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Caregivers' Challenges in Delivery of Family-Based Care to Older Adults in Nigeria

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Abstract

Global trends and the nature of some people necessitate that they receive some special care. Older adults in Nigeria require such special care. They need family based care. The present study aimed at finding out caregivers' challenges in delivering family based care to older adults in a Nigerian state. Cross sectional survey design was adopted for this study. 1107 respondents served as the sample size for questionnaire distribution while 12 respondents (comprising of 2older adults and 2 caregivers) was selected from each of the 3 Local Government Areas[LGA] for In-depth interview [IDI]. 48 respondents made up of 24 caregivers and 24 older adults was purposively selected for Focus Group Discussion [FGD], from the three LGAs. This implies 16 (8 caregivers and 8 older adults from each LGA. Thus, the total sample size for the study was 1167 respondents. Descriptive statistics such as percentages and frequency tables were used in presenting the results. The qualitative data were analysed in themes as complement to the quantitative data. The study revealed that caregivers have problems and challenges with caring for older adults. The most reoccurring problems and challenges were financial problems; caregiving is time consuming and older adult's poor attitude such as lack of appreciation, loss of personal time, and lack of time for social relaxation. Older adult face some challenges and problems from caregivers such as lack of respect, lack of companionship, lack of adequate financial support and their needs not met on time by the caregivers. Caregivers face enormous challenges in the process of caring for older adults, and older adults face challenges from those taking care of them. Caregivers face financial challenges among others. It was recommended that the challenges faced by caregivers can be solved through provision of fund, caregivers also taking care of themselves, more help from relatives and good planning.

Keywords: *special needs, social work, caregivers, challenges, older adults, family-based care.*

I. INTRODUCTION

One can describe the year 2020 as one of the most disturbed years in the century. Notwithstanding some human and natural disasters that humanity experienced, COVID-19 took the globe to a new level of trouble. As if that was not enough, the post pandemic and the new wave are fraught with fears and apprehension. The levels of stress are very high. People are trying to cope with the situation and the aftermath of the disease.

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People with special needs including the vulnerable and older adults seem to bear the greater brunt and they need special care.

Caregiving brings about several unintended and undesirable outcomes that require mitigation either at individual or group levels. Literature has suggested that care giving produces great amount of burden and stress for caregivers (Gupta & Pillar, 2009). These caregivers in the family setting compose primarily of spouses, children, relatives and other members of the filial hood. Some of these caregivers may or may not be engaged meaningfully with paying jobs but are however expected to contribute psychologically, socially and economically to the care of older adults and other dependants regardless of their income or nature of work (Akinemi, Adepoju & Ogunbaneru, 2010; Munsu, Tareque & Rehman, 2010). The stress associated with taking care of the frail older adults, tells on their economic and social contributions to other pressing responsibilities. Poor management of these negative consequences of caregiving could lead to relational disequilibrium and eventual breakdown (Bacsu, Bonnie, Johnson, Martz, Novik & Abonyi, 2013). Nevertheless, caregivers of older adults still are active in carrying out their daily chores and possess resilience to bear the burden and stress that goes with caregiving. Hence, the task becomes a responsibility added to other responsibilities of caregivers (Fajemilehin, Oyadiran & Salami, 2006).

It should be noted that caregiving itself might adversely affect health. Many caregivers when asked to define their health conditions would usually refer to it as poor, which is due to sleepless nights and daily stress (Okoye & Asa, 2011). Aging is associated with high level of stress, high blood pressure and other symptoms of depression/emotional problems such as sleep disturbance, suicidal thought, low self-esteem, difficulty in concentration and loss of energy among the aged (Asharaf, 2009). Such situations tend to be disturbing for caregivers as well, especially those of filial relationships, who must match up the challenges of aging with intensive caregiving, so as to guarantee successful aging for older adults Chorn-Dunhan & Dietz). To this end, caregivers find themselves being weary because of psychological, emotional, economic and bodily stress they incur in the process of caring for their older adults. These could induce poor health conditions for caregivers and would in turn affect the quality of care they offer to older adults who are the receivers of care (Asogwa & Igbokwu, 2010).

Furthermore, Sijuwade (2008) noted that both in developed and developing countries, older adults as well as their caregivers prefer to take care of the aged within the family. The author opined that in developing countries like Nigeria, the family is the main provider of care to their older relatives. Family Based Care for older adults is the most preferred source of care because it assures the health and well-being of the aged through respectful family partnership (Lou, 2009). However, care for older adults by family caregivers are full of some challenges on the part of older adults and their caregivers. Challenges on the part of older adults include abuse, neglect and abandonment, while stress and depression can be found on the part of their caregivers (Eze, 2013).

In traditional Nigerian society, family members are the most natural and conducive social organization for the care and support of older adults especially the wife, sons, daughters, sons in law, daughters in law. This caregiving was backed not simply by the emotional bonds of relationship emerging out of blood relationship or marital relationship but by the force of pervasive influence of traditional value, norms, and behaviour, which were not simply practiced as a matter of routine but also deified (Okoye, 2013). However, this traditional bond between older adults and the younger members of the family is gradually becoming weak in Nigeria and in other

countries also. This is because of combined effects of disorganised social institutions, values and norms arising out of their surroundings, social forces of urbanisation, industrialization, modernization, and globalization (Ushasne, 2004). All these are affecting negatively on the family and caregiving for older adults.

In many developed countries, social workers and providers of special needs education have replaced some of these family roles in the provision of such services. These they do through the following: special needs assessment, social work assessment, counselling and solution focussed-brief therapy, stress management, advocacy work (both individual and group), group and community development assessment of elder abuse (physical and emotional) and neglect (including self-neglect), complaints by older persons about the standard of care they are receiving and case managing (Mudiare, 2013). Families, spouses, adult children, siblings, grandchildren and other carers, paid and unpaid, can also be clients of social workers and special educators (Ngwu, 2015). The care from families can range from information and advice giving, counselling, crisis intervention, basic social work support, brief therapy, crisis management, conflict management and mediation, bereavement counselling, advocacy, assistance in navigating bureaucracies (e.g. social welfare), special training courses and support services for family caregivers (Teater, 2010). Older adults are helped to identify strength, resources, goals and opportunities that connect them with personal and community resources to meet their goals of successful ageing and coordinate the process if necessary (Fast & Chapin, 2000). In a different development, these services are obviously lacking in Nigeria, which makes Family Based Care the most feasible and prominent kind of support for older adults. Lack of care for older adults could portend grave threats to their wellbeing (Tucker & Ludi, 2012). [1] Caregiving comes in form of reciprocity between older adults and those they took care of in their active periods (Oluwabamide, & Eghafona, 2012). It is against these backdrops that this study sought to explore caregivers challenges in delivery of Family Based Care to older adults in Nigeria using Ndokwa area in Delta State as study area.

Population ageing is now a predominant demographic issue as there is growing concern regarding the global phenomenon of aging, both in developed and developing nations (Grundy, 2008). In the opinion of Sijuwade (2008), a decline in death rate due to improvement in medical care has resulted in an increase in population of older adults. In 2010, an estimated 524 million people were aged 65 (8% of the world's population), and it is estimated that by 2050 this number is expected to nearly triple to about 1.5 billion, representing 16% of the world's population (WHO, 2011).

Globally, older persons aged 80 years or over (the "oldest old") within the older population was 14% in 2013 and is projected to reach 19% in 2050. If this projection is realized, there will be 392 million persons aged 80 years or over by 2050, more than three times than today (UN, 2013). More developed nations have adjusted to their changing age structures by initiating programmes and developing policies. For instance, it took more than 100 years for the population of France (aged 65 or older) to rise from 7 % to 14 % (WHO, 2011). In addition, over the 25-year period of 1985 to 2010, the median age of the United Kingdom (UK) population (age at which half the population is younger and half the population is older) increased from 35.4 years to 39.7 years (Office for National Statistics (United Kingdom), 2012).

In contrast, developing countries are experiencing a rapid increase in the number and percentage of older people, often within a single generation (WHO, 2011). Also in the developing countries, the population aged 60 or over is currently increasing at the fastest pace ever. For instance, the report of the United Nation

(2013) shows 3.7% growth annually in the period 2010-2013 and it is projected to increase by 2.9% annually before 2050 and 0.9% annually from 2050 to 2100. These numbers are expected to rise from 554 million in 2013 to 1.6 billion in 2050 and to 2.5 billion in 2100 (UN, 2013).

In Africa, the story is also the same. For instance, the proportion of persons aged 60 years and above in Sub-Saharan Africa (SSA) will be higher than those in other regions of the world. According to African Research on Ageing Network (2009), the absolute number of older persons in SSA is projected to rise sharply from 37.1 million in 2005 to 155.4 million in 2050 – a more rapid increase than in any other world region and for any other age group. In 2006, eight countries in Sub-Saharan Africa had over 1 million people aged 60 and over. Nigeria had by far the largest older population of these Sub-Saharan countries, with 6.6 million people aged 60 and over in 2006, and it ranks among the top 20 countries in the world with the size of this population and vast possibilities of increment in future (Akpan & Umobong, 2013). It is therefore predicted that Nigeria will have the largest older population, with over 12 million people aged 60 and over in 2030 (Velkoff & Kowell, 2007).

Population of the aged presents formidable challenges to developing countries like Nigeria (Okunlola, 2009). When people age, there is decline in physical activities, this presupposes the fact that these older adults would not be able (at most times) to support themselves financially, and physically (Adedokun, 2010). Older people's lives are characterized by growing inadequacies in customary family supports, social exclusion and non-existent social security targeted at them, thus being very vulnerable to poverty and disease (Ajomale, 2007). Therefore, they would need some form of support and care to address the following potential needs. They include; laundry, putting out the waste bin, sweeping the premises, getting in and out of the bathroom, lifting/moving of heavy household equipments, providing firewood, water, replacing light bulbs, arranging unruly carpets and other floor coverings, shopping, taking a walk, collecting drug prescriptions and transportation (Olough, Manthorpe, Raymond, Summer, Bright Hay, 2007).

One of the predisposing factors to older adults' abuse and neglect is caregiver stress that takes varying dimensions ranging from psychological, physiological, economic and social stress. This usually occasions situations where those who give care, crave for care to be given them (Asagba, 2005). This could amount to the abuse of older adults who are frail and dependent on care from their stressed caregivers becoming inevitable (Ajomale, 2007). According to National Centre for Biotechnology Information [NCBI] (2008), due to the demanding work of the caregivers, they might undergo stress, and pressure. This may result into harmful consequences. For example, certain problems like neglect and abuse of older adults may arise, which may further result to malnutrition [due to older adults not getting adequate nutrition] and ill health [as a result of not administering proper medical care] (Reihard, Given, Huhtula &Bemis, 2008).

There has been lot of studies carried out in Nigeria in the areas of health services for older adults, family care giving for ageing parents, strategies for quality social and special needs care in the family (Sijuwade, 2008; African Research on Aging Network, 2009; Adedokun, 2010; Sharma, Thakur & Kaur, 2012; Okumagba, 2011 & Okoye, 2013). These studies have built separately on the challenges of older adults and those of caregivers, cutting across institutional and filial care. They have also looked into areas of health and nutritional services for older adults, as well as governmental interventions. However, few studies had been done in the area of challenges and prospects of Family Based Care for older adults in Nigeria utilising the views of caregivers

and care-receivers. It is based on the foregoing that this study sets out to explore caregivers challenges in delivery of Family Based Care to older adults in Ndokwa area of Delta State, Nigeria.

II. METHODOLOGY

Ethical approval

Ethical approval to conduct this study was obtained from the Ethical Review Board of the University of Nigeria Teaching Hospital, Ituku Ozara, Informed consent was obtained from respondents; questionnaires administration was anonymous to ensure confidentiality and protection; voluntary participation for the purpose of human dignity and rights among others was observed. Participants were informed about the proposed study before the commencement of the study following a debriefing.

Study setting

The Nigerian state used for the study is Delta state. The study was carried in Ndokwa area of Delta State. Delta state is one of the 36 states of Nigeria. Ndokwa area primarily houses Ndokwa West, Ndokwa East and Ukwuani Local Government Areas (LGA's). The study concentrated on these three areas because of the traditional label they carry hitherto as the Ndokwa people. Ndokwa area is a coastal area located at the Delta North Senatorial District and is among the oil producing areas of Delta State. The area shares boundary with other LGAs such as Aniocha South, Oshimili South, Isoko North and Ughelli North. Ukwuani, Ndokwa West and Ndokwa East LGAs of the Ndokwa area accommodate nine, six and nineteen communities respectively. Some of which include: Akoku, Amai, Ebedei, Eziokpor, Ezionum, Umutu, Umu ebu, Utagbe Ogbe, Emu, Ogume, Abbi, Aboh, Ibrede, Akarai, Ashaka, Ase, Okpai, Onyah, Afor, Obikwele, Onogbokor, Igbuku and among others.

The LGAs that form Ndokwa area have their population figures aggregated to get the actual population of the area. Ndokwa West has a population of 149,325 while Ndokwa East and Ukwuani LGAs have 103,171 and 103,000 respectively (NPC, 2010). The total population of the three areas when put together becomes 355,496. This figure becomes the population of Ndokwa area and the target population for the study. It consists of male and female older adults from 60 years and above and as well their caregivers. Therefore, to get the population proportion, the target population was used against the population of Delta State, as a whole is 4,098,291 (NPC, 2010).

Study participants

The sample size for this study was statistically derived using Taro Yamene formular of 1967 for derivation of sample size. By the calculation, 1107 respondents served as the sample size for questionnaire distribution while 12 respondents(comprising of 2older adults and 2 caregivers) was selected from each of the 3 LGAs for In-depth interview [IDI] 48 respondents made up of 24 caregivers and 24 older adults was purposively selected for Focus Group Discussion [FGD], from the three LGAs. This implies 16 (8 caregivers and 8 older adults from each LGA. Thus, the total sample size for the study was 1167 respondents. Ndokwa West LGA was allotted the sample size of 465 while Ndokwa East and Ukwuani LGA was allotted the same size of 321 respectively. This made up the 1107 sample size for questionnaire distribution.

The study adopted both probability and non-probability sampling procedures. The multistage sampling procedure that will also include purposive and snowball sampling techniques was used for the study. The researcher used the multistage sampling technique because of the large population involved lots of steps before getting to the respondents. Ndokwa area is made up of three LGAs with 34 communities spread across them. Using stratification procedure, the 34 communities were grouped into their respective LGAs. Ndokwa West [Utagbe Ogbe, Emu, Ogume, Abbi, Utagbe Uno, Onicha-Ukwuani]; Ukwuani [Akoku, Amai, Ebedei, Eziokpor, Ezionum, Obiarumu, Umu ebu, Umu kwata, Umutu]; Ndokwa East [Aboh, Ibrede, Akarai, Onogbokor, Igbuku, Umuolu, Ibedemi, Ushie, Ashaka, Adiai, Ase, Okpai, Otuoko, Onyah, Afor, Onuaboh, Ossissa, Obikwele, Anyi].

To get to the 60 respondents for the qualitative part of the research, purposive and snowball sampling was used. The purposive sampling targeted those who have the needed information for the research (Older adults and caregivers). In addition to that, the snowball sampling aided in referrals to those who are also (older adults and caregivers).The FGD was in groups of two for each of the LGAs. One for older adults and another for caregivers respectively in each of the LGA's. Eight persons of the same sex was present for each of the two FDGs [all older adults and all caregivers] at different times). Each group was made up of either older adults or caregivers in all the three selected LGAs. The IDI took four participants from each of the LGAs. Two older adults and two caregivers was purposively selected from the 3 LGAs making 12 respondents. In addition, care was taken to ensure that each group was homogenous in terms of educational and economic backgrounds.

Measures

The instruments for data collection were both quantitative and qualitative. The quantitative instruments was questionnaire while qualitative were In-depth interviews (IDI) and Focus Group Discussion (FGD). The questionnaire served as the major instrument for collection of data, which had open and close-ended questions. The questionnaire was in two parts, which covered demographic characteristics of the respondents and specific issues of the research respectively. The IDI and FGD guide contained unstructured questions. This provided the freedom to probe and further stimulate further questions which may not be included in the guide but within the scope of the study.

Demographic questionnaire

Characteristics demographic participants were from demographic questionnaire. They provided personal information ranging from gender, age as at last birthday, marital status, occupation, educational qualification, religion, location and what best describes the person in terms of male or female caregiver.

Table 1: Distribution of respondents by socio-demographic characteristics (caregivers) and place of residence

Gender	**Urban**	**Semi-Urban**	**Rural**	**Total**
Male	71(54.6)	93(50.0)	96(52.5)	260(52.1)
Female	59(45.4)	93(50.0)	87(47.5)	239(47.9)
Total	**130(100.0)**	**186(100.0)**	**183(100.0)**	**499(100.0)**
Age				
15-25yrs	55(42.3)	110(59.1)	83(45.4)	248(49.7)
26-36yrs	42(32.3)	27(14.5)	38(20.8)	107(21.4)
36-46yrs	15(11.5)	26(14.0)	27(14.8)	68(13.6)
46-56yrs	10(7.7)	12(6.5)	19(10.4)	41(8.2)
56-66yrs	6(4.6)	11(5.9)	11(6.0)	28(5.6)
66-76yrs	2(1.5)	0(0.0)	5(2.7)	7(1.4)
Total	**130(100.0)**	**186(100.0)**	**183(100.0)**	**499(100.0%)**
Marital Status				
Single	74(56.9)	116(62.4)	96(52.5)	286(57.3)
Married	37(28.5)	54(29.0)	62(33.9)	153(30.7)
Separated	4(3.1)	5(2.7)	2(1.1)	11(2.2)
Divorced	1(0.8)	3(1.6)	5(2.7)	9(1.8)
Widowed	14(10.8)	8(4.3)	18(9.8)	40(8.0)
Total	**130(100.0)**	**186(100.0)**	**183(100.0)**	**499(100.0)**
Educational Qualification of respondents				
No formal education	16(12.3)	14(7.5)	17(9.3)	47(9.4)
primary education	15(11.5)	17(9.1)	17(9.3)	49(9.8)
Secondary education	38(29.2)	105(56.5)	91(49.7)	234(46.9)
Tertiary education	61(46.9)	50(26.9)	58(31.7)	169(33.9)
Total	**130(100.0)**	**186(100.0)**	**183(100.0)**	**499(100.0)**
Religion				
Christianity	117(90.0)	168(90.3)	174(95.1)	459(92.0)
Islam	3(2.3)	8(4.3)	1(0.5)	12(2.4)
ATR	10(7.7)	10(5.4)	8(4.4)	28(5.6)
Total	**130(100.0)**	**186(100.0)**	**183(100.0)**	**499(100.0)**
Monthly income				
No income	44(33.8)	84(45.2)	66(36.1)	194(38.9)
Less than 18,000	36(27.7)	39(21.0)	57(31.1)	132(26.5)
18,000 -48,000	18(13.8)	24(12.9)	26(14.2)	68(13.6)
49,000-78,000	16(12.3)	31(16.7)	23(12.6)	70(14.0)
79,000-108,000	8(6.2)	5(2.7)	4(2.2)	17(3.4)
109,000-138,000	7(5.4)	0(0.0)	4(2.2)	11(2.2)

139,000 and above	1(0.8)	3(1.6)	3(1.6)	7(1.4)
Total	**130(100.0)**	**186(100.0)**	**183(100.0)**	**499(100.0)**

Study design

The study adopted the cross-sectional survey design. The essence of such research design is to guarantee the observation of a population's cross section at one point in time (Barbie, 2007). Therefore, this research design enabled the researchers to make appropriate inferences and generalizations from studying a sample that is the representative of a population under study.

Instruments for data collection

The instruments for data collection were both quantitative and qualitative. The quantitative instruments was questionnaire while qualitative were In-depth interviews (IDI) and Focus Group Discussion (FGD). The questionnaire served as the major instrument for collection of data, which had open and close-ended questions. The questionnaire was in two parts, which covered demographic characteristics of the respondents and specific issues of the research respectively. The IDI and FGD guide contained unstructured questions. This provided the freedom to probe and further stimulate further questions which may not be included in the guide but within the scope of the study.

The respondents were divided into two groups, older adults also known as care receivers and caregivers. Five hundred and fifty-two (552) copies of questionnaire were distributed older adults. There was a return rate of 97%. On the other hand, five hundred and fifty-five (555) copies of questionnaire were distributed to caregivers and there was a return rate 97%. The high return rate was ensured through greater effort made towards other administered method when compared to self-administered method even though both were employed. The qualitative data collected through Focus Group Discussions (FGD) and In-depth Interviews (IDI) were used to support and elucidate the quantitative data.

Administration of research instruments

The researchers administered the questionnaires with the help of 6 research assistants. The research assistants were students of the Delta State University Abraka who are familiar with the language of the Ndokwa people. Two-day training was held for four hours on each day on basic research investigations. The questionnaires were self and other administered. Respondents who decided to fill the questionnaire were allowed but those who could not were objectively guided by the researcher and her assistants. For In-depth interview and Focus Group Discussion, the researchers moderated the interview and discussion sessions while one of the research assistants served as the note taker. The participants were informed and given an appointment schedule prior to the exercise. The venue for the IDI was at their homes while the FGD was conducted at a relatively convenient central location in each of the communities. Participation was based on the consent and willingness of the participants to be part of the study.

Methods of data analysis

This study utilized both quantitative and qualitative methods in data analysis. The data from the questionnaire were coded, computer processed and analysed using the Version 20 of the Statistical Package for the Social Sciences (SPSS). Descriptive statistics such as percentages and frequency tables were used in presenting the results. The qualitative data were analysed in themes as complement to the quantitative data. The data was translated into English. From the transcription words and phrases special in the local language was translated into English to ensure that both versions carry same meanings as identified and used in supporting findings from the quantitative method.

III. RESULTS

Table 2: Distribution of respondents by what was the nature of the sickness (caregivers)

Nature of the sickness	Frequency	Percent
Malaria	202	44.5
Stomach upset	102	22.5
Cough and catarrh	97	21.4
Arthritis	22	4.8
Hypertension	19	4.2
Prostrate	12	2.6
Total	454	100.0

Table 2 shows that 44.5% of the caregivers indicated that the nature of their sickness for the past one month was malaria, 22.5% indicated that it was stomach upset, 21.4% indicated that it was cough and catarrh, 4.8% indicated that it was arthritis, 4.2% indicated that it was hypertension while 2.6% indicated that it was prostate cancer.

Table 3: Distribution of respondents by whether they think taking care of older adults can affect some one's sleep and health and place of residence (caregivers)

Affect sleep and health	Place of Residence			Total
	Urban	Semi-urban	Rural	
Yes	70(53.8)	90(48.4)	100(54.6)	260(52.1)
No	44(33.8)	61(32.8)	60(32.8)	165(33.1)
No idea	16(12.3)	35(18.8)	23(12.6)	74(14.8)

Total	130(100.0)	186(100.0)	183(100.0)	499(100.0)

Table 3 revealed that majority (52.1%) of caregivers reported that taking care of older adults can affect some one's sleep and health, among them 53.8% were urban residents, 48.4% were semi-urban residents while 54.6% were rural residents. On the other hand, 33.1% of caregivers were of the view that taking care of older adults cannot affect some ones sleep and health, among them 33.8% were urban residents, 32.8% were semi-urban residents while 32.8% were rural residents. In addition, 14.8% of caregivers indicated that they had no idea on whether care for older adults can affect some ones sleep and health, among them 12.3% were urban residents, 18.8% were semi-urban residents while 12.6% were rural residents.

Views from a female participant in an IDI throws more light as she opined that:

It does affect us adversely…when the older adult is sick and giving trouble, I will not be able to sleep. I will be in hospital for weeks taking care of my mother I will not sleep, it is frustrating most times but I endure it because it is my mother, I always go for medical check-up because the stress on my health is too much. I carry her faeces and urine and you see without proper medical attention I will be ill, this leads to breakdown , it is just too much most times, but it is the price we have to pay so that my own children will also look after me **(IDI: Female care giver at Umuolu)**.

Table 4: Distribution of respondents by how often they feel they cannot continue in care giving of older adults and gender of caregiver (caregivers)

How often care givers feel they cannot continue to care	Gender		Total
	Male	Female	
Often	196(75.4)	175(73.2)	371(74.3)
Rarely	64(24.6)	64(26.8)	128(25.7)
Total	260(100.0)	239(100.0)	499(100.0)

Table 4 showed that majority (74.3%) of the caregivers reported that most often they feel they cannot continue in caregiving of older adults; among them 75.4% were male caregivers while 73.2% were female caregivers. On the other hand, another 25.7% indicated that they rarely feel that they cannot continue in care giving of older adults; among them 24.6% were male caregivers while 26.8% were female caregivers.

Table 5: Distribution of respondents by how difficult is it to give care to older adult in their house or at other home and place of residence (caregivers)

Views on whether it is difficult to care for older adults.	Place of Residence			Total
	Urban	Semi-urban	Rural	
Difficult	82(63.1)	107(57.5)	119(65.0)	308(61.7)
Not really	48(36.9)	79(42.5)	64(35.0)	191(38.3)

difficult				
Total	130(100.0)	186(100.0)	183(100.0)	499(100.0)

Table 5 illustrated that majority of caregivers indicated that it is difficult to care to older adults, among them 63.1% were urban residents, 57.5% were semi-urban residents while 65.0% were rural residents. On the other hand, 38.3% indicated that it was not difficult to take care of older adults, among them 36.9% were urban residents, 42.5% were semi-urban residents while 35.0% were rural residents. It can be observed that greater proportion (65.0%) of caregivers who noted that it was difficult to take care of an older were rural residents.

Table 6: Distribution of respondents by whether there are problems in taking care of older adult in their own homes and place of residence (caregivers)

Views on whether there are Problems in taking care of older adults	Place of Residence			Total
	Urban	Semi-urban	Rural	
Yes	59(45.4)	66(35.5)	79(43.2)	204(40.9)
No	51(39.2)	72(38.7)	75(41.0)	198(39.7)
Don't know	20(15.4)	48(25.8)	29(15.8)	97(19.4)
Total	130(100.0)	186(100.0)	183(100.0)	499(100.0)

The distribution on Table 6 revealed that a little less than half (40.9%) of the caregivers indicated that there are problems in taking care of older adults, among them 45.4% were urban residents, 35.5% were semi-urban residents while 43.2% were rural residents. On the other hand, 39.7% indicated that there are no problems in taking care of older adults in their own homes, among them 39.2% were urban residents, 38.7% were semi-urban residents while 41.0% were rural residents. In addition, another proportion (19.4%) indicated that they do not know if there were problems in taking care of older adults, among them 15.4% were urban residents, 25.8% were semi-urban residents while 15.8% were rural residents. It can be observed that greater proportion of the caregivers (45.4%) who indicated that there are problems in taking care of older adults were urban residents.

Furthermore, a view of a caregiver in an FGD session where a male caregiver opined:

Yes, there are a lot of problem in taking care of older adult. First, you lose your own time, I am not able to go out all the time to attend to my own needs because my sick old father always need my attention to eat, to drink, to bath or to even move or to lie down. So it is a big problem, if I go out for something very important, I always rush back home because my father might have need for me **(FGD: Male caregiver in urban area Kwale).**

Table 7: Distribution of respondents by challenges or problems they are facing because of caring for older adults within the family and place of residence (Caregivers)

Views from care giver on whether they face challenges as a result of care for older adult	Place of Residence			Total
	Urban	Semi-urban	Rural	
Yes	56(43.1)	59(31.7)	50(27.3)	165(33.1)
No	45(34.6)	79(42.5)	80(43.7)	204(40.9)
can't say	29(22.3)	48(25.8)	53(29.0)	130(26.1)
Total	130(100.0)	186(100.0)	183(100.0)	499(100.0)

Table 7 shows that some of the caregivers believe that they are facing challenges and problems because of caring for older adults within the family, among them 43.1% were urban residents, 31.7% were semi-urban residents while 27.3% were rural residents. On the other hand, some of the caregivers were of the view that they are not facing any challenges or problems because of taking care of older adults, among them 34.6% were urban residents, 42.5% were semi-urban residents while 43.7% were rural residents. In addition, some of the respondents were of the view that they can't say if they were facing any problem for caring for older adults within the family, among them 22.3% were urban residents, 25.8% were semi-urban residents while 29.0% were rural residents. It can be observed that the greater proportion of urban residents (43.1%) indicated that they face challenges from taking care of older adults.

In an IDI, a male participant corroborated these findings when he asserted:

The challenges are much for example like I am here now is where he is. When I went for an eye operation in Kaduna I always called, you have seen the one that is around that is why I was able to go for it, when he got sick they did not call me and they took him to the hospital. So there are challenges, you must be eager to monitor him, whenever you go out you rush to come, back you cannot relax. I don't attend parties; I don't go anywhere because I can't always be rushing back due to my own age challenges **(IDI: Male caregiver in urban area Kwale).**

In another IDI session, a female caregiver indicated that caring for older adult is very challenges and mostly requires God's grace:

Taking care of my mother is by God's grace and she disturbs sometimes, someone that used to sweep the compound, wash plates now she doesn't know any of that, she might not know that she is about to defecate and she will do it in the house, she doesn't know when to urinate and she will do it on her body and after urinating if you ask her she will tell you that it rained that she is not the one that did it **(IDI: Female caregiver Ebedei community).**

Table 8: Distribution of respondents by the challenges/ problems caregivers face in the process of caring for older adults (caregivers)

Views of the caregivers on the challenges they face in care giving	Frequency	Percent
Financial problem	55	33.3
Time consuming	80	48.5
Care receivers' poor attitude	30	18.2
Total	165	100.0

Table 8 shows that 48.5% of caregivers indicated that the major challenge they face is that caregiving is time consuming, 33.3% indicated financial problems and 18.2% indicated the care receivers have poor attitudes towards caregivers.

The view from an IDI session corresponds with the above finding; a female caregiver indicated that the major problem she faces in caring for older adult is financial problem. According to her:

The major challenges is finance, another is electricity which we need to function better, and access to road sometimes you needs to move the older adults around, but there is no facility to make it easier. It is not necessarily mobility but an assisted facility that can help for exercise, instead of confiding in one place, for example as we live in a flat we mind our apartment (**IDI: Female caregiver in urban community of Obiaruku**).

Table 9: Distribution of respondents by how the problems can be solved (caregivers)

Solution	Frequency	Percent
Provision of money for care	30	18.2
Taking care of myself	28	16.9
Problem cannot be solved	26	15.8
More help from relatives	14	8.5
Good planning	67	40.6
Total	165	100.0

Table 9 reveals that 40.6% of caregivers indicates that good planning as solution, 18.2% suggested provision of money for care, 16.9% indicated taking care of self and 15.8% indicated that the problem cannot be solved. Only a small proportion (8.5%) suggested more help from relatives. The above finding corresponds with the view of a female caregiver in an IDI session. The respondent indicated that provision of fund/finances is a panacea to the challenges of caring for older adults, thus: "Money can solve everything like good apartment whereby everything is available and the money to provide "I need this, I want to eat this" (IDI: Female caregiver).

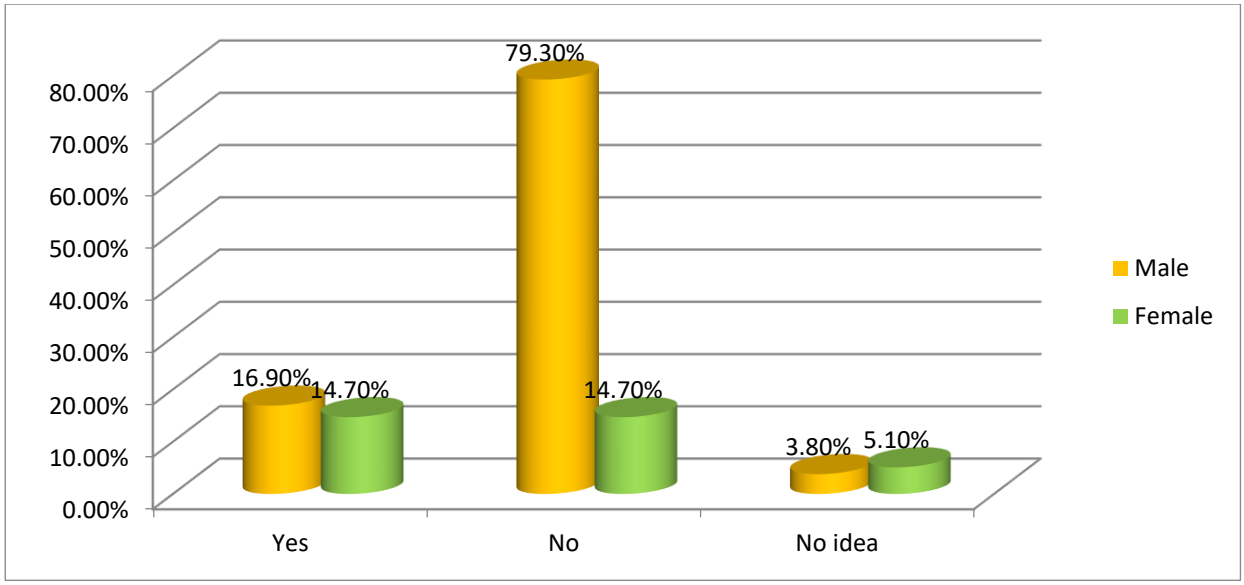

Figure 1: Distribution of respondents by whether their caregivers face challenges and place of residence (Care receiver)

Figure 1 shows that some of the older adults reported that there are challenges they face from those taking care of them, among them 16.9% were male older adults while 14.7% were female older adults. On the other hand, some of the older adults indicated that they do not face any challenges from those taking care of them; among them 79.3% were male older adults while 80.2% were female older adults. In addition, some of the caregivers were of the view that they have no idea if those caring for them face challenges or problems, among them 3.8% were male older adults while 5.1% were female older adults. These distributions show that greater proportion of male older adults (16.9%) face challenges from those taking care them when compared to female older adults (14.7%).

Table 10 Distribution of respondents by challenges/ problems older adults face as a result of those taking care of them. (Care receiver)

The Challenges	Frequency	Percent
lack of respect from them	6	7.1
lack of companionship from them	17	20.0
lack of financial support	50	58.8
don't attend to my needs on time	12	14.1
Total	85	100.0

Table 10 presented opinions of the care receivers on their challenges and problems. The distribution indicated that majority (58.8%) cited lack of financial support. A smaller proportion had these distributions, 20.0% who indicated lack of companionship from them, 14.1% indicated that they do not attend to them on time and 7.1% that they lack respect from them.

As illustrative quote, the view of an FGD participant female older adult had this opinion:

The challenges we face with the ones taking care of us is lack of financial support, my son and relative who care for me always say there is no money. The other time I needed special medical attention but my son does not have the money. This our problem, when the one taking care of you do not have money, there is nothing much he can do and because you that don't have money won't take care of yourself **(FGD: Female older adult in rural area).**

Table 11: Distribution of respondents by how the problems can be solved (Care receiver)

Solution	Frequency	Percent
By providing companionship	14	16.5
By attending to my needs on time	12	14.1
Showing morale support	7	8.2
It doesn't have a solution	2	2.4
Providing financial support/employment	50	58.8
Total	85	100.0

Table 11 indicated that majority (58.8%) of the care receivers suggested providing financial support/ employment as solution to the problem. Other proportions had the following suggestions; 16.5% providing companionship, 14.1% attending to needs on time, 8.2% showing moral support and 2.4% suggested that there is no solution.

The qualitative data further elucidates the suggested solutions on Table 42. According to data from an FGD session, an older adult indicated:

The solution to many of our problem is making finances available to us. Some of us die not because it is our time to die but because we do not have money for proper medical care. If the government can make money available to older adults in this community it will help us very well, there are some of us that their children don't have work, they are struggling and they cannot provide our needs **(FGD: Male older adult)**.

Table 12: Distribution of respondents on what contributes to stress in caregiving (caregivers)

Statement	**Very high**	**High**	**Moderate**	**Small**	**Very small**	**Total**
	F %	**F %**	**F %**	**F %**	**F %**	**F %**
Arriving late to work	137(27.5)	94(18.8)	85(17.0)	80(16.0)	88(17.6)	484(97.0)
Leaving early at work place	73(14.6)	88(17.6)	136(27.3)	98(19.6)	89(17.8)	484(97.0)
Taking time off at work Place	58 (11.6)	103(20.6)	85(17.0)	96(19.2)	142(28.5)	484(97.0)

Giving up work entirely	81(16.2)	43(8.6)	72(14.4)	112(22.4)	176(35.3)	484(97.0)
Turning down promotion	59(11.8)	69(13.8)	71(14.2)	103(20.6)	182(36.5)	484(97.0)
Being denied promotion	91(18.2)	74(14.8)	60(12.0)	71(14.2)	188(37.7)	484(97.0)
Negatively affect other family members	51(10.2)	71(14.2)	85(17.0)	87(17.4)	190(38.1)	484(97.0)

Table 12 explored what contributes to stress, 27.5% of caregivers indicated that arriving late to work contributes very high to stress in caregiving, 18.8% indicated high, 17.0% indicated moderately, 16.0% indicated small, 17.6% indicated very small. This also indicates that greater proportion of caregivers were of the view that arriving late to work contributes very high to stress in caregiving. In the seconds statement, 14.6% of the caregivers indicated that leaving early at work place contribute very high to stress in care giving, 17.6% indicate high, 27.3% indicated moderately, 19.6% indicated small, 17.8% indicated very small. This also indicated that greater proportion of caregivers 27.3% reported that leaving early at work place contribute moderately to stress in caregiving.

In the third statement, 14.6% of the caregivers indicated that taking time off at work place contributes very high to stress in caregiving, 20.6% indicated high, 17.0% indicated moderately, 19.2% indicated small, 28.5% indicated very small. This also indicates that greater proportion of caregivers (28.5%) reported that taking time off at work place contributes very small to stress in care giving. In the fourth statement, 16.2% of the caregivers indicated that giving up work entirely contributes very high to stress in care giving, 8.6% indicated high, 14.4% indicated moderately, 22.4% indicated small, 35.3% indicated very small. This also indicates that greater proportion of caregivers 35.3% were of the view that giving up work entirely contributes very small to stress in care giving. In the fifth statement, 11.8% of the caregivers indicated that turning down promotion contributes very high to stress in caregiving, 13.8% indicated high, 14.2% indicated moderately, 20.6% indicated small, 36.5% indicated very small. This also indicates that greater proportion of caregivers (36.5%) reported that turning down promotion contributes very small to stress in caregiving.

In the sixth statement, 18.2% of the caregivers indicated that being denied promotion contributes very high to stress in caregiving, 14.8% indicated high, 12.0% indicated moderately, 14.2% indicated small, 37.7% indicated very small. This also indicates that greater proportion of caregivers 37.7% indicated that being denied promotion contributes very small to stress in care giving. In the seventh statement, 10.2% of the caregivers indicated that negatively affect other family members contributes very high to stress in caregiving, 14.2% indicated high, 17.0% indicated moderately, 17.4% indicated small, 38.1% indicated very small. This also indicates that greater proportion of caregivers (38.1%) reported that negative effects on family members contributes very small to stress in caregiving.

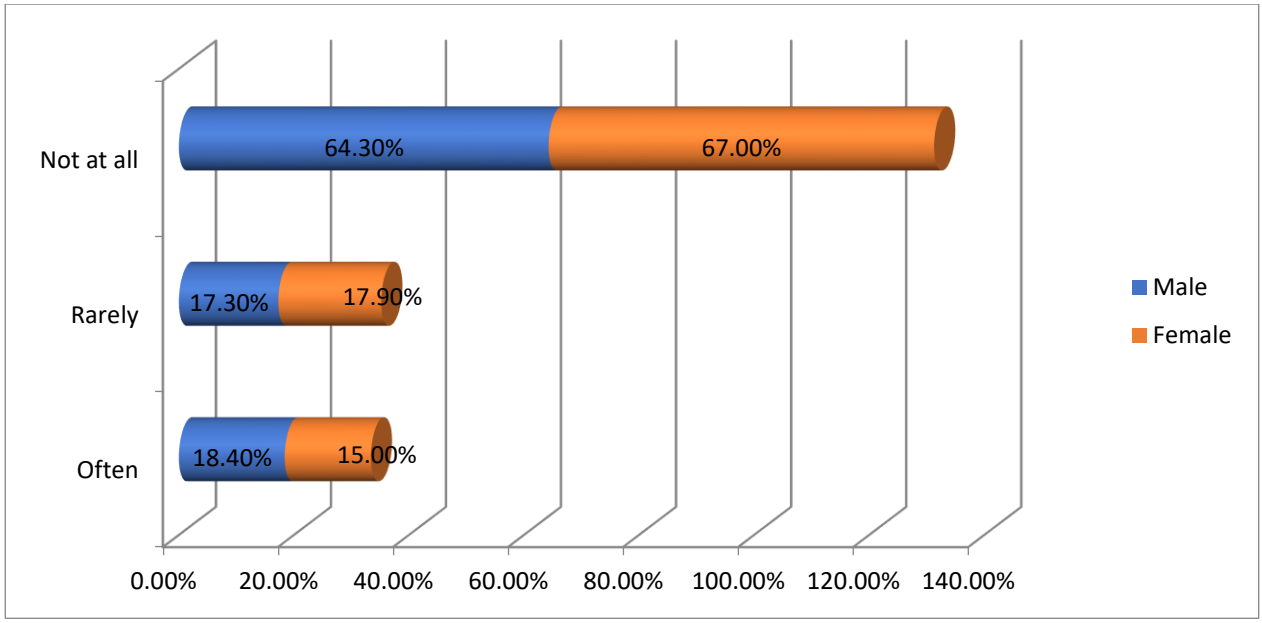

Figure 2: Distribution of respondents by how often they feel they can't continue and tired of living and gender of older adults (Care receiver)

Figure 2 shows that some of the older adults indicated that often they feel they cannot continue and tired of living, among them 18.4% were male older adults while 15.0% were female older adults. On the other hand, some of the older adults reported that rarely do they feel they cannot continue and tired of living, among them 17.3% were male older adults while 17.9% were female older adults. In addition, 65.7% of the older adults indicated that they do not feel they cannot continue and tired of living, among them 64.3% were male older adults while 67.0% were female older adults.

It can be observed that greater proportion of the female older adults (67.0%) were of the view that they do not feel they cannot continue and tired of living.

Table 13: Distribution of respondents by when feeling bad who they talk to and gender (Care receiver)

Views on who older adults talk to when they are feeling bad	Gender		Total
	Male	Female	
Children	96(36.1)	111(40.7)	207(38.4)
Priest	9(3.4)	17(6.2)	26(4.8)
Relations	58(21.8)	51(18.7)	109(20.2)
Close friends	86(32.3)	86(31.5)	172(31.9)
Neighbor's	17(6.4)	8(2.9)	25(4.6)
Total	266(100.0)	273(100.0)	539(100.0)

Table 13 shows that 38.4% of older adults indicated that they talk to their children when they are feeling bad, among them 36.1% were males while 40.7% were females. Again, 4.8% of the older adults reported that they talk to their priest when they are feeling bad, among them 3.4% were males while 6.2% were females. Furthermore, 20.2% of the older adults indicated that they talk to their relations when they are feeling bad, among them 21.8% were males while 18.7% were females. In addition, 31.9% indicated that they talk to their close friends when they feel bad, among them 32.3% were males while 31.5% were females and 4.6% of the older adults indicated that they talk to their neighbour when they are feeling, among them 6.4% were males while 2.9% were females. It can be observed that majority of the older adults (38.4%) reported that they talk to their children when they are feeling bad, predominantly female older adults (40.7%).

IV. DISCUSSION

The result of the study showed that most of the caregivers especially those in rural areas have been sick once or twice in a month and the sickness cut across malaria, stomach upset, cough and catarrh, arthritis, hypertension and prostrate. On the other hand, the study revealed that caregiving to older adult affects caregivers sleep, put in other words; caregivers do not get enough sleep because of caring for older adults. Okoye and Asa (2011) revealed that caregivers pass through many challenges such as stress in caregiving for older adults. Furthermore, caregivers often feel they cannot continue to care for older adults; reason is that majority of them feel that caregiving is difficult and weary.

The study revealed that caregivers have problems and challenges with caring for older adults especially urban residents. The most reoccurring problems and challenges were financial problems; caregiving is time consuming and older adult's poor attitude like lack of appreciation. Other problems include loss of personal time, and lack of time for social relaxation. Furthermore, the study revealed that the problems and challenges caregivers face in caregiving could be solved by provision of funds, taking good care of one own self, good planning and more help from relatives. On the other hand, the study revealed that older adult face some challenges and problems from caregivers such as lack of respect from caregivers, lack of companionship from caregivers, lack of adequate financial support and their needs are not met on time by the caregivers. Asharaf (2009)[l] avers that financial problem is the major challenge faced by older adults. Furthermore, caregivers are not able to satisfy the basic needs of older adults. In addition, the study revealed that the challenges and problems older adult face from their caregivers can be solved by provision of companionship, attending to their needs, showing moral support, provision of financial support and provision of employment for their caregivers.

The study revealed that the following contribute to stress in caregiving; arriving late at work; leaving early at work place; taking time off at work place, giving up work entirely; being denied promotion and negatively affecting other family members. Mudiare (2013) opined that the physical, emotional and social burdens attached to providing care to frail older adults can exact a heavy toll on family caregivers, including loss of leisure time, increased stress and impaired physical and psychological health.

The result of the study revealed that older adult talk to their Priest, relations, close friends, neighbors and more often than their children. Similarly, a study in Delta State of Nigeria by Okumagba (2011) revealed that older adults talk to and receive support from their children whenever they are in distress or want. Furthermore, most of the older adults cannot remember how many times they have been to the hospital in the

last three months, some indicated once, others twice. The natures of sickness that take older adults to the hospital are predominantly stomach upset, cough, catarrh, and mostly reoccurring malaria.

The study revealed that there are things older adults are unable to do presently because of their age such as going to the farm, shopping and most of the daily chores had to the done through others assistance. The study acknowledged that as older adults grow older they would be unable to do certain things they can do before. There is declination in terms of physical energy, health resilience and socio-cultural participation. In addition, the study revealed that older adults are adjusted to the old age related conditions they face.

The findings also revealed that older adults face challenges from those taking care of them, especially higher educated older adults. On the other hand, older adults revealed that those taking care of them face challenges. Lou (2009) observed that old age comes with its peculiar challenges and special needs. Furthermore, the study revealed that the main challenge older adults face was financial. Other challenges include environmental, health and stress challenges. In addition, the study revealed that the challenges and problems faced by older adults can be solved through government improvement on the economy; constant care by their children; provision of finance for upkeep and finding time to have adequate care. This also corresponded with the work of Brown and Brown (Brown & Brown, 2014) which stated that caregiving has its positive effects on the caregivers.

In various ways, the findings of this study are significant. This research will add to the existing body of knowledge on care for older adults in the African context, especially in a time of increased modernization and globalization. It will also stimulate further research on Family Based Care or related fields of study. Also, it will bring to limelight the problems families are facing in taking care of older adults, alongside possible remedies in relation to economic, cultural, transitional, religious, political, health/emotional and social factors.

Practically, this study will through its findings, equip people with knowledge on the challenges faced by older adults and their caregivers, and possible solutions. It will also address the state of older adults and equally caregivers on how to cope with the varying challenges of caregiving. The research findings will further provide guide for policy formulation for older adults and bring about favourable changes in the already existing policy that is yet to be implemented in our country Nigeria, regarding older adults.

Strengths and limitations of the study

The findings of this study have revealed that caregivers face enormous challenges in caregiving to older adults. These challenges range from finance, lack of time for personal engagement and lack of appreciation by older adults. Older adults face challenges from those taking care of them. These challenges ranged from lack of financial support, lack of respect, lack of companionship and untimely attention to needs of the older adults and this very painful to the older adults. Because of the challenges of caregiving, caregivers often feel they cannot continue with care giving. Caregiving is a difficult task and the cost of Caregiving is exorbitant

The study has numbers of limitations. Firstly, the constant demand for incentives for participation in either In-depth interview, (IDI) Focus group discussion (FGD) or questionnaire. In such situations the researchers had to spend time to explain to the respondent the reason for the study which made respondent happy that their own daughter will soon join the group of doctors in the community. Secondly, some of the older adults are weak and some suffer from dementia prior unknown to the researchers until interview has started as

such researchers cannot vouch for the validity of information gotten in some of the cases. Thirdly, the researchers witnessed a number of rainy days. Constant rainfall obstructed data collation irrespective of efforts to use umbrella to access home. The rainy days shortened the time for data collection and resources available, hence the researchers made haste at some point during the good whether to meet up with data collection.

V. CONCLUSION

This study provided data on caregivers challenges in delivery of Family Based Care for older adults in a Nigerian state. Caregivers face enormous challenges in the process of caring for older adults, and older adults face challenges from those taking care of them. Caregivers face financial challenges. Caregiving is time consuming and caregivers face poor attitudes and lack of appreciation from older adults. Challenges older adults face from those taking care of them are lack of respect from caregivers, lack of companionship from caregivers, lack of adequate financial support and their needs are not met on time. Finally the study revealed that the challenges faced by older adults can be solved through government improvement on the economy; constant care by their children, provision of finance for upkeep and finding time to have adequate rest. The challenges faced by caregivers can be solved through provision of fund, providing for their special needs and caregivers also taking care of themselves, more help from relatives and good planning.

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