





Caregiver Burdens of Cancer Patients in Rivers State University Teaching Hospital (RSUTH)

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Abstract	Article History
<p>Abstract</p> <p>Cancer causes significant physical and emotional impairments in its sufferers. Not only patients, cancer may indirectly affect many of whom are the primary caregivers. This work investigated the caregiver burdens of cancer patients in Rivers State University Teaching Hospital (RSUTH). The study hypotheses were developed and a population size of 100 respondents was determined using Taro Yamane's formula. A questionnaire was designed and validated while data was collected from primary and secondary sources. Data collected were analyzed using a frequency table, percentage and mean score analysis while the nonparametric statistical test (Chi-square) was used to test the formulated hypothesis using SPSS. The results obtained from the three hypotheses which include the test: (i) that there was no level of care burdens among informal caregivers of cancer patients, (ii) that there was no quality of life of informal caregivers of cancer patients, and (iii) that there was no correlation between burdens of care and quality of life of family caregivers of cancer patients revealed that the majority of the respondents were of the opinion that there was a level of care burdens among informal caregivers of cancer patients. Secondly, there was a quality of life of informal caregivers of cancer patients and thirdly, there was a correlation between burdens of care and quality of life of family caregivers of cancer patients in RSUTH.</p> <p>Keywords: <i>Cancer, cancer burden, cancer patients, informal caregivers</i></p>	<p>Received: 03 March 2023 Accepted: 22 March 2023 Published: 25 March 2023</p> <p>Scan QR code to view*</p>  <p>License: CC BY 4.0*</p>  <p>Open Access article.</p>
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Introduction

Cancer is one of the leading causes of morbidity and mortality worldwide. In 2018, approximately 18 million new cases were diagnosed based on the Global Burden of Cancer study conducted by the International Agency for Research on Cancer of the World Health Organization. This number is postulated to increase to over 20 million by 2025, with the low and middle-income countries bearing most of the cancer burden (Ferlay, Colombet, Soerjomataram, Mathers, Parkin, Pineros, 2019). According to the Nigerian National Cancer Registry, a total of 103,507 new cancer cases were diagnosed between 2007 and 2011 in Nigeria. Sarawak state documented 9,734 new cancer cases or equivalent to about 9.4% of the national figures (Manan, Tamin, Abdullah, Abidin, & Wahab, 2016). It is well known that cancer causes significant physical and emotional impairments in its sufferers. Not only the patients, cancer also indirectly affects their significant others, many of whom are the primary caregivers. Cancer patients and their caregivers are frequently exposed to the complications of the disease itself.

According to Family Caregiver Alliance based in the United States, family (or informal) caregiver refers to any person, e.g. spouse, adult children, other relatives, neighbor or friend, who has a personal relationship with, and provides a wide range of unpaid assistance for, an older person or an adult with a chronic or disabling condition (Family Caregiver Alliance, 2014). This is different from a professional (or formal) caregiver, who is either a paid carer or a volunteer with no personal relationship with the person he or she is looking after.

There is a significant reciprocal relationship between the emotional distress of cancer patients and their caregivers. Thus, the management of cancer patients would be compromised if the caregivers' well-being is affected. Despite

caregiving has a significant impact on the caregivers' well-being, the needs of the caregivers are often overlooked or considered secondary to those of the patients (Payne, Smith, & Dean, 2019).

Recent advancement in the diagnostic and therapeutic modalities has resulted in a paradigm shift in the cancer course and care plan. The course of cancer has changed from being an acute condition with rapid or direct consequences, usually fatality, to a chronic illness with variable outcomes. This may translate to a need for long-term and continuous care for cancer patients with the integration of both informal and formal care systems.

Consequently, family caregivers are at increased risk of being burdened with multiple stressful physical and psychosocial problems (Girgis, Lambert, Johnson, Waller & Currow, 2013). Psychological problems such as anxiety, depression, and loneliness, are the commonly recognized burdens on caregivers (Stenberg, Ruland, & Miaskowski, 2010). In line with the increasing trend of cancer cases and caregiver burden worldwide, there is a need to look into the caregiving aspects and to find ways to improve the well-being of the family caregivers.

One suggested the solution is through the study of religious or spiritual beliefs and practices. Yet, research on the roles of religion and its relation to the human well-being accounts only a small fraction of the current literature in psychology (Ano & Vasconcelles, 2015). Religiosity, spirituality and religious coping have been shown to play important buffering roles in helping cancer patients to deal with psychological distress (Weaver & Flannelly, 2014). Thus, these benefits might be extended to cancer caregivers as well. However, the study tends to examine a caregiver burdens of cancer patients in Rivers State University Teaching Hospital (RSUTH).

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Methodology

Research Design

For this study, the survey research design was adopted. The choice of the design was informed by the objectives of the study. This research design provides a quickly efficient and accurate means of assessing information about a population of interest. It intends to study caregiver burdens of cancer patients in RSUTH. The study was conducted in Rivers state.

Research Questions

- i. What is the level of care burdens among informal caregivers of cancer patients?
- ii. What is the quality of life of informal caregivers of cancer patients?
- iii. What is the correlation between burdens of care and quality of life of family caregivers of cancer patients?

Research Hypotheses

H₀: There is no level of care burdens among informal caregivers of cancer patients

H₁: There is no quality of life of informal caregivers of cancer patients.

H₂: There is no correlation between burdens of care and quality of life of family caregivers of cancer patients.

Population of the Study

The population for this study were health workers in RSUTH, Rivers state, Nigeria. A total of 134 respondents were selected from the population figure out of which the sample size was determined. The reason for choosing Rivers state is because of its proximity to the researcher.

Sample and Sampling Techniques

The researcher used Taro Yamane’s formula to determine the sample size from the population.

Taro Yamane’s formula is given as;

$$n = \frac{N}{1 + N(e)^2}$$

Where N = Population of study (134)
 n = Sample size (?)
 e = Level of significance at 5% (0.05)
 1 = Constant

$$n = \frac{134}{1 + 134(0.05)^2}$$

n = 100

Therefore, the sample size is 100 respondents.

Research Instrument and Instrumentation

Data for this study was collected from primary and secondary sources. The primary source of data collected was mainly the use of a structured questionnaire which was designed to elicit information on caregiver burdens of cancer patients in RSUTH. The secondary source of data collections were textbooks, journals and scholarly materials.

Validity of Instrument

The instrument of this study was subjected to face validation. Face validation tests the appropriateness of the questionnaire items. This is because face validation is often used to indicate whether an instrument on the face of it appears to measure what it contains. Face validations therefore aims at determining the extent to which the questionnaire is relevant to the objectives of the study. In subjecting the instrument for face validation, copies of the initial draft of the questionnaire was validated by supervisor. The supervisor is expected to critically examine the items of the instrument with specific objectives of the study and make useful suggestions to improve the quality of the instrument. Based on his recommendations the instrument was adjusted and re-adjusted before being administered for the study.

Reliability of Instrument

The coefficient of 0.81 was considered a reliability coefficient because according to Etuk (1990), a test-retest coefficient of 0.5 was enough to justify the use of a research instrument.

Method of Data Collection

This study was based on the two possible sources of data which were the primary and secondary sources.

a. Primary Source of Data: The primary data for this study consist of raw data generated from responses to questionnaires and interview by the respondents.

b. Secondary Source of Data: The secondary data includes information obtained through the review of literature that is journals, monographs, textbooks and other periodicals.

Method of Data Analysis

Data collected was analyzed using frequency table, percentage and mean score analysis while the nonparametric statistical test (Chi-square) was used to test the formulated hypothesis using SPSS (statistical package for social sciences). Haven gathered the data through the administration of questionnaire, the collected data was coded, tabulated and analyzed using SPSS statistical software according to the research question and hypothesis. In order to effectively analyze the data collected for easy management and accuracy, the chi square method was used for test of independence. Chi square is given as:

$$\chi^2 = \frac{\sum(o - e)^2}{e}$$

Where, χ^2 = Chi square
 o = Observed frequency
 e = Expected frequency

Level of confidence / degree of freedom

When employing the chi – square test, a certain level of confidence or margin of error has to be assumed. More also, the degree of freedom in the table has to be determined in simple variable, row and column distribution, degree of freedom is: df = (r-1) (c-1)

Where; df = Degree of freedom

r = Number of rows

c = Number of columns.

In determining the critical chi _ square value, the value of confidence is assumed to be at 95% or 0.95. a margin of 5% or 0.05 is allowed for judgment error.

Results and Discussion

This section deals with the presentation and analysis of the result obtained from questionnaires. The data gathered were presented according to the order in which they were arranged in the research questions and simple percentage were used to analyze the demographic information of the respondents while the chi square test was adopted to test the research hypothesis.

Analysis of Demographic Data of Respondents

Table 1 shows the gender distribution of the respondents used for this study. Out of the total number of 100 respondents, 65 respondents which represent 65.0 percent of the population are male. Thirty-five (35) which represent 35.0 percent of the population are female.

Table 1: Gender of respondents

	Frequency	Percent	Cumulative Percent
Valid Male	65	65.0	65.0
Female	35	35.0	100.0
Total	100	100.0	

Table 2 shows the age grade of the respondents used for this study. Out of the total number of 100 respondents, 15 respondents which represent 15.0 percent of the population are between 20-30 years. Ten (10) respondents which represent 10.0 percent of the population are between 31-40 years. Twenty-five (25) respondents which represent 25.0 percent of the population are between 41-50 years. Twenty (20) respondents which represent 20.0 percent of the population are between 51-60 years. Thirty (30) respondents which represent 30.0 percent of the population are above 60 years.

Table 2: Age range of respondents

	Frequency	Percent	Cumulative Percent
Valid 20-30years	15	15.0	15.0
31-40years	10	10.0	25.0
41-50years	25	25.0	50.0
51-60years	20	20.0	70.0
above 60years	30	30.0	100.0
Total	100	100.0	

Table 3 shows the educational background of the respondents used for this study. Out of the total number of 100 respondents, 20 respondents which represent 20.0 percent of the population are FSLC holders. Twenty-five (25) which represent 25.0 percent of the population are SSCE/GCE/WASSCE holders. 35 which represent 35.0 percent of the population are OND/HND/BSC holders. Fifteen (15) which represent 15.0 percent of the

population are MSC/PGD/PHD holders. Five (5) which represent 5.0 percent of the population had other type of educational qualifications.

Table 3: Educational background of respondents

	Frequency	Percent	Cumulative Percent
Valid FSLC	20	20.0	20.0
WASSCE/GCE/NECO	25	25.0	45.0
OND/HND/BSc	35	35.0	80.0
MSc/PGD/PhD	15	15.0	95.0
OTHERS	5	5.0	100.0
Total	100	100.0	

Table 4 shows the marital status of the respondents used for this study. 30 which represent 30.0percent of the population are single. 55 which represent 55.0percent of the population are married. Five (5) which represent 5.0percent of the population are divorced. 10 which represent 10.0percent of the population are widowed.

Table 4: Marital status

	Frequency	Percent	Cumulative Percent
Valid Single	30	30.0	30.0
Married	55	55.0	85.0
Divorced	5	5.0	90.0
Widowed	10	10.0	100.0
Total	100	100.0	

Analysis of Psychographic Data

Table 5 shows the responses of respondents if there is a high level of care burdens among informal caregivers of cancer patients. Thirty (30) respondents representing 30.0 percent strongly agreed that there is a high level of care burdens among informal caregivers of cancer patients. Forty-two (42) respondents representing 42.0 percent agreed that there is a high level of care burdens among informal caregivers of cancer patients. Ten (10) respondents representing 10.0 percent were undecided. Ten (10) respondents representing 10.0 percent disagreed that there is a high level of care burdens among informal caregivers of cancer patients. 8 respondents representing 8.0percent strongly disagreed that there is a high level of care burdens among informal caregivers of cancer patients.

Table 5: High level of care burdens among informal caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	30	30.0	30.0
Agree	42	42.0	72.0
Undecided	10	10.0	82.0
Disagree	10	10.0	92.0
Strongly disagree	8	8.0	100.0
Total	100	100.0	

Table 6 show the responses of respondents if there are causes of care burdens among informal caregivers of cancer patients. Ten (10) of the respondents representing 10.0 percent strongly agree that there are causes of care burdens among informal caregivers of cancer patients. Fifteen (15) of the respondents representing 15.0 percent agree that there are causes of care burdens among informal caregivers of cancer patients. Five (5) of them representing 5.0 percent were undecided. Forty (40) of the respondents representing 40.0 percent disagree that there are causes of care burdens among informal caregivers of cancer patients. Thirty (30) of the respondents representing 30.0 percent strongly disagree that there are causes of care burdens among informal caregivers of cancer patients.

Table 6: Causes of care burdens among informal caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	10	10.0	10.0
Agree	15	15.0	25.0
Undecided	5	5.0	30.0
Disagree	40	40.0	70.0
Strongly disagree	30	30.0	100.0
Total	100	100.0	

Table 7 show the responses of respondents if there are different types of care burdens among informal caregivers of cancer patients. Sixty (60) of the respondents representing 60.0 percent strongly agree that there are different types of care burdens among informal caregivers of cancer patients. Twenty-five (25) of the respondents representing 25.0 percent agree that there are different types of care burdens among informal caregivers of cancer patients. Ten (10) of them representing 10.0 percent were undecided. Five (5) of the respondents representing 5.0 percent disagree that there are different types of care burdens among informal caregivers of cancer patients.

Table 7: Different types of care burdens among informal caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	60	60.0	60.0
Agree	25	25.0	85.0
Undecided	10	10.0	95.0
Disagree	5	5.0	100.0
Total	100	100.0	

Table 8 shows the responses of respondents if physical, emotional and social burden are the basic types of care burdens among informal caregivers of cancer patients. Twenty-five (25) of the respondents representing 25.0 percent strongly agree that physical, emotional and social burden are the basic types of care burdens among informal caregivers of cancer patients. Thirty-two (32) of the respondents representing 32.0 percent agree that physical, emotional and social burden are the basic types of care burdens among informal caregivers of cancer patients. Thirteen (13) of the respondents representing 13.0 percent were undecided. Fifteen (15) of the respondents representing 15.0 percent disagree that physical, emotional and social burden are the basic types of care burdens among informal caregivers of cancer patients. Fifteen (15) of the respondents representing 15.0 percent strongly disagree that physical, emotional and social burden are the basic types of care burdens among informal caregivers of cancer patients.

Table 8: Physical, emotional and social burden are the basic types of care burdens among informal caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	25	25.0	25.0
Agree	32	32.0	57.0
Undecided	13	13.0	70.0
Disagree	15	15.0	85.0
Strongly disagree	15	15.0	100.0
Total	100	100.0	

Table 9 show the responses of respondents if there is a correlation between time-dependence and development on the level of care burdens. Sixty-five (65) of the respondents representing 65.0 percent strongly agree that there is a correlation between time-dependence and development on the level of care burdens. Thirty (30) of the respondents representing 30.0 percent agree that there is a correlation between time-dependence and development on the level of care burdens. Three (3) respondents representing 3.0 percent were undecided. Three (3) of the respondents representing 3.0 percent disagree that there is a correlation between time-dependence and development on the level of care burdens. Two (2) of the respondents representing 2.0 percent strongly disagree that there is a correlation between time-dependence and development on the level of care burdens.

Table 9: Correlation between time-dependence and development on the level of care burdens

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	65	65.0	65.0
Agree	30	30.0	95.0
Disagree	3	3.0	98.0
Strongly disagree	2	2.0	100.0
Total	100	100.0	

Table 10 shows the responses of respondents if there is a quality of life of informal caregivers of cancer patients. Thirty (30) respondents representing 30.0 percent strongly agreed that there is a quality of life of informal caregivers of cancer patients. Forty-two (42) respondents representing 42.0 percent agreed that there is a quality of life of informal caregivers of cancer

patients. Ten (10) respondents representing 10.0 percent were undecided. Ten (10) respondents representing 10.0 percent disagreed that there is a quality of life of informal caregivers of cancer patients. 8 respondents representing 8.0 percent strongly disagreed that there is a quality of life of informal caregivers of cancer patients.

Table 10: Quality of life of informal caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	30	30.0	30.0
Agree	42	42.0	72.0
Undecided	10	10.0	82.0
Disagree	10	10.0	92.0
Strongly disagree	8	8.0	100.0
Total	100	100.0	

Table 11 show the responses of respondents if informal caregivers of cancer patient bath, dresses and transfer cancer patients. Ten (10) of the respondents representing 10.0 percent strongly agree that informal caregivers of cancer patient bath, dresses and transfer cancer patients. Fifteen (15) of the respondents representing 15.0 percent agree that informal caregivers of cancer patient bath, dresses and transfer cancer patients. Five (5) of them representing 5.0 percent were undecided. Forty (40) of the respondents representing 40.0 percent disagree that informal caregivers of cancer patient bath, dresses and transfer cancer patients. Thirty (30) of the respondents representing 30.0 percent strongly disagree that informal caregivers of cancer patient bath, dresses and transfer cancer patients.

Table 11: Informal caregivers of cancer patient bath, dresses and transfer cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	10	10.0	10.0
Agree	15	15.0	25.0
Undecided	5	5.0	30.0
Disagree	40	40.0	70.0
Strongly disagree	30	30.0	100.0
Total	100	100.0	

Table 12 show the responses of respondents if there is a relationship between quality of life of informal caregivers and the well-being of cancer patients. Sixty (60) of the respondents representing 60.0 percent strongly agree that there is a relationship between quality of life of informal caregivers and the well-being of cancer patients. Twenty-five (25) of the respondents representing 25.0 percent agree that there is a relationship between quality of life of informal caregivers and the well-being of cancer patients. Ten (10) of them representing 10.0 percent were undecided. Five (5) of the respondents representing 5.0percent disagree that there is a relationship between quality of life of informal caregivers and the well-being of cancer patients.

Table 12: Relationship between quality of life of informal caregivers and the well-being of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	60	60.0	60.0
Agree	25	25.0	85.0
Undecided	10	10.0	95.0
Disagree	5	5.0	100.0
Total	100	100.0	

Table 13 shows the responses of respondents if informal caregivers are an essential pillar for ensuring and maintaining the outpatient care of the frail elderly. Twenty-five (25) of the respondents representing 25.0 percent strongly agree that informal caregivers are an essential pillar for ensuring and maintaining the outpatient care of the frail elderly. Thirty-two (32) of the respondents representing 32.0 percent agree that informal caregivers are an essential pillar for ensuring and maintaining the outpatient care of the frail elderly. Thirteen (13) of the respondents representing 13.0 percent were undecided. Fifteen (15) of the respondents representing 15.0 percent disagree that informal caregivers are an essential pillar for ensuring and maintaining the outpatient care of the frail elderly. Fifteen (15) of the respondents representing 15.0 percent strongly disagree that informal caregivers are an essential pillar for ensuring and maintaining the outpatient care of the frail elderly.

Table 13: Informal caregivers are an essential pillar for ensuring and maintaining the outpatient care of the frail elderly

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	25	25.0	25.0
Agree	32	32.0	57.0
Undecided	13	13.0	70.0
Disagree	15	15.0	85.0
Strongly disagree	15	15.0	100.0
Total	100	100.0	

Table 14 show the responses of respondents if there is a correlation between burdens of care and quality of life of family caregivers of cancer patients. 65 of the respondents representing 65.0 percent strongly agree that there is a correlation between burdens of care and quality of life of family caregivers of cancer patients. 30 of the respondents representing 30.0percent agree that there is a correlation between burdens of care and quality of life of family caregivers of cancer patients. 3 respondents representing 3.0percent were undecided. 3 of the respondents representing 3.0percent disagree that there is a correlation between burdens of care and quality of life of family caregivers of cancer patients. 2 of the respondents representing 2.0 percent strongly disagree that there is a correlation between burdens of care and quality of life of family caregivers of cancer patients.

Table 14: There is a correlation between burdens of care and quality of life of family caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	65	65.0	65.0
Agree	30	30.0	95.0
Disagree	3	3.0	98.0
Strongly disagree	2	2.0	100.0
Total	100	100.0	

Table 15 shows the responses of respondents if the burdens of care have negative effect on family caregivers of cancer patients. Thirty (30) respondents representing 30.0 percent strongly agreed that the burdens of care have negative effect on family caregivers of cancer patients. Forty-two (42) respondents representing 42.0 percent agreed that the burdens of care have negative effect on family caregivers of cancer patients. 10 respondents representing 10.0 percent were undecided. Ten (10) respondents representing 10.0 percent disagreed that the burdens of care have negative effect on family caregivers of cancer patients. Eight (8) respondents representing 8.0 percent strongly disagreed that the burdens of care have negative effect on family caregivers of cancer patients.

Table 15: The burdens of care have negative effect on family caregivers of cancer patients

	Frequency	Percent	Cumulative Percent
Valid Strongly agree	30	30.0	30.0
Agree	42	42.0	72.0
Undecided	10	10.0	82.0
Disagree	10	10.0	92.0
Strongly disagree	8	8.0	100.0
Total	100	100.0	

Test of Hypothesis

Hypothesis I

H₀: There is no level of care burdens among informal caregivers of cancer patients.

H₁: There is a level of care burdens among informal caregivers of cancer patients.

Level of significance: 0.05

Decision rule: Reject the null hypothesis H₀ if the p value is less than the level of significance. Accept the null hypothesis if otherwise.

Test statistics	
	There is a level of care burdens among informal caregivers of cancer patients
Chi-Square	105.520 ^a
Df	3
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.

Conclusions based on decision rule:

Since the p-value = 0.000 is less than the level of significance (0.05), we reject the null hypothesis and conclude that there is a level of care burdens among informal caregivers of cancer patients.

Hypothesis II

H₀: There is no quality of life of informal caregivers of cancer patients.

H₁: There is a quality of life of informal caregivers of cancer patients.

Level of significance: 0.05

Decision rule: Reject the null hypothesis H₀ if the p value is less than the level of significance. Accept the null hypothesis if otherwise.

Test statistics	
	There is a quality of life of informal caregivers of cancer patients
Chi-Square	74.520 ^a
Df	2
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.

Conclusions based on decision rule:

Since the p-value = 0.000 is less than the level of significance (0.05), we reject the null hypothesis and conclude that there is a quality of life of informal caregivers of cancer patients.

Hypothesis III

H₀: There is no correlation between burdens of care and quality of life of family caregivers of cancer patients.

H₁: There is a correlation between burdens of care and quality of life of family caregivers of cancer patients.

Level of significance: 0.05

Decision rule: Reject the null hypothesis H₀ if the p value is less than the level of significance. Accept the null hypothesis if otherwise.

Test statistics	
	There is a correlation between burdens of care and quality of life of family caregivers of cancer patients
Chi-Square	74.520 ^a
Df	2
Asymp. Sig.	.000

• Thank you for publishing with us.

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.

Conclusions based on decision rule:

Since the p-value = 0.000 is less than the level of significance (0.05), we reject the null hypothesis and conclude that there is a correlation between burdens of care and quality of life of family caregivers of cancer patients.

The study is on the caregiver burdens of cancer patients in RSUTH. Three hypotheses were formed to test that there is no level of care burdens among informal caregivers of cancer patients, also that there is no quality of life of informal caregivers of cancer patients, lastly that there is no correlation between burdens of care and quality of life of family caregivers of cancer patients.

Findings from the study revealed that majority of the respondents were of the opinion that

i. there is a level of care burdens among informal caregivers of cancer patients

Decision Rule: The null hypothesis is rejected.

ii. there is a quality of life of informal caregivers of cancer patients

Decision Rule: The null hypothesis is rejected.

iii. there is a correlation between burdens of care and quality of life of family caregivers of cancer patients.

Decision Rule: The null hypothesis is rejected.

Conclusion

In conclusion, it is well known that cancer causes significant physical and emotional impairments in its sufferers. Not only the patients, cancer also indirectly affects, many of whom are the primary caregivers. Cancer patients and their caregivers are frequently exposed to the complications of the disease itself. Recent advancement in the diagnostic and therapeutic modalities has resulted in a paradigm shift in the cancer course and care plan. The course of cancer has changed from being an acute condition with rapid or direct consequences, usually fatality, to a chronic illness with variable outcomes. This translates to a need for long-term and continuous care for cancer patients with the integration of both informal and formal care systems.

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