Introduction

The responsibility for care to older persons with chronic health problems and disabilities is increasingly part of national policy agendas. Such discourses about care are important given that values underpinning government approaches will influence policy decisions that will in turn affect the lives of older persons and their carers. Across regions of the world, families are central in these national discourses. This is more so in the Global South where organised systems of long-term care are generally lacking and families are the main source of care for older people (WHO 2015).

The United Nations Decade of Healthy Ageing (2021-2030) (WHO, 2020) provides a focal point for understanding the embeddedness of beliefs about family responsibility for care and its impact on older people and their carers. The United Nations (UN) Plan (WHO, 2020) that will guide work during this decade builds on the Madrid Plan of Action on Ageing (2002) and is aligned with the UN Agenda 3030 on Sustainable Development (UN 2015). The Plan was developed following extensive consultation and draws directly on the World Report on Ageing and Health (WHO 2015). One of the four areas for action identified in the Plan is for every country to offer long term care for older adults. The action item notes that holding families as solely responsible for care is unsustainable and inequitable, especially for women (WHO, 2020). This position acknowledges the challenges and limitations associated with familist discourses that advocate a care framework centred entirely on family relationships.

Familism is a core construct framing discussions about care. It is defined as "beliefs about the centrality and responsibility for families for their individual members (Mucchi-Faina et al, 2010)" (Keating, 2022, p4). In analyses of state approaches to assigning responsibility for care, researchers have described how family responsibility may be entrenched through a lack of legislative or programme support (familism by default); or actively through legislation of programmes such as income transfers to carers (supported familism) (Ting and Woo, 2009; Saraceno, 2016). In the Global North, researchers have documented a shift toward more familist approaches. In their analyses of countries in Europe and Asia, Kodate and Tinomen (2017) have labelled changes that have occurred through the gradual withdrawal of public care programmes as "families by stealth."

In Latin America, individuals' obligations to meet family needs are seen as important cultural values (Hernandez and Bamaca-Colbert, 2016); while in Central, East, South, West (CESW) Africa, families have long been viewed as central to Africa's identity. Within this paper we use the term CESW Africa as opposed to the term sub-Saharan Africa, since the latter is increasingly viewed as a problematic binary (Pailey, 2020) and it is not a category recognised by the African Union. The tone of familist discourses from these two regions of the Global South is positive. These discourses reflect an ideology of "families by acclamation", that is accompanied by widespread belief that governments should reinforce traditional values in which elders are part of systems of family support (Aboderin and Hoffman, 2015).

Across both regions, familism is often expressed as a core societal belief, that is formalised by legislation. There is evidence of policies supporting familism in 19 out of 22 Latin

American countries, with legislation holding descendants, especially children, responsible for the care of older family members. Examples include Cuba's Family Code (Republica de Cuba, 1975) and the Integral Law in Protection of Older Adults and Retired Persons in Honduras (National Congress of Honduras, 2007). In CESW Africa, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa, indicates that States shall ¨identify, promote and strengthen traditional support systems to enhance the ability of families and communities to care for older family members¨ (African Union, 2016, p.6). Two examples of state legislation affirming familism in CESW Africa are found in Kenya´s National Policy on Older Persons and Ageing (Republic of Kenya, 2014), and in South Africa´s Boberg´s Law of Persons and the Family of 1977 (Carnelley and Mamashela, 2016).

Given the pervasiveness of familism and the UN Decade Call for Action, it is timely to explore and respond to notions of familism and its potential for impact on families. To date, there has been very little examination of the extent to which familism is embraced by family members themselves, or about how the concept of familism relates to contemporary contexts of care (Hoffman and Pype, 2016). In this paper we address the challenge of framing responsibility for care within familist discourses by undertaking a review of the state of knowledge of beliefs of family members about care for older people in CESW Africa and Latin America. We examine the ways and extent to which families in these regions believe they are responsible for the care of older relatives and the beliefs that shape the obligation to care.

This scoping study was conceived during a collaborative meeting between academics, policy makers and third sector organisations in Nairobi, Kenya that drew upon expertise from across Africa and the UK. As the idea for the review developed, the opportunity to include team members who had research experience in Latin America and who could review papers in Spanish and Portuguese expanded the scope of the review to include the two regions. This was a unique opportunity to review and analyse research on beliefs about family care in parts of the Global South. The research addressed the question: What is the scope of family beliefs about the provision of family care for older people in CESW Africa and Latin America?

Methods

Study design

A scoping review was selected as the method to meet the research aims because its purpose is to allow for a broad topic and question (Arksey and O'Malley, 2005) and to ¨identify key characteristics (...) related to a concept¨ (Munn et al,2018, p.2). This scoping review was conducted following the PRISMA-Extension Guidelines (Tricco et al, 2018). PRISMA stands for Preferred Reporting Items for Systematic Reviews and Meta-Analyses and is the recognised standard for reporting evidence in literature reviews. Standard databases and those

specific to Latin America and CESW Africa were utilised to allow for the most local and relevant literature. A parallel search strategy enabled searches to be completed both in English and in Spanish, the two main languages of the regions. Ten databases were searched: 6 in English; 4 in Spanish. Using English search terms, the databases MEDLINE, CINAHL Complete, PsycInfo, SocINDEX with Full Text (via EBSCO), Web of Science Core Collection, Scopus, Social Care Online, Sociological Abstracts, and AJOL African Journals Online were consulted. Using Spanish search terms, the databases SciELO Citation Index in Spanish, LILACS (Spanish acronym for Latin American and Caribbean Health Science Literature), CLASE (Spanish acronym for Latin American Citation in Social Sciences and Humanities), and DialNetPlus were searched. Language filters were not used in any of the searches, allowing for results in the other regional languages: Afrikaans, French, and Portuguese. A multilingual research team was available to screen records in all the languages.

Accessing journals and manuscripts from the two regions, that might not be accessible through standard English language databases, was an important part of this study. This approach did increase the effort in performing the searches and extracting and consolidating the results. This is due to the variety of search and extraction methods presented across the databases. At the same time, we are confident that this method led to a more complete review of the extant literature on the topic.

Inclusion and Exclusion criteria

Inclusion criteria included peer reviewed sources published between 2010 and 2021; in English, Spanish, Portuguese, or French; from a Latin American or CESW African country. The key search terms were determined in both English and Spanish, maintaining culturally appropriate terms for the search concepts. The population of interest was families. The concept of interest was responsibility for care of older adults. The context of interest was the countries of Latin America (23), including Cuba and the Dominican Republic, and CESW Africa (53). Papers were excluded if they did not meet these criteria and/or if the focus was not older adults, or if the full text was irretrievable.

Search Terms

Key words were determined in English and then translated into Spanish. Spanish key terms were discussed in team consultations to confirm relevance and syntax. Examples of key search terms in English representing the population of interest were ¨informal* OR non-professional* OR nonprofessional* OR unpaid* OR spous* OR sibling* OR son* OR daughter* OR husband* OR wife OR partner* OR filial OR friend* OR fictive kin*¨. Appendix 1 provides information on the key search terms for both English and Spanish.

[Figure 1. PRISMA flow chart insert near here]
Alt Text Flow chart showing PRISMA process of inclusion.

Studies included for full review

Thirty-five studies were included in the review (Table 1). Of the 35 studies, 28 included findings from Latin America and eight included findings CESW Africa; one study had findings from both regions and four had findings from multiple countries within Latin America. The countries included in the studies from Latin America were Argentina (n=2); Brazil (n=10); Chile (n=8); Colombia (n=2); Mexico (n=7); Peru (n=3); Uruguay (n=1); and from CESW Africa: Ghana (n=4); Kenya (n=1); Nigeria (n=3); South Africa (n=1); Tanzania (n=1). Of these 35 studies, 24 used qualitative methods, three used a quantitative research design, six used mixed methods and two were systematic literature reviews.

Data extraction and analysis

The flowchart (Figure 1) illustrates the initial screening process which yielded 911 records after removing duplicates and adding key articles. The records were then screened by title and maintained in separate groups according to the search language (English or Spanish). This method allowed for one reviewer to screen Spanish titles and any Portuguese and French titles, while the other reviewer screened the English language titles. Cross checks for agreement were made on random samples, and inclusion/exclusion discussed across the researchers. The title screening excluded a total of 603 records, 140 English language articles and 84 Spanish and Portuguese articles, leaving 308 for the abstract screening. Through the same method used to screen titles, 308 records were screened by abstract, 128 were excluded and 180 were included for the full text screening phase. This final screening excluded 145 of the articles which did not meet the inclusion criteria; 35 were included in the data synthesis for this study. Inclusion and exclusion agreement between the reviewers was tested in each phase and where dissonance occurred discussions ensued until agreement was reached.

Data extraction at the full text stage was undertaken by both reviewers who annotated emerging main themes regarding the beliefs about family responsibility for the care of older adults. The extraction was also completed in parallel, with one reviewer extracting from the results of the Spanish language searches and the other from the English language results. As a validity check, a small number of articles were reviewed by both reviewers to ensure consistency. Regular meetings of the reviewers were used to address any issues arising from the complexities of reviewing across the languages.

Data extracted in the full text review phase were inputted into separate Excel tables, which were subsequently consolidated to allow for thematic analysis conducted by the researchers (Braun and Clarke 2006). A working data table was developed that included the title, citation, country, and study design for each full text included in the review. The themes emerging from each article were coded. Relevant codes, statistics, and qualitative data including relevant quotes were logged in a separate data table to enrich the description of the findings. The independent coding completed by each researcher combined into eleven initial codes on beliefs about families´ responsibility to care for older adults. Through further analysis, team

meetings and discussions, the codes were reassessed and regrouped into four main themes and subthemes, which were subsequently reassessed, rearranged and finalised with unanimous agreement as outlined in Table 2.

[Table 1. Thematic codes table insert near here]

[Table 2. Thematic codes legend insert near here]

Findings

This review finds strong and consistent beliefs around the premise that families are obliged to care for their older adults. Beliefs are driven by moral, cultural or religious norms and by exchanges within families. There is evidence of beliefs that guide who should provide care and about where care takes places. While there is evidence of some differences within and across and regions, the overall message is of familist beliefs. A traditional definition of family is used within the papers included in this review that comprises the descendants of a common ancestor and their spouses.

Four themes illustrate beliefs that shape the obligation that families feel to provide care for their older relatives: families have a duty to care; responsibility to care is based on exchange; responsibility to care is gendered; and responsibility to care implies families provide care at home. Table 1 shows all of the included studies, with the themes and subthemes found in each.

Theme 1: Families have a duty to care

The most common theme emerging from the review is that providing care for an older adult is a duty. Thirty-one studies included the belief that there is familial duty to provide care (Table 1.). This duty is not shared equally across family members; children are the most strongly obligated. Within this theme we found three sub-themes: filial duty, moral responsibility and religious or spiritual beliefs about care.

Filial duty

Filial duty, also described as filial piety, filial obligation, and filial responsibility was most prevalent (n=26). There is a strong sense that responsibility for taking care of older persons lies with their children (Fernandez et al, 2014; Hanrahan, 2018; Ramirez-Pereira et al, 2018; Aires et al, 2019a; Aires et al, 2019b). Filial duty is a powerful sociocultural norm (Silvia and Garcia, 2014; Lorca and Ponce, 2015; Gutierrez and Ochoa, 2021). This norm is reflected in

studies from both CESW Africa and Latin America (Faller et al, 2017; Six et al, 2019; Adonteng-Kissi et al, 2020). Most older adults also subscribe to this norm as reflected in a Brazilian study in which most older adults expect to be cared for by their children (Mocellin et al, 2019). Similarly, filial piety in Mexicans is linked to a sense of loyalty and 'homage' (Nance et al, 2018). Spouses are not expected to provide care because of their similar age and likelihood of having their own health conditions (Robles and Perez 2012). There is evidence that these beliefs have been passed across generations placing family, and more specifically women, as obligated to care (Pedreira and Oliveria, 2012; Robles and Perez, 2012; Troncoso Miranda, 2015; Sant´Ana and D´Elboux, 2019a; Sant´Ana and D´Elboux, 2019b). Emotional and financial support are assumed (Aires et al, 2019a; Aires et al, 2019b).

Moral responsibility

Twelve studies from CESW Africa and Latin America discuss the moral sense of responsibility that underscores the unconditional nature of obligations for parent care (Nance et al, 2018; Oyegbile and Brysiewicz, 2016; Aires et al, 2019a; Aires et al, 2019b). Also referred to as a moral debt with parents (Silvia and Garcia 2014), moral obligation arises from the belief that children owe their lives to their parents (Friedemann-Sánchez, 2012). Evidence from Kenya, Mexico and Nigeria illustrates expectations that children make sacrifices for older people and support them (Hernandez 2016; Faronbi et al, 2019; Six et al, 2019). In Chile, the moral duty is dictated by the standing relationship between the older adult and the adult child; if good, the child will take care of the parent; if the older adult is considered a bad parent, the adult child is not morally obliged to provide care (Troncoso Miranda, 2015).

Religious or spiritual beliefs

Spiritual and religious beliefs also guide care for older people as found in twelve studies. Religious and spiritual notions of having God's help to endure the duty to care are highlighted in a study in Mexico (Nance et al, 2018). In studies from CESW Africa, karma is described as a motivator for providing care for older relatives as the carer believes they are doing something good that will be rewarded (Faronbi et al, 2019). In Ghanaian and Kenyan cultures care for older people may be driven by a fear of being cursed if care is not provided (Oyegbile and Brysiewicz, 2016; Hanrahan, 2018). Similarly in Nigeria there is fear of repercussions if an older person is abandoned (Faronbi et al, 2019). In a study in several CESW African countries, the belief that wrong-doing in early life may lead to long term health problems and the need for care later in life is presented (Adonteng-Kissi et al, 2020).

Theme 2: Responsibility for care is based in exchange

A second theme is that family responsibility for care is based on the history of exchanges and reciprocity in families. Twenty-nine articles illustrate this theme (Table 1). Two subthemes are: reciprocal exchanges of care and material exchanges.

Reciprocal exchange

Reciprocity is presented as a reason that children are expected to care for their parents. The notion of reciprocal exchanges was found in eleven studies from Latin America and five studies from CESW Africa. It is based on the idea that children care for a parent because that parent cared for them when they were a child, creating a pattern of past and future exchanges of care across the life course (Fernandez et al, 2014; Silva and Garcia, 2014; Lorca and Ponce, 2015; Coe, 2016; Oyegbile and Brysiewicz, 2016; van der Geest, 2016; Nance et al, 2018; Gutierrez and Ochoa, 2021;). These beliefs are sometimes termed as 'retribution' (Mocellin et al, 2019) or 'oblique' reciprocity (Silva and Garcia, 2014), based on the principle that returns from caring for children are deferred until later life. Participants in a study by Aires et al (2019b) talked about paying a debt to their parents through the provision of care. This exchange may also be from a daughter to a mother who has provided care for a grandchild (Jesus et al, 2013). Hanrahan (2018) found that older women felt entitled to care from their children in exchange for care given when the children were young. Participants in a qualitative study in Ghana believe that providing good care for their children strengthens the exchange between generations and ensures good care for them when they become old (Van der geest, 2016). In a study from Chile, care is also found to be enhanced when children see their parents providing loving care to their grandparents and then model that behaviour when their parents become older (Fernandez et al, 2014). Older people reported feelings of hurt where reciprocity is not fulfilled (Gempp and Benadof, 2018).

Love and affection for the older person are seldom the main motivators for care. However, studies from Argentina, Brazil, Chile, Columbia, Kenya, Mexico, Peru, and Uruguay demonstrate that the quality of care provided is strongly affected by the relationships between older people and family members who care for them (Friedemann-Sanchez, 2012; Silva and Garcia, 2014; Faller et al, 2017; Lloyd-Sherlock et al, 2017; Six et al, 2019; Aires et al, 2019b; Gutierrez and Ochoa, 2021). Positive relationships strengthen bonds and may improve experiences of care. Gutierrez and Ochoa (2021) demonstrate that people who felt closer to their grandparents are more likely to undertake time and resource intensive care tasks. For those providing the care there is a sense that care for reasons of love and friendship brings its own rewards through closer relationships (Silva and Garcia, 2014, Oyegbile and Brysiewicz, 2016) and people in Nigeria report that they feel pride from caring for their older relatives (Faronbi et al, 2019). For older people, being provided with good care within their family also brings rewards, such as feelings of happiness reported by adults in Brazil (Faller et al, 2017), and in closer relationships reported in a study from Kenya (Oyegbile and Brysiewicz, 2016).

Where relationships between older people and their family members are strained, this can lead beliefs about care obligations being ignored or denied. The exchange of care could be disrupted if the relationship between parent and child has been difficult. Findings from a study in Colombia (Friedemann-Sanchez, 2012) demonstrate that when a parent has been

violent towards a child, the obligation to care is relieved and older people may end up in institutional care. In Ghana, parents who did not provide good care for children forfeit the right to receive care when they become older (van der Geest, 2016). A study from Chile (Gempp and Benadof, 2018) found that dementia can also disrupt people's relationships and sense of obligation to care. Participants in this study believed that the person with dementia is no longer present, therefore does not need family care and can be placed in an institution or abandoned.

Material exchange

Material exchanges also influence beliefs about family care and are described in ten studies. Care responsibility is based on a promise of material advantage such as inheritance of the family home in exchange for care. Where resources are scarce and little material advantage can be offered, there may be a breakdown of family care for older people.

Research in Mexico and Columbia finds that care may be provided in expectation of inheritance of the family home (Friedemann-Sanchez, 2012; Silva and Garcia, 2014) but this is dependent on a will being in place. One study, undertaken in Peru and Mexico, found that children who benefit from being residents in the family home are expected to provide care, exchanging care for a place to live (Bustamante-Edquen et al, 2018). A study in Ghana similarly found that women who return to the family home following divorce or other life events are then expected to provide care in exchange for residence (Coe, 2016). Friedemann-Sanchez (2012) found that property ownership is key within negotiations about care in later life in Columbia and can be used to leverage care from family members. Family members who do not provide hands-on care may provide financial support instead (Lloyd-Sherlock et al, 2017), especially for migrant children who live at a distance from the family home (Hernandez, 2016).

There is some indication that material exchange may be more important in resource-limited settings. Coe's (2016) research with women in Ghana found that family members who return to the family home to provide care may do so knowing they will benefit from financial assistance from other family members. A study in Columbia found that people on low incomes or where employment opportunities are limited may resist normative expectations to care for older relatives (Friedemann-Sanchez, 2012). Research in CESW Africa found that increasing levels of poverty have reduced the ability of families to care for older people (Adonteng-Kissi et al, 2020).

Material exchange is not acceptable in all contexts, participants in one study shared their reluctance to discuss monetary aspects of care exchange and young people in Mexico believe that money should only be paid for care when it is not provided by a family member (Lloyd Sherlock et al, 2017). There is some indication that financial support from older people can strengthen beliefs of filial duty to care among children in Brazil (Aires et al, 2019a; Aires et al, 2019b).

Theme 3: Responsibility for care is gendered

Within families, responsibility for care may fall on different family members and beliefs dictate who within the family should take on the caring role. Mexican and Peruvian family members bargain about who takes the carer role (Lloyd-Sherlock et al, 2017) with socio-economic status and resources, and those with the least to offer found to usually be assigned the role in Colombia (Friedemann-Sánchez, 2012). The strongest influence on who provides care is gender with 21 studies presenting the gendered nature of care (Table 1).

Gender roles in care

Gender roles in families´ beliefs about care for older adults emerge clearly and consistently in both CESW African and Latin American literature. Most carers participating in the studies included in this review are female, and most participants in studies view the carer role as women´s duty (Pedreira & Oliveria, 2012; Jesus et al, 2013; Fernandez et al, 2014; Lloyd-Sherlock et al, 2017; Aires et al, 2019a; Aires et al, 2019b; Sant´Ana and D´Elboux, 2019a; Sant´Ana and D´Elboux, 2019b; Six et al, 2019; Gutierrez and Ochoa, 2021; Agyeman et al, 2019). Participants in one study report that the ideal carer is a woman, and ideally one wants to be cared for by a woman (Robles and Perez, 2012). A woman is expected to fulfil her responsibilities as a daughter, wife, and mother with the provision of care perceived to be an integral part of this (Hanrahan, 2018). In Chile, the likelihood of women providing care is 9.88 times that of men providing care (Lorca and Ponce, 2015).

The outright rejection of men in the carer role also emerges in two Latin American studies (Robles and Perez, 2012; Mocellin et al, 2019) because men are perceived to lack the virtues necessary for care. Men are reported to be less loving, less patient and less available than women, so the quality of care is expected to be lower (Robles and Perez, 2012).

Male carers in Acapulco, Mexico contradict the gendered social construct by claiming it is not related to femininity, instead they see a carer as needing to be brave, strong, and dedicated (Nance et al, 2018). In some cases, men fell into the carer role due to circumstances and learnt how to care as a necessity (Troncoso Miranda, 2015), but felt out of place in a feminine role (Ramirez-Pereira et al, 2018).

There is also evidence that specific care responsibilities are gendered, with direct care assigned to women and indirect care, such as organising and paying for care, more commonly undertaken by men. This is the case in Andean central Colombia where direct care duties fall on the women and indirect tasks are assigned to the men of the family (Friedemann-Sánchez, 2012). Men assume the decision making in the Yoruba culture of Nigeria (Faronbi et al, 2019) and are the economic providers in Argentina (Venturiello, 2014). In Ghana, Coe (2016) found that women are dependent on their male family members, where structural inequality leads them to take on the carer role (Coe, 2016). However, Agyeman et al (2019) found that

Ghanian women providing care may also take on wider financial decision-making for the family (Agyeman et al, 2019).

A study in Brazil indicates that traditions may be changing across generations with older people no longer choosing to have many children to ensure they are cared for in later life but instead focusing on ensuring their children have good lives (Mocellin et al, 2019). The availability of women to provide care is also changing, reflecting wider demographic shifts. According to Adonteng-Kissi and colleagues' (2020) review, the number of women caring for older adults in African countries is shrinking due to women´s increased education, employment, and migration coupled with lower fertility rates.

Theme 4: Care occurs at home

This review found consistent beliefs about the preferred location of care in nine of the articles included (Table 1). Two subthemes emerged: care should be provided within the family home; and paid and institutional care are of poor quality.

Care within the family home

There are strong beliefs that older adults should live within a family home (Faller et al, 2017; Lloyd-Sherlock et al, 2017; Rosa et al, 2017; Gempp and Benadof, 2018;Hanrahan, 2018; Ramirez-Pereira et al, 2018; Aires et al, 2019b; Mocellin et al, 2019; Galvis-Palacios et al, 2019;). Where families are providing complex and demanding care, Brazilian families feel pressured to keep their older family members at home because institutionalisation is deemed abandonment (Aires et al, 2019b) or an admission of helplessness (Mocellin et al, 2019). Older people themselves are found to reject the idea of living anywhere besides their family home (Gempp and Benadof, 2018; Mocellin et al, 2019). For carers and older adults in Columbia, paid care is believed to be necessary only in a dire situation where life is at risk, and the preferred traditional remedies do not work (Galvis-Palacios et al, 2019). In Chile, older adult carers fear institutionalisation of their relative, preferring to provide care themselves even if other relatives do not help (Ramirez-Pereira et al, 2018). Institutionalisation is considered wrong by older Brazilians and Paraguayans. It is linked to becoming useless and being sent away (Faller et al, 2017). Families would rather rely on neighbours, faith-based networks, or community members for unpaid care than place an older family member in a care home; thus preserving the older person´s strength, optimism, and financial stability (Venturiello, 2014; Hanrahan, 2018; Adonteng-Kissi et al, 2020;).

Co-residence with the older person may be a factor further obligating family members to care for their parents in Mexico and Peru, where care could evolve as a consequence from living together continuously (Lloyd-Sherlock et al, 2017). A study in Ghana describes a tradition where sons live in their father's home or village and take care of their own families, while daughters move to live in the husband's home and take care of their families (Hanrahan, 2018).

Paid and institutional care

The duty families feel to provide care is reinforced by a widely held belief that paid care is poor quality, with negative perceptions of long-term care institutions (Faller et al, 2017; Aires et al, 2019b; Mocellin et al, 2019). Previous negative experiences with institutions corroborate and strengthen the cultural beliefs that care should be provided by family members at home (Rosa et al, 2017). The review reveals that limited or non-existent social services in communities, lead to care being imposed on families as there is no other option (Pedreira and Oliveria, 2012; Venturiello, 2014; Troncoso Miranda, 2015; Rosa et al, 2017;Ramirez-Pereira et al, 2018;). One Brazilian family member´s father was mistreated and poorly taken care of in a nursing home, and another family member confirms that even if the care is good in a care home, it would not be considered desirable since it would never be the older person's home (Mocellin et al, 2019).

As noted in the discussion of exchange above, there are circumstances where it is considered appropriate for an older person to receive care outside the family home within an institutional setting in both CESW Africa and Latin America. These include when the person has dementia (Gempp and Benadof, 2018) and when the older person has been violent or abusive towards their child or children (Friedemann-Sanchez, 2012; Van der geest, 2016). Furthermore, findings also indicate that under some circumstances such as if the family is no longer able to provide care at home, because of changes in family structure or an increase in an older adult’s medical needs, institutionalisation would be considered if it were financially accessible (Mocellin et al, 2019). There is recognition that external support would be helpful to families (Rosa et al, 2017).

Discussion

The United Nations (WHO, 2020) suggests that reliance on family care is unsustainable. Yet our review suggests that the obligation families believe they have to care for older relatives is deeply held and consistent and there are few opportunities to opt out of it. Families, especially women, are bound into care through ingrained familist beliefs that are reinforced through the sociocultural context and passed on through family generations in both regions included in this review. Care is believed to be best provided within the family home both through a sense of this being the right place to care and due to a lack of acceptable alternatives in these regions. Beliefs about care fall into two main categories: those underpinned by sociocultural and religious norms about duty, and those about exchange within families based in intergenerational relationships. In turn, these beliefs frame expectations about who should provide care and where that care is best provided.

The review highlighted how beliefs interact with relational and structural factors and can be strengthened or diminished by them. The strong sense of responsibility for care is further strengthened by feelings of attachment and close relationships within families but can also be disrupted where relationships have been poor, or children have experienced abuse from their

parents or older relatives. Findings suggest that structural inequalities may weaken people's adherence to beliefs where they are living in poverty and are not able to provide care due to financial constraints. Further, individuals may not be able to give up work to provide care or may require material exchange if they are expected to care. These findings suggest an urgent need for governments to recognise the gaps within care systems that rely solely on families and to recognise the cost of care for families.

The belief in the family and the family home as the provider and place of care for older people appears within findings to be reinforced by the poor quality of paid alternatives. The poor quality of paid services and support in these regions provides further stimulus to families' sense of responsibility and obligation to provide care within the family home. This context underscores the urgency of the UN Decade call for action to develop systems of long-term care for those who need them.

While the gendered nature of care has long been recognised (Leira and Saraceno, 2002), the belief that women should provide direct care within families needs to be considered in the context of global initiatives such as the drive for gender equality anchored in UN Sustainable Development Goal 5 (United Nations, 2015). To the extent that women are trapped within these gendered familist beliefs about care, equity will not be achieved. There is evidence that as more women join the paid workforce, they start to resist familist beliefs about care (Adonteng-Kissi et al, 2020). Alongside gender, socio-economic equalities, play an important role in care for older people in these regions. As Kröger (2022) suggests, a focus on inequalities in care may provide a useful lens to understand the complexities and intersections among beliefs found in this review.

In the context of wider demographic changes leading to increasing numbers of older people across the Global South (United Nations 2019) and higher numbers of women in paid employment (Ortiz-Ospina et al, 2018) the strain on family care and familist beliefs will continue to increase. Our review clearly highlights the need to understand these complex beliefs and crucially how they interact with policy, with service provision, with structural inequalities and with ongoing social and demographic change.

Conclusion

This review suggests key implications for policy makers in the Global South in how they engage with and support families to provide care for older adults. With evidence of an increasing return to familism in countries in Europe and Asia (Kodate and Tinomen, 2017) these policy implications will also have resonance around the globe. Policy makers in Latin America and CESW Africa must be convinced that there is a pressing need to develop a paid social care sector that provides good quality provision, responds sensitively to local beliefs, and provides affordable care that families are willing and able to access. Policy that assumes families will provide care or compels them to do so fails to take into account wider demographic changes and global goals to promote gender equality and eradicate poverty. The

UN's Decade of Healthy Ageing calls for a ¨whole-of-government and whole-of-society partnership¨ response to achieve its aims (WHO, 2020, p 21). The beliefs discussed in this review need to be understood and incorporated within these partnership discussions to find consensus on what positive partnerships between paid and unpaid care ought to look like in each national context.

Limitations and suggestions for future research

As a scoping review our intent was to present the current state of knowledge on beliefs about family responsibility to care. When reflecting on the methodologies and frameworks of the articles reviewed the authors noted gaps in deeper understandings of beliefs, and assumptions in some research that beliefs are normative, shared, and do not require further exploration. Further research could unpack the nuances in beliefs within and across regions to provide a more detailed and culturally specific understanding.

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Conflict of interest

The authors report no conflict of interest.

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[Appendix 1 Key concepts and search terms insert near here**]**