



Experiences of older adults as caregivers during times of disruption in Lesotho—Implications for adult education

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Abstract The high mortality rate among Lesotho’s younger generation, caused by disruptions such as chronic illnesses and other socio-economic and cultural changes, has led older adults to become caregivers. This paper reports on the experiences of older adults regarding their caregiving role during times of disruption. It further reveals how older adults have learned about their role as caregivers. Adult learning theories were reviewed and used to interpret the results of the study. The interpretive paradigm using a qualitative approach was used with 25 older adults, who were purposively chosen. Their responses were filled in a questionnaire with open- and close-ended questions, whereas five community leaders were purposively selected and interviewed using a semi-structured interview guide. The results reveal that older adults learned about caregiving roles in non-formal ways, with health education issues disseminated in a workshop by community health workers. On the other hand, other older adults indicated that they learned informally through awareness raising campaigns held by community home-based caregivers and volunteers from various non-governmental organisations. The results point to the compromised well-being of older adults as a consequence of the burden of caring for their grandchildren with little or no resources to perform such caring roles. It is recommended that a holistic approach to build the capacity of older adults be used. This will empower older adults to participate in self-help groups and income-generating projects, and it will train them in vocational skills and knowledge alongside caregiving issues.

Keywords Older adults · Caregivers · Disruption times · Adult education

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Erfahrungen Älterer als Pflegende während Zeiten des Umbruchs in Lesotho – Implikationen für die Erwachsenenbildung

Zusammenfassung Die hohe Sterblichkeit unter jüngeren Erwachsenen in Lesotho, hervorgerufen z. B. durch chronische Krankheiten sowie sozioökonomische und kulturelle Krisen, hat dazu geführt, dass ältere Menschen häufig zu Pflegenden von Angehörigen wurden. Dieser Beitrag zeigt die Erfahrungen auf, die ältere Menschen in ihrer Rolle als Pflegekraft für jüngere Angehörige gemacht und was sie dadurch gelernt haben. Zur Auswertung der Studie wurden Lerntheorien aus der Erwachsenenbildung herangezogen. Die qualitative Umfrage wurde mit 25 älteren Erwachsenen durchgeführt. Die Ergebnisse zeigen, dass sich ältere Menschen ihr Wissen ihre Rolle als Pflegende auf non-formalem Wege aneigneten, etwa in einem lokalen Workshop zu Themen der Gesundheitsbildung. Andererseits gaben sie an, durch Aufklärungskampagnen, die von Pflegern aus der eigenen Community und Freiwilligen von verschiedenen NGO organisiert wurden, informell zu lernen. Die Ergebnisse zeigen auch, dass das Wohlbefinden der älteren Menschen darunter leidet, wenn sie sich um ihre Enkel kümmern müssen, ohne über ausreichende Fähigkeiten für diese Aufgabe zu verfügen. Es ist empfehlenswert, einen ganzheitlichen Ansatz zu verwenden, um diese Fähigkeiten bei den älteren Erwachsenen auszubilden.

Schlüsselwörter Ältere · Gesundheitsbildung · Erwachsenenbildung

1 Introduction

In Lesotho, caring for the chronically ill has placed a burden on various institutions of care, such as hospitals generally and specifically on caregivers who further extend nursing roles in a home environment. According to the 2008 report by the Ministry of Health and Social Welfare (MoHSW), more than 60% of inpatients and outpatients visiting health facilities suffer from chronic illnesses that are HIV/AIDS-related in nature (2008). This has resulted in long queues at hospitals and congestion in hospital wards; therefore, home care by community-based caregivers came as an intervention (Nyaphisi and Obioha 2015). In Lesotho, at district and community level, communities take full responsibility for their own health by providing integrated care and support to terminally ill people in their homes. This care is provided by family members, neighbours, other relatives and community members who serve as volunteer caregivers.

A caregiver is any person giving care to a sick, elderly, or disabled person or a vulnerable child in a home environment. The primary caregiver is the main person who lives with the care recipient in a home environment. This often includes family members, parents, foster parents, legal guardians, siblings, uncles, aunts and grandparents or close family friends and neighbours. Secondary caregivers include community members and professionals, such as nurses, teachers or priests, who interact with recipients of care in the community or visit them at home but do not necessarily live with these recipients of care (Ministry of Social Development

[MoSD] 2014a). The concept of caregiver in this study shall denote both primary and secondary members who offer care to sick people and other recipients.

The least acknowledged caregivers within the home, however, are older adults.

Consequently, the traditional cultural practice of older people depending on their children is no longer intact. This is because the younger generation is dying off, leaving their parents with scarce resources, and as caregivers of grandchildren (Ramashala 2001). Accordingly, other social changes, economic security and geographic mobility increase the chance of older adults becoming caregivers, particularly in the rural areas of Lesotho (MoSD 2014a). Rapid urbanization, with young families migrating away from their parents, is one acute challenge facing the older adults. This rural-urban migration is also partly caused by the search for employment in industrial areas and the availability of better housing and living conditions in the urban areas of Lesotho. All these social changes have a significant impact not only on the lives of grandchildren but also on the conditions and quality of life of the grandparents acting as caregivers.

Clearly, the above disruptions pose enormous challenges to the lives of older persons, who also need to be cared for and supported during the process of healthy ageing (MoSD 2014a). The Lesotho Policy for Older Persons advocates for the protection and realisation of the rights of older persons. It gives directions on the most effective approaches to dealing with the challenges facing older adults (MoSD 2014a) and urges families to continue to meet some of the social and emotional needs of the older adults in society. The alternative is a drain of older adults who serve as caregivers to the former. Despite the list of policy statements made generally (MoSD 2014a) and in particular the policy statements with the component of education, there is no direct means of providing education and training to older persons in Lesotho. The Lesotho policy for older persons is silent on how older adults should be empowered to cope with, adapt and adjust to changes in times of disruption; neither does it say anything on older persons' new roles such as caregiving. It has been further reported that caregivers continued to experience many challenges while implementing care services in the community. These challenges include: capacity, resources in general, lack of technical skills, stress, food insecurity and lack of coordination of services (Lesotho Ministry of Health and Social Welfare Annual Report 2009).

Older adults as caregivers need guidance, support and training on how to provide informal care to different individuals in complex situations. Therefore, adult education, with its long-standing history of integrating education with social action (Stein 2006), can empower and develop older adults to foster both personal growth and social action while providing them with wide-ranging nursing skills to enable them to meet the challenges of caring. In Lesotho, adult education falls under the non-formal education policy of the Ministry of Education and Training (MoET). As Pitikoe and Morojele (2017) point out, the Lesotho non-formal education policy has remained a draft that has not been ratified by the Lesotho government for years. This has implications for how non-formal education is provided, how its curriculum is developed and by whom, how it is coordinated and supported. Caregivers are largely taken care of by non-governmental organisations that are mostly foreign bodies and

donor-driven (Pitikoe and Morojele 2017) and not context based, resulting in little support and a lack of proper recognition from the Lesotho government.

Regardless of the abovementioned challenges, older adults continue to provide voluntary caregiving services to their communities. Given these challenges and responsibilities, coupled with the general situation in Lesotho as a poor country, it became necessary to inquire into what actually motivates older adults to continue rendering the services. This article reports on the experiences shared by older adults regarding their role as caregivers in times of disruptions in Lesotho. It aims at providing a better understanding of the knowledge that older adults have acquired and of the ways in which they have acquired such knowledge to overcome the challenges of caring. Since the study focus is on the older generation of adults, whose learning has been different from that of the younger generation, the Sesotho indigenous education is discussed after the concept of caregivers. This is followed by adult learning in a social context demonstrating on how adults learn, then the methodology, findings and discussion, and finally the concluding remarks. Initially, the socio-cultural context of Lesotho is discussed for background information.

2 Lesotho: socio-cultural background

Lesotho is part of the Sub-Saharan African countries with the highest HIV and AIDS prevalence rate of 23% for a population of 1.89 million (Lesotho Ministry of Health and Social Welfare Demographic Health Survey 2009, 2010). Lesotho adopted a multi-sectoral approach by establishing many community-based organizations (CBOs) to implement HIV and AIDS interventions including palliative care for chronically ill clients (Kell and Walley 2009) with the assistance of caregivers, who undertake the duties of nurses without training.

Lesotho is a traditional African country promoting the collective philosophy of bringing people together (Ngozwana 2015; Lekoko and Modise 2011). The extended family as a mutual support system is an important feature of Basotho culture but has been severely strained by decades of migrant labour, poverty and the burden of chronic diseases (MoSD 2014a). The domestic unit consists of any number of members of the extended family. Often second or third cousins become brothers or sisters, while grandmothers become mothers or caregivers.

However, with development and globalisation, socio-cultural norms are rapidly changing in Lesotho. These include household structures resulting from shifts in employment characteristics and the impact of HIV and AIDS, marriage occurring late in life, fewer new households being created, and bigger households emerging as younger generations do not move out, and more children are being born outside of marriage (MoSD 2014b). Young couples who have managed to establish a household often survive on very little income and are often supported by parents or older adults who are relatives. Moreover, the increased vulnerability of these households has led to an increase in broken marriages and relationships, causing women to return to their parental home with their children or to leave their children with grandparents while they lead separate lives in urban areas (MoSD 2014b). Such a socio-cultural situation highlights the continued strength of social capital in Lesotho, although

social networks are under severe strain due to HIV and AIDS and economic shocks. However, the community support mechanisms are still relatively resilient, with older adults assuming new roles as caregivers for the sick people in their homes.

3 Caregivers: their selection, training and services

Community caregivers have become the backbone of caring and supporting the terminally ill, assisting in social support services, addressing livelihood needs and serving as treatment supporters that administer medication and ensure the adherence and well-being of sick people. According to Obioha and Matšela (2013), community home-based health care in Lesotho was a method of providing care and support to sick individuals in their homes by families, neighbours, friends and community members long before Lesotho was colonised and before the emergence of institutions like hospitals and schools. After colonisation by the British, several care institutions took the role of the family, from caring for the sick in their homes to hospitalising them. Lately, the vast number of sick people as a result of multiple chronic illnesses has caused long queues at health care institutions and rising congestion, causing shortages in medication, hospital beds, and nurses and doctors, resulting in poor health care provision (Obioha and Matšela 2013; Nyaphisi and Obioha 2015). Consequently, hospitals discharge patients when they still require care, leaving them to be nursed at home by family and volunteer caregivers. It can be seen that caregiving would be unsustainable without the unpaid volunteers.

Van Dyk (2005) explains community home-based health care as the care given to individuals in their own homes when they are supported by their families, their extended families or those of their choice as members of a community. Obioha and Matšela (2013) observe that a large number of the caregivers are old and frail, with few or no other opportunities to sustain a comfortable lifestyle. This has implications for the well-being of older adults as caregivers facing the increasing demand for caregiving.

Providing long-term care in the home is proving to be a viable and cost-effective alternative to institutional care; however, the current shortage of trained caregivers makes in-home care difficult to accomplish (Stone and Wiener 2001; Makoae 2015). Most experts view this workforce shortage as multifaceted, involving important challenges such as inadequate education and training, unpaid work or low wages, minimal worker benefits, lack of career advancement opportunities, and erratic and often part-time employment. Among these important factors, education and training can be seen as most critical. Without adequate skills and knowledge, individuals attracted to in-home caregiving can actually present countless safety risks for older adults who serve as caregivers.

On the other hand, Masanjala and Kajumi (2013) found that in Malawi, community caregivers are an essential resource in the delivery of primary health care services both conceptually and operationally. The authors establish that the major evolution in the role of caregivers has been two-fold: from basic nursing care to i) broader livelihood, nutritional and psychosocial support; and ii) toward key treatment-related support, including ensuring adherence to antiretroviral therapy (ART)

and monitoring. Moreover, in Malawi, community care and support is provided by several government departments, non-governmental organisations (NGOs) and communities themselves while the Ministry of Health defines and regulates the framework for NGO service provision in line with the Community Home Based Care (CHBC) policy (Masanjala and Kajumi 2013; Makoae 2015).

In terms of home-based care (HBC) training for caregivers in Lesotho, the Ministry of Health and Social Welfare, in partnership with the WHO and the Christian Health Association of Lesotho, produced a HIV/AIDS HBC training package titled “HIV Prevention, Treatment, Care and Support—A Training Package for Community-Based Caregivers” (Lo lacono and Allen 2011). The package includes a ten-day training course targeted at village health workers, support groups and community volunteers. Additionally, NGOs like the Lesotho Red Cross Society, the Lesotho Network of AIDS Service Organizations and the Lesotho Network of People living with HIV and AIDS sometimes provide home-based care (HBC) kits to the community volunteers. However, supplies are not sufficient to meet the demand. There is also no formal system for supplying and replenishing HBC kits used by volunteer caregivers (Lo lacono and Allen 2011).

Despite a commitment to providing HBC to sick people, the caregivers have varying levels of commitment and capacity to implement HBC for terminally ill people. Additionally, the quality of HBC provision varies between caregivers. In Lesotho, in households where HIV/AIDS HBC is provided by the village health workers, the services are more likely to be comprehensive and adequate because the village health workers have been through formal HBC training, which adheres to the prescribed national standards (Lo lacono and Allen 2011). In contrast, caregivers who are community volunteers or members of support groups do not have formal training but received health care awareness through campaigns and through information disseminated by village health workers in various public gatherings (*ibid.*).

4 Sesotho indigenous education

Historically, the Basotho lived in an extended family system in which the primary family with one or several wives and children lived in a very close proximity and shared life socially. Sesotho indigenous education was transmitted orally from generation to generation (Ngozwana 2015) and included a wide range of activities, such as skills training, mainly by the family members in a non-formal situation. Sesotho indigenous education included all forms of education and training taking place anywhere, anytime through formal, informal and non-formal means of learning. However, the following discussion will be based only on non-formal and informal education, mainly because education in these forms happens socially and through collective interaction, which is how older adults have learned. Some of the goals of Sesotho indigenous education were to acquire values of excellence in service and behaviour, learning skills by actual involvement in the skills themselves (apprenticeship), preparation for participation by involvement in family and community life, respect for the established authority and observance of the law, among others (Matšela 1979).

Matšela outlines some of the key principles aspired to by Sesotho indigenous education as follows:

*“Every man should give freely some of his/her time for social/communal services like matsema (work parties) at the chief’s field (ts’imo ea lira).
The young must honour their parents and respect all adults.
Each must help another (who is in need) without expecting to be repaid.
Everyone is responsible for the welfare of their neighbour: crimes must be reported to the chief; parents are responsible for their family members; there is a collective responsibility for collective crime of omission or commission”*
(1979, p. 251).

Clearly, Sesotho indigenous education emphasised respect for authority, love of practical work learned on the job, and dedication to family service. This is in conflict with the perceived practices and lifestyles of the current youth, who dislike and neglect practical work but instead prefer idle talk and entertainment (Matšela 1979).

Attitudes, beliefs and skills are not inborn but are learned and therefore acquired abilities. Basotho values, norms and principles were delivered through oral forms such as poetry, songs, story-telling, myths, riddles, legends and fables. All adults in families and communities, including older children, served as instructors who delivered content to different age structures in society (Matšela 1979): infancy, childhood, adolescence and adulthood. Matšela (1979) showed that what was offered was situation-controlled, depending on the situation of every learning experience, with persons assuming the role of instructors in some situations and the role of learners in others. As such, this education was comprehensive and relevant, as it covered all aspects of a person’s life, where communal and parental participation was linked to non-formal education.

However, it is worth mentioning that Sesotho indigenous education was not written and relied heavily on the past, using the authoritative guidance of the elders, as opposed to modern education, which uses a variety of instructional media such as libraries, television and multimedia, to mention a few.

5 Adult learning in a social context

Adult learning usually happens in a social context across different social roles in the home, the community and the workplace, which fits well with situated learning, as learning does not happen in isolation from the environment. The concept of situated learning is explained by Anderson, Reder and Simon (1996) as focussing on the relationships that take place between people and their environment. This means that people are part of the constructed environment including their social relationships. This corresponds well with African communalism and the notion of Ubuntu, as African worldviews think of the individual as being inherently embedded in a context of social and interdependent relationships (Sefotho 2018), and never as an isolated individual. As such, the environment serves as the characteristic that constitutes individuals (Anderson et al. 1996).

In situated learning, knowledge is not separated from the activities through which it is produced (Brown et al. 1989), including the situations in which it is produced. In other words, knowledge keeps evolving with each new occasion in which it is used, producing new activities and then changing thereafter. Additionally, the acquisition of knowledge and skills in the traditional African context like Lesotho has been an active process (Fasokun et al. 2005) for individuals, who would instantly put into practice what they have learned. In that case, an individual would be motivated from within and in return actively participate in what is expected of them.

On the other hand, there are some people who like to learn from other people; they would rather ask someone how to do something than look it up in a book or simply start trying to do it (Nicolson and Bayne 1990). Such a socially oriented learning theme is usually practiced in an African setting and may evolve into a full-fledged relationship, such as peers working together to learn the ropes of new jobs or assignments (Nafukho et al. 2005), as in the indigenous education system. Usually people with a social learning theme naturally find a person who knows something and then discuss how to learn a specific task from them.

When people use or share their experiences with others pertaining to a given learning task, they feel motivated and energised to do so (Ekoto and Gaikwad 2015; Finn 2011; Knowles 1984). For Rao (2008), skills and knowledge acquired through experience are of high quality, because there is no time or age limit, no specific time table and no curriculum. Experiential learning extends beyond the formal teaching-learning process. It takes place in a variety of contexts: family, community, workplace and school, among others. Examples of activities include small group discussions, experiments, role play, observation and sketches, or informal learning by performing an activity, as in apprenticeships.

Another adult learning theory that fits well with adults is the socio-cultural perspective, which considers the social and cultural context in which learning takes place in interactive and collaborative ways. According to Taylor, Peplau and Sears (1994), the socio-cultural perspective is concerned with how people's diverse social backgrounds influence their thoughts, feelings and behaviour. In this case, culture plays an important role due to the interaction between people who share the same beliefs, traditions, values and behaviour patterns. This is similar to the African indigenous system of knowledge (as discussed earlier), where socialisation played a key role in facilitating learning among adults. Actually, this is where culture is transmitted from generation to generation through the process of socialisation in informal learning situations. In Lesotho, this is learned from parents in the families or from peers in social groups or from senior members of society either during songs, totems, proverbs, ceremonies or campaigns. The socio-cultural perspective is important because it helps people understand behaviour within a particular social or cultural context. The next section discusses the methodology used to engage with participants who were older adults.

6 Methodology

The study was carried out at Thaba-Bosiu, a sandstone plateau located between the Orange and Caledon Rivers in the Maseru District of Lesotho, 24 km east of the country's capital Maseru. In Thaba-Bosiu, the community home-based care concept was initiated by the Lesotho Red Cross Society in 2003 as an integrated approach of care and support for the terminally ill. An interpretive paradigm using a qualitative approach was used in the study. 25 older adults serving as caregivers were purposively sampled from different sections of the community care network (village health workers, support group members and community volunteers). Snowball sampling was used to further identify and locate the additional number of caregivers at their own homes.

The researcher went to the local health centre, which served as an entry point into the community. Three village health workers were identified and approached to be interviewed by the researcher, who also explained the purpose of the study and asked for permission to engage them as participants who would be interviewed individually. The researcher filled in their responses for open-ended questions, while indicating their suitable responses pertaining to closed-ended questions. The participants gave the researcher clues as to where to find other caregivers. All the participants were women aged 60 years and above. Additionally, five key informants (three village chiefs and two retired nurses) were purposively selected for in-depth interviews using a semi-structured interview guide. The following questions are examples of what was asked:

Would you please share your experiences and the activities you perform as a caregiver?

As a leader, how do you support the work of caregivers in your community?

Would you please tell me more about how you have learned/acquired knowledge about your role as caregiver?

What motivates you to continue with your caregiving services?

What challenges do you encounter in performing your work?

What do you think could be done to support you when doing your work?

With all participants, permission to engage them in a study was required prior to asking them questions, and they gave their consent verbally. The participants were assured confidentiality and anonymity, and they were given the freedom to withdraw at any time when need arose. Sesotho was the language used during data collection, which enabled the participants to express their opinions and feelings as clearly as possible. The researcher asked for and was granted permission to record the voices. After each interview, the tape-recorded interviews were transcribed and translated into English. Continuous qualitative content analysis was used. The transcriptions were read carefully, and ideas were noted. Then the transcriptions were coded and reflected on, thoughts were written in the margins next to the transcribed interviews (Burns and Grove 2012), and themes and sub-themes were identified (Creswell 2009, 2013), with similar ones being put into one category.

7 Research findings

Older adults as caregivers in Lesotho are facilitated by different entities that operate differently on the ground; therefore, their learning experiences differ. Nevertheless, their major function is to provide care and support to people who are terminally ill at their homes. Older adults learned the role of caregiver by observing some of the activities performed by the trained volunteers, that is, through informal learning, whereas others learned non-formally in the workshop conducted by the local health centre. The findings are presented in categories derived from the data and in line with the objectives of the study. Findings are grouped into “functional learning of older adults and the modalities of their caregiving”; “recruitment and training of caregivers”; “sustainability of caregivers’ work” and “learning from challenges of caregiving”.

7.1 Functional learning of older adults and the modalities of their caregiving

Functional learning—that is, learning that is relevant to the experience of learners and the work context of older adults in performing their caregiving roles—occurred partially. The community care practice essentially points to the responsibility of community members to take care of sick members. This idea was echoed in the response of one support group member who is a caregiver: “I am one of the volunteers who were chosen to provide care and support to family members having sick people. My role is to show them [family members] how to nurse a patient in the home using the home and locally available remedies.” It became apparent that patients do not receive the adequate care they expect from the health centres, which has necessitated the health centres to shift or delegate care services from institutions to homes. Apparently, nursing care is performed by untrained family members who informally learn from the trained volunteers by observing when nursing activities are performed.

Additionally, a retired professional nurse echoed similar sentiments regarding the functions of community caring: “Lately, caring is multidimensional, and it is not only the responsibility of the nurses and doctors to take care of patients but also the responsibility of community members to look after their sick relatives at home.” Certainly, the role of older adults who serve as caregivers is to provide health services at homes together with the relatives of the sick, but the extent to which this actually happens in reality is the main question investigated in this study. The way older adults are trained as caregivers is of great importance in this respect.

7.2 Recruitment and training of caregivers

Trainings and workshops are held for those older adults who are community health workers and members of support groups. This is where caregivers are provided with basic skills in caring for patients with different illnesses. Older adults who are caregivers are taught the basic diagnostic criteria and symptoms of some common diseases and how they could best deal with them and also how to protect themselves from being infected during care provision. For instance, a village health worker

reiterated: “We do this work voluntarily without getting paid. We were chosen from the community public gathering by other community members and I agreed. We received training from the health centre nearby [pointing at the health clinic] ... we were trained by different facilitators such as the social worker, nurse, first aid officer and nutritionist.” It shows that some older adults received workshop training, that is, non-formal learning.

Community members willing to volunteer are mobilised through public gatherings facilitated by local chiefs and local government councils in the villages. At the gatherings, people are usually made aware of the problem and encouraged to participate as caregivers in community home-based health care, and they are shown how to use local resources. In another scenario, caregivers are relatives and family members of the sick person who are not chosen but receive informal guidance and support from the trained caregivers. Furthermore, other community members such as priests, school teachers, traditional healers and other members of community-based organisations contribute significantly to supporting and caring for people in different conditions of life.

7.3 Sustainability of caregivers’ work

In terms of sustaining their work as caregivers, older adults abide by the principle of voluntarism, which is a person’s willingness to perform a task without expecting payment or anything to be given in return. This reflects Sesotho indigenous learning, for which Matšela (1979) highlighted that one of the Basotho principles was that every person should assist others without expecting payment when there is need. Sesotho indigenous education instilled the love of practical work amongst the older adults. Caregivers further mentioned that they received training and were then given materials such as bandages, cotton wool, pain killers, gloves, methylated spirit, Vaseline as contents for the kit enabling them to perform their caring roles better. However, it should be mentioned that the kit’s contents were not sufficient, as the time for replenishment was not fixed. Another retired professional nurse said:

“We used to hold monthly meetings where caregivers came together to share their experiences, refilled their kits and reported on the challenges they encountered. They even expanded the network of their friendship with people from far villages with whom they even exchanged some knowledge on health issues. They would further indicate that they have acquired skills on how best they could communicate sensitive information among people of different social categories based on the culture, values and norms of their specific society and families, including discussion on sex and HIV/AIDS-related issues with their children, which they previously considered a taboo in Basotho culture.”

The above sentiments from a retired nurse indicate that older adults learned through socio-cultural learning (Taylor et al. 1994) by sharing their experiences (Rao 2008) in social interaction. It is worth noting that the coming together and sharing of experiences by caregivers builds some form of confidence, which could ultimately sustain their involvement and participation as caregivers. This extends to best practices regarding information and knowledge packed with proper skills to deal with different illnesses in a culturally acceptable manner.

7.4 Learning from the challenges of caregiving

Older adults also learned from the challenges of caring, becoming careful not to risk their own lives while performing their caregiving role. An older adult caregiver said:

“We do not have gloves to wear when bathing my child here, we just use our bare hands because there is nothing we can do, and they [support group members] tell us that the contents are finished.”

The lack of gloves was shared as a concern by almost all the caregivers that were interviewed. One village health worker echoed:

“We are reluctant to visit the patients because we cannot touch them with our uncovered hands. We cannot assist them with bathing or even with turning over in their beds. We cannot put ourselves at risk or even put the sick people at risk either.”

Inadequacy and scarcity of resources were reported as some of the challenges encountered by caregivers, as shown above. Another older adult person who was looking after her grandchild said:

“We depend on the support group members’ kit since we can’t afford to buy the painkillers and other dressing materials for my grandchild who has bed sores.”

This has implications for the quality of care given to sick people, including their psychosocial well-being. Some of them might feel isolated, neglected or even discriminated against, which might affect their process of healing. On the other hand, some older adults were careful not to handle the patients without protecting themselves as well.

In fact, caregivers, especially the village health workers and support group members, emphasised that even relatives and family members of sick people are encouraged not to touch the sick with their bare hands. Another challenge was raised by a community volunteer who mentioned that she was caring for a bed-ridden son-in-law, who gives her stress because of his moody and hostile behaviour. This kind of frustration was allegedly worse when caring for patients from poverty-stricken families who have nothing to eat before taking their medication. This was confirmed by a statement from a support group member:

“It is very stressful and practically discouraging to take care of poor, angry and hungry sick people.”

Furthermore, the caregivers expressed a concern that they usually use their families’ resources, resulting in relationship tensions with their family members. This was also confirmed by a local chief, whose wife is a caregiver:

“The worst thing is that my wife would use scarce family resources to buy food for some sick people who have nothing to eat at our own expense. I don’t like that.”

The chief even suggested that it would be better if the government could provide sick people with food packages as a way to ease hunger, particularly those adversely affected patients who are taking medication.

8 Discussion of the findings

The findings demonstrate that older adults were exposed to functional learning where they got information about caregiving modalities. Older adults learned about their caregiving role from the activity of caring for and nursing their sick family members. The way older adults learned affirms the concept of situated learning by Anderson et al. (1996), Brown et al. (1989), because what they learned cannot be separated from the activity of caregiving. Again, the situation upholds African communalism, as described by Sefotho (2018), showing that individuals are embedded in a context of interdependent social relationships and hence not isolated from their environment. The participants stated that they were trained in aspects of behaviour change communication, first aid, basic nursing care skills, nutrition and how to administer medication to patients taking their treatment. These findings are in accordance with Masanja and Kajumi (2013) and Makoae (2015), who suggest that caregivers are trained in a two-fold manner: from basic nursing care to broader livelihood, nutritional and psychological support; and towards treatment-related support, which includes ensuring adherence to ART and monitoring.

Turning now to the way older adults learned about their caregiving role, the data indicate that they received workshop training, sensitisation, and awareness creation through information disseminated at public gatherings. It can be seen that older adults learned informally and non-formally through social and socio-cultural means of learning (Rao 2008; Taylor et al. 1994; Finn 2011; Nicolson and Bayne 1990). The way these older adults remained in their caring role is in line with a key principle of Sesotho indigenous education: that each person must help another who is in need, without expecting payment (Matšela 1979). It was found that older adults volunteered to become caregivers and performed nursing care without receiving any payment; hence they learned through engaging in practical work. It is also worth noting that adult learning, with its emphasis on the freedom to learn and on putting more effort in what one wants to learn in one's own way (Ekoto and Gaikwad 2015; Knowles 1984), has been exercised by older adults, who showed an interest in what seemed relevant to them. However, these findings suggest that older adults learned informally and inconsistently.

It was discovered that older adults sustained their caregiving work as a result of socialisation through what was instilled in them as the love of practical work (Matšela 1979). They stated that they were motivated by the HBC kit contents, which enabled them to do their caregiving work effectively. Another motivating activity was sharing their experiences by exchanging information in a collaborative way. The data confirm research findings indicating that adults learn from their experience (Rao 2008) and are always motivated to learn what serves their interests (Finn 2011; Nicolson and Bayne 1990). Furthermore, the findings show that older adults learn

from the challenges of caregiving, as they carefully took precautions to avoid putting their lives at risk.

However, the data revealed that older adults' caregivers were overwhelmed by taking care of sick members in their homes with little or no resources to provide effective care. This was mentioned by almost all participants of the study. This confirms observations by Obioha and Matsela (2013), who identified several challenges encountered by older adults during their caring role, limiting the chances of them living a quality and comfortable life while ageing. The absence of a national social policy governing the concept of community home-based care in Lesotho is one of the barriers to the success of the concept, Nyanguru (2003) argues. This has implications for how caregivers' wellbeing, welfare and needs are addressed and financed in Lesotho. With proper financing, home care would be a success, because materials and volunteer incentives would be ensured. This would safeguard against poor relationships between caregivers and their relatives whilst addressing issues of food and transport costs.

9 Concluding remarks

The results of this study point to the compromised well-being of older adults due to the magnitude of disruptions like chronic diseases that affect most of the younger generation. Socio-economic and cultural factors play a role as well. Consequently, older adults take over nursing care roles in their homes, communities and society-at-large during their own crucial time of ageing. Older adults perform this caregiving role with few or no resources.

Additionally, they serve as backbones for providing care and support to terminally ill people in the home with little or no support from the government. Some older adults were trained non-formally through workshops, whereas many of them received informal training and information through sensitization meetings, public gatherings and by watching others who performed an activity of nursing. It can be concluded that older adults' learning was inconsistent and not monitored. Moreover, older adults' learning was hampered by a lack of resources. The findings suggest that communalist and social learning were the main (inconsistent) ways in which older adults learned about their caregiving roles.

It is therefore recommended that the government should consider absorbing all caregivers into the health system by giving them employment and that a holistic approach to build the capacity of older adults should be used in which all the existing structures can contribute and participate wherever they can in a collaborative manner. That is, the business sector can provide food packages to patients taking their medication and so on. This will empower older adults to participate in self-help groups and income-generating projects, and it will train them in vocational skills and knowledge alongside caregiving issues. The Lesotho government should demonstrate its willingness to support the work of caregivers, and a social policy that will govern the work of caregivers should be developed. Lastly, the Lesotho policy for older persons needs to roughly indicate how older adults should be empowered to cope with, adapt and adjust to changes in times of disruptions and unforeseen

circumstances. This means that the policy should have a clear training element for older persons in Lesotho.

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