



Development of a Training Program for Family Caregivers on Home Care of Older Adults in Cameroon

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Authors' contributions

This work was carried out in collaboration among all authors. Authors USU, NB and JNP designed the study, author USU did the literature search, performed the data analysis, wrote the protocol, wrote the first draft of the manuscript and conceived the conceptual framework for the Training program. Authors NB and JNP supervised data collection and provided major contributions in the writing of the manuscript. All authors read and approved the final manuscript

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ABSTRACT

Background: Family caregivers who are the primary care providers to the elderly in communities in Cameroon, specifically in the Buea health district, are not aware of available resources and lack adequate knowledge and skills on the care of the elderly. As a result, the elderly are not receiving adequate care and support which might also affect their quality of life. In line with the World Health Organization's (WHO) strategic proposed objectives of promoting healthy aging, the aim of this study was to develop a training program for family caregivers of the elderly.

Methods: An exploratory, cross-sectional study research design was employed, with the use of qualitative methods for data collection. In-depth interviews were conducted with 15 key informants including nurses, social workers, community relay persons, personnel from the ministries (Public

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Health and Social Affairs), director of a geriatric nurse training school and directors of Non-Governmental Organizations (NGOs) concerned with age-care who were purposively recruited. Information on the scope of practice and available resources was obtained. The sample size was determined based on data saturation. Data was transcribed verbatim and analysed using thematic content analysis.

Results: Two major themes emerged from data analysis; 'Recognise the boundary' for the scope of practice of family caregivers which was further divided into two categories (bridge the gap and shared responsibilities) and 'Health and wellbeing' as all available resources were aimed at improving the health and wellbeing of the elderly.

Conclusion: The training program should include a psycho-educational intervention with information on available resources such as: Geriatric nurses and social centers, the scope of practice for family caregivers which includes: Assistance with Activities of Daily Living & Instrumental Activities of Daily Living, Psychosocial care, strategies to involve elderly persons in various activities and the creation of age- friendly environments.

Keywords: Buea health district; family caregivers; home care; older adults in Cameroon; training program.

1. INTRODUCTION

The alarming rise in global population aging is presently a call for concern in both developed and developing countries. According to the World Health Organization (WHO), by 2050, the world's population aged 60 years and older is expected to total 2 billion, up from 900 million in 2015 [1]. Moreover, projections by the United Nations indicate an increase of more than 63% of people aged 60 years and over between 2015 and 2030 in the African region [2]. In line with the above projection, is the rising interest on the wellbeing of the older adults in Africa though research in relation to the Madrid International Plan of Action on Aging (MIPAA) especially on aspects such as the training of family caregivers, health and social care professionals is still lagging [3]. Regrettably, despite the complex nature of aging and aged care, very little is being done to meet WHO's strategic proposed objectives of promoting healthy aging such as aligning health systems to the needs of the older population and developing long-term care [2]. In Cameroon, the healthcare system is divided into the central (strategic), intermediary (technical) and peripheral (operational) levels and comprises both public and private entities, institutions, and organizations that provide health services to the population. The public healthcare sector is the main health provider. Though the Ministry of Public Health is at the central level and is responsible for the maintenance of all public health services in the country [4], it pays more attention on issues related to maternal and child health and diseases such as HIV/ AIDS and malaria and very little attention on issues related to aging and aged care. This therefore

necessitates the drawing up of health education programs that can meet the needs of family caregivers who play the major role of caregivers of the elderly in communities. Moreover, a majority of these family caregivers are often less knowledgeable about their role, available resources and social support [5] leading to inadequate care and support to the elderly who depend on them [6]. However, the concept of family caregiving has been proven to provide better outcomes to the elderly over those living in elderly homes. A study by Singh et al. [7] on the perception of old age and self, revealed that elderly women living in communities had a greater satisfaction of life, better emotional support and demonstrated a more positive attitude that reflected acceptance of the ageing process (old age) than those in nursing homes. Moreover, the findings of a study in Cameroon by Bassah et al. [5] suggest that family caregivers will not consider a nursing home as an ideal place for quality care of their elderly family member as up to 62.8% of the caregivers did not consider nursing homes or institutions as a perceived need for elderly care. It is therefore crucial to develop training programs to empower these family caregivers with adequate skills and knowledge for the provision of quality care to their elderly family member.

Observably, the older people grow the more dependent they become. A number of studies have supported a significant association between aging and complexity of care [8,9], stipulating that caregiving functions change overtime in response to the increasing needs of the care-recipient [8]. Though family caregivers are the major care providers to the elderly in

communities, there is a need to define their scope of practice. Bassah et al. [5] revealed that despite their lack of adequate knowledge and skills, some family caregivers do carry out complex activities which could be detrimental to both the care recipients and the care providers. Davis et al. [10] suggest four dimensions for informal care which include direct care (providing assistance with bathing, dressing, managing medications), emotional care (providing social support and encouragement), mediation care (negotiating with others on behalf of the care recipient), and financial care (through gifts or service purchases). Gibson et al. [11] also mentions the medically-oriented care role of the family caregiver. However, Booker (2015) [12], in a study on lessons learnt about aging revealed that successful aging in South Africa will depend greatly on a sound collaboration between the family caregivers of the elderly and the nursing profession. This scenario seems to be true for many African countries like Cameroon that rely mostly on family caregivers.

Quality care is guaranteed when the carer has a vivid understanding of his or her care recipient. Consequently, there have been a number of studies pertaining to the elderly and aged-care. For instance, a study by Hadeel Halaweh et al. [13] in 2018 on the perspectives of older adults on aging well revealed that most of the elderly considered autonomy or staying independent as one of the factors that favours aging well. Another study by Ten Bruggencate et al. [14] emphasized on the social needs of the elderly such as connecting with others and taking part in social activities. Furthermore, though aging is frequently associated with a number of physical challenges, some researchers [15] argue that the psychological challenges of the elderly is equally important because they are often faced with issues of isolation, low self-esteem and depression, amongst others.

Quality care is also directly linked to the awareness, accessibility and use of available resources. Moreover, in order to promote active and healthy aging, WHO [16] recommends community-based support and assistance to older people. Though geriatric nurses have remarkably improved the quality of care provided to the elderly, their scarcity remains a major challenge to the rising aging population as many countries are witnessing problems in recruiting nurses to work with the elderly [17]. According to Henni et al. [18], geriatric nurses are specialized with knowledge and skills to better understand

the elderly, their relations and the systems in which they work. In developed countries such as Australia, there exist a number of support services for aged care such as My aged care, support services for remote and indigenous aged care and the national aged care advocacy program just to name a few as well as websites where interested persons could get access to information on aged care [19]. Grove [20], states that the Australian government has an aged-care system which caters for frail older adults in both communities and nursing homes. Though resources for aged care in this country are mostly provided by the government, other international and local non- governmental organizations do provide support to older adults. On the other hand, in developing countries such as Nigeria there are very limited resources allocated to the care of elderly persons. The pension scheme which most often is dedicated only to older adults who have been government employed seems to be the major resource for aged care [21]. Awareness and utilization of the available resources for aged care by family caregivers could lead to the provision of quality care to the elderly.

In order to improve the quality of life of the elderly, as well as ensure that they receive adequate care and support that promotes healthy aging, it is essential to equip their caregivers with knowledge and skills on aged care. This study therefore sought to define the scope of practice for family caregivers of the elderly and identify available resources for aged care with the aim of developing a training program for these family caregivers.

The study was conducted in Buea, a town situated in the South West Region of Cameroon. This site was chosen for the study because it attempts to address the gaps of a previous study by Bassah et al. [5] carried out in 2018 in communities in Buea Health District which revealed that a majority of the family caregivers lacked adequate knowledge and skills on aged-care and were not aware of the available resources for aged-care within the health district.

2. MATERIALS AND METHODS

2.1 Study Design

The study employed an exploratory, cross-sectional study research design with the use of qualitative method for data collection.

2.2 Sampling Method and Sample Size

Purposive sampling was utilised in order to recruit key informants who had a deep insight on aged care and/or resource availability. Purposive sampling is a non-probability sampling method in which the research participants that can meet the objectives of the study are chosen based on the researcher’s judgment [22].

The key informants were identified and interviewed by the researchers. The sample size was estimated at 15 key informants based on data saturation, that is, when the interview process reached a point where no new information related to the research objective was gotten from the interviews. Fig. 1 shows an overview of the composition of the sampled population n= 15.

2.3 Data Collection

The main tool for data collection was an interview guide (made up of open ended questions) that was used for face to face in-depth interviews conducted with key informants at their respective offices or other sites convenient for them that was free from noise and distraction. This method ensured first-hand information on the scope of practice for family caregivers and available resources for aged care in their various fields of

work. All interviews were tape-recorded and field notes were taken alongside. The interviews were conducted in English language and lasted between 30 and 45 minutes.

2.4 Data Analysis

The interviews were analysed using thematic analysis. That is, after being fully transcribed verbatim, the interviews were read several times in order to get a better comprehension of the data as well as search for similarities and aspects of interest relevant to the objectives of the study. This led to the development of codes. All codes with similar meanings were then identified and grouped together in order to create categories. The categories were then placed under themes that emerged from the data. The themes were considered the main idea that cut across the various categories. Finally, the researcher wrote a narrative report supported by excerpts from the participants’ responses (KI = Key informant) as evidence of the data.

3. RESULTS

Based on the interviews, two themes emerged from data analysis; 1) ‘Recognise the boundary for the scope of practice of family caregivers and 2) ‘Health and wellbeing’ for available resources. They are represented below.

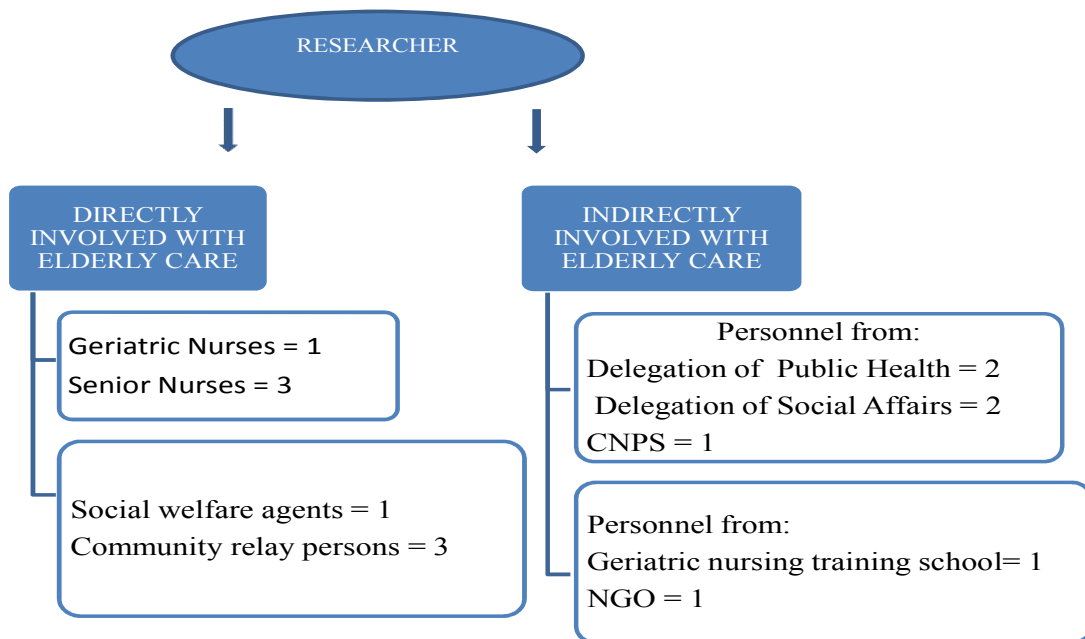


Fig. 1. Flow chart for key informant recruitment

Theme 1. 'Recognize the boundary'



Fig. 2. The theme 'recognize the boundary' and the various categories

3.1 Defining the Scope of Practice for Family Caregivers

With respect to the scope of practice for the family caregiver, a majority of the key informants had conflicting ideas on what a family caregiver should know, do and should not do as shown in Fig. 2. A few of the key informants were of the opinion that family caregivers should carry out some nursing skills such as positioning and wound dressing which they classified as non-complex activities, while a majority said they should collaborate with the nurse in caring for the elderly and should not attempt to carry out any procedure meant for the nurse or professional. However all of the key informants unanimously agreed on activities of daily living as part of their scope of practice.

3.2 Bridge the Gap

The gap was identified in the knowledge and skills of the nurse (formal caregiver) and that of the family caregiver (informal caregiver) who has received little or no training on the provision of care to the elderly. A few (4) of the key informants were of the opinion that Family caregivers' scope of practice should go beyond Activities of Daily living (ADLs) and Instrumental Activities of Daily Living (IADL) with main reason being that empowerment of these caregivers could help solve the issue of shortage of nurses.

"I think a family caregiver should be able to know some basic nursing procedures such as how to move an elderly for the prevention of bedsores especially if their elderly is bedridden" (KI 13).

"To me, she should be able to communicate effectively with the elderly in a way that she can detect any problems especially with the elderly's health. Let her live in their world" (KI 8).

"They can do certain technical procedures but should not try any procedure that is invasive" (KI 9).

"No unique format should be used but from their experiences, we can address their difficulties and teach them how to care for the elderly in their context so as to avoid rejection" (KI 10).

3.3 Shared Responsibility

A majority (11) of the respondents accepted the notion that the care of the elderly is a duty for both the informal and formal caregiver, but the line had to be drawn as to the limit of the informal caregivers' competencies.

"They should take care of the nutrition and hygiene of the elderly but they have to know their limits and leave the medical care aspects to the health professional" (KI 3).

"Psychosocial support can be given by both the nurse and the family caregiver" (KI 6).

"There should be no definition as to what a family caregiver should do or not do. It's his/her relation, you can't tell him/her what to do. Rather, the nurse should be teaching them those basic things such as communication, nutrition and the aging process" (KI 14).

"A lot of barriers exist in the care of the elderly. Sensitisation should be done so people can understand that other people such as geriatric nurses can assist them in the care of their elderly relative" (KI 10).

3.4 Available Resources

With regard to available resources within each sector, all of the key informants acknowledged the fact that maintaining good health of the elderly was of key interest to their available resources, hence improving their wellbeing as seen in fig. 3. Some of them (8) talked of no fixed time for available resources with finances or lack of sponsor being the most common factor accounting for this. Moreover, most of the

sectors organised healthcare campaigns where screening for certain chronic diseases of the elderly was done. Material and sometimes financial assistants were also provided, but this was mostly during the period of the commemoration of the world's day of the elderly. However, a few of the sectors had fixed and steady resources even though access to some of these resources is not possible because they have not been officially launched but will be in the nearest future. The available resources included;

a) Geriatric health care agency

One of the key informants gave a detailed account of a geriatric healthcare agency which they run.

“Our agency has been functional for two years now. We have a variety of options for care ranging from 2 hours to 24 hours and we provide holistic care. The agency provides the client with a care team made up of geriatric nurse and other auxiliary staff depending on the clients’ request. We provide home care services and they are affordable. You can contact us via our website where all registrations are done online or via phone number. We already have some clients in Buea and Douala” (KI 9).

“Our agency also has a philanthropic arm which at times subsidises the cost of care for some elderly and even offers free services to others depending on their condition” (KI 9).

b) Self-employed geriatric nurses

One of the key informants who is a geriatric nurse explained how she makes use of her services even though many people are not aware and are skeptical of accepting them. She also talked about her plans to spread her wings.

“I meet my clients in the hospital and explain my services to them. At times when they are discharged, they invite me to their homes where I render my services. But, most of these carers don’t understand the complex nature of my job. They keep assessing the financial benefits and finally end my contract prematurely. I don’t charge too much but just enough for my services, at least my time and skills need to be compensated” (KI 10).

“Since only a few geriatric nurses exist, I plan to train auxiliary geriatric nurses to work in the community and bring me feedback. I will only step in where I find lapses. I won’t create a home for the elderly but care for them in their homes” (KI 10).

Theme 2. ‘Health and wellbeing’

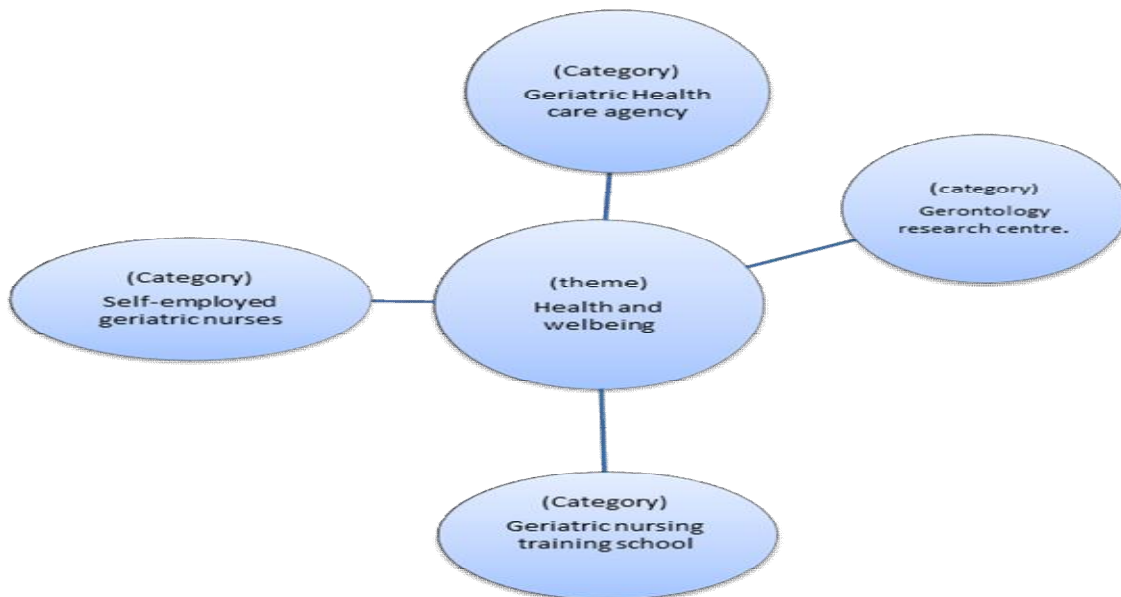


Fig. 3. The theme ‘Health and wellbeing’ and the various categories

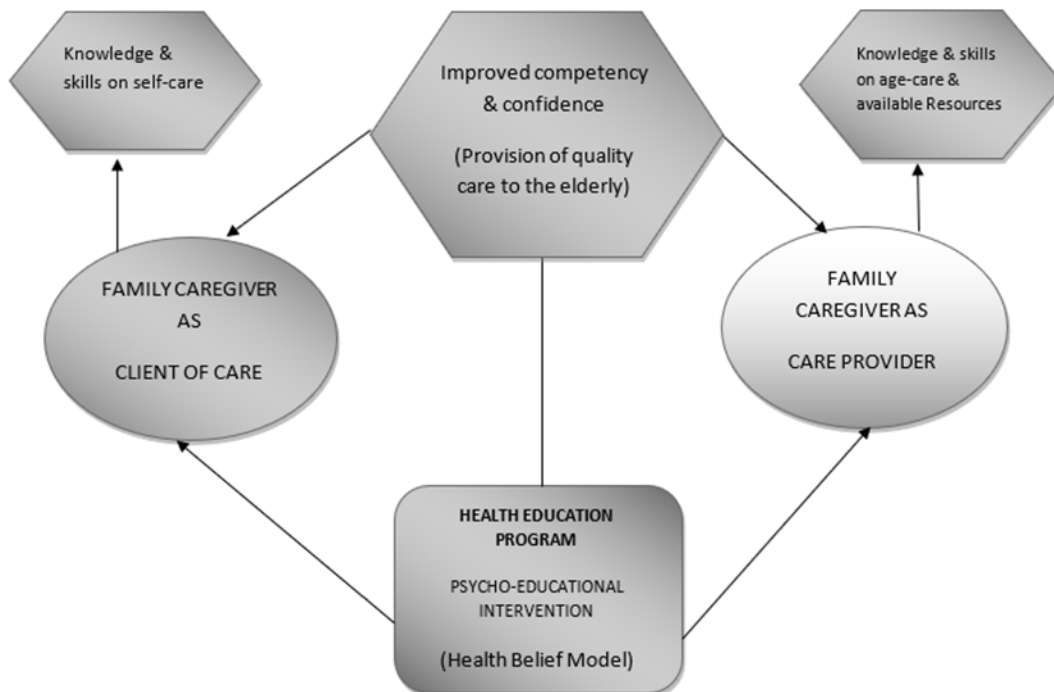


Fig. 4. Conceptual framework for health education program of family caregivers of the elderly as conceived by Ukum Susan Ubenoh

c) Gerontology research center

One of the key informants also did mention a research center where information on the elderly could be gotten. As for data, he further explained that the population cannot get access to their data since it has not yet been published.

“We do collaborate with our partners in Australia to run a research center whose aim is to promote positive aging through research. We have partnered with the Ministry of Social Affairs and carried out a survey assessing the needs of elderly persons in Yaounde, Douala and part of the South West Region but our data is not yet published” (KI 9).

d) Geriatric nursing training school

One of the key informants passionately talked about its existence and how family caregivers could benefit from their highly qualified graduates.

“Our geriatric nursing training model is unique as we equip our students to be able to provide home care services to the elderly, institutional as well as hospital services that meet both international and national standards. They are an

all-round geriatric nurse and we also train them to empower family caregivers of the elderly as well as to be self-employed” (KI 9).

e) Healthcare facilities with Performance Base Financing (PBF)

Three of the key informants who were nurses acting as the community relay persons in their health centers talked of not having any special fund from the government or their centers to cater for the elderly but they were all partnering with an NGO under a program called Performance Base Financing, which paid for the hospital bills of vulnerable persons including vulnerable elderly persons.

“Most elderly patients who have been assessed as vulnerable are treated for free from consultation to buying of drugs under the PBF program” (KI 6).

“People need sensitization on the PBF program as many family caregivers refuse to register their elderly relative with the excuse that they don’t want to be known as poor and needy” (KI 3).

“We prioritise cases of the elderly under the PBF” (KI 12).

f) Social welfare centers

All of the key informants from the Ministry of Social Welfare acknowledged the presence of a social center in Buea which focuses on issues of the elderly.

"We have a social welfare center in Buea whose function is to receive and solve problems of the elderly. It is the operational body of the ministry" (KI 5).

"As a social welfare agent, I go down to the community from time to time to assess the needs of the elderly. Depending on the needs, I may counsel the family caregiver or negotiate for material or financial assistants for the elderly. People also come to us for assistance, but we must do needs assessment first" (KI 8).

"We encourage national solidarity in the community. Elderly people have contributed to the growth of the community, so the community should pay them back" (KI 4).

g) NGOs and Ministry of Public Health's campaign on elderly care

Even though it was earlier mentioned that the Ministry of Public Health had no special structure for elderly care, key informants from this ministry did cite some of the campaigns organised by the ministry in collaboration with some international and local NGOs but stressing on the fact that they were done spontaneously and not a routine or fixed program. An NGO member also expressed their good intentions of organising several healthcare campaigns for elderly care but the lack of sponsorship limits them.

"The ministry has partnered with an organisation called Mercyship that caters for every disabled person, children and the elderly" (KI 7).

"From time to time, especially during the period of the commemoration of the World's Elderly Day, the ministry does sponsor programs of free screening for chronic diseases such as hypertension, diabetes and prostate cancer for the elderly in some government owned health institutions" (KI 1).

"In my organisation, we have equipment for diabetes and hypertension screening. We do these tests for free for the elderly but only during the period surrounding the 1st of October. The

kits for diabetes are expensive, and our hands are short. So we are trying our best" (KI 11).

"We are also working on a project to bring together all the elderly persons. We want family caregivers to come and register their elderly and if the elderly is mobile, let him also come and register. We want to come out with a program called senior citizens network where we can easily reach elderly persons" (KI 11).

"We link relatives of the elderly in various communities to NGOs so they can receive support to cater for their elderly family member" (KI 15).

h) CNPS benefits for pensioners

The key informant from the CNPS (National Social Insurance Fund) sector did give a detailed account on the resources available in his sector for elderly care. However, he did emphasise on the fact that only elderly persons with a social security number; those who receive pension could benefit from these services.

"CNPS has hospitals that offer free consultations to pensioners and a 50% reduction of other hospital bills. In Buea, we no longer have this hospital but we do have a clinic. The referral hospitals are found in Yaounde and Garoua while other smaller hospitals are found in Bamenda and Douala. CNPS also carries out health campaigns every three months during key pay periods" (KI 2).

"We have a building known as 'pensioners' house' where pensioners most at times hold their meetings" (KI 2).

4. DISCUSSION

With regard to the definition of the scope of practice of family caregivers of the elderly, the findings revealed conflicting ideas as to where to draw the line. What family caregivers should do and not do is not very clear as lots of clauses are being attached to every duty of the family caregiver.

A majority of the subjects were of the opinion that family caregivers should not bite more than they can chew. That means they should leave what is meant for the professional to the professional. Taking a critical look at this opinion and analysing it within the Cameroonian context, basic nursing skills should be taught to these

family caregivers. This might include: massaging, monitoring and measuring vital signs, positioning and catheter care, amongst others which if taught to the family caregiver, could help him/her to easily identify danger signs, hence early diagnosis and treatment, consequently dismissing complications. Moreover, most of the elderly are usually faced with more than one chronic health condition making their care more complex [8]. Family caregivers could be taught these basic nursing skills by nurse educators or community health nurses via the development of training programs that meet this need. This finding concurs with the medically oriented role of the caregiver stipulated by Gibson et al. [11]. This finding also supports the findings of Booker in 2015 [12] which asserted that successful aging can be guaranteed via the collaboration between family caregivers of the elderly and the nursing profession. However a unanimous agreement by the key informants was the involvement of family caregivers in ADL and IADL in situations where the elderly is not in a critical state that warrants medical attention or specialised skills. This is in line with the four dimensions of informal caregiving suggested by Davis et al. [10] which includes direct care, emotional care, mediated care and financial care. The mentioning of good communication and psycho-social skills by the key informants in the scope of practice for family caregivers underscores their importance in aged-care. This plays a great role in meeting the psycho-social needs of the elderly, thereby eradicating feelings of isolation, low self-esteem and depression as documented by Kourkouta et al. [15]. This gives the elderly a sense of autonomy, belonging as well as being able to connect with others guaranteeing healthy aging as stipulated by Hadeel Halaweh et al. [13] and Ten Bruggencate et al. [14]. This therefore implies that family caregivers should be able to assist their care-recipients with ADLs and IADLs. They also need to have good communication skills that can meet the psychological needs of their care-recipients. Moreover, they need to know their limits and not carry out complex healthcare activities such as wound dressing and administration of injections, amongst others. However, there is a need for them to work hand in glove with healthcare personnel in the care and management of their care-recipient especially in cases of sickness or complications where the healthcare personnel could guide them on what to do and how to do it.

It is worth noting that an awareness of family caregivers of the various resources available can

be very instrumental in enhancing the quality of care provided to the elderly. The study revealed the available resources for elderly care in the various ministries and sectors. Most of the available resources were a product of the private sector. This finding contradicts with the scenario of aged care support in Australia where the government plays a great role in assisting with aged care via the aged care system [20] but concurs with the situation in Nigeria where the government has very little resources allocated for aged care [21]. The study also indicates that there are geriatric nursing services available. Henni et al. [18] asserts that geriatric nurses are specialised with knowledge and skills to better understand the elderly, their relations and the systems in which they work. This implies that, family caregivers could make use of geriatric nurses to learn skills and gain knowledge on elderly care as well as even hire some of them for those who can afford their services during periods when they are at work or tired as such ensuring that despite their absence, their elderly care-recipient is in good hands and receiving quality care. Furthermore, they could register their care-recipients in NGOs and receive all the benefits these organisations provide. They could also benefit from social service centers as well as PBF (Performance Based Financing) found in most healthcare facilities and all other resources mentioned above. These findings match with WHO's recommendations of community-based support and assistance to older people for the promotion of active and healthy aging [16].

These findings could be used by policy makers in the Ministry of Public Health and other related ministries involved in aged care to plan and draw up policies for aged care, specifically on the scope of practice of the family caregiver. This will also aid in clearly identifying the role of the family caregiver; what they can do and should not do. Similarly the findings could be used in developing training programs using the model of the conceptual frame work above (fig 4) and implementing them as well as building strong bonds between nurses (the health sector) and family caregivers as part of the strategy for promoting healthy aging in most resource poor countries that rely on family caregivers for provision of care and support to the elderly.

In line with the findings of a previous study by Bassah et al. [5] on the Knowledge and Practices of Family Caregivers in the Care of the Elderly at Home in the Buea Health District, Cameroon, the training program will therefore comprise a

psycho-educational intervention, in which the family caregiver will be considered as both a client of care and a care provider. Information on aged-care, self-care and available resources will be included in the training program.

5. CONCLUSION

The study has revealed that the scope of practice for family caregivers should be limited to activities of daily living, instrumental activities of daily living, communication and psychosocial skills that enable the elderly to feel loved, connected and a sense of autonomy as well as basic nursing skills such as vital signs monitoring and massage. The study also revealed some of the available resources for aged care which included; geriatric nurses, social service centers, gerontology research center, NGOs and a geriatric home care agency, amongst others.

CONSENT AND ETHICAL APPROVAL

Before the study was carried out, an ethical approval was obtained from the University of Buea Faculty of Health Sciences Institutional Review Board. Confidentiality and anonymity were ensured.

Ethical and administrative approvals were obtained from the University of Buea, Faculty of Health Sciences Institutional Review Board (FHS-IRB), and the South West Regional Delegation of Public Health respectively.

The participants were also assured of confidentiality. Written and verbal informed consents were obtained from all the participants and the principle of beneficence; non-maleficence and justice were also ensured throughout the course of the study.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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