the state's role in elder care. For example, the NHIS currently excludes critical medications and covers only adults aged 70 and above, leaving many older participants underserved. Participants in this study described the NHIS as a "headache" because it does not cover their essential healthcare needs. Lowering the eligibility age to 60 and expanding drug coverage would directly address these gaps, aligning with gerontologists' calls for policies that recognize the elderly's disproportionate health vulnerabilities (Hooyman et al., 2012; Nkansah et al., 2021). Similarly, LEAP provides

insufficient and inconsistent stipends, often delaying payments for months, which calls for consistency in support services for this target population.

The needs of older adults during retirement have become increasingly critical, particularly for those who were once farmers, artisans, and petty traders in the informal employment sector (Nkansah et al., 2021). The findings of this study, similar to those by Ottie-Boakye (2020), recommend the implementation of a non-contributory universal old-age pension policy that targets not only individuals in the formal employment sector but also all senior citizens across the country, aiming to alleviate poverty levels among the elderly in rural and impoverished urban communities in Ghana. Countries such as Mauritius and South Africa have implemented universal pensions that significantly reduce old-age poverty (WHO, 2017). Ghana can learn from these models to ensure more inclusive financial security for its elderly.

With many older adults living in poverty, intensive advocacy is essential, particularly regarding the National Ageing Policy, to ensure its funding and effective implementation. This policy offers a framework capable of transforming and improving the lives of older people, which can lead to interventions aimed at lowering the NHIS eligibility to the retirement age of 60 and specific ageing programs that enhance their well-being.

Policy advocates should also focus on infrastructure. Participants reported environmental barriers, including shared toilets and inaccessible roads. Space, policy, and gender shape ageing experiences (Bozalek & Hooyman, 2013). Social workers must advocate for age-friendly communities, including accessible public toilets, disability-friendly housing, and enhanced transportation options. These reforms would improve elder care and strengthen the adaptability dimension of Drive to Negotiate by reducing systemic constraints on older adults and caregivers.

5.4.4 Research

The findings emphasize key areas for future research. First, longitudinal studies are needed to understand how cumulative socio-economic and environmental pressures affect elder care over time. Following caregivers' financial, emotional, and health journeys will uncover the long-term effects of unpaid caregiving, especially for women. Research should also go beyond female caregivers to include the experiences of male caregivers, urban families, and formal care workers. Doing so would provide a more detailed understanding of how caregiving varies across different genders, geographic locations, and socioeconomic contexts.

Social work researchers should document community-led innovations such as church-based day centres, rotating caregiving networks, and collaborations among NPOs. These initiatives demonstrate how interdependence and adaptability function in practice, providing models that can be replicated in other communities. For instance, Christ Presby's Ageing Centre shows how faith-based groups address systemic gaps, similar to initiatives in countries like Japan, where community-based day services support family caregiving (Rocard et al., 2021).

Finally, research should examine advanced care planning (ACP) conversations and approaches. This study found that none of the elderly participants had discussed their future caregiving preferences, assuming that their children "should already know." Social work research could effectively utilize mixed-methods analyses to explore barriers to ACP discourse in Ghana, such as cultural taboos and a lack of awareness, and develop context-sensitive strategies to normalize these conversations (Scott et al., 2013).

5.4.5 Theory to practice

The feminist gerontological perspective and the emerging theory of Drive to Negotiate together offer a strong framework for guiding social work practice. Both highlight that elder care

is deeply rooted in gendered inequalities, structural barriers, and relational negotiations. While feminist gerontology focuses on empowerment, equity, and social justice, Drive to Negotiate shows how older adults, caregivers, and service providers demonstrate resilience through interdependence and adaptability.

Social workers can apply these insights in practice by building on existing resilience strategies within communities. For example, they can formalize support networks like peer caregiver groups and church-based outreach into structured programs, while advocating for resources that improve adaptability, such as caregiver stipends or geriatric training. In doing so, they uphold the principles of the professional code of dignity, worth, and social justice (CASW, 2005) in ways that align with Ghanaian cultural realities. Most importantly, both frameworks change how elder care is viewed, from a private, feminized duty to a societal responsibility that calls for collective effort. This change underscores the importance of interdisciplinary collaboration among social work, healthcare, and community development to establish resilient caregiving systems.

In summary, the Drive to Negotiate theory offers a lens through which social work can reimagine elder care as a dynamic, collective process rooted in interdependence and adaptability. By incorporating feminist gerontological perspectives, the implications for practice, education, policy, and research emphasize the importance of dismantling structural inequalities while strengthening community resilience. Social workers, community leaders, and caregivers are not passive participants; they actively negotiate and innovate to sustain elder care amid systemic challenges. These findings underscore the urgency of integrating elder care into Ghana's broader social development agenda and viewing caregiving as both a public and gender-equitable responsibility.

5.5 Strengths of the Study

One strength of this study is its ability to address a gap in the literature and provide new insights into the experiences of stakeholders involved in the elder caregiving process within the Ghanaian community. The substantive theory of *"Drive To Negotiate"* enhances understanding of the challenges faced by stakeholders and their unique methods for dealing with these struggles amid social, economic, and environmental changes through interdependency and adaptability in the traditional Ghanaian community. It illuminates the complexity of communities under pressure during difficult circumstances while prioritizing evolving strategies to maintain care for caregivers and the elderly within the community.

Most importantly, it acknowledges community leaders and organizational representatives whose voices are often overlooked in the literature on elder caregiving. It provides a potential framework for future research that expands the experiences and perspectives of stakeholders to develop care strategies tailored to the social, economic, and environmental needs of the elderly and their caregivers. Recognizing the intersectionality of systemic, socio-cultural, and environmental oppressions in elder care will create pathways for more suitable services and programs designed to meet the specific needs of elder care stakeholders.

5.5.1 Credibility

This study employed a qualitative constructivist grounded theory approach to explore the current state of elder caregiving within the context of social, economic, and environmental influences. An important aspect of qualitative research is promoting transparency. Charmaz (2006) suggests that reflexivity enhances transparency when examining and questioning data. Throughout this study, I was careful to share my perspectives and the aspects of the research that resonated with my understanding and experiences related to this topic. Chapter three outlines the

methodological approaches used to explore commonalities in experiences, highlight differences, and discover unexpected insights during the interview process. As Charmaz emphasized (2006; 2014), ensuring credibility involves considering whether the data are sufficient. My familiarity with the setting and topic was both personal and professional; therefore, positioning myself within the data was crucial for illustrating core categories and sub-themes, fostering unique interpretations.

5.5.2 Originality

This study highlights the social, economic, and environmental gaps that influence elder caregiving in the Ghanaian community, a central theme throughout the findings. It uses feminist gerontological theory, stressing the complexity of managing challenges such as economic hardship, weakening family structures, emotional stress, and limited community-based support to meet elders' care needs. The emerging theory, “Drive To Negotiate,” not only sheds light on the difficulties faced by the elderly and their caregivers but also those faced by service providers in rural and suburban areas, along with the unique care strategies they develop to support the elderly. For example, while many studies focus on nursing or care homes, this research, through substantive theory, highlights “senior care centres and advanced care planning conversations” specific to the community’s elderly population.

5.5.3 Resonance

One aspect that meets the resonance criteria is using theoretical sampling during the initial coding and categorization in the interview process. The first interview involved a focus group discussion with representatives from government organizations before engaging with the community to gather additional information from older adults and caregivers. After collecting enough data, I met with more government representatives to facilitate preliminary testing of core

categories from the interviews. Indeed, through the elder interviews, I discovered a not-for-profit ageing centre owned by a church for its older members. During this process, I interviewed a nurse from this organization, a church leader, and a physician involved in the program to explore solutions for elder care. The data analysis systematically compared older adults, caregivers, and service providers regarding the evolving themes and categories. This ultimately led to the "Drive To Negotiate" model.

5.5.4 Usefulness and Transferability

During this study, a change in a government program became evident. On January 11, 2024, Social Security and National Insurance (SSNIT) announced a 15 percent increase in the monthly pension (UTV, 2024). While some participants will benefit from this change, it illustrates how adjustments to government policies and programs can significantly alleviate older adults' concerns about the high cost of living during economic hardship. Furthermore, the findings suggest that investing in senior daycare centres would be beneficial, drawing lessons from the impact of the Christ Presby Ageing Centre in Akuapem-Akropong, one of the research settings. The experiences of the elderly participants from this centre demonstrate the social and economic benefits, even with limited funding. Although cultural practices differ for each ethnic community in the country, the in-depth understanding of elder care, services, and programs recommended in this study could be transferable to effectively study the unique needs of older adults across various regions, especially in the formalization of care.

Chapter 6: Reflection & Conclusion

6.1 Reflection of the Researcher

Repositioning the researcher involves recognizing and critically examining one's experiences, biases, and interactions that influence the research process (Charmaz, 2014). Charmaz (2006, 2013) argues that reflexivity provides transparency in data analysis and interpretation, allowing readers to assess how and to what extent the researcher's interests, positions, and assumptions influence inquiry (Charmaz, 2013, p. 186). Charmaz (2014) posits that researchers must be transparent about their positionality, including their social, cultural, and personal contexts, as these factors shape their interpretations and interactions with participants. Reality is co-constructed through social interactions and shared meanings, from accessing the field site to the semi-structured interview, transcription, coding of data, and interpretation. According to Charmaz (2000), the story told reflects 'the viewer as well as the viewed' to some extent, making my positioning and potential impact on interpretation relevant to the discussion.

The entire process of this study spanned from 2023 to 2025, beginning with the literature review phase and continuing through data collection and analysis. McKechnie (2008) in The SAGE Encyclopedia of Qualitative Research Methods emphasizes that researchers must recognize how their backgrounds influence their observations, especially as they seek "insider" perspectives that reflect the lived experiences of those they study. My experience mirrors this trajectory, shifting from insider to insider-outsider and ultimately to outsider. For example, before I started this doctoral journey, I served as a caregiver for my maternal grandmother until her passing. Since then, I have become an outsider in my community, where I occasionally visit and observe the elderly navigating social and economic changes in their environments. Even while collaborating with government agencies like DSW, I observed their struggle to fulfill their

roles in delivering services to vulnerable populations amid limited resources and a changing environment. As the study progressed and I entered the field, I was a native of the community in name but an outsider as a researcher.

I recognized that my role as a researcher and caregiver would influence my interactions. However, after the third interview, I realized that being a native and having a name that resonates with this ethnic group helped build rapport, making it much easier to access homes and participants. For example, when I introduce myself as "Adobea," the next question is often, 'Come in, which family house do you come from?' Although many still withheld certain information, numerous participants were open about topics like "their finances" because I was recognized as 'Afie-nipa' (household person). Understanding something through literature and having personal experience are very different from walking through homes and engaging with individuals. These roles shaped my interactions, and the interviews that remain vividly in my mind are those that resonate personally.

For example, a caregiver shared her difficulty in balancing caring for her 38-year-old son, who has lived with a disability all his life, and her elderly spouse, who also has a disability, while trying to make ends meet to support her two other children in high school. Although her experience differed from mine, her story resonated with the challenges I saw my mother face, prompting me to reflect on how carefully I considered my responses to these different situations. I also realized how much I empathized with the frustrations of social welfare officers when dealing with economic and environmental challenges that affected the elderly participants.

Receptiveness to certain aspects of the data revealed biases. However, Charmaz (2014) argues that reflexivity enhances awareness of the researcher's preconceptions and interpretations. Therefore, I remained alert to the possibility that my perceptions could influence the

interpretation of the data. I analyzed the data through coding and examined the ideas and categories to identify connections and relationships within the data. My reflections further refined my analysis, ensuring that I kept the interpretation grounded in the data.

For instance, my personal experiences helped shape my understanding of the stakeholders' journeys in this study. They enabled me to comprehend their decisions regarding the quality of eldercare. I was careful not to make assumptions based on my own experiences and instead followed Charmaz's (2006; 2014) suggestion of mapping and memoing to facilitate a deeper inquiry into the data. Therefore, the study aims to advocate for social justice through the stories conveyed in the findings and to situate them within current literature and theory.

6.2 Limitations of the Study

This study has several limitations that influence how we should interpret its findings. The sample consisted entirely of older women aged 60 and above from two communities within the Akuapim-North Municipality. These participants reflect the realities of their geographical area but do not represent the entire municipality, which includes about 20 additional communities, nor Ghana as a whole. As such, the findings cannot be generalized to broader populations or communities with different cultural or religious contexts. Instead, these findings offer context-specific insights that deepen our understanding of elder caregiving and provide recommendations to address social, economic, and environmental challenges.

Another limitation is the caregiver sample. All caregivers in this study were women with relatively low levels of education and employment in small-scale trading. Their shared profile suggests a common caregiving experience shaped by informal economic conditions and gendered labour roles. However, the study did not capture the perspectives of caregivers with

different educational, occupational, or socio-economic backgrounds. Caregivers employed in the formal sector or with higher education may experience caregiving differently, especially regarding financial stability, access to resources, and negotiation of care responsibilities.

The study also excluded non-family caregivers, including paid domestic workers and professional aides. As a result, only family-based caregiving arrangements are reflected in the findings. Including non-family caregivers could have revealed additional strategies, constraints, or opportunities for strengthening elder care systems. Therefore, future research should expand the participant pool to include older men, caregivers of varied socio-economic backgrounds, and non-family caregivers to build a more comprehensive understanding of elder care.

6.3 Conclusion

My question pertained to the current state of elder care amid the social, economic, and environmental changes that have followed the COVID-19 pandemic. The findings from the Akuapim-North study indicate that resource limitations, such as financial constraints, rising living costs, inadequate government support, and the disruptive impact of COVID-19, pose significant challenges to elder caregiving in rural and suburban communities. The substantive theory of "Drive to Negotiate," centring on interdependence and adaptability, reframes care as a dynamic, relational, and contextually negotiated process, offering promising pathways to strengthen the resilience of stakeholders. Currently, Ghanaians are migrating more, people are having fewer children, and there is an increasing exposure to a nuclear orientation, while many older adults are living longer. Addressing these challenges requires coordinated efforts from governments, healthcare providers, community leaders, and organizations to create a supportive system that is culturally sensitive and adaptable to the evolving needs of elderly populations and

their caregivers. Collaboration between traditional care systems and formalized care is essential for providing adequate and sustainable elder care in these communities

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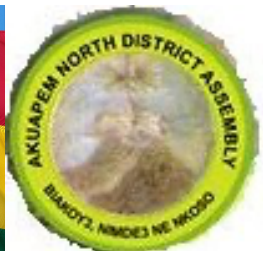
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Appendix A: Publicity Poster/Flyer





VOLUNTEERS NEEDED
(Akuapim-Mampong & Akuapim-Akropong Residents)

Are you a Caregiver or Care Recipient?
You are cordially invited to share your experiences in a study that explores the current state of elder caregiving in your community.

Title of the Study:

Exploring Elder Caregiving in Two Communities in Ghana, West Africa, within the Current State of Social, Economic and Environmental Influences.

Researcher: Abena Adobea Boateng boatenga@myumanitoba.ca

Participant must:

- Reside in Akuapim-Mampong or Akuapim-Akropong community.
- Be 60 years and above and receive caregiving support.
- Provide caregiving duties to an elderly person (60 years and above) at home, in a home care facility, or in a community health centre.

Participation includes completing a demographic questionnaire and participating in an interview.

Commemoration of Participation:

- You will help contribute to the research literature on elder caregiving in Ghana and Sub-Saharan Africa.
- Receive a compensation of GH70 cedis plus transportation of GH30 cedis at the end of the interview.
- Receive a copy of the findings upon request at the end of the study.

Informed Consent Statement: The consent form, including the procedures and any potential risks, will be discussed, and a signature taken before participation.
Participation is 100% voluntary, and you may withdraw from the study at any time.

Contact: Abena Adobea Boateng

Appendix B: Email/ Letter Sample

Subject/ Letter Head: Letter of Invitation for A Research Study in Your District/ Community

Date:

Dear Name,

I hope this email finds you well. My name is Abena Adobea Boateng, a Ph.D. candidate with the Faculty of Social Work at the University of Manitoba, Manitoba, Canada. During October through to the first week in December 2023, I will conduct interviews in your district, specifically, Akuapim-Mampong and Akuapim-Akropong communities, for research purposes.

Before I conduct any interviews, I wanted to reach out to you for a formal meeting to discuss my research purpose and target population for your critical guidance and direction during this process.

My research is on the topic: Exploring Elder Caregiving within the context of Social, Economic and Environmental Influences in Two Communities in the Akuapim-North District of the Eastern Region of Ghana.

The study aims to explore the formal and informal elder caregiving experiences within the context of social, economic, and environmental influences in these two communities. To achieve this, I want to invite potential participants for individual and/or focus group discussion interviews lasting between 40 and 120 minutes. I am asking questions about elder caregiving, challenges, recommendations, and the impact of COVID-19 on elder care in these two communities.

As you play a crucial role in the community, I would appreciate your collaboration and recommendations as I seek to interview social workers, health professionals, elders, their caregivers, and community leaders who can offer valuable insights into this research project.

I have enclosed some information (Participation Flyer and Consent Form) about what participating in the research involves and how the data collected will be used. Kindly contact me by email at boatenga@myumanitoba.ca

Thank you for taking the time to consider this request. I look forward to further discussion in person.

Yours sincerely

Abena Adobea Boateng

Student Researcher

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Appendix C1: Individual Consent Form

Research Title: Exploring the Elder Caregiving within the context of Social, Economic and Environmental Influences in Two communities in the Akuapim-North District of the Eastern Region of Ghana.

Investigator: Abena Adobea Boateng
PhD Candidate, Faculty of Social Work
University of Manitoba
Email: boatenga@myumanitoba.ca

Research Supervisors: Dr. Hai Luo, Ph.D.
Professor
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Dr. Don Fuchs, Ph.D.
Professor Emeritus
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Dr. Michelle Lobchuk, Ph.D.
Professor
College of Nursing, Rady Faculty of Health Sciences

University of Manitoba

Email: Michelle.Lobchuk@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you a basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Research

This study aims to explore the formal and informal elder caregiving experiences within the context of social, economic, and environmental influences.

Procedures Involving the Participant

Participation in this study is voluntary. If you agree to participate in the study, you will be assigned a pseudonym, and any information you provide for the study will be treated with the utmost confidentiality. Your identity will never be disclosed, as you will be assigned a pseudonym. You will be asked to complete a demographic profile (consisting of 13 questions including age, gender, educational status, etc.). This will help to describe the group characteristics of those who participate. You will be asked to engage in a 40 to 60-minute individual interview with the researcher from the Faculty of Social Work at the University of Manitoba. The interview will involve answering questions about your definition of elder care, caregiving challenges, the impact of COVID-19, support systems you have accessed and how you manage elder care. It may be possible that the interview may trigger some challenging memories and experiences related to the issue under study. You are free to withdraw your participation in the study at any time or before the data is published with no penalty.

Potential Benefits and Risks

The potential benefit that participants will derive from this study is the opportunity to express their personal experiences and issues that have been ignored. The findings from the study will inform policymakers and social workers in future about the issues the elderly encounter in receiving care and possible interventions that can enhance the lives of this target population. To show commemoration for participation, respondents will receive a total of GHC100. The only potential or perceivable risk to your participation may be the tendency to trigger some old memories or emotions. For this perceived risk, a provision will be made for individuals who desire and need to see a counsellor for this exercise. If you would like more information or clarity on any of these points, please do not hesitate to contact- Abena Adobea Boateng by email: boatenga@myumanitoba.ca.

Confidentiality and Anonymity

Information you provide for this study will be kept confidential and seen only by the research team (the student and research supervisor). All signed documents/interview transcripts will be scanned and stored using Teams, UM's recommended data-sharing and storage platform. The hard copies

will be kept in a folder and locked in a filing cabinet of the researcher's home. Your name will not be associated with the research findings in any way, and your identity as a participant will be known only to the researcher. If any quotes are used in the final paper, pseudonyms will be used.

Limitation of Confidentiality

For the purpose of this study, confidentiality will be ensured such that participants' identities or information will not be shared with a party or individual who is not directly involved in the study. For instance, the committee members, who are also the research supervisors of this study, will be part of the individuals who will have access to the anonymized data. A translator will also have access to the audio recording for translation purposes. Nevertheless, in an instance where a participant discloses suicidal thoughts, a discussion will be held with the participant to refer them to the Department of Social Welfare (DSW) or the Ghana Health Service (GHS) in their community for help.

Withdrawal and Debriefing

You are free to withdraw anytime from the study without any sanctions or consequences to you. The participants can withdraw three months from the date they signed the consent form, and their data will be destroyed immediately after the withdrawal. All the information you provided as part of the study will be scanned, kept strictly confidential, and stored on the password-protected UM Microsoft Teams platform. However, all hard copies of data stored in folders, including your identifiable information (e.g., name, email), will also be destroyed approximately two years after data collection (31 July 2025). There will be an individual debriefing meeting with the participants through the UofM version of Zoom or the preferred platform of their choice (between April 1 and May 31, 2024) to share their version of the data collected. Participants will be given a choice of having an oral debriefing or a written summary of the results, which will be sent to them by email, regular mail, or other preferred means of the participants.

Dissemination of Information

The anonymized findings from the study will be presented to representatives of DSW, GHS and other international non-governmental organizations such as HelpAge Ghana. A special information session will be held with the leaders of the two communities. Finally, anonymized findings from this study will be presented at appropriate conferences related to this area of the study and in a peer-reviewed journal (e.g., Journal of Aging and Health, Canadian Journal on Aging).

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. This does not waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study during the interview day or three months from the interview date and /or refrain from answering any questions you prefer to omit without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to see that the research is being done safely and properly. The Research Ethics Board has approved

this research at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, contact any of the above persons or the Human Ethics Officer at HumanEthics@umanitoba.ca. A copy of this consent form has been given to you for your records and reference.

Please place a checkmark in the corresponding box to signal your consent and agreement.

I have read and reviewed the consent form with the principal investigator ☐

I have had the opportunity to have any of my questions answered ☐

I, _____ (Print Name) agree to participate in the study. I agree to be contacted if further information is required after the interview. I agree to have the findings (which may include quotations) from this project published or presented in a manner that does not reveal my identity.

I want to receive a summary of the findings: Yes ☐ No ☐

Email address: _____ (Please provide email address)

Participant's Name_____ (Printed name)

Participant's Signature_____Date_____

Researcher's name_____ (Printed name)

Researcher's Signature_____Date_____

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173 Dafoe Road
Winnipeg, Manitoba
Canada R3T 2N2
T: 204 474 7050
F: 204 474 7594
Social_Work@umanitoba.ca

Appendix C2: Focus Group Discussion-Consent Form

Research Title: Exploring the Elder Caregiving within the context of Social, Economic and Environmental Influences in Two communities in the Akuapim-North District of the Eastern Region of Ghana.

Investigator: Abena Adobea Boateng
PhD Candidate, Faculty of Social Work
University of Manitoba
Email: boatenga@myumanitoba.ca

Research Supervisors: Dr. Hai Luo, Ph.D.
Professor
Faculty of Social Work
University of Manitoba
Email: Hai.Luo@umanitoba.ca

Dr. Don Fuchs, Ph.D.
Professor Emeritus
Faculty of Social Work
University of Manitoba
Email: Don.Fuchs@umanitoba.ca

Dr. Michelle Lobchuk, Ph.D.
Professor
College of Nursing, Rady Faculty of Health Sciences

University of Manitoba

Email: Michelle.Lobchuk@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you a basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Research

This study aims to explore the formal and informal elder caregiving experiences within the context of social, economic, and environmental influences.

Procedures Involving the Participant

Participation in this study is voluntary. If you agree to participate in the study, you will be assigned a pseudonym, and any information you provide for the study will be treated with the utmost confidentiality. Your identity will never be disclosed, as you will be assigned a pseudonym. You will be asked to complete a demographic profile (consisting of 13 questions including age, gender, educational status, etc.). This will help to describe the group characteristics of those who participate. You will be asked to engage in 90 to 120-minute focus group discussions with other participants and the researcher from the Faculty of Social Work at the University of Manitoba. The interview will involve answering questions about your definition of elder care, caregiving challenges, the impact of COVID-19, support systems you have accessed and how you manage elder care. It may be possible that the interview may trigger some challenging memories and experiences related to the issue under study. You are free to withdraw your participation in the study at any time or before the data is published with no penalty.

Potential Benefits and Risks

The potential benefit that participants will derive from this study is the opportunity to express their personal experiences and issues that have been ignored. The findings from the study will inform policymakers and social workers in future about the issues the elderly encounter in receiving care and possible interventions that can enhance the lives of this target population. To show commemoration for participation, respondents will receive a total of GHC100. The only potential or perceivable risk to your participation may be the tendency to trigger some old memories or emotions. For this perceived risk, a provision will be made for individuals who desire and need to see a counsellor for this exercise. If you would like more information or clarity on any of these points, please do not hesitate to contact -Abena Adobea Boateng by email: boatenga@myumanitoba.ca.

Confidentiality and Anonymity

Information you provide for this study will be kept confidential and seen only by the research team (the student and research supervisors). All signed documents/interview transcripts will be scanned and stored using Teams, UM's recommended data-sharing and storage platform. The hard copies

will be kept in a file and locked in a filing cabinet of the researcher's home. Your name will not be associated with the research findings in any way, and your identity as a participant will be known only to the researcher. If any quotes are used in the final paper, pseudonyms will be used.

Limitation of Confidentiality and Anonymity

For the purpose of this study, confidentiality will be ensured to an extent such that participants' identities or information will not be shared with a party or individual who is not directly involved in the study. For instance, the committee members who are also the research supervisors of this study will be the individuals who will have access to the anonymized data. A translator will also have access to the audio recording for translation purposes. However, although consent form discussions will be made during the focus group discussions, the confidentiality of anything you say cannot be guaranteed during such sessions. Additionally, your anonymity during the group discussion cannot be assured. Nevertheless, in an instance where a participant discloses suicidal thoughts, a discussion will be held with the participant to refer them to the Department of Social Welfare (DSW) or the Ghana Health Service (GHS) in their community for help.

Withdrawal and Debriefing

You are free to withdraw anytime from the study without any sanctions or consequences to you. The participants can withdraw three months from the date they signed the consent form, and their data will be destroyed immediately after the withdrawal. All the information you provided as part of the study will be scanned and kept strictly confidential and stored on the UM Microsoft Teams platform, which is password-protected. However, all hard copies of data stored in folders, including your identifiable information (e.g., name, email), will also be destroyed approximately two years after data collection (31 July 2025). We will hold individual debriefing meetings with the participants through the UofM version of Zoom or the preferred platform of their choice (between April 1- and May 31, 2024) to share their version of the data collected. Participants will be given a choice of having an oral debriefing or a written summary of the results, which will be sent to them by email, regular mail, or other preferred means of the participants.

Dissemination of Information

The anonymized findings from the study will be presented to representatives of DSW, GHS and other international non-governmental organizations such as HelpAge Ghana. A special information session will be held with the leaders of the two communities. Finally, anonymized findings from this study will be presented at appropriate conferences related to this area of the study and in a peer-reviewed journal (e.g., Journal of Aging and Health, Canadian Journal on Aging).

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. This does not waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study during the interview day or three months from the interview date and /or refrain from answering any questions you prefer to omit without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to

see that the research is being done safely and properly. The Research Ethics Board has approved this research at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, contact any of the above persons or the Human Ethics Officer at HumanEthics@umanitoba.ca. A copy of this consent form has been given to you for your records and reference.

Please place a checkmark in the corresponding box to signal your consent and agreement.

I have read and reviewed the consent form with the principal investigator ☐

I have had the opportunity to have any of my questions answered ☐

I, _____ (Print Name) agree to participate in the study. I agree to be contacted if further information is required after the interview. I agree to have the findings (which may include quotations) from this project published or presented in a manner that does not reveal my identity.

I want to receive a summary of the findings: Yes ☐ No ☐

Email address: _____ (Please provide email address)

Participant's Name_____ (Printed name)

Participant's Signature_____Date_____

Researcher's name_____ (Printed name)

Researcher's Signature_____Date_____

Appendix D: Demographic Questionnaire

Research Topic: Exploring Elder Caregiving within the context of Social, Economic and Environmental Influences in Two communities in the Akuapim-North District of the Eastern Region of Ghana.

Researcher: Abena Adobea Boateng, PhD Candidate, University of Manitoba

Date:_____

Code Number: _____

Demographic Background

1. Age: _____
2. Gender: Male [ ] Female [ ] Other [ ] _____ Prefer not to answer [ ]
3. Ethnicity: Akan [ ] Ga-Dangme [ ] Ewe [ ] Guan [ ] Mole-Dagbani [ ] Other [ ] _____ Prefer not to answer [ ]
4. Marital Status: Never married [ ] Married [ ] Separated [ ] Cohabiting [ ] Widowed [ ] Prefer not to answer [ ]
5. Religious Affiliation: Christian [ ] Islam [ ] Traditional [ ] Other [ ] _____ Prefer not to answer [ ]
6. Educational level: No education [ ] Primary [ ] Junior High School/Middle [ ] Secondary [ ] Tertiary [ ] Other [ ] _____ Prefer not to answer [ ]
7. Employment status: Unemployed [ ] Full-time [ ] as_____ Part-Time [ ] as_____
8. Income (Estimated Monthly) _____ Prefer not to answer [ ]
9. Other Source of Income (If not personal) _____ Prefer not to answer [ ]
10. Number of children/dependents: _____ Prefer not to answer [ ]
11. Living arrangement: Family house [ ] Own house [ ] Spouse's house [ ] Children's house [ ] Other [ ] Specify _____ Prefer not to answer [ ]
12. Health Status (Any health diagnosis you want to disclose)_____ Prefer not to answer [ ]
13. Relationship with caregiver/ recipient _____ Prefer not to answer [ ]

Appendix E1: Interview Guide for The Elderly/Older Adults

Research Topic: Exploring Elder Caregiving within the context of Social, Economic and Environmental Influences in Two communities in the Akuapim-North District of the Eastern Region of Ghana.

Researcher: Abena Adobea Boateng, PhD Candidate, University of Manitoba

Date of Interview:_____

Start Time:_____ End Time: _____

Code Number:_____

Location of Interview: _____

Additional Information:_____

R.Q. #1.

How do the elderly, their caregivers and service providers define elder caregiving from their perspective?

1. What does it mean to receive care or to be provided with care?
   Probe: Who is the main person or people who provide you with the needed care? What type of care do you receive from your caregiver? How long have you been receiving care?
2. Can you share the cultural values and norms associated with elder caregiving in your community?
   Probe: Did you ever decide or plan who or how you wanted to receive care?
3. Are there any other perspectives related to caregiving you feel are important to share during this interview?

R.Q. #2.

What are the driving factors contributing to the current state of elder caregiving?

1. Can you describe your daily routine of receiving care?
   Probe: What are some things you want to do but cannot do, and why?
2. What are some of the challenges you have come across since receiving care?
   Probe: Any barriers that hinder your overall well-being in terms of your social, economic, and environmental situation in the community?

3. Are there any other issues you want to address related to your current state and how they affect your overall well-being and care? What has helped in addressing your issues related to care?

R.Q. #3.

How has the COVID-19 pandemic contributed to elder caregiving in the community?

1. How did the pandemic affect your caregiving needs? Positively? Negatively?
   Probe: What was the state of your social and mental well-being during COVID-19?
2. What were the support systems (government/ non-government) like for you during COVID-19?
3. Are there any other issues regarding COVID-19 you wish to add?

R.Q. #4.

What are the formal and informal support systems for service users (elders and caregivers) and

service providers to manage care deficits in their community?

1. What specific form of caregiving services have you accessed in the community since you began receiving care?
   Probe: Have you observed any changes in how older adults receive care in your community? What are some of them?
2. How has the government been involved in your well-being since receiving care?
   Probe: What difficulties have you encountered accessing social welfare services, and how have you coped with these challenges when there is no external support?
3. Are there elderly or geriatric facilities available in the community? Government or private? Probe: Can you share your perspectives on placing dependent elderly in the care of geriatric facilities? Would you be open to using formal care services yourself if circumstances permit?
4. What would be your recommendations to the community regarding caring for the elderly in our Ghanaian society?
5. Is there any other issue related to your caregiving experience that you feel is important that we have not brought up in this interview?

Appendix E2: Interview Guide for Caregivers (Formal/Informal)

Date of Interview:_____

Start Time:_____ End Time: _____

Code Number:_____

Location of Interview: _____

Additional Information:_____

R.Q. #1.

How do the elderly, their caregivers and service providers define elder caregiving from their perspective?

1. What does it mean to provide care for the elderly?
   Probe: Are you the primary caregiver, and how did you become the caregiver? How long have you been providing care for the recipient (years, months, hours a day?) Can you describe in specifics what your caregiving role looks like?
2. Can you share the cultural values and norms associated with elder caregiving in your community?
   Probe: What is society's perception of you since taking on the role of a caregiver? What did you wish you knew before taking on the caregiving role?
3. Are there any other caregiving-related issues you feel are important to share during this interview?

R.Q. #2.

What are the driving factors contributing to the current state of elder caregiving?

1. Can you describe your daily routine of providing care?
   Probe: Do you feel well-equipped to provide care for your recipient?
2. What are some of the challenges experienced since taking on the role of a caregiver?
   Probe: What are the factors causing these challenges that hinder your caregiving role? What are some of the rewards of providing care? Are you paid? How has taking on this role as a caregiver impacted your life? (Social life, finances, psychologically, environmentally?
3. Are there any issues you want to address related to the current state of the caregiving role and how it affects your overall well-being and that of the elderly client?

R.Q. #3.

How has the Covid-19 pandemic contributed to elder caregiving in the community?

1. How did the COVID-19 pandemic affect your role as a caregiver?

Probe: How did you manage to provide care during the pandemic? What was the state of your social and mental well-being during COVID-19?

2. What were the support systems (government/ non-government) like for you during COVID-19?
3. Are there any other issues regarding COVID-19 you wish to add?

R.Q. #4.

What are the formal and informal support systems for service users (elders and caregivers) and service providers to manage care deficits in their community?

1. Have you observed any changes in how older adults receive care in your community? What are some of them? Probe: What specific forms of caregiving services have you accessed in the community since you began providing care?
2. How has the government supported you since becoming an elderly caregiver? Probe: What difficulties have you encountered accessing social welfare services for your care recipient? How have you coped with these challenges when there was no external support?
3. Are there elderly or geriatric facilities available in the community? Government or private? Probe: Can you share your perspectives on placing dependent elderly in these facilities? Would you hire someone else, if you can afford it, to provide care for an elderly relative?
4. What would be your recommendations to the community regarding caring for the elderly in our Ghanaian society?
5. Is there any other issue related to formal and informal caregiving experience that you feel is important that we have not brought up in this interview?

Appendix E3: Interview Guide for Organizations (Government/Non-Government Representative)

Date of Interview:_____

Start Time:_____ End Time: _____

Current Position:_____

Location of Interview: _____

Additional Information:_____

R.Q. #1.

How do the elderly, their caregivers and service providers define elder caregiving from their perspective?

1. How long have you been working with the agency, and what is your current role?
2. How would you define elder care in the Ghanaian community?
   Probe: Can you share the cultural values and norms associated with elder caregiving in the community? How has that changed over the years?
3. How does your organization play a role in elder caregiving in the community?
   Probe: Can you describe what role you play in providing elder care?
4. Are there any other caregiving-related issues you feel are important to share during this interview?

R.Q. #2.

What are the driving factors contributing to the current state of elder caregiving?

1. Can you describe the current state, including the challenges of elder caregiving in the community today?
   Probe: What are the contributing factors leading to this current state of caregiving? (Probe: social, economic, and environmental factors)
2. Are there any other caregiving-related issues you feel are important to share during this interview?

R.Q. #3.

How has the Covid-19 pandemic contributed to elder caregiving in the community?

1. Can you describe how providing care for the elderly was met during COVID-19?
2. What were the support systems (government/ non-government) you provided to this target population during the pandemic?
   Probe: What is the state of elder care now after the pandemic?

3. Are there any other issues regarding COVID-19 you wish to add?

R.Q. #4.

What are the formal and informal support systems for service users (elders and caregivers) and service providers to manage care deficits in their community?

1. What resource constraints have you encountered in providing services for your client?
   Probe: How has the agency coped or managed to provide services during these such difficult times?
2. What national policies and programs are available to improve the caregiving services for this target population? How practical are their implementations to ensure quality care?
3. How does your agency support the well-being of caregivers?
4. Can you share some recommendations or interventions to improve the quality of caregiving in the community and the country?
5. Are there elderly or geriatric facilities available in the community? Government or private?
   Probe: Can you share your perspectives on placing dependent elderly in the care of geriatric facilities?
6. Is there any other issue related to formal and informal caregiving experience that you feel is important that we have not brought up in this interview?

Appendix F1: Focus Group Protocol for Caregivers (Formal/Informal)

Date of Interview:_____

Start Time:_____ End Time: _____

Group Interview Code:_____

Location of Interview: _____

Additional Information:_____

Guiding Questions

1. How do you define elder caregiving in your community?
   Probe: What have been your expectations as a caregiver for the elderly?
2. What have been some of the challenges being faced in your role as the caregiver for this target population, and how do you cope?
   Probe: How has this role impacted you personally, and how do you cope with it? (Probe: positively, negatively- mentally, financially)
3. How have government or non-government organizations provided support specifically to you in your role as the caregiver? (Probe: what these agencies can do if they are not already)
4. How did the COVID-19 pandemic affect you and your role as an elderly caregiver?
5. What is your perspective on care homes or geriatric facilities providing care to the elderly?
   Probe: Would you be willing to access such services for your care recipient or relative if you could afford them?
6. What would be your recommendation or advice for other caregivers?
7. Are there any other contributions or additional comments?

Appendix F2: Focus Group Protocol for Organizational Representatives

Date of Interview:_____

Start Time:_____ End Time: _____

Group Interview Code:_____

Location of Interview: _____

Additional Information:_____

Guiding Questions

1. How do you define elder caregiving in your community?
2. Can you share some of the challenges faced by the elderly in this community?
   Probe: What are some of the supports or activities in the community that help older members and their caregivers?
3. How did the COVID-19 pandemic affect the elderly?
4. Are there elderly or geriatric facilities available in the community? Government or private?
   Probe: Can you share your perspectives on placing dependent elderly in the care of geriatric facilities?
5. What are some interventions or recommendations as a leader that you think will be helpful to the elderly and their caregivers in this community?
6. Is there any other information or comments about elder caregiving that you wish to add?

Appendix G: Elderly Demographic Profile

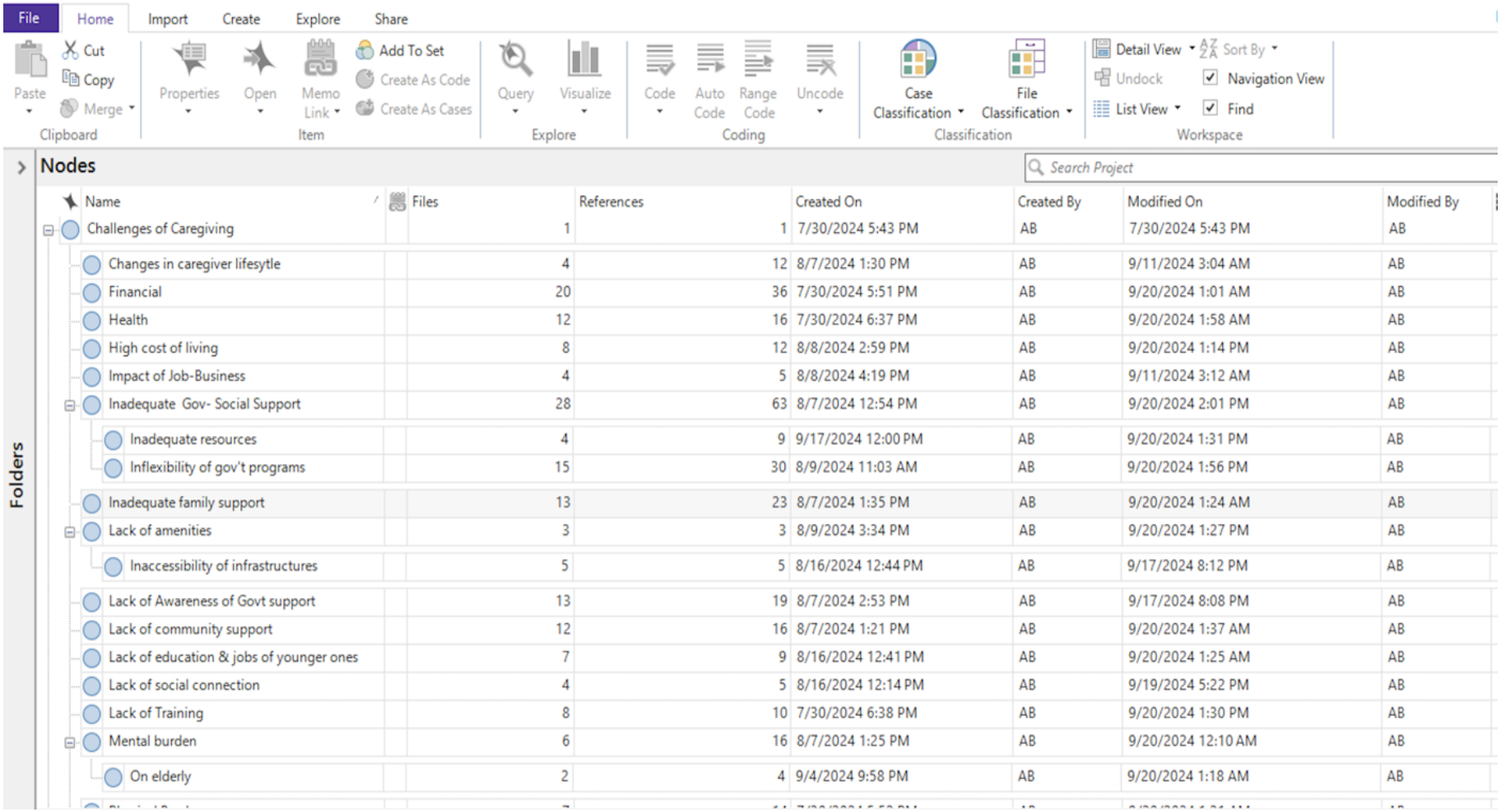
Participant - Elderly	Age	Marital Status	No. of Children	Religious Affiliation	Education Status	Employment Status	Income (Mthly)	Other Source of Income	Living Arrangements	Health Status	Relationship with Caregiver
P1	72	Widowed	3	Christian	Primary	Unemployed	N/A	Remittance (60ghc-occasional)	Family house	Blood Pressure, Diabetes & Spiritual	Self (recently lost caregiver-1 child)
P2	65	Married	12	Christian	Secondary	Shop keeper	Prefer not to answer	Family inheritance	Family house	Arthritis (Joint pains)	Relatives
P3	62	Widowed	7	Christian	Primary	Trader	50ghc	None	Family house	Cataract	Son
P4	72	Cohabiting	1	Christian	Junior High	Trader	300ghc	Remittance	Family house	Heart problems	Step-Son
P5	62	Married	11	Christian	Primary	Food vendor	300ghc	None	Own house	High Cholesterol	Husband
P6	62	Separated	1	Christian	Primary	Food vendor	Prefer not to answer	Remittance	Family house	Arthritis	Granddaughter
P7	65	Widowed	7	Christian	Junior High	Unemployed	N/A	Remittance	Own house	Stroke	Daughter
P8	85	Widowed	7	Christian	Tertiary	Store owner	Prefer not to answer	Remittance	Family house	Arthritis	Niece
P9	70	Widowed	1	Christian	Junior High	Unemployed	N/A	Remittance	Own house	Arthritis (Waist problem) & Hypertension	Granddaughter
P10	73	Widowed	11	Christian	Primary	Unemployed	N/A	Remittance (200ghc-Occasional)	Own house	Cataract	Son/grandchildren
P11	76	Separated	3	Christian	Secondary	Unemployed	N/A	SSNIT Pension (800ghc) & Remittance (600ghc-Occasional)	Family house	Arthritis (Waist/Knee problems)	Hired help (14yrs)
P12	69	Separated	6	Christian	Secondary	Unemployed	N/A	Remittance	Family house	Diabetes	Daughter
P13	73	Widowed	1	Christian	Tertiary	Unemployed	N/A	SSNIT Pension	Own house	Cataract	Daughter

P14	69	Separated	2	Christian	Tertiary	Unemployed	N/A	SSNIT Pension	Family house	Diabetes/ Hypertension/ Cataract	Self & relatives (occasional)
P15	79	Widowed	4	Christian	Tertiary	Unemployed	N/A	SSNIT Pension (2400ghc) & Remittance (1000gh)	Family house	Hypertension/ Spinal cord injury	Daughter
P16	85	Widowed	8	Christian	Primary	Unemployed	N/A	Remittance (800ghc-Occasional)	Family house	Arthritis	Self & relatives (occasional)
P17	76	Separated	5	Christian	Tertiary	Store owner	200ghc-800ghc	SSNIT Pension (1244ghc) & Remittance	Family house	Arthritis (Joint pains)	Help (F-20 years)
FGP1	66	Separated	3	Christian	Primary	Unemployed	N/A	Remittance (200ghc or more)	Family house	Stomach issues	Older daughter
FGP2	60	Widowed	4	Christian	Primary	Trader	50ghc	None	Family house	Arthritis (Muscle/body pains)	Self & step-children
FGP3	73	Widowed	0	Christian	Junior High	Trader	25ghc-30ghc	None	Family house	Arthritis	Children
FGP4	73	Widowed	1	Christian	Junior High	Trader	100ghc	Remittance (150ghc-Occasional)	Family house	Diabetes/Blood Pressure	Self & sister-in-law
FGP5	60	Widowed	5	Islam	Primary	Food vendor	500ghc	None	Own house	Blood Pressure	Self & Children
FGP6	94	Widowed	2	Christian	No education	Unemployed	N/A	Remittance (200ghc-Occasional)	Family house	Insomnia	Self & relatives (occasional)
FGP7	84	Widowed	3	Christian	Primary	Unemployed	N/A	Remittance (200ghc-300ghc)	Family house	Arthritis	Daughter & granddaughter
FGP8	79	Widowed	5	Christian	Junior High	Unemployed	N/A	Remittance (500ghc-600ghc-Occasional)	Family house	Arthritis/ Hypertension	Niece

Appendix H: Caregivers Demographic Profile

Participant - Elderly	Age	Marital Status	No. of Children	Religious Affiliation	Education Status	Employment Status	Income (Mthly)	Other Source of Income	Living Arrangements	Health Status	Relationship with Caregiver
P1	81	Married	2	Christian	No education	Unemployed	N/A	Spouse's pension & Remittance	Family house	Frequent headaches/ dizziness	Husband
P2	63	Separated	3	Christian	Primary	Food vendor	50	Spouse's Disability benefits	Rent	BP	Ex-husband
P3	44	Never married	4	Christian	Primary	Food vendor	800ghc (seasonal)	Child support	Family house	N/A	Mother
P4	48	Widowed	2	Christian	Junior high	Trader	300ghc	Remittance (occasional)	Family house	N/A	Mother & Big Aunt
P5	57	Never married	0	Christian	Primary	Trader	20-40ghc	LEAP Remittance	Family house	Muscle pains	Mother
FG1	61	Cohabiting	12	Christian	Primary	Unemployed	N/A	Prefer not to answer	Rent	Body pains	Father
FG2	72	Married	2	Christian	Junior high	Trader	100ghc	Remittance (occasional)	Children's house	Diabetes & Hypertension	Husband
FG3	73	Married	3	Christian	Junior high	Unemployed	N/A	Remittance	Family house	Hypertension & Ulcer	Aunt
FG4	82	Cohabiting	4	Christian	Junior high	Unemployed	N/A	Remittance	Family house	Hypertension & Eye problems	Big Sister

Appendix I: NVivo Coding Sample



Name	Files	References	Created On	Created By	Modified On	Modified By
Challenges of Caregiving	1	1	7/30/2024 5:43 PM	AB	7/30/2024 5:43 PM	AB
Changes in caregiver lifesytle	4	12	8/7/2024 1:30 PM	AB	9/11/2024 3:04 AM	AB
Financial	20	36	7/30/2024 5:51 PM	AB	9/20/2024 1:01 AM	AB
Health	12	16	7/30/2024 6:37 PM	AB	9/20/2024 1:58 AM	AB
High cost of living	8	12	8/8/2024 2:59 PM	AB	9/20/2024 1:14 PM	AB
Impact of Job-Business	4	5	8/8/2024 4:19 PM	AB	9/11/2024 3:12 AM	AB
Inadequate Gov- Social Support	28	63	8/7/2024 12:54 PM	AB	9/20/2024 2:01 PM	AB
Inadequate resources	4	9	9/17/2024 12:00 PM	AB	9/20/2024 1:31 PM	AB
Inflexibility of gov't programs	15	30	8/9/2024 11:03 AM	AB	9/20/2024 1:56 PM	AB
Inadequate family support	13	23	8/7/2024 1:35 PM	AB	9/20/2024 1:24 AM	AB
Lack of amenities	3	3	8/9/2024 3:34 PM	AB	9/20/2024 1:27 PM	AB
Inaccessibility of infrastructures	5	5	8/16/2024 12:44 PM	AB	9/17/2024 8:12 PM	AB
Lack of Awareness of Govt support	13	19	8/7/2024 2:53 PM	AB	9/17/2024 8:08 PM	AB
Lack of community support	12	16	8/7/2024 1:21 PM	AB	9/20/2024 1:37 AM	AB
Lack of education & jobs of younger ones	7	9	8/16/2024 12:41 PM	AB	9/20/2024 1:25 AM	AB
Lack of social connection	4	5	8/16/2024 12:14 PM	AB	9/19/2024 5:22 PM	AB
Lack of Training	8	10	7/30/2024 6:38 PM	AB	9/20/2024 1:30 PM	AB
Mental burden	6	16	8/7/2024 1:25 PM	AB	9/20/2024 12:10 AM	AB
On elderly	2	4	9/4/2024 9:58 PM	AB	9/20/2024 1:18 AM	AB