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PATTERN OF RELATIONSHIP BETWEEN FAMILY CAREGIVERS AND THE ELDERLY CARE RECIPIENTS IN KANO MUNICIPAL LOCAL GOVERNMENT AREA OF KANO STATE, NIGERIA

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Abstract
Aging individuals are now living longer with increasing life expectancy and availability of better health facilities but are also requiring more assistance or care to manage their day to day activities. Family members have long provided care for aging and older adults at home, especially in low and middle-income countries. This study examines the interaction patterns and perceived care satisfaction among the family caregivers and the elderly care recipients in Kano Municipal local government area of Kano State. A sample size of 200 respondents comprising of family caregivers and care recipients was drawn using a multistage and purposive sampling techniques. The data were collected using questionnaire and in-depth interviews; analyzed using Statistical package of Social Sciences (SPSS) and content analysis. The findings of the study reveal that a significant number of caregivers had up to secondary level educational attainment followed by primary level. However, a relatively smaller percentage of them had tertiary level education. Majority of the family caregivers reported moderate level of satisfaction as perceived by care receivers. However a substantial percentage of the female caregivers reported that their respective care receivers were highly satisfied with the care provided to them. The findings also indicate that reciprocity and obligation are the interaction patterns that motivated the family caregivers to provide continuous care to their elderly family members. Most of the elderly care recipients also implicitly indicated that self-care opportunities in the caring process were desirable. The study recommends the creation of caregivers' support services in order to reduce the burden, strain, and depression family caregivers' experience.

Keywords: Pattern, relationship, elderly, caregiving, family caregivers and elderly care recipients.

Introduction

The number and proportion of elderly people is increasing in both the developed and less developed countries as a result of improved health facilities, declining birth rates, expansion of health care services in quality and quantity. In 2005, there were 34 million people age 60 and over in Sub-Saharan Africa, and this number is projected to increase to over 67 million by 2030 (UNFPA, HAI, 2012). The 2006 Nigerian Census showed that 9.5% of the total population are aged 50 years and above and 4.3% are aged 65 years and above and the absolute number of people entering the older cohort is increasing (National Population Commission, 2006). As a result of the increase in the number and proportion of the elderly people, caregiving has gained attention as a research topic (Talley and Crews (2007). Across all countries, caregivers make substantial contributions to providing support and assistance to people living with disabilities and/or caring for ageing adults. It is well established in most developing countries that the family, as a social institution, is the main care provider for its older adult members. The family is particularly important for older persons, especially when they require assistance due to debilitating chronic conditions and diseases, such as severe arthritis, disability, significant sensory loss, Parkinson's disease, Alzheimer's disease, or when they are otherwise frail (Walker, et al., 1995). Since the culture of developing societies stresses respect for older people, values highly the natural bond of affection between all members of the family and places enormous obligations on family to support members in old age, most older adults in developing countries live at home and receive care from one or more family members like children, spouses or other close relatives (Sinunu *et al*., 2008; Yount *et al*., 2009). In view of that, the family as a social institution assumes responsibility for enhancing or maintaining older adults' quality of life and their survival and wellbeing by assisting them with the daily chores, including personal care activities (e.g., bathing, eating, dressing, mobility, meal preparation, grocery

shopping and making telephone calls), illness-related care (e.g., managing symptoms, coping with illness behaviors, carrying out treatments), care management (accessing resources, communicating with health care professionals, communicating with and navigating the health care and social services systems and acting as an advocate quality care and services), financial management (direct financial assistance and help with bill-paying) and emotional support (Abyad, 2001; Walker, 1995; Smith, 1994).

A family caregiver is an individual who provide ongoing care and assistance, without pay, for family members and friends in need of support due to physical, cognitive, or mental health conditions. Family caregivers providing unpaid care, represent a major source of care for older persons in almost all countries. Despite the substantial physical and psychological burdens associated with this role, it remains the most common form of long-term care in the developed countries. Few studies have examined the prevalence of family care and the characteristics of caregivers in different countries. It has been established that most family caregivers are female family members, especially spouses or adult children, including daughters-in-law (Sundstrom, 1994).

Family caregivers can be categorized in different ways depending on living conditions, frequency of caregiving and whether he/she provides care alone or not. Jeppsson Grassman (2001) divides family caregivers into two groups based on whether they live with the care receiver or not: 1) family caregivers who take care of someone in their own household and 2) care providers who take care of a person who does not live with them. Lyons, Zarit and Townsend (2000) classify family caregivers according to whether the family caregiver provides care alone or in combination with another caregiver. They describe three categories of caregivers: 1) isolated caregivers, who receive no assistance with caregiving; 2) family dependent caregivers, who receive assistance from other family members but not from the formal care system; and 3) caregivers who also receive support from formal caregivers, sometimes in combination with family care.

The family caregiver's role varies with the age and nature of the impairment of the recipient. The family caregivers provide care to older family members who need assistance to manage a variety of tasks, from bathing, dressing, and taking medications to tube feeding and ventilator care. They assist with the tasks that recipients are unable to do for themselves. These may involve undertaking personal care household, financial and administrative tasks, providing assistance with mobility, along with emotional support and companionship. Family caregivers spend a substantial amount of time interacting with their care recipients, while providing care in a wide range of activities. Family caregiving is strongly grounded in the relationship between caregiver and recipient. This relationship is dynamic and evolving. The present study aims to examine (1) the characteristics of the family caregivers; (2) Caregivers' satisfaction with Caregiving task; (3) perceived satisfaction of the elderly care recipients; and (4) interaction patterns among the elderly and family caregivers and provide possible explanations for the interaction patterns in these caring relationships.

Material and Methods

Study site and Subjects

This is a descriptive cross sectional study conducted between May and July, 2016 in Kano Municipal Local Government Area of Kano State. The local government has a total population of 1,828,861 (National Population Commission, 2006) and 13 political wards namely Cedi, Dan Agundi, Gandun Albasa, Jakara, Kankarofi, Shahuci, Sharada, Sheshe, Tudun Nufawa, Tudun Wuzirci, Yakasai, Zaitawa, and Zango. Its area covers 499 Km^2 and the indigenes of these areas are the Hausa people. As in most parts of northern Nigeria, the Hausa language is widely spoken in Kano Municipal local government area of Kano State.

Sampling Procedure

A sample size of 200 respondents comprising of 100 family caregivers and 100 care recipients was drawn from Kano Municipal Local Government Area of Kano State, using a multistage and purposive sampling techniques. The first stage involved the random selection of five political wards from the 13 political wards in the Local Government Area. The second stage involved the random selection of one Residential Quarters from each of the selected five political wards. Thereafter, purposive sampling technique was used to select twenty households with older people aged 60 and above in each of the five residential quarters. The households were identified through key informants. In each of these twenty households one elderly person aged 60 years and above and his caregiver were interviewed.

Data Collection

The data for the study were collected using questionnaire and in-depth interviews. In-depth interviews were used in order to get a deeper understanding of the caregiving process and patterns. The in-depth interviews were conducted with elderly people and their family caregivers. The interviews were guided by a theoretical

framework with interview guidelines. An interview guideline was made beforehand, from which a list of domains of study was generated.

Data Analysis

The quantitative data collected through the questionnaire were analyzed using Statistical package of Social Sciences (SPSS) and presented in the form of frequencies and percentages. While the qualitative data collected through in-depth interviews were analyzed using content analysis. For the purpose of this analysis, care recipients were defined as older people aged 60 and above and who receive care from family caregivers. Family caregivers were defined as non-paid individuals who are primarily responsible for providing and/or coordinating care in the home such as spouse, offspring, other relatives and non-relative caregivers (friends and neighbors). Analysis was both deductive (based on care demands, caregiving role and responsibilities) and inductive (based on new themes that emerged from the interviews and not originally included in the guide).

Findings

Table 1 shows the characteristics of the family caregivers. Table 1 reveals that family caregiving was a female domain as vast majority (60%) of the caregivers were females and they provided care to both male and female older family members. Only 40% caregivers were males. Table 1 shows that most of the male and female caregivers were aged ≤30 years. Caregiving might have certain implications for those in the prime labor force age group (caregivers aged ≤30 years). The caregivers aged 51 years and above either did not have adult children or their adult children were located elsewhere. In such cases, spouses were the main source of care giving.

Table 1 Characteristics of Family Caregivers

Characteristics	Percentage
Age	
≤ 30 years	40.2
31 – 35 years	14.1
36 – 40 years	24.4
Over 40 years	3.9
Gender	
Male	40.0
Female	60.0
Marital Status	
Currently Married	66.9
Widow	2.4
Separated	1.6
Never Married	29.1
Education	
Illiterate	16.5
Primary	22.0
Secondary	39.7
Tertiary	10.7
Relationship with Care Recipient	
Spouse	14.2
Son or Daughter	40.9
Daughter in law	39.4
Grand child	4.7
Other relative	0.8
Work Status	
Working	33.8
Not Working	66.2

Source: Field work

The results in Table 1 indicate that a significant percentage (39.7%) of the caregivers had up to secondary level educational attainment followed by primary level. Only a relatively smaller percentage of them (10.7%)

had tertiary level education; while a considerable percentage of them (16.5%) were illiterate. Table 1 also shows that most of the care was provided to older family members by either daughters-in-law or sons and daughters. The results in Table 1 indicate that most of the caregivers were not working.

Distribution of Care Recipients by age, gender and major chronic conditions

Table 2 provides information about percent distribution of care recipients by their age, gender and major chronic conditions. The data show that a substantial proportion of care recipients with greater share of males was aged ≥70 years, while females constituted greater share in receiving care in younger age group (i.e. ≤ 60 years). Table 2 also reveal that a significant proportions of both male and female care recipients were suffering from heart diseases (21.3 % males and 17.3% females) followed by diabetes (8.7% males and 13.4% females), stroke/paralysis (8.7% males and 9.4% females), arthritis (7.1% males and 3.1% females), cancer of any type (4.7% males and 3.1% females) and hip fracture (1% male and 3.1% females only) respectively.

Table 2 Percent distribution of care recipients by age, gender and major chronic conditions Age (in Years)

Care Recipients age and Chronic conditions	**Gender**		**Total**
	Male	**Female**	
Age (in years)			
≤ 60 years	6.3	14.2	20.5
61 – 69	10.2	7.9	18.1
≥70 years	33.9	27.6	61.4
Total	**50.4**	**49.6**	**100.0**
Major Chronic Conditions			
Hip fracture	1.0	3.1	4.1
Heart disease/attack	20.3	17.3	37.6
Diabetes	8.7	13.4	22.0
Stroke/paralysis	8.7	9.4	18.1
Cancer (of any type)	4.7	3.1	7.9
Arthritis	7.1	3.1	10.2
Total	**50.4**	**49.6**	**100.0**

Source: Field work

Care Recipients' Satisfaction with Caregiving as Reported by Caregivers

Caregivers were asked to report as to how care recipients were satisfied with the care they were providing to them. Caregivers reported varying levels of satisfaction perceived by the care receivers. Table 3 presents reported satisfaction levels of care recipients. The results show that a little less than one-half (48.1%) of the caregivers reported moderate level of satisfaction as perceived by care receivers. It is important to note that 26.3 % of the female as opposed to 21.8% of male reported moderate satisfaction of care recipients with care being provided to them. Similarly 20.5% female and 18.2% male caregivers reported that their respective care receivers were highly satisfied with the care provided to them.

Table 3 Perceived satisfaction of care recipients as reported by caregivers by gender

Gender	**Satisfaction of the Care Recipient with caregiving**			**Total**
	Not at all	**To some extent**	**To a greater extent**	
Male	0.00	21.8	18.2	40.0
Female	13.2	26.3	20.5	60.0
Total	13.2	48.1	38.7	100.0
N	**17**	**45**	**38**	**100**

Source: Field work

Caregivers' Satisfaction with Caregiving Task

Caregivers' satisfaction with caregiving can be important for their own life quality. The extent of satisfaction with caregiving may influence motivation and health of caregivers. Table 4 presents percent distribution of caregivers by their satisfaction with caregiving task by gender. The data show that 93% male and 45.7% female caregivers were highly satisfied about caregiving role. On the other hand, 7% males and 43.7% females reported their satisfaction about the role of caregiving 'to some extent'.

Table 4 Percent Distribution of Caregivers by their satisfaction with Caregiving Role by Gender

Gender of Caregiver	Relationship to Care Recipient	Extent of Satisfaction with Caregiving Role			
		Not at all	**To some extent**	**To a greater extent**	**Total**
Male	Husband	0.0	0.0	3.0	3.0
	Son	0.0	2.0	78.0	80.0
	Son in law	0.0	2.0	4.0	6.0
	Grand Child	0.0	2.0	5.0	7.0
	Other Relatives	0.0	1.0	3.0	4.0
	Total	0.0	7.0	93.0	100.0
	N	**0.0**	**3**	**37**	**40**
Female	Wife	3.0	6.6	5.8	15.4
	Daughter	2.0	4.8	22.2	29.0
	Daughter in law	4.6	27.2	14.1	45.9
	Grand Child	1.0	3.0	2.6	6.6
	Other Relatives	0.0	2.0	1.1	3.1
	Total	10.6	43.6	45.8	
100.0					
	N	**6**	**26**	**28**	**60**

Source: Field work

Views of Family caregiver in caring for the elderly people

The results of the in-depth interviews reveal that reciprocity and obligation were the interaction patterns that motivated the family caregivers to provide continuous care to their elderly family members. In these interaction patterns, marriage and love were the major explanations for the spouse taking care of their frail partners, while filial piety and norms of caregiving were the reasons for adult children caring for their older parents. As explained by the interviewees, the marriage philosophy of traditional Hausa people is a promise to care for their spouse for their whole life, taking love as a life-long commitment and doing what needs to be done.

Caring expectations

The results of the in-depth interviews indicate that the elderly people have certain caring expectations towards family caregivers. As explained by the elderly respondents, they generally preferred their family caregivers to provide the intimate personal care. In addition, most elderly respondents interviewed also implicitly indicated that self-care opportunities in the caring process were desirable, as they did not want to become a burden of their family members. Some of the family caregivers interviewed reported that most of the frail elderly people insisted on toileting by themselves; and that they always emphasized on the functional mobility.

Discussion

The findings of the study reveal that a significant percentage of the family caregivers had up to secondary level educational attainment followed by primary level. Only a relatively smaller percentage of them had tertiary level education. It also shows that most of the care for chronically ill older family members were

provided by either daughters-in-law or sons and daughters. The results of the study indicates that females start to experience chronic ailments at an early age compared to males. This could be attributed to the life course disadvantageous position of females in countries like Nigeria.

The findings also reveal that a large proportion of the care recipients were afflicted with multiple morbidities, apart from the reported condition for receiving health care from their respective family members. It may, however, be argued that severely limiting morbidities of the care recipients could have resulted from their early life conditions and health related behaviors. Studies indicate not only working conditions, residential conditions and behaviors (Marmot *et al*, 1991) affect the health status in late life, but also the role of events and situations over life course (Smith *et al*, 1997). Others, for example, Holland *et al* (2000) indicated that behaviors in adulthood are largely responsible for inducing multiple morbidities, disabilities and death.

The results of the study also reveal that majority of the caregivers reported moderate level **of** satisfaction as perceived by care receivers. It is important to note that a significant proportion of daughters-in-law compared to other family members reported low satisfaction with caregiving role. It is understandable because greater proportion of daughters-in-law compared to other family members were spending larger amount of time on caregiving. Their low satisfaction with caregiving might be due to high demand on their time from life circumstances. However a substantial percentage of the female caregivers reported that their respective care receivers were highly satisfied with the care provided to them. This was expected as children were socialized to look after their elderly family members. Moreover, the value of self-sacrifice is instilled among females and the same socialization pattern prepares them for such caring roles. However, female caregivers provided more care in basic activities such as dressing, bathing, eating or preparing meals. Such activities are taken as domestic and feminine and both males and females expect that. It may be noted that males generally provided instrumental support which was valued more than what their female counterparts provided. That is why males thought that their care receivers were more satisfied with their care than their female counterparts. On the other hand, female caregivers faced double jeopardy; spending more hours in caregiving and receiving little appreciation.

The findings of the study also reveal that reciprocity and obligation were the interaction patterns that motivated the family caregivers to provide continuous care to their elderly family members. In these interaction patterns, marriage and love were the major explanations for the spouse taking care of their frail partners, while filial piety and norms of caregiving were the reasons for adult children caring for their older parents.

Conclusion

In conclusion it is pertinent to note the families and friends provide most of caring services to older people in Kano municipal local government area. The caring relationships between family caregivers and care recipients and the interaction patterns were based on reciprocity and obligation. As for the family caregivers such as spouses, marriage means taking care of their partners for their entire life. This life-long commitment motivates spouses to take care of their frail partners. On the other hand, the perception of parental love, norms of caregiving (filial piety), and gratification and satisfaction from family members are the explanations for adult children caring for their older parents in these interaction patterns.

Recommendations

The study recommends the creation of caregiver support services in order for the family caregivers to stay healthy, improve their caregiving skills, remain in their caregiving role, reduces the burden, strain, and depression caregivers' experience. These caregiver supportive services include education and skills training, coping techniques, and counseling; as well information about managing chronic conditions and respite care (to provide temporary relief from caregiving tasks).

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