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Ph.D. PROGRAM IN SOCIAL WORK
DISSERTATION APPROVAL FORM

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DETERMINANTS OF INTERNATIONAL LONG-DISTANCE ELDERCARE: EVIDENCE FROM GHANAIAN IMMIGRANTS IN THE UNITED STATES

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

By

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Dedication

I dedicate this work to

all my family members whose sacrifices made it possible for me to get this far,

all my teachers who believed in me and motivated me to soar higher,

all my friends who encouraged me to pursue my dreams, and

Sandra Amponsah who gave me all the support I needed and confidence to maneuver the detours along the way.

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Abstract

DETERMINANTS OF INTERNATIONAL LONG-DISTANCE ELDERCARE: EVIDENCE FROM GHANAIAN IMMIGRANTS IN THE UNITED STATES

By Stephen Raymond Kodwo, PhD

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

Virginia Commonwealth University, 2009

Director: F. Ellen Netting, PhD
Professor and Samuel S Wurtzel Endowed Chair
School of Social Work

Studies of Ghanaians who have immigrated to the United States indicate that both economic and emotional support continue to be provided to non-migrant families in Ghana. However support to "family relatives" has been studied generally, without specifying age. Thus, relationships between immigrants and their elderly relatives, particularly those who may be frail and vulnerable, have not been the focus of previous research. In addition, it is necessary to examine the dynamics that shape attitudes towards elderly people, and which in turn influence eldercare patterns among Ghanaian immigrants. Based on the literature, the researcher identified four factors relevant to international long-distance eldercare: (1) support caregivers receive (or previously received) from elderly relatives, (2) filial obligation towards elderly relatives, (3) perceived vulnerability of the elderly people in Ghana, and (4) vulnerabilities that make immigrants unable to provide eldercare. The main objective of this study was to examine

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the extent to which these four factors shape the provision of eldercare by Ghanaian immigrants in the United States to their elderly relatives in Ghana. To achieve this objective, a convenience sample of 124 Ghanaian immigrants who resided in a large metropolitan area in the southern United States was surveyed.

Study results reveal that the dominant type of eldercare provided was emotional care, but special circumstances in elderly people's lives, such as serious financial problems may significantly increase their chances of receiving financial support. For caregivers, their levels of income significantly determined the level of financial support provided to their elderly relatives and how often they visited them. It was also found that there are always some siblings left in Ghana to take care of the physical needs of elderly parents in the absence of those who have migrated. Elderly people having multiple migrant adult children or relatives were more likely to receive financial support from multiple sources. Factors contributing to immigrants supporting elders in Ghana included feelings of high obligation toward elderly relatives, readiness to show love and appreciation for elderly relatives, and acceptance of eldercare as a moral obligation for all adult children. Overall, there was evidence to conclude that most immigrants provided care to their elderly relatives and that most were influenced by the social and cultural tenets that underlie elder caregiving in Ghanaian society.

Implications of the study for social work research include the importance of further exploration of factors that might result in reduction in the care immigrants provide to their non-migrant elderly relatives, and replication of the current study with the view of explaining the inability of both elderly relatives' and immigrants' vulnerabilities to predict level of care. Given the possible psychological distress

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associated with caregiving and its effect on immigrants' time and financial resources, social work practitioners need to be sensitive to the financial and emotional aspects of long distance caregiving by providing services to caregivers who may need them. Policy implications include maximizing remittances by reducing transaction cost and using remittance as leverage for financial grants for family investments.

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CHAPTER 1

Background and Study Rationale

Long-distance caregiving activities undertaken by immigrants are crucial to the welfare of their family members in their home country. There is evidence that financial support from relatives who have left the country reduces poverty at the household level, increases family health, and helps smooth household consumption. Phone communication helps provide avenues for families separated by geographic distance to stay in contact, while return visits help rekindle relationships and allow migrants and non-migrant family members to participant in one another's lives. Consequently, these activities of immigrants are particularly important to older adults, many of whom depend financially and emotionally on their immigrant children for long-distance caregiving. In this regard, this study focuses on factors associated with older adult Ghanaians and Ghanaian immigrant caregivers that determine the level of elder care provided.

This chapter discusses the rationale for the current study and examines the reasons for contemporary emigration from Ghana. Factors that impact Ghanaian immigrants' ability to accumulate resources in their host countries are highlighted, focusing on legalities involving migration and labor market participation. The chapter also examines theoretical understandings of migration and provision of elder care.

Rationale for Study

Ghana, like other developing countries, is experiencing rapid population aging. Two main factors have been identified as contributing to the aging of the population: (1) improvements in sanitation, nutrition, and public health that have reduced premature

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deaths; and (2) decreasing fertility rates due to improved access and use of effective birth control methods (Kinsella & Phillips, 2005). According to Aboderin (2006), the number of Ghanaians aged 60 years and above which currently stands at just over one million is expected to increase five fold to almost 6 million by 2050 (p.17).

Although older adult Ghanaians presently form a small proportion of the total population, there are concerns for their care because the traditional eldercare structure is expected to decline, a situation attributed to features of modernization, including industrialization, urbanization, and migration (Aboderin, 2006; Apt, 2000, 1993). It is expected that the increased numbers of older people and increased life span will lead to additional need and demand for eldercare services due to aging-related chronic health conditions, morbidity, and functional impairment (Aboderin, 2006). There are concerns that migration of younger and middle-aged people will negatively affect the care and support available for older adult family members left behind (United Nations, 1982, 1991). While many researchers have reported the emotional and financial support Ghanaian immigrants provide for their parents and other family members in Ghana, other researchers have noted that not all Ghanaian immigrants send remittances and/or stay in contact with their families in Ghana (Van der Geert, 2002a).

There are no exact records on current Ghanaian emigrants, but evidence from the migration and remittance literature indicate that large numbers of Ghanaians live and work abroad (Anarfi, Kwankye, Ababio & Tiemoko, 2003; Opoku-Dapaah, 2006; Owusu, 2000). From pre-colonial times up to the late 1960s, international migration from Ghana was temporary and involved a relatively small number of people, mostly traders moving within the West African sub-region, and career professionals and students going abroad

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for career and academic reasons (Anarfi, Awusabo-Asare, & Nsowah-Nuamah, 2000). In recent times, there have been increases in both the number of people and types of emigrants. While many Ghanaian emigrants view their stay abroad as temporary, it appears many more are emigrating than returning (Peil, 1995).

The major reason behind Ghanaian emigration is economics; the expectations of finding a job and financial gain underlie the decision of the majority of Ghanaians to migrate (Kabki, Mazzucato & Appiah, 2004; Schoorl, Heering, Esveldt, Groenewold, van der Erf, Bosch, et al., 2000; van Dalen, Groenewold, & Schoorl, 2004). While the recent modest up-turn in Ghana's economy (Institute of Statistical, Social and Economic Research [ISSER], 2005), and the political and economic turbulence in migration destinations within the West African sub-region have combined to reduce the number of emigrants, emigration to western Europe, United States and Canada still persist, and appear to be intensifying (Carling, 2007; Konadu-Agyemang & Takyi, 2006).

While the need to ensure a good livelihood for themselves and their families may drive middle-aged Ghanaians and youth to emigrate, a derived consequence is the changes in the dynamics of eldercare in Ghana. In societies, like Ghana where there is no public welfare system, emigration has an impact on older adults who rely on their children for instrumental, physical, and emotional care. The traditional living arrangements whereby elderly Ghanaians co-reside with or live in close proximity to their extended family members means there are younger members often close by to support and care for them. Migration disrupts these living arrangements; it separates younger family members from older adult members who need care. It has been argued that migration weakens the eldercare structures, reduces the psychological and material

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incentive to support older parents, and erodes the social controls to penalize neglectful adult children (Ikels & Beall as cited in Zimmer, Korinek, Knodel & Chayovan, 2007; United Nations, 1982, 1991).

It is unlikely that Ghanaian emigration to Western countries will drastically reduce or cease in the immediate future, for at least two reasons. First, there is a high propensity for international migration to perpetuate itself. Areas with high emigrant populations usually have well developed structures that encourage emigration (Massey, Arango, Koucouci, Pelligrino & Taylor, 1998). A number of communities in Ghana have become deeply involved in migration to Europe and North America, which in itself contributes to future emigration pressure. Second, there are indications that migration is used as a household social protection strategy to diversify risk for families in many parts of Africa (Sabates-Wheeler & Waite, 2003). Economic migration is viewed as a means to protect households at the migrant's place of origin from economic hardships by receipt of remittances (Gubert, 2002; Schrieder & Knerr, 2000). Consequently, economic migration is encouraged and actively pursued by persons who are young or middle-aged, including those from relatively wealthier families and professionals such as doctors, nurses, engineers and teachers who hold reasonably good paying jobs (Anarfi et al., 2003; Carrington & Detragiache, 1999; Dovlo & Nyonator, 1999; Hatton & Williamson, 2003).

Many researchers have studied the role Ghanaian immigrants play in the lives of their non-migrant family members. There is evidence that the majority of Ghanaian immigrants around the world continue to provide financial and emotional support to their non-migrant families in Ghana (Kabki et al., 2004; Orozco, Bump, Fedewa, & Sienkiewicz, 2005). However, most of these studies focus on the causes and impacts of

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transfer on the entire household, without a disaggregated older-adult focus. In most of the studies, "older adults" are often subsumed under "family relatives," "close family relatives," or "household," obscuring caregiving dimensions that are unique to older adults. Although there is evidence from other countries that show that support from immigrants are directed to older adults' relatives who are the most vulnerable, none of the existing literature on Ghana has focused on old-age vulnerabilities in a caregiving context or linked old-age vulnerabilities and immigrant caregiver's vulnerabilities to the frequency and magnitude of eldercare provided.

Understanding the relationships between old-age vulnerabilities and care provided by immigrants is important for two main reasons. First, it reveals how immigrant children decide to support relatives in a society with a rapidly growing older adult population and no informal eldercare structures. Second, the relationship between old-age and migration vulnerabilities and elder care provision will shed light on deeper elder care issues such as the motives behind caregiving and thus contribute to the ongoing discourse on care of older adults in Ghana.

These reasons are particularly relevant to the profession of social work. Social workers are increasingly encountering immigrant populations in their work and it is important for them to know the types of issues they are facing. Long-distance caregiving and sensitivity to an aging society are relevant concerns within the United States, but are exacerbated when the dimensions of caregiving are extended into an international arena. Understanding the cultural expectations, along with the social and economic implications of what Ghanaian immigrants are experiencing will be invaluable to social workers engaged in both direct and macro practice roles. This study is designed to add to the

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knowledge base of the profession so that practitioners, policy-makers, and researchers will gain insight into these somewhat invisible caregiving roles that transcend international boundaries.

Ghanaian Emigration

Reasons for contemporary Ghanaian emigration are multiple and often overlap. Evidence from Ghana suggests a long history of emigration from Ghana to Europe, particularly the United Kingdom, for education and training purposes (Jenkins as cited in Peil, 1995; Kea as cited in Akyeampong, 2000). After Ghana's independence in 1957, more scholarships became available to more Ghanaians in Europe as well as in North America. The earliest Ghanaian immigrants were those who initially traveled for education and/or training but stayed behind after completing their studies or programs. Many of the children born abroad by these Ghanaian students and/or professionals either stayed behind when their parents returned to Ghana or returned to their birthplaces when they were old enough or could afford to travel on their own (Anarfi et al., 2003).

The increase in international out-migration in the late 1970s and early 1980s however, has been attributed to economic decline and political instability (Fosu as cited in Peil, 1995). By the mid-1980s, the economy of Ghana was growing at a negative rate. To arrest the economic decline, the government at the time introduced a *structural adjustment program*, which included staff redeployment and the withdrawal of subsidies on social services such as health, transportation, and education (Anarfi, et al., 2003). While the government's economic strategies resulted in cuts in public services and state-run corporation jobs, the growth in the other sectors of the economy was not enough to provide employment to those seeking work. The unemployment and the resultant

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economic hardships coupled with a strong desire for a higher standard of living provided incentives for many Ghanaians to seek work abroad (Peil, 1995). Political insecurity brought about by military *coups d'etat* in the 1970s and 1980s also generated a small number of emigrants. Displaced and aspiring politicians, military officers, and former government officials who fall foul of the coups or new leaders sometimes seek asylum abroad. Many other Ghanaians who sought to emigrate for economic reasons used the political instability as a basis to seek asylum or refugee status in many Western countries (Peil, 1995).

There is a wide variation between the official and unofficial statistics of the numbers of Ghanaian who have migrated to the United States, but both sources seem to agree that the number of Ghanaians living in the United States has been increasing rapidly over the years. United States Census Bureau data quoted by Orozco et al., (2005, p. 47) indicate that in 1990, there were 20,889 Ghanaians living in the United States. By 2000, this population had grown over 210 percent to 65,570. In the new millennium, the Ghanaian immigrant population in the United States has continued to grow, reaching 101,169 in 2004, a 384 percentage increase between 1990 and 2004. However, unofficial sources estimate the number of Ghanaian immigrants in the United States to be higher. Orozco et al. (2005) estimate the number to be around 300,000 (p.6). In contrast, Ghanaian community leaders cited by Opoku-Dapaah (2006) estimate the number of Ghanaians who have settled in the United States since the early 1970s to be about 500,000 (p.238). Ghanaians in the United States are concentrated in few urban areas on the east coast. For example, in 2004, the New York City metropolitan area had over 35

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percent of the population, Washington DC had 19 percent, Atlanta had 11 percent, and Boston, eight percent.

Characteristics of Ghanaian Immigrants in the United States

According Orozco et al. (2005), over 80 percent of the Ghanaian population in the United States falls between the ages of 20 and 54 with females slightly outnumbered by their male counterparts. According to United States Census Bureau's 2004 American Community Survey data analyzed by Orozco et al. (2005), about 9 out of 10 Ghanaians living in the United States have graduated from high school while approximately one third of them over 25 years of age has completed a bachelor's degree or higher. This means that the majority of Ghanaians immigrants in the United States may be capable of reading and/or speaking English albeit at various degrees of competence. This is not surprising since English is Ghana's official language and is used as the language of instruction in schools and mass communication. It is worth noting that most Ghanaian immigrants may also, besides English, speak one or more of the multiple Ghanaian languages.

Ghanaian immigrants are noted to establish religious groups to fulfill their spiritual needs. Using a combination of observation, participatory, and survey methods, Opoku-Dapaah (2006) examined features of U. S.-based Ghanaian religious sects and their adaptation to American society. He counted over 400 predominantly Ghanaian churches across the major cities in the United States. Besides religious groups, Ghanaian immigrants are noted to establish networks of associations to fulfill a variety of economic, cultural, social, and political functions related to their needs in their host countries and in Ghana. These associations include: (i) township or hometown

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associations – those whose members are drawn from individuals originating from the same town or locality, (ii) ethnic associations – consists of individuals belonging to the same ethnic group in Ghana, and (iii) national associations – those that are opened to all Ghanaian immigrants regardless of hometown or ethnic origin (Owusu, 2000).

Vulnerability to Illegal Migration

As already indicated, most Ghanaians emigrate in search of job opportunities that will help them improve their standard of living and that of their families. But, there are several factors that threaten to derail the aspirations of these emigrants. Two such issues faced by Ghanaian immigrants in the United States include legality regarding residency, and participation in the American labor market.

Under current U.S. law, nearly all legal immigrants are either refugees or the relatives of a U.S. citizen or resident alien, but a small number of individuals receive immigration visas on the basis of their own skills (Chiswick, 1988) or under the recently introduced *diversity visa lottery* (Law, 2002). Ghanaians who aspire to work in the U.S., but do not qualify under current immigration law, often enter the country as students or tourists. Upon entry, they either work in violation of the visa or remain longer than is permitted by the visa, thereby becoming illegal residents or aliens, i.e. foreign-born persons whose mere presence in the United States is in violation of the law or who have violated a condition of a lawful entry (Chiswick, 1988, p.102).

There is no exact figure of the current number of illegal Ghanaian aliens in the United States. In the past, the Immigration Reform and Control Act (IRCA) of 1986 provided amnesty to most illegal immigrants in the country at the time. The Act allowed those who filed petitions during a 12-month period beginning May 5, 1987 to legalize

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their stay (Chiswick, 1988). According to Orozco et al. (2005), about 64 percent of the Ghanaian born population in the United States as of 2004 entered the country between 1990 and 2000. This means the majority of Ghanaians presently in the United States entered the country, at least a year and a half after the expiration of the “illegal immigration amnesty” provision of the IRCA Act. There is a strong possibility that many, except diversity visa lottery winners, who entered the country within this period may be illegally residing in the United States.

The consequences of illegality are wide-ranging. Various state and federal laws restrict illegal aliens’ access to many federal, state, and local publicly-funded services. For instance, the Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 makes illegal aliens ineligible for any retirement, welfare, health disability or similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency or a State or local government or by appropriated funds of a State or local government (Kullgren, 2003). The IRCA Act makes it illegal for employers to hire illegal aliens (Chiswick, 1988), thereby restricting their access to the labor market and exposing those who work illegally to exploitation by employers, some of whom pay their illegal alien workers wages below the legal minimum (Lazaridis & Romaniszyn, 1998). Furthermore, illegal aliens are vulnerable to arrest and deportation by the authorities. In fact, a calculation made by this researcher using data from the United States Department of Homeland Security’s *Yearbook of Immigration Statistics: 2003* indicated that between 1993 and 2003, approximately 206 Ghanaians on average were annually deported from the U.S. for various reasons.

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To deal with post-migration insecurities such as threats to deportation and limited access to the labor market, some illegal immigrants establish contacts in the Ghanaian immigrant community through membership in Ghanaian social organizations (Opoku-Dapaah, 2006; Owusu, 2000). Others turn to “fraudulent marriage gangs” that put them in contact with legal resident aliens or citizens who “marry” them for a fee in order to obtain immigration benefits, including employment authorization and permanent residence status (United States Department of Justice, 2003). Such illegal attempts at regularizing immigration status expose illegal immigrants to further vulnerabilities.

There are few studies that have looked directly at the effects of illegal status on economic outcomes of immigrants or their families of origin. A pilot study conducted by Black, Koser, Munk, Atfield, D’Onofrio, and Tiemoko (2004) with returning refugees in Bosnia and Kosovo found no correlation between the immigrant’s legal status obtained abroad, and socio-economic outcomes on return, although this was based on a very small sample. Sabates-Wheeler, Natali, and Black (2007) studied the issue by considering the assets of Ghanaian return migrants. They found that on average, the number of assets reported by those who had migrated legally was consistently higher than those who had migrated illegally. Thus, given the illegal alien highly marginal position in American society, it seems reasonable to assume that their ability to accumulate assets, and for that matter, provide elder care support might be more limited than for legal migrants.

Vulnerability to Labor Market Outcome

Many studies point to poor labor market outcomes for many immigrants in the United States. Most studies focus on immigrant’s labor market outcomes in comparison with those of United States natives with similar characteristics. Results show that

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immigrants earn less than U. S. natives with comparable levels of education and work experience (Hanson, Scheve, Slaughter & Spilimbergo, 2001). Some studies also indicate that recent immigrants encounter more difficulty finding employment than citizens and long term immigrants, and experience systematically lower employment rates (Fleury, 2007). Other studies however, show that generally, immigrants manage to catch up with the performance of native-born citizens in the labor market after 10 or 15 years of residence (Thompson & Worswick as cited in Fleury, 2007).

The majority of the Ghanaian immigrant population, like the general immigrant population, is concentrated in specific occupation and industries and is over-represented in low income-paying jobs. According to Opoku-Dapaah (2006), Ghanaians with relatively less human capital tend to be over-represented among service workers and manual laborers. He noted that such Ghanaians are more likely to remain in the United States as illegal aliens, thereby aggravating their relative disadvantage with respect to income and labor force participation. However, there are many highly educated Ghanaians – comprising educators, medical doctors, nurses and pharmacists – who receive high incomes.

The concentration of Ghanaian and other immigrants in low wage and manual jobs could be a reflection of high proportions of them with relatively low levels of education and limited experience in the United State labor market (Hanson et al., 2001). On the other hand, it may be that immigrants' skills and experience outside the United States are generally undervalued as suggested by Akesh (2006). She compared immigrants' last job in their home country and their job in the United States, one year after receiving their green card. She found that "more than three-fourth of the highest-

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skilled immigrants from Latin America and the Caribbean [Africa has similar socioeconomic features like these two regions] end up in lower skilled jobs than what they had in their home country" (p. 854). Another reason for the high concentration of Ghanaian immigrants in manual and service industries may be because of less immigration enforcement in those sectors, thus allowing both unskilled immigrants and skilled ones without legal documentation to work in those industries. In the same study, Akesh (2006) found that English ability and education acquired in the United States increased the returns to education acquired before emigrating. Undoubtedly, without the legal work authorization, the academic qualifications and language skills acquired may be worthless or undervalued. Furthermore, for illegal immigrants, acquiring education in the United States is extremely difficult since federal and state laws forbid schools and colleges from providing instruction to students who are not lawful residents (Ziv & Lo, 1995).

The greater difficulties experience by many Ghanaian immigrants in the labor market due to their illegal immigration status may translate into higher economic vulnerability with a negative consequence for asset accumulation. Those particularly vulnerable include illegal aliens; those with less education and skills, limited experience in the United States labor market; and recent immigrants who have limited social networks in the United States.

Vulnerability to Poor Health Conditions

A person may have a good attitude toward eldercare and be well motivated to undertake caregiving activities but may still not be able to do so because of ill health. So, it is important to look at the health status of long-distance caregivers. Several researchers

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have studied the health status of immigrants in the United States; some have concluded that immigrants in the United States are healthier compared with the native-born population. Drawing on the National Health Interview Survey (NHIS) data of 1989 and 1990, Stephen, Foote, Hendershot, and Schoenborn (1994) reported that, overall, foreign-born residents had better health than the U.S.-born population, although this health advantage varied by length of residence in the United States. They found that the most recent immigrants were healthier than foreign-born persons who have lived in the United States 10 years or more as well as healthier than the U.S.-born population. Immigrants who had lived in the United States 10 years or longer were generally healthier than U.S.-born adults, although the differences were not as striking as between recent immigrants and the native-born population.

Another study conducted by Frisbie, Cho, and Hummer (2001), using the NHIS data pooled for 1992 to 1995 reached similar conclusions. They focused on Asian and Pacific Islander respondents aged 25 years or older, which yielded a sample of 8,249. After adjusting for age, marital status, living arrangement, family size, and other socioeconomic indicators, the researchers found that immigrants were in better health than their U.S.-born counterparts, but their health advantages consistently decreased with duration of residence. The study also reported that the health of certain subgroups, particularly Pacific Islanders and Vietnamese, were less favorable than average. Finally, the researchers after adjusting for health status found that immigrants have less adequate access to formal medical care.

Contrary to the studies above, the literature on health insurance implicitly suggests that immigrants in the United States may be in poorer health compared with

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native-born, if adequate access to formal medical care is used as a yardstick for assessing health status. Carrasquillo, Carrasquillo, and Shea (2000) examined health insurance coverage among immigrants from 16 countries using data from the 1998 Current Population Survey. They found that only about 50 percent of immigrant full-time workers had employer-sponsored coverage, compared with 81 percent of American full-time workers. Overall, 44 percent of immigrants who are not U.S. citizens were found to be uninsured. Thamer, Richard, Casebeer, and Ray (1997) also examined the health insurance status of the U.S. foreign-born population drawing on data from the 1989 and 1990 National Health Interview Surveys. They reported that immigrants were twice as likely as native-born people to be uninsured (26 percent versus 13 percent), those who had lived in the United States for less than 15 years were found to be 1.5 to 4.7 times more likely to be uninsured than were U.S.-born Caucasians.

The low income status of many immigrants means they would be less able to afford private health insurance. Any adverse health condition experienced by immigrants, particularly illegal immigrants, is likely to be exacerbated by their work condition and extremely limited access to public assistance. Many immigrants work at jobs without paid sick leave or holidays. It is likely that those who cannot afford to miss a paycheck may continue to work, even when they are sick, until it becomes physically impossible to do so. Moreover, the federal Personal Responsibility and Work Opportunity Reconciliation (PRWOR) Act of 1996 excludes immigrants, even some who are legal but are yet to become naturalized citizens from receiving certain types of public assistance. Immigrants who are struggling financially may postpone routine physician and other medical assistance until it becomes an emergency situation.

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We can assume that Ghanaian immigrants, particularly low-income earners, illegal immigrants, part-time workers, and full-time workers without employer-sponsored insurance will have limited access to health services. These groups are, at certain points, more likely to suffer health conditions that may limit their ability to participate "fully" in the labor market or their ability to provide care to their elderly relatives in Ghana.

Theoretical Perspectives on Migration

In any given year thousands of middle-aged and young adults move from low income-countries to high-income countries. Many leave behind elderly parents and relatives who need some sort of care. In this section I discuss two theoretically based models proposed to explain migration – the neoclassical economic model and *the new economics of labor migration* model (NELM).

According to the theory undergirding the neoclassical economic model, migration is considered as a sum of individual cost-benefit decisions initiated to maximize expected personal income (Massey, Arango, Hugo, Kouaouci, Pellegrino, & Taylor, 1993, 1994). The literature on this model falls along two main lines of thought – macroeconomic and microeconomic. Macroeconomic theorists posit that international migration occurs because of geographic differences in wages, although the decision to migrate is based on the perception of "expected" employment and income rather than actual wage rates (Todaro, 1989). They argue that the income people expect to receive in developing countries is low, while they expect to receive high-incomes in the developed countries. The resulting differential in wages induces people from the developing countries in search of higher wages to emigrant to the developed countries.

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On the other hand, microeconomic theorists focus on individual characteristics that increase people's chances of receiving higher remuneration or the probability of being hired at a new destination. They view migration as a form of human capital, assuming that individual rational actors seeking to maximize their returns will migrate when the benefits of migration outweigh the costs (Sjaastad as cited in Massey et al., 1994; Todaro, 1989). In this cost-benefit analysis, benefit refers to potential higher income at the new place of destination, and cost refers to traveling expenses, and "emotional costs" such as moving into an unfamiliar environment and leaving family and friends behind.

Unlike neoclassical economic models, the theory supporting NELM posits that migration decisions are not made by isolated individuals, but by larger units of related people, mainly families or households, who act collectively to maximize expected income and to minimize risks associated with a variety of market failures, associated with developing economies (Lauby & Stark, 1988; Stark, 1991; Stark, & Bloom, 1985; Taylor, 1999). Proponents of this model argue that, in parts of the world where private insurance and public assistance for managing economic and income risks are either inadequate or unavailable, families make "conscious" efforts to minimize their risks by sending some of their members to work in high-income areas. In the event of adverse conditions in the local economy, the families can rely on migrants' remittances for support.

The neoclassical model (i.e., individual decision to migrate) and NELM model (i.e., family's decision to migrate) are arguably compatible. It is possible, for example, that an immigrant may act individually to maximize his or her personal income while his or her family acts as a unit to minimize its economic and income risks. What is important

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to recognize is that the cultural and socioeconomic context within which these migration decisions are made, in extended family-oriented societies like Ghana, are guided by cultural norms and values that consider filial responsibility to be a societal expectation.

Both neoclassical economic and NELM suggest that the main reason people emigrate from low-income country to high-income countries is economic. While the idea to emigrate may come from an individual, the process of emigration is, in a sense, a family survival strategy to accumulate savings in the form of remittances. As a family venture, migration may be planned and supported both financially and instrumentally by an entire family. Family members who have "marketable" skills such as higher education and skills, work experience, and language skills, and who have the potential to secure jobs are likely to be encouraged and supported financially and instrumentally by their families to migrate to high-income countries. Since the immigrants' trips are "paid for" by their families, they become indebted to and repay their "debt" by staying in touch with their original family units and sending them remittances.

Theoretical Perspectives on Elder Caregiving

Millions of young and middle-aged people around the world take care of their older adult relatives. In this section I review two theoretical approaches to understanding caregiving for older adults – (1) *"ethical existence and generativity"* concept and (2) social exchange theory.

Concept of Ethical Existence and Generativity

In Ghanaian societies, all aspects of life are underlined by a concept Ephirim-Donkor (1997) refers to as *ethical existence and generativity*, a dual concept encompassing the view that individual existence determines essence, that individuals

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have freedom of choice but that there are religious, social, and economic consequences for a moral and ethical way of life. Within this context eldercare is considered for how it develops and is undertaken by family members, for the rewards, difficulties and dilemmas that arise in caring for older people, and for an understanding of the [societal] ethic implicit in family caregiving and relationships (Smith-Battle, 1996). This practical approach to ethics is different from rational ethical theory which is based exclusively on reasoning from principles, and relies instead on exploring and uncovering the ethic embodied in specific traditions and practices (Benner, 1994; Bernstein, 1992).

The core of ethical existence and generativity is "obedience and respect for elders and authority" (Ephirim-Donkor, 1997, p. 92). Ethical existence and generativity requires individual adults to live morally and ethically, and to be concerned about both physical and existential issues that may bring shame unto oneself or one's family and/or prevent one from becoming an ancestor. It is important to state that, according to traditional Ghanaian eschatology, the ultimate goal of human existence is to become an ancestor worthy of emulation and invocation (Ephirim-Donkor, 1997).

Ethical existence and generativity is conceptualized as a continuum with a *beginning* and an *end,* with the former "corresponding" to *young adulthood* through *middle-aged* and the latter to *old-age*. However, these periods are arbitrary and do not necessarily coincide with chronological ages. With regard to family care, in the *beginning phase* young adults and middle-aged people are obliged to adhere to certain key ethical behaviors such as respect for elders. Respect is viewed as showing concern for the welfare of older adult relatives and being aware of the caregiving customs and practices that preserve the dignity of care recipients. In Ghanaian society giving money, assisting

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with housework and chores, providing decent housing, and organizing proper funerals for parents (van der Geest, 1997, 1998, 2002a) are ways of showing respect to older adults. In addition to these instrumental eldercare activities, children and young adults are expected to actively listen to what their elders have to say, follow their advice, comfort them in stressful situations, and show deference to older people. And, for young adults who have moved away from where their elders live, they are required to stay in touch, and to return to visit them, particularly in emergency and other stressful situations and on celebratory occasions.

To prepare young adults for a "good end," they are trained to revere and respect older people, and to view eldercare as a cardinal traditional ethic. The end is used here to refer to the "end of physical existence on earth," but also to mean physical frailty – a period in life when one is unable to do things for oneself and is dependent on others for support. In the *end phase*, older adults reflect as to whether or not they have lived ethically and morally. In other words, they ponder whether or not they have lived their lives according to societal norms. The reflectivity of this period is spurred largely by the imminence of death, which is followed by accountability of one's past actions before God and one's ancestors (Ephirim-Donkor, 1997). The spiritual consequence of unethical living is denial into ancestorship, while the secular ramification is neglect in old age.

If this concept is applied in the context of eldercare, one can argue that attitudes of today's youth and middle-aged persons toward eldercare is shaped by socialization in culturally appropriate behaviors of elder caregiving and consequences of elder neglect. Those who are concerned about "saving their soul" after their death and want their names invoked are likely to fulfill their eldercare obligations. Also, to have provided care to

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one's parents or other family members when they were old serves as a moral basis for receipt of similar family care on reaching old age oneself (Hashimoto, & Kendig, 1992). Thus, the prospect of future eldercare is dependent on eldercare services one provided in the past. Furthermore, since eldercare is prescribed as a moral and ethical duty, those who do not fulfill these duties as expected may be shamed or feel guilty. Thus, providing eldercare gives caregivers an opportunity to show their respect and gain respect from members of their family and society. In addition, those who provide good care to their older adult relatives do not only secure their status on the earth and in the afterworld, but are rewarded with good care by their younger generations.

Social Exchange Theory

A number of perspectives have emerged over the years to explain exchanges within social relationships; however, theorists agree that social exchange involves a series of interdependent interactions that generate social bonds of obligations (Blau as cited in Cropanzano & Mitchell, 2005). Social exchange relationships are governed by values and norms, which are embedded within the culturally prescribed role expectations that arise from the broader social context within which relationships exist. These values and norms hold the social partners together, allowing for exchanges to occur at different periods of time without the use of a contract or other explicit indication of expectations.

The fundamental norm underlying social exchanges is reciprocity (DePaulo, & Fisher, 1980; Keith, & Schafer, 1985; Malinowski, 1999; Rook, 1987). Proponents of reciprocity argue that people feel obligated to help others who have helped them. Thus, reciprocity has to do with fairness of exchanges and when and how resources should be repaid. In most societies, raising children earlier in life serves as a foundation for

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receiving assistance from them in old age (Apt, 1993; Hashimoto, & Kendig, 1992). By receiving child rearing services from their parents, children incur an obligation to return the favor by providing eldercare services. Arguing in favor of parental obligation on the part of adult children, Narveson (as cited in Li, 1997) contended that "parents do put themselves to much trouble to benefit their children, and if the children in question agree that the effect of those efforts really have been beneficial, then they should see to it that they are benefited in turn to at least the degree that renders it non-irrational for the parents to have done this" (p. 214).

But the provision and receipt of care can be mutual throughout the life course. Many older adults continue to provide various forms of assistance such as financial support, and childcare to their adult children, and in return, they receive assistance from these adult children when necessary. Because of the "give and take" nature of reciprocity, some researchers view it as a *quid pro quo* phenomenon, where negative behavior is returned for negative behavior and positive behavior returned for positive behavior (Cropanzano & Mitchell, 2005).

When applying social exchange theory to eldercare, the focus is on the costs incurred or to be incurred, and rewards received or to be received by caregivers and care recipients. It is assumed that a "normal" adult child "keeps track" or recognizes the hardships parents endure and the sacrifice they make to raise their children. This person "owes" his or her parents a favor for providing for his or her needs in the past or supporting him or her at present. The adult child is under a moral obligation to reciprocate the parents' favor he or she received or is receiving when the parents are old and are in need of support. It implies that caregiving is not susceptible to "free-riding"

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because a parent must take care of his or her children in order to receive eldercare from them. Thus, children who were neglected by their parents may not provide eldercare services to those parents in their old age.

The timing of reciprocity can vary on a continuum from the immediate to the distant future (Sabatelli, & Shehan, 1993). Reciprocity in a form of elder caregiving falls in the future, and the level of "payback" in the form of eldercare activities may follow a continuum from partial care to complete dependence. An eldercare relationship is predicated on the needs of an older person and the fulfillment of those needs by a caregiver. If an older person is "fit" to a degree that help is not required for him or her to "survive," there will be no need for caregiving. The type and level of eldercare provided depend on the health, physical, and financial capacities of the older person. As the older person's capacities decrease, the level of eldercare increases until the older person reaches a point where he or she may become completely dependent on the caregiver.

Conclusion

Studies to date of Ghanaians who have immigrated to the United States indicate that both economic and emotional support do continue to be provided to non-migrant families in Ghana. In these studies support in the form of remittances to elderly relatives is subsumed under what is provided to "family relatives." Thus, exchanged relationships between immigrants and their older relatives, particularly those who may be frail and vulnerable, have not been the focus of current research. This study will focus on determinants of long-distance eldercare for aging relatives in Ghana.

In addition to the theoretical perspectives just presented, it is necessary to examine what is known about long-distance caregiving and elder care. Eldercare

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dynamics are underlined by cultural norms and values that shape attitudes towards older people, and which in turn influence eldercare patterns. The “forces” that engender eldercare may take many forms, and may include a combination of the following: feelings of obligation, reciprocity, and threats of social disapproval and/or spiritual damnation. In Chapter 2 the pertinent literature on elder caregiving will be explored, along with what is known specifically about older adult Ghanaians and their needs. Following Chapter 2, potential determinants of long-distance caregiving by Ghanaian immigrants will be placed within a conceptual framework that guides the reported study.

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CHAPTER 2

Review of the Literature

Family care from a distance is a fact of life for millions of people around the world. Long-distance caregiving is complex and challenging. In this chapter, a review of eldercare and long-distance caregiving literature is provided as background for the reported study. I discuss long-distance care by Ghanaian immigrants, and then consider motivational, structural and demographic factors that influence the provision of care to older adult parents by adult children. In this chapter there is a focus on old age vulnerabilities with particular reference to Ghana, in order to identify the groups of older adult Ghanaians who are likely to be susceptible to lack of care due to emigration of younger members in their families.

Caregiving and Long-Distance Caregivers

Elder care and caregiving are both used in the literature to describe a wide range of institutional and home-based services provided to older people who are unable to take care of themselves. Eldercare can be classified into two types: formal, i.e., care provided by professional caregivers, and informal, i.e., care provided by family and kin. Five broad types of eldercare activities are described in the literature: (1) Activities of Daily Living (ADLs), (2) Instrumental Activities of Daily Living (IADLs), (3) financial assistance, (4) supervisory care, and (5) medical care (Liu & Kendig, 2000). In most societies, eldercare is provided by family relatives, particularly adult children; a responsibility embedded in societal norms of family care. However, in western countries, formal care may be an option for families who are able to pay or qualify under public assistance.

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In today's mobile and global world, it has become fairly common for adult children to move away from home to establish their own families and pursue career opportunities. As a result of these movements, a number of adult children who have eldercare obligations live hundreds, if not thousands, of miles away from elderly relatives for whom they are caring, with an increasing number of them living across international boundaries. Conservative estimates indicate that around 200 million people migrate annually (Harris as cited in Orozco, 2003) with many of them moving from different parts of the developing world or low-income regions (including Africa, Asia, the Caribbean, Eastern Europe, Latin America, and the Middle East) to the industrialized and high-income regions and countries such as the United States, Canada, Australia, the European Union, Japan, the Persian Gulf, and East and Southeast Asia (Martin, 2001). Despite the physical distance, adult children who migrate are still expected to remain in contact with their family elders and to see to their welfare.

A review of the migration, remittance, and family care literature show that immigrants do not “forget” their family members they left behind. They keep in touch with them through visits, phone calls, and other means of telecommunications, and also transfer financial and material resources to them. The geographical distance requires that long-distance caregivers rely on social and family support networks in close proximity with their care recipients to provide many care activities. Long-distance caregivers may be classified into two types: primary and secondary caregivers. Primary caregivers make or are consulted on all major caregiving decisions. They have “regular” contacts with the secondary caregivers, coordinate all caregiving activities and monitor the welfare of the

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care recipient. On the other hand, secondary long-distance caregivers assist other caregivers; their role may be limited to certain types of caregiving activities.

An American study conducted by the National Alliance for Caregiving with Zogby International (2004) reported that only a quarter of long-distance caregivers reported that they were the only or primary caregiver. The study in which 1,130 long-distance caregivers were surveyed online found that nearly one third of long-distance caregivers were helped by a sibling who lived near the care recipient, 13 percent by other relatives other than siblings, 20 percent by a spouse, 12 percent by the care recipient's spouse, four percent by friends, and another four percent reported paying someone to provide care. The study's other results showed that some long-distance caregivers played secondary caregiver roles; half of the respondents provided eldercare as a helper to other caregivers, five percent were the only helper, 18 percent were the main helper, and 23 percent shared caregiving duties equally with another caregiver. In developing countries where informal eldercare structures are limited or non-existent or "outside" caregivers are stigmatized (van der Geest, 2002a), close and extended family members would be the preferred social support network.

Studies about Caregiving by Immigrants from Other Countries

Motivation for Long-Distance Caregiving

There is ample evidence to suggest that adult children who have migrated continue to provide care to their older adult parents, although there are factors that may limit the extent to which these adult children are willing or able to provide care to their parents. Understanding what motivates immigrants to provide care to their family of origin and how much care they are willing to provide is important in explaining the levels

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of welfare provided for non-migrant older adult family members. In this section, I review some of these motives for provision of eldercare among immigrants from developing countries.

Various arguments have been advanced in the literature to explain the motivations of adult children who migrate to support their relatives in their home country. One of the arguments is that adult children provide care to insure their elderly parents against old-age insecurity. Proponents of the old-age insurance argument focuses on the difficulties people in developing countries face in finding a reliable outlet for saving for old-age. In these countries financial institutions are less developed, property rights are insecure, currencies are subject to inflation, and government social security schemes, private pensions, and health insurance are inadequate or nonexistent (Lillard and Willis, 1997). Adult children fulfill an old-age insurance function through the transfer of goods and financial resources to their parents and by assisting with everyday and other household tasks that parents are unable to perform.

Several researchers have studied this old-age security hypothesis. For example, Frankenberg, Lillard, and Willis (2002) investigated transfers between parents and their adult children using the Indonesia Family Life Survey data, based on information on 7,224 households. Their results demonstrate that transfers are systematically related to the needs of the receiver and to the resources of the giver in ways that suggest that families use transfers to help one another out in times of need. They found that parents are more likely to receive transfers from their adult children when their income is limited, but the likelihood of them receiving transfers declines when their income rises. This raises the question of fulfillment of these old-age insurance expectations by adult children,

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especially those who have migrated and are out of the reach of traditional norms and values that compel eldercare.

Studies of dynamics of family caregiving in developing countries suggest that adult children, irrespective of their geographic location, support their elderly parents because they feel obligated to them. Parental obligations are values and norms which "emerge from societal expectations that older parents have a 'right' to be taken care of and adult children have a 'duty' to do so" (Stein, & Wemmerus, 1998, p. 613). Writing on the motivation of adult children to assume this duty, Blenkner (as cited in Gans, & Silverstein, 2006) invoked the concept of filial maturity to describe adult children's transition from being relatively autonomous from their parents to being dependable sources of support to them. She posits that the transition involves a change in perspective that allows adult children to view their parents as vulnerable individuals, which then strengthens their commitment to provide care for them. Other researchers have looked at parental obligations within the context of the Confucian ethic of filial piety, which requires children to recognize the care and support received from their parents, and in turn, respect and reciprocate the care for their aging parents. The literature on filial piety identifies two types of filial behaviors that are relevant to eldercare – first, supporting of one's parents, including financial and physical support, and second, honoring, revering, and obeying one's parents (Gallois, 1998; Gallois, Giles, Ota, Pierson, Ng., Lim, et al., 1999; Sung, 1995; 1996). Extended family-focused societies who emphasize family care for older adult members instill filial obligation and elder respect in their members beginning in early childhood through young adulthood. Immigrants from such societies carry these family care values with them to their new destinations.

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The findings of a study conducted by Liu, Ng, Weatherall, & Loong (2000) among Chinese immigrant families in New Zealand revealed that immigrants carry their view of filial obligations to their destination countries. Liu and his colleagues surveyed 286 Chinese immigrants who were randomly selected from among two generations, young (10-25 years old; N=136) and middle-aged (35-55 years old; N=150), to find out their attitudes toward filial piety. Their results showed a strong acceptance of filial obligation among their participants with "younger generation rating [filial] expectations on them higher than the middle-aged" (p. 213). They also found that social identifications as a New Zealander and as a Chinese were positive predictors of filial piety obligations and expectations. Base on this finding the researchers argued that "aspects of New Zealand identity augment or add to aspects of Chinese identity (and vice versa) so that each contributes independently to maintaining a positive, respectful, and supportive attitude toward elderly family members" (p. 221). This is consistent with Ramirez's (as cited in Freeberg, & Stein, 1996) assertion that immigrant families do not necessarily "replace" their values, beliefs, and life-style of their original culture, but rather maintain aspects of their original culture while accommodating attitudes and practices of the host culture. This suggests that immigrants from developing countries or extended family-focused societies who believe in filial responsibilities will continue to support their older family members they left behind.

It is important to note that traditional family norms and values in which eldercare is embedded have been undergoing tremendous changes over the years due to decades of education, migration, urbanization, and other socioeconomic changes (Aboderin, 2004a). Recently, Sung (2001) reviewed the literature on "elder respect," (a term which in most

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traditional societies embodies eldercare) with particular reference to some East Asian cultures. He found that, in response to social changes, there have been modifications in the ways elders are respected; there has been a shift from authoritarian and patriarchal relationships to egalitarian and reciprocal patterns of mutual respect between the generations. Despite these modifications, it was noted that most adult children continued to respect or support elderly members of their families (Beate, Trommsdorff, Kim, & Park, 2006; Ng, Loong, Liu, & Weatherall, 2000; Sung, 1995; 1996).

A second argument advanced to explain motivations for providing eldercare is an implicit "contractual arrangement" between adult children and their parents. The argument is that adult children provide eldercare services as repayment or exchange for support received by the caregiver from the care recipient. In this contractual arrangement, parents invest in their children's future by supporting, for example, their education, training, cost of migration, and other ventures that will command higher returns to the adult child. In return, the adult children gives a portion of their future "earnings" and "free time" to their parents as a repayment for the parent's investments (Hoddinott, 1994; Poirine, 1997).

A study by Lillard, and Willis (1997), in which they used data from the Malaysian Family Life Survey, supported the education repayment motive. Their analysis was based on 1,433 households (couples) in which both sets of parents were alive, and 2,360 households in which at least one of either the husband's or the wife's parents was alive. They found that, as the educational attainment of the non-co-resident children increased, the probability of transfer receipt was significantly enhanced. For example the effect of having an additional son on the probit index for receiving a transfer is 0.08 if the son had

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only an elementary school education, 0.23 if he had a high school degree, and 0.34 if he had some college education. The effects of having an additional daughter were equally positive if she had an elementary or high school education, but there was no marginal increase if she had gone to college. An earlier study by Lucas and Stark (1985) using information from a Botswana National Household Survey of migration also supported the education repayment motive. They examined remittance patterns of Botswana migrants during seasonal drought and found evidence to suggest that for families who were facing drought, the family's own migrant members who had more education increased their remittances compared to those with less education.

However, Brown's (1997) study among Tongans and Samoans in Australia was not supportive of the educational repayment argument. He surveyed 982 households of Tongan- and Samoan-born immigrants residing in Australia. His results showed that the level of educational attainment before migrating was not associated with any differences in immigrants' remittance behavior. He found no evidence that in situations where parents have invested more in a migrant's education that it induced a higher than otherwise level of remittances, after taking level of income and other related variables into account. However, he found evidence that financial obligation, or indebtedness, to the home community is importance among Western Samoans. His results indicated that having received financial assistance from relatives at home to emigrate positively affected an immigrant's subsequent remittance behavior.

A third motive for provision of family care, and for that matter eldercare, is that immigrants keep in touch with their family of origin and provide their needs in order to secure their membership rights within their families and to maintain the option to return

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to their community of origin with dignity. Membership rights in most societies are based on descent and kinship ties, but they are strengthened by adherence to norms and values of the society. Provision of eldercare attests to the immigrant's motive to, despite the distance, remain a member of his or her family and community of origin, and to secure his or her privileges, such as inheritance due him or her as a family member.

Studies conducted by Hoddinott (1994), de la Briere, Sadoulet, de Janvry, and Lambert (2002), and Regmi, and Tisdell (2002) have supported this argument. Hoddinott (1994) examined migration from Kenya and found evidence to suggest that the level of remittances was influenced by parents' ability to reward a migrant child's good behavior (i.e., parental support) through the promise of inheritance of land, especially if there was more than one migrant from the same family. He surveyed 216 migrants and 89 non-migrants. Hoddinott argued that as the number of migrants from the same household grew, each individual migrant faced greater competition from his siblings, since land can be passed on to any migrant. He found that parents who could credibly threaten migrant children with disinheritance of land captured a greater share of the benefits of migration, and that, wealthier parents who could offer a greater reward for remittances were better placed to extract a greater share of the migration benefits.

In another study, de la Briere et al. (2002) tested two-non exclusive hypothesis about what motives resulted in remittances being sent by Dominican migrants to their parents in the Sierra region in the Dominican Republic: (1) an insurance contract taken by parents with their migrant children, and (2) an investment by migrants in potential inheritances. The authors interviewed 379 individuals who were randomly selected from among 20 randomly selected communities. The results showed that the relative

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importance of the two motives to remit was affected by destination (whether the migrants lived in the United States versus cities in the Dominican Republic), gender, and household composition. De la Briere et al. (2002) concluded that the insurance function was mainly fulfilled by female migrants to the United States, and only when a male was the sole migrant in his household did he play the role of insurer. Providing financial support for the purpose of future inheritances, by contrast, was found to be pursued by both males and females, but only migrants in the United States.

As the above literature shows, migrants have different motives for providing eldercare. While each motive for eldercare provision is likely to be at work to some extent, and most studies tend to focus on individual motives, there is reason to argue that they complement each other. This is supported by an earlier study by Lucas and Stark (1985). After comparing two motives for remittances: altruistic and contractual arrangements, they argued that these two motives complemented one another, in that, contractual arrangement were indeed self-enforcing due to mutual altruism. This argument was backed by Chami and Fisher (1996) who showed that altruism could lead to contractual arrangements that were self-enforcing.

Notwithstanding adult children's motivation to care for their elderly parents, the ability of an immigrant to provide for the needs of his or her elderly parents back home is limited by the physical separation. In fact, certain eldercare activities such as personal care, health care, housework, and transportation require physical presence and can be provided only by people who live with or near the older person needing those services. Consequently, long-distance caregivers are restricted (unless when they visit the care recipient) to financial and emotional support which may be provided from a distance.

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Financial Support or Remittances and Their Determinants

Migrants from developing countries can often earn more by migrating to work in developed countries. Consequently, migration often generates flows of financial resources or remittances from migrants in developed countries to their family of origin in developing countries. Remittances are generally defined as the part of migrants' income that is sent to the migrants' place of origin. Although remittances can also be sent in-kind, the term "remittances" usually refers to cash transfers. Remittances are important source of support for non-migrant family members in developing countries as shown by the increases in the size of remittances over the years. The World Bank data cited by Addison (2004, p. 5) show that the total global remittance flow increased from US$ 51.1 billion in 1995 to about US$ 77 billion in 2001. The literature indicates that a large part of remittances are used for household expenses such as food, and clothing, and health care. Remittances are also spent on housing and investments. The size and frequency of total remittance flows is determined by several demographic and structural factors. In this section immigrant-specific factors known to affect the level of care provided by immigrants are examined, along with factors specific to non-migrant older adult family members that affect the level of remittances.

Gender and Remittance

The family care literature suggests that women are expected to fulfill caregiving obligations, or are more inclined than men to attach more significance to family care (Chant & Radcliffe, 1992), and generally report higher levels of felt obligation and caregiving to parents (Stein, 1992). The essential issue is whether men and women provide eldercare differently from a distance. The literature, thus far, is mixed. Using

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survey data from the Bangkok Metropolitan Area, Phongpaichit (1993) found that a higher proportion of female migrants, although they had lower income levels, sent more remittances, and did so more frequently than male migrants. She attributed this to the fact that more female migrants were single and tended to have stronger ties with their families of origin than the men. Using data from two nation-wide random sample surveys in the Philippines, Lauby and Stark (1988) found that within rural Filipino households, younger women members were preferred migrants because they were more likely to send remittance to their household of origin. De la Briere et al. (2002) argued that women migrants tended to maintain more regular contacts, e.g., they visit home more often than men.

Contrary to the above findings, the literature on remittance, on the whole, shows that men migrants remit more than women migrants. Semyonov and Gorodzeisky (2005) examined gender differences in patterns of labor market activity, economic behavior and economic outcomes among labor migrants by surveying 1,128 household and children of overseas workers from the Philippines. Their analysis revealed that men send more money back home than did women, even when taking into consideration earnings differentials between the genders. Their findings further revealed that the earnings of women migrants were, on average, lower than those of men, even after controlling for variations in occupational distributions, country of destination, and social and demographic attributes. This may explain why migrant women remitted lesser amounts as compared to their male counterparts. Agarwal, & Horowitz (2002), although they did not set out to look at difference in gender remittance, found that men migrants remitted higher amounts than women.

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In another study, Vanwey (2004) examined the propensity of male and female immigrants to provide financial assistance to families of origin using data from Thailand. For her analysis she surveyed 51 villages, collecting information on household members who had moved out of the village two months or more prior to the survey. She found that women responded more strongly to the needs of their household of birth, however, they were much less likely to provide financial support when they married. She argued the reasons for the gender difference were that women relative to men tended to be less likely to be employed, or earned less, or had fewer ties to their home country after migration.

Length of Time Spent Abroad and Remittance

The level of eldercare an immigrant provides may also be affected by his or her age, and years spent abroad. In terms of absolute age, younger immigrants may have moved recently compared to older immigrants and might be less settled in at their new destinations. These younger migrants may be struggling financially to get a “foothold” in their new place, and as a result, might not be in a position to remit. Rodriquez’s (1996) work on migrants from the Philippines showed that age and time spent abroad had a positive influence on the probability of remitting. Drawing on data from a national survey of Filipinos working overseas, he revealed that compared to the non-remitters, the migrants who sent money home were on average older. His results indicated that the older the migrants and the longer their stay abroad, the more likely they were to remit, although this incidence eventually decreased for long absences or older migrants.

Funkhouser’s (1995) study of El Salvadoran migrants in the United States is supportive of the association between long stay overseas and higher remittances. Using national survey data that had information on 1,112 emigrants, he found that family

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members who had been in the United States longer tended to be more likely to remit and to remit more than recent arrivals. He argued that the relationship between the level of remittances and the amount of time in the United States reflected how the emigrant valued the relative importance of his or her personal needs versus that of remaining household members over time. He showed that the remittance attachment of non-family members decreased with time out of El Salvador, while that of family members increased. Unlike Rodriquez's (1996) study, Funkhouser (1995) reported that neither sex nor age was significantly correlated to either the probability or level of remittances.

Intent to Return and Remittance

Another factor that may affect the level of transfer between migrants and family of origin is whether the migrant intends to return. For instance, if immigrants decide to remain permanently in a host country, they may have different savings behaviors and different interactional patterns with their families of origin, both in terms of frequency and intensity. However, if they plan to return home, these savings patterns may look different. Brown's (1997) study (cited earlier) among Tongans and Samoans in Australia reported that migrants who intend to return home have a significantly higher propensity and level of remittance than those who do not. Brown indicated that the prospect of return-migration is associated with a higher than otherwise transfer of remittances, although he noticed differences between the Tongan and the Western Samoan communities. With the Tongan community it was only migrants who were 55 years and older whose remittance behavior was positively related to the intention of returning, while Western Samoan community migrants in that age category remitted less than others intending to return.

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Level of Income and Remittance

While the literature reports mixed results on most of the factors that influence the level of remittances, the level of income of the migrant or its proxy, employment has consistently been reported as having a positive effect on the level of financial support provided by immigrants (Elbadawi, & Rocha, 1992; Lucas, & Stark, 1985). As expected, the effect of the migrant's income on the level of financial support will be positive. Higher income levels should increase the immigrant's ability to provide financial support while the opposite is true for immigrants who are unemployed. An immigrant who is unemployed partly or wholly should have reduced income. Increased unemployment may, at least, in the short term, create uncertainties for the immigrant's immediate future and thus reduce financial support.

Lianos (1997) conducted a time series study by examining the flow of migrant remittances from three European countries to Greece using diverse sources of data which covered a period of 30 years. He reported that migrant income in the country of destination had statistically significant effects on the volume of remittances Greeks in the three countries sent back home. His analysis revealed that the elasticity of remittances with respect to income, measured by per capita income or by the wage rate, was greater than one (1.40 and 1.61, respectively), which indicated a high propensity among the Greek immigrants to save and remit. Funkhouser's (1995) study among Salvadorans and Nicaraguans emigrants showed that immigrants who were working were significantly more likely to remit and to remit more.

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Situation of the Older Person and Remittance

Aside from immigrant-specific factors, several demographic and structural factors relating to the older adult person may also affect the level of remittances. One such factor is the economic situation of the older person. It has been argued that the propensity of receiving remittances is associated with the recipient's risk of economic deprivation. The Lucas and Stark (1985) study (cited earlier) reported that families in Botswana who were at risk of losing cattle received greater remittances during time of drought. They observed that the more severe the drought in the family's home area, the more remittances migrant family members sent. Thus, the remittances were sent not only to shield parents from income loss but also to protect their parents' drought sensitive assets – cattle.

Ratha (2003) corroborates the point that migrants may remit in times of economic hardship, especially in low-income countries where families live at subsistence levels, and may depend significantly on remittances as a source of income. Drawing on aggregated data of remittances received in developing countries in the 1980s, 1990s and 2000, he reported that remittances (for household consumption) were less volatile, and even grew in response to bad economic situations in recipient countries. He found, for example, that remittances to developing countries continued to rise steadily, especially during 1998-2001, a period characterized by a decline in private capital flows in the wake of the Asian financial crisis. In this case, it may mean that migrants remitted to augment recipients' incomes in order to offset some of the economic shocks that families in recipient countries were suffering.

Aside from economic factors, other factors that influence the receipt of remittances by older non-migrant family members include the health status of the recipient. In a

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study conducted in Peru, Cox, Ezer and Jimenez (1998) tested for what motivates private transfers using the Peruvian Living Standard Survey which gathered information from 27,000 respondents. Their results indicated that private transfers were targeted to the unemployed and those stricken with illness. They found that being unemployed raised the probability of transfer receipts by over 13 percentage point while illness raised the probability by over five percentage point. Another result of this study was that a disproportionate share of the child-parent transfers went to female-headed households. In fact, being headed by a female increased a household probability of receiving a transfer by nearly 10 percentage point.

Petrova (2004) also found that health status mattered for transfer from adult children. Using the Mexican Health and Aging Study (MHAS) data set, a survey of a nationally representative sample of 15,000 respondents, Petrova found that for older family couples, single mothers, and grandparents, poverty and poor health elicited higher transfers from adult children. On the contrary, a single father's health status did not matter for transfers although his age did. Using the same MHAS data set, Wong, and Espinoza (2005) surmised that socio-demographic as well as economic factors and health shock were associated with the level of care received by older adult Mexicans from their adult children. They concluded that economic factors captured by income and wealth had important effects on the economic assistance older adults received, although it had no general effect on time-help. In contrast, health shocks elicited time-help from adult children. With regard to health shock, Wong, and Espinoza found functionality and self-reported health to be closely associated with transfer flows, but not so much the self-reports of chronic conditions.

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Age was found to be another influencing factor for receiving financial care. Using a data set from the Ethiopian Urban Socio-economic survey, Aredo (2005) found that the age of the household head was statistically significant with respect to the flows of international remittances implying the possibility that older households enjoyed more access to international remittances than the younger ones. He argued that older people compared to young families, have grown up household members who were capable of migrating to work overseas to send money back to their aging parents. Drawing on survey data from Indonesia, Frankenberg et al. (2002) reported that older couples were more likely to receive transfers from their adult children when the female was not working and when she was older. They further reported that adult children were more likely to transfer money to widowed mothers and to fathers in poor health, and the amount transferred rose when the mother's health was poor.

Types of Emotional Support and Their Determinants

Much of the literature on intergenerational interactions between older adults in developing countries and their relatives who have migrated are focused on issues relating to financial support. Emotional support, defined here to include expression of affection and advice, has not received much attention in the literature. This is perhaps, due to the "bread and butter" and everyday care issues older people in these countries face in the absence of their adult children, or the implicit assumption that there are many people around them to take care of their emotional needs, since they often live in large extended families. It is also more difficult to measure emotional support from a long-distance. But as other studies, mainly from the developed countries have shown, emotional support from distant adult children remain important in the eldercare context, and is, in fact,

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related to the other eldercare activities given to elderly people. Climo (1992) has noted that long-distance adult child-parent relationships are similar to residential relationships in emotional attachments, love and affection, obligations, and endurance over time. Bowlby (as cited in Climo, 1992) argued that the parent-child bond can maintain cohesion under conditions of limited face-to-face contact and is very resistant to the effects of geographical separation, socioeconomic mobility, and even developmental changes.

Climo (1992) characterized (from the perception of the caregiver) the feelings or emotional attachments within long-distance eldercare relationships as three "voices:" a displaced voice, a well-adapted voice, and an alienated voice. The displaced voice is not satisfied with distant living and expresses a desire to reunite with parents. The well-adapted voice accepts distant living as a normal result of occupational and educational mobility, maintaining close contact and strong affection without desiring to change the situation. The alienated voice is glad to live away from parents because relationships are unsatisfying, filled with unresolved conflicts from the past. He contends that the long-distance caregiver can have different voices or change from one voice to another as the stresses of divided loyalties increase or decrease, corresponding to life transitions and different stages in the distant-family cycle.

Since face-to-face contacts are unavailable in long-distance care, emotionally supportive relationships between immigrants and their non-migrant parents are maintained via patterns of contacts, mainly through letters, phone calls, and return visits. Return visits are periodic but temporary trips made by members of immigrant communities to their countries of origin or to another location where strong social ties

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exist (Duval, 2004). The most predominant means for emotional contact between immigrants and their non-migrant relatives is through phone calls (Baldock, 2000; Climo, 1992; Parker, Call, Dunkle, & Vaitkus, 2002). Distant telephone communications serve to reinforce bonds of affection, and provide immigrant caregivers the opportunity to receive "firsthand" information on the welfare of care recipients, and any other issues that may require their attention. Some of the issues distance children and their parents commonly talk about include family and related issues, recent personal events and travel, health, work, news events, plans for future family visits, financial issues, personal problems, politics, planning reunions with friends, and purchases (Climo, 1992).

The frequency of phone calls to distant relatives is influenced by several factors. Parker, et al. (2002) explored some of the variables that influenced parental contact among senior officers in the United States military who faced frequent moves, restricted housing, and overseas assignments and had been geographically separated from their parents. They collected data on 277 senior ranking male officers. Their results suggested that senior male officers were in contact with their parents almost weekly through telephone, mail, and email. But, they found that officers with more siblings tended to have less contact with their parents whereas those who had excellent relationships with parents were more likely to contact them, as were officers serving in ground forces. They rightly argued that when there are more people "watching out" for care recipients the care responsibility is diffused and the need for contact is reduced for each caregiver. Other factors that Parker et al. (2002) found to generate frequent contacts from adult children were parent's age, prior parental illness, and an underlying angry personality. These factors increased worry on the part of long-distance caregivers (Field, Minklet, Falk, &

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Leino, 1993) resulting in a high frequency of phone calls, in order to assure themselves that assistance and support were not needed (Baldock, 2000; Climo, 1992).

In another study, Climo (1992) found that the frequency of telephone calls in long-distance eldercare relationship was influenced by factors, including distance, parent's age, marital status, health status, and cost. Using an ethnographic method, he studied the relationships between 40 adult children (all of them professors in American universities) and their parents who lived 200 or more miles away. He found that as distance increased, the frequency of telephone conversations decreased: three quarters of his participants living closest (200 miles) spoke one or more times each week compared to only one quarter of those living more than 600 miles away. He surmised that when distance is very great, routine calling is so expensive that families may be limited to one call a month or even less. The study also found that as parents' age increased, the children's desire to call decreased, which is contrary to Parker et al. (2002) findings which show that old age led to increased phone calls from adult children. Furthermore, Climo's study reported that children with married mothers and fathers reported a greater desire to call than those with widowed parents, but this pattern is typically reversed during the year after the death of a parent; phone calls to recently widowed parents increased markedly. Climo (1992) like Parker et al. (2002) found that a parent's illness or disability and closeness between adult child and parents led to increased phone calls from adult children.

Another medium by which long-distance caregivers and their care recipients may exchange emotions is during return visits. According to Climo (1992), distant children and parents engaged in two kinds of visits: routine visits during vacations and holidays;

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and transition visits, which take place during health emergencies, and social-status changes such as birthdays, marriage, and funerals. Since most adult children work, most intergenerational visits occurred during their vacations and holidays.

Just like other eldercare activities, there are several factors that influence the frequency of return visits. In a qualitative study conducted by Baldock (2000), 12 college professors who migrated to Australia from the United Kingdom and North America were interviewed to examine the nature and effects of their contact with their parents in their home countries. She found a high frequency of return visits among her participants. She attributed the high return visits to the fact that her participants worked in a university context, where they took advantage of the long Christmas university break, and long service leave that allowed time for visits. She argued further that her participants probably "subsidized" their return visits by combining visits home with paid academic work, such as sabbaticals, conference, and research travels. The time and financial costs of international travel are high, and these limit the frequency of visits immigrants can make to their home countries, particularly for low-income and intercontinental immigrants. Return visits may be postponed until immigrants are older and financially better off (Baldassar, 1997)

In his study among professors in American universities, Climo (1992) identified factors such as time since the last visit, distance, parents' health status, responsibilities to other family members, work and retirement, children's age, and marital status as influencing factors for return visits. He reported that children who had not seen their parents in more than six months were more likely to say they were not satisfied with the frequency of visits and experienced positive emotions anticipating visits. On the whole,

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those who lived farther away visited less frequently and parents who were ill were visited frequently. Climo (1992) reported also that work obligations, an adult child's own parental responsibilities and travel costs limited children's ability to visit frequently. For many people, particularly, lower income families, finding time to leave work and saving money for childcare and travel hindered frequent visits. He reported that when children visited they stayed longer when they or their parents were ill; but as distance between the adult child and the parent increased, the frequency of visits decreased but visits lasted longer.

Some researchers have investigated the general disposition of adult child-parent relationships as well as the sources of variation in adult child-parent relationship quality. There appears to be a consensus among researchers that an overwhelming majority of adult children have close relationships with their parents. For instance, Lawton, Silverstein, and Bengtson (1994) investigated intergenerational relationships in the United States using a nationally representative study of 1,500 adults (18 and over) who reported at least one surviving non-coresident biological parent. Their results indicated that a large majority, approximately 80 percent of their respondents had "emotionally close" relationships with their parents, though the father-child relationship was somewhat less close than the mother-child relationship. They also found a pattern of weakened intergenerational solidarity among children whose parents were no longer married to each other, particularly among children with unmarried fathers.

Another American study conducted by Umberson (1992) that assessed both parents' and adult children's evaluation of relationship quality showed similar results. The data for her study were from a national probability sample of 3,618 people living in

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non-institutionalized housing. The study's descriptive results suggested fairly positive relationships between parents and children. When asked how much their children made them feel loved and cared for, 89 percent of parents reported that their children made them feel loved and cared for either a great deal or quite a bit. Also a high percent of parents and children reported that others were willing to listen to their problems and worries. The study revealed that the quality of intergenerational relationships was influenced by the structural circumstances of the parents and adult children, especially as defined by divorced status, gender and age.

Effects of Caregiving

A lot has been written about the outcomes of caregiving on caregivers. Some researchers have suggested that caregiving is a rewarding experience. One study suggested that caregivers experienced satisfaction in their role and the potential for personal fulfillment even when faced with challenging caregiving situations (Jensen, Ferrari, & Cavanaugh, 2004). However, a considerable proportion of the research on the outcome of eldercare is focused on the negative effects. These adverse effects are often discussed as caregiver burden, a multidimensional concept that includes the physical, psychological, emotional, social, and financial stressors associated with the caregiving experience (Gallant & Connell, 1997; Russo, Vitaliano, Brewer, Katon, & Becker, 1995; Schulz, O'Brien, Bookwala, & Fleissner, 1995; Song, Biegel, & Milligan, 1997).

The dynamics of the effects of eldercare on long-distance caregivers may differ from proximal elder caregivers. Unless they visit, long-distance caregivers may not experience burden associated with prolonged and physically-demanding ADL activities, such as lifting a care recipient , but they may suffer from stress and worry over the

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uncertainty about the actual and perceived health condition and physical needs of their elderly relative (Parker et al., 2002). The financial worry of immigrant caregivers from developing countries may be very intense, especially for those who care for elderly and younger family members. While long-distance caregivers may not provide regular eldercare activities, they may be "called back" to provide brief but intense ADL activities and IADL activities during health care crises and other emergencies. These short and direct caregiving "sessions" may have intra-psychic consequences for long-distance caregivers (Parker et al., 2002).

It has been reported that social support networks reduce the level of caregiver burden. Informal sources of support, such as family, neighbors, and friends, and formal sources, including paid care providers were found to reduce the degree of burden reported by caregivers, albeit at difference levels (Belle, Burgio, Burns, Coon, Czaja, Gallagher-Thompson, et al., 2006; Collins, Holt, Moore, & Bledsoe, 2003; Jivanjee, 1994; Ostwald, Hepburn, Caron, Burns, & Mantell, 1999).

Notwithstanding the likely burden of elder caregiving, the above review suggests that adult children who have migrated continue to keep in touch with their relatives back home, and maintain emotional attachment to their non-migrant relatives. Furthermore, immigrants from developing countries provide financial support to their relatives. Nonetheless, the level of relationships between immigrants and their non-migrant relatives are influenced by various economic, socio-cultural, structural and demographic factors that are related to both immigrants and non-migrants relatives. The following section focuses on the dynamics of long-distance care, with a focus on Ghanaian immigrants.

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Studies about Caregiving by Ghanaian Immigrants

It has been argued that when the extended family functioned as a productive unit and everyone lived in intergenerational households it insured each member throughout life (Asamoah & Nortey, 1987; Mba, 2004). Migration of the youth and middle-aged people from where their older adult relatives live has been seen to reduce the quantity of social interactions among family members, undermining the traditional norms and values that assure the care of older adult members of the extended family (United Nations, 1982, 1991). Despite these concerns, various studies have reported high levels of interactions (including financial, material, and personal) between Ghanaian migrants and their non-migrant relatives in Ghana.

For instance, Orozco et al. (2005) studied the extent to which Ghanaian immigrants maintain relationships with their home country by surveying Ghanaian immigrants in the United States, Germany, and the United Kingdom. They sampled 986 immigrant remitters, 842 of whom were Ghanaians. They also conducted 30 interviews with leaders of Ghanaian hometown associations in the United States. With regard to financial assistance to non-migrant family members, Orozco et al. (2005) reported that Ghanaian immigrants in the United States and the United Kingdom sent on average US$380 and US$225, respectively to their relatives in Ghana, while their counterparts in Germany sent US$510 yearly (p.10). Orozco et al. (2005) also examined the characteristics of the remitters and the recipients of financial support. Their results indicated that those who sent more than the average remittances were older, less educated, had higher incomes, and made regular phone contact with their relatives. The majority of the remitters were reported to be males. The major groups of recipients of

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remittances were parents who formed 40-46 percent of the total recipients, followed by spouses, 16-24 percent; children, 11-23; siblings, 3-12; other relatives, 2-8 percent; grandparents, 2-4; and friends, two percent or less (p. 12). It is important to state that this study is the only one so far that disaggregated the remittance receivers to show the proportion of older adult (grandparents) recipients.

Mazzucato, van den Boom, and Nsowah-Nuamah (2004) studied the dynamics of remittances drawing on data from the 1998/99 Ghana Living Standards Survey (GLSS) data gathered via a national representative sample. In addition to the GLSS data, the researchers conducted an in-depth survey of 30 networks of Ghanaian migrants based in The Netherlands, interviewing both immigrants and remittance recipients in Ghana. They reported that Ghanaian immigrants residing outside of Africa remitted an average of US$410 per year. This amount was more than that reported by Orozco et al. (2005) for Ghanaians in the United States and the United Kingdom but less than those in Germany. Mazzucato et al. (2004) found that most remitters were children and siblings of the household head comprising 38 percent and 23 percent of all remitters, respectively, with spouses of the household heads remitting the greatest, averaging US$ 474 over a 12 month period. Furthermore, the study found that 41 percent of all households in Ghana received at least one remittance a year, and for many of these households, remittances formed 20 percent of their total household incomes. Mazzucato et al. (2004) argued that since remittances from outside Africa were large, they most likely provided possibilities for recipients to “redistribute” portions to other family relatives.

Different micro and macro factors shape the tendency, frequency and magnitude of remittance and contacts between immigrant and non-migrant family members. Tiemoko

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(2004) surveyed 304 return immigrants from Ghana and 300 from Cote d'Ivoire identified through snowball sampling, and conducted 40 in-depth interviews. He found that immigrants were more likely to send remittances when family members influenced their initial decision to migrate. On average, family-influenced Ghanaian immigrants remitted significantly higher amounts per transfer than those whose decision to emigrant had been taken more independently of their family (p.12). Tiemoko (2004) also found that immigrants who maintained contact with their relatives while they are abroad were significantly more likely to remit, with the less-skilled family-influenced immigrants group having up to 2.5 times the chances of remitting compared with the non-family-influenced group.

In another study, Kabki et al. (2004) found three key factors that impacted the volume, and frequency of remittances sent home by Ghanaian immigrants. Their findings were based on 60 in-depth interviews with village leaders and families of Netherland-based Ghanaian immigrants in 25 Ashanti villages in Ghana. First, they found that the quality of the relationship between a migrant and a family member influenced the level of remittance. A cordial relationship was likely to generate some financial support and personal contacts. A second factor was closeness between the immigrant and the non-migrant relatives. Close family members of the immigrants, mostly parents, often received the bulk of remittances. The final influencing factor was the legal status of the immigrant in the destination country. Immigrants who did not have a legal status were hampered in their efforts in finding jobs, and thereby earning a regular income. This situation was likely to reduce the ability of affected immigrants to remit.

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Remittances were sent for multiple purposes with the highest proportion often going to household consumption. Other uses of remittance included social functions such as funerals, community development projects, schooling, and economic investments (de Witte, 2001; Kabki, et al., 2004; Mazzucato, Kabki, & Smith, 2006; Orozco et al., 2005; Tiemoko, 2004). In developing countries such as Ghana, the socio-economic impact of remittances on the life of the remittance receivers cannot be underestimated, as demonstrated by the impact of remittances in Ghanaian society.

Quartey and Blankson (2005) drew on 1991/92 and 1998/99 of the Ghana Living Standards Survey data to investigate whether migrant remittances have been a source of income smoothing in Ghana, particularly in times of macro-volatility. The major findings of this study included the following: first, it was found that migrant remittances are counter-cyclical in Ghana; inflows of remittances increased in times of economic shock. Second, remittances significantly affected household welfare and therefore tended to reduce any economic shock that affected household income and consequently welfare. This was found to be particularly true in the case of food crop farmers who were one of the poorest population groups in Ghana. Also using the 1998/99 Ghana Living Standard Survey, Adams (2006) found that internal and international remittances reduced the level, depth and severity of poverty in Ghana, though the size of the poverty reduction depended much on the type of remittances (internal or international) received, and how poverty was measured (headcount index or indices for depth and severity of poverty). He reported that international remittances reduced the depth and severity of poverty in Ghana more than internal remittances because of the kinds of income (expenditure) by groups receiving the remittances.

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The preceding review suggests that remittances have a tremendous impact on non-migrant family members. Remittances are used for multiple purposes, and are likely to have "spin offs" that may benefit different family members, including older family members and even entire communities. The question that arises, however, is how much of these transfers go to older members of the immigrants' families. We have difficulties knowing how much the remittances from Ghanaian immigrants impacts the welfare of older members of their families because most of the studies, except Orozco et al.'s (2005) study, often cluster the recipients of these supports into groups such as "family members," "spouses," "parents," and "household." "Household," for the purposes of the Ghana Living Standards Survey, one of the main data sources used to study remittances in Ghana, is defined as "a person or group of people living in the same compound (fenced or unfenced), answerable to the same head, and sharing the same source of food and/or income" (World Bank Africa Region, 2003, p. 6). Since a household head, and for that matter, parent, spouse, and family head could be an older person or a young adult, there is no way of knowing the proportion of older adults who received remittances or support if these terms are used by researchers.

Aside from financial support, most immigrants continue to stay emotionally involved in the lives of their non-migrant family members. They exchange ideas, information, and feelings. While physical distance affects the type and frequency of physical intimacy between immigrants and their elderly parents, some researchers have argued that parent-child relationships can remain strong even at a distance, and that physical proximity should not be a prerequisite for maintaining close family bonds or emotional attachment to older adult relatives (Dewit, Wister, & Burch, 1988; Schoonover,

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Brody, Hoffman, & Kleban, 1988). Advances in telecommunication, which are mirrored in the spread of telephone (both fixed and mobile), and internet has heightened the immediacy and frequency of immigrants' contact with their non-migrant family members, and allowed them to be "actively" involved in everyday life in their country of origin (Parrenas, 2005). It is important to mention that access and use of modern telecommunication in Ghana, and many parts of the developing world is limited, but nonetheless, increasing rapidly (Gray, 2006).

There are many situations that cause emotional distress to many older people, such as lost of family members, old friends, and physical incapacity. The emotional distress associated with these losses may be compounded by the loss of potential caregivers to migration, particularly for those who have fewer or no other sources of caregivers, and those nearing the end of life. For these stressful situations and other life events, most older adults will require emotional support or thoughtful and caring relatives with whom they can share their thoughts and feelings. Many adult children who have migrated from Ghana are likely to provide "conversational interventions" to their parents in many situations during return visits or phone calls.

Orozco et al. (2005) examined the personal contacts between Ghanaian immigrants and their families in Ghana by looking at the immigrants' number of visits, and phone calls to Ghana. They reported that the majority of Ghanaian immigrants in Germany, the United Kingdom and the United States traveled to Ghana once a year. Sixty-three and 65 percent respectively of their participants in the United States and the United Kingdom visited Ghana at least once a year; with visits lasting between one and two months (p.21). They found also that apart from personal visits, Ghanaian immigrants

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maintained contact with their relatives back home via regular phone calls. They found that 88 percent of Ghanaians in the United States, 73 percent in the United Kingdom, and 43 percent in Germany called their family in Ghana once a week or more (p. 22). They reported that roughly half of Ghanaians in the United Kingdom (52 percent) and the United States (46 percent) spoke with their relatives for about 20 minutes each time they called; their counterparts in Germany spoke for 20 minutes or more (p. 22). While Orozco et al.'s research indicates that Ghanaian immigrants had some contacts with families in Ghana; the study did not provide any idea of what was "discussed."

It has been argued that long-distance caregivers who do not have reliable caregivers worry over the welfare of their care recipients (Parker et al. (2002). This was supported in the findings of an exploratory qualitative study conducted by Kodwo-Nyameazea, and Nguyen (2008) among five Ghanaian immigrants in the United States. Using in-depth, open-ended interviews, they discovered that their participants worried because of their inability to visit (due to financial and immigration reasons) their elderly parents regularly and during time of sickness and other emergencies. They found also that even when their participants were striving to provide for the financial needs of their elderly parents, they experienced guilt because of their inability to fulfill other expected roles such as regular contact with parents and provision of hands-on care. Increased guilt among long-distance caregivers may be the result of the disparity between the social expectation of caregiving and the realities imposed by the geographic distance (Climo, 1992).

Throughout life children remain children to their parents, and for many, their parents' opinions are very important to them. Parents share their lives with, and at certain

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point in later life, depend on their children for comfort and care. For many elderly people the views of their adult children, particularly the "well-traveled" ones, on the "ever-changing" world around them are crucial. But despite the significance of the relationships between adult children who have migrated and their non-migrant elderly parents, little is known about their efforts to keep their emotional bonds intact from a distance. Few studies in the international long-distance care literature have focused specifically on emotional support immigrants provide to their elderly parents. Migration from Ghana to developed countries is not likely to slow down soon, thus it is timely to investigate the dynamics of the emotional aspects of these long-distance relationships.

Old-Age Vulnerability and Elder Care Provision

Generally, all non-migrant family members who depend on immigrant relatives for support could be vulnerable, but old age often involves certain biological, social, and economic challenges that reduce many older adults' ability to respond to changes in life situations, thereby making them vulnerable to the loss of support of the immigrant caregiver. The literature suggests that immigrant caregivers direct more resources to non-migrant family members who are more vulnerable (Cox et al., 1998; Lucas and Stark, 1985; Petrova, 2004; Quartey, 2006). It is appropriate at this juncture to discuss some of the factors that make older people vulnerable and in need of care.

Definitions of vulnerability are numerous. Chambers (1989) defined it as "the exposure to contingencies and stress, and difficulty coping with them (p. 1)." Moser (1998) referred to vulnerability "as the insecurity of the well-being of individuals, households, or communities in the face of changing environment, and implicit in this, their responsiveness and resilience to risks that they face during such negative changes"

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(p. 3). The United Nations Environmental Program (2003) regarded vulnerability as "the exposure to hazard by external activity (e.g. climatic change) together with the coping capacity of the people to reduce the risk from the exposure (p. 4)." In general, vulnerability could be seen as the manifestation of the interplay of social, economic, and political factors within a specific environmental and societal context. Vulnerability has two sides: exposure to hazard and coping with the hazard. Naturally, people who are less vulnerable to risk are those who have more capacity to cope with extreme events.

Schroder-Butterfill and Marianti (2006) developed a conceptual framework for understanding the differential vulnerabilities in old age as they relate to older adults' needs. They identified four domains that shape vulnerability in old age – outcomes, threats, exposure, and coping capacities. In their framework, outcomes refers to "states that older people might feel vulnerable to" (p. 15), for example, degrading death, lack of physical and health care, poverty, lack of social contacts and loneliness. They view threat as "specific events that have the power of propelling [older] people towards bad outcomes, unless they have access to resources for mitigation" (p.16). Examples of threat are: decline in health and physical strength, loss of income and loss of [family] network members. Exposure is regarded as personal, demographic and social-economic circumstances (including mental status, marital status, and age discrimination), "which affect the probability of encountering a given threat or outcome" (p. 16-17); and coping capacities are defined as "the set of assets and relationships [e.g. individual characteristics, and family and community networks] that allow [older] people to protect themselves from a 'bad outcome' or to recover from a crisis" (p. 18).

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According to Schroder-Butterfill (2005), the different domains can interact to compensate for each other, or can be mutually exacerbating. She posits that an [older] person's vulnerability is the result of a set of distinct, but related, risks, namely: the risk of being exposed to a threat, the risk of a threat occurring and the risk of lacking the abilities to deal with a threat. She argues that differential exposure, differential likelihood and magnitude of threat, and differential coping capacity all have an impact on the risks of encountering a bad outcome. There are therefore degrees of vulnerability, both in the proximity to harm that an older person faces, and in the severity of harm that she or he may encounter.

In the context of international long-distance eldercare, vulnerability signifies insecurity in old age in the face of migrating caregivers. The vulnerabilities are related to what older adults lose as a result of migration rather than the mere absence of the caregiver. Implicit in the vulnerability concept is that, if adequate steps are not taken to ensure provision of eldercare, older people whose caregivers have migrated will suffer "bad outcomes." However, the extent of vulnerability among older adults will differ because the resources each older adult has and can draw on in the absence of caregivers differ. In this regard, the degree of vulnerability and the severity of "bad outcomes" they may experience will differ among older adults whose children have migrated.

To determine the most vulnerable older adults who might need most assistance from their immigrant children, I have discussed three key areas of vulnerabilities that researchers indicate the majority of older adult Ghanaians are likely to experience – income, family care, and health and functional abilities (Aboderin, 2004, 2006; Apt, 1993,

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1996; Darkwa, 2000; van der Geest, 2002a, 2004), although the three are not necessarily mutually exclusive.

Vulnerability to Income and Material Support

It is difficult to estimate reliably the levels of incomes in Ghana due to inadequate documentation of private earnings and non-monetized transactions. However, various household income analyses in Ghana estimated that those working in the formal sector are more likely to have a more stable income than those operating in the informal sector as farmers, artisans, and traders (Apt, 1992). It has been steadily reported that incomes of households in which older people live are lower than the national average; such differences are particularly higher in rural areas (Kakwani & Subbarao, 2005). Some researchers have questioned whether reported rural-urban income gaps in developing countries accurately represent differences in material vulnerability since the cash needs in urban areas are higher than in rural areas (Lloyd-Sherlock, 2006).

Income status across older adults in Ghana appears gendered. Given that men have higher levels of education than women (Stephens, 2000), more men than women are likely to be exposed to the formal wage sector during their active working years, and men are more likely to receive statutory insurance benefits such as social security upon retirement (Darkwa, 2000). Furthermore, older men, especially those in rural areas, by virtue of their positions in traditional institutions, and control over family and community resources tend to have more opportunities to earn income than elderly women, though the latter may receive income from petty trading and in-kind compensation as grandparent and "house-help" (Darkwa, 2000).

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On the whole, however, old age in Ghana is synonymous with lack of "cash-saving and income." Since the overwhelming majority of both sexes of Ghanaian older adults spend all their active life in subsistence farming, which yields very little or no surplus income, they retire with little or no savings (Darkwa, 2000). The proportion of Ghanaians who contribute to the *pay-as-you-go* social security scheme, and subsequently qualify for old-age pension benefits is very small (Kumado & Gockel, 2003). Furthermore, the general low income remuneration in the formal sector means that what is received as social security income in old age is not enough to meet the needs of the recipients (Darkwa, 1997).

Older adults who are most vulnerable to economic shocks are the very old and those with the lowest reported incomes (Lloyd-Sherlock, 2006). This is not surprising since old older adults are much less likely to be engaged in or capable of undertaking paid employment. It should however, be noted that older adults in Africa are noted to work far into old age, and many considered "retired" continue to contribute indirectly to their household incomes by assuming activities such as grandparenting and household chores while "able-bodied" adults in their family work outside the home (Apt & Katila, 1994). Other vulnerable groups include older adults with no regular source of income; those who spend their working life in farming and other subsistence occupations; older adults who worked in low paying jobs; and those who are unable to work for whatever reason to generate any income but receive very little or no income support from any source.

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Vulnerability to Familial Care Support

Living with or near family members is considered vital to reducing old age vulnerability. This is because older adults tend to require assistance, particularly when they suffer from health and physical conditions that limit their ability to carry out tasks necessary for survival (Zimmer & Dayton, 2005). Demographic studies have shown that the vast majority of older Ghanaians (99%) share a home with family members (Darkwa, 2000, p. 67). The typical Ghanaian household is an extended one, and in many cases, this means living in a three-generation household. Elderly men are more likely to be living in nuclear households, while older women are more likely to live in extended family households (Mba, 2007). One reason for this is that, grandmothers, rather than grandfathers are seen as the most natural individuals to assist in caring for grandchildren, and consequently move in with extended family for that purpose. Urban elders are found to be more likely than their rural counterparts to live alone and with children only (Zimmer & Dayton, 2005).

A common practice used by sub-Saharan African societies to mitigate lack of children or "living alone" is child fostering – that is, sending a child to live with someone other than the parents. Many sub-Saharan African children spend substantial parts of their childhood away from their parents, often as the foster children of their grandparent (Isiugo-Abanihe, 1985), although this living arrangement could also be the result of ill-health or migration of the foster child's parents (Zimmer & Dayton, 2005). Nonetheless, living with family members does not necessarily translate into care for older adults; in some cases, it could be detrimental to their welfare, particularly for those accused of social evils such as witchcraft (Adinkrah, 2004; van der Geest, 2002b)

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Elder care provision in Ghanaian society is “supposed” to be a joint family affair. Often, adult children and their own children and/or grandchildren combine to provide the care needed by older adult parents (Apt, 1996). Who does what is very much a matter of physical presence and abilities. Nonetheless, elder care is highly gendered, with hands-on care activities such as cooking, bathing, and cleaning regarded as women’s duties; and financial support, visitation, and organization of funerals as men’s domain (van der Geest, 2002a). Although not unusual, care by non-relatives is stigmatized in Ghanaian society (van der Geest, Mul, & Vermeulen, 2004). As a result, lack of adult children due to biological or demographic factors could be a source of vulnerability to many Ghanaian older adults.

Another demographic factor that may impact the level of eldercare is divorce and remarriage. Some researchers suggest that single and divorced adult children have more time to assist their elderly parents (Ganong, & Coleman, 1999). On the other hand, parental divorce may weaken the filial norms of children, especially toward divorced father who are less likely to reside with their children and more likely to remarry than divorced mothers (Ganong & Coleman, 1999).

While there is evidence to suggest that older adult Ghanaians are cared for by family members, it is increasingly common to come across news reports and anecdotal evidence of incidences of elder neglect. In fact, some few Ghanaian studies have reported incidences of elder abuse and neglect (Aboderin, 2004b, 2006; Adinkrah, 2004; van der Geest, 2002a, 2002b, 2004). Older adults who are likely to be vulnerable to lack of care include those with no surviving children; those whose children have migrated or have no adult child nearby; very old people and/or frail ones who are unable to do things for

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themselves; older adults with no adult daughters or granddaughters to provide physical care; divorced and single elderly men with no children or adopted children, and older adults who are accused of witchcraft and consequently refused family support.

Vulnerability to Health and Functional Abilities

Physical and mental health is critical in appreciating the vulnerability of older people. Poor health and functional disability indicators show a strong association with age, with a higher prevalence of morbidity and disability in the oldest age groups (Medical Research Council Cognitive Function and Ageing Study, 2001). In general, elderly Ghanaians are more likely to suffer from high blood pressure, heart attacks, and arthritis than any other disease (Apt, 1995), although there are some regional disparities. The incidence of high blood pressure and heart attack is higher among urban males than rural males. Whereas the distribution of heart attacks is higher among urban females, heart diseases are found among urban and rural females. Other health problems among elderly Ghanaians include eye troubles, deafness, pelvic pains, hypertension, and stroke (Banga, as cited in Darkwa, 2000). Although women have lower mortality than men, generally, they are more at risk of disability in later life, especially from musculo-skeletal impairments. Overall they spend a larger proportion of their later life with some functional limitations (Robine et al. as cited in Grundy, 2006).

In Ghana, public health spending tilts against rural areas (Darkwa, 2000) where 68 percent of older adult Ghanaians reside (Mba, 2007, p.160). Not surprisingly, rural dwellers were found to have poorer health status compared to their urban counterparts (Banga as cited in Darkwa, 2000). While the list of medical conditions and lack of

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medical access, particularly in the rural areas, may portray older adult Ghanaians as "unhealthy," the majority report a greater sense of satisfaction in their lives.

Given the evidence available, it appears that the most vulnerable groups of Ghanaian older adults, with regard to health and functional abilities are very old older adults, especially older women; older adults who cannot afford medical care; those with backgrounds in less-skilled occupations (which may have involved exposure to unhealthy environments); older adults with poor family support (Grundy, 2006); and older adults living in rural areas.

A Framework for International Long-Distance Elder Caregiving

The migration of a caregiver results in the "fusion" of the care system in his or her country of origin and socioeconomic events in his or her host country. In other words, the elder care system in an immigrant's home country combined with socio-economic and political factors in the destination country become interlinked for the immigrant caregiver. Risks to the immigrant's current socioeconomic environment eventually translate into risks to the eldercare system in the home country because of its dependence on the resources of the immigrant. This means that overall vulnerability of older people whose children have migrated should include dimensions of vulnerabilities relating to both the older adult and the immigrant. Thus, it is important to explore the factors that impact the patterns of care for older adults whose adult children have migrated. When adult children migrate, it results in changes in available eldercare resources, which in turn, may negatively impact the level of eldercare receipts.

Figure 1.1 provides an overall representation of the vulnerability to lack of eldercare in the event of migration of caregivers. It suggests that there are deep seated

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cultural factors pertaining to filial obligation, eldercare recipient-specific factors related to perceived vulnerabilities, and immigrant caregiver-specific factors that may impact available eldercare resources. Each of these factors is disaggregated into the more specific variables that comprise it.

The framework suggests that all the eldercare dynamics are underlined by cultural norms and values that shape attitudes towards older people, and which in turn influence eldercare patterns. Eldercare is viewed in this framework as any assistance rendered to meet specific needs of older people. The "forces" that engender eldercare take many forms, and may include a combination of the following: concern over social disapproval if care is not given, a belief in ethical generativity, the desire to role model for future caregivers, and support received from older family members which result in an obligation to reciprocate.

The range of care resources an individual brings to old age includes wealth and other material resources, family and social relationships, and health and physical capabilities. Demographic factors, such as living arrangements, number of adult children, and family composition set limits for potential available care resources. The individual's past participation in the economy influences the resources potentially available to him or her in old age. Health and physical ability determines an individual's capacity to perform certain types of activities and the level of care he or she may need. And, while most older adults may be able to take care of their own needs, with age, many lose muscle strength and functional abilities.

While in theory older adults can "increase" their care resources in the absence of potential caregivers, their ability to do so may be limited. The gamut of resources on

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which an individual can draw in old age is dependent on life course factors and reflects a lifetime's accumulation. Except in a few cases, with age, these resources will likely diminish. For instance, an older adult may increase the number of family members through adoption or may improve his or her physical strength and general health through physical training or medication, although some chronic conditions can make it difficult for older people to regain some functions lost. Since it is relatively harder for older people, particularly the "very old" to replace depleted care resources, many of them downgrade their expectation for care receipt to accommodate for lost care resources.

Notwithstanding the needs of older adult relatives, what immigrant caregivers can do to assist is dependent on their own resources, which in turn, is dependent on the life circumstances in their host countries. The everyday realities of many migrants are flout with a wide range of vulnerabilities, including economic, political, and demographic situations that threaten to derail their main objective for migrating: accumulation of economic assets. For instance, the economic structures and conditions in the host country may limit an immigrant's ability to accumulate adequate economic resources for oneself and family. Besides, political decisions regarding immigration status in the destination country may prevent or restrict their participation in the labor market. Furthermore, the immigrants' immediate family and social obligations in the host country may influence how many resources he or she can afford to give to his or her elderly relatives. Based on the theory and literature reviewed, Figure 1 provides a conceptual framework that guides the study design. In Chapter 3 study methods will be thoroughly discussed.

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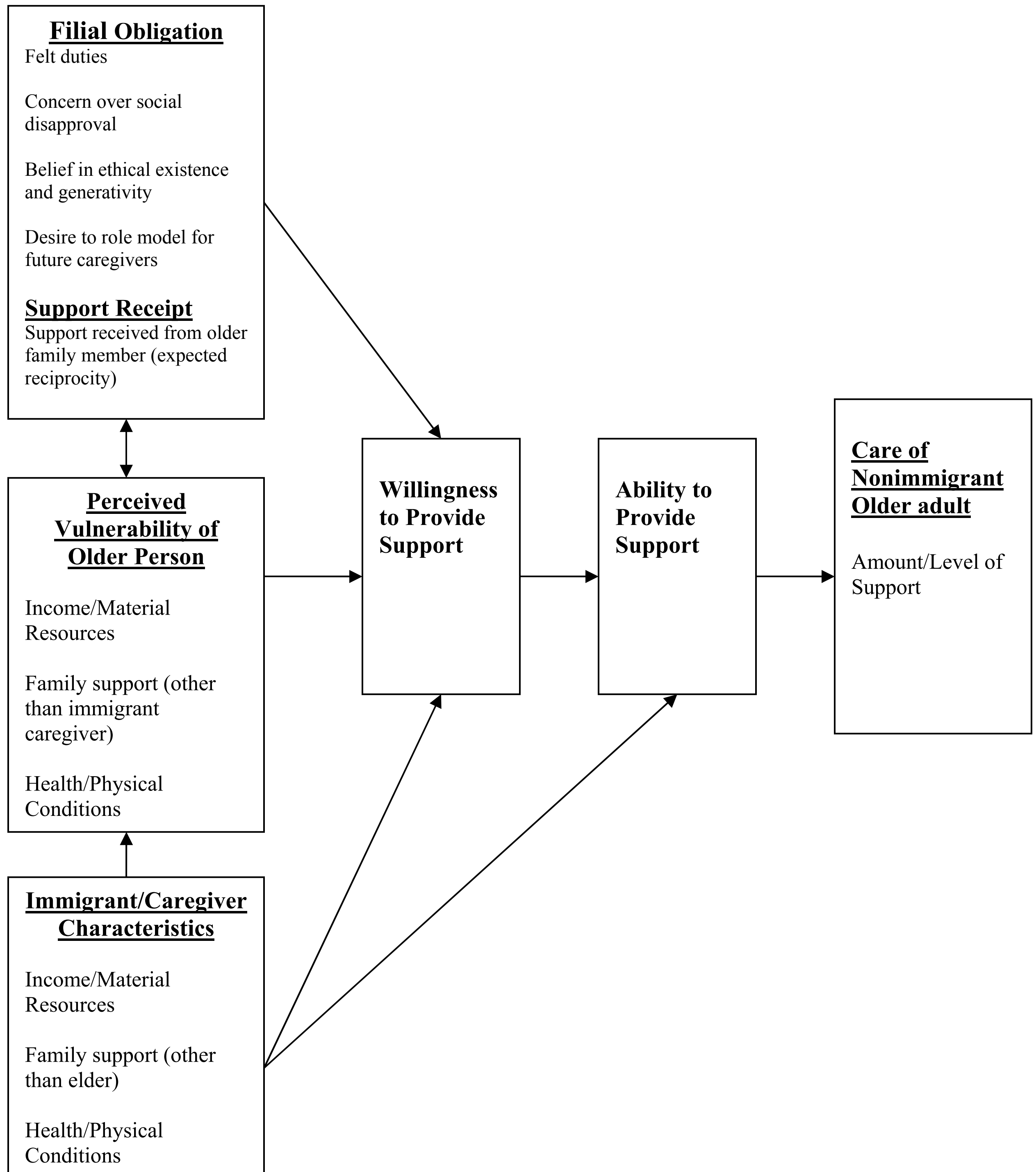
Figure 1.1: Conceptual Framework for International Long-Distance Eldercare



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CHAPTER 3

Research Methodology

In this chapter, the research question and hypotheses, including their underlying premises (based on the model developed in Chapter 2; see Figure 1.1) are provided. The chapter also provides a detailed description of the research methodology, including a description of the development of the measures, a data collection and analysis plan, and the questionnaire.

Research Focus and Key Terms

In this study the researcher investigated factors that influence long-distance caregiving among Ghanaian immigrants in the United States. Based on the literature in Chapter 2, these factors were identified: (1) support caregivers received from elderly relatives, (2) filial obligation towards elderly relatives, (3) perceived vulnerability of the elderly people in Ghana, and (4) vulnerabilities that make immigrants unable to provide eldercare. The major research question was: *To what extent do these four factors – support receipt, filial obligation, perceived elder vulnerability and immigrant vulnerability – influence the provision of eldercare by Ghanaian immigrants in the United States to their elderly relatives in Ghana?* In line with the research focus, four hypotheses and their rationales were identified.

In examining international long-distance eldercare, it is important to define who an elderly person is, and clarify the concept of family relative in Ghanaian context. Officially, the chronological age of 65 years is accepted as a definition of "elderly person" or "older person" or "older adult." It is the age at which one becomes eligible for statutory and occupational retirement pensions (Kumado & Gockel, 2003). Yet, using

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chronological age to define elderly person in African societies is flout with difficulties because most often, actual birth dates are unknown. In addition, the official retirement age does not necessarily correspond with old-age in Ghanaian socio-cultural contexts. Socially constructed meanings of age such as roles assigned to “mature’ people in society (Ephirim-Donkor, 1997), changes in social roles, including reduction in economic activities, and attainment of grandparenthood (Apt, 1993; Glascock, & Feinman, 1980; Gorman, 1999); and changes in physical capabilities and characteristics (Glascock, & Feinman, 1980) are significant in defining old age in Ghanaian society.

In 2001, the Minimum Data Set (MDS) Project on Ageing “team” made up of an international group of experts on aging in Africa, agreed to use the chronological age of 50 as the working definition of “older” or “old” for the purpose of their project. The team argued that age 50 incorporates the chronological, functional and social definition of old age in African societies. The MDS’s definition of “older person or adult” was adopted for the current research. In this study “older adult,” “older person,” and “elder,” and “elderly person” were used interchangeably.

Another key term that needs explanation is “family relative.” The concept of family relative is fluid, especially in Africa where there is a plurality of family types. From this variety, researchers have identified some key features of the African family, including high separation of gender responsibilities, integration of reproductive and productive functions, dominance by elders (Locoh as cited in Tiemoko, 2004), and the tendency for strong lineage and conjugal solidarity (O’Laughlin, 1995). In practice, people’s definition and perception of family is influenced by their cultural and life situations. For this reason, Tiemoko (2004) suggests that African immigrants “constantly

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shape and reshape conceptions of the family" (p. 157). For the current study, participants were given the option to define the boundaries of their families, they could choose to include or exclude whomever they deemed as their family relatives.

Hypotheses and Their Rationales

Based on the conceptual framework developed in Chapter 2, four hypotheses emerged. In this section, each hypothesis is stated, followed by its rationale.

Hypothesis # 1: *If immigrants have strong feelings of filial obligation (felt duties, concern over social disapproval, belief in ethical existence and generativity, and a desire to role model for future caregivers), they will provide high levels of eldercare.*

Many social actions are underlined by elements of obligation. In the context of family eldercare, obligation may include the duties one is expected to perform for elderly relatives such as offering advice and providing physical and emotional care. One's belief in ethical existence and generativity is part of feeling obligated, based on one's socialization to an ethic of care. Family and societal values emphasize family members as the people with both the desire and the obligation to help one another. In this regard, adult family relatives and children are expected and/or feel obligated to take care of elderly parents and relatives. Thus, normative obligation, often backed by threat of social disapproval, may dictate eldercare even in the face of a "poor" personal relationship between the caregiver and the care recipient.

Hypothesis # 2: *If immigrants are currently receiving or have previously received any support from older family members in Ghana, they will provide care to these benefactors.*

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Internalized social norms such as reciprocity which engenders indebtedness and exchange, in lieu of sanctions such as social disapproval, elicit high levels of support for one's benefactors. For instance, an elderly person who invests in his or her children's or younger family members' education is likely to receive "something" in return for his or her investment. In other words, beneficiaries to older family members support are likely to feel obligated to give back of their benefactors. This "obligation" garnered by actual receipt of support (either material or non-material) from older family members may or may not co-exist with the other types of filial obligation identified in hypothesis # 1 above.

Hypothesis # 3: *If older persons are perceived to be vulnerable (less able to take care of themselves economically (income/materiality) and physically, and receiving less familial care support in Ghana) they will receive more care from their immigrant adult children.*

The chance for elderly persons receiving care and support from their immigrant adult children depends upon their need, as perceived by the adult children. For instance, older adults perceived to have enough financial resources, either from personal or other sources, are likely to receive less financial assistance. Those perceived, for example, to be lonely and frail, may receive more emotional support. Thus, faced with limited resources, an immigrant is more likely to provide resources for remedying situations he/she perceived to be more crucial for the survival of an older adult relative. Also, in an extended family-oriented society like Ghana, an immigrant might be responsible for the care of multiple family relatives. An immigrant elder caregiver is more likely to provide more care to older adult relatives perceived to be the neediest.

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Hypothesis # 4: *If immigrants have high income, are legal residents, and are in good health, they will be able to provide elder care.*

The ability to provide economic assistance largely depends on the financial resources available to the immigrant at his or her destination. Immigrants with requisite educational background, professional skills, linguistic ability, and legal documentation (a requirement for work authorization) will most likely have an easier transition and accumulate more resources. In an open labor market, like the United States, the type of job one can secure is generally dependent on one's education and work experience. The return on education is likely to vary; education acquired in the United States is more desirable in the American job market (Akesh, 2006). Permanent residents or green cardholders would have greater success in accumulating resources due to the higher likelihood of securing jobs, and receiving commensurate compensation. An immigrant's immediate household structure may also influence the frequency and level of support he or she can give to family elders in Ghana. For instance, having minor children may be associated with an increase in "immediate family" expenditure which may have an influence on ability to provide care. The immigrant's health/physical conditions will play a role as well. All things being equal, immigrants who are in good health are more likely to work more hours and accumulate more resources.

Constructs and Measurements

After a review of available measurement tools used in previous studies of international long-distance eldercare, it became clear that the researcher would have to design new measures for the major variables in his study. An optimal international long-

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distance eldercare measure must capture caregivers' and care recipients' social, cultural, and economic circumstances that influence the type and level of eldercare provided. In addition, an eldercare measure must assess both instrumental and emotional care. To do this accurately, such measures must be designed with the study population's cultural context in mind. The researcher did not find any tools that measure eldercare obligations from a Ghanaian perspective or that capture the concepts the researcher sought to measure within Ghanaian sociocultural context. Consequently, new measures were developed for the independent variables: *filial obligation, support receipt, and perceived elder vulnerability.*

Filial Obligation Scale

Filial obligation was comprised of four sub-scales – felt duties, social disapproval, ethical existence and generativity, and eldercare modeling. The rationale for each subscale follows.

Felt Duties sub-scale

Kinship norms specify the ways in which family relatives are expected to behave toward each other, ranging from prescribed terms of address through rights of access, to obligations to exchange and provision of support (Rossi, & Rossi, 1990). Thus, exchanges within families are affected by the levels of obligations family members feel towards each other. For the current study, a 12-item measure covering instrumental, emotional and financial eldercare activities was developed to assess how strongly obligated participants felt to undertake those activities for their elderly relatives (see Appendix A). Participants rated their response on a Likert scale from 0 (no obligation) to 5 (very strong obligation).

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Social Disapproval sub-scale

An anticipation of experience such as embarrassment, shame or guilty feeling may serve to increase an immigrant's "willingness" to provide care to their elderly relatives. Generally, these self-conscious emotions are woven into social and family relationships, serving as an emotional mechanism that enables people to honor their societal and family obligations (Bedford, & Hwang, 2003). People who fail to live up to their own expectations or those of significant others usually lose some amount of honor or dignity. In essence, eldercare may be provided in order to maintain one's dignity or avoid social disapproval, defined here as an expectation of negative evaluation by self and others – family members, friends, and community members. The purpose of this measure was to assess elder caregiving by means of social approval. The social disapproval measure was comprised of nine items that asked participants to indicate on a Likert-type scale of 0 to 5 how strongly they agreed to statements relating to individual and social expectations of elder caregiving (see Appendix A).

Ethical Existence and Generativity sub-scale

Eldercare, like most aspects of Ghanaian life is underlined by a belief in ethical existence and generativity. This dual concept encompasses the view that individuals have freedom of choice but that there are religious, social, and economic consequences for moral and ethical way of life. Therefore, studies seeking to understand eldercare relationships in Ghanaian society must take into account these religious and philosophical "doctrines" as they relate to elder caregiving. Naturally, individuals for various reasons understand eldercare beliefs differently and act accordingly when it comes to provision of eldercare. For the purpose of this study, a measure called ethical existence and

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generativity was developed to capture this concept. The measure consisted of 14 items that asked participants about their general attitude concerning religious and philosophical beliefs undergirding eldercare relationships (see Appendix A). Participants rated how strongly they agreed or disagreed to each statement on a 5-point Likert-type scale, with 0 indicating "strong disagreement" and 5 indicating "strong agreement."

Eldercare Role Modeling sub-scale

Parents serve as models to their child and demonstrate how they should behave in different circumstances. When parents perform eldercare activities, they are providing opportunities for their own children to learn how to do similar activities in the future. A single item was used to assess the desire of participants to role model eldercare for their own children or younger family members (see Appendix A). The item "Providing eldercare to my elderly relatives in Ghana is a way to show my own children or younger members of my family how I want to be treated in old age," was rated on a 5-point Likert response scale ranging from strongly disagree to strongly agree.

Support Receipt Scale

It has been noted that contemporary relationships between elderly parents and adult children are influenced by past parent-child interactions (Rossi, & Rossi, 1990). To this end, a measure referred to as *support receipt* was developed to measure past and present support participants received or were receiving at the time of the research from their elderly, which may have obligated them to reciprocate. The implication for collection of information on past support is reliance on retrospective data. While retrospective data is deemed "suspicious" because it is subject to distorted memories (Halverson, 1988), the impact of recalled sentiments on contemporary life cannot be

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overlooked. Rossi, and Rossi, (1990) contend that even [childhood] “fantasies” have real implications for how adult children relate to their parents in latter life.

Specifically, the support receipt measure covered the role elderly relatives played in participants’ childhood and adolescence and/or adult life. The researcher recognizes that the major family obligations often have significant variation by gender. To make the questionnaire easy to administer, measures were limited to global items that contain, where necessary, both male- and female-activity “equivalents.” As stated earlier, support receipt was made up of two sub-scales. The childhood and adolescence support receipt sub-scale included three items on activities relating to childcare, socialization, and basic education, whereas the adulthood support receipt sub-scale consisted of eight social- and economic-related items (see Appendix A). On each sub-scale, participants rated their responses on a five-point Likert scale ranging from 0 (no role) to 5 (very high role).

Perceived Old-Age Vulnerability Scale

The literature review has shown that the life situations of older people determine the type and extent of support they receive from their adult children. Consequently, participants were asked to rate the current life circumstances of their elderly relatives based on their own perception and information received from other people. Specifically, participants rated income/material resources available to the elderly relatives, and family members available to take care of their physical needs on a 5-point Likert scale. It was possible that participants had not seen their elderly relatives in question in years. Consequently, participants’ perception of their elderly relatives may be susceptible to subjective interpretation and perhaps, “faulty.” Nonetheless, the faulty information formed the basis upon which participants based their eldercare decisions. Thus,

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perception rather than actual socioeconomic and health condition were measured (see Appendix A).

Computation of Scale Score

Scores were calculated for main and sub-scales. To get a total score for a scale or sub-scale, the mean scores of the non-missing values were computed, and then, converted into a total score by multiplying the mean by the maximum number of items on that scale or sub-scale (Bryman & Cramer, 2009). This approach ensured that scores corresponded to the general responses given by participants and that missing values due to "not applicable" and "failure to respond" did not unduly influence the total scores. Thus, a scale or sub-scale was operationalized as the mean score of the non-missing values of that scale/sub-scale multiplied by the total number of items on that scale/sub-scale. For instance, the score of the social disapproval scale was operationalized as the mean score of the non-missing values multiplied by nine (i.e., the total number of items on the social disapproval scale). Where a main scale had sub-scales, the scores for the main scale were calculated by summing up the total scores of their sub-scales. For example, the total score of the four sub-scales (felt duties, social disapproval, ethical generativity, and eldercare modeling) were summed up to get the total score for filial obligation.

Demographic and other Research Variables

Apart from the predictor variables discussed above, demographic characteristics of both the elderly relatives and immigrant may influence the level of eldercare. For elderly people demographic data collected included gender, marital status, age, educational level, familial relationship, and employment status. For the immigrants, relevant demographic data collected included gender, marital status, age, educational

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level, number of elderly people participant provided care for, familial relationship, and immigration status. Other immigrant data collected were number of dependent children, income and employment. A person's health significantly influences his or her ability to undertake several activities. Thus, immigrants were asked to provide a self-report about their health status. Due to geographical distance, long-distance caregivers often need the assistance of people who are in close proximity to their elderly relative to provide physical and other care. Thus, data were collected on types of care activities elderly relatives received from other sources.

Dependent Variables

The outcome variable for the current research is *care of non-immigrant older adult*, referred to as support provided by adult children to their older adult relatives in Ghana within the past 12 months. There were two major constructs for the outcome measure: financial support and emotional support. Emotional support was operationalized as phone contact and return visit since they are the primary means for providing emotional support at a geographic distance. Due to the communal nature of Ghanaian society, outcome measurements of some items were included to gather information on the relationship between immigrants and their entire family of origin.

Pilot Testing

The instructions and the measures were pilot tested with five Ghanaian immigrants. After completing the questionnaire, pilot participants were interviewed regarding instructions for survey participants, clarity of the measure as a whole and the individual items and their usefulness. This exercise gave the researcher a chance to ascertain whether participants understood the concepts used, to find out about the logical

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sequencing and flow of the questions, and the average amount of time required to complete a questionnaire. Based on the pilot participants' feedbacks, the questionnaire was slightly modified before the main data collection began.

Research Design

This study was conducted using survey research methods. The decision was made to use survey research because of its strengths which include the ability to collect data on multiple variables from larger numbers of people (Rubin, & Babbie, 2005). A survey research uses carefully designed measurement tool or questionnaire that allows for large samples to be interviewed and for the questionnaire to be administered in various ways, such as face-to-face, self-administration, telephone, email, and mail.

There are some weaknesses of survey research worth mentioning. The standardization of questionnaires required by survey research forces the researcher to develop questions that are appropriate for all respondents. Furthermore, survey research methodology requires the initial research design (the questionnaire and method of administration) to remain unchanged throughout data collection (Rubin, & Babbie, 2005). These restrictions seldom allow the context of real social life to be taken into consideration, when necessary. Consequently, researchers may miss what is most important or appropriate to many research participants.

Study Population

The sample for the current research was drawn from the Ghanaian immigrant population in Atlanta. The choice of Atlanta was based on pragmatic reasons related to accessibility. For one, the metropolis has one of the largest concentrations of Ghanaian immigrants, which gave the researcher access to a large pool of potential research

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participants. Furthermore, the researcher had contacts in the community who offered to assist him in gaining access to the study population. The other reason was cost. It was less expensive to sample from participants in one place than multiple areas scattered across the nation. Participants were Ghanaian immigrants in Atlanta who have elderly relatives, aged 50 or above living in Ghana within the past 12 months of the research.

Sampling Method

Convenience sampling was used to recruit 124 participants for the current study. This sampling method was employed because it was impractical to compile an exhaustive sampling frame of the target population (Rubin, & Babbie, 2005). Convenience sampling allows researchers to survey the section of the target population that is available. It is also useful when a study population is widely dispersed, as the current one was, and the researcher is faced with restricted time and resources. Since there is no randomness in convenience sampling the likelihood of bias is high. There is the risk of selecting a sample that has a disproportionate number of participants with certain characteristics that differ from the general population (Rubin, & Babbie, 2005). Consequently, the results of the current survey may not be generalized to the general Ghanaian immigrant population in the United States.

Recruitment of Study Participants

I used different strategies to recruit participants for this study. First, I contacted leaders of Ghanaian groups and associations to request their help in gaining access to their members. Given the small size of the Ghanaian immigrant population within the study area, these “naturally” occurring groups were the easiest way to access the majority of them. I arranged with the community leaders to attend some of their pre-arranged

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group meetings. At the meetings, I explained the objectives of the research, the consent form, the role of the participants, how they might participate, and incentives for participation. Flyers on the study (see Appendix E) with contact information were also distributed at these meetings. Potential participants were told to contact me if they decided to participate in the study. I also approached people at the meetings to ask for their participation. Secondly, in case I could not be present at a meeting, a recruitment script (see Appendix F) was given to the group leaders to disseminate information about the research to their members. Third, flyers about the study were posted at vantage places within the Atlanta Metropolitan Area frequented by Ghanaian immigrants. Fourth, I arranged to attend informal gatherings of friends and family group meetings in the company of community contacts or gatekeepers who were familiar with members of those groups. Fifth, I went door-to-door or canvassed, either alone or with individual gatekeepers, neighborhoods with high concentration of Ghanaian immigrant populations using information provided by gatekeepers. The fourth and the fifth strategies yielded the highest number (85%) of participants for this research.

Data Collection

Potential participants who agreed to participate in the research had primarily two ways to complete the questionnaire: (1) one-on-one interview with the researcher either face-to-face (N = 74) or by phone (N = 3), and (2) self-administration (N = 47). Those who opted for phone or face-to-face interviews provided their phone contacts and were contacted later to arrange for interviews. Those who chose self-administration were given research packets to be taken home. I arranged with them to go to their homes to pick up the completed questionnaire. However, at some of the informal small group gatherings,

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some participants chose to complete their questionnaire individually in the group setting. I was present at all the group self-administrations. I ensured privacy at the group administration by asking participants to keep their responses private and respect each other's privacy. All participants were offered cash incentives of $10.

It is important to acknowledge the debate in the scientific community about the payment of people for research purposes. A literature review conducted by Tishler, and Bartholomae (2002) examined research volunteer motivation and the role of financial incentives. They concluded that studies that have systematically investigated volunteer motivation have found financial rewards to be an important motivator among normal healthy volunteers in their decision to participate in clinical trials, albeit some differences based on demographic characteristics. Nonetheless, it has been argued that "undue" or "excessive" financial inducement in exchange for research participation may attract certain population groups, particularly economically vulnerable individuals over other groups (McGee, 1997). It is my opinion that $10 was small enough that it did not constitute an undue financial inducement.

Cultural Sensitivity

Ghana and Ghanaian immigrant communities are ethnically and culturally diverse. While there may be some variation between the ethnic group with regards to values and norms, being respectful as exemplified in greetings, temperament, public speaking and other interpersonal etiquette is important in all Ghanaian societies. As a result, I strived to be polite and well mannered at all times in my interaction with my gatekeepers and participants. Although, a Ghanaian myself and aware of some of the cultural nuances, I regularly discussed with my gatekeepers, particularly during the door-to-door recruitment,

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about how to interact with potential participants. This helped to ensure that appropriate manners are shown.

Pre-analysis Data Screening

Missing data

The data were analyzed for missing values. On the 11-item *support received from older adult or support receipt*, 25 cases had a single item missing, nine cases were missing two items each, one case was missing four items and one case had eight items missing. Item six on this scale which inquired about older adult's support for participant's college education had the greatest number of missing values, but also had two non-responses. Other items on the same scale inquiring about *older adult's financial support for participant's trip to the United States* and *older adult's support for respondent's career* also had four (3%) and 10 (8%) of values missing respectively.

All four filial obligation sub-scales were each analyzed for missing values. Apart from one participant who missed all the items on the 8-item *felt duties* sub-scale, no other participants missed any item on this sub-scale. On the 8-item *social disapproval* sub-scale two participants missed an item each while another five missed a single item on the 11-item *ethical generativity* sub-scale. Three participants missed all the items on the *social disapproval* sub-scale, *ethical generativity* sub-scale, and *the single item eldercare role modeling* sub-scale. Overall, only one participant missed a substantial number of items (89%) on the *filial obligation* scale and was thus classified as missing. Excluding the items on the *support from older adult* index described above, the numbers of missing data found on all the independent indices were relatively small. They ranged between zero to less than five percent.

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Demographic variables were also analyzed to identify patterns of missing data. The percentages of missing values caused by failure of participants to give responses were between 0.8 and four percent. For two participants who said they worked but failed to give responses to the question of income, their missing values were replaced by the median income. This conservative approach to dealing with missing data is appropriate since the overall median income remains the same and only less than two percent of the participants who responded to this item had their values substituted (Mertler & Vannatta, 2005). Generally, none of the variables missed significant numbers of items that would exclude them from further analysis.

Outliers

All the key variables were subjected to analysis to identify any outliers. Outliers are data points or cases with extreme values which have the potential to bias the model that fits the data (Field, 2005; Tabachnick & Fidell, 2007). In univariate analyses, they are generally designated as cases lying over three standard deviations from either side of the regression line and having large residuals (Wiggins, 2000). Box plot method was used to detect outliers. Outliers were found for both dependent and independent variables. On the *filial obligation* variable, five cases, all in the bottom quartile, were found to be outliers. Income had one upper quartile outlier. Dependent variables that had outliers included *number of phone calls* (5 outliers) and *remittance* (5 outliers). All the outliers on these dependent variables were located in the upper quartile.

Most outliers are often caused when either the participant or the researcher enters incorrect data. However, a careful investigation of the current research data found the outlying values to be "legitimate" responses and correctly entered. According to Gaussian

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distribution, it is normal to have about five percent outliers beyond two standard deviations from the mean in both directions because this mirrors the population at large (Wiggins, 2000). Iglewicz and Hoaglin (1993) suggested that if a researcher cannot determine the cause of an outlier, is should be used in the data analysis.

Reliability of Measures

The internal consistency of each scale or index was measured to determine whether each scale was measuring a single idea and hence whether the items making up each scale were internally consistent (Bryman & Cramer, 2009). The correlation coefficient ranges from 0 and 1 and the closer the result is to 1, preferably 0.8 and above, the more internally reliable a scale (Bryman & Cramer, 2009). Table 3.1 summarizes the results of the test of reliability of the measures for the current research.

Table 3.1: Test of Reliability of Measures

Measure	Cronbach's α
Support Receipt	0.91
Childhood/Adolescent support	0.94
Adulthood support	0.89
Filial Obligation	0.88
Felt duties	0.92
Social disapproval	0.87
Ethical Existence & generativity	0.87
Eldercare modeling*	--
Elder Vulnerability	0.90

Note: *One-item scale

All the original scales and subscales, except elder vulnerability, were internally consistent since their coefficients ranged between 0.87 and 0.94. The support receipt

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scale yielded an internal consistency coefficient of 0.91. Its constituent sub-scales, the 3-item childhood/adolescent sub-scale and 8-item adulthood support scale yield internal consistency coefficient of 0.94 and 0.89 respectively. Filial obligation comprised four sub-scales: 7-item felt duties sub-scale, 8-item social approval of eldercare sub-scale, 11-item ethical generativity subscale, and a 1-item eldercare modeling sub-scale. All the three multiple-item sub-scales and the main scale registered high internal consistency. Both social approval, and ethical generativity sub-scales yielded a coefficient of 0.87 while felt duties registered 0.92. The overall internal consistency of filial obligation was 0.88.

The elder vulnerability scale was the only scale that registered low internal consistency. Bryman and Cramer (2009) suggest that if a scale has a low internal reliability one or more items may be dropped in order to determine whether reliability can be boosted. The 4-item elder vulnerability scale initially registered a coefficient of 0.63 but when two items were dropped from the scale its coefficient eventually increased to 0.90. Consequently, only the two items – *how would you describe the current health condition of this elderly relative?"* and *"how would you describe the ability of this elderly relative to take care of his/her own physical needs?"* – which registered high internal consistency were included in further analysis.

Multivariate Assumptions

The data were examined to determine whether they conformed to the three general assumptions underlying multivariate statistical analysis – normality, linearity, and homoscedasticity. The results of the analysis may be biased if any one or more of the assumptions are violated (Kennedy & Bush as cited in Mertler & Vannatta, 2005).

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Normality

A data element is deemed normally distributed or symmetrical if its mean, median and mode coincide and the graph of its probability density is bell-shaped (Bryman & Cramer, 2009; Healey, 2005). A perfect normal distribution is devoid of extreme skewness (i.e., unbalanced or lopsided distribution) and extreme kurtosis (i.e., peakedness or flatness of the probability distribution). If there is a skew in a distribution, the mean is farther out in the tail than is the median. In a perfect normal distribution the values of skewness and kurtosis equal zero. The further away the values are from zero, the higher the possibility that the data are non-normal (Field, 2005). Since a perfect normal distribution is unlikely in real world situation, Bulmer (as cited in Brown, 2009) suggests the following guide: skewness less than -1 or greater than 1 is highly skewed, between -1 and –0.5 or between 0.5 and 1 is moderately skewed, and between -0.5 and 0.5 is approximately symmetric.

A careful observation of the histograms and normal curves showed all the independent variables appeared normal except filial obligation which was slightly negatively skewed (i.e., the distributions had relatively few low values). Conversely, the two continuous dependent variables – financial support, and phone calls were all positively skewed (i.e., the distributions had relatively few high values). The skewness and kurtosis statistics as shown in Table 3.2 indicates that, apart from support receipt (skewness statistics = -0.29) the rest of the key variables were either moderately or highly skewed. The kurtosis values indicate the possibility of leptokurtic distribution (i.e., too peaked) or platykurtic distribution (i.e., too flat).

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Table 3.2: Skewness and Kurtosis of variables

Variable	Skewness	Kurtosis
Support receipt index	-0.294	-0.948
Vulnerability index	-0.477	-0.742
Filial obligation index	-1.244	2.915
Income	0.698	0.424
Financial Support	2.923	12.800
Emotional support	1.787	3.777

Two other methods – Kolmogorov-Smirnov statistic, and normal probability plot or normal Q-Q plot – were used to assess the normality of the distribution. The Kolmogorov-Smirnov statistic tests the null hypothesis that the population is normally distributed by comparing the scores in the sample to a normally distributed set of scores with the same mean and standard deviation (Field, 2005; Mertler & Vannatta, 2005). A non-significant test means a distribution is probably normal, and vice versa (Field, 2005). Table 3.3 indicates that participant's income (KS = 0.09, p = .059) and support receipt index (KS = 0.092, p = .09) were non-significant, indicating that they were probably normally distributed.

A Q-Q plot is a graphical technique that compares the expected values, represented by a straight diagonal line, to the observed values, plotted as individual points (Field, 2005). If values are normally distributed, the dots will fall exactly on the line. If the dotted "line sags consistently below the diagonal or consistently rises above it, then it shows that the kurtosis differs from a normal distribution, and when the curve is S-shaped, the problem is skewness" (Field, 2005, p. 96). A careful observation of the Q-Q plots of the independent variables showed that, with exception of a few values at the extreme ends, most of the values fell on or were close to the diagonal. Compared with the

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independent variables, a relatively larger number of values of the dependent variables deviated from the diagonal, although only a few deviated substantially.

Table 3.3: Test of normality of key continuous variables

Variable	Statistic	df	sig.
Participant Income	.097	81	.059
Support Receipt	.092	81	.090
Elder Vulnerability	.184	81	.000
Filial Obligation	.129	81	.002
Phone Contact	.204	81	.000
Financial Support	.207	81	.000

a. Lilliefors Significance Correction

Linearity

The second assumption – linearity presumes that the dependent variable has a linear relationship with each independent variable. This assumption is crucial since most of the multivariate techniques are based on a linear combination of variables (Mertler & Vannatta, 2005). In this study residual plots, which are also used to assess another multivariate assumption – heteroscedasticity, were used. Since residual plots were used to assess both linearity and heteroscedasticity, the results of both assumptions are discussed in the next section.

Heteroscedasticity

The final assumption underlying regression was examined. This assumption is that the variance of the errors is constant across observation, in which case, the errors are termed homoscedastic. But if the spread of the errors are uneven they are said to be heteroscedastic. In the presence of heteroscedasticity, the ordinary least square (OLS) estimator remains consistent but inefficient. Therefore, inferences made from the

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standard errors are likely to be unreliable. Two of the main causes of heteroscedasticity are the presence of outliers and skewness in the data distribution – conditions that earlier discussions have shown to be present to some extent in the current data.

There are several methods for determining the presence of heteroscedasticity. For the current study, it was assessed through visual examination of standard residual plots or scatterplots. The scatterplot distributions typically assume funnel shapes in the presence of heteroscedasticity and oval, elliptical or rectangular shapes in its absence (Bryman & Cramer, 2009; Mertler & Vannatta, 2005). Figure 3.1 shows the residual plots between each continuous dependent variable and each independent variable. A visual inspection of the residual plots suggests a good homogeneity of variance between *support receipt* and *financial support*, *filial obligation* and *financial support,* and *filial obligation* and *phone calls* but moderate heteroscedasticity between *support receipt* and *phone calls, elder vulnerability* and *financial support*, and *elder vulnerability* and *phone calls.*

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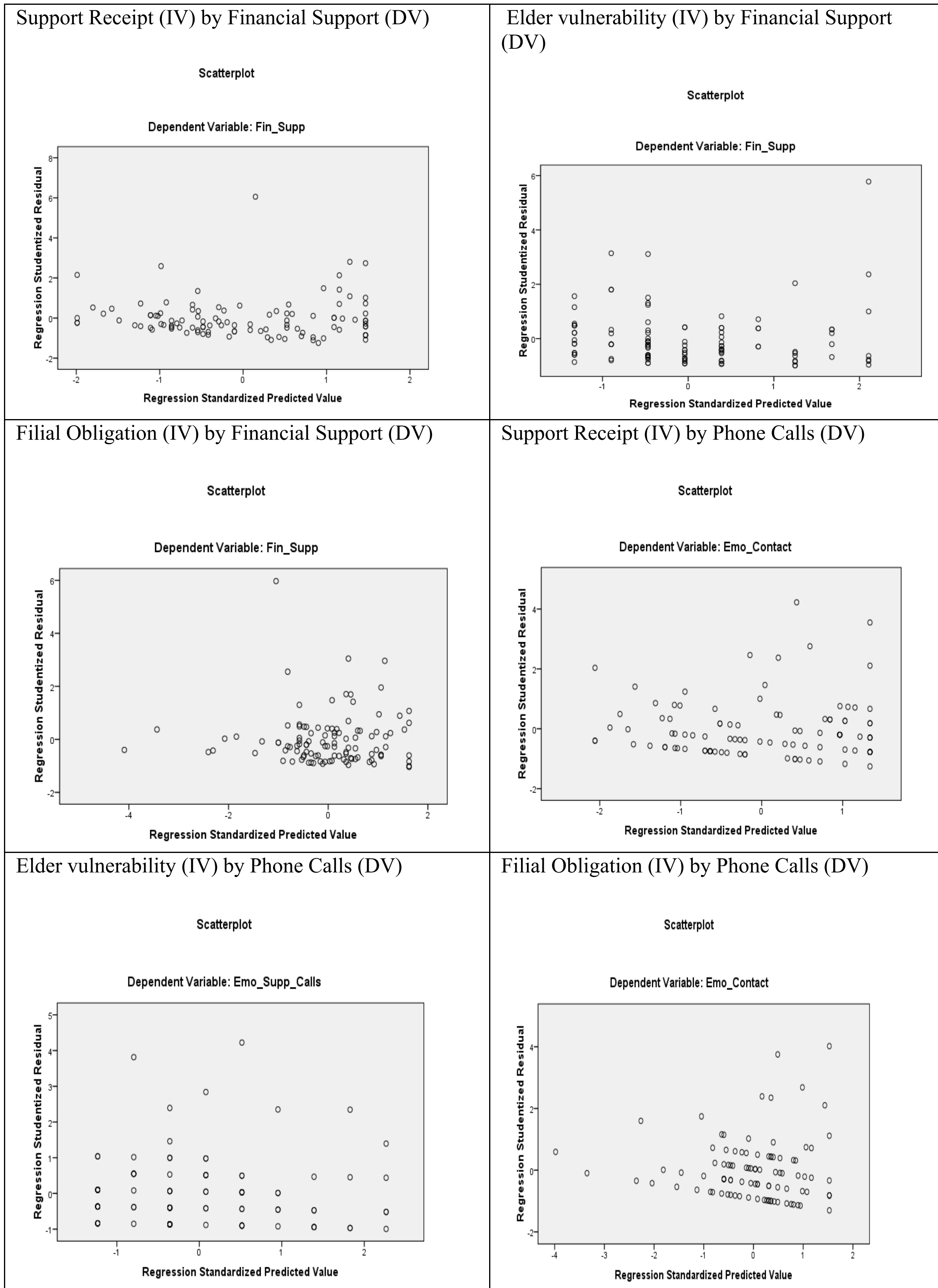
Figure 3.1: Residual Plots of independent and dependent variables



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Data Analysis

Data analysis began with a descriptive analysis of the demographic data followed by a description of the research variables and their bivariate relationships, and then, the multivariate analysis. Tables were used to provide graphical representation of the descriptive data. Relationships between key research variables were examined using bivariate correlation technique. For continuous or interval variables, Pearson correlation coefficient (r) was used. It allows researchers to assess the strength and direction of relationship between variables (Field, 2005). To assess the relationship between continuous variables and those measured at nominal or ordinal levels a series of *eta* coefficients were calculated (Bryman, & Cramer, 2009). *Eta* analysis requires that all variables be either at nominal or ordinal level (Bryman, & Cramer, 2009) so that all the continuous variables were dichotomized at their median before being included in the analysis. Scores above their median were categorized as high scores, while scores at the median or below were classified as low scores.

To test the research hypotheses a series of hierarchical or sequential multiple and logistic regressions were conducted. In both techniques, the researcher decides the order in which the predictor or independent variables are entered into the model (Tabachnick, & Fidell, 2007) based on theory or temporal order (Cohen, & Cohen as cited in Petrocelli, 2003). Sequential regression allows researchers to determine how much an independent variable adds to the prediction of a dependent variable, over and above what other independent variables in the model accounted for (Petrocelli, 2003). In the current research, the focus was how much the independent variables – *filial obligation, support receipt, and perceived elder vulnerability* contributed over and above what caregiver-care

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recipient relationship, and caregiver's education in the United States contributed to the prediction of eldercare provided by immigrant caregivers. Thus, to determine the contribution of each of the independent variables of each type of elder, caregiver-care recipient, and caregiver's education were controlled. The rationale for selection and the order in which the independent variables were entered into the models is detailed in Chapter 4.

Although hierarchical multiple regression and sequential logistic regression are similar and use identical procedures, their use is determined by the measurement level of the dependent variable of interest (Field, 2005). Hierarchical regression is used when the dependent variable is continuous. Therefore, it was employed in the assessment of the contributions of financial support, and phone contact which were continuous variables. In this case, the *R-square change* and its corresponding change in F and p values were the most important statistics (Wampold, & Freund as cited in Petrocelli, 2003). On the other hand, sequential logistic regression was employed in the assessment of the contribution of return visit which was a dichotomous or nominal dependent variable. Logistic regression in this case helped determine the extent to which the independent variables increased the odds of either caregivers visiting or not visiting elderly relatives in Ghana. The statistic of interest in logistic regression include *wald statistic*, *B*-value and *Exp(B)*.

In this chapter I have described the research methodology. Specifically, a description of the study area and the rationale for selecting it were provided, the recruitment and the data collection procedures were outlined, and the specific data analyses methods and procedures were described. In Chapter 4, I present the research findings.

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CHAPTER 4

Study Findings

The study findings are divided into four sections. The first section highlights the background and demographic characteristics of the caregivers and care recipients on whom they based their responses. In the second section I provide descriptive statistics on the independent research variables, including summary scores on each scale. In the third section I report the descriptive statistics on the dependent variables. A fourth section elaborates on the bivariate analyses of the relationships among the research variables and details the results of the hierarchical and logistic regression analyses used to test the research hypotheses.

Sample Characteristics

Characteristics of Caregivers

Caregivers included 124, with 66 men (53%) and 58 women (47%). The average age for the caregivers was 34 years with a vast majority (73%) between 26 and 45 years of age. A large majority of them were married (65%), identified with the Akan ethnic group (70%), and were members of a Ghanaian social and/or religious organization (63%). Their median income was $26,000, although three-quarters of participants had an income of $35,000 or below. Men had a higher mean income ($29,888) than women ($23,549). Warehouse operator/factory hand (22%) dominated the reported occupations. Prior to their migration, teaching (22%) was the dominate occupation among the participants.

The median years caregivers had resided in the United States was six. Five participants (4%) were born in the United States while another two migrated with their

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families before they were of school age. Fifty-five percent migrated to the United States having completed "some college" or higher levels of education in Ghana. Forty percent had acquired "some college" or a higher level of education in the United States after their migration.

About 72 percent of participants had at least one child who was less than 18 years old. Out of those who had children, about a quarter had none of their children living with them in the United States. The mean number of children living with caregivers in the United States was two. A vast majority of participants (98%) reported having siblings and the mean number of siblings was five. About 22 percent of participants were either first-borns, oldest among their living siblings or the only child, 64 percent were middle-borns, and 14 percent were last-borns. Ninety-two percent of participants described their health as good or excellent. Thirteen percent of participants had missed work due to a health situation, out of which four percent said they could not perform their eldercare duties to their targeted older adult relative due to their ill-health. Sixty-one percent of participants reported that they had health insurance while 38 percent did not. Only 15 percent of participants reported missing work due to immigration-related issues.

Besides the targeted older adult relative, caregivers provided some form of care to an average of about three other older adult relatives living in Ghana. Participants gave multiple reasons why they based their responses on their chosen older adult relatives. The two major reasons were "he/she gave me most support" (30%), and "he/she is my parent" (22%). Table 4.1 summarizes the demographic characteristics of caregivers.

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Table 4.1:

Demographic Characteristics of Caregivers

Variable	Category	N	%	M	SD
Gender	Male	66	53.2		
	Female	58	46.8		
Age (years)		124		34	9.06
	18 – 25 years	21	16.9		
	26 – 35 years	50	40.3		
	36 – 45 years	41	33.1		
	46 years and above	12	9.7		
Marital Status	Single	38	30.6		
	Married	80	64.5		
	Divorce	5	4.0		
	Separated	1	0.8		
Relationship to care recipient	Mother	38	30.64		
	Father	20	16.12		
	Grandmother	16	12.90		
	Grandfather	11	8.90		
	Other Relative	39	31.44		
Caregiver Income	$15000 or less	30	25.2		
	$15000 ≥ 25000	29	24.4		
	$25000 ≥ 35000	30	25.2		
	$35000 ≥ 45000	16	13.4		
	More than $45000	14	11.7		
Are you a member of any Ghanaian Association/group?	Yes	78	62.9		
	No	46	37.1		
Ethnicity	Akan	87	70.2		
	Ewe	13	10.5		
	Ga	11	8.9		
	Dagbani	4	3.2		
	Larteh	4	3.2		
	Gonja	3	2.4		
	Others	2	1.6		

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Table 4.1 contd.

Demographic Characteristics of Caregivers

Variable	Category	N	%	M	SD
*Education acquired in Ghana	Less than high school	19	15.6		
	Completed high school	35	28.7		
	Some college/bachelors	57	46.7		
	Graduate degree	4	3.3		
Education acquired in the US	None	65	52.4		
	High school/Some College	23	18.6		
	Bachelors/Graduate degree	35	28.2		
# of children < 18 yrs		123		1.60	1.38
# of children < 18 yrs living with caregiver		83		1.51	1.15
# of siblings		116		4.88	2.61
Position among siblings	First-born/Oldest living	26	21.7		
	Middle-born	77	64.2		
	Last-born	17	14.2		
# of yrs residence in the US Range: 6 months – 42 years		118		6.08	6.18
# of other older adult relatives caregivers providing care for		123		2.43	2.61
Self-reported health status of participants	Excellent	89	71.8		
	Good	25	20.2		
	Average	8	6.5		
	Below average	2	1.6		
Do you have health insurance	Yes	76	61.3		
	No	47	37.9		
Did you miss work for health-related issues	Yes	16	12.9		
	No	105	84.7		
Did you miss work for immigration-related issues	Yes	19	15.3		
	No	104	83.9		

Note: If a total does not add up to 124 or 100% it means some participants chose not to answer that particular question. *Excluded five caregivers who were born in the United States and two who migrated with their families before they were of school age.

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Characteristics of Care Recipients

A majority of care recipients were married women (57%), and maternal relatives of the caregivers (63%). The largest group of care recipients were parents (48 %) followed by aunts/uncles (25%), grandparents (21%), and other relatives (7%). Their ages ranged from 50 to 101 years (M = 66.59) with about 55 percent within the 50-65 age group. A slight majority of care recipients were reported to be economically active (53%) with farming (29%), trading (18%), and teaching (13%) as the most reported past or current occupations.

About 20 percent (n = 25) of care recipients, had within the past 12 months, provided childcare for children of their care providers. The mean number of children cared for was two. Thirty-six percent (n = 45) were reported to have experienced serious medical problems within the past 12 months, while another 18 percent (n = 22) had a major financial problem. Excluding participants, about 52 percent of targeted older adult relatives received financial support from other relatives residing in other Western and high-income countries. Financial support that targeted older adults received from family relatives living in Ghana is reported under a separate financial support section below. Table 4.2 summarizes the demographic characteristics of eldercare recipients.

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Table 4.2

Demographic Characteristics of Care Recipients

Variable	Category	N	%	M	SD
Gender	Male	53	42.7		
	Female	71	57.3		
Age (years)		124		66.59	11.61
	50 – 65 years	68	54.8		
	66 – 79 years	37	29.8		
	80 years and above	19	15.3		
Marital Status	Single	0	0.0		
	Married	71	57.3		
	Divorce	15	12.1		
	Widowed	38	30.6		
Participation in economy	Active	66	53.2		
	Retired/inactive	58	46.8		
# of children older adult cared for		24		1.62	0.77
Did older adult person have a major medical problem	Yes	45	36.3		
	No	71	57.3		
	Don't know	8	6.4		
Did older adult person have a major financial problem	Yes	22	17.7		
	No	88	71.0		
	Don't know	14	11.3		
Excluding you, did older person receive financial support from any relatives in a high-income or Western country	Yes	64	51.6		
	No	56	45.2		
	Don't know	3	2.4		

Note: if a total does not add up to 124 or 100% it means some participants chose not to answer that particular question.

Descriptive Statistics of Independent Variables

In this section, I will report the findings of each item within each of the five indices that were developed, followed by a computation of the summary scores within

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each scale. These five include: (1) support received from elderly persons in childhood and adolescence, (2) support received from elderly persons in adult life, (3) felt duties, social disapproval, (4) ethical existence and generatively, and (5) perception of old-age vulnerability. Support for both childhood and adolescence as well as for adulthood will be included in the following section under Social Support.

Support Receipt Scale

Caregivers were asked to report on two types of social support – that received from elderly persons in their childhood and adolescence, and support received as adults. Each item was ranked on a six-point scale according to the role played by the targeted elder: 0 (no role), 1 (very low role), 2 (low role), 3 (neither high nor low role), 4 (high role), or 5 (very high role). Table 4.3 summaries the three types of support received in childhood and adolescence. Note that for the purposes of reporting these data, "very low role" and "low" role were collapsed into "low role," and "very high role" and "high role" were collapsed.

Table 4.3: Ranking of Support Receipt in Childhood and Adolescence

Type of Support	**High Role**	**Neither High nor Low**	**Low Role**	**No Role**	**Mean**	**SD**	**N**
Socialization	84 (67%)	14 (11%)	13 (11%)	13 (11%)	3.85	1.687	124
Child care	87 (70%)	11 (9%)	9 (7%)	17 (14%)	3.83	1.811	124
Elementary school education	80 (65%)	9 (7%)	14 (11%)	21 (17%)	3.58	1.947	124

Socialization includes activities such as provision of advice, and teaching of domestic and social skills. Child care comprises infant care, babysitting, and provision of

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food and material assistance. Activities included in elementary school education were school expenses and assistance with school work. On the whole, an overwhelming majority of caregivers rated each type of support received from elders in childhood and adolescence as high, with childcare (70%) receiving the highest percentage, followed by socialization (67%) and elementary school education (65%). The mean score for the three types of childhood and adolescence support was equally high. On a scale of 0-5, the mean scores ranged between 3.35 and 3.84.

Table 4.4 summarizes the eight types of support received in adulthood. Representation at social events (including funeral, marriage, and other sociocultural events) in Ghana, and financial/material/emotional support to the caregiver or family were the main areas caregivers received the most support from elders. About 60 percent of caregivers ranked each of these two items as a major source of support. The mean score for both were 3.36 out of a possible 5.0.

However, Table 4.4 indicates that a large majority of caregivers received no support from elders in five of the eight areas of support as reflected in their low mean scores of 1.78-2.09. Specifically, 69 percent of caregivers received no support from elders in “care for property in Ghana,” 67 percent in “financial support for US trip,” 60 percent in “care for immediate family in Ghana,” 60 percent in “material and social support for US trip,” and 57 percent in “support for career in Ghana.” Forty-four percent of caregivers reported receiving high support from elders for their college education in Ghana while 40 percent received low or no support.

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Table 4.4: Ranking of Support Receipt in Adult Life

Type of Support	High Role	Neither High nor Low	Low Role	No Role	Mean	SD	N
Representation at Social Event	72 (59%)	11 (9%)	17 (14%)	22 (18%)	3.37	1.955	122
Financial/material/emotional needs	73 (59%)	15 (12%)	10 (8%)	25 (20%)	3.37	2.021	123
*College Education	44 (48%)	7 (8%)	10 (11%)	30 (33%)	2.73	2.196	91
Care for immediate family in Ghana	44 (36%)	10 (8%)	9 (7%)	60 (49%)	2.09	2.243	123
Social/material Support for US Trip	41 (34%)	9 (7%)	11 (9%)	60 (50%)	2.00	2.214	121
Care for Property/Business in Ghana	41 (33%)	6 (5%)	7 (6%)	69 (56%)	1.80	2.231	123
Financial support for US Trip	38 (32%)	4 (3%)	11 (9%)	67 (56%)	1.79	2.245	120
**Support for Career in Ghana	32 (28%)	7 (6%)	17 (15%)	58 (51%)	1.78	2.136	114

Note: * Item was not applicable to caregivers who did not attend college in Ghana
** Item was not applicable to caregivers who did not actively seek employment in Ghana or some caregivers chose not to answer that particular question.

Felt Duties Scale

Seven items comprise the felt duties index. Each item is listed in Table 4.5 with frequencies, percentages, and means. Overall, caregivers felt strongly about performing all the listed activities for their elders. Two-third of caregivers felt strongly about doing each of the listed care duties, with “show love” registering the highest percentage (84%) of caregivers and “offer support in everyday care activities (e.g. housework, chores, providing housing, etc) being the least (67%). The mean score for all the felt duties index fell between 3.82 and 4.39 out of a possible 5.0.

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Table 4.5: Ranking of Felt Duties for Elderly Relatives

How obligated do you feel to do the following for your elder?	Strong Feeling	Neither High nor Low	Low Feeling	No Feeling	Mean	SD	N
Show love	103 (84%)	7 (6%)	10 (8%)	3 (2%)	4.39	1.259	123
Provide emotional support	100 (81%)	10 (8%)	12 (10%)	1 (1%)	4.36	1.181	123
Show appreciation	99 (81%)	9 (7%)	9 (7%)	6 (5%)	4.24	1.381	123
Please them	89 (72%)	12 (10%)	17 (14%)	4 (4%)	4.01	1.485	123
Provide financial support	87 (71%)	12 (10%)	21 (17%)	3 (2%)	3.97	1.459	123
Provide everyday care activities	83 (67%)	13 (11%)	21 (17%)	6 (5%)	3.85	1.566	123
Return Favors	86 (70%)	7 (6%)	21 (17%)	9 (7%)	3.82	1.674	123

Note: if a total does not add up to 124 or 100% it means some participants chose not to answer that particular question.

Social disapproval Scale

In Table 4.6 the distribution of the rating of each type of social disapproval items are shown. Caregivers reported how much they agreed or disagreed with each statement. Generally, the vast majority of caregivers said they agreed with all the statements. The highest percentage of caregivers (88%) agreed that providing eldercare enhances the standing of their elders. The statement that received the least agreement from caregivers was "people who take good care of their elderly relatives deserve social recognition." The high percentages of caregivers agreeing with the disapproval statements resulted in high mean scores, which ranged between 3.43 and 4.58 out of a possible 5.0.

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Table 4.6: Ranking of Social Implication of Eldercare

Opinion on social implication of elderly caregiving in Ghanaian society	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Mean**	**SD**	**N**
Social Standing of Elders	106 (88%)	10 (8%)	5 (4%)	4.58	.873	121
Social Standing of Caregivers	97 (80%)	17 (14%)	7 (6%)	4.40	1.061	121
Opinion of Others	97 (81%)	10 (8%)	13 (11%)	4.27	1.235	120
Opinion of Eldercare Recipients	97 (80%)	9 (7%)	15 (13%)	4.21	1.233	121
Impression of Family/Friends about Elder Neglect	88 (73%)	3 (2%)	30 (25%)	4.00	1.517	121
Opinion of Family and Friends	86 (72%)	10 (9%)	23 (19%)	4.00	1.378	119
Impression of Others	82 (68%)	6 (5%)	33 (27%)	3.85	1.558	121
Social Recognition of Caregivers	71 (59%)	8 (6%)	42 (35%)	3.43	1.783	121

Note: if a total does not add up to 124 or 100% it means some participants chose not to answer that particular question.

Ethical Existence and Generativity Scale

Caregivers were also asked their opinion on whether they agreed or disagreed with eleven statements on religious and philosophical beliefs about eldercare in Ghana. See Table 4.7 for a summary of results. The highest percentage of caregivers believed that "elder care is a moral obligation for all adult children" (93%). An overwhelming proportion of caregivers agreed with other statements. These were "providing eldercare is a way of showing respect to elders" (86%), "people who take good care of their elderly relatives will receive blessings from God" (73%), and "elder caregiving is a religious obligation for all adult children" (72%).

Nonetheless, a majority of caregivers disagreed with seven out of 11 items. Two-thirds of participants disagreed with two statements – "the souls of people who took good care of their elderly relatives will go to Heaven" and "people who did not take good

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care of their elderly relatives will be punished by the gods and the ancestors" registering the highest percentage of disagreement (65%).

Table 4.7: Ranking of Religious and Philosophical Beliefs about Eldercare

Religious and philosophical beliefs underlying elder caregiving in Ghana	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Mean**	**SD**	**N**
Moral Obligation for Adult Children	113 (93%)	3 (3%)	5 (4%)	4.69	.847	121
Showing Respect to Elders	104 (86%)	9 (7%)	8 (7%)	4.51	1.026	121
Blessings from God	89 (73%)	13 (11%)	19 (16%)	4.10	1.417	121
Religious Obligation	87 (72%)	12 (10%)	22 (18%)	3.98	1.508	121
Neglect by own Adult Children	52 (43%)	8 (7%)	61 (50%)	2.85	1.801	121
Punishment by God	49 (40%)	12 (10%)	60 (50%)	2.82	1.775	121
Blessings from Ancestors	41 (35%)	11 (9%)	66 (56%)	2.55	1.708	118
Acceptance into the Spirit World	40 (33%)	9 (7%)	72 (60%)	2.50	1.733	121
Personal Prosperity	35 (29%)	13 (11%)	73 (60%)	2.43	1.717	121
Soul go to Heaven	35 (29%)	8 (7%)	76 (64%)	2.39	1.703	119
Punishment by the gods	34 (28%)	8 (7%)	79 (65%)	2.32	1.719	121

Note: if a total does not add up to 124 or 100% it means some participants chose not to answer that particular question.

Perception of Old-Age Vulnerability Scale

Table 4.8 summarizes the four types of old-age vulnerability index. The highest proportion of caregivers (90%) reported that their elders have adequate numbers of people to provide them with care. Asked to describe the money/material resources available to their elder person to take care of his/her needs (not counting money/material support from the caregiver), 63 percent reported "sufficient" resources. On a five point

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scale ranging from "very bad" to "very good" more than half of caregivers described the current health condition of their elder as adequate or good. One-half of caregivers described the ability of the elderly person to take care of his/her own physical needs as "good."

Table 4.8: Ranking of Care Needs of Elders

Type of Care Need	Adequate or Good	Neither adequate/good nor inadequate/bad	Inadequate or Bad	Mean	SD	N
Number of Caregivers	112 (90%)	7 (6%)	5 (4%)	4.5081	.84098	124
Money/Material for Caregiving	78 (63%)	32 (26%)	14 (11%)	3.8548	1.13118	124
Health Condition	68 (55%)	31 (25%)	25 (20%)	3.4597	1.21240	124
Physical Ability	62 (50%)	28 (23%)	34 (27%)	3.2984	1.33727	124

Summary Scores of Each Scale

Having reported the responses to the items in each scale, I will now provide summary scores for each scale. How the total score of the scale were computed has been described in Chapter 3. Table 4.9 summarizes the statistics for the independent variables.

Summary Score of Support Receipt Scale (Childhood and Adulthood combined)

Most caregivers reported high scores on the childhood/adolescent support sub-scale. It had a mean score of 11.25 with a range of 0-15. On the other hand, the mean score for the adulthood support sub-scale was low, ranging from 0-40 with a mean of 18.79. Overall, the mean score of support receipt which was 30.17 fell around the middle point of its range which was 0-55 range. High scores indicate caregivers had received high levels of support from their older adult relatives. It is worth noting that about 30

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percent of caregivers based their responses on specific targeted older adult relatives because they previously had, or were at the time of the research, receiving support from those targeted older adult relatives. In other words, since caregivers were asked to select only one targeted older adult for the sake of answering the questionnaire, approximately a third based their selection decision on their having been supported at some time in their life by that person.

Summary Score of Filial Obligation Scale

Caregivers reported high scores on the felt duties sub-scale. The mean was 28.64 out of a maximum score of 35. High scores indicate an acceptance of eldercare duties. Scores on social disapproval ranged between 12 and 40 with a mean score of 32.74. The remarkably high scores suggest that caregivers were responding to eldercare the way they felt they should. Caregivers also reported high scores on eldercare modeling. High scores show that caregivers responded to their eldercare duties the way they felt their children should see them respond. Similar to the other filial obligation sub-scales, the ethical generativity sub-scale also registered high scores ranging from 13 to 55 with a mean of 35.19. A high score on the ethical generativity sub-scale indicates caregivers approached eldercare the way in which they had been socialized to approach it. On the whole, participants felt obligated, as reflected in the high scores generated by the felt obligation scale, to provide care for their older adult relatives. The scores on this scale ranged from 13 and 135 with a mean of 99.78.

Summary Score of Elder Vulnerability Scale

The scores on the elder vulnerability scale ranged from 2 to 10 with a mean of 6.75. A high score indicates that the older adult person is in good health and able to take

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care of his or her own physical needs. The majority of care recipients (55%) were either 65 years or younger, and this may reflect why scores indicated that elders were not seen as highly vulnerable.

Table 4.9: Descriptive Statistics of Independent Variables

Measure	Range	Mean	SD	N
Support Receipt	0 – 55	30.17	16.72	122
Childhood/Adolescent support	0 – 15	11.25	5.16	124
Adulthood support	0 – 40	18.79	13.36	122
Filial Obligation	13 – 135	99.78	22.37	123
Felt duties	0 – 35	28.64	8.38	123
Social disapproval	12 – 40	32.74	7.90	121
Ethical Existence & generativity	13 – 55	35.19	11.48	121
Eldercare modeling	1 – 5	4.39	1.12	121
Elder Vulnerability	2 – 10	6.75	2.43	124

Note: If a total does not add up to 124 or 100% it means some participants chose not to answer that particular question.

Descriptive Statistics of Dependent Variables

This section reports the findings of the three dependent variables. They include financial support (i.e., the dollar amount caregivers sent to their care recipients per month), phone contact (i.e., the sum of the number of phone calls caregivers and care recipients had per month), and return visit (i.e., the number of times caregivers visited care recipients in Ghana within 12 months of the research). I report the level of support provided, and where applicable, the related cost, the method, and other sources of support are described.

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Financial support

Table 4.10 summarizes the results of financial support. About 90 percent of respondents sent remittance to their entire family members in Ghana within the past 12 months of the research. Out of this number, about 92 percent sent remittance to elderly family relatives. A high level remittance indicates higher financial/material support. The lowest monthly financial support for elders was one dollar and the highest was $500. The median monthly remittance was $50, on average, about 40 percent of the total amount caregivers remitted monthly to their entire family in Ghana. The average cost for sending money to elders was $5 and the major mode of remittance was bank/electronic transfer.

Caregivers gave multiple reasons for providing financial/material support to their older adult relatives. They included food and other household expenses (56%), medical expenses (44%), gifts (23%), housing (14%) and other reasons (1%). Despite the high percentage of caregivers (82%) who provided some kind of financial/material care to the targeted older adult relative, only about 32 percent considered themselves as the main financial caregiver of their targeted older adult relatives. Family relatives who gave financial/physical care to the targeted older adult person within the period under investigation were caregivers' siblings in Ghana (40%), caregiver's own parents (24%) (often to caregivers' own grandparents), other family members (36%), and siblings of caregivers in other high-income and Western countries (19%). Twenty-one percent of participants said their targeted older adult relative did not receive financial support from any other sources or did not need any financial support.

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Table 4.10: Descriptive Statistics of Financial Support

Variable	Category	N	%	M	SD
Did you send money to any of your family members in Ghana	Yes	111	89.5		
	No	12	9.7		
Did any of the money your sent go to your elderly relatives in Ghana	Yes	101	91.8		
	No	9	8.2		
Average monthly remittance to all family members in Ghana		111		$150	142.55
Cost of remittance transfer to all family members in Ghana		124		$19	30.05
Proportion of total family remittance that goes to elderly family members		101		$40	31.83
Average monthly remittance to elders only		101		$50	75.21
Cost of remittance transfer to elders only		101		$5	6.33
Method of transfer	Bank/Electronic transfer	106	85.5		
	Acquaintance visiting Ghana	19	15.3		
Use of remittance by elders	Food/Household expenses	69	55.6		
	Medical expenses	55	44.4		
	Gift	28	22.6		
	Housing	17	13.7		
	Others	1	0.8		
Would you describe yourself as the main financial provider of elders	Yes	39	31.5		
	No	84	67.7		
Excluding caregiver, other family members who provided financial/material resource to elders	Siblings in Ghana	50	40.3		
	Other family members	45	36.3		
	Caregivers own parent	30	24.2		
	Elder did not need financial assistance	26	21.0		
	Siblings in Western countries	24	19.4		
	Siblings in African countries	12	9.7		

Note: (1) If a total does not add up to 124 or 100% it means some participants chose not to answer that particular question. (2) If a total adds up to more than 124 or 100% it means participants had the choice to provide multiple responses

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Phone Contact

Table 4.11 summarizes the results of phone contact. Like financial support, a large proportion of caregivers (76%) had phone contacts with their older adult relatives. The median number of phone contacts was two per month. The length of a phone conversation with elders was 20 minutes and the cost per phone call was about $6.00. Some of the reasons for phone contacts with elders included saying hello (67%), checking on the older adult person's health (58%), giving information to the older adult person about remittance (40%), and discussing issues relating to other family members (37%).

Despite the large majority of participants who had phone contact with their elders, only about 10 percent regarded themselves as the main emotional supporters of the target older adult relative. The largest groups of relatives mentioned as providing emotional support to older adult relatives were other family members who lived in Ghana (85%), caregivers' own siblings living in Ghana (65%) and caregivers' own parents living in Ghana (54%).

The main reasons given by caregivers who did not have any phone contact with their elders were that they "talked to other family relatives about older adult person" (16%), there was "no phone reception or access where older adult lives" (13%), and "older adult person's health condition made it impossible for him or her to talk" (4%).

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Table 4.11: Descriptive Statistics of Phone Contact

Variable	Category	N	%	M	SD
Number of phone calls to all family members in Ghana		120	96.8	4.00	4.55
Did you talk to elderly relative in your phone calls	Yes	94	75.8		
	No	26	21.0		
Number of phone calls to elders per month		94		2.00	2.09
Cost of phone calls to all family members in Ghana		117		$13.00	20.80
Cost of phone calls to elders only		92		$5.66	9.58
Length of conversation with elders (in minutes)		93		20.00	12.84
Purpose of phone conversation with elders	Say hello	83	66.9		
	Check on health	72	58.1		
	Send money	50	40.3		
	Discuss family-related issues	46	37.1		
	Others reasons	9	7.3		
Would you describe yourself as the main financial provider of elders	Yes	12	9.7		
	No	112	90.3		
Why didn't you talk with elderly person?	No phone access/reception	16	12.9		
	Talked with other family members	20	16.1		
	Elderly person cannot talk	5	4.0		
	Other reasons	5	4.0		
Excluding caregiver, other family members who had phone contact with elders	Other family members	105	84.7		
	Siblings in Ghana	81	65.3		
	Caregivers own parent	56	45.2		
	Siblings in Western countries	17	13.7		
	Siblings in African countries	11	8.9		

Note: (1) If a total does not add up to 124 or 100% it means some participants chose not to answer that particular question. (2) If a total adds up to more than 124 or 100% it means participants had the choice to provide multiple responses.

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Return visit

Only about a quarter of caregivers visited their care recipients and did so only once within the past 12 months. The median number of days return visitors stayed in Ghana was 37 and the median number of days they lived, visited or spent time in the household in which elders live was seven. Since there was no variation in the number of return visits, the variable was recoded into a dichotomous variable, with one category defined as return visitors and the other category as non-return visitors, for further analyses.

Table 4.12: Descriptive Statistics of Return Visit

Variable	**Category**	**N**	**%**	**M**	**SD**
Did you visit Ghana?	Yes No	30 93	24.2 75.0		
How many times did you visit within the past 12 months		30		1	
How many days did you stay in Ghana?		30		37	45.75
How many days did you live, visit, or spend time in the household in which elders live?		29		7	20.93

Note: 1. If a total does not add up to 124 or 100% it means some participants chose not to answer that particular question or question was not applicable.
2. If a total adds up to more than 124 or 100% it means participants had the choice to provide multiple responses.

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Summary of the Dependent Variables

Table 4.13 provides a summary of the key statistics of the dependent variables.

Table 4.13: *Descriptive Statistics of Dependent Variables*

Measure	Category	N	%	Mean	SD
Financial Support		101		$50	$75
Phone Contact		94		2.89	2.15
Did you visit care recipient?	Yes	30	23.4		
	No	95	76.6		

Bivariate Analyses

A series of bivariate correlations were conducted to assess relationships between the key research variables. It is prudent for researchers to know such relationships since a strong correlation increases the chances of spurious results (Bryman & Cramer, 2009). Cohen and Holliday (as cited in Bryman & Cramer, 2009) have suggested the following guidelines to determine desirable correlations: 0.19 and below is considered very low; 0.20 to 0.39 is low; 0.40 to 0.69 is modest; 0.70 to 0.89 is high; and 0.90 to 1 is very high.

Correlation among continuous variables

Pearson's correlation was used to assess relationships between key variables measured at interval or ratio level. The result of the Pearson's correlations matrix is shown in Table 4.14. All the significant correlations were positive and of low strength. *Support receipt* was correlated positively to filial obligation ($r = .36$, $p = .000$), phone calls ($r = .24$, $p = .016$), and financial support ($r = .35$, $p = .000$), indicating these variables increased if a participant received support from an older adult relative. Filial

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obligation was positively correlated to phone calls (r = .23, p = .018). Thus, the more one felt obligated to an older adult relative, the more phone contacts were made. Income and financial support were also correlated positively (r = .31, p = 001) implying that the higher a participant's income, the higher financial support he or she gave. However, income did not have any relationship with number of phone calls participants made with care recipients. Not surprisingly, financial support and phone calls were correlated positively (r = .30, p = 004) since remitters often call recipients to give them the necessary electronic transfer password required to access the wired money.

Table 4.14

Correlation matrix among all key continuous variables

Variable	1	2	3	4	5	6	7
Support Receipt	--	.289**	.364**	.244**	.356**	.310**	-.172
Elder Vulnerability		--	.099	.019	.033	.064	-.445**
Filial Obligation			--	.238*	.138	.026	-.030
Phone Contact				--	.302 **	.148	.108
Financial Support					--	.310**	.091
Participant's Income						--	.091
Age of older adult persons							--

Note: * $p < .05$; ** $p < .01$

Correlation among dichotomous and continuous variables key variables

Previous studies suggest that various long-distance caregiver- and eldercare recipient-specific demographic characteristics influence the level of eldercare provided by long-distance caregiver. To explore these in depth a series of *eta coefficients* were

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calculated for variables measured at nominal and ordinal levels (Bryman & Cramer, 2009). Of all the caregiver- and care recipient demographic variables in the study, only two – *participant's level of education attained in the United States* (F = 3.961 at $p < .005$, η = .367, η2 = .134) and *familial relationship between caregiver and care recipient* (F = 2.714 p < .006, η = 2.714, η^2 = .219) varied with financial support. The eta coefficients suggested that participant's level of education attained in the United States explain 13 percent of the variance in financial support while more than a fifth of the variance can be attributed to the familial relationship. Demographic characteristics that varied with phone calls were caregiver's marital status (F = 2.743, $p < .047$, η = .282, η^2 = .080) and whether the caregiver was the main financial provider of the older adult person or not (F = 3.994, $p < .022$, η = .277, η^2 = .077) suggesting each contributes less than 10 percent of the variance in phone calls.

Hypotheses Testing

Two main types of regression analyses – hierarchical multiple regression (for continuous dependent variables) and logistic regression (for dichotomous dependent variables) – were conducted to test the research hypotheses. Three independent variables – participant education acquired in the United States, participant income, and participant-older adult person relationship – were controlled for before the effect of each of the independent variables was assessed. The rationales for controlling for these three independent variables follow.

Education acquired in the United States was selected because higher education has a strong relationship with financial resources since highly educated people generally are employed in high-end jobs that pay higher remuneration and vice versa. The literature

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shows that education acquired in the United States is preferred by employers. Given this circumstance, I expected higher education acquired in the United States to influence the levels of eldercare participants were capable of providing. Education was aggregated and was represented in the models as two dummy variables – caregivers who had complete college or higher education in the U.S. and those who had less than college education (e.g. high school in U.S.). The reference group was participants who have not had any education in the United States.

Income of caregivers was selected since international long-distance eldercare requires financial resources (for remittance, cost of transportation for return visits, and phone bills) the importance of a participant's income is very crucial. All things being equal, caregivers can only provide care if they have financial resources. Since wage income is the main source of economic resources for most immigrants it was included in the model. Participant income was coded in U.S. dollars.

Family relationship was selected because parental relationship affects caregivers' decisions about elder caregiving. In Ghanaian society, having a child and/or raising a child entitles a person to eldercare from those for whom one cared. Consequently, the variable was included in the model and was represented by four dummy variables – mother, father, grandmother, and grandfather. The reference group for this variable was other family relatives.

A series of hierarchical multiple regression analyses were conducted to assess the effect of continuous independent variables (support receipt, elder vulnerability, and filial obligation) on continuous dependent variables (financial support and phone contacts). I should note that the filial obligation index consists of four sub-indices. Separate

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regression analyses were conducted for each as autonomous predictors to see if they predicted eldercare. Furthermore, eldercare has three different aspects (financial support, phone contact, and return visit) and each was separately tested. No regression analyses were conducted for the continuous independent variable, *participant self-reported health status* because there was minimal variation in the reported caregiver health scores.

A series of logistic regression analyses were conducted to assess the effect of continuous independent variables (support receipt, elder vulnerability, and filial obligation) on one dichotomous dependent variable (return visit). The procedure for analyzing data was the same for both hierarchical multiple regression and logistic regression.

Each independent variable was tested separately in a different model controlling for caregiver education acquired in the United States, caregiver income, and caregiver-care recipient relationship. The controlled variables were separately entered first before the independent variable of interest. The controlled independent variables were entered into the model based on their natural progression in time. In this regard, caregiver-care recipient relationship was entered first, followed by caregiver education, caregiver income, and then, the independent variable of interest. For hierarchical regression analyses, at each step in the model, the next independent variable was entered and their effect or increment in R^2 change over the previous model was assessed. For the logistic regressions only the final model was interpreted.

When the independent variable of interest was not statistically significant, the model was re-examined across key sub-samples. The sample was sub-categorized by caregiver gender since men and women are known to have different roles and perceptions

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about eldercare. The sample was also sub-categorized by whether older adult care recipients had experienced a major medical or financial problem within the past twelve months. I posit that these emergency situations may have differential impacts on level of eldercare. Another criterion used in sub-categorizing the sample was whether participants were the main financial and/or emotional care providers for older adult relatives. Just like emergency situation, being a key eldercare provider is likely to influence the level of care provided.

The focus of the analysis was to determine the contribution each key independent variable of interest made to variation in the dependent variable over and above what was contributed by the controlled variables. As noted earlier, each aspect of elder care was tested separately. What follows are the research hypotheses and the result of the tests.

Hypothesis # 1: *If immigrants have strong feelings of filial obligation (felt duties, concern over social disapproval, belief in ethical existence and generativity, and a desire to role model for future caregivers), they will provide high levels of eldercare.*

Hypothesis 1(a): If immigrants have strong feelings of filial obligation they will provide high levels of financial support to older adult relatives.

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Table 4.15: Summary of hierarchical regression analysis for Filial Obligation predicting Financial Support, controlling for Participant-Older Adult Person Relationship, Participant Education in the US, and Participant Income

Model	$R^2\Delta$	FΔ	Sig. FΔ	Beta	*p*
1. Relationship	.191	5.716	.000		
Mother				.384	.000
Father				.355	.001
Grandmother				-.290	.773
Grandfather				.031	.746
2. Education in US	.014	.840	.435		
High School/Some College				-.076	.431
Bachelors/Graduate				.075	.448
3. Participant income	.040	4.935	.029	.239	.029
4. Filial Obligation	.005	.574	.451	.074	.451

Model 1: R^2=.191; Adj R^2 = .157; F = 5.716; df = 97 (.000) Model 2: R^2=.205; Adj R^2 = .155; F = 4.078; df = 95 (.001)
Model 3: R^2=.244; Adj R^2 = .188; F = 4.346; df = 94 (.000) Model 4: R^2=.249; Adj R^2 = .185; F = 3.857; df = 93; (.001)

The results of the hierarchical regression as shown in Table 4.15 indicate that filial obligation R^2 = .249, F Change (93) = .574 accounted for ($R^2\Delta$ = .005) 0.5% in the variation of the financial support but this was not significant (p = .451). Each of the four sub-indices of filial obligation was also tested but all were not significant. There were also no significant results when the sample was sub-categorized by gender, by older adult persons who experienced major medical conditions, and by participants who were either the main financial or emotional care provider for the older adult. However, filial obligation was significant when the sample was sub-categorized into older adults who experienced major financial problem and those who did not. Specifically, the model that included elderly relatives who had experienced major financial problem indicated that filial obligation, R^2 = .565, $F(9)$ = 6.120, p = .035 significantly contributed 29.6% of the variance in financial support. But as the degree of freedom [F(9)] shows, the sample in the model was too small to give any conclusive evidence to this finding. This hypothesis was not supported.

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Hypothesis 1(b): If immigrants have strong feelings of filial obligation they will have more phone contacts with older adult relatives.

Table 4.16: Summary of hierarchical regression analysis for Filial Obligation predicting Phone Contact, controlling for Participant-Older Adult Person Relationship, Participant Education in the US, and Participant Income

Model	$R^2\Delta$	$F\Delta$	Sig. $F\Delta$	Beta	*p*
1. Relationship	.094	2.279	.067		
Mother				.031	.795
Father				.228	.050
Grandmother				-.123	.267
Grandfather				-.124	.249
2. Education in US	.011	.550	.579		
High School/Some College				-.069	.529
Bachelors/Graduate				.070	.525
3. Participant income	.013	1.258	.265	1.121	.265
4. Filial Obligation	.062	6.389	.013	.272	.013

Model 1: R^2=.094; Adj R^2 = .053; F = 2.279; df = 88 (.067) Model 2: R^2=.105; Adj R^2 = .043; F = 1.687; df = 86 (.134)
Model 3: R^2=.118; Adj R^2 = .046; F = 1. 630; df = 85 (.138) Model 4: R^2=.181; Adj R^2 = .103; F = 2.315; df = 84 (.027)

The results of Table 4.16 shows that filial obligation, R^2 = .181 F change (84) = 6.389 significantly predicted phone contact. It contributes ($R^2\Delta$ = .062) 6.2% of the variation in phone contact. None of the other variables in the model significantly contributed to the variation in phone contact. Only one of the sub-indices of filial obligation, social disapproval equally predicted phone contact significantly. Both results supported the hypothesis. Table 4.16 shows that strong feelings of filial obligation (beta = .272) increased the likelihood of caregiver-care recipient phone contacts after controlling for the other variables in the model.

Hypothesis 1(c): If immigrants have strong feelings of filial obligation they will visit older adult relatives (This hypothesis was tested using logistic regression because the dependent variable was dichotomous).

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The logistic regression results as shown in Table 4.17 below indicate filial obligation was not a predictor of return visit. Grouping the sample into various sub-categories failed to yield any significant results. This hypothesis was not supported.

Table 4.17: Summary of logistic regression analysis for Filial Obligation predicting return visit, controlling for Participant-Older Adult Person Relationship, and Participant Education in the US, and Participant Income

Model	B	S.E	Wald	df	Exp (B)	*P*
Constant	-3.510	1.455	5.822		.030	
Mother	.258	.614	.177	1	1.295	.674
Father	.168	.636	.070	1	1.184	.791
Grandmother	-1.403	.1.145	1.501	1	.246	.220
Grandfather	-.211	.960	.048	1	.810	.826
Less than College Educ.	.970	.726	1.784	1	2.638	.182
College Education	.727	.593	1.504	1	2.069	.220
Participant Income	.000	.000	5.663	1	1.000	.017
Filial Obligation	.007	.013	.328	1	1.007	.567

Hypothesis # 2: *If immigrants are currently receiving or have previously received any support from older family members in Ghana, they will provide care to these benefactors.*

Hypothesis 2(a): If immigrant are currently receiving or have previously received any support from older family members in Ghana, they will provide more financial support to these benefactors.

The result for this hypothesis is shown in Table 4.18. It indicates Support Receipt, R^2 = .255, *F* change (92) = .414, *p* = 522 did not significantly contribute to the variation in Financial Support over and above what was significantly contributed by participant-older adult relationship (R^2 = .194, *F* change (96) = 5.788, *p* = 000), and participant income (R^2 = .252, *F* change (93) = 5.223, *p* = .025). The childhood/adolescence and

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adulthood sub-scales equally did not predict financial support. There were also no significant results when the sample was sub-categorized by gender, by older adult persons who experienced a major medical condition, and by participants who were either the main financial or emotional care provider for the older adult. Thus, the hypothesis was not supported.

Table 4.18: Summary of hierarchical regression analysis for Support Receipt predicting Financial Support, controlling for Participant-Older Adult Person Relationship, Participant Education in the US, and Participant Income

Model	$R^2\Delta$	F∆	Sig. F∆	Beta	*p*
1. Relationship	.194	5.788	.000		
Mother				.390	.000
Father				.355	.001
Grandmother				-.029	.773
Grandfather				.031	.747
2. Education in US	.016	.930	.398		
High School/Some College				-.076	.435
Bachelors/Graduate				.084	.396
3. Participant income	.042	5.223	.025	.237	.025
4. Support Receipt	.003	.414	522	.072	.522

Model 1: R^2=.194; Adj R^2 = .161; F = 5.788; df = 96 (.000) Model 2: R^2=.210; Adj R^2 = .160; F = 4.164; df = 94 (.001)
Model 3: R^2=.252; Adj R^2 = .196; F = 4.475; df = 93 (.000) Model 4: R^2=.255; Adj R^2 = .191; F = 3.943; df = 92 (.000)

Hypothesis 2(b): If immigrants are currently receiving or have previously received any support from older family members in Ghana, they will have more phone contacts with these benefactors.

The results shown in Table 4.19 indicate Support Receipt R^2 = .136, F Change (83) = 1.704 accounted for 1.8% in the variation in phone contact but this was not significant (p = .195). Analysis to assess individual contribution of the childhood/adolescence and adulthood sub-scales also yielded non-significant results. A further analysis was conducted by sub-categorizing the sample into participants who were the main emotional caregivers and those who were not. The results of this model, Support Receipt R^2 = .603,

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$F(5) = 6.952$, $p = .046$ was significant, contributing 55.1% of the variation in phone contact. However, the strength of the effect size may be affected by the small number (n = 12) of participants who were the main emotional caregiver of the benefactors. This hypothesis was not supported.

Table 4.19: Summary of hierarchical regression analysis for Support Receipt predicting Phone Contact, controlling for Participant-Older Adult Person Relationship, Participant Education in the US, and Participant Income

Model	$R^2\Delta$	$F\Delta$	Sig. $F\Delta$	Beta	*p*
1. Relationship	.094	2.253	.070		
Mother				.030	.800
Father				1.976	.051
Grandmother				-1.112	.269
Grandfather				-1.153	.252
2. Education in US	.012	.547	.581		
High School/Some College				-.069	.532
Bachelors/Graduate				.070	.524
3. Participant income	.013	1.260	.265	.132	.265
4. Support Receipt	.018	1.704	.195	.176	.195

Model 1: R^2=.094; Adj R^2 = .052; F = 2.253; df = 87 (.070) Model 2: R^2=.105; Adj R^2 = .042; F = 1.668; df = 85 (.139)
Model 3: R^2=.119; Adj R^2 = .045; F = 1.614; df = 84 (.143) Model 4: R^2=.136; Adj R^2 = .053; F = 1.637; df = 83 (.127)

Hypothesis 2(c): If immigrant are currently receiving or have previously received any support from older family members in Ghana, they will visit these benefactors. (This hypothesis was tested using logistic regression because the dependent variable was dichotomous). The logistic regression results as shown in Table 4.20 indicate Support Receipt was not a predictor of return visit. Grouping the sample into various sub-categories failed to yield any significant results. Thus, the hypothesis was not supported.

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Table 4.20: Summary of logistic regression analysis for Support Receipt predicting Return Visit controlling for Participant-Older Adult Person Relationship, and Participant Education in the United States, and Participant Income

Model	B	S.E	Wald	df	Exp (B)	*P*
Constant	-2.827	.738	14.687		.059	
Mother	.404	.688	.345	1	1.498	.557
Father	.184	.705	.068	1	1.203	.794
Grandmother	-1.335	1.140	1.373	1	.263	.241
Grandfather	-.194	.954	.041	1	.824	.839
Less than College Educ.	.835	.698	1.431	1	2.305	.232
College Education	.780	.591	1.741	1	2.181	.187
Participant Income	.000	.000	5.692	1	1.000	.017
Support Receipt	.000	.018	.000	1	1.000	.996

Hypothesis # 3: *If older persons are perceived to be vulnerable (less able to take care of themselves physically) they will receive more care from their immigrant adult children.*

Elder vulnerability did not have any correlation with any of the dependent variables. According to Allison (1999), if a dependent and an independent variable are unrelated there is no need to put that independent variable in a model [that is testing for effects on the dependent variable]. Consequently, the hypotheses involving elder vulnerability were not tested. This hypothesis was not supported.

Hypothesis # 4: *If immigrants have income/material resources, are legal residents, and are in good health, they will be able to provide elder care.*

Hypothesis 4(a)(i): If caregivers have high income and are legal residents, they will provide more financial support to older adult relatives.

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Table 4.21: Summary of hierarchical regression analysis for Participant Income predicting Financial Support, controlling for Participant-Older Adult Person Relationship, and Participant Education in the US

Model	$R^2\Delta$	FΔ	Sig. FΔ	Beta	*p*
1. Relationship	.194	5.901	.000		
Mother				.384	.000
Father				.354	.001
Grandmother				-.029	.772
Grandfather				.008	.930
2. Education in US	.016	.988	.376		
High School/Some College				-.085	.384
Bachelors/Graduate				.077	.432
3. Participant income	.039	4.976	.028	.238	.028

Model 1: R^2=.194; Adj R^2 = .161; F = 5.901; df = 98 (.000) Model 2: R^2=.210; Adj R^2 = .161; F = 4.262; df = 96 (.001)
Model 3: R^2=.250; Adj R^2 = .194; F = 4.515; df = 95 (.000)

The results of Table 4.21 shows Participant Income, R^2 = .250 F change (96) = 4.976 significantly predicted financial support, contributing 3.9% of the variation in the variable. The result is that high income (beta = .238) is associated with high level of financial support. The sample was grouped into participants who experienced immigration-related problems and those who did not to find any difference between the two groups. The results indicate participant income did not predict financial support among the two groups. Thus, the hypothesis is partially supported.

Hypothesis 4(a)(ii): If caregivers have high income and are legal residents, they will make more phone contacts with older adult relatives.

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Table 4.22: Summary of hierarchical regression analysis for Participant Income predicting Phone contact, controlling for Participant-Older Adult Person Relationship, and Participant Education acquired in the United States

Model	$R^2\Delta$	$F\Delta$	Sig. $F\Delta$	Beta	*p*
1. Relationship	.101	2.488	.049		
Mother				.031	.794
Father				.227	.049
Grandmother				-.123	.264
Grandfather				-.145	.176
2. Education in US	.012	.582	.561		
High School/Some College				-.073	.510
Bachelors/Graduate				.069	.523
3. Participant income	.013	1.240	.269	.129	.269

Model 1: R^2=.101; Adj R^2 = .060; F = 2.488; df = 89 (.049) Model 2: R^2=.112; Adj R^2 = .051; F = 1.837; df = 87 (.101)
Model 3: R^2=.125; Adj R^2 = .054; F = 1.756; df = 86 (.107)

The result shown in Table 4.22 indicate Participant Income, R^2 = .125, F change (86) = 1.240, p = .269 did not significantly contribute to the variation in Phone Contact. The variable also did not predict phone contact when the sample was grouped into participants who experienced immigration-related problems and those who did not. Thus, the hypothesis was not supported.

Hypothesis 4(a)(iii): If immigrants have high income/material resources, they will be able to visit the older adult relative.

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Table 4.23: Summary of logistic regression analysis for Participant Income predicting Return Visit controlling for Participant-Older Adult Person Relationship, and Participant Education acquired in the United States

Model	B	S.E	Wald	df	Exp (B)	*P*
Constant	-2.830	.637	19.751		.059	
Mother	.339	.598	.321	1	1.403	.571
Father	.199	.636	.098	1	1.220	.755
Grandmother	-1.348	1.139	1.400	1	.260	.237
Grandfather	.165	.863	.037	1	1.179	.848
Less than College Educ.	.957	.664	2.073	1	2.603	.150
College Education	.686	.591	1.348	1	1.986	.246
Participant Income	.000	.000	5.963	1	1.000	.015

The logistic regression results for this hypothesis (see Table 4.23) indicate participant income was statistically reliable in distinguishing between participants who visited older adult relatives and those who did not (-2 Log Likelihood 111.989; $\chi 2(7) = 20.174$, $p = .005$). The model correctly predicted 79% of the cases. Thus, the hypothesis was supported. However, the odds ratio (Exp (B) = 1.000) indicates very little or no change in the likelihood of visit.

Hypothesis 4(b): If immigrants have good health, they will be able to provide elder care.

There was little variability in participant health indicators. No further statistical analyses were conducted. Hypotheses involving participant health were not supported.

Summary of Findings

In summary, the results of the independent variables showed that care recipients played high roles in their caregivers' lives as shown by the support receipt mean of 30.17

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with a 0-55 range. The most important roles care recipients played were providing child care (70%) to their caregivers during childhood and adolescence, and representing them at social events in Ghana (59%) during their adult lives. The high mean score, 99.78 with 13-135 range, registered on the composite four-sub-scale filial obligation measure indicated caregivers' strong feeling of obligation toward their care recipients. The results of the respective filial obligation sub-scales showed that the highest percentage of caregivers felt obligated to show love to their caregivers (84%), believed providing care enhanced their care recipients' social standing (88%), and felt that elder caregiving was a moral obligation for all adult children (93%). An overwhelming majority of caregivers' (90%) reported that their care recipients had adequate numbers of people in Ghana to take care of their physical care needs, while 63 percent reported that their care recipients had adequate material/financial resources. On care recipients' health condition, 55 percent of caregivers said it was good, while 50 percent reported that their care recipients were capable of taking care of their own physical needs. The results of the dependent variable indicated that, per month, caregivers called their care recipients twice to say hello (67%) and/or check on their health (58%), and remitted $50, mainly for food/household expenses (56%).

The results of the hypotheses testing as summarized in Table 4.30 show that Filial Obligation predicted Phone Contact with elderly relatives. Support Receipt also predicted phone contact but only in cases where caregivers were the main emotional care providers for elderly relatives. Caregiver Income predicted financial support but Filial Obligation predicted it where care recipients had experienced major financial problems, and Elder Vulnerability also predicted Financial Support if care recipients had experienced major

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medical conditions. Caregiver Income was the only independent variable that predicted visits.

Table 4.24: Summary Results from Hypotheses Testing

Hypothesis		Was model Significant?
H1(a):	Filial Obligation predicting Financial Support	No[1]
H1(b):	Filial Obligation predicting Phone Contact	**Yes**
H1(c):	Filial Obligation predicting Visit	No
H2(a):	Support Receipt predicting Financial Support	No
H2(b):	Support Receipt predicting Phone Contact	No[1]
H2(c):	Support Receipt predicting Visit	No
H3 (a)-(c):	Elder Vulnerability predicting Eldercare	No[2]
H4(a)(i):	Caregiver Income predicting Financial Support	**Yes**
H4(a)(ii):	Caregiver Income predicting Phone Contact	No
H4(a)(iii):	Caregiver Income predicting Visit	**Yes**
H4 (b) (i)-(iii):	Caregiver health predicting eldercare	No[2]
H4 (c) (i)-(iii):	Caregiver immigration status prediction eldercare	No[2]

[1]Model significant with sub-sample but sample size too small for result to be meaningful
[2]Hypotheses not tested

Study Limitations

Just like any other research study, the current one is not without limitations. One of its main limitations was the lack of ethnic diversity among the caregivers, the vast majority of which were from the Akan ethnic group. It is possible that eldercare dynamics among Akans, who are matrilineal, and other Ghanaian ethnic groups, who are

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mainly patrilineal may differ. A fair representation of patrilineal ethnic groups in the research sample may have resulted in different findings.

Although the current research had a high response rate from potential caregivers who were contacted by the researcher and/or his community contacts, a fair number of them refused to participate. Anecdotal evidence indicated that some caregivers refused to participate because they feared their participation might expose them to agents of the immigration services. It can be speculated that some caregivers who were suspicious but chose to participate in the research gave misleading information on immigration-related items. This may account for why only 15 percent of caregivers reported having experienced immigration-related work problems. It is possible the results of the research may have been skewed due to these suspicions.

Since immigration status often determines immigrants' access to jobs and subsequently, income, one might surmise that immigration status is an important factor for determining level of care immigrants provide. In the current research it was found to be non-significant. It can be assumed the insufficient numbers of caregivers who responded to the immigration-related item affected the power resulting in non-significant findings. On the other hand, some small sample categories such as "Caregivers who are Main Emotional Care Providers" and "Care recipients who experienced major financial problem" resulted in significant findings, although the required sample sizes needed to accept these findings may not be enough.

In conclusion, the findings of this study must be evaluated in light of the limitations discussed. This discussion has indicated where caution should be observed in interpreting these data. Despite these limitations, the study addresses the purpose of the

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research and has implications for future research, policy, and practice. These implications are discussed in Chapter 5.

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CHAPTER 5

Discussion and Implications

This study began with the following research question: *To what extent do these four factors – support receipt, filial obligation, perceived elder vulnerability and immigrant vulnerability – influence the provision of eldercare by Ghanaian immigrants in the United States to their elderly relatives in Ghana?* Study findings were detailed in Chapter 4. In this chapter I provide a brief overview of the research followed by a discussion of the findings and their implications for future research on immigrant caregiving and international long-distance eldercare, social work practice and social welfare policy.

Elder caregiving across international boundaries is a fact of life for many immigrants in the United States and other parts of the world. The purpose of the research was to investigate the impact of filial obligation, support received from elderly relatives, perceived vulnerability of the elderly relatives, and caregiver/care recipient characteristics on international long-distance eldercare. Understanding the interplay of cultural expectations, along with the social and economic implications of international long-distance care will contribute to our knowledge and insight into societies with a rapidly growing older adult population and no or limited formal eldercare support systems, a situation that is exacerbated by out-migration of potential elder caregivers. Using a convenience sampling technique, 124 Ghanaian immigrants residing in the United States who have elderly relatives living in Ghana were recruited to participate in the study and their participation provided the basis for the discussion of the current study.

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Filial Obligation and Eldercare

In this study, filial obligation significantly predicted phone contact between Ghanaian immigrant caregivers and their non-migrant elderly relatives. Thus, the stronger caregivers felt obligated to their care recipients the higher they reported making phone contacts. This finding appears to indicate that stronger filial obligation elicits elder caregiving "activity" that put less strain on caregivers' resources. For example, caregivers in the current study on the average made two 20-minute phone calls per month at a cost of $14, which is far less than the monthly financial support of $50 plus $5 transfer fee, and the hundreds of dollars required for travel to Ghana. This supports Rossi and Rossi's (1990) earlier findings that family care obligations that were easier to fulfill in terms of time and resource commitments were more easily evoked.

The relationship between filial obligation and phone contact may also be explained by looking at how caregivers ranked their caregiving obligations and their perceptions of the social and religious implications of elder caregiving. On the "felt duties" sub-scale that included an item that asked caregivers how obligated they felt to provide financial support to elders, obligation to "show love" to elders was ranked first, followed by "offer them emotional support" and "show appreciation for the past support." These three items can all be addressed (to some extent) through frequent phone contact. In that same subscale, financial support came fourth out of six activities. On the social disapproval sub-scale "providing eldercare enhances the social standing of their elderly relatives" was ranked first, while "elder caregiving is a moral obligation for all adult children" was ranked first on the ethical existence and generativity sub-scale. It could be argued that caregivers felt morally responsible as adult children to raise the

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social standing of their elders by showing them love. While in Ghanaian society showing love to elders could be expressed in monetary terms (Kodwo-Nyameazea & Nguyen, 2008; van der Geest, 1997, 1998) it seems that in the current study other means of showing elders love and appreciation were more important than monetary means, given its low ranking. If showing love and appreciation in financial terms was not paramount, we can assume that verbal expression may have been crucial for caregivers in this context. Verbal expression of love and appreciation at a distance meant phone contacts, as indicated by the large numbers of caregivers who called their elders to "say hello" (67%) and/or check on their health (58%). Hence, the significant relationship between filial obligation and phone contact.

Filial obligation did not predict return visit. But as noted in Chapter 4, it predicted financial support when elderly relatives experienced major financial problems, although the sub-sample in that model (n = 22) was too small to provide any conclusive evidence. Nonetheless, it is conceivable that caregivers may have felt obligated to provide financial support either in place of or in addition to emotional support, if they become aware of financial problems of their care recipients. It can be argued that a person facing financial difficulties may find it difficult to have emotional contentment. Logically, caregivers may feel obligated to help eliminate financial crises that their elderly relatives were facing in order for their "hello, how are you" to have the intended emotional effect. In other words, to show love and appreciation caregivers may feel obligated to provide the right type of care, and in times of financial crises, it would likely be financial support.

Since major health problems are often associated with major financial problems, it is logical to assume that filial obligation will predict financial support when elderly

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relatives experience major health problems. For instance, a study by Petrova (2004) among Mexican immigrants in the United States found that poor health of parents and grandparents elicited higher financial support from their immigrant adult children. Other studies have also reported similar relationships between eldercare recipients' poor health and increase remittance (Wong, & Espinoza, 2005). On the contrary however, in the reported study, filial obligation did not significantly predict financial support when elderly relatives experienced major health problems. Perhaps, the small sub-sample of the elderly people who experienced major health problem may have contributed to these findings.

Support Receipt and Eldercare

Several studies have found that past support received from parents influence the level of care adult children give their parents in their old age (Lillard, & Willis, 1997; Lucas, & Stark, 1985). In one such study, Koh and MacDonald (2006) used past parent-to-child financial assistance as a primary indicator of earlier family relationships to test adult child-parent transfer behavior. They found that past financial assistance from parents was positively related to caregiving and time-help from adult children to parents. Contrary to this and similar findings, the current research did not find any relationship between support received from elderly relatives and level of elder care provided.

The lack of support receipt to significantly predict any type of eldercare could be due to the time frame within which intensive reciprocity is expected to occur between adult children or relatives and elderly relatives. It could be argued that caregiving support within close family relations occurs at the extreme ends of the lifecycle, with parents giving more support to their children in their earlier years and adult children giving more

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support in their parents' later years, when health and physical conditions hinder their ability to take care of much of their own needs. The middle is characterized by "low level situational exchanges" (Rossi, & Rossi, 1990). The sample of the reported study appears to lie in the middle of the family relations lifecycle. An overwhelming majority (90%) of the caregivers were between 18 and 45. About 55 percent of the care recipients were fairly young, between 50 and 65 years, hardly a time in life to need intensive support from the adult children or relatives. In fact, 53 per cent of the care recipients were economically active and presumably, could fend for themselves financially.

The argument that the relationship between caregivers and care recipients lie in the middle of the family relations lifecycle is borne by the active exchanges between the two groups. Asked to indicate the kind of support they had received in their adult life from their care recipients in the past or were receiving at the time of the research, 59 percent of caregivers said their care recipients had represented them at social events in Ghana. Another 59 percent said they had received financial/material or emotional support from them. Between 30 and 50 percent of caregivers had received support from their care recipients in areas ranging from financial support for their trips to the U.S. to caring for immediate family members in Ghana. In fact, at the time of the research about a fifth of care recipients were caring for the children of their caregivers in Ghana. These examples show that the caregivers and care recipients were actively exchanging support, and that, most care recipients were active enough to care for themselves, which may explain the lack of relationship between support receipt and eldercare.

Furthermore, a fifth of the caregivers were grandchildren. One may surmise that these grandchildren were not the main caregivers but supplemented their parents'

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caregiving efforts. Indeed, 25 percent of caregivers said their own parents in Ghana provided financial care to their grandparents and 45 percent offered them emotional care. Thus, notwithstanding the high level of support caregivers received from their elderly relatives, perhaps the time was not due to reciprocate with eldercare or that intense elder caregiving was not yet required of them.

Elder Vulnerability and Eldercare

Just like support receipt, elder vulnerability did not predict any type of eldercare. In this research, elder vulnerability was defined to include caregiving resources non-migrant elderly relatives were likely to loose in the absence of their potential caregivers. This meant lack of financial and material resources and people to provide physical care, particularly for those who were unable to take care of their own physical needs.

In the reported study, the data on the elder vulnerability index seem to indicate that the majority of care recipients were not vulnerable. As already explained in the preceding section, the majority of care recipients were relatively young and economically active. It is therefore not surprising that 55 percent of caregivers described the health of their care recipients as good and 50 percent also described their abilities to take care of their own needs as adequate or good. Ninety percent of caregivers said their elderly relatives had adequate numbers of caregivers available in Ghana to take care of their needs, while 63 percent considered financial and material resources available to their care recipients as adequate. It is worth noting that 21 percent of caregivers said their elderly relatives did not need financial support. Perhaps, the lack of perceived vulnerability among the care recipients explains the lack of relationship between elder vulnerability and eldercare. Alternatively, there seems to be adequate caregiving resources available to

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make even those caregivers who perceived their elderly relatives as vulnerable to be concerned about their care or provide care.

Caregiver Income and Eldercare

In this study, caregivers' income is significantly related to financial support and return visit. Thus, the higher a caregiver's income the higher the possibility of him or her offering financial support and visiting elderly relatives in Ghana. The finding is consistent with other studies (Elbadawi, & Rocha, 1992; Funkhouser, 1995; Lianos, 1997; Lucas, & Stark, 1985) that found a positive relationship between immigrants' income and level of remittance. Naturally, higher income should increase a caregiver's ability to finance caregiving-related expenses. The caregiver's income is even more crucial with regards to return visit given the relatively large amount of financial outlay required. The reported study did not ask caregivers how much it cost to visit elderly relatives in Ghana, but it can safely be assumed that trips between the United States and Ghana will cost several hundred dollars. Apart from the financial resources to make the journey, caregivers will also need to take time off work, and possibly lose income, to make the trip to Ghana. Given this scenario, it is possible that only caregivers with higher incomes, paid leave, and higher savings visited their elderly relatives. In the current study, I did not collect data on paid leave, current savings, and other variables that may impact financial support and visiting. Perhaps, the inclusion of these factors may lead to a different conclusion about the relationship between caregiver's income and return visits.

Immigrant Vulnerability and Eldercare

Several studies have shown that immigrants encounter difficulties finding employment and experience lower employment rates (Fleury, 2007; Hanson, et al., 2001).

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Other studies, using insurance data, have suggested that immigrants may be in poor health compared to American citizens (Carrasquillo, et al., 2000; Thamer, et al., 1997). Based on these findings, it was assumed that the ability of some immigrants to accumulate financial resources needed for eldercare will be limited due to poor health and limited access to job opportunities. This assumption was not substantiated by the present data.

The reported study showed that most caregivers were healthy. Asked to report on their health, 90 percent of caregivers said their health was good or excellent, which may explain why only 13 percent of caregivers missed work due to health-related reasons. While their good health may be attributed to their youthful age, it could be because most of them could afford medical care. In fact, 61 percent of them had health insurance, although the type of health conditions covered was not asked. The near unanimous good health condition of the caregivers meant it was not a significant factor in predicting the level of eldercare provided. It should be noted that persons in poor health at the time of the research would not have likely been active in the community and would not have been tapped for the study or felt like completing it. The relationship between immigration status and eldercare provision was also non-significant.

While it is strongly suspected that some caregivers may be residing in the United States illegally, their immigration status did not appear to negatively impact their access to work. Perhaps, immigration illegality coping strategies such as membership in immigrant social organizations (Opoku-Dapaah, 2006; Owusu, 2000) and fraudulent marriages to Americans and permanent citizens (United States Department of Justice, 2003) was effectively adopted by many of the immigrants. On the whole, caregivers did

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not appear to be vulnerable to labor market outcomes. Eighty-one percent had jobs albeit concentrated in low-paying job sectors as noted earlier by Opoku-Dapaah (2000). Fifteen percent of caregivers (n = 19) reported missing job opportunities due to immigration-related issues, however only five percent (n = 6) of caregivers were unemployed at the time of the research, meaning the majority have had their immigration-related job problems solved within 12 month of the research. Results of analyses conducted to assess differences in the level of eldercare provided by those who experienced immigration-related problems and those who did not was not statistically significant, although there is the possibility that unequal group samples may have affected the results.

Theoretical Concepts underlying Eldercare

While the present research did not seek to test any model or theory it is worth noting some findings that lend support to the theories underlying the research. Social exchange theory was cited in Chapter 1 as relevant to what happens in Ghanaian society. Study findings reinforce the concept of intergenerational exchange. Over 80 percent of respondents reported receiving support in childhood and adolescence (socialization, childcare, and elementary school education) from their targeted elders. The majority indicated that representation at social events and financial/material and emotional support needs constituted forms of support received in adulthood. The fact that participants selected a particular person as their targeted elder may reflect their inherent belief that this is a person to whom they are obligated to reciprocate in some way.

The findings also highlight ethical existence and generativity as a core concept underlying eldercare in Ghanaian society. In line with the "code of ethical living" espoused by this concept, between 72 and 93 percent of participants regarded eldercare as

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a moral and/or religious obligation for adult children, 86 percent considered it as a way of showing respect to elders, and 73 percent agreed that elder caregivers receive blessings from God. By providing care for their elderly relatives, caregivers were showing concern for physical and/or existential issues that may bring shame unto themselves or their families (Ephirim-Donkor, 1997).

The research findings as discussed above have several implications for social work practitioners, policy makers, and researchers. Social workers have always been at the forefront of immigration related issues. Beginning with the settlement house movements to legalization of immigration status, social workers have always strived to help immigrants integrate into American society and to deal with their physical, emotional, and social challenges. However, the present immigration discourse poses a serious challenge for social workers who work with immigrants. The next section discusses the implications of the research for social work research, practice and policy.

Implications for Future Research

The strong sense of filial obligation shown by caregivers in the current research indicates that Ghanaian immigrants are likely to continue to support their elderly relatives in Ghana. However, the remittance literature suggests that the level of remittances sent by immigrants declines over time and may even cease at certain points (Lucas & Stark, 1985; Stark & Lucas, 1988), a phenomenon described as remittance decay. This raises some interesting questions. For example, what may prompt changes in remittance behavior among Ghanaians? The quest for answers to this question should provide an opportunity for future research.

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Future research may also explore the relationship between immigrant's level of acculturation and level of long-distance eldercare. Redfield, Linton and Herskovits (1936) define acculturation as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (p. 149). The numbers of years the current research participants have resided in the United States ranged between 6 months and 42 years. It is possible that those who have lived in the United States for longer periods of time may have adopted eldercare values and norms that might be different from the newcomers.

To explore issues relating to remittance decay and immigrant acculturation, researchers might need to use longitudinal research designs that will allow them to map out changes in remittance and caregiving behavior over time. However, recruiting immigrants for longitudinal research will be challenging due to immigrants' "exposure avoidance" tendencies discussed earlier and other immigrants' life situations such as residential mobility and time constraints. It is therefore crucial for researchers to pay attention to strategies that will help them to recruit and retain immigrants for long periods of time. Researchers may consider some of the strategies I used in the current research to deal with immigrant exposure avoidance.

As noted in the limitations section, some potential participants were concerned that their participation would expose them to Immigration Services agents. This was after information about the research had been circulated through the Ghanaian immigrant community via community leaders at various community gatherings and from word of mouth, and the researcher had begun canvassing the community for potential participants.

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It was evident that the initial introduction of the survey to the Ghanaian community via community leaders through church sessions and big formal community gatherings, either in my presence or absence, and the displaying of recruitment materials at vantage places were not enough to give some potential participants confidence to want to take part.

I sought to allay their concerns by asking permission to attend pre-arranged informal gatherings of friends and other small group meetings in the company of some of my community contacts who were familiar with members of respective groups. With the help of the community contacts, I "re-introduced" the research and assured potential participants that the survey is for academic and research purposes only, and that it had nothing to do with immigration services or issues. I used the word "re-introduced" because in many cases some people at these gatherings had already heard "bits and pieces" about my research. I believe the presence of the community contacts or "familiar faces" helped calm some of their concerns as indicated by the response from people at these re-introductory meetings. The responses from people who were at these meetings were good; most voluntary calls for participation in the research came from them or their friends and family members.

By design, the current survey was only to be administered by me or self-administered by a participant. However, I asked some of my community contacts to accompany me on my canvassing efforts through the communities; just like the re-introductory meetings, to calm any concerns potential participants might have. The only role played by my community contacts during canvassing was to introduce me first on a personal level, and then, as a student researcher. Then I took it from there. I realized that more caregivers agreed to participate in the research when I approached them in the

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company of a community contact than when I approached them alone. Given this observation, it is possible that the response rate of the current research could have been higher if they (community contacts or members) were conducting the survey. Thus, future researchers of immigrant population groups should consider recruiting and training members of the immigrant community to conduct some of their surveys.

The measures used in the current research should also provide opportunity for future research. Since there were no available measures that captured the concepts I sought to investigate, I developed new measures for the current study. Although efforts were made to identify and include various concepts that typify eldercare in Ghanaian society, it is important that the validity of the new measure be assessed. Researchers exploring the validity of the measures should ensure that there are adequate representations of different ethnic and other demographic population groups in their sample.

One crucial factor that future researchers might seriously consider is the language for data collection. While an overwhelming proportion of the sample in the current study had completed high school, many expressed interest in using their Ghanaian ethnic language in the survey. I observed that most continued to communicate among themselves and with their families in their ethnic Ghanaian languages. There is no doubt that using their ethnic languages would make participants comfortable, particularly those who are not fluent in English. Although no participant who agreed to take part in the survey withdrew because he or she could not use his or her ethnic language, I cannot confidently rule it out as a reason why some participants refused to participant in the research. Nonetheless, the sheer numbers of Ghanaian languages (about 65 linguistic

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groups according to Gordon's [2005] estimation) makes it nearly impossible to include all of them in one study. Focusing on only ethnic groups with high populations in the United States may be the most viable option.

One other area that could provide an opportunity for further research was the inability of elder vulnerability to predict elder caregiving. The literature on elderly people in Africa appears to suggest that many are at risk of poor health and lack of eldercare resources. This is inconsistent with the results of the current research. Future researchers could replicate the current research with the view of explaining some of the inconsistencies. The same can be said of immigrant illegality and immigrant self-reported health status, both of which had no relationship with the levels of eldercare provided by immigrants. Specifically, future research could investigate the strategies immigrants adopt to reduce their vulnerabilities to economic, health, and immigration-related outcomes. Another area of focus could be how immigrants define good and bad health.

Future studies may also focus on the medium of communication used by migrant families. Despite the geographic distance, Ghanaian immigrants and their non-migrant family members continue to stay in contact. Results from the current study pointed to the telephone as the predominant medium for maintaining family contact, perhaps due to the high cost of travel between Ghana and the United States and the telephone's ability to accelerate interaction and provide some level of personal intimacy. The current study showed that some families (13%) were deprived of interaction because there was no reception in the area where the elderly relatives lived in Ghana or the elderly relatives did not have phones. It is prudent that migrant families have access to affordable telephone services, including newer telecommunication technologies such as internet, email,

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webcam, videophone, and video conferencing some of which can allow families to have virtual interaction in real-time. However, each medium is likely to influence family interactions differently. It would be interesting, for instance, to know how the various media affect the quality of family interactions. Such information would assist Ghanaian policy makers, faced with limited resources, to decide which media to improve upon or give priority attention.

The current study has shown that most Ghanaian immigrants feel obligated to support their non-migrant elderly relatives. Given the limited financial resources available to many immigrants, the financial and other eldercare obligations may bring conflicts in marriages or among partners if each has to take care of elderly relatives on their side of the family. In case of emergency situations on both sides of a couple's family there could be conflict over whose relatives get the limited resources available. The situation could be more complicated if the couple or partners are from different ethnic groups or countries. Thus, the processes of negotiating and allocating resources for eldercare purposes by spouses or partners may be a focus of future research.

Implications for Social Work Practice

The effects of elder caregiving on caregivers are well documented. The positive effects include personal fulfillment and satisfaction experienced by caregivers (Jensen et al., 2004). The negative effects are often discussed within the multidimensional concept of caregiver burden or stressors associated with caregiving experience (Gallant, & Connell, 1997; Song, et al., 1997). The current study has shown that most Ghanaian immigrants feel obligated to provide eldercare, and there is no doubt that many take pride in providing care as Kodwo-Nyameazea, and Nguyen (2008) found in their research.

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However, the current study appears to suggest that some immigrants might need financial and/or material assistance themselves if they were to continue to provide care to their elderly relatives without compromising their own welfare or that of their immediate family in the United States.

The current data indicate that caregivers spent an average of $69 per month ($55 for remittance plus transfer cost, and $14 for phone calls) on eldercare. The amount may go up if elderly relatives experience major financial crises and go up further if an immigrant is required to visit an elderly relative. The data also showed that caregivers provided care to an average of two elderly relatives in Ghana. In light of their low incomes, many immigrants may require assistance to supplement their own resources. Social workers may be able to help by locating agencies that could assist in providing services for those who need it.

The communal nature of Ghanaian society is illustrated in the study data when the majority of participants indicate that the older person for whom they are caregiving are also receiving financial support from other relatives in a high-income or Western country. This means that the caregiving network is not simply an immigrant caregiver in Atlanta providing resources for the person they selected as the subject of this survey, but that there are multiple parties contributing to the same person's welfare. Understanding how these informal systems of care are constituted will give social workers clues to how complex these relationships are.

However, working with immigrants is made more complicated by the tendency for some immigrants to avoid services for fear of exposure to Immigration Services agents and deportation, and the number of federal, state, and local laws and policies that

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make many immigrants ineligible for publicly funded services (Kullgren, 2003). Social workers need to identify immigrant-friendly agencies that could help but also provide conducive environments that will encourage immigrants to patronize identified services. Still social workers could educate immigrants, particularly legal residents about the Family Medical Leave Act and other employment-related benefits that may be available. Social workers could help coordinate the needed services, and where possible assist immigrants in accessing employment-related services.

Beside financial demand that may be a source of stress, international long-distance caregivers may also increase stress over uncertainty about the actual and perceived condition of their care recipients (Parker et al., 2002), particularly caregivers who believe their elderly relatives are vulnerable to lack of caregiving resources. Presumably, stress is likely to be higher among immigrants who lack the required immigration documentation to leave and enter the United States at will, and those with low income or who do not have the resources to provide the amount of care they feel is adequate. In response, clinical social workers can provide counseling services to long-distance caregivers who experience distress over their presumed or actual inadequacy in their caregiving roles.

It is critical for clinical social workers to note that, in Ghanaian society, counseling is often strongly associated with serious mental and psychological conditions, which precludes routine or the everyday counseling common in the United States. The thought of seeking professional assistance with eldercare-related (which most consider as part and parcel of their family obligations) distress may not occur to many Ghanaian immigrants. Furthermore, psychological distress is often explained in a religious and

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moral context, which may require the invocation of higher power and/or prescription of good moral conduct (Ramisetty-Mikler, 1993). Thus, for counseling to be effective social workers must be cognizant of the Ghanaian culture, as it relates to counseling and also find ways to assess caregivers' attitude towards the counseling process.

Implications for Policy

Several studies have reported that a sizeable proportion of Ghanaians live and work outside Ghana (Anarfi, et al., 2000; Kabki, et al., 2004; Schoorl, et al., 2000; van Dalen et al., 2004). The results of the current study show that 30 percent of immigrants have at least a sibling living and working in a Western or an African country, which appear to give credence to those findings. But while migration takes potential caregivers away from their caregivers, the current study and earlier ones have found that Ghanaian immigrants continue to stay in touch and remit their non-migrant elderly relatives in Ghana. It is unlikely that emigration from Ghana would reduce or cease in the immediate future due to the poor economic situation. Policy makers need to be creative in figuring out how to maximize the financial resources Ghanaian immigrants send to their non-migrant elderly relatives.

One way of maximizing the financial resource sent by immigrants is to reduce the transaction cost of remittance in order to increase the amount of remittance that goes to the care recipients. In the current study the transaction cost was 10 percent of the remittance sent to elderly relatives; other studies cited by Taylor (2006) have reported 15-20 percent. Taylor (2006) has suggested two ways of maximizing remittance to receiving family members. The first is facilitating relationships between banks in remittance receiving countries and in immigrants' destinations. With this approach, he suggested

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that governments of remittance-receiving countries initiate negotiations between banks in their countries and banks in immigrants' destinations. In this context it may require the Ghanaian government and the American government to liaise and/or pass legislation to enforce agreements reached between the banks. The second strategy proposed by Taylor (2006) is leveraging of remittances by which he meant, "seek[ing] ways to multiply the amount of funds available to invest [by remittance-receivers]" (p. 16). He suggested that remittance receivers open bank accounts to which remittances can be paid. The bank may decide to grant loans based on the household remittance income. This strategy will be appropriate for elderly people who still have the abilities to undertake economic activities.

Conclusion

The study used survey method to investigate the level of care Ghanaian immigrants provided to their elderly relatives in Ghana, and especially, to explore the factors that influence the level of care provided. The results of the regression analyses showed that the dominant type of care provided was emotional care, but special circumstances in elderly people lives, such as serious financial problem may significantly increase the elderly people's chance of receiving financial support. For caregivers, their levels of income significantly determined the level of financial support they were able to provide their care recipients and how often they visited them.

With the large sibling groups, averaging five in the current research, there are always some siblings left in Ghana to take care of the needs of the parents in the absence of those who have migrated. In addition, the seemingly high emigration rate from Ghana meant elderly people have multiple migrant adult children or relatives, which increase

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their chances of receiving financial support from multiple sources as exemplified by about a third of care recipients in the current research.

Perhaps the most interesting findings of the current research is the high obligation immigrants felt toward their elderly relatives, their readiness to show love and appreciation for their elderly relatives, and their acceptance of eldercare as a moral obligation for all adult children. Immigrant caregivers' concern for the welfare of their elderly relative is apparent in their motivation to assist them in time of crises. While there is always the possibility of some elderly people not getting adequate care or some immigrant shirking their eldercare obligations, there is much evidence to conclude that most immigrants provided care to their elderly relatives and that most immigrants were influenced by the social and cultural tenets that underlie elder caregiving in Ghanaian society.

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Appendix A

International Long-Distance Eldercare Questionnaire

This questionnaire is designed to identify issues relating to being a caregiver of an "elderly person" in Ghana. In this survey, elderly person refers to a person who is 50 years old and above. In order to participate, you must have an elderly "relative" in this age group living in Ghana within the past 12 months. For this survey, you may choose any one elderly person in Ghana you consider as your relative to base your responses on. It will take approximately 45 minutes for you to complete this survey questionnaire.

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Section A: Background on elderly relative

A1. What is the current age of the elderly relative that you are going to base your responses on?	(i) __________ years old (ii) Don't know If "**Don't know**," is elderly relative born on or before Ghana's independence (6th March 1957)? 1. Yes 2. No/Don't know **If you answer "No/Don't know" to A1, please stop completing this survey and mail questionnaire to researcher**
A2. Sex of elderly relative?	1. Male 2. Female
A3. Marital status of elderly relative?	1. Single 4. Widowed 2. Married 5. Other (specify) __________ 3. Divorced
A4. What is your relationship to this elderly relative?	1. Mother 2. Maternal relative (specify) ______________ 3. Father 4. Paternal relative (specify) ______________ 5. In-Law (specify) ______________________ 6. Other relations (specify) ________________ ____
A5. Is elderly relative currently economically active (e.g. farming, office work, etc.)?	1. No 2.Yes
A6. What is elderly relative's main previous or current occupation? (specify) ___________________	

Section B: This section asks questions about support you received from this elderly relative in your childhood and adolescence. Base your responses on your own personal experience and what you have heard from family members and others who knew you while you were growing up.

B1. Did elderly relative take care of you or assist in taking care of you during your childhood or adolescence (before you turned 18 years)?	1. Yes 2. No [If no, skip to **Section C1**]
How would you describe the role this elderly relative played in your childhood and adolescence in the following areas? (Write the number that corresponds to your response in the space provided) Played no role ... Played very high role 0 1 2 3 4 5	
B2. Child care (e.g., infant care, babysitting, providing food, shelter, clothing, etc.)	
B3. Socialization (e.g., provided advice, taught domestic skills, trade, culture, etc.)	
B4. Elementary school education (e.g., paid fees, assisted with homework, advice, etc.)	

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Section C: Support Received from Elderly Relative in Adult Life

How would you describe the role this elderly relative played or is playing in your adult life in the following areas? (Write the number that corresponds to your response in the space provided) Played no role — Played very high role 0 1 2 3 4 5	
C1. Financial/material/emotional support to you or family	
C2. Representation at social events in Ghana (e.g. funeral, marriage, child-naming, etc.)	
C3. Support for college and other higher education	
C4. Support for career (e.g., job search, job training, etc.)	
C5. Financial support for trip to the United States	
C6. Social/material support for trip to the United States (e.g., contacts, immigration matters, etc.)	
C7. Taking care of immediate family member(s) left behind (e.g., child, parent, etc.)	
C8. Taking care of property and/or business (e.g., houses, business, land, etc.) left behind	

Section D: This section asks questions about obligation you feel towards this elderly relative.

How obligated do you feel to do each of the following things for this elderly relative? (Write the number that corresponds to your response in the space provided) No obligation — Very strong obligation 0 1 2 3 4 5	
D1. Offer emotional support (e.g., visit, advice, phone call, etc).	
D2. Do things to please him/her	
D3. Show that you love him/her	
D4. Offer financial support	
D5. Offer support in everyday care activities (e.g., housework, chores, providing housing, etc).	
D6. Show appreciation for support you received from him/her	
D7. Return favors he/she offered you	

Section E: This section asks your opinion on social implications of elder caregiving in Ghanaian society.

How much do you agree with the following statements? (Write the number that corresponds to your response in the space provided) Completely disagree — Completely agree 0 1 2 3 4 5	
E1. Providing good care to my elderly relatives enhances their social standing.	
E2. People who take good care of their elderly relatives deserve social recognition.	
E3. Most people whose opinion I value expect me take good care of my elderly relatives.	
E4. My elderly relatives' opinion about how I take care of them is important me.	
E5. Providing good care to my elderly relatives enhances my own social standing.	
E6. My family's and friends' opinions about the way I care for my elderly relative are important.	
E7. I will worry if my family and friends have the impression that I am neglecting my elderly relative.	
E8. I care about the kind of impression I make on other people about the way I care for my elderly relative.	

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Section F: This section asks your opinion on religious and philosophical beliefs underlying elder caregiving in Ghanaian society.

How much do you agree with the following statements? (Write the number that corresponds to your response in the space provided) Completely disagree — Completely agree 0 1 2 3 4 5	
F1. Elder caregiving is a religious obligation for all adult children.	
F2. People who take good care of their elderly relatives will receive blessings from God.	
F3. The souls of those who took good care of elderly people will be accepted into the spirit world (samanadze) by their ancestors.	
F4. Elder caregiving is a moral obligation for all adult children.	
F5. Those who take good care of elderly people will receive blessings from their ancestors.	
F6. People who did not take good care of their elderly relatives will be punished by the gods and the ancestors.	
F7. Any person, who for any reason neglects his /her elderly relatives, will never be prosperous.	
F8. People who did not take good care of their elderly relatives will be punished by God.	
F9. Providing eldercare is a way of showing respect to elderly people.	
F10. The souls of people who took good care of their elderly relatives will go to Heaven.	
F11. Any person, who for any reason neglects his /her elderly relatives shall, in turn, be neglected by his/her own adult children in old age.	
F12. Providing care to your elderly relatives is a way of showing one's own children about how you want to be treated in old age.	

Section G: This section asks about the elderly relative's health and living conditions. Base your responses on what you know; what you have heard from family members and others who know this elderly relative.

Question	
G1. How would you describe the current number of people available to take care of this elderly relative's physical and emotional needs in case of emergency or sickness? Very Inadequate — Very Adequate 1 2 3 4 5	
G2. Not counting money/material support from you, how would you describe the money/material resources available to this elderly relative to take care of his/her needs? Very Insufficient — Very Sufficient 1 2 3 4 5	
G3. How would you describe the current health condition of this elderly relative? Very bad — Very good 1 2 3 4 5	
G4. How would you describe the ability of this elderly relative to take care of his/her own physical needs? Very low — Very high 1 2 3 4 5	

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G5. Did this elderly relative have any major medical problem within the past 12 months (e.g., hospitalization, fall, etc.)?	1. No 2. Yes 3. Don't know
G6. Has this elderly relative had a major financial problem within the past 12 months (e.g., fines, etc)?	1. No 2. Yes 3. Don't know
G7. Not including financial support from you, has this elderly relative received financial support from any other relative/person who lives in a high income country (e.g., US, UK, Japan, Canada, etc.) within the past 12 months?	1. No 2. Yes 3. Don't know

SECTION H: Visits to Ghana

H1. Did you visit Ghana within the past 12 months?	1. No **[skip to J1]** 2. Yes (specify number of times) ___
H2. On average, how long do you stay in Ghana on visits?	____ years____ months _____ days
H3. Of your average days of stay in Ghana, how many days did you live, visit or spend time in the household in which this elderly relative lives?	___ years___ months ___ days _____ Entire period of visits

SECTION J: Phone calls to Ghana

J1. Did you make phone calls to your family in Ghana within the past 12 months	1. Yes 2. No **[skip to J9]**
J2. On average, how much does it cost you to make one minute of phone call to Ghana?	______ cents
J3. On average, how many phone calls do you make to your family in Ghana in a month? (Estimate if you don't know the exact number)?	__________ phone calls
J4. Of the total phone calls you make in a month, in how many of them do you talk directly to this elderly relative (Estimate if you don't know the exact number)?	______ Phone calls ______ None **[skip to J7]**
J5. If you talked to your elderly relative in any of your phone calls, what was the purpose of your conversation? **[Circle all that apply]**	1. Say hello to elderly relative 2. Send money to elderly relative 3. Check on health of elderly relative 4. Discuss issues relating to other family members 5. Others (specify) ___________________ ____________________________________
J6. On average, how long do your phone conversations with this elderly relative take?	______ hours _____ minutes
J7. If you did not talk to this elderly relative in any of your phone calls, what was the reason? (Circle all that apply)	1.There is no phone reception or access at where elderly relative lives. 2. Elderly relative cannot talk 3. Talked to other family members about elderly relative. 4. To avoid stressful situation 5. Do not have good relationship with elderly relative 6. Others (specify) ___________________ ____________________________________

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J8. Would you describe yourself as the main person who gives emotional support (e.g. visit, phone calls, advice, etc) to this elderly relative?	1. Yes 2. No
J9. Excluding you, specify other family member(s) who have provided emotional support (e.g. visit, phone calls, advice, etc) to this elderly relative within the past 12 months. (Circle all that apply)	1. Siblings in Ghana 2. Siblings living in Western countries 3. Siblings living African/other countries 4. Parent(s) 5. Adult children/grandchildren 6. Spouse 7. Other family members 8. Don't know 9. None 10. Others (specify) ___________________ _____________________________________

SECTION K: Financial/material support you gave to this elderly relative

K1. Did you send money/material support to your family in Ghana within the past 12 months (estimate the number of times if you don't know the exact number)?	1. Yes 2. No **[skip to K7]**
K2. On average, how much do you send in a month (estimate the amount)?	$ ________ per month
K3. What proportion of your remittances goes to take care of the needs of this elderly relative (estimate the proportion)?	_________ percent
K4. What were the needs of this elderly relative that the remittances are used for? **[Circle all that apply]**	1. Food/household expenses 2. Housing 3. Medical expenses 4. Others (specify) _________________ ___________________________________
K5. How do you send money to this elderly relative?	1. Bank/Electronic transfer 2. Acquaintances visiting Ghana 3. Other (specify) __________________ ___________________________________
K6. How much does it cost you to send the monthly amount specified above?	$ _________________
K7. Would you describe yourself as the main financial provider for this elderly relative?	1. Yes 2. No
K8. Excluding you, specify other family member(s) who provided any material or financial support to elderly relative with the past 12 months.	1. Siblings in Ghana 2. Siblings living in Western countries 3. Siblings living African/other countries 4. Parent(s) 5. Adult children/grandchildren 6. Spouse 7. Other family members 8. Don't know 9. None 10. Others (specify) ________________ ___________________________________

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Section L: Questions about you

<table>
<tr><td>L1. What is the highest level of schooling that you attained in Ghana?</td><td colspan="2">1. None
2. Less than high school
3. Completed high school
7. Other (specify) __________</td><td>4. Some college
5. Bachelor degree
6. Graduate degree</td></tr>
<tr><td>L2. What is the highest level of schooling that you attained in the United States?</td><td colspan="2">1. None
2. Less than high school
3. Completed high school
7. Other (specify) __________</td><td>4. Some college
5. Bachelor degree
6. Graduate degree</td></tr>
<tr><td colspan="4">L3. What was your last main occupation in Ghana? (specify) ___________________________________</td></tr>
<tr><td colspan="4">L4. What is your present main occupation in the United States? (specify) ________________________</td></tr>
<tr><td colspan="4">L5. What was your gross income last year? (specify) $ ______________________________________</td></tr>
<tr><td colspan="2">L6. Were you ever out of work for a continuous period of at least 4 weeks within the past 12 months for any reason, apart from health reasons?</td><td colspan="2">1. No
2. Yes (If yes, circle all that apply)
1. Immigration related issues
2. Laid off
3. Holidays
4. Family related issues
5. Other (specify) ____________
___________________________</td></tr>
<tr><td colspan="2">L7. Within the last 12 months, have you missed more than half a day from work due to any health situation you experienced yourself?</td><td colspan="2">1. No
2. Yes (estimate number and cost)
….. times $….. per week</td></tr>
<tr><td colspan="2">L8. Within the last 12 months, have you experienced any physical or health conditions that prevented you from performing any care activities (such as calling, visiting, or providing financial support) for this elderly relative?</td><td colspan="2">1. No
2. Yes (estimate number of times)
….. calls
….. visits</td></tr>
<tr><td colspan="2">L9. Do you have any health insurance?</td><td colspan="2">1. No
2. Yes (specify)
________Employer-sponsored
________Medicaid/Medicare
________Self-sponsored
3. Other (specify) _________________
_________________________________</td></tr>
<tr><td colspan="4">L10. How would you describe your health in general, within the last 12 months?

Excellent 1   2   3   4   Poor 5</td></tr>
</table>

Section P: Your Characteristics

P1. Your sex	1. Male 2. Female
P2. Your current age	__________ years

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P3. Do you have any siblings?	1. No **[skip to P6]** 2. Yes (specify only the number of siblings alive) ________ female ________ male
P.4 Where do you place among all your siblings who are alive?	1st 2nd 3rd 4th 5th 6th Other (specify) ____
P5. Where do you place among your siblings who are of the same gender as you?	1st 2nd 3rd 4th 5th 6th Other (specify) ____ _____ Not Applicable
P6. With what Ghanaian ethnic group do you identify?	1. Akan 2. Ga/Adamgbe 3. Mole/Dagbani 4. Ewe 5. Other (specify) _____________
P7. Are you a member of any Ghanaian social organization or predominantly Ghanaian church group?	1. Yes 2. No
P8. What is your marital status?	1. Single 4. Widowed 2. Married 5. Separated 3. Divorced 6. Other (specify)
P9. Do you have children (both biological and adopted) who are less than 18 years of age?	1. No **(skip to P12)** 2. Yes (specify number) ________
P10. How many of your children live with you?	____________ children
P11. Do any of your children live with this elderly relative in Ghana?	1. No 2. Yes (specify number) ________
P12. How long have you resided in the United States?	_____ years _____ months _____ Born and raised in the US
P13. Apart from this elderly relative, how many other elderly relatives in Ghana did you provide financial or non-financial support to?	_______ elderly people
P14. Of all your elderly relatives in Ghana, why did you choose to base your responses of the survey on this elderly relative?	1. Received the most support from me in the past 12 months. 2. Received the most recent support from me 3. Gave me the most support 4. The first whose name came to mind 5. He/she is my favorite elderly relative 6. Had the most recent information about him/her 7. He/she is my parent 8. Have no particular reason 9. Gave me support for my trip to the US 10. Other (specify) ________________________

Comments:
Use the next page to share any comments and views you have on this issue or anything you think I should know in order to have a full understanding of your caregiving situation

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Appendix B

Requesting for Meeting with Leaders of Social Groups/Associations

Virginia Commonwealth University
1001 W Franklin, Richmond, VA 23248
Phone: 804-908-3682
Email: kodwosr@vcu.edu

[Date]

To:
[Title and full name]
[Address of group/association]

Re: Request for a Meeting

Dear [Title and last name],

I am a Ph.D. student working on my dissertation at Virginia Commonwealth University (VCU) School of Social Work. My research is in the area of elder caregiving by Ghanaian immigrants in the United States. I am contacting you to see if members of your association might be interested in taking part in this research. If you are interested, we could set up a meeting to discuss the details of the study.

In the meantime, I can give you a few details regarding the research. The research has been approved by the VCU ethics board and is being conducted under the supervision of a team of professors at VCU. As part of the study, I am looking for 150 Ghanaian immigrants who have elderly relatives in Ghana. Research participants will complete a survey questionnaire individually, either by telephone or face-to-face. The survey will be administered by me. I wish to inform you that I have received training regarding the ethics of conducting social research. It will take approximately 45 minutes for each participant to complete a survey questionnaire. There are no costs for participating in this research other than the time spent completing the questionnaire. Every person who completes a questionnaire will be given a cash amount of $10.

The results of this research will be used to further our understanding of the issues that Ghanaian immigrants deal with as caregivers of elderly people in Ghana. The results may be presented at conferences or published in journals, however, only aggregated results will be presented. Information regarding individual participants or associations will be kept confidential within legal limits. Only researchers associated with this study will have access to the data.

I will call you, in the next few days, to confirm receipt of this letter and to see if you might be interested in setting up a meeting to discuss the research in more detail. Please feel free to contact me if you would like more details regarding the study. I look forward to the potential of discussing this research with you.

Sincerely,

Stephen Kodwo
Ph.D. Student

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Appendix C

Recruitment Script

My name is Stephen Kodwo and I am a Ph.D. student at Virginia Commonwealth University School of Social Work. I would like to let you know about a research I am conducting that involves Ghanaians in the United States. The purpose of the research is to examine the factors that affect the level and frequency of care Ghanaian immigrants give to their elderly relatives in Ghana. It will take about 5 minutes of your time to hear more about it. If you decide to participate in the study, you will receive $10 in appreciation for your time and effort. It will take approximately 45 minutes for you to complete a survey questionnaire.

The study is completely separate from your involvement with [name of organization]. Your decision about whether to participate in the research will not affect your relationship with [name of organization] in any way. If you would like to hear more about the research at a later time, I can take your contact details and contact you at a more convenient time. You may also contact me at **804-908-3682** or at

Stephen Kodwo, Ph.D. Student
Virginia Commonwealth University
School of Social Work
1001 W. Franklin St.
Richmond, VA 23284
Email: kodwosr@vcu.edu

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Appendix D

Participant's Contact Information Form

Name of Participant: ____

Telephone No.: ____

Date to call: ____

Time to call: ____

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Appendix E

Recruitment Flyer

Attention Ghanaians Living in Atlanta!!

Do you have elderly relatives living in Ghana?

Are you interested in contributing to our knowledge of issues relating to elder caregiving in Ghana?

Do you want a chance to receive $10 for about 45 minutes of your spare time?

If so please read on!!!

My name is Stephen Kodwo and I am a Ph.D. student at Virginia Commonwealth University (VCU). I am conducting a research under the auspices of VCU on issues relating to care and support Ghanaian immigrants in the United States give to elderly relatives in Ghana. I am looking for Ghanaians aged 18 years old and above who have elderly relatives living in Ghana, and would be interested in taking about 45 minutes to complete a survey questionnaire relating to issues they deal with as elder caregivers. Every person who completes a survey will be given a cash amount of $10.

If you decide to participate in this research, you may choose to be interviewed by me in-person, at a place of your choice or by telephone. All your responses will be kept confidential, and your name will never be used in the report of this research.

If you would like to take part in this research or more information, please contact:

Stephen Kodwo at 804-908-3682

or

Stephen Kodwo, Ph.D. Student
Virginia Commonwealth University
School of Social Work
1001 W. Franklin St.
Richmond, VA 23284
Email: kodwosr@vcu.edu

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Appendix F

Third Party Recruitment Script

I would like to inform you about a research being conducted under the auspices of Virginia Commonwealth University by Stephen Kodwo, a Ph.D. student of the university. The research involves Ghanaians in the United States, and its purpose is to examine issues relating to care and support Ghanaian immigrants give to their elderly relatives in Ghana. If you decide to participate in the research, you will receive $10 in appreciation for your time and effort. It will take approximately 45 minutes for you to complete a survey questionnaire.

The study is completely separate from your involvement with [organization and/or recruiter name]. Your decision about whether to participate in the research will not affect your relationship with [organization and/or recruiter name] in any way. If you would like to hear more about the research, you may contact Stephen Kodwo at 804-908-3682 or you may sign the Permission to Release of Contact Information form and I will give the information to Stephen Kodwo who will contact you.

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Appendix G

Permission to Release Contact Information

I, ____________________________________, with phone number _____________ give permission to [organization and/or recruiter name] to release my name and contact information to Stephen Kodwo and research staff of VCU IRB Protocol # ___________, “Determinants of Long-Distance Eldercare: Evidence from Ghanaian Immigrants in the United States.”

Signed ____ Date _______________

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Appendix H

List of Community Counseling Resources

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Appendix I

Participant Information and Consent without Documentation

Title: Determinants of long-distance eldercare: Evidence from Ghanaian immigrants in the United States.

The purpose of this research study is to find out about care Ghanaian immigrants in the United States provide to their elderly relatives in Ghana. You are being asked to take part in this research because you have an elderly relative living in Ghana. If you decide to take part in this study, you will be required to give your consent verbally.

In this study, you will be required to complete a survey questionnaire that asks questions about your views on eldercare in Ghana and any actual eldercare experiences you have had with your elderly relatives in Ghana within the past 12 months. Sometimes talking about these issues causes people to become upset or homesick. You do not have to respond to any questions about issues you do not want to talk about. If you become upset, I will give you names of counselors to contact so you can get help in dealing with these issues.

There are no costs for participating in this study other than about 45 minutes of your time to complete the survey questionnaire. If you decide to participate in this study, you will receive $10 in appreciation for your time and effort. Be aware that Virginia Commonwealth University and the VCU Health System (also known as MCV Hospital) do not have a plan to give long-term care or money if you are injured because you are in the study.

Your participation in this study is completely voluntary. There will be no consequences either positive or negative if you decide to participate or not to participate. You may stop the completion of the survey questionnaire at any time, even if, you have given your consent. Your participation in this study may be stopped at any time without your consent if I deem it necessary for your health and safety. There will be no way to connect your responses to your personal identity. By participating in this study you are giving your permission to use the information you provided as part of research analysis and reports in which no individuals will be identified.

VERBAL CONSENT

Do you understand the information about this study?	Yes ___	No ___
Are you willing to participate in this study?	Yes ___	No ___
Would you like to sign and/or keep a copy of this consent form?	Yes ___	No ___

____

Participant Name   Participant Signature   Date

____

Investigator Signature   Date

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Appendix J

Contact Information

For any issues or questions about your participation in this research you may contact the researchers or the Virginia Commonwealth University Office of Research

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Vita

Stephen Raymond Kodwo was born on May 21, 1965 in Takoradi, Ghana, and is a citizen of Ghana. After his primary education at Half Assini Catholic School and secondary education at Nkroful Agricultural Secondary School, he obtained a Bachelor of Arts degree in Geography and Resource Development with a minor in Sociology from University of Ghana in 1994 and later a Master of Arts degree in Development Studies from the same university in 2001. He received a Master of Social Work degree from University of South Carolina, Columbia in 2004. Mr. Kodwo is a licensed master social worker.

Mr. Kodwo's past professional experience include working for PLAN International Ghana, a nonprofit community development agency, as a community facilitator. Among other duties, he provided training in participatory project planning and management to community leaders and coordinated communication activities between PLAN program sponsors and sponsored families and communities. He was a member of PLAN's Child Survival Project Team responsible for child and maternal preventive health programs. He also worked for Kansas Department of Social and Rehabilitation Services as a social worker where he conducted investigations into child and adult abuse and neglect allegations and made referrals to appropriate agencies. During the final year of his doctoral studies, he taught the Person in Society course to students in the Bachelor of Social Work program at Virginia Commonwealth University.

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