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SYSTEMATIC REVIEW ON EXPERIENCE OF GENDER BASED FOR OLD PEOPLE CARE

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ABSTRACT

The effect of caregiving on the quality of life of informal caregivers and gender stereotypes make informal care for older people a complicated process about which we still know very little. The goal of this review is to find out how gender affects informal carers' experiences of caring for people over 60 with mental and physical health needs. This will be done by putting all of the empirical data published between 2000 and 2020 into one big picture. Using the PRISMA checklist and the ENTREQ statement, a systematic way of reviewing and putting together qualitative data was done. The CASP tool was used to look at how good the papers that were included were. The method that was used was called "thematic synthesis." This review came up with two main themes: how gender affects the work of caregivers and how people deal with their gender identity in relation to themselves, society, and cultural norms. Even though informal caregivers are driven by the same things, traditional gender roles have an effect on how much caregiving they have to do and how they deal with stress. After taking on the role of caregiver, informal caregivers have to keep looking for ways to be independent. Cultural values and how they interact with gender seem to affect how well caregivers adjust to their new roles as caregivers. The ability to cross gender lines could help caregivers reach an agreement with themselves and society about their new caregiving identity. When older people get a lot of informal primary care, it affects both their mental and physical health. Gender ideals about the nurturing role of women make it harder for them to figure out how they will care for others, what strategies and resources they will need, and how they will be able to adjust to their new caregiving role in a positive way.

Keywords: Gender, care, health, facility, and facility care

1.INTRODUCTION

Health inequality and the social determinants of health are not an afterthought when it comes to the things that affect health. [1] Everyone understands that our social environment has a big impact on our physical and mental health. The complicated and intertwined ways in which our

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environment helps or hurts our lives have a big impact on how long we live and what causes our deaths. Because of this, palliative care should put a lot of attention on the social factors that affect how people feel at the end of their lives. In fact, though, it's the other way around. Even though women make up the majority of the population, their health and health care are sometimes treated as a special case or a minority issue when it comes to research funding and practice. [2] If you don't have enough information, your efforts to fix differences between men and women in health care and health outcomes are likely to be both inefficient and ineffective. Furthermore, incorrect information and ignoring evidence about how biological and social differences affect health can make closing the health and health care gaps between men and women more difficult.To keep things simple, we call these differences between men and women "gender differences," but they can be both biological (caused by sex) and social (i.e., gender-based). Even though these differences don't always favour men, improving women's health will require a systematic look at how and how much access, treatments, and outcomes are different for men and women. Access, quality, and outcomes of care won't be able to be tracked by gender until then. This means that differences in treatment won't be able to be measured, and potential intervention points won't be studied enough. Gender-based analysis can lay the groundwork for better decision tools and interventions, which can improve both women's and men's health and health care. To solve this problem, research, policy, practise, and publishing need to be led by people with new ideas. [3] A lot of the problems with women's health research stem from the fact that there aren't enough requirements for gender-based analyses, which try to figure out how different certain findings are for women and men. Yet, neither the NIH nor the Agency for Healthcare Research and Quality, which funds health services research, requires samples large enough to allow gender-based analyses or requires gender-stratified analyses when it is possible to do so. [4] In contrast, since December 2010, the Canadian Institutes of Health Research (CIHR), which funds projects and researchers across the full range of clinical and health services research, has required that all research funding applicants answer mandatory questions about whether and how they will look at gender and sex, or why they don't plan to do so. This policy is meant to make applicants more aware of gender differences and may encourage them to include enough women in their samples to look for important differences and do analyses. In the United States, there is no similar standard, but investigators must explain why they want to do single-sex studies when they propose them. [5] Most people who take care of the elderly are women. Nearly 70% to 80% of elderly people with disabilities are cared for at home by their families. Estimates from different countries show that between 57% and 81% of the people who care for the elderly are women. Most of the time, the older person's wife or adult daughter is taking care of her. They are usually in their middle years, and a large number of them are over 65 years old. Also, they are more likely to work outside the home than they were in the past. Most of the elderly people who get care are frail or have long-term physical illnesses. However, the majority have dementia or other mental illnesses. Even though women are more common, men are under more pressure to care for the elderly because people are living longer, more women are working outside the home, and families are getting smaller. In the 1980s, studies in the

United States showed that, even though most caregivers were women, between 20% and 33% of those who helped the elderly were men. More recently, it has been said that the number of men who care for the elderly has been steadily rising, to the point where men may be nearly half of the elderly's main caregivers. Even though more and more men are becoming caregivers, research has not taken this into account and continues to focus on female caregivers as it always has. Even though it seems like men take caregiving in different ways, men's experiences with caregiving have not been looked at as much as women's.

How caregiving is different for men and women

Several studies have shown that the experience of caring for someone is different for men and women. There are differences in how care is given to people with dementia or physical illnesses based on their gender in a number of areas.

Time spent taking care of someone and how long it lasts:

Several reviews and studies on caregiving have looked at how much time men and women spend on caregiving. Some of them have come to the conclusion that, even though there are different reports, most of the evidence shows that women spend more time caring for the elderly than men do. In a detailed narrative review of research reports, it was found that most studies that looked at how much time men and women spend caring for others found that women spend more time caring for others than men. People have said that women are more likely to care for the elderly because they are less likely to work outside the home. This is because paid work is different for men and women. People think that women's jobs revolve around the home, which may show that women have a stronger sense of family duty. This makes it more likely that women will spend more time caring for others. Long-term care is also more likely to be provided by women in societies and cultures that value the traditional role of the woman as caregiver.But research results about how much time men and women spend caring for others have not always been the same. Several reviews and studies have not found that gender is a good predictor of how much time is spent caring for someone. In particular, two meta-analytic reviews, one of which included studies, came to the conclusion that, even though women spent more time taking care of others, the differences between men and women in this area were small and probably didn't matter much in the real world. There is also a lot of agreement that the differences between men and women in how much time they spend caring for others are complicated by things like family ties (spouses vs. children) and cultural or ethnic differences. When it comes to how long caregiving lasts, most people agree that gender doesn't affect how long caregiving lasts overall. [6]

Healthcare system and discrimination against women:

People know that social, cultural, and economic structures have an effect on health care systems. So, health systems are seen not only as "producers of health and health care" but also

as "providers of a wider set of societal norms and values," many of which are biassed against women. According to a WHO report, health systems in many countries haven't been able to provide equal health care for men and women because they don't take into account that their needs can be very different. [7] The way women are seen as both users (people who get health care) and providers (people who give care) of health care services can contribute to health differences between men and women. When it comes to reproductive health services, they are often given to women as a way to control their fertility rather than as care for their health. Even though most of the people who work in health care systems are women, many of the working conditions are still unfair to women. Women are often expected to follow male role models that don't take into account their unique needs, like taking care of children or staying safe from violence. This makes it much harder and less effective for female caregivers to take care of patients, especially female patients.

2. MATERIALS AND METHOD

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement were used to do a systematic review and synthesis of qualitative data.The International Prospective Register of Systematic Reviews has put this protocol for a systematic review on file (PROSPERO).

Methodology

There are different ways to put together a synthesis of qualitative evidence, and the degree of interpretiveness is a topic of ongoing debate. Qualitative research comes from many different fields and traditions, each with its own philosophy. Data synthesis methods need to be in line with the main studies' philosophical assumptions, and extra care needs to be taken not to break these philosophical assumptions during the synthesis process. This review used the RETREAT framework, which focuses on qualitative syntheses and helps choose the right synthesis method. The thematic synthesis method was chosen by using the framework. Coding the included studies is part of thematic synthesis, which is used to come up with descriptive and analytical themes.

Criteria for eligibility

This review looked at studies that came out between 2000 and 2020. They were written in either English or Greek, and the author has access to the full text. Since 2000, gender analysis in research studies has grown by leaps and bounds, and gender issues have become an important part of strategy and policymaking. This time period gave us enough time to include a good number of studies that looked at gender.

3. RESULTS

Twenty-one studies met the criteria for this review and were looked at. They used first-hand information from 484 participants, 329 of whom were women and 155 of whom were men. In two of the studies, the same men and women took part, and in two of the other studies, the same men took part. Ten of the studies were done in the United States with participants who were Native American, Asian, African, Hispanic, or Chinese. Two were done in Canada, two in Japan, one in Sweden, one in Poland, one in China, one in Mexico, one in Portugal, one in Australia, and the last one was done in Israel with Russian women as participants. The people who took part had different levels of education and jobs, and most of them took care of a spouse or partner. Fewer were daughters, daughters-in-law, sons, and other relatives whose relationship status was not specified by the studies. The people who participated in the informal careers ranged in age from 38 to over 80.Twenty studies used qualitative methods to collect data, and one study used a semi-structured questionnaire to collect both quantitative and qualitative data. Twelve studies looked at caregiving by a spouse or partner, six looked at caregiving by family members, and three looked at both.

4.DISCUSSIONS

This review conducted a thematic synthesis of qualitative studies that investigated how gender influences the experiences of informal caregivers of the elderly.[9] Two analytical themes came out of putting all the data together: a) how gender affects the work of caregivers, and b) how gender identity is negotiated with oneself, society, and cultural norms. These analysis themes demonstrate how gender influences how caring for older people feels.The results show that caregiving arrangements in households are based on gender. Gender affects the caregivers' reasons for providing care, how they do the caring tasks, and how they deal with the caregiving burden. [10] Gender affects a person's ability to adapt to their new role as a caretaker at the crucial and sudden moment when they become a caretaker and their life changes, as well as during the whole care process. Gender interacts with the caregiver's relationship to the person getting care, as well as with other identity-defining factors like age and ethnicity, which makes it harder for some caregivers to get jobs. All of these findings show that gender has a big effect on how informal care is given by family to older people.

5. CONCLUSIONS

The goal of this systematic review of the literature was to find out how gender affects the experiences of older people's informal caregivers. [11] When older people get a lot of informal primary care, it affects both their mental and physical health. Gender stereotypes about the nurturing role of women make it harder for them to make decisions about how they will care for others, what strategies and resources they will use, and how well they can adjust to their new role. Men seem to be more willing to talk about their hegemonic masculinity and defend their role as caretakers. [12] Women and men both have informal careers because they love, care about, and feel like they have a duty to take care of their loved ones. Informal caregivers,

both women and men, are driven by the same things, but traditional gender stereotypes affect women and men in different ways. When it comes to caregiving, women who are influenced by traditional female roles are more emotional, while men who are influenced by traditional male roles are more practical. [14] Also, there is a link between traditional gender stereotypes and how women and men feel about caring for others and how they deal with it. Men and women adapt to their new roles as caregivers in different ways because of gender stereotypes. Women use coping strategies that are more focused on their feelings, while men use coping strategies that are more focused on solving problems. Crossing gender lines and making more choices about gender can make being a caregiver easier and help people deal with stress better. By using the language of diversity in caring information and caring processes, health professionals can give informal careers the power to challenge gender binaries and open up more gender options. [15] Lastly, the review's results suggest a path for future research on gender identity development in the care of older people, focusing on how gender interacts with other identity-defining factors like ethnicity, age, and class. There is a need for multimethod research that is sensitive to gender and culture and includes people of all genders. Future studies need to go beyond the usual ways of judging femininity and masculinity and look at how gender affects the experiences of informal caregivers.

REFERENCES

1. Baumann, Lurbe - Puerto, , “Increased residual disability among poststroke survivors and the repercussions for the lives of informal caregivers”. Top Stroke Rehabil. ,Vol 18, Issue (2), page 162-71,2011.
2. Bruce Ovbiagele. “Stroke Epidemiology: Advancing Our Understanding of Disease Mechanism and Therapy”. Neurotherapeutics. Vol 8 , Issue (3); 2011
3. BeenaT, Malathi, “Risk status of stroke among adults and the effectiveness of an awareness program on primary prevention of stroke”. International journal of nursing ,Vol 3, Issue (2), page 12-14,2011.
4. Burton CR. “A description of the nursing role in stroke rehabilitation”.J Adv Nurs; vol 32, issue (1),page 174-1,2000.
5. Cullagh EM,Brigstocke G,. “Determinants of care giving burden and quality of life of caregivers of stroke patients”. Stroke;Vol 36, issue (1), page 21-81,2005.
6. Cameron, V. “Best Practices for stroke patient and family education in the acute care setting: a literature review”. Med-Surgical Nursing. Vol 22, issue (1),page 51-55,2013.
7. Elisabeth T.P, et al, “Long-term effects of a group support program and an individual support program for informal caregivers of stroke patients: which caregivers benefit the most, patient education and counselling”, vol. 47, Issue (4), pages 291- 299, 2002.
8. Exel J, "Give me a break, informal caregiver attitude towards respite care”. Health policy; Vol 88, issue (1), page 73-87,2008.
9. Gallagher-Thompson D, Choryan Bilbrey A, Apesoa-Varano EC, Ghatak R, Kim KK, Cothran F, et al. “Conceptual framework to guide intervention research across the trajectory of dementia caregiving”. Gerontologist.; Vol 60, issue (1), page 29 –40,2020

10. Knight BG, Sayegh P. “Cultural values and caregiving: the updated sociocultural stress and coping model”. J Gerontol Ser B Psychol Sci Soc Sci.;Vol 65,issue (1), page 5 – 13,2010
11. McLean KC, Shucard H, Syed M. “Applying the master narrative framework to gender identity development in emerging adulthood”. Emerg Adulthood. Vol 5, Issue (2), Page 93 –105,2017.
12. McLean KC, Pasupathi M. “Processes of identity development: where i am and how i got there”. Identity. Vol 12,Issue (1), page 8 –28,2012.
13. Friedemann ML, Buckwalter KC. “Family caregiver role and burden related to gender and family relationships”. J Fam Nurs. Vol 20,Issue (3), page 313 –36,2014.
14. Kashdan TB, Rottenberg J. “Psychological flexibility as a fundamental aspect of health”. Clin Psychol Rev. Vol 30, Issue (1), page 865 –78,2010.
15. Shifren K. “Caregiving identity and flexibility. In: Identity flexibility during adulthood: perspectives in adult development”: Springer International Publishing; Vol 1.Issue (1), page 289 –301,2017.