



## A STUDY OF THE CAREGIVING ACTIVITIES OF FORMAL AND INFORMAL CAREGIVERS AT THE PAEDIATRIC WARD OF THE CAPE COAST TEACHING HOSPITAL, GHANA

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### **Abstract:**

Relationships are formed between formal and informal caregivers as they cater for in-patients. These relationships are formed as they perform their caregiving activities. The various caregiving tasks of formal and informal caregivers tend to overlap, causing conflict in the relationships between formal and informal caregivers. Conflicts between caregivers negatively affect the health care of in-patients. There is therefore the need for caregivers (both formal and informal) to know what their various tasks are, which is a step toward a coordinated working relationship between them. Studies have found that caregiving roles, communication and role expectations and perceptions of formal and informal caregivers determine whether both parties can coordinate their various caregiving tasks. Limited research is also found on how formal and informal caregivers relate with one another in providing care for the elderly and those with specific ailments such as Alzheimer's disease, dementia and delirium who might not be necessarily hospitalised. Previous studies have not treated the various tasks performed by formal and informal caregivers and the tasks that overlap between them which is the focus of this study. A sample size of 21 study participants, including eight in-patients, eight informal caregivers and five formal caregivers, was used. The study adopted the qualitative research approach using interviews and observation to gather data from formal and informal caregivers. It was found that specialised caregiving tasks were performed by formal caregivers while unspecialised caregiving tasks were performed by informal caregivers. Overlaps in the performance of specialised and unspecialised caregiving tasks were detected when some caregiving tasks that otherwise required unspecialised skills needed to be performed with specialised skills. Where a minimum level of skill was required, informal caregivers were taught a few skills to enable them to undertake those tasks. In order to improve the working relationship between formal and informal caregivers at the paediatric ward of the Cape Coast Teaching Hospital, it is recommended that these minor training by formal caregivers are intensified to improve

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the working relationship between formal and informal caregivers. Hospitals should also have clearly delineated roles for formal and informal caregivers to avoid overlapping caregiving tasks. This will ultimately enhance the quality of care provided to in-patients by improving communication between caregivers and reducing conflicts.

**Keywords:** caregiving, caregivers, relationship, paediatric ward, roles

## 1. Introduction

*"Health is wealth"* remains, primarily an intuition out of proposition (Yaussy, 2019). Many researchers rather present empirical and theoretical arguments for the converse proposition, *"wealth is health"* (Husain, 2010, p1). However, recent literature shows changes in the views that improvement of longevity and health are no more seen as mere end-products or by-products of socio-economic development. Longevity and health are seen as the major determinants of social and economic development as well as poverty reduction (Husain, 2010). Hence, better health does not have to wait for an improved economy; rather, measures to reduce the burden of disease, give children healthy childhood, increase life expectancy etc. will in themselves contribute to creating richer economies (Alsan et al., 2006). The provision of healthcare therefore must be a vital part of a country's strategies for socio-economic development as it reduces the rates of absenteeism, cuts down losses during production (as a result of sick workers) and enhances productivity. Good quality healthcare positively affects peoples' future incomes by improving school children's learning (Lustig, 2007). Alsan, Bloom and Canning (2006) also argue that steps to providing healthy childhoods for children, improving life expectancy and decreasing the problem of diseases contribute to the creation of wealthier economies.

The provision of healthcare involves key elements one of which is caregivers (providers of care (Litwin & Attias Donfut, 2009). Healthcare providers could be formal or informal. Formal and informal caregivers have been defined differently by many authors. Formal caregivers, on one hand, are seen as individuals who provide care and receive remuneration in return (Lai, 2003); are registered (Sudhinaraset, Ingram, Lofthouse, & Montagu, 2013); are institutionalised (Byrne, Goeree, Hiedemann, & Stern, 2009); are trained (Baskin Dalal, Das, Goyal, Harkins, Nanda, Nanda, Silberstein, Singh, Singh, Singh & Svenson, 2016) and skilled in the area of healthcare (Egan & Labyak, 2006). On the other hand, informal caregivers are those who provide unspecialised care and do not receive remuneration in return (Lai, 2003); are unregistered (Sudhinaraset, et al., 2013); are not institutionalised (Byrne et al., 2009); are untrained (Baskin et al., 2016) and unskilled in healthcare delivery (Egan & Labyak, 2006). While this distinction is widely recognised, some studies have shown that there are situations where these definitions may not apply. For instance, sometimes informal caregivers are paid for their health services (IFA, 2014; Heitmueller, & Inglis, 2007). Also, there are situations where informal caregivers have some skills (Smith, Lawrence, Kerr, Langhorne, & Lees, 2004). Such

overlaps make it difficult to have clear-cut distinctions in the definition of formal and informal caregivers. This study operationalises formal caregivers as people who are trained in public health and employed at the Cape Coast Teaching Hospital to enhance the health of patients. While informal caregivers include relatives, friends, neighbours and other non-hospital staff who are unskilled and unpaid in the area of healthcare delivery.

As caregivers perform their tasks, learning relationships, friendly relationships or conscious ignoring relationships (Salin, Kaunonen, & Åstedt-Kurki, 2013), as well as working relationships, dynamic relationships with considerable conflict relationships could develop within or outside care institutions. These relationships affect the mental, emotional, health, psychological and social aspects of the lives of care recipients and have been increasingly emphasised over the years (Büscher, Astedt-Kurki, Paavilainen, & Schnepf, 2011; Toscan, Mairs, Hinton, & Stolee, 2012; Orpin, Stirling, Hetherington & Robinson, 2014). Theories such as the substitution theory, supplementation theory, hierarchical compensatory theory and task-specific theory have been adopted to explain the relationship between formal and informal caregivers (Cantor, 1975; Edelman, 1986; Greene, 1983; Litwak, 1985). According to Greene's (1983) substitution theory, most informal caregivers are likely to substitute the care they provide with formal care when given the option. Edelman's (1986) supplementation theory proposes that formal care merely supplements the care that informal caregivers provide to save time and minimise stress, while Cantor's (1975) hierarchical compensatory theory asserts that care recipients choose their caregivers based on their preferences which are based on the closeness, accessibility and availability of caregivers (Litwin & Attias-Donfut, 2009).

The involvement of informal caregivers in the formal care delivery process is due to social obligations (Li, 2005) and poor public perceptions of the quality of healthcare being provided at the hospitals (Agbelie, 2017). Studies on patient satisfaction over the years show that patients and formal caregivers report of poor-quality healthcare delivery (GHS, 2008; MOH, 2007). This has often been attributed to long waiting hours in the Out-patient Department, poor hospital environments, poor attitudes of formal caregivers towards patients and poor communication among formal caregivers (Turkson, 2009; Atinga, Abekah-Nkrumah, & Domfeh, 2011).

According to the Agency for Health Care Research and Quality (2016), the involvement of informal caregivers in patient care speeds up the recovery process and patient safety while ensuring effective healthcare quality delivery. However, the AHRQ found that a break in communication between caregivers contributed to 70 percent of medical errors. This can be avoided by informing and engaging patients and informal caregivers to improve patients' safety through informed choices, infection control initiatives, safe medication use, observation of care processes, practicing self-management and reporting complications (Loghmani et al., 2014).

The task-specific theory (Litwak, 1985) which underpins this study also postulates that formal and informal caregiving tasks are distinct based on the type of assistance needed and the caregivers' ability to perform certain tasks (Luong, 2000). The task specific

theory thus encompasses the concepts of caregiving tasks, coordination and conflicts that characterise relationships between formal and informal caregivers. The knowledge, skills and specialisations of formal caregivers on one side of the divide may allow them to perform caregiving tasks that informal caregivers may be sometimes legally barred from performing due to their lack of skills and specialisation. Informal caregivers on the other side of the divide may perform caregiving tasks based on the knowledge they acquire through everyday socialisation and familiarity with care recipients. Informal caregivers might have certain information such as the preference and health history of the care receiver which formal caregivers may lack. As a result, formal and informal caregivers may best be equipped to perform different tasks that are relevant to the care needs of the care recipient (Litwak, 1985).

Studies on caregiving mostly explore care for the elderly and those with specific diseases like Alzheimer's disease (Carpentier, 2008), dementia (Orpin, Stirling, Hetherington & Robinson, 2014) and Delirium (Hagerling, 2015) who might not be necessarily hospitalised. Schulz, Eden, & National Academies of Sciences, Engineering, and Medicine. (2016) also examined the various evolving tasks of caregivers of the elderly and how the performance of these tasks impacts the well-being and health of caregivers. They described the caregiving tasks, the growing scope and complexity of caregiving tasks, the dynamic or changing nature of caregiving over a period of time, and matters of decision-making in surrogacy. Given, Sherwood and Given, (2017) researched the requisite skills and knowledge that were needed by informal caregivers in the provision of care. Little attention has been paid to the various caregiving activities of formal and informal caregivers and how their caregiving activities overlap in the caregiving process. This study, therefore, sought to examine the caregiving activities of formal and informal caregivers respectively and the areas where these caregiving activities overlap at the paediatric ward of the Cape Coast Teaching Hospital.

## **2. Material and Methods**

### **2.1 Research Paradigm and Design**

The philosophical paradigm of this study is interpretivism. The epistemological principle of interpretivism is that the researcher forms a part of the research as his/her interests are the basis of the research. Interpretivists are concerned with particular contextualised environments and recognise that knowledge and reality are not objective (Whiting, 2020). Instead, knowledge and reality are determined by those within that particular environment. Interpretivism was used to explore the relationship between formal and informal caregivers at the Paediatric Ward of the Cape Coast Teaching Hospital. This was deemed necessary as the interpretivist school of thought gives researchers the opportunity to thoroughly analyse a given issue in its context. Interpretivism assumes that social reality is studied best by reconciling people's subjective interpretations (Maxwell, 2012). Considering the interpretivist philosophical viewpoint, the study adopted a qualitative research design. The basis of qualitative research lies in the

interpretative approach to social reality and in the description of the lived experience of human beings.

Interpretivism rejects the idea that peoples' behaviours are predictable in the same light as the natural world and that human behaviour is not as a result of external forces. The qualitative research design was used because it sought to understand the reasons, motivations and opinions underlying the research problem (Schoonenboom & Johnson, 2017). A disadvantage of the qualitative research design is that results from the study cannot be generalised to the parent population. However, this study adopted the qualitative research design because results can be applied to contexts that are similar to the parent population which is the Cape Coast Teaching Hospital (Brannen, 2005). The qualitative research design was used to understand the nature of the phenomenon under study rather than generalising it.

An exploratory study was conducted to better understand the relationship between formal and informal caregivers at the Paediatric Ward of the Cape Coast Teaching Hospital. The exploratory study design is used to investigate a research problem which has not been clearly defined and gain a better understanding of it without providing conclusive results.

## **2.2 Sample and Sampling Procedure**

The sample comprised of eight in-patients, eight informal caregivers and five formal caregivers. Non-probability sampling was used to select in-patients and their formal and informal caregivers at the Paediatric Ward. Specifically, the convenience and purposeful (maximum variation) sampling techniques were used to select in-patients as well as formal and informal caregivers of in-patients who were easily accessible, willing and available to participate in the study and who could bring out different perspectives on the relationship between formal and informal caregivers. The maximum variation sampling technique was used because it helped to include diverse participants (in-patients and formal and informal caregivers) that were relevant for this study (Benoot, Hannes, & Bilsen, 2016). Saturation of data was attained after interviewing 21 study participants. These 21 participants included eight in-patients, eight informal caregivers and five informal caregivers.

Sampling was done by selecting participants based on a set of criteria relevant to this study. The criteria for selecting in-patients included in-patients between the ages of 10-15 years for ethical, validity and reliability concerns. The selection criteria for in-patients also included those that had been admitted within a period of not less than two days and, those whose medical conditions allowed interaction. The presence of in-patients and their informal caregivers on the ward ranged from two days to seven days at the time of interviews which commenced on the 15<sup>th</sup> of June 2020 and ended on the 29<sup>th</sup> of June 2020. The participants' selection procedure ensured that all ailments of in-patients at the ward at the time of data collection except ailments with medical conditions that did not allow the researcher to interact with the patient were represented in the sample. This is because the nature of an in-patient's ailment can affect the interface between formal

and informal caregivers (Quinn, Clare, & Woods, 2009). The criteria for selecting formal caregivers (doctors and nurses) and informal caregivers (family) of in-patients at the Paediatric Ward included those who were linked to selected in-patients by virtue of being their primary or main caregivers (informal caregivers who have the greater responsibility of caring for the in-patient on admission).

### **2.3 Research Instrument and Rigor**

In-depth interview and observation guides were used to collect data from participants. In-depth interviews involved a one-on-one dialogue with the interviewees (King, Horrocks, & Brooks, 2018). They were used to solicit information on the task specifics of formal and informal caregivers which allowed participants to freely express their underlying beliefs, attitudes and values around the area of caregiving tasks and who performs what tasks in the Paediatric Ward. At the end of each day, responses from interviews were transcribed and observations were edited. Follow-ups were made where necessary to seek further clarity on issues. Narratives in the local dialect were translated into English and transcribed. Credibility and dependability were ensured by the use of triangulation of sources of data and methods of data collection. Validity was ensured through systematically exploring the convergence of different and multiple information sources (in-patients, formal and informal caregivers).

### **2.4 Data Analysis**

A thematic analysis was done manually. It involved familiarisation with data gathered from the field was done to gain a general overview of the data. Common trends and patterns (experiences, opinions and sentiments) were then coded (identified and organised) into themes. These themes were then reviewed to ensure that they were a true reflection of the data gathered and presented in the write-up. The researcher read across the different interviews to obtain the patterns in the data. These patterns formed the basis for the themes. The themes included caregiving activities, activities of daily living and instrumental activities of daily living, communication, information sharing and understanding of the information shared, role expectations and perceptions. These concepts guided the analysis of the data gathered.

### **2.5 Ethical Considerations**

The Institutional Review Board of the University of Cape Coast was given a copy of the research proposal upon request and also gave ethical clearance for the research to be carried out. The hospital then gave the researcher a letter indicating approval for the study to proceed. The researcher upon arrival then showed this letter to the doctors and nurses at the paediatric ward to be given access to the ward and also the patients and their formal and informal caregivers. The paediatric ward was visited five days prior to the start of interviews to establish rapport geared towards gaining their trust and confidence. Informed consent from participants was sought before conducting interviews. Participants were informed that their voluntary participation is priceless and

as such, they could decline to answer any question that they did not wish to respond to. They were also informed that they could withdraw from interviews at any time that they felt uncomfortable without any penalty. Identification codes were used instead of the actual names of participants to ensure their anonymity. De-identified data were stored separately from the coding list to avoid tracing data back to a particular participant. Confidentiality was achieved by ensuring that issues arising from interviews with participants were not discussed with others in a manner that made participants identifiable. What a participant said in an interview was also not disclosed. Pictures and videos of participants were not taken at the hospital for this study to protect the identity of participants. This was also to ensure the confidentiality of the information gathered.

## **2.6 Limitations of the Study**

Also, the researcher could not stay for longer periods in the paediatric ward to gather data on the caregiving activities performed by formal and informal caregivers. This was due to COVID 19 which made interactions unsafe for participants and the researcher as well. As a result, the duration of data collection was prolonged, even though this did not significantly affect the time for completing the study. In addition, the study was limited to the paediatric ward of the Cape Coast Teaching Hospital only which limits the generalisability of the findings. The study participants included caregivers and care receivers from the paediatric ward and hence the sample was only representative of the paediatric ward hence results could only be generalised for the paediatric and no other wards within the hospital. Further studies could consider other wards and other hospitals to obtain a broader view of the topic in other settings such as the Korle Bu, Tamale Teaching Hospital and the Komfo Anokye Teaching Hospital.

Despite the limitations of this study, it contributes to the theoretical and empirical discourse on the various tasks performed by formal and informal caregivers at the Paediatric Ward of the Cape Coast Teaching Hospital. The study concludes based on the findings above that, though literature assigns specialised tasks to formal caregivers and unspecialised tasks to informal caregivers, this study found that there were no clear cuts in this distinction. This is because there were instances where formal caregivers performed unspecialised tasks while informal caregivers performed specialised tasks. These tasks have been labelled as overlapping tasks in this study. Specialised, unspecialised and overlapping caregiving tasks are essential for the recovery of in-patients at the Paediatric Ward of the Cape Coast Teaching Hospital. If formal and informal caregivers fail to communicate amongst themselves and fail to perform their various caregiving activities as expected, they will not be able to offer their best to ensure the recovery of in-patients.

### **3. Findings and Discussions**

#### **3.1 Demographic Variables**

The background information of participants considered in this study included the age distribution of participants, their sex, the relationship between informal caregivers and in-patients, the duration of stay of study participants, health conditions of in-patients and the professional background of formal caregivers. The ages of in-patients admitted to the Paediatric Ward ranged from neonates to 15 years old. The ages of informal caregivers ranged from 31-45. Out of the eight informal caregivers interviewed, six were mothers and two were fathers (6 females and 2 males). Formal caregivers comprised 3 females and 2 males. The duration of stay of study participants was concerned with informal caregivers and in-patients that had been admitted to the ward for not less than two days.

The ailments of in-patients included bone fracture, typhoid fever, malaria, esophageal foreign body disease and nephrotic syndrome. Two patients had a bone fracture, two had typhoid fever, two had malaria, one suffered from esophageal foreign body disease and another had nephrotic syndrome. Four in-patients with nephrotic syndrome, malaria, typhoid fever and bone fracture were met in critical conditions as compared to the other four in-patients in less critical conditions. The professional background of formal caregivers was considered in this study. Formal caregivers interviewed included two junior doctors who were doing their housemanship and three nurses who had been working at the hospital for between three and five years.

#### **3.2 Caregiving Activities Performed by Formal Caregivers**

The activities performed by doctors at the Paediatric Ward were diagnosis, drawing of treatment plans, drug administration, providing informal caregivers with information on the health of in-patients, prescription of drugs, daily consultations with in-patients, and monitoring the health progress or decline of in-patients and discharge of in-patients.

Nurses bathed in-patients, collected the medical history of the patient and administered drugs. Their activities also included the laying of hospital beds, daily consultations with in-patients, monitoring the health progress or decline of in-patients and feeding in-patients. In addition to the above, the nurses also provided informal caregivers with information on the health of in-patients, coordinated laboratory investigations and dressed the wounds of in-patients.

#### **3.3 Caregiving Activities Performed by Informal Caregivers**

The caregiving activities performed by informal caregivers were feeding in-patients, bathing in-patients, assisting in-patients in using the washroom, assisting in-patients to walk around and changing in-patients' clothes. They also included assisting formal caregivers to administer drugs to in-patients by providing emotional and psychological support, monitoring the health progress or decline of in-patients, and running errands on behalf of the in-patients (purchasing prescribed drugs) and providing companionship to the in-patients.



### **3.4 How the Caregiving Activities Overlap**

Through observation and interviews, it was found that doctors, nurses and informal caregivers formed ad hoc caregiving teams for in-patients. In these caregiving teams, doctors came out with the treatment plans and performed caregiving activities to carry out the treatment plans while nurses performed caregiving activities to implement the plans and informal caregivers assisted doctors and nurses in implementing the treatment plans. According to two formal caregivers, this order of performance of caregiving activities was based on the skills formal and informal caregivers had and the roles each party played to support the care of in-patients.

From interviews with in-patients and caregivers, it was found that the first activity performed when patients came to the Paediatric Ward was to provide information on their health conditions. This activity was done with the help of informal caregivers, especially in instances where patients were too young or too sick to provide the needed information to formal caregivers by themselves. All other caregiving activities performed by informal caregivers were delegated to them by formal caregivers. This was because all caregiving tasks (whether specialised or unspecialised) are supposed to be performed by formal caregivers as part of their duties.

According to formal caregivers, the caregiving tasks of feeding in-patients, bathing in-patients, drug administration, providing information on the health of in-patients, and monitoring the health progress, or decline of in-patients were both basic and specialised and were found to overlap between formal and informal caregivers. Two doctors and a nurse indicated that the performance of basic and specialised tasks was based on whether the overlapping caregiving tasks required specialised skills gained from training and education in health care. The performance of overlapping caregiving tasks was also based on whether they required basic skills gained from knowledge, familiarity and socialisation with in-patients.

From the observations and interviews with in-patients and caregivers, it was found that six informal caregivers of in-patients were educated by formal caregivers on what to look out for in monitoring the health of in-patients. These in-patients suffered from health conditions which included; nephrotic syndrome (two in-patients); malaria (two in-patients); and typhoid fever (two in-patients). Since this caregiving activity required some level of skills to perform, it was ideally to be performed by formal caregivers. However, informal caregivers were educated by formal caregivers on the quantity of food intake as well as the colour, nature and quantity of their excretion. For instance, informal caregivers were taught to monitor details such as the timing of medications before and after meals.

The kinds and quantities of food and liquid intake and excretion were also critically monitored due to in-patients' ailments and any changes noticed were reported to doctors and nurses. This enabled formal caregivers to determine whether the child's health was improving or not since informal caregivers spent more time beside in-patients than formal caregivers did. Details such as the blood pressure, pulse and respiratory rates and temperature of in-patients were, however, monitored solely by the five formal

caregivers who included two doctors and three nurses due to the use of special equipment. This was because formal caregivers had the know-how due to their training in health care. This constituted an overlap because both formal and informal caregivers performed a specialised caregiving task through some level of education of informal caregivers by formal caregivers.

An overlap was also found in the feeding of in-patients by formal and informal caregivers based on the skills required. From interviews and observations, it was found that two in-patients were fed solely by formal caregivers. One of these two had to be fed through a tube due to the esophageal foreign body disease he was suffering from, which affected his ability to ingest food through his throat. According to the formal caregivers, feeding a patient through a nasal tube required some skills that informal caregivers lacked and hence could not carry out. It was observed in the second instance that an in-patient was not supposed to take in food after a surgical operation and her feeding was to be done after some hours. For this reason, the feeding of this in-patient was solely handled by formal caregivers who had to strictly monitor the timing and feeding of the in-patient.

The other six in-patients out of the eight were fed solely by informal caregivers because their ailments did not require specialised skills in the feeding regime. The informal caregivers of these six in-patients revealed that they performed caregiving tasks delegated to them by formal caregivers. Formal caregivers delegated caregiving tasks to informal caregivers based on their judgment of the informal caregiver's ability to deliver those services. A nurse explained that:

*"Some of the activities are done by the doctors and nurses. However, some are done by the patients' families when we think it's something within their ability because we know they don't have any training in health care. So, what the patients' families do are just the basic things and when specialised skills and expertise are needed for a task, we have to step in."*  
(35 years old, female, nurse)

The caregiving task of bathing in-patients was also found to overlap in its performance by both formal and informal caregivers. It was found that an in-patient admitted with a bone fracture from an accident with injuries was bathed solely by formal caregivers. According to the formal caregivers, the severity of the injury required that nurses bathed her (the in-patient) skilfully to prevent further complications such as infection that could require amputation. However, with the other seven in-patients, bathing was done by informal caregivers since they did not have health conditions that required special skills to perform that task.

Interviews conducted with formal caregivers and informal caregivers revealed that the caregiving tasks of formal and informal caregivers were interdependent. It was found that the order of performance of caregiving activities for in-patients at the Paediatric Ward differed from one in-patient to the other, based on their different ailments. This was because the different ailments of different in-patients might have

required the same caregiving activities, but varied in the order of performance. For instance, the activity of the diagnosis of in-patients by formal caregivers was dependent on the provision of information by informal caregivers. Diagnosis and the provision of information took place before in-patients were fed, or before they were given their medications. The order of drug administration and feeding of in-patients was dependent on the drug to be administered and the ailment of the in-patient. Out of eight in-patients, three needed drug administration before meals, while three needed drug administration after meals. Two other in-patients also needed drug administration before and after meals.

It was observed that formal caregivers had difficulty in administering drugs to some in-patients. When asked to mention the difficulty, one informal caregiver said, "The in-patients feared injections because they were painful and that some of the drugs were bitter to swallow". Indeed, this made in-patients resist medication. In such cases, informal caregivers were made to administer drugs to in-patients under the supervision of formal caregivers. Informal caregivers responded that, in such cases, they administered drugs to in-patients based on the knowledge they had of in-patients' preferences, temperaments and behaviour. They provided the emotional and psychological encouragement with the children needed by holding in-patients' hands, convincing them to take injections, luring them with gifts and consoling them. According to four informal caregivers and four in-patients, the trust in-patients had in their informal caregivers and the comfort and assurance in-patients felt in their presence eased the administration of drugs. During an interview with a nurse, she had this to say:

*"Most often when the children see their parents or guardians around, it helps speed up the recovery process. Sometimes I do all I can to make the child (in-patient) take the medication but they will never take it. However, when you give the drug to the mother, she has a way she does it and the child will take the medication without any hesitation because the children feel more at ease with their mothers around (nurse)."*

The above results from the data gathered around what caregiving tasks were performed by formal and informal caregivers indicate that caregiving tasks performed by formal caregivers required specialised skills, while caregiving tasks performed by informal caregivers required basic skills as espoused by Litwak's (1985) tasks specific theory. The task-specific theory states that specialised tasks are performed by formal caregivers whereas informal caregivers performed unspecialised tasks based on their structural features such as skills, expertise and knowledge in health care possessed by formal caregivers and everyday socialisation and familiarity with care recipients. However, there were overlaps in the performance of caregiving activities. These overlaps in the performance of specialised and unspecialised caregiving tasks were due to the various ailments of in-patients. Therefore, where a minimum level of skill is required, informal caregivers were taught a few skills to enable them to undertake those caregiving

tasks. This is akin to Bruhn's (2016) assertion that formal caregivers gave informal caregivers some training on the performance of some caregiving activities.

The caregiving activities of toileting, eating, dressing, bathing of in-patients, mobility and grooming were consistent with Noelker and Browdie's (2013) findings on ADL while medication management, community mobility/movement within the hospital, communication management and history taking were consistent with Noelker and Browdie's IADL. However, some other caregiving activities, including history taking, drawing of treatment plans, laying of hospital beds, daily consultations with in-patients, laboratory investigations, diagnosis and discharge of in-patients that were found to be performed at the Paediatric Ward did not concur with Noelker and Browdie's (2013) findings on ADL and IADL and have been termed as Medical Caregiving Activities for this study.

#### **4. Recommendations**

Formal caregivers gave informal caregivers some minimum level of training when needed in the provision of care to in-patients. In order to improve the working relationship between formal and informal caregivers at the paediatric ward of the Cape Coast Teaching Hospital, it is recommended that these minor training by formal caregivers are intensified to improve the working relationship between formal and informal caregivers. Hospitals should also have clearly delineated roles for formal and informal caregivers to avoid overlapping caregiving tasks. This will ultimately enhance the quality of care provided to in-patients by improving communication between caregivers and reducing conflicts.

#### **5. Conclusion**

Limited research is found on how formal and informal caregivers relate with one another in providing care for the elderly and those with specific ailments such as Alzheimer's disease, dementia and Delirium who might not be necessarily hospitalised. Previous studies have not treated the various tasks performed by formal and informal caregivers and the tasks that overlap between them which is the focus of this study.

This study found that the caregiving activities performed by formal caregivers included diagnosis, drawing of treatment plans, drug administration, providing information on the health of in-patients and prescription of drugs. The rest were daily consultations with in-patients during ward rounds, monitoring the health progress or decline of in-patients, discharge of in-patients, history taking, bathing of in-patients and laying of hospital beds. They also checked vital signs such as temperature, blood pressure, respiratory rate and pulse rate, dressed wounds, and fed in-patients. Caregiving tasks performed by informal caregivers included feeding in-patients, monitoring the health progress or decline of in-patients, bathing, and cleaning in-patients with water and a towel. Informal caregivers also assisted in-patients in using the

washroom, and assisted in-patients to walk around and changed their clothes. They were also involved in assisting formal caregivers to administer drugs to in-patients by providing emotional and psychological support. They ran errands on behalf of the in-patients (buying prescribed drugs) and provided companionship.

The study also found that specialised tasks were performed by formal caregivers while informal caregivers performed unspecialised tasks delegated to them by formal caregivers. However, due to the ailments of some in-patients, some caregiving tasks that otherwise required unspecialised skills needed to be performed with specialised skills. Where a minimum level of skill was required, informal caregivers were taught a few skills to enable them to undertake those tasks. Formal caregivers performed unspecialised caregiving tasks as part of their roles as formal caregivers at the Paediatric Ward of the Cape Coast Teaching Hospital. According to formal caregivers, the caregiving tasks of feeding in-patients, bathing in-patients, medication management (drug administration), communication management (providing information on the health of in-patients), and monitoring the health progress, or decline of in-patients were both basic and specialised and therefore overlapped between formal and formal caregivers.

### **Conflict of Interest Statement**

There is no conflict of interest on the part of the author.

### **About the Author**

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### **References**

- Abekah-Nkrumah, G., Manu, A., & Atinga, R. A. (2010). Assessing the implementation of Ghana's patient charter. *Health Education, 110* (3), 169-185.
- Abuosi, A. A., Domfeh, K. A., Abor, J. Y., & Nketiah-Amponsah, E. (2016). Health insurance and quality of care: Comparing perceptions of quality between insured and uninsured patients in Ghana's hospitals. *International Journal for Equity in Health, 15*(1), 1-11.
- Agbelie, J. A. D. (2017). *Caregivers' perception of quality of care at the out-patient department of Princess Marie Louise Hospital, Accra* (Doctoral dissertation, University of Ghana).
- Alsan, M., Bloom, D. E., & Canning, D. (2006). The effect of population health on foreign direct investment inflows to low-and middle-income countries. *World Development, 34*(4), 613-630.

- Baskin, A., et al. (2016). Informal providers: Understanding motivations and behaviours. Stanford India health policy initiative Institute of Socio-Economic Research on Development and Democracy (ISERDD).
- Brannen, J. (2005). Mixing Methods: The entry of qualitative and quantitative approaches into the research process. *International Journal of Social Research Methodology*, 8(3), 173-184.
- Bruhn, J. G. (2016). Who are caregivers? In J. G. Bruhn, *After diagnosis: Family caregiving with hospice patients* (pp. 1-6). Switzerland: Springer International Publishing AG.
- Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC medical research methodology*, 16(1), 1-12.
- Büscher, A., Astedt-Kurki, P., Paavilainen, E., & Schnepf, W. (2011). Negotiations about helpfulness—the relationship between formal and informal care in home care arrangements. *Scandinavian Journal of Caring Sciences*, 25(4), 706-715.
- Byrne, D., Goeree, M. S., Hiedemann, B., & Stern, S. (2009). Formal home health care, informal care, and family decision-making. *International Economic Review*, 50(4), 1205-1242.
- Cantor, M. H. (1975). Life space and the social support system of the inner-city elderly of New York. *The Gerontologist*.
- Carpentier, N., Pomey, M. P., Contreras, R., & Olazabal, I. (2008). Social care interface in early-stage dementia: practitioners' perspectives on the links between formal and informal networks. *Journal of Aging and Health*, 20(6), 710-738.
- Covinsky, K. E. et al. (2013). A survey of nurses' practices and perceptions of family-centered care in Ireland. *Journal of Family Nursing*, 19(4), 469-488.
- Edelman, P. (1986). The impact of community care to the home-bound elderly on provision of informal care. *Gerontologist*, 45(2), 74-84.
- Egan, K. A., & Labyak, M. (2006). Hospice palliative care: A theory for quality End-of-life Care. In B. Ferrell, & N. Coyle (Eds), *Textbook of Palliative Nursing* (pp. 13-46). New York: Oxford University Press.
- Ghana Health Service. (2015). *The health sector in Ghana facts and figures*. Accra: MOH.
- Given, B., Paula R. Sherwood, R., & Given, W. (2008). What knowledge and skills do caregivers need? *Journal of Social Work Education*, 44:sup3, 115-123.
- Greene, V. (1983) Substitution between formally and informally provided care for the impaired elderly in the community. *Med. Care* 21, 609±619.
- Hagerling, F. L. (2015). *Nurse attitudes toward caring for older patients with delirium*. Doctoral dissertation, Colorado State University.
- Heitmueller, A., & Inglis, K. (2007). The earnings of informal carers: Wage differentials and opportunity costs. *Journal of Health Economics*, 26(4), 821-841.
- Husain, M. J. (2010). Contribution of health to economic development: A survey and overview. *Economics*, 4(1). 1-37
- IFA. (2014). *Connecting the dots: Formal caregivers and informal Care*. Toronto: SOM.
- King, N., Horrocks, C., & Brooks, J. (2018). *Interviews in qualitative research*. Sage.

- Kumpers, S., Mur, I., Maarse, H., & van Raak, A. (2005). A comparative study of dementia care in England and the Netherlands using neo-institutionalist perspectives. *Qualitative Health Research, 15*, 1199-1230.
- US Department of Health and Human Services. (2006). Agency for Healthcare Research and Quality. TeamSTEPPS: Instructor guide.
- Lai, C. K. (2003). *Formal caregivers, informal caregivers, and carers*. Retrieved from reflections on nursing leadership  
[https://www.reflectionsonnursingleadership.org/features/morefeatures/Vol39\\_3\\_formal-caregivers-informal-caregivers](https://www.reflectionsonnursingleadership.org/features/morefeatures/Vol39_3_formal-caregivers-informal-caregivers)
- Litwak, E. (1985). *Helping the elderly: The complementary roles of informal networks and formal systems*. New York: Guilford Press.
- Litwin, H., & Attias-Donfut, C. (2009). The Inter-relationship between formal health care and informal care: A study in France and Israel. *Ageing and Society, 29*(1), 71-91.
- Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Factors affecting the nurse-patients' family communication in intensive care unit of Kerman: a qualitative study. *Journal of Caring Sciences, 3*(1), 67.
- Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Determination of the content of communication between the care team and family members of patients in the intensive care unit: The experience of nurses and patients' families. *Journal of Qualitative Research in Health Sciences, 3*(3), 257-268.
- Luong, V. (2000). Theoretical explanations of differences in community-Based Long-Term care use between black and white elders. *African-American Research Perspectives, 6*(2), 3-10.
- Lustig, N. (2007). Investing in health for economic development: The case of Mexico. In G. Mavrotas & A. Shorrocks (Eds.), *Advancing development* (pp.168-182). London: Palgrave Macmillan.
- Maxwell, J. A. (2012). *Qualitative research design: An interactive approach*. London: Sage Publication Inc.
- Noelker, S. L., & Browdie, R. (2013). Sidney Katz, MD: A new paradigm for chronic illness and long-term care. *The Gerontologist 54*(1), 13-20.
- Orpin, P., Stirling, C., Hetherington, S., & Robinson, A. (2014). Rural dementia carers: formal and informal sources of support. *Ageing & Society, 34*(2), 185-208.
- Quinn, C., Clare, L., & Woods, B. (2009). The impact of the quality of relationship on the experiences and wellbeing of caregivers of people with dementia: A systematic review. *Aging and Mental Health, 13*(2), 143-154.
- Salin, S., Kaunonen, M., & Åstedt-Kurki, P. (2013). Nurses' perceptions of their relationships with informal carers in institutional respite care for older people. *Nursing Research and Practice, 2013*, 1-9.
- Schoonenboom, J., & Johnson, R. B. (2017). How to construct a mixed methods research design. *KZfSS Kölner Zeitschrift für Soziologie und Sozialpsychologie, 69*(2), 107-131.

- Schulz, R., Eden, J., & National Academies of Sciences, Engineering, and Medicine. (2016). Family caregiving roles and impacts. In *Families caring for an aging America*. National Academies Press (US).
- Sicotte, C., D'Amour, D., & Moreault, M.-P. (2002). Interdisciplinary coordination within Quebec community health care centres. *Social Science & Medicine*, 55, 991-1003.
- Smith, L. N., Lawrence, M., Kerr, S. M., Langhorne, P., & Lees, K. R. (2004). Informal carers' experience of caring for stroke survivors. *Journal of Advanced Nursing*, 46(3), 235-244.
- Sudhinaraset, M., Ingram, M., Lofthouse, H. K., & Montagu, D. (2013). What is the role of informal care providers in developing countries? A systematic review. *Plos One*, 8(2), 1-12.
- Toscan, J., Mairs, K., Hinton, S., Stolee, P., & Info Rehab Research Team. (2012). Integrated transitional care: patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture. *International Journal of Integrated Care*, 12(2), 1-9.
- Victor, C. R., Healy, J., Thomas, A., & Sergeant, J. (2000). Older patients and delayed discharge from hospital. *Health and Social Care in the Community*, 8, 443-452.
- Whiting, D. (2020). Epistemic worth. *Ergo*, 7(3), 15-45. Yaussy, S. L. (2019). *The intersections of health and wealth: Socioeconomic status, frailty, and mortality in industrial England*. Doctoral dissertation, College of Arts and Sciences, University of South Carolina.



Dorinda Npoiden Nyala  
A STUDY OF THE CAREGIVING ACTIVITIES OF FORMAL AND INFORMAL CAREGIVERS  
AT THE PAEDIATRIC WARD OF THE CAPE COAST TEACHING HOSPITAL, GHANA

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