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Experience of Family Caregivers in ENT and Cervico-Maxillo-Facial Surgery Wards: A Thematic Analysis in Yaounde

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Abstract **Original Research Article**

Background*:** The quality of hospital care is a major determinant of patient satisfaction and therapeutic effectiveness, particularly in resource-limited settings where family caregivers play a central role. This study aims to explore family caregivers' perceptions of care quality in ENT and cervico-maxillo-facial surgery wards at Yaoundé Central Hospital. ***Subjects and Methods: We conducted a qualitative exploratory study between January and June 2024 at Yaounde Central Hospital. Purposive sampling was used to recruit 67 family caregivers of patients hospitalized in ENT and cervico-maxillo-facial surgery. In-depth semi-structured interviews (45±10 minutes) were conducted until data saturation. The interview guide explored five dimensions: care experience, communication with healthcare staff, hospital environment, challenges encountered, and improvement suggestions. Data were transcribed verbatim and analyzed using Braun and Clarke's thematic approach with NVivo 12 software. Data triangulation was performed by comparing interviews with direct observations and field notes. Reliability was ensured through independent double coding and participant verification. ***Results*:** Five major themes emerged from the thematic analysis: (1) communication with healthcare staff (75% of participants emphasizing its critical importance); (2) hospitalization conditions, including hygiene and infrastructure (90%); (3) availability of medications and medical equipment (80%); (4) involvement in care and need for training (60%); and (5) influence of cultural factors on expectations and perceived role of family caregivers (95%). Illustrative verbatim quotes were selected for each theme, demonstrating the impact of these factors on the overall experience of family caregivers. ***Conclusion*:** This study highlights the need for a holistic and culturally adapted approach to improve care quality, integrating the perspective of family caregivers as essential stakeholders in the therapeutic process. Targeted interventions focusing on communication, infrastructure improvement, resource management, and family training could significantly enhance the care experience.

Keywords: Family Caregivers, ENT, Cervico-Maxillo-Facial Surgery, Thematic Analysis, Yaounde.

1. INTRODUCTION

The quality of hospital care is a major determinant of patient satisfaction and treatment effectiveness [1]. It encompasses not only the technical aspects of care but also communication, respect for patients' rights, and the hospital environment [2]. In many African countries, particularly in Cameroon, the healthcare system faces significant structural challenges: shortage of healthcare personnel, inadequate infrastructure, and limited material resources [3, 4]. In this context, the role of family caregivers—generally family members who accompany the patient during hospitalization—becomes essential [5].

These companions ensure a continuous presence with patients, thus filling gaps in the healthcare system in terms of personnel and resources [6]. They actively participate in daily care, feeding, hygiene, and psychological support for the patient, thus becoming indispensable actors in patient care [7]. Despite this

significant contribution, few studies in Cameroon have explored the perspective of family caregivers on the quality of care, particularly in specialized services such as ENT and cervico-maxillo-facial surgery.

These services present important particularities: the pathologies treated often affect essential functions such as breathing, swallowing, phonation, and facial appearance, with considerable functional, aesthetic, and psychosocial implications [8]. The complexity of post-operative care and potential sequelae require particular involvement of family caregivers [9].

This study aims to fill this gap in the literature by systematically exploring family caregivers' perceptions of the quality of care in ENT and cervico-maxillo-facial surgery hospitalization at Yaounde Central Hospital. By identifying factors influencing their satisfaction and the challenges they face, we seek to provide evidence to guide interventions aimed at improving the overall quality of care in this specific context.

2. MATERIALS AND METHODS

2.1 Conceptual Framework and Research Paradigm

This study is situated within the constructivist paradigm, recognizing that perceptions of care quality are socially constructed and contextually anchored [10]. We adopted Donabedian's conceptual framework [11], adapted to the African context by De Brouwere *et al*., [3], which structures the evaluation of care quality according to three dimensions: structure (material and human resources), process (interactions and procedures), and outcomes (satisfaction and experience).

2.2 Study Design

We conducted a qualitative exploratory study using Braun and Clarke's thematic analysis approach [12]. This methodology was chosen for its ability to identify, analyze, and report patterns (themes) within the data, while offering a rich interpretation of the phenomenon under study [13].

2.3 Study Setting

The study was conducted at Yaounde Central Hospital (YCH), a reference hospital in Cameroon.

3. Population and Sampling

3.1 Sampling Strategy

Purposive sampling was employed to select participants, ensuring maximum diversity according to the following criteria:

- Type of pathology (trauma, tumors, infections)
- Duration of hospitalization (short: <7 days, medium: 7-14 days, long: >14 days)
- Relationship with the patient (spouse, parent, child, sibling, other)
- Age and gender of the family caregiver

This approach allowed us to capture the diversity of experiences and perspectives.

4. Inclusion and Exclusion Criteria

4.1 Inclusion Criteria:

- Being a family caregiver of a patient hospitalized in the ENT and cervico-maxillo-facial surgery department
- Continuous presence of at least 48 hours with the patient
- Age ≥18 years
- Informed consent to participate in the study

4.2 Exclusion criteria:

- Professional paid caregivers
- Inability to communicate in French or English
- Refusal to participate in the study

5. Sample Size

Recruitment continued until data saturation, that is, until no new substantial information emerged from the interviews [14]. This saturation was reached after 67 interviews.

6. Data Collection

6.1 Preparation and Piloting of Tools

A semi-structured interview guide was developed based on existing literature and the study objectives. This guide was piloted with five family caregivers not included in the final sample, allowing for adjustments to improve the clarity and relevance of questions.

6.2 Interview Guide

The interview guide explored five main dimensions:

- General care experience and daily interactions
- Communication with healthcare staff (frequency, quality, understanding)
- Perception of the hospital environment (comfort, hygiene, privacy)
- Challenges and obstacles encountered during hospitalization
- Suggestions for improving care quality

Follow-up and in-depth questions were used to encourage participants to elaborate on their responses.

6.3 Interview Procedure

Individual interviews were conducted by the principal researcher and a research assistant trained in qualitative interview techniques. Interviews took place in a private space within the hospital, ensuring confidentiality. Each interview lasted an average of 45 minutes (±10 minutes) and was recorded with the participant's consent. Field notes were taken during and immediately after each interview to capture non-verbal observations and immediate reflections.

6.4 Direct Observations

As a complement to the interviews, structured direct observations were conducted in the hospitalization services to contextualize the interview data and allow triangulation. These observations were documented according to a pre-established grid, covering the physical environment, interactions between family caregivers and healthcare staff, and the daily activities of family caregivers.

7. Data Analysis

7.1 Transcription and Data Preparation

All interviews were transcribed verbatim within 48 hours of their completion. Transcriptions were checked for accuracy by comparison with audio recordings, then imported into NVivo 12 software (QSR International) to facilitate the organization and systematic analysis of data.

7.2 Thematic Analysis Process

The analysis followed the six steps of thematic analysis according to Braun and Clarke [12]:

- Familiarization with the data: repeated reading of transcriptions and field notes
- Generation of initial codes: systematic coding of interesting characteristics of the data
- Search for themes: grouping codes into potential themes
- Review of themes: checking the consistency of themes in relation to coded extracts and the entire dataset
- Definition and naming of themes: refining the specificities of each theme and generating clear definitions
- Production of the report: selection of convincing extracts, final analysis, and relating to the literature

7.3 Quality Assurance and Methodological Rigor

Several strategies were employed to ensure methodological rigor:

- Source triangulation: comparison of interview data with direct observations and field notes
- Participant verification: preliminary interpretations were shared with a subset of participants (n=10) for validation
- Double coding: two researchers independently coded 20% of transcriptions, with discussion of discrepancies until consensus (Cohen's kappa coefficient = 0.82)
- External audit: an experienced qualitative researcher not involved in the study reviewed the analysis process and interpretations
- Reflexivity: maintaining a reflexive journal documenting the researcher's assumptions and positions throughout the process

8. Ethical Considerations

This study received approval from the Institutional Ethics Committee of the Faculty of Medicine and Biomedical Sciences of the University of Yaoundé I. Administrative authorization was also obtained from the management of Yaoundé Central Hospital.

Written informed consent was obtained from all participants before the interviews. Participation was entirely voluntary, and participants could withdraw at any time without consequence. Confidentiality was strictly respected: data were anonymized, recordings stored on a secure password-protected device, and only the principal researchers had access to them. The quotations used in this report were anonymized to prevent any identification of participants.

3. RESULTS

3.1. Participant Characteristics

The final sample included 67 family caregivers, whose sociodemographic characteristics are presented in Table 1. The mean age was 42.3 years (±11.5), with a female predominance (58.2%). The majority of family caregivers were close family members (spouse, parent, child, sibling) (85.1%), and nearly half (47.8%) had a secondary level of education. (Table 1)

Table 1: Sociodemographic Characteristics of Family Caregivers (N=67)

Characteristics	n (%)
Age (years)	
18-30	15 (22.4)
31-45	28 (41.8)
46-60	19 (28.4)
>60	5 (7.5)
Gender	
Female	39 (58.2)
Male	28 (41.8)
Relationship with the patient	
Spouse	23 (34.3)
Parent	18 (26.9)
Child	10 (14.9)
Sibling	6 (9.0)

Characteristics	n (%)
Other family	8 (11.9)
Friend	2 (3.0)
Education level	
None/Primary	12 (17.9)
Secondary	32 (47.8)
Higher education	23 (34.3)
Length of hospital stay	
<7 days	24 (35.8)
7-14 days	29 (43.3)
>14 days	14 (20.9)
Patient's pathology	
Trauma	19 (28.4)
Tumor	26 (38.8)
Infection	15 (22.4)
Other	7 (10.4)

3.2. Emerging Themes

Thematic analysis revealed five major themes influencing family caregivers' perception of care quality: (1) communication with healthcare staff, (2) hospitalization conditions, (3) availability of medications and equipment, (4) involvement in care, and (5) cultural factors.

Theme 1: Communication with Healthcare Staff

The quality of communication with healthcare staff was identified as a determining factor of satisfaction by 75% (n=50) of family caregivers. This communication encompassed several dimensions: staff accessibility, clarity of explanations, active listening, and respect.

Participants particularly valued clear explanations regarding diagnosis, treatment, and post-operative care:

> "When the doctor takes time to explain what's happening with my son, I feel calmer and have confidence in what they're doing. But sometimes, they talk among themselves using terms I don't understand, and I feel excluded." (Patient 23, male, 47 years, father of a 17-year-old patient)

The analysis revealed significant variation in the perceived quality of communication according to the education level of family caregivers and the professional status of healthcare staff. Family caregivers with lower education levels reported more difficulties understanding medical information and asking questions:

> "I didn't go to school for long, so when they talk with all these medical words, I don't understand anything. I'm afraid to ask questions because I don't want to appear ignorant or disturb the doctors who are very busy." (Patient 42, female, 56 years, mother of a 23-year-old patient)

Language barriers were also identified as a major obstacle, particularly for family caregivers from rural areas who are not fluent in French or English:

> "I mainly speak Bassa. French, I understand a little, but when they speak quickly or use technical words, I'm lost. Fortunately, my niece who is more educated sometimes comes to help me understand." (Patient 19, female, 61 years, aunt of a 34-year-old patient)

Theme 2: Hospitalization Conditions

The material conditions of hospitalization were mentioned by 90% (n=60) of participants as a crucial element of their experience. This theme encompassed the hygiene of the premises, comfort of facilities, availability of basic services such as water and electricity, and space management.

The hygiene of the premises, particularly toilets and common areas, was a major concern:

> "The toilets are often dirty and there isn't always water. I have to bring buckets of water from outside to clean my mother. This is not worthy of a hospital." (Patient 42, female, 39 years, daughter of a 68-year-old patient)

The lack of space and appropriate beds for family caregivers was also frequently mentioned:

> "At night, I sleep on a mat on the floor next to my husband's bed. It's very uncomfortable and I wake up with pain everywhere. After two weeks like this, I'm exhausted, which affects my ability to take good care of him." (Patient 15, female, 43 years, wife of a 53-year-old patient)

Frequent power and water outages were described as particularly problematic, affecting the quality of care and adding to the stress of family caregivers:

> "When electricity is cut, sometimes for hours, especially at night, it's very distressing. My father needs oxygen, and I constantly worry about whether the equipment is working properly." (Patient 31, male, 36 years, son of a 74-year-old patient)

Theme 3: Availability of Medications and Equipment

Access to necessary medications and medical equipment was identified as a major challenge by 80% (n=54) of family caregivers. This issue had several aspects: stock shortages at the hospital pharmacy, high cost of medications in private pharmacies, and difficulty finding certain specific medications.

"I was given a prescription and had to search five different pharmacies before finding all the medications. Meanwhile, my husband was suffering. It's frustrating when the hospital can't provide the medications he urgently needs." (Patient 15, female, 43 years, wife of a 53-year-old patient)

The financial burden of these endeavors was highlighted by many participants:

> "The medications are very expensive, especially those for infections after surgery. I had to borrow money from the whole family. And when a medication isn't available at the hospital, we have to buy it outside at a much higher price." (Patient 38, male, 41 years, brother of a 33-year-old patient)

The lack of transparency regarding medication availability and the need to sometimes make informal payments were also mentioned:

> "Sometimes, you're told a medication isn't available, but if you know someone or if you pay a little more, miraculously it appears. This system isn't fair for those who don't have connections or extra money." (Patient 27, male, 52 years, uncle of a 22-year-old patient)

Theme 4: Involvement in Care

Involvement in patient care was a significant theme for 60% (n=40) of family caregivers, who expressed the desire to be more integrated into the care process. This theme included participation in medical decisions, training in basic care techniques, and recognition of their role in the patient's recovery.

"I would like to know how to help him properly with eating and washing. Sometimes, I'm afraid of doing something wrong or causing an infection. If someone could show me how to do it, I would be more useful." (Patient 31, male, 29 years, nephew of a 45-year-old patient)

The need for information and adapted training was particularly emphasized for specific care related to ENT and maxillofacial pathologies:

> "After the throat surgery, my sister had trouble swallowing. No one explained to me how to help her eat without risk of choking. I had to learn by trial and error, which was stressful for both of us." (Patient 7, female, 34 years, sister of a 29-year-old patient)

Family caregivers also expressed the wish to be more consulted in medical decisions, believing that they knew the patient well and could provide valuable information:

> "Doctors decide on treatment without really asking for our opinion. Yet, I know my father better than anyone. I know how he usually reacts to medications, his allergies, his preferences. This information could be useful." (Patient 44, male, 33 years, son of a 67-year-old patient)

Theme 5: Cultural Factors

Cultural factors had a significant influence on the perceptions and expectations of family caregivers, mentioned by 95% (n=63) of participants. This theme encompassed traditional beliefs about illness and healing, the importance of family support, and cultural practices surrounding care.

"In our culture, we don't leave a family member alone in the hospital. It's our responsibility to stay with them, pray for them, give them courage. It's not just about physical care, it's also spiritual and emotional." (Patient 7, female, 34 years, sister of a 29-year-old patient)

The notion of reciprocity in care, particularly toward elderly parents, was frequently mentioned:

> "My mother took care of me all my life. Now that she is sick, it's my turn to take care of her. It's a duty, a way to give back what she gave me." (Patient 12, male, 38 years, son of a 72-year-old patient)

The integration of traditional practices into hospital care was also an important topic:

> "Some traditional remedies really help relieve pain and accelerate healing. I bring my brother herbal teas prepared by our village healer. I do it discreetly because I don't know if it's allowed, but in our tradition, it's important." (Patient 38, male, 41 years, brother of a 33-year-old patient)

3.3. Cross-analysis and Interrelationships between Themes

The analysis revealed significant interrelationships between the five identified themes. For example, the quality of communication directly influenced the level of involvement of family caregivers in care. Similarly, hospitalization conditions and resource availability had an impact on the overall perception of care quality, regardless of the technical competence of medical staff.

Cultural factors acted as a lens through which other aspects of the hospital experience were interpreted and evaluated. This complex interconnection underscores the need for a holistic approach to improve the experience of family caregivers.

4. DISCUSSION

This study provides an in-depth insight into the perceptions of family caregivers regarding the quality of care in ENT and cervico-maxillo-facial surgery hospitalization at Yaoundé Central Hospital. Our results highlight five interdependent dimensions that shape their experience: communication, hospitalization conditions, resource availability, involvement in care, and cultural factors.

4.1. Communication and Therapeutic Relationship

Our findings regarding the crucial importance of communication align with those of Street *et al*., [15], who demonstrated that the quality of communication directly influences participation in medical decisions and overall satisfaction. However, our study goes further by identifying challenges specific to the Cameroonian context, particularly language barriers and differences in education level.

These communication obstacles can be particularly problematic in the context of ENT and maxillofacial pathologies, where understanding complex post-operative care is essential to prevent complications [16]. As highlighted by Napier *et al*., [17], effective intercultural communication in hospital settings requires not only linguistic skills but also sensitivity to cultural norms that shape the understanding of illness and treatments.

A promising strategy to overcome these obstacles would be to develop visual and multilingual information supports adapted to the local context, as well as training healthcare staff in transcultural communication techniques [18]. The use of trained interpreters or cultural mediators could also significantly improve the quality of exchanges, particularly for patients and family caregivers from rural areas [19].

4.2. Material Conditions and Care Experience

Concerns about hygiene, comfort, and basic infrastructure corroborate WHO findings on the importance of the physical environment in care quality [20]. Our study reveals that these material factors are not simply "extras" but essential components of the care experience that directly influence the dignity and well-being of patients and their family caregivers.

The challenges identified reflect the broader structural constraints of the Cameroonian healthcare system, characterized by chronic underfunding and insufficient infrastructure maintenance [21]. However, even in this context of limited resources, targeted improvements are possible, as suggested by Kruk *et al*., [22], in their study on low-cost interventions to improve care quality in low- and middle-income countries.

Pragmatic solutions could include creating dedicated spaces for family caregivers in hospital rooms, improving cleaning protocols, and installing backup power systems for essential equipment. These relatively modest interventions could have a significant impact on the overall care experience.

4.3. Resource Availability and Equity of Access

The difficulties in accessing medications and medical equipment identified in our study raise important questions of equity and governance in the healthcare system [23]. Our findings echo the work of Bigdeli *et al*., [24], on barriers to accessing essential medicines in developing countries, but add an important dimension by highlighting the additional burden these constraints impose on family caregivers.

The obligation for families to seek medications outside the hospital not only increases the cost of care but also compromises treatment continuity. This situation is particularly concerning for ENT and maxillofacial patients, whose post-operative treatments often require specific antibiotics to prevent infections in anatomically complex and high-risk areas [25].

The informal payments mentioned by some participants also reveal systemic governance issues that require political and institutional interventions [26]. More transparent and efficient stock management systems, coupled with innovative financing mechanisms such as solidarity funds or community health mutual funds, could help improve equitable access to essential medicines [27].

4.4. Involvement of Family Caregivers and Family-Centered Care

The desire expressed by family caregivers to be more involved in care aligns with the global trend toward more collaborative and family-centered care approaches [28]. However, our study shows that this involvement in the Cameroonian context is not just preferential but often necessary due to constraints in healthcare personnel.

This reality contrasts with Western models where family involvement is generally considered complementary rather than fundamental [29]. As highlighted by Jaffré and Olivier de Sardan [30], in their work on healthcare systems in West Africa, the presence of family caregivers addresses a structural necessity that health policies must recognize and support rather than merely tolerate.

The formal integration of family caregivers into the care team, with appropriate training on basic techniques adapted to ENT and maxillofacial pathologies, could not only improve the quality of care but also reduce the anxiety and sense of helplessness often reported by families [31]. "Care partnership" models adapted to the African context, such as that proposed by Rispel *et al*., [32], offer promising avenues for this integration.

4.5. Cultural Dimensions and Contextualized Care

The strong influence of cultural factors identified in our study underscores the importance of a culturally sensitive and contextualized approach to care [33]. Our results reveal that for 95% of participants, presence with the sick person is not simply a response to system gaps but is part of a deeply rooted conception of family duty and reciprocity relationships.

This cultural dimension is often neglected in standardized approaches to care quality, which tend to prioritize technical and measurable aspects [34]. As demonstrated by Airhihenbuwa *et al*., [35], in their work on public health in Africa, interventions that do not take into account local cultural frameworks risk having limited effectiveness and acceptability.

The integration of traditional practices mentioned by some participants raises complex questions about the coexistence of different medical systems. Rather than ignoring or opposing these practices, a more productive approach would be to establish an open and respectful dialogue with family caregivers to identify safe and potentially beneficial complementary practices [36].

5. Implications for Clinical Practice and Health Policies

Our findings have several important implications for clinical practice and health policies in the context of hospital care in Cameroon:

- Improving communication: Develop communication training programs for healthcare staff, with particular emphasis on transcultural communication and the use of visual tools to overcome language barriers.
- Formal recognition of the role of family caregivers: Integrate family caregivers into hospital policies, with clear protocols defining their role, responsibilities, and rights.
- Training family caregivers: Create simple and adapted training modules for family caregivers on specific care for ENT and maxillofacial pathologies, including feeding, hygiene, and recognition of complications.
- Improving infrastructure: Invest in basic facilities for family caregivers (rest areas, secure lockers, access to water and sanitary facilities).
- Transparent medication management: Implement information systems on medication availability and develop alternatives for stock shortage situations.
- Culturally sensitive approach: Develop care protocols that recognize and respect local cultural practices, while ensuring patient safety.
- Participatory research: Involve family caregivers in identifying problems and developing solutions adapted to the local context.

6. Strengths and Limitations of the Study

6.1. Strengths

This study presents several notable methodological strengths. First, the use of an in-depth qualitative approach allowed for capturing the richness and complexity of family caregivers' experiences, offering insights that would not have emerged from a quantitative survey. Second, purposive sampling ensured a diversity of perspectives in terms of age, gender, education level, and type of pathology. Third, data triangulation with direct observations strengthened the validity of the results. Finally, the rigorous thematic analysis approach allowed for identifying significant patterns while preserving the richness of individual testimonies.

6.2. Limitations

Despite these strengths, our study has certain limitations. First, it was conducted in a single hospital in Yaoundé, which may limit the generalization of results to other hospital contexts in Cameroon or the region. Second, despite purposive sampling, some categories of family caregivers might be underrepresented, particularly those with significant language barriers who were excluded by our criteria. Third, the qualitative nature of the study does not allow for establishing precise causal relationships between the identified factors and overall satisfaction. Complementary quantitative studies would be necessary to confirm and quantify these relationships.

Fourth, the presence of researchers in the hospital environment may have influenced some responses, although various strategies were employed to minimize this bias, including establishing a relationship of trust and ensuring confidentiality.

Finally, our study did not include the perspectives of healthcare staff, which could have provided complementary insight into interactions with family caregivers.

7. CONCLUSION

This study highlights the complexity and multidimensionality of the experience of family caregivers in ENT and cervico-maxillo-facial surgery services at Yaoundé Central Hospital. Our findings demonstrate that their satisfaction is influenced by an interweaving of medical, environmental, interpersonal, and cultural factors that must be considered as a whole to truly improve the quality of care.

Improving the quality of care in ENT and maxillofacial hospitalization in Cameroon is not limited to technical adjustments; it requires a profound transformation of our approach. This study reveals that the voice of family caregivers, often relegated to the

background, constitutes an essential barometer of care quality. Their experiences, marked by emotions and pragmatic concerns, highlight crucial issues: the need for compassionate and culturally adapted communication, improvement of hospitalization conditions for a more humane environment, guaranteeing the availability of resources for effective care, and formal recognition of family involvement as full partners in the therapeutic process.

These findings call for a holistic approach that recognizes the central role of family caregivers in the Cameroonian healthcare system, not as a temporary solution to structural deficiencies, but as a culturally significant expression of family and community solidarity values. By integrating these perspectives into hospital policies and practices, we are not simply improving quality indicators, we are humanizing the hospital experience by creating an environment where compassion, listening, and mutual respect are at the heart of every interaction.

This transformation, guided by evidence and anchored in local realities, represents an essential step toward more equitable, effective, and culturally resonant healthcare systems, capable of responding to the complex needs of patients and their families in the specific context of sub-Saharan Africa.

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Authors' contributions: Nkolo Tolo Francis Daniel and Obono Ekamena Mariane designed and directed the study, participated in the data collection and analysis, and wrote the first draft of the manuscript.

Meva'a Bioule Roger Christian contributed to the study design, data collection, and critical revision of the manuscript.

Aba'a Marthe Dereine participated in the data collection and interpretation of the results.
Nseme Etoukey Eric contributed to the data analysis and revision of the manuscript.
All authors read and approved the final version of the manuscript.

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