

Evaluation of Care Rendered By Healthcare Workers To Caregivers Of Children With Cancer Regarding Burden and Stress Management At Parinyatwa Group Of Hospital Ward Pediatric Oncology Department: An Analytical Cross-Sectional Study Survey

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Abstract

Background

Childhood cancer prevalence is at 262 281 globally all cases in 2020, (WHO,2020 cancer profile). Pediatric is a special population with unique palliative care needs. The World Health Organization (WHO) acknowledges the significance of family caregiving roles for sick children, especially in the case of cancer and other chronic diseases. (Harding et al, 2020). Studies suggests that family interventions increase pediatric cancer patients' survival rate to over 80% for sick children in High-Income Countries. However, the depiction is different for Low-and-Middle-Income Countries such as Zimbabwe in sub-Saharan Africa where survival rates for childhood cancer stands at around 20% Shah et al., (2018 in Bekui et al 2020).

Objectives

The main objective of this study explored the care rendered to care givers of childhood cancer patients regarding burden and stress management.

Results

Sixty-eight (68) care givers were enrolled in the study with the majority (n=43; 63.2%) being females and aged more than 35 years (n=33; 49%). In addition, the age distribution differed between males and females ($p<0.001$) with male participants likely to be older as compared to females (n=21; 84% vs n=12; 28%). More specifically, there were no male participants at most 25 years old. Additionally, the vast number of participants were either formally employed (25%) or informally employed (44%) and there was a disproportionate employment status by sex ($p=0.007$). The type of cancer was associated with whether the condition was intermittent or progressive ($p=0.039$). Most of the caregivers reported that they have difficulties in sleeping (n=47; 69%) and find it emotional discussing the child condition (n=48; 71%). Most caregivers (n=49; 72%) reported that it was constrained, and this was borderline associated with sex, with male caregivers likely to report a supportive social network as compared to females (n=10; 40% vs n=9; 21%)., caregivers mostly indicated that they were spiritually detached (54%) since child illness and this was more reported in females as compared to males (n=10; 40% vs n=27; 63%). Most caregivers indicated lack of church support (n=42; 62%) and they never interacted with the hospital Chaplin (n=62; 91%).

Conclusion

The findings from this study confirms that care givers of childhood cancer patients are burdened and there is need for a multidimensional approach in addressing their burden and stress. There is also need for a tool for assessment and classification of the caregiver burden and stress for proper and comprehensive care and management.

keywords: Childhood Cancer, Burden, Stress and Management

1. Introduction & Background

1.1. Introduction

This study focuses on the health care given to caregivers of childhood cancer patients. The chapter will give the introduction of whole study that is the background, problem statement, research questions, objectives, significance, key

terms, delimitations and the hypothesis of the study.

1.2. Background

Childhood cancer prevalence was at 262 281 globally, all cases in 2020, (WHO,2020 cancer profile). Pediatric is a special population with unique palliative care needs. Care

givers are key in the delivery of pediatric palliative care from diagnosis to end of life. The World Health Organization (WHO) acknowledges the significance of family caregiving roles for sick children, especially in the case of cancer and other chronic diseases, (Harding et al, 2020). According to the Childhood Cancer—Statistics, (2012), the data suggests that family interventions increase pediatric cancer patients' survival rate to over 80% for sick children in High-Income Countries. However, the depiction is different for Low-and-Middle-Income Countries such as Zimbabwe in sub-Saharan Africa where survival rates for childhood cancer stands at around 20% Shah et al., (2018) in Bekui et al, (2020). Due to cognitive developmental variance in children population (pediatric patients), primary caregivers are the totally involved in the care of their children and bear all the burden of cancer management including making tough decisions for their children, (Dambi et al, 2015). In a meta-analysis of randomized trials by Northhouse et.al, (2010), the diagnosis of cancer has emotional, social and physical impact on the wellbeing of care givers. Caregiver burden and stress results in family breakdown and poor outcome of palliative care. A cross sectional study by Dambi, et al, (2015), concluded that care giving may have negative health consequences on the caregivers. The logic behind palliative care is to assist patients and their families in achieving the best quality of life surrounded by their loved ones. Palliative caregiving is stressful, multifaceted, and all-time obligation, which care givers bear alone. It is challenging and impact the caregivers' physical, emotional, psychological, and economic aspects of life. (Chellappan S, and Rajamanikam R, 2016) The American cancer society, (2019), defines a cancer caregiver as "the person who most often helps the person with cancer and is not paid to do so." The main (primary) caregiver is often the spouse, parent or the elder child. This however brings the caregiver to a close relative or significant other who in most cases is emotionally attached. According to Kastel, A. and Ensker K., (2103), caregiving is a multifaceted task which involves providing financial support, psychological support, advocate for the minor throughout the care, physical presence for the minor during admission times and home care times. The roles may also extend to assisting with activities of daily living such as feeding, grooming, mobilizing, voiding. Cancer management involves a multidisciplinary team approach hence the caregiver for pediatric patient is in constant interaction with the members and planning way forward for the patient. The caregiver takes all the burden of the uncertainties and bad news in the continuum of cancer progression. Statistics have shown an increase in the number of depression-related to cancer care giving, (Johnson, E., 2020). Other sources of stress and burden are the change of roles within the family that may lead to a strenuous adaptive system until there is equilibrium within the family structure. (Walsh, 2012; Laizner, 2018) [1-10].

1.3. Problem Statement

Cancer caregiving burden and stress, studies have shown that there is an increase in caregiving related depression and breakdown (Antony, Gorge and Jose, 2021; Commodali, 2010). The magnitude burden among cancer caregivers worldwide is escalating around the world as indicated by high global to

national cancer burden. The Global cancer burden as stated in the WHO cancer fact sheet, 2020, indicated approximately 400 000 children develop cancer each year, 80% of these children in high income countries will survive however only 20% of these in the low-income countries will survive. (WHO Country profiles Cancer Zimbabwe 2020). According to the American Cancer Society statistics, 10470 children in the United states will be diagnosed of cancer in 2022 and 1050 will die of cancer in 2022. In 2017 childhood cancers classified according to the International Classification of Childhood Cancer (ICCC) included leukemia (21%), retinoblastoma (14%), renal tumors (13%), lymphoma (10%), central nervous system (9%), soft tissue (9%), bone tumors (4%) and neuroblastoma (4%). Other unspecified malignant tumors accounted for 16% on the childhood cancers. The Zimbabwe National cancer registry indicted a total of 253 childhood cancers (age 0-14) of all races were registered in 2017. These comprised of 151 (59.7%) boys and 102 (40.3%) girls. Pediatric cancers accounted for 3.3% of all the cancers recorded in 2017, (WHO Zimbabwe, 2021). Raw data from pediatric oncology ward at PGH shows 194 new pediatric cancer patients for the year 2021, (ward statistics unpublished, 2021). Zimbabwe Cancer country profile indicted documented 838 children (0-14) cancer cases in 2020, this indicate a significant rise in the pediatric cancer burden. The burden is escalated by poverty, socioeconomic factors. This all sums up to the risk of caregiver burden in oncology caregivers. However, in Zimbabwe a few studies to the researcher's knowledge have been done to determine prevalence of cancer related burden. Nevertheless, a study by Dambi et al, (2015), done at PGH, indicates that there is high burden among caregivers of childhood cancer patient. The study further indicated that recommended the need to develop context-specific interventions aimed at increasing caregivers' health related quality of living and reducing the burden of care, (Dambi, et al, 2015). Pediatric cancer care services in the sub-Saharan countries mainly occur in established health care facilities where diagnostic and treatment services are often inadequate and accessible to the minority of the population. (Burns et al, 2018; Hopkins et al., 2013). Zimbabwe situation aggravated with low socio-economic factors is not spared from the ordeal. Due to limited resources pediatric patients and their caregivers are referred from all around the country for assessment, treatment and stabilization at PGH pediatric oncology ward. This pose strain on transport cost, accommodation, catering, bills and more to the caregiver. This results in internal crisis in the human system (caregiver) until equilibrium is reached. Failure or delayed resolution then manifest as depression, stress, psychological breakdown, physical exhaustion and other incapacitating symptoms. To maintain the philosophy of palliative care there is need to assess, diagnose and manage caregivers promptly and comprehensively to prevent the devastating effects of stress and burden to the human body [11-15].

1.4. Aim Of The Study

The aim of the study is to evaluate the care rendered to caregivers of children with cancer regarding burden and stress management. It also aims to estimate the timeliness of

initiation of care.

1.5. Study Questions

1. What is the care rendered to the caregivers of children with cancer regarding burden and stress management?
2. When is the care regarding burden and stress initiated for caregivers of children with cancer?

1.6. Study Objectives

1. To evaluate care rendered to caregivers of children with cancer regarding burden and stress management.
2. To estimate the timeliness of initiation of care rendered to caregivers of children with cancer.

1.7. Hypothesis

H0: There is need for caregiver assessment and management during the care of childhood cancer patients.

H1: There is no need for caregiver assessment and management during the care of childhood cancer patients.

2. Methods

2.1. Study Design

The study will be an analytical cross-sectional study using quantitative methods that sought to determine the time factor and management of caregiver burden and stress of childhood cancer patients at Parirenyatwa group of hospitals, pediatric oncology department 2022.

2.2. Study Setting

The study was conducted at Parirenyatwa group of hospitals, (PGH). PGH is one of the largest and historical tertiary and central referral hospital in Zimbabwe. It is located in Capital city, Harare of Zimbabwe. PGH has the accessibility of many pediatric specialists such as the hematologists, oncologists, radiologists and physicists hence most of the childhood cancer cases are referred to PGH and also the availability of the radiotherapy machines at PGH makes it more suitable for childhood cancer management. The pediatric wards are located on the A-floor floor and are branded as, A4, A5, A1, A4 special being the pediatric oncology ward. These wards admit all children from the age of 0-12 years with all medical conditions in the other pediatric wards and children cancer patients in A4 special. The wards have a bed capacity of 30. There are cubicles that accommodates 4 patients each and side wards that accommodates one patient each. Each ward has around 5 Nurses (oncology and 14 non-oncology trained in A4 special) that take care of these children and there are several oncology and medical specialist that are consulted in the multidisciplinary team approach. The caregivers of these ill children are constantly with the children in the wards until discharge. Hematological cancer patients occupy the side wards while solid cancer patient occupy the cubicles. This is because the ward is too small and it accommodate the caregivers too [16].

2.3. Study Population

The study included male or female caregivers of children with cancer. These are defined as the person who most often helps the person with cancer and is not paid to do so, (American Cancer Association, 2019). They have to be

primary care givers that is they have to be caring for a child terminal condition that is any childhood cancer [17].

2.4. Inclusion Criteria

Caregivers with children diagnosed of any cancer and have been commenced on either chemotherapy or radiotherapy treatment at PGH pediatric oncology ward, pediatric outpatients or radiotherapy department. Caregivers who are primary caregivers to the child diagnosed with cancer and admitted. Caregivers who voluntarily consented and agreed to participate in the study [18].

2.5. Exclusion Criteria

Caregivers who could have lost their child in the course of the day of data collection.

Those whose children had not started on either chemotherapy or radiotherapy. Caregivers who are not primary caregivers and have not consented to be part of the participants for this study.

2.6. Sample Size Calculation

Sample size calculation is going to be done using the formula $n = (za)^2(p \times q)/d^2$ (Pourhoseinholi, et al, 2013)

n = sample size

p = prevalence of condition

$q = (1-p)$ if p is expressed in decimal

d = study precision estimate

za (z alpha) value of z from probability tables

for this particular study: (Pagano, 2006)

$p = 0.217$ (According to Dambi et al, 2015)

$q = (1 - 0.217)$

$za = 1.96$ (Pagano, 2008 pp)

$d = 0.05$ Study precision estimate (derived from 95 % confidence interval)

therefore; $n = (1.96)^2(1 - 0.217 \times 0.217) / (0.05)^2$

$n = 67.96$ The sample size will be 68 participants.

2.7. Sampling Method

Convenient sampling method was used to pick eligible participants from the A4 special ward, pediatric oncology outpatient clinic and radiotherapy department. Caregivers who will be found on the day of data collection and meet the inclusion criteria will be considered for participation in the study [19].

2.8. Permission And Ethical Considerations

Permission was sought from the CEO PGHs, The Medical Research Council of Zimbabwe (MCRZ) and the Joint Parirenyatwa Group of Hospitals and College of Health Sciences research committee, (JREC). A written consent was obtained from eligible participants after full explanation of the study objectives benefits and discomforts. It shall be translated into a language the patient understands. A counsellor was ready for participants who will get emotionally broken during time of data collection. The right to privacy and confidentiality of the study participants will be maintained through anonymity on questionnaires and provision of private room for questionnaire completion. No names on the questionnaires shall be used, instead of serialization and the generation of unique codes will be

done throughout the study. Completed questionnaires shall be kept under lock separate from the code names reference.

2.9 Data Collection

Data collection was done using researcher administered structured questionnaires. For caregivers with admitted children it was done after morning ward activities such as doctors rounds and nursing procedures. For outpatients and radiotherapy patients, was collected after patients have been served continuously as they complete their business of the visit. The participants are going to be identified and taken into privacy where data collection will be done. The responses of the participants will be recorded and coded.

2.10. Pretesting Of the Questionnaire

The questionnaire was submitted to a palliative care specialist for review and was pretested in Sekuru Kaguvu Hospital, paediatric ward that is also found at PGHs and it admits children with ophthalmic cancers. Ten percent (10%) of the sample size was considered for pretesting [20-23].

2.11. Data Presentation and Analysis

The data was analyzed using inferential and analytic statistics. Quantitative data shall be entered and analyzed using SPSS computer package, odds ratio and logistic regression analysis is going to be done to determine caregiver time factor and management of burden and stress. A p-value equal to or <

0.05 indicated statistical significance. Percentages were used for categorizing data. Pie charts, tables, and bar graphs will be used to represent data.

3. Results Or Findings

This chapter included important aspect of the study, it brings the study to completion by analyzing the data collected in order to test the hypothesis and answer the research questions. As already indicated in the preceding chapter, data is interpreted in a descriptive form.

This chapter comprises the analysis, presentation and interpretation of the findings of this study. The results are based on the findings which were elicited from the questionnaire and it deals with a quantitative analysis of data, which was achieved through STATA statistical analysis. Data gathered through the questionnaire was subjected to frequency counts. In other words, the subjects' responses for each individual question were added together to find the highest frequency of occurrence (i.e., the number of times that a particular response occurs). These responses to the questions, which are quantified, are then presented in percentage forms.

This analysis is presented in tabular form. The researcher uses tables containing a variable and in some cases, combines two or more variables in a single table [24,25].

Variables		Total (n=68)	Males (n=25)	Females (n=43)	p-value
Age	≤ 25	8 (12%)	0 (0%)	8 (19%)	<0.001
	26-35	27 (40%)	4 (16%)	23 (53%)	
	>35	33 (49%)	21 (84%)	12 (28%)	
Relationship with child	Parent	59 (87%)	25 (100%)	34 (79%)	0.049
	Sibling	5 (7%)	0 (0%)	5 (12%)	
	Guardian	4 (6%)	0 (0%)	4 (9%)	
Geographical location	Harare	33 (49%)	16 (64%)	17 (40%)	0.052
	Out of Harare	35 (51%)	9 (36%)	26 (60%)	
Employment status	Formally employed	17 (25%)	9 (36%)	8 (19%)	0.007
	Informally employed	30 (44%)	14 (56%)	16 (37%)	
	Unemployed	21 (31%)	2 (8%)	19 (44%)	

Table 1: Participant's Demographics

The study enrolled 68 care givers where the majority (n=43; 63.2%) were females and aged more than 35 years (n=33; 49%). In addition, the age distribution differed between males and females (p<0.001) with male participants likely to be older as compared to females (n=21; 84% vs n=12; 28%). More specifically, there were no male participants at

most 25 years old. The study also identified the relationships between the caregivers and the cancer patient (child), where most of them (n=59; 87%) were female parents. More-so there were no male guardians. Equally, enrolled participants were geographically from Harare (49%) and out of Harare (51%), whilst more female participants were from the later

(n=26; 60%) as compared to males (n=9; 36%). Additionally, the vast number of participants were either formally employed (25%) or informally employed (44%) and there

was a disproportionate employment status by sex ($p=0.007$) (Table 1).

		Total (n=68)	Intermittent (n=26)	Progressive (n=42)	p-value
Type of cancer	Wilms tumour	9 (13%)	2 (8%)	7 (17%)	0.039
	Blood cancer	16 (24%)	11 (42%)	5 (12%)	
	Lymphomas	12 (18%)	3 (12%)	9 (21%)	
	Retinoblastoma	3 (4%)	0 (0%)	3 (7%)	
	Other	28 (41%)	10 (38%)	18 (43%)	
Time since diagnosis (years)	<1	25 (37%)	6 (23%)	19 (45%)	0.20
	1	25 (37%)	11 (42%)	14 (33%)	
	>1	18 (26%)	9 (35%)	9 (21%)	
Time since treatment (years)	<1	26 (38%)	8 (31%)	18 (43%)	
	1	26 (38%)	11 (42%)	15 (36%)	
	>1	16 (24%)	7 (27%)	9 (21%)	
Feeling on child diagnosis	Crisis	37 (54%)	10 (38%)	27 (64%)	0.033
	Chronic	26 (38%)	15 (58%)	11 (26%)	
	Terminal	5 (7%)	1 (4%)	4 (10%)	
Type of treatment	Chemotherapy	48 (71%)	21 (81%)	27 (64%)	0.17
	Radiotherapy	6 (9%)	2 (8%)	4 (10%)	
	Palliative care	7 (10%)	3 (12%)	4 (10%)	
	Surgery	7 (10%)	0 (0%)	7 (17%)	

Table 2: The Clinical History Of Children Under Care Stratified By The Child's Illness Status

The study also reports the clinical history of the children whose caregivers are under study. Respondents indicated that, most (n=42; 61.8%) of the cancer patients were progressive, whilst the remainder were intermittent (n=26; 38.2). Blood cancer (24%) was the most reported condition followed by lymphomas (18%) and Wilms tumor (13%). The

type of cancer was associated with whether the condition was intermittent or progressive ($p=0.039$), with lymphomas and Wilms tumor likely progressive. Most of the patients had their diagnosis in the previous year (n=50; 74%), likewise the time since treatment (n=52; 76%). When caregivers were asked about their feeling on child diagnosis, more

than half (n=37; 54%) reported that they discern a crisis, whilst the least (n=5; 7%) indicated that it was terminal. In addition, the caregiver's feeling on child diagnosis was associated with their perception on whether the condition

was progressive/intermittent (p=0.033). Most of the patients were on chemotherapy (n=48; 71%), equally on surgery and palliative care (10%) and least on radiotherapy (n=6; 9%) (Table 2)

		Total (n=68)	Male (n=25)	Female (n=43)	p- value
Emotional domain					
Sleeping patterns	Sleep well	21 (31%)	10 (40%)	11 (26%)	0.21
	Insomnia	47 (69%)	15 (60%)	32 (74%)	
Feeling when discussing the child condition	Therapeutic	20 (29%)	7 (28%)	13 (30%)	0.85
	Emotional	48 (71%)	18 (72%)	30 (70%)	
Most frightening aspect of the child's illness	Detachment	5 (7%)	1 (4%)	4 (9%)	0.71
	Losing the child	60 (88%)	23 (92%)	37 (86%)	
	Other	3 (4%)	1 (4%)	2 (5%)	
Ever received professional care	No	68 (100%)	25 (100%)	43 (100%)	-
Social domain					
Impact of child's illness on life	Adjusting	33 (49%)	12 (48%)	21 (49%)	0.38
	Struggling	32 (47%)	13 (52%)	19 (44%)	
	Other	3 (4%)	0 (0%)	3 (7%)	
How other siblings copying with the child's illness	Anxious	33 (49%)	13 (52%)	20 (47%)	0.43
	Depressed	28 (41%)	11 (44%)	17 (40%)	
	Other	7 (10%)	1 (4%)	6 (14%)	
State of social support	Supportive	19 (28%)	10 (40%)	9 (21%)	0.09
	Constrained	49 (72%)	15 (60%)	34 (79%)	
Spiritual domain					
Spiritual relationship since child illness	Detached	37 (54%)	10 (40%)	27 (63%)	0.06
	Connected	31 (46%)	15 (60%)	16 (37%)	
Church support	Contented	26 (38%)	13 (52%)	13 (30%)	0.07
	Spiritual pain	42 (62%)	12 (48%)	30 (70%)	
Interaction with hospital Chaplin	Satisfactory	6 (9%)	2 (8%)	4 (9%)	0.86
	Never interacted	62 (91%)	23 (92%)	39 (91%)	
Feeling about spiritual care inclusion in medical- care	Satisfied	57 (84%)	19 (76%)	38 (88%)	0.18
	Concerned	11 (16%)	6 (24%)	5 (12%)	
Source of children treatment funding	Self	55 (81%)	22 (88%)	33 (77%)	0.46
	Social-welfare	12 (18%)	3 (12%)	9 (21%)	
	Other	1 (1%)	0 (0%)	1 (2%)	
Support from organizations	Formal organizations	51 (75%)	18 (72%)	33 (77%)	0.88
	Informal groups	2 (3%)	1 (4%)	1 (2%)	
	No	15 (22%)	6 (24%)	9 (21%)	
Impact of child's illness non income	Managing	16 (24%)	11 (44%)	5 (12%)	0.00
	Constrained	52 (76%)	14 (56%)	38 (88%)	

Table 3: Participant's Experience Regarding Burden And Stress Management

Most of the caregivers reported that they have difficulties in sleeping (n=47; 69%) and find it emotional discussing the child condition (n=48; 71%). In addition, equally in males and females, they were most frightened with losing the child (n=60; 88%). However, all the caregivers indicated that they had never received professional care regarding burden and

stress management from multidisciplinary team since the diagnosis of the child. Stillmore, caregivers were equally socially adjusting (n=33; 49%) or struggling (n=32; 47%) due to the child's illness. As a result, the other siblings were mostly either anxious (n=33; 49%) or depressed (n=28; 41%). With respect to social support, most caregivers

(n=49; 72%) reported that it was constrained, and this was borderline associated with sex, with male caregivers likely to report a supportive social network as compared to females (n=10; 40% vs n=9; 21%). Likewise, caregivers mostly indicated that they were spiritually detached (54%) since child illness and this was more reported in females as compared to males (n=10; 40% vs n=27; 63%). In addition, most respondents highlighted that they lacked church support (n=42; 62%) and they never interacted with the hospital Chaplain (n=62; 91%). Furthermore, the vast number of participants (n=57; 84%) were satisfied with spiritual care inclusion in medical care. Over half (81%) of the caregivers reported that they self-fund their child's treatment with 18% of caregivers indicating support from social-welfare. Support from formal organizations was also reported (n=51; 75%) and 22% were not supported by any organizations. Overall, three quarters (n=52; 76%) of the caregivers were constrained financially due to the child's illness. Specifically, more female participants indicated that they were constrained as compared to males (n=14; 56% vs n=34; 88%) (Table 3) [26-30].

3.1. Summary Of The Study

The study focused on the management of burden and stress faced by caregiver's childhood cancer patients, rendered by health care workers. The literature review was done on the main domains of burden and stress, derived from the conceptual framework by Rolland, (1994) As already been alluded too by many researchers the study also indicated marked burden and stress among care givers of childhood cancer patients. furthermore, the study shows the lack or inadequate management of caregivers with burden and stress. Questionnaire approach was used in a quantitative design to elicit data. The study utilized cross-sectional descriptive methods. Quantitative data collection was done and STATA statistical methods were used to analyze data. The study concentrated on the primary caregivers who were available during data collection as in patients or outpatients [31].

4. Discussion and Interpretation of Results

The study shows that caregivers carry with them a lot of burden regarding care of childhood cancer patients care. It also reveals how caregivers need active management of the stress and burden they encounter. the study shows that in the acute phase of diagnosis most parents are overwhelmed and finds it difficult to cope with the stress (Table 2). As alluded to by Rolland, (1994), most of the caregivers will be trying to adjust to the new way of life the is the diagnosis and some will be in denial of the diagnosis. This means critical care is necessary in this phase of diseases continuum. It is also reflecting that caregivers have expectations regarding their wellbeing despite the care and attention given to their children. Most of the caregivers indicated that it would help if there is spiritual involvement in their care. The study has also reflected that both males and females are involved in caregiving. However, to a lesser extend siblings are also involved in the caring of childhood cancer patients. All of them have significantly reported constraints. Similarly,

to Chiemerigo and Rose, (2021), the study showed that caregivers experienced physical effects of stress with change in sleep patterns. Chiemerigo and Rose, (2021), further shows the dimensions of physical exhaustion such as frustrations and change in eating patterns. According to the study most of the caregivers indicated family disruptions such as sibling's anxiety, depression and change of family routines to accommodate the sick child. The study results also concur with the findings from Lui at el, (2020) that the background of caregiver burden includes insufficient financial resources, multiple responsibility conflict and lack of social activities and support. This study showed that caregiver burden is a multiple facet that encompasses more than physical, social, financial and spiritual domains. The conceptual framework selected for this study proposed that individuals go through phases of stress along the continuum of disease progression. This was a significant feature in findings of the study, most care givers in the crisis phase had their children diagnosed in not more than 12months. Those who reported the child disease progressing showed coping as compared to those who reported child illness as acute and within a year of diagnosis. Moreover, those with their children in palliation phase showed that they were able to live with child illness. (Rolland, J.S,1994). The overall conclusion drawn from this finding is that stress management needs to be instituted as early as in the child diagnosis phases as to prepare the caregiver for the uncertainties. That study also shows that most of the caregivers indicated getting support from formal organizations, however they also verbalized being constrained despite the assistance. According to Thompson et al, (2020), organizational support target specific health assistance. He further explains that financial and health resource assistance is important additional there are likely other components such as social support from church/religious groups that vary in level of importance depending on the unique sociocultural perspectives of populations. This finding also agrees the finding of this study. Interventions are needed that support cancer caregivers and protect their own health outcomes. Developers should consider the variation of experiences and meanings attributed to cancer caregiving when choosing intervention targets [32-35].

4.1. Significance Of Study

This study acknowledges the burden and stress faced by caregivers of childhood cancers, it also evaluates the present care rendered to caregivers. This evaluation helps policy developers to consider the multifactorial aspect of burden and stress among caregivers of childhood cancer patients. burden and stress tools could also be developed from the findings of the study.

Recommendations

The study focused on the caregivers of a variety of cancer patients. Versed the knowledge of different cancer progression and outcome, individuals experience different impact of the cancer on the individuals. Further studies should look into different cancers and their impact on care givers. Studies can also focus on the copying mechanisms employed by caregivers of children with cancer.

Limitations

The main limitation for the study was time, the researcher was constrained time wise due to other demanding commitments of the academic program. Also, the researcher was limited to participants who were at the hospital at the time of data collection hence those who are on palliative care at home may have been missed.

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