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training and skills needed for long-term care

Erkuden Aldaz Arroyo[1], Elisa Berrios Prieto[2], Laura Fernández Cordero[3], Mónica Leiva Marín[4], Laura C. López Franco[5], Alejandro López Gómez[6], Fiorella Benedetti[7], Pura Díaz-Veiga[8]

Abstract[9]

The accelerated process of population aging in Latin America and the Caribbean is leading to an increase in the number of older persons and, in particular, of those who are in a situation of functional dependence and need care. To ensure this is high quality care, one of the challenges the countries of the region face is the training of caregivers.

In a survey of caregivers in Colombia, Costa Rica and Uruguay, we found that the level of training of most caregivers is low or nonexistent. There are gaps in technical skills (e.g., how to support changes in posture), relational skills (e.g., how to tackle depression or communicate with persons with dementia) and self-care skills. We also found significant gaps in the number of trained caregivers by country.

Likewise, with the aim of promoting training and professionalization of the care sector, one of the added values of this study is that we analyze and compare, for the first time, training policies, curricula, approaches, contents and methodologies in Latin America and the Caribbean, and internationally. In this research, which arises from a technical cooperation executed by the Astur Foundation, we have particularly studied the cases of Colombia, Costa Rica, Uruguay, Spain, Finland, France and Italy. One of the main findings is that training programs in the region are in transition from a service-based model to a person-centered model.

In addition, another added value of this study is that, based on the lessons learned from good practices in Latin America and the Caribbean and internationally, and on the skills gaps identified in caregivers, we propose four training courses. The novelty of this training is that they mainstream the Person-Centered Care approach and propose a theoretical, practical and experiential methodology. Moreover, the competencies to be developed, the contents and the course load of each training are included. These four training courses are aimed at: 1) those who are already working in the care field, 2) those without any previous experience, 3) those who wish to specialize in care in high-dependence situations and 4) care service coordinators and decision makers.

Key Words: training, certification, dependence, care, older persons, aging, caregivers, caregiving, Latin America and the Caribbean.

JEL: H4, I18, I38, J14, J16, J2.

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Table of Contents:

1. Introduction

Latin America and the Caribbean are aging rapidly. In 2020, there were 58.7 million people over the age of 65 in the region, compared to 21.4 million 30 years earlier. Among them, almost eight million are in a situation of care dependence, i.e., they need support to perform basic activities of daily life. It is estimated that in 2050 there will be 23 million people over 65 in a situation of care dependence (Aranco et al., 2022a.)

Considering the growing need for long-term care and the decrease in care traditionally provided by families, particularly by women, it is estimated that 4.8 million paid caregivers are needed in Latin America and the Caribbean in 2020. In 2050 the need will be 13.9 million paid caregivers (Villalobos et al., 2022.) In the few countries of the region with available data on human resources for caregiving, there is a significant gap between need and availability (Scheil-Adlung, 2018.)

Just as essential as having the necessary number of caregivers in each country in the region is that they have the skills to provide quality care and to care for themselves. The training of caregivers is essential for them to acquire these skills and is one of the main components of comprehensive care systems (UN Women and ECLAC, 2021.) Unfortunately, most caregivers in Latin America and the Caribbean have little or no training (Traverso et al., 2022.)

With the goal of promoting training and professionalization in the caregiving sector, one of the added values of this study is that we have analyzed and compared, for the first time, the training policies and curricula for paid caregivers in Latin America and the Caribbean, as well as internationally. Furthermore, another added value of this study is that we have developed four training programs based on the lessons learned from these good practices and the skills gaps identified in caregivers.

Our research stems from a technical cooperation on caregiver training in Colombia, Costa Rica and Uruguay in long-term and daycare centers, executed by Fundación Astur with the technical support of Fundación Matia, both leaders in knowledge and innovation in policies for older people. Given that these countries represent the three regions of Latin America (Southern Cone, Andean Region and Central America, respectively) and that they are at different stages of development of their care and training systems, we believe that this research reflects the diversity and challenges faced by the region. Even if the initial context of the research is long-term and day care centers, the training we propose is equally relevant and replicable for home care. However, it would be necessary to add some specific competencies for these services. Therefore, we will not include context specifications throughout the document, except when it is necessary to do so for a particular setting.

In our research we have found that 46% of the caregivers interviewed didn't have any training and that 20% had less than 60 hours of training. This is coupled with a low general educational level: 63.3% do not have more than 9 years of formal education. Although our sample is limited and not representative of workers in the sector, these findings are consistent with those of previous research on paid caregivers. This low qualification increases the risk of poor care, especially for older people with more complex care needs (OECD, 2020.)

Likewise, we found that the paid caregivers interviewed identify multiple challenges in coping with caregiving tasks. Overcoming these challenges requires a combination of technical, relational and self-care competencies. Technical competencies include, for example, first aid and nursing techniques, as well as strategies for moving and posture changes. Relational skills include communication with people with dementia, end-of-life support, and dealing with depression, among others. Finally, self-care competencies include, for example, identifying signs of physical and emotional exhaustion and strategies to improve the wellbeing of caregivers. In section 2 we analyze the challenges faced by caregivers, such as their working conditions, skills gaps, and training.

Given that training needs involve technical, relational and self-care competencies, in this study we promote training with a Person-Centered Care (PCA) approach. In other words, we encourage training that does not focus solely on instrumental support (helping to walk, eat, or clean, among others), but also provides tools to relate to the cared person, to promote their own autonomy in daily tasks, and to develop meaningful activities for the cared person based on their knowledge and participation (Bermejo, 2014.) This approach addresses the main work challenges and training needs identified in our research and what has been analyzed internationally as good practices. In section 3.1 we define what the PCA approach is and throughout the document we expand on what working from the PCA approach involves in practical terms and with examples.

The training of caregivers in the PCA approach has multiple advantages for them and for the cared persons. Training is associated with an improvement in caregiver job satisfaction and a reduction in caregiver distress, stress and turnover. Training is also correlated with an increase in caregiver quality of life, a decrease in medicalization and disruptive behaviors, and a delay in institutionalization. In view of these benefits, human resource training is one of the most important policies to impact the quality of care (Cafagna et al., 2019) and it is essential, as the overall quality is low in the region (Aranco et al., 2022b.) In section 3.2 we discuss the benefits of training.

In section 4, we study international best practices on PCA training, its curricula, contents and methodologies. We analyze in depth the cases of Spain, France, Finland and Italy and also borrow from Belgium, Canada, South Korea, and Denmark. In addition, we have reviewed the existing literature to establish which are the main topics addressed in PCA training and which methodologies have been successful.

In section 5 we analyze current training for caregivers in Colombia, Costa Rica and Uruguay and compare them with international experiences. We focus on training with governmental and technical recognition, which are the inclusion criteria we use throughout this study.

Based on existing good practices in the region and internationally, and on the skills gaps identified in caregivers, in section 6 we develop a proposal for four training courses with a PCA approach aimed at: 1) those who already work in caregiving tasks; 2) those who lack previous experience; 3) those with previous training and interest in expanding their knowledge of issues related to the care of high dependence persons; 4) service managers and professionals linked to caregiving. This training mainstreams the PCA approach, proposes a theoretical, practical and experiential methodology, and can be used as a basis for the development of training programs in Latin America and the Caribbean. Finally, in section 7, we present our conclusions and, in Annex F, the details of the training programs and methodologies we propose.

2. Caregivers in the Americas and the Caribbean: Challenges and Training Needs

This section identifies the main strengths and challenges of caregivers in Latin America and the Caribbean both from a general and a training perspective. The main sources of information are a review of regional and international literature, 109 surveys of caregivers working in long-term and day care centers, and 47 in-depth interviews[10] with agents involved in caregiving (older persons in care, caregivers, trainers, care center managers, and government technicians and officials.) The research was carried out in Colombia, Costa Rica and Uruguay.

93% of the caregivers interviewed were women, with an average age of 40. The survey allowed corroborating, once again, the feminization of caregiving pointed out by previous studies (UN Women, 2018.) In Uruguay, studies such as Aguirre (2013) and López (2021) also find in their samples that 95% of caregivers in long-term centers are women. Moreover, 7.7% of women in Uruguay have a job linked to the care sector, compared to 0.3% of men.

This horizontal segmentation of the labor market by gender is associated with the low social and economic recognition of the care tasks that fall to women (ONU).

[10] Of the 109 caregiver surveys, 19 were conducted in Colombia, 44 in Costa Rica and 46 in Uruguay. Of the 47 interviews, 21 were conducted in Colombia, 11 in Costa Rica and 15 in Uruguay.

Women, 2018.) This is not new: historically, caregiving has been associated with women and identified as a natural resource of women, which makes their work invisible (Federici, 2018.) Caregivers are among the worst paid and receive lower compensation even than those working with similar skills in the healthcare sector (e.g., in hospitals) (OECD, 2020.) In Uruguay, a caregiver in a long-term facility is paid 3.5 USD per hour. Based on 2023 data, this is slightly above the minimum hourly wage (3 USD) and significantly lower than the average hourly wage (6 USD.) As we will see in more detail below, within the framework of the Personal Assistants Program, the government pays 6 USD per hour to caregivers with the objective of raising the status and professionalizing their role. In Colombia, there is currently no degree or program associated with caregiving and nursing assistant is the main human resource in institutionalized care. The basic monthly salary of a nursing assistant is 254-271 USD and is slightly above the minimum wage (242 USD in 2023.) The salary is coupled with work precariousness, short-term contracts for services and, consequently, job insecurity (Colombian Ministry of Health, 2022.) In addition, the care sector has fewer possibilities of job promotion than others, such as hospitals (OECD, 2020.)

The difficult working conditions of caregivers are associated with high turnover. In Uruguay, 30.4% of the caregivers interviewed have been in their current job for less than a year and, in Colombia, this percentage rises to 47.4%, reflecting high turnover. Possible hypotheses about the reasons for this turnover may be related to working conditions. In this regard, 68.8% of the people surveyed reported having only one day off per week and long working hours. In Uruguay, López (2021) found in her sample that 78.4% of caregivers in long-term centers work 48 or more hours per week. Similarly, Aguirre (2013) suggests that the weekly workload of caregivers of older people (in facilities or at home) is 44.7 hours on average. This workday is significantly longer than that of caregivers of children (in facilities or at home): 31.5 hours per week. Finally, 55.1% of the caregivers surveyed care for more than 10 people in their shift. In the case of Uruguay, this means exceeding the number set by regulations.

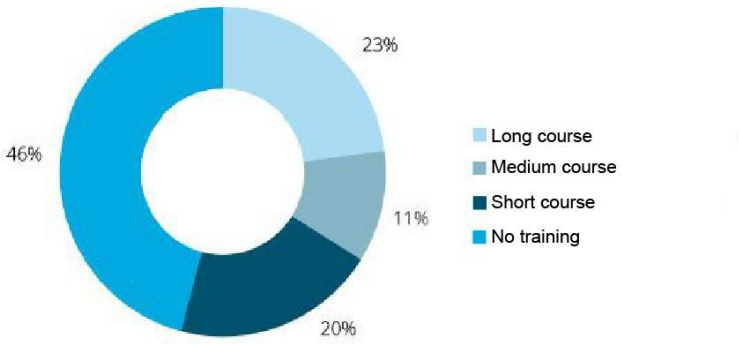
Caregivers suffer physical and mental exhaustion. This overload is a determining factor in staff turnover (Al Sabei et al., 2020; Briones-Peralta et al., 2020), neglectful behaviors, and situations of mistreatment (Jaramillo et al., 2015.) Only 6.4% of the caregivers surveyed report that they do not have any difficulties in exercising the role. 41.8% report physical exhaustion in caregiving, 35.5% emotional exhaustion, and 22% report physical and emotional exhaustion, which entails a risk of burnout. Some 38.2% of caregivers report difficulties in managing material and human resources. Only 6.4% mention that dealing with older persons represents a difficulty.

Despite these challenging conditions, 82.6% of the caregivers interviewed stated that they perform the task out of vocation. At the same time, 50.5% mentioned the possibility of access to employment as another factor, 29.4% economic necessity, and 33% previous experience in informal care. Finally, 81.7% stated that they intend to remain involved in this line of work in the next five years.

2.1. Gaps in the number of trained caregivers

The first major challenge in terms of training is the low educational level of caregivers, in general, together with low or no training in caregiving. A total of 63.3% of the caregivers consulted do not have more than nine years of formal education, which is equivalent to lower secondary level education. Within this percentage, 23.9% do not have more than primary level education (see Table A1 in Annex A.) In addition, as shown in Figure 1, 45.9% have no specific training in caregiving and 20.2% have taken courses that do not exceed 60 hours. In summary, 66.1% have no or very little training in aspects related to the care of older people. This result is consistent with previous research in the same countries. For example, in Colombia, 70% of the staff of long-term centers had not received training (Ministry of Health of Colombia, 2013) and, in Uruguay, 71.8% had no training or it did not exceed 30 hours (López, 2021.) The low level of training is even more pronounced in other countries in the region such as Mexico, where 97% of the staff of long-term centers do not have proper certification of competencies (López-Ortega et al., 2019.) Finally, the training situation is even more deficient in rural areas or in home services, where paid care tasks are mostly performed by domestic workers without specific training.

FIGURE 1. Level of training in care or dependence care of caregivers.



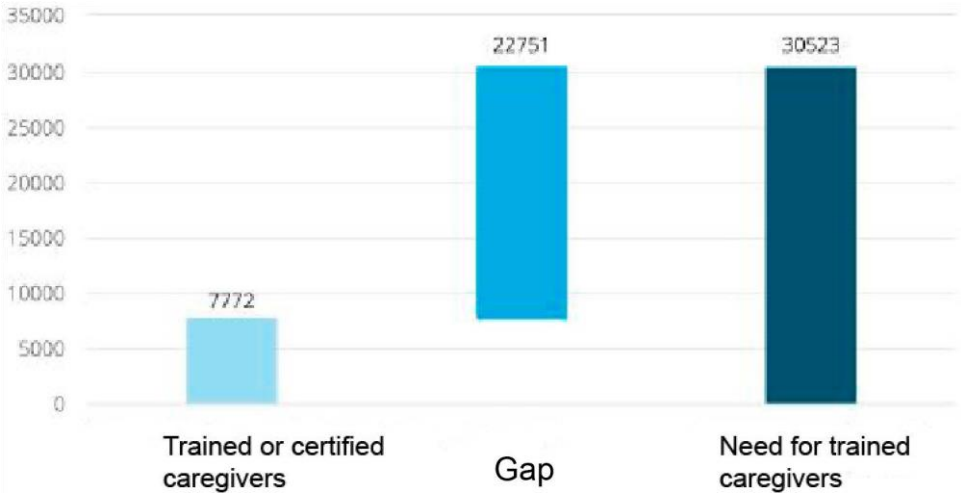
Source: Developed by authors based on surveys of caregivers. Number of observations: 109.

The low percentage of trained paid caregivers represents a huge challenge for countries in the region. In most countries, data on human resources for caregiving and their training are not available and, where information does exist, there is a significant gap between need and availability (Scheil-Adlung, 2018.) Below, we present a preliminary estimation of the gaps between the potential need for trained caregivers and those currently trained with technical recognition in Costa Rica and Uruguay. We were unable to perform this same exercise in Colombia since we were unable to access data on graduates of technical training in care for older persons.

Estimating the gaps requires making several assumptions. Based on Villalobos et. al. (2022), the potential need for paid caregivers was estimated, assuming a service of 20 hours per week for all dependent older persons and a model of care in which the system provides only one paid caregiver (instead of a multidisciplinary team.) In other words, these estimates represent a scenario of total coverage of the target population (even with a potentially insufficient number of hours per beneficiary), which is far from the coverage currently provided by the care systems in the region.

To estimate the number of trained people in these countries, we set the standard that the training must be official and technically recognized. If the country has a qualification standard for caregivers, only graduates of programs which meet that standard are considered. We are aware that this definition may underestimate the number of people trained since we do not include training that has governmental recognition, but is of short and has no technical recognition. In particular, we include in our estimation the total number of people who have graduated from the course on dependence care and validation of competencies in Uruguay, and the people who have graduated from the comprehensive assistance programs for older persons of the National Institute of Learning and Comprehensive Orientation for the Family in Costa Rica. In Uruguay, as the following graph shows, there are 7,253 graduates of the course on care for dependent persons since its inception until the beginning of 2023 and 519 people who validated their competencies for care in the same period. In total, there are 7,772 caregivers trained or certified to care. The need for trained caregivers is estimated at 30,523, which means a gap of 22,751 caregivers, or 75% of the need.

FIGURE 2. Trained caregivers vs. need for trained caregivers in Uruguay.

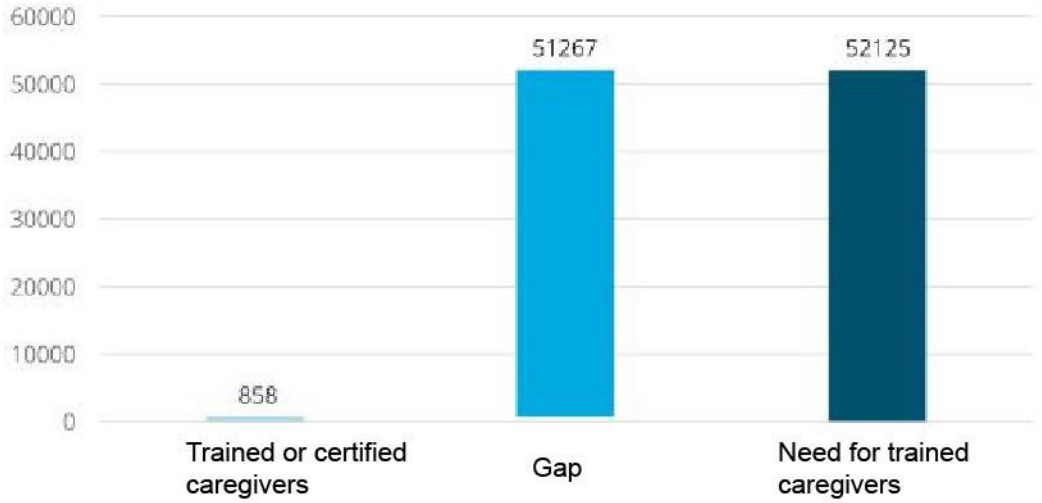


Source: Developed by authors based on Villalobos et al., 2022 and data collected in interviews.

In the case of Costa Rica, 667 people graduated from the National Learning Institute and 191 from the Comprehensive Family Counseling training. The number of graduates is relatively low (and, consequently, the gap is significant) because the national qualification of Comprehensive Assistance for the Elderly, the framework to which both educational proposals are aligned, was set in 2020. Moreover, there are other training programs of varying duration for caregivers at the national level, which are not taken into account for these estimations (including technical training.)

For example, Comprehensive Family Counseling has trained approximately 900 people in courses of between 40 and 160 hours. As Figure 3 indicates, the need for trained caregivers in Costa Rica is 52,125 and the gap is 51,267 (98%.)

FIGURE 3. Trained caregivers vs. need for trained caregivers in Costa Rica



Source: Developed by authors based on Villalobos et al., 2022 and data collected in interviews.

2.2. Care model and skills gaps of caregivers

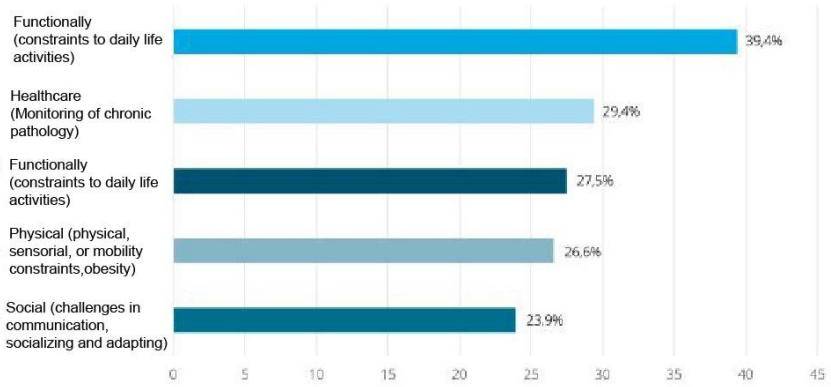
A total of 73.1% of the caregivers participating in the survey identify themselves with a definition of care aligned with the PCA approach[11] and at the same time they raise key needs and issues to enable them to care within this paradigm (see Table A2 in Annex A.) Likewise, the PCA approach is present at the discursive and normative level and in different country documents. However, those involved in the task of care at all levels (political, management and direct care) recognize that this perspective coexists with practices from traditional paradigms of care, associated with the idea of establishing routines, guaranteeing physical safety and satisfying the needs of older persons, standardizing times and procedures, and prioritizing aspects of hygiene and comfort. For example, when the older person retains functional capacity to collaborate in the sanitation process but the procedure is carried out entirely by the caregiver, the task is faster. However, from a PCA perspective, the caregiver should encourage the autonomy of the cared-for person, supporting him or her in performing the activity by their own means. In this sense, there is interest in introducing the model, but also resistance at the level of implementing daily care practices with a PCA perspective. To this end, it is essential to mainstream the PCA approach in training courses and to provide both content and strategies to further develop the PCA model in the region.

[11] We understand care from the PCA approach to provide care to older persons who need support in their daily lives, seeking their welfare and a meaningful life, putting them at the center, and based on respect for their rights, needs and preferences.

In order to understand the most pressing challenges in caregiving, we first explored the characteristics of the cared-for persons and then the tasks that are challenging for the caregivers. Regarding the characteristics of the cared-for persons, 39.4% of the caregivers interviewed indicated that managing disruptive behaviors, such as aggressiveness, hallucinations, erratic wandering or dealing with psycho-affective manifestations related to depression or anxiety, is a daily challenge. At the same time, 29.4% indicated that the control and follow-up of chronic pathologies such as diabetes, hypertension, or incontinence is also challenging (see Figure 4.)

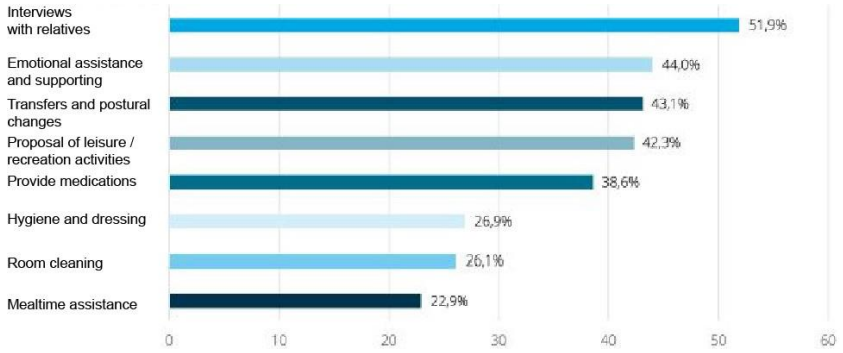
Regarding the tasks inherent to the role of caregiver, the main challenges identified are related, firstly, to tasks involving relational skills such as conducting interviews with family members (51.9%), supporting and emotionally assisting the older person (44%) and proposing leisure activities (42.3%.) Regarding the tasks involving technical skills, the most challenging is transfers and postural changes (43.1%) (see Figure 5.) Tasks related to hygiene, grooming and feeding are reported as the least challenging. Out of a total of eight options to select from, 20.2% of the caregivers interviewed considered that no task was challenging. In contrast, 33.9% stated that four or more tasks were challenging.

FIGURE 4. Characteristics of the older person perceived as challenges to caregiving



Source: Developed by authors based on surveys of caregivers. Number of observations: 109.

FIGURE 5. Tasks inherent to the role perceived as challenging



Source: Developed by authors based on surveys of caregivers. Number of observations: 109. For each option, those who stated that they did not perform the task were excluded.

The interviewees were motivated by the need for training opportunities. When caregivers were asked about their areas of interest for training, once again there was a need for both relational and technical skills. Regarding relational skills, 75.2% request training in emotional support and assistance of the older person, 63.3% require training in planning and development of cognitive, social and motor stimulation techniques, 62.4% in communication strategies with the older person and 59.6% wish training in palliative and end-of-life care (see Table A3 and A4 in Annex A.)

With respect to technical skills, scoring 68.8%, the most requested area is first aid, followed by care techniques associated with nursing, which are prioritized by 56.9% of those surveyed. Among these, 48.6% emphasize the need for training in transfers and postural mobilization, which avoid both risks for the person being cared for and physical overload for the person performing the task.

These results suggest the need for programs for caregivers to contemplate aspects related to healthcare , as well as the development of emotional and bonding skills, which would be a protective factor for both the older person and the caregiver. In European and Asian countries, similar needs are also observed in terms of caregiver competencies (e.g., interpersonal skills, emergency management and knowledge of geriatric conditions) (OECD, 2020.) Finally, the physical and emotional exhaustion reported by caregivers reflects the need for training in self-care skills.

2.3. Preferences on the methodology of training

Regarding preferences for the duration of training courses, 47.2% show interest in technical-vocational training courses of more than 500 hours, followed by 30.6% who request short courses of no more than 100 hours (see Table A5 in Annex A.)

The Most prefer to embark on an educational path that leads to a professional technical degree, on the understanding that this could socially legitimize the task, improve the quality of care, and improve working conditions, mainly in terms of compensation. However, the diversity of the population and educational profile of caregivers means that a large group prefers short courses, as they consider them are more feasible to sustain, since they have to reconcile work, school and family time. Finally, in all countries, it was evident very little time was available for training.

The type of courses shows a dispersion of responses (see Table A6 in Annex A.) While 31% indicate classroom attendance as the preferred option, another 59.7% are divided between hybrid or synchronous virtual modalities that may involve classroom attendance, but minimize travel. These latter options allow a better balance between training and work and personal life. Finally, only 7.3% indicated the asynchronous virtual option as their preferred option for training.

3. Conceptual framework: Person-centered approach (PCA) and advantages of PCA training

3.1. Person-Centered Care Approach (PCA)

The PCA approach has been used for some time now in different areas related to care services and it is a suitable methodology that ensures people are treated well. To this end, it is essential to train work teams in line with its principles. Therefore, a brief introduction to the origins and development of the PCA approach is necessary before tackling certain features of training.

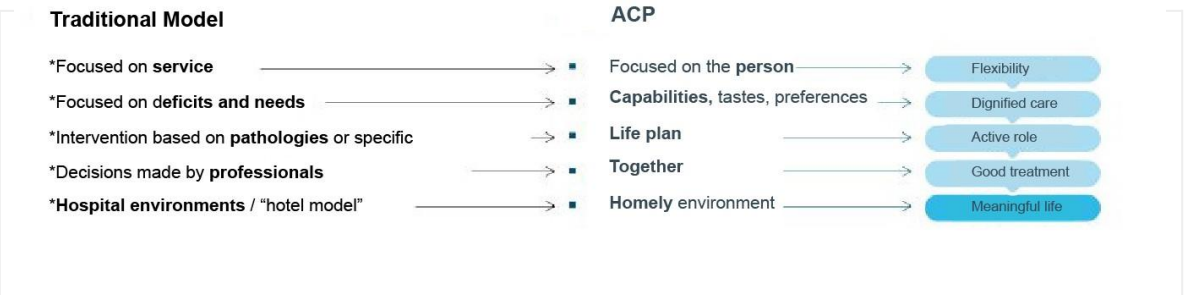
The origin of PCA is attributed to humanistic psychology and, more specifically, to Carl Rogers (Gallegos, 2015.) His Client-Centered Therapy model is based on the assumption that no one has more knowledge about oneself than each of us, and that each person, regardless of the support they need, has the necessary tools to understand and self-direct their life. This perspective, initially applied to the psychotherapeutic field, has been progressively extended to the fields of health, care for the disabled, and older persons in need of long-term care.

In gerontology, this approach has been dominant in the most advanced countries in social and health policies (Australia, Canada, the United States, France, the Nordic countries, United Kingdom, among others), and a key element to comprehensively guarantee the rights and improve the care of older persons who need it. In contrast to the traditional model of care, based on a medical assistance approach, and where the main focus of the design and organization of care and services is addressing deficits and deterioration, PCA aims to transform it through a notion of the quality of care based on the rights and preferences of individuals, regardless of their need for support.

In this way, they become the key players in their care and services, making decisions together with their caregivers (Martínez, 2013.)

In this approach, physical-organizational environments acquire great relevance and must also be transformed from the traditional model, in which the priory was a layout akin to the hospital environment. In PCA, spaces must be able to adapt to people, who feel more comfortable, safe and secure in those spaces that they recognize as their own and that are as similar as possible to a home (Díaz-Veiga, 2020.) One example would be the inclusion of their own photos and objects. Figure 1 summarizes the change in perspective from the traditional healthcare model to the PCA model.

CHART1. Comparison of the Traditional model vs. the PCA model



Source: Developed by authors based on contributions from Martínez (2010), Martín and Santos (2016.)

In order to advance in this paradigm shift, it is essential that training for people working in long-term care be carried out in line with the PCA approach. Traditionally, these professionals were trained in knowledge and skills oriented to the provision of instrumental support (help with walking, eating, hygiene, etc..) Although learning these skills guarantees the appropriate application of a given technique, it does not ensure the development of personalized and comprehensive care. Along the same lines, Bermejo (2014) points out the importance of developing ethical and relational competencies that make it possible to establish the necessary connections for a suitable relationship with older persons and their relatives, to know their preferences and life stories, to identify opportunities for their wellbeing and independence, to work in a team and to resolve conflicts. In other words, it is a matter of making a transition from standardized practices associated with the mere execution of routine tasks to the comprehensive care of the person. In this perspective, guaranteeing dignity and generating conditions for the person to keep their autonomy, maintain control over their life, develop their life projects and carry out meaningful and significant activities are cross- cutting elements that permeate all care practices. As an example, instead of proposing that everyone should make handicrafts in a long-term center, it is recommended that activities be organized collaboratively with the cared-for persons, taking their preferences and interests into account. Likewise, it is recommended to include family members in activities that are meaningful for the cared-for persons and are based on the quality of the bond, so it is essential to care for the caregivers.

For this reason, training for caregivers should include attention to their own self-care, providing tools to identify and prevent risks to their physical and emotional health (Sancho and Martínez, 2020; Díaz-Veiga, 2020.) Burnout syndrome (Al Sabei et al., 2020; Briones-Peralta et al., 2020) is one of the reasons that affects job satisfaction and the desire to remain in the job, while placing the caregiver at greater risk of suffering various forms of abuse or neglect.

3.2. Advantages of training with PCA approach

Training caregivers with an PCA approach is associated with an increase in the wellbeing of cared-for persons, as well as a decrease in negative behaviors (defined as resistances to caregiving and expressions of pain, discomfort and anxiety) (Husebø et al., 2019; Savundranayagam et al., 2016.) Furthermore, training is associated with a reduction in medication use of cared-for persons (Galiana et al., 2019; Husebø et al.,2019) and in a delay in their institutionalization (Gresham et al., 2018.) The latter is an important outcome for older persons, who often prefer to age in their homes, close to family and friends (WHO, 2015.)

From the PCA approach, a primary component of the quality of care is the quality and strength of the bond that is generated between caregivers and those who require care. There is evidence that PCA training is associated with improved interaction and trust between those cared for and caregivers, and this improved bond has an impact on the wellbeing of both. Boumans et al. (2022) suggest that the interaction between the cared-caregiver binomial, as well as the behavior and attitudes of caregivers improve the provision of care and influence the autonomy of people with dementia. Savundranayagam et al. (2016) obtain similar results and find a correlation between the use of person-centered communication by the caregiver and positive reactions on the part of the cared persons. This could be explained by the fact that facilitating conversations about topics that divert the focus away from nursing care contributes to the caregiver being recognized as a unique person with personal experiences and traits (Saldert et al., 2018.)

The benefits of PCA training have also been studied in caregivers who work with people with dementia. In particular, training is associated with a decrease in symptoms of depression and an improvement in behavioral and psychological symptoms and the quality of life of caregivers (Ballard et al., 2018; Boumans et al., 2022; da Silva Serelli et al., 2016; Goyder et al., 2012; Yasuda et al., 2017.) Also, as previously mentioned, PCA training contributes to the autonomy of people with dementia. At the same time, there is evidence that training is linked to caregivers feeling significantly more qualified to establish a bond with people with dementia (Goyder et al., 2012.)

On the other hand, there is evidence about the benefits PCA training has for caregivers themselves. Training is associated with improved job satisfaction and a reduction in angst, stress levels and turnover (Husebø et al. 2019, Gresham et al., 2018; Rajamohan et al., 2019.) The decrease in turnover is a key element of PCA, as the role of go-to professional has a central role. This role entails that each older person needs to have a caregiver with whom they establish a close, ongoing bond of trust, which allows for better support in the decision-making processes and agreements between the older person and the environment. For this role to be consolidated, caregivers must know the cared person and their life story in order to be able to provide care considering their preferences (Martínez, 2016.)

Some practices which can contribute to improving the wellbeing of caregivers through training may be self-observation, reflection and boundary setting. Training with an PCA approach helps caregivers to critically and consciously assess their daily interactions. Waterschoot et al. (2021) point out the importance of training in self-reflection skills and personal boundaries in order to keep a professional distance, since judgment may be compromised and wellbeing may be reduced when there is none.

4. Best training practices worldwide

This section deals with international, mainly European, good practices and evidence in relation to the design, development and implementation of training programs for caregivers of older persons. For this purpose, an in-depth analysis has been made of caregiving training and curricula in Spain, Finland, France and Italy. The criterion for selecting countries was to show successful training experiences with the PCA approach, but with different nuances in content, time and formats that represent the existing variability. Therefore, the selection allows us to analyze and draw contributions that can be adapted to different contexts and situations. Elements have also been taken from experiences in Belgium, Canada, South Korea and Denmark. Finally, the existing literature has been reviewed to establish which the main topics addressed in the framework of PCA training are, and which methodologies have been successful in training caregivers. The information in this section is summarized in a comparative table in Annex B.

4.1. Training experiences analyzed

All the countries analyzed in depth (Spain, Finland, France and Italy) have a professional qualifications framework for the training and certification of caregivers that was established by the national government.

Professional qualifications are a set of competence standards required for employment which can be acquired through training or through work experience. This set of competencies contributes to gain access to occupations and jobs with value and recognition in the labor market.

There are differences between countries with respect to the areas of intervention and the target group of each training. In Spain, there are two training programs that clearly differentiate between intervention in institutional settings and intervention at home. In the Spanish case, the training reviewed in this study is that of assistants for dependent persons, which is specific to work in social and health care institutions. The rest of the training analyzed has a broader scope of intervention that also includes interventions at home. This breadth allows for greater job mobility and satisfaction among caregivers.

In France, we have analyzed two training programs. The first is that of nursing assistant, which enables trainees to work in the health (including hospital), domestic and housing environments. The second French training is the profile of educational and social support professional, which enables work in educational, social and housing structures and with different groups, including children, young, and older persons.

In Finland, the training is that of a social and health care assistant and also has a broad scope depending on the chosen specialization. They can work with different groups (older persons, persons with disabilities, children and young persons, persons with mental health problems, drug addictions), in different fields (nursing and care, pediatric care, oral health care, etc.), as well as in a wide variety of structures or types of resources (health, social and health care, education, housing, etc..) Finally, in Italy, the profile is that of a socio-health operator and allows them to work in healthcare, community and domestic environments.

The number of hours or course load of each training program differs markedly. While the Spanish training program is the shortest, with a total of 450 hours, in Finland the training program for social and health care assistants can be completed in a period varying between 2 and 4 years[12], with 3 years being the most common. The training programs analyzed in Italy and France have an intermediate duration between the Spanish and Finnish cases (i.e., 1000 hours in Italy, 1365 hours in the case of the educational and social assistant degree in France and 1540 hours in the case of the nursing assistant degree in the same country.)

4.2. Care model and contents of training

The training courses analyzed have a PCA approach, where the person must be cared for as a whole, comprehensively, in all areas of their life. All the curricula include content aimed at acquiring the necessary competencies to prioritize physical and emotional wellbeing, guaranteeing assistance for health, hygiene and nutrition needs, as well as catering to relational, affective and communicative needs.

[12] The professional qualification of social and health care assistant in Finland is distributed in a total of 180 ECVET (European Credit System for Vocational Education and Training) points and cannot be translated into an exact number of hours.

The most significant differences between the curricula of the four countries are their areas of intervention and the groups they prepare trainees to work with.

On the other hand, a review of PCA training literature worldwide suggests that other important issues are addressed in training: end of life, dementia, non-pharmacological therapies, music therapy, sexuality, relational skills, communication, healthy habits, families, shared decision making, strategies for postponing entry into long-term facilities, comfortable environments, participation and overload.

Dementia is a clinical condition associated with situations of high dependence, increased institutionalization and greater overload of caregivers. Consequently, it is an issue that is of major importance in the good curricular practices analyzed, focusing on the treatment of persons with dementia in order to foster autonomy or encourage communication. However, there are differences in the approach to dementia in the various international programs. Some approach it from a neurological point of view and focus mainly on cognitive characteristics, while others approach it from a social perspective, taking into account the diversity of people with neurodegenerative diseases and promoting social intervention to enhance quality of life. A prominent case is Denmark, which boasts the Danish Dementia Research Centre, a public organization dedicated to training, but also to the research and outreach of dementia.

Another important issue in the training of caregivers is encouraging the effective participation of older persons. It has been shown that the participation of older persons in daily decision making increases their satisfaction and that of the professional teams, since it helps them to better understand the cared person and contributes to the questioning of their own practices. A service model that stands out in terms of participation is the Lemberge residence in Belgium. There, the cared-for persons decide for themselves what happens in the small society that is their long-term center, from the daily menu and activities to the hiring and dismissal of staff.

4.3. Training methodology

To achieve effective training, not only is an adequate selection of competencies and content important, but also training methodology. Several studies have analyzed learning by doing as a training method for caregivers of older persons. It is a method that proposes learning by doing and developing skills in a real context to ensure that the contents are trained, reflected upon and internalized. This methodology, according to some authors, was particularly successful in working on the spiritual and existential aspects of end-of-life care (Tornøe et al., 2015.)

In line with the learning by doing approach, the training courses in the four countries analyzed in depth (Spain, Finland, France and Italy) propose theoretical and practical training. However, the percentage devoted to practical training varied significantly among them.

The highest percentage of time devoted to practice is France, which boasts 61% in the case of the Educational and Social Assistant Diploma, and 50% in the case of Nursing Assistant. At the other end of the spectrum is Spain, where only 18% of the time is devoted to practice.

Another widely studied successful training methodology is e-learning or learning in virtual mode (Klimova et al., 2019), together with micro e-learning, which entails offering specific training content in small amounts, spaced over time, and which was especially successful in improving care for persons with dementia (Inker et al., 2021.) Along the same lines, in all cases analyzed in depth it is possible to perform all or part of the theoretical content online. In recent years, virtual tools have become more prevalent, whether in the form of applications or online platforms. Some projects analyzed (such as App for Dem or ABC Dementia e-learning) have associated these tools to them as the main learning strategy or as a complement to training.

Likewise, some studies pinpointed some characteristics associated with effective training programs: a) they include active participation; b) they reinforce theory-derived knowledge with experience; c) they ensure experiential and/or simulation learning by dedicating enough time for analysis and reflection; d) they are developed by experienced facilitators able to adapt to the needs of each group; e) they do not include as the only support materials (in paper or online) written or task-based resources (Surr et al., 2017.) Furthermore, the review shows that training in a workshop format (Sin et al., 2018) and focus groups for reflection are good tools for training staff in PCA (Rokstad et al., 2017.)

As for assessment methodology, evaluations in the real work environment are included in all countries (except in Italy, where a single final exam must be passed, consisting of a written and a practical test, generally conducted in the classroom.) For example, in Finland, training in practical work environments is particularly important and assessment is carried out in close collaboration with companies. This happens to such an extent that during assessments the participation of representatives from both the educational and work fields is mandatory.

Finally, there are relevant differences in the standards required of trainers. While in all cases practical experience in the field of the competencies to be taught is required, with some differences in the length of experience required (between 3 and 5 years), in some cases a university degree in the field of the subject is also required, as is the case in Spain and Finland.

4.4. Incentives for training

In an attempt to help ensure that more and more caregivers undergo training, some countries have made training or certification of competencies a mandatory requirement for access to the labor market. In European and Asian countries these policies are more advanced than in Latin America and the Caribbean: almost half of the countries require caregivers to be trained or have a license or certification (OECD, 2020.) In the four countries analyzed (Spain, Finland, France and Italy), it is required to have attain some basic training standards to work in centers.

For example, in the case of Spain, a minimum training criterion is established for home care and another for long-term centers.

Certification has multiple advantages. For example, setting common quality standards for exercising the caregiving role and ensuring that certified individuals have the appropriate competencies. Also, providing formal recognition and a career path for caregiving tasks (Chiodi, 2021.)

South Korea is a success story in terms of the number of certified caregivers. Caregiver training was implemented to ensure a sufficient number of trained caregivers with the introduction of the long-term care system in 2008. In order to be able to work providing the services offered by the care system, caregivers must be certified (i.e. they must have completed the training and passed the exams.)

The training for caregivers in South Korea consists of 240 hours with a strong practical focus. This is divided into 80 hours of theory, 80 hours of practical classes and 80 hours of on- the-job training. As of 2023, a reorganization of the training is scheduled, which will include an increase in the course load to 320 hours. Both practical and theoretical subjects must be passed in order to obtain certification. The training model of care is the traditional one, where more than 80% of the content is technical skills and few hours are dedicated to communication and self-care, elements that correspond to the PCA model.

From the beginning of the system until 2021, more than 2.2 million people (4.3% of the country's total population) have been certified. Some 24% of them are currently working in care. 9.4% of those certified are men, but 94.6% of caregivers working in long-term care are women (similar to the 93% reported in our survey of caregivers) (information provided by the National Health Insurance Service of South Korea, NHIS, 2023.)

5. Current Situation of Training in Latin America and the Caribbean

The goal of this section is to review training programs for paid caregivers of older persons in Latin America and the Caribbean, with a special focus on Colombia, Costa Rica, and Uruguay. In addition, the models of care, contents, and training methodologies are analyzed.

In this study, we focus mainly on formal training with technical recognition. This is the same criterion we have used in section 2.1 to calculate the gaps in trained caregivers. We are aware that in all countries there are more courses than those discussed here. These courses, in many cases short, are valuable steps to train caregivers who currently lack training. However, in this study we analyze the courses that produce a high level of professionalization of the caregiving task. The information in this section is summarized in a comparative table in Annex C.

5.1. Training experiences analyzed

Based on pre-existing research and 36 interviews with experts from government, civil society and the gerontological sector, we have analyzed 12 countries in Latin America and the Caribbean, all of which have some type of training for caregivers. This training is national, provincial or municipal in some cases. In turn, the providers of this training vary from country to country: in some cases the training is designed and implemented by the government and in others by the private sector (whether for-profit or not-for-profit.) However, in most countries, training courses do not have an institutional and regulatory framework that defines a graduate profile, course content, time load, etc. Also, in most countries, the PCA approach is not present in training courses or is not mainstreamed throughout the curriculum. Based on pre-existing research and 36 interviews with experts from government, civil society and the gerontological sector, we have analyzed 12 countries in Latin America and the Caribbean, all of which have some type of training for caregivers. This training is national, provincial or municipal in some cases. In turn, the providers of this training vary from country to country: in some cases the training is designed and implemented by the government and in others by the private sector (whether for-profit or not-for-profit.) However, in most countries, training courses do not have an institutional and regulatory framework that defines a graduate profile, course content, time load, etc. Also, in most countries, the PCA approach is not present in training courses or is not mainstreamed throughout the curriculum.

Colombia, Costa Rica, and Uruguay all have training programs for caregivers of older persons, provided by public and private organizations. However, only Costa Rica has a qualification standard for caregivers within the National Qualifications Framework for Technical Vocational Education and Training (Marco Nacional de Cualificaciones para la Educación y Formación Técnico Profesional.) The Qualifications Framework is a set of job-relevant competence standards established at the national level by state institutions and by the governing body of technical education (in the case of Costa Rica, the National Learning Institute.) The qualification standard in Costa Rica is for assistants to older adults and, currently, there are six educational institutions that have aligned their educational programs to this standard.

In Uruguay, although there is no professional qualification framework for the training of caregivers of older persons, there is a course on dependence care approved by the National Care Board and authorized by the Ministry of Education and Culture for the training of caregivers. The courses can be accessed through the General Directorate of Technical Vocational Education and through 40 private training institutions authorized to provide it.

Finally, the Unified Classification of Occupations for Colombia - Ministry of Labor does not yet include the role of caregivers. Nor are there specific norms or regulatory frameworks for the definition of the role, contents, teaching methodology, etc. However, this was not a hindrance for the National Apprenticeship Service to have programs for caregivers that offer degrees or are complements of others.

In Costa Rica, we have analyzed two training programs: the Personal Assistant for the comprehensive care of older persons[13] of the National Learning Institute and the Comprehensive Care for the Elderly program of Comprehensive Family Counseling.

[13] The curriculum is currently undergoing a design transition.

The scope of intervention of both training programs includes care in centers and at home. The National Learning Institute also provides a 60-hour course for the care of dependent persons. This is a response to the recent National Care Policy and is aimed to center-based and home-based work. Since it is not a technical training program, we do not analyze it in this study, but it is a valuable step towards increasing the number of trained caregivers.

In Uruguay, the course on dependence care is not specific to working with older persons populations, but covers all people in a situation of dependence throughout the life cycle. As in Costa Rica, the scope of intervention includes care both in centers and at home, with emphasis on the latter. At the private level, there are several training proposals specifically aimed at older persons, addressed to people who work in home care, day centers or long-term centers.

In Colombia, we have analyzed the programs offered by the National Learning Service, a pioneer in offering technical and technological programs in the country and present in urban and rural areas. This institution offers two types of programs: degree programs and complementary programs. In the former, there are programs at the operator and technician levels, among others. In the complementary programs, short courses are offered to update or further knowledge of different topics. Specifically for caregivers at the operator level, there is a course called Basic Care for Persons with Functional Dependence. Given the non- existence of this role in the Unified Classification of Occupations for Colombia, it is currently an invitation-only course (i.e., it is only offered when a company requests it to train its employees.) Also, at the technical deep-dive level, there is a course called Skills Development for Comprehensive Assistance to Older Persons, as well as four other complementary programs.

The number of hours or duration of each training program varies considerably, as is the case with international best practices. In Costa Rica, the National Qualifications Framework establishes that people must complete between 400 and 700 hours approximately to obtain the qualification of technician 1 in Comprehensive Assistance for older persons. The time load of the training courses analyzed is 700 hours in the case of the National Learning Institute program and 750 hours in the case of Comprehensive Family Counseling. In Uruguay, the hourly load of the course on dependence care is 152 hours, taken over 4 months, while the private courses are approximately 120 hours. Finally, the duration of the training in Colombia depends on the program. For example, the operator level has a duration of 1296 hours and the technical furthering has a duration of 432 hours. With the exception of the operator level in Colombia, the training load in Finland, France and Italy is significantly higher than in Latin America and the Caribbean.

In addition to training, some countries have processes of certification and validation of competencies to recognize the experience and work capacity of those who have acquired knowledge and skills for caregiving tasks in their jobs or in previous training. In the case of Uruguay, the certification of occupational competencies falls under the purview of the National Committee of Occupational Certification called Uruguay Certifica.

The caregiver applies and a committee of experts, applying various evaluation instruments, determines whether the person has the required competencies based on an occupational profile. Two possible outcomes are that the person obtains the certification or is offered a training path to complement the missing competencies. During the years 2021 and 2022, out of 496 people who entered the process, 284 certified their competencies and 212 were offered complementary competence development plans. Furthermore, the validation of knowledge is a procedure carried out before the Ministry of Education and Culture to revalidate the dependence care course, based on knowledge and competencies acquired in other courses. This may result in a complete revalidation or in the advice to take complementary courses. From 2017 to the beginning of 2023, 519 people succeeded in the certification of their competencies.

In Colombia, the National Learning Service is leading a project called Yo me cuido y me certifico (I take care of myself and I certify myself), which began in 2021. It is a pilot scheme that seeks to certify competencies in care actions throughout the country. Currently, two sector competence standards are being certified: caring for people according to protocols for basic daily activities and degree of autonomy, and catering for the needs of support depending on spiritual and emotional preferences. A total of 192 people have been certified in these two competencies. Finally, Costa Rica is in the process of certifying competencies in the area of assistance by applying certification tests through the National Learning Institute.

5.2. Care model and contents of training

In Colombia, Costa Rica, and Uruguay, we did not find training that mainstreamed the PCA approach in the curricula. However, in all three countries there are some elements of the PCA approach in technical and relational competencies. However, the representation of topics and time load related to health care or hygiene-comfort is significantly higher than communication, time management, promotion of life plans in old age, human rights, which are elements that are within the PCA model.

There are different approaches among the training courses in Costa Rica. The Comprehensive Family Counseling training includes content from the PCA approach: different areas and personalization of care (psychological, social, biological and spiritual), as well as a module dedicated to the self-care of the caregiver. In contrast, the training at the National Learning Institute is composed of seven modules: contextualization of care for older persons, application of biosafety protocols in the care of older persons (e.g., prevention of infectious diseases), addressing risks and emergencies during care (e.g., protocols for falls), transfer and human movement (e.g., transfers from bed to chair) and cognitive stimulation, in which PCA and the physical and emotional self-care of the caregiver are not clearly included.

In Colombia, the curricular approach focuses mainly on the socio-health model, with contents such as: nutrition, biosafety, body mechanics, sleep hygiene , normal aging changes, chronic diseases (e.g., diabetes, hypertension), geriatric syndromes (e.g., urinary incontinence, and cognitive impairment), vision care, oral hygiene, hearing and pharmacological therapies (e.g., common medicines and their adverse reactions.)

Similarly, infrequent topics such as physical stimulation, occupational therapy, massage techniques, sexuality in old age and some others related to the PCA approach were found, among them assertive communication, active aging, recreation for older persons, assertive grief management and self-care.

In Uruguay, the contents of the different training courses cover topics such as: biopsychosocial characteristics of aging, social vision of old age, care and assistance related to activities of daily living, first aid, prevention of violence and abuse, humanization of care, empathic communication, end-of-life care, cognitive and motor stimulation strategies, management of free and leisure time, communication with families, self-care and caregiver's rights, thus combining technical aspects and those associated with the PCA approach. When viewing the different curricula, some content is present in most cases, such as the rights of older persons, analyses of stereotypes about old age, care related to hygiene routines, feeding, transfers and basic care, effective communication and recreation techniques.

5.3. Training Methodology

Both Colombia and Uruguay propose a theoretical-practical training, in the understanding that these practices allow the assessment of students to verify if they have internalized the concepts and can apply the skills in real contexts. In Costa Rica, the National Qualifications Framework does not establish internships, so institutions such as the National Learning Institute and the Comprehensive Family Counseling implement practical exercises during their courses, but do not have an established final internship.

The percentage devoted to practical training varies significantly. In Uruguay, the dependence care course devotes 12 hours to practice. In Colombia, all training offered by the National Apprenticeship Service requires internships and the number of hours depends on the program. In the case of the operator level course, of the 1296 total hours, 519 hours are practical (40%.) This is similar to international internships, which dedicate a significant percentage of the training hours to practice (in some cases, 50% or more.) In Uruguay, few hours of practice are included compared to the international cases studied. The practice is brief, and does not reach 8% of the total hours of the course. It should be noted that internships in Uruguay and Colombia do not always take place in care centers for older persons, since this is not the only population profile at which the training is aimed.

The teaching strategies used are also diverse. In Colombia, most of the training offerings use various traditional teaching methods such as the master class, with the exception of the National Learning Service (Servicio Nacional de Aprendizaje), which promotes practical and experiential learning.

In Uruguay, several strategies are proposed to promote the exchange of knowledge, reflection and analysis of practices. For this purpose, instances of communication of theoretical contents are combined with practical instances, outside the specific work environment, through simulations, group and individual exercises, observation among peers and analysis of the resolution of everyday problem situations (Sistema Nacional de Cuidados, 2016.)

Similarly, in Costa Rica, in the course of the National Learning Institute, learning by doing and student participation are also encouraged. Some of the methodologies used are evidence portfolios (documents that compile information showing learning progress), concept and mind maps, and project-based learning, among others. In the case of the Comprehensive Family Counseling training, they describe working in activities that integrate previous knowledge with classroom practices, and simulations, among others.

There are different assistance modalities, but most training courses do not offer e-learning (virtual learning) as an option. In Uruguay, there are synchronous virtual courses offered by the private sector, but the dependence care course is fully in-person. Similarly, the National Learning Service in Colombia is one of the few exceptions with e- learning courses. In Costa Rica, the Comprehensive Family Counseling training is in-person. The training of the National Learning Institute is essentially in-person, but since the COVID-19 pandemic, it has started a transition to being online and has added platforms for some of its contents. Furthermore, in all the international cases studied it is possible to complete all or part of the theoretical contents online.

There is assessment in all training courses. In Uruguay, the courses formally include an accreditation stage at the end of each module or at the end of the entire program, integrating theoretical and practical contents, as well as individual follow-ups of the training processes. In Colombia and Costa Rica, evaluation is continuous and takes place throughout the training process, including internships. To ensure that the evaluation is formative, learning activities are developed with all the teachers of the course. There are practical-theoretical assessment formats that are previously designed and, in order to attain the degree, the student must show that they are sufficiently prepared in each of the competencies.

The teaching teams include professionals from various disciplines. In the case of Uruguay, the selection criterion is based on technical suitability and practical experience in the subject to be addressed. In the course on dependence care, four groups of professionals are validated in the areas of health, social, legal and recreational. In Costa Rica, the teaching team includes professionals from areas such as psychology, social work, nursing, and physical therapy, among others, who have previous training and/or experience in caring for older persons. In Colombia, all degree programs offered by the National Learning Service have an interdisciplinary team, since each competence must have a teaching profile. Some of these profiles are psychology, nursing, social work, or Bachelor in education, among others. In all countries, given the scarce development of the PCA model, teachers are not required to link the contents they offer to this approach.

Finally, we are interested in highlighting the case of Argentina because it is one of the few countries in the region that boasts a framework of reference for caregivers of older persons and has had one for over a decade (since 2011.) In addition, there is a significant number of trained people. Given that Argentina was unfortunately not part of our research, we summarize information on their caregiver training policies in Box 1.

BOX 1. Training of home-based caregivers of older persons in Argentina.

Argentina, like Costa Rica, is one of the few countries in the region that has had a reference framework for the professional training of gerontological care assistants since 1996. Since 2011 it has been certified by the Ministry of Education, Culture, Science and Technology. The Ministry of Social Development, through the National Directorate of Policies for Older Adults, and as part of the National Home Care Program, develops training for caregivers aligned with this qualification standard. The training is provided by institutions and civil society organizations, which enabled them to have a national scope. Also, since 2022, the National Institute of Social Services for Retired and Pensioners (Spanish acronym: PAMI) has been providing training in care tasks to people who are working with members of PAMI, through agreements with national universities. This training was agreed with the National Directorate of Policies for Older Adults and its training manual is available online.

The specific objectives of training in Argentina include some innovative elements for the region: it clearly states that the model of care being taught is PCA and mentions that the aim is to develop technical, social and self-care skills. It also provides tools to organize work through associativism and cooperativism. It also addresses the Inter-American Convention on Protecting the Human Rights of Older Persons, as well as gender inequalities and sexual diversity. Although the scope of intervention of this training is home care, its contents are valuable for the training of caregivers in different areas and it includes centers as an area where part of the internships are carried out. The training has a duration of 485 hours over 4 months. Of these, 225 hours (46% of the total) correspond to internships, which must be carried out simultaneously with lessons (35 hours of community internships, 70 hours of internships in centers and 120 hours of internships at home.)

Course design and methodology depend on the institution providing the course. For example, those provided by the University of Chubut include classroom and virtual training. Each week there are seven hours of work to be done in an online platform, which includes materials, videos, activities and opportunities for exchange.

It is estimated that by the end of 2015 Argentina had close to 50,000 trained caregivers (ECLAC, 2016.) Taking into account that until 2020 an average of 2,200 people were trained per year (Oliveri, 2020) and, making the strong assumptions that the number of trained people remained stable and that there were no retirements or sector displacements among graduates, Argentina currently has at most 65,400 trained caregivers. This is 27% of required 243,000 caregivers to cover the total demand for care in Argentina (Villalobos et al., 2022.)

Finally, there are policies that encourage training and professionalization. Those who pass the course receive a certification that enables them to register in the National Registry of Home Caregivers. This registry allows employers to contact trained caregivers, which contributes to labor intermediation.

Source: Argentina national government website
https://www.argentina.gob.ar/desarrollosocial/senaf/personas-mayores/cuidados-en-la-comunidad

5.4. Incentives for training

With the aim of contributing to the training of more and more caregivers, some countries have mandatory training or certification of competencies as a requirement to be able to work within their caregiving policies. In Latin America and the Caribbean, only Argentina, Chile and Uruguay have mandatory human resources training/certification requirements. Given that caregivers working within the care policy are a small proportion of care workers, even in these countries, those who meet the requirements are a smaller percentage of the workforce (Aranco et al., 2022b.)

In Uruguay, the creation of the Care System promoted the figure of Personal Assistant, the worker in charge of providing care to people in a situation of dependence, both at home and in long-term centers and day care centers. In order to perform this role, there are mandatory training or certification requirements for caregivers, either by attaining the certificate of the course of care for dependent persons or by having knowledge in care for dependent persons validated. This allows you to be listed in the Registry of Personal Assistants. In the case of long-term centers and day care centers[14], the same is required in the qualification process: the center staff must have completed the course on dependence care or the certification of competencies, as well as being listed in the Registry. Finally, training is also required in the terms of reference for public hiring when opening new care services.

Similarly, in Uruguay there are economic incentives for training and participation in the Personal Assistants program. There is a significant difference in the minimum wage of a person hired as a caregiver in a long-term center, with or without training, and those trained personal assistants who are hired to work at home under the Personal Assistants Program. While the former are paid 23,873 Uruguayan pesos (600 USD) per month for 44 hours per week[15] as of January 2023, personal assistants are paid 20,100 Uruguayan pesos (500 USD) per month for 20 hours per week[16] . This implies that a caregiver receives the equivalent of 3.5 USD per hour, while a Personal Assistant receives 6 USD.

In Costa Rica, the National Care Policy establishes the need to improve the qualifications of people who perform different types of care, stating that caregivers require specific and certified training. An incentive for training is that this policy provides for wage differentiation. The National Council of Older Persons (Spanish acronym: CONAPAM) pays a maximum monthly amount of 178,700 colones (331 USD) to a caregiver, deems their work unskilled labor and that falls within the Solidarity Bonds program. On the other hand, a person who has certified training in this area has a maximum monthly compensation of 384,888 colones (713 USD.) As in Uruguay, another incentive for training in Costa Rica is that it is generally specified in the terms of reference and conditions for the transfer of public funds to caregiving services that the organizations must have qualified personnel to provide the services.

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[14] Although public day-care centers are not yet regulated, private day-care centers are currently governed by the same regulations as long-term centers.

[15] Details of compensation in accordance with the agreements of the Salary Councils can be found and periodically updated at: https://www.gub.uy/ministerio-trabajo-seguridad-social/tematica/casas-salud-residenciales-ancianos-fin.

[16] Details of the conditions to access the Personal Assistants service and their compensation can be found at the following link: https://www.bps.gub.uy/9973/programa-de-asistentes-personales.html

In Colombia, since the role of caregivers does not exist in the Unified Classification of Occupations, incentives for training have not yet been developed.

Finally, even in countries with policies that encourage training, the wages of caregivers remain low and there is no prospect of significant increases in the near future. In a context of low wages, it is a challenge to have caregivers who want training.

6. Proposed training programs for Latin America and the Caribbean

6.1. Training proposed

Learning from regional and international best practices and based on the needs identified in surveys and interviews with caregivers and other relevant agents (cared-for persons, trainers, center directors and government officials and technicians), we have developed four training curricula for caregivers in day and long-term centers. These four training courses are for people: 1) already working in the caregiving field, 2) with no previous experience, 3) who wish to specialize in care in high dependence situations and 4) who coordinate care services and are decision makers.

The training load proposed is less than international experiences (which range between 450 and 1540 hours) and that of the technical or operational training currently available in Costa Rica and Colombia. The training load for people with no previous experience is 300 hours. There are several reasons for having decided on this hourly load. First, the low educational level of caregivers, their irregular educational backgrounds and the need to reconcile work, family and student time make it unlikely that they will be able to sustain educational experiences that require more time. Second, it is a challenge to motivate people to undertake long-term training given their low compensation. Third, given the significant gaps between availability and need for trained caregivers, decision makers have mentioned strong budgetary constraints to implement massive and lengthy training. Fourth, the proposed hourly loads are in line with the Ibero-American protocol for training in caregiving, which recommends a course duration of between 260 and 380 hours (Organización Iberoamericana de Seguridad Social, 2022.) Finally, it should be stated that the hourly load refers to curricular hours and does not include the independent work of students in their reading, assignments, records, etc.

This is a basic proposal for the region based on the results of research in Colombia, Costa Rica, and Uruguay. The program should be contextualized to the realities of the countries where it is offered.

In addition, we recommend that Training 2 be aligned with the qualifications framework of each country so that students can graduate with a technical qualification level. Finally, these training courses are designed for current and future workers in long-term and day care centers. In order to have more versatile profiles that can perform tasks both in centers and in home settings, some countries will prefer to have training courses that include competencies and content for both areas of intervention. In this case, a module can be added to the proposed training to address the specific challenges of home-based services (e.g., the boundaries between care tasks and other household tasks, conflict resolution with the family, etc..)

6.1.1. Training 1: for caregivers working in centers

Significant training deficit was detected among caregivers, both in relation to the level of general education and to training in caregiving in particular. In this group's information survey, the interest and motivation for training stand out. Therefore, this training is aimed at people who are currently working as caregivers for older persons in long-term centers and day care centers with at least six months' experience. The next training, however, is aimed at people with no experience who are interested in the care sector.

Training 1 is an update for caregivers and is called PCA in the Care of Older Persons in Long-Term and Day Centers. The general competence to be developed is adding skills for the good care of older persons in accordance with the ethical principles of the PCA approach. The specific competencies are listed in Table D1 of Annex D.

The curriculum is divided into four theoretical-practical modules plus professional practice that combines learning-by-doing in the workplace and teaching supervision of the tools learned throughout the training (for example, making life plans with the cared-for person.)

Taking into account that the training is intended for working people and, considering the barriers identified for them to be able to stay in the courses, the duration of this training is 240 hours. 77% (192 hours) corresponds to theoretical-practical courses and 23% (48 hours) to practical training. The practical training hours are split equally between work in the institution where the trainee works and teaching supervision and visits to centers with a PCA approach. The organization by modules and the assessment strategies of each allows the student to manage curricular advancement times according to their needs. More information on this training can be found in Table 1, which contains the modules, thematic units and time load of each module. In addition, Annex F presents the syllabus of this training in detail, together with the proposed methodologies.

6.1.2. Training 2: for future caregivers

As reflected in the estimates of the gaps of trained caregivers, in the medium term it will be necessary to have a significant number of trained caregivers in the face of the growing demand associated with demographic changes, as well as family structure and arrangements. It is necessary to create attractive educational experiences for the new generations of caregivers, since younger generations show less interest or future prospects in caregiving tasks. Moreover, in countries that require certifications to work in caregiving, these must be available at the time of job search. For this reason, Training 2 is aimed at future care professionals who will work in care centers. Access to this course only requires complete basic school education (6 years.) .

Training 2 is a basic technical training and is called The Care of Older Persons from the PCA Approach. The general competencies to be developed are skills for the good care of older persons in accordance with the ethical principles of the PCA approach, like Training 1. The specific competencies are listed in Table D2 of Annex D.

As this program is intended to train future care professionals, but without previous experience, it has a greater course load compared to the first curriculum. In addition, the curriculum is extended to integrate some of the contents of Training 3 on care for high dependence persons. The duration of Training 2 is 300 hours. 80% (240 hours) is theoretical-practical courses and 20% (60 hours) is practical training. The practical training hours are 40 hours of work in an institution and 20 hours of teaching supervision and visits to centers with an PCA approach. Table 2 provides more information on this training, including the modules, thematic units and time load of each module, and Annex F presents the syllabus of this training in detail together with the proposed methodologies.

Training 2 has a technical-professional focus. This training must be aligned with and governed by the qualifications framework of the country in which it is to be applied. This is important so that students can graduate with a level of technical qualification, in the understanding that this could lead to improving working conditions, social recognition, and continuing their educational experiences.

6.1.3. Training 3: specialization in the care of high dependence persons

Training 3 is aimed at people who have already completed or certified Training 1, and want to further their knowledge of the comprehensive care of older persons, focusing on high dependence persons (associated with neurodegenerative, neurological, physical, mental health, and functional diversity pathologies.) This experience is considered of vital importance, since it addresses one of the most demanded training needs according to our research.

Training 3 is a specialization and is called Care Focused on High Dependence Older Persons in Long-Term and Day Centers. In this training, previously acquired competencies are enhanced. It also adds skills that allow caregivers to be more secure and confident in taking certain risks associated with the development of the autonomy of dependent persons. It also provides them with new theoretical and practical knowledge applicable to situations of high dependence that may arise on a daily basis. The general and specific competencies of Training 3 are listed in Table D3 of Annex D. The module structure is maintained. The duration of Training 3 is 60 hours. 87% (52 hours) is theoretical-practical courses and 13% (8 hours) is analysis of practical situations. Table 3 provides more information on Training 3, including the modules, thematic units and time load of each module. Annex F presents the proposed syllabus in detail, together with training methodologies.

6.1.4. Training 4: for employers, managers, coordinators, professionals, and other relevant agents.

From a holistic and comprehensive perspective of caregiving, there is a need to train those who do not perform direct caregiving tasks, but who have relevant roles in providing quality care or supervising it. Although caregivers are the cornerstone of caregiving, the task is complex and all the responsibility cannot fall solely on them. Administrators, coordinators, government decision-makers, and even those who perform oversight tasks have an impact on improving the experiences of older persons in care facilities. Hence the importance of Training 4, which also encourages the application of the PCA model in centers and its inclusion in political agendas. Finally, in our research we have observed that this group is motivated to access training.

Training 4 is called Leadership and Management of Centers for Older Persons in PCA. The general competence of Training 4 is adding skills for the management and leadership of institutions, proposals, and teams that care for older persons in accordance with the ethical principles of the PCA approach. The specific competencies are listed in Table D4 of Annex D.

This study plan is short, since it takes into account the responsibilities of participants. It is 70 hours, of which 32 are online, 16 in-person, 10 in an operative group, and 12 in a supervised final project. The operative group is 5-10 people who, guided by a teacher under the problem-based learning modality, analyze in detail the reality and challenges of their workplaces. The group then builds strategies and good care practices that can be included in their center projects. The support throughout the training via operational groups and in the drafting of the final project seeks to facilitate roadmaps to advance in the implementation of the PCA model in the centers, complying with existing regulations. Table 4 provides more information on this training, including modules, thematic units, and time load of each module, and Annex F provides a detailed description of the syllabus and proposed methodologies.

6.2. Care model and contents of training courses

As stated above, Tables 1, 2, 3 and 4 present the modules, contents and time load for each training. In the first module of the four training courses, the ethical and conceptual framework of PCA is developed. In the following modules, students are expected to envision and implement this approach in their daily practices providing healthcare and wellbeing for people, promoting their autonomy through daily life activities, and also in the skills and strategies for self-care and teamwork.

The second module of Training 1, 2 and 3 is on health care and wellbeing of older persons. Its aim is to understand the diversity of the aging processes, the diversity in old age and its associated changes (which entail losses, but also gains.) Similarly, it addresses diseases and situations that generate dependence, but avoiding reducing the person to their condition of disease. This module in Training 3 addresses neurological and neurodegenerative diseases, among others, associated with high dependence. For example, useful tools are developed to address complex behaviors and identification of needs in persons with dementia.

The third module of Training 1, 2 and 3 addresses the support in daily life from the point of view of personalization and promotion of autonomy. In particular, how to support in all activities of daily life, avoiding the overprotection of doing tasks for the cared person, promoting their autonomy in decision making, their functional independence, and respect for their time. For example, supporting and assisting the dressing and undressing (instead of doing it for the cared person), respecting privacy, choices and personal image. However, the approach to this module is different between Training 1 and 2. The first program seeks to enable those who are already working to integrate the PCA approach to their previous knowledge. That is to say, to review and critically analyze the contents and health practices they already know so that they can promote and personalize the autonomy of older persons. The second program, for trainees without experience, devotes a greater number of hours to health techniques and procedures, calling for their development from the PCA approach in the work practice. Finally, in this module in Training 3, skills are developed in caregivers to enable them to be more secure and confident in taking certain risks associated with promoting the autonomy of high dependence persons.

In the last module of Training 1, 2 and 3, skills, strategies and resources for self-care and teamwork are developed. The modules of Training 4 are different from those of the other programs, since this training emphasizes the development of skills for the management and leadership of institutions and teams aimed at the care of older persons, as well as understanding the scope of support necessary for the advancement of good care.

The aforementioned modules allow for the development of technical and health competencies, relational competencies, and self-care competencies. These competencies are described in Annex E and examples are included. The technical competencies developed in Table E1 of Annex E include, among others, emergency situation skills (e.g., cardiopulmonary resuscitation techniques.) Emotional competencies, developed in Table E2 of Annex E, include active listening, empathy, and negotiation skills, among others.

By way of example, transforming care and communication practices that marginalize the person cared to a passive place, or infantilize hem, into conversations that promote expression, initiative, and decision making of older persons. Finally, the competencies for self-care, developed in Table E3 of Annex E, include knowing of the rights and legal standing of the caregiver, so that they are able to identify possible abuses and set limits.

TABLE 1. Training 1 for people already working in the care sector: modules, thematic units and time load

MODULE	THEMATIC UNIT	TIME LOAD	
Ethical and conceptual framework in PCA	TU1: Care as a right for older people	24 hours	WORK
	TU2: Conceptual approach to PCA		
	TU3: Role of the caregiver in centers from a PCA perspective		
Health care and wellness in individuals	TU1: The aging process and old ages	44 hours	PRACTICE
	TU2: Changes associated with the aging process		
	TU3: Diseases and situations that generate dependence in older persons.		
	TU4: Action protocols for emergency and urgency situations		
Personalization and promotion of autonomy in daily life support	TU1. Assistance in daily life	84 hours	48 hours (24 of autonomous work and 24 of supervision)
	TU2. Meaningful and significant activities		
	TU3: Support in daily life from a perspective of personalization, self- determination and independence.		
	TU4: Affectively meaningful others: allies in caregiving		
	TU5: Assistance in important moments of life		
Skills, strategies and resources for self- care and teamwork	TU1: Skills and strategies for physical and emotional self- care	40 hours	
	TU2: Social and relational skills for caregiving		
	TU3: Teamwork Skills in DCC and LTC		

Source: developed by authors

TABLE 2. Training 1 for people already working in the care sector: modules, thematic units and time load

MODULE	THEMATIC UNIT	TIME LOAD	
Ethical and conceptual framework in PCA	TU1: Care as a right for older people	24 hours	WORK
	TU2: Conceptual approach to PCA		
	TU3: Role of the caregiver in centers from a PCA perspective		
Health care and wellness in individuals	TU1: The aging process and old ages	56 hours	PRACTICE
	TU2: Changes associated with the aging process		
	TU3: Illnesses and situations that generate dependence		
	TU 4: Action protocols for emergency and urgency situations		
Personalization and promotion of autonomy in daily life support	TU1. Assistance in daily life	116 hours	60 hours(40 on-site and 20 supervised)
	TU2. Meaningful and significant activities		
	TU3: Support in daily life from a perspective of personalization, self-determination and independence.		
	TU4: Affectively meaningful others: allies in caregiving		
	TU5: Assisting people in high dependence situations		
	TU6: Assistance in important moments of life		
Skills, strategies and resources for self-care and teamwork	TU1: Skills and strategies for physical and emotional self-care	44 hours	
	TU2: Social and Relational Skills for Caregiving		
	TU3: Teamwork skills in DCC and LTC		

Source: developed by authors

TABLE 3. Training 3 for those who want to specialize in high dependence care: modules, thematic units and time load

MODULE	THEMATIC UNIT	TIME LOAD
PCA and its benefits for high dependence people	TU1: Challenges of the implementation of the PCA Framework for high dependence individuals	8 hours
	TU2: The rights of older persons	
Situations generating high dependence	TU1 Diseases neurological and neurodegenerative diseases associated with high dependence and/or disability in older persons.	12 hours
	TU2: Other diseases and situations of high prevalence that generate dependence and/or disability in older persons.	
Personalization and promotion of autonomy in daily life support	TU1: The expert professional	24 hours
	TU2: Personal identity, meaningful activities and professional tools in the context of everyday life	
	TU3: Resources for the promotion of autonomy in activities of daily living for high dependence persons.	
Skills, strategies and resources for self-care	TU1. Communication and social interaction in persons with dementia	8 hours
	TU2. Skills and strategies for physical and emotional self-care.	
Practical workshop: Analysis of daily situations in long- term and day care centers.	TU1: Review of professional practices	8 hours

Source: developed by authors

TABLE 4. Training 4 for care service coordinators and decision-makers: modules, thematic units and time load

MODULE	THEMATIC UNIT	TIME LOAD	
Toward the implementation the PCA	TU1: Care as a right for older persons	8 classroom hours 4 online hours	OPERATIVE GROUP 10 hours
	TU2: Conceptual approach to PCA		
	TU3: Roles related to care in centers		
Good care	TU1: Good treatment: Assistance in daily life from personalization, participation and promotion of autonomy.	12 virtual hours	
	TU2: Assistance in relevant moments of life		
	TU3: Families and/or significant people in the care process		
Scope of support needed to advance good care	TU1. Inclusive and personalized homely environments	8 classroom hours 8 online hours	
	TU2. Organizational challenges for the implementation of the PCA approach.		
	TU3: People-centered culture, leadership and self-leadership.		
Final project of the center	TU1: Formulation, management and quality standards for the transformation of the centers.	8 hours of autonomous work 8 hours of online theoretical training 4 hours synchronous supervision	

Source: developed by authors

6.3. Training methodology

After observing a low level of education in caregivers, that their education was discontinued, and how diverse they were in age and experiences, the proposed training seeks a methodological transformation. This transformation intends to foster the change from a memoristic and passive learning model to a more interactive and constructivist one, taking into consideration the previous experiences of participants. We encourage learning environments that inspire the exchange of ideas, theoretical-practical reflection, and the use of multiple forms of content presentation, including audiovisual resources. The proposed methodology is based on international and regional best practices, literature review, new educational paradigms and, mainly, the needs and preferences identified after consulting with caregivers in the region.

This training is oriented towards educational practices that favor the development of competencies in students. Competencies are a combination of knowledge, practical skills, interests, motivations, ethical values, attitudes, and emotions, which come together and make it possible to respond to a given situation. This requires that curricula and teaching practices allow for knowledge to be built progressively, giving each student what they need to reach their own personal goal, understanding what each one needs to learn.

Moreover, training must be based on active learning methodologies, where people are the protagonists of their teaching-learning processes, through activities that promote the exchange of ideas, interaction, and theoretical-practical reflection for each module. Examples of active learning methods include case analyses based on real situations, or debates related to challenging daily situations that allow for different of points of view. Another example is project-based learning to build, implement and assess work initiatives that can, for example, generate changes in the way daily tasks are organized, enhancing interactions between the caregiver and the cared person.

The use of this methodology allows students to develop, in addition to the planned content and technical competencies, skills such as autonomy, collaboration, problem solving, self-learning, self-regulation, critical, complex and creative thinking, and group work, among others. In other words, key relational and emotional skills for the task of care

The suggested training model is hybrid: it combines synchronous and asynchronous instances, both in-person and through virtual learning environments and online education, taking into account the significant workload of caregivers. While respecting the preference of a significant proportion of caregivers for in-person training, the use of hybrid training models makes training sustainable for those caregivers who have less accessibility to each country’s main population centers and for those who find it difficult to reconcile work, training and family time.

For in-person instances, the implementation of existential and experiential learning strategies is essential. These should include, among others, experiences through gamified physical activities, simulation of situations (for example, care routines in daily life), management of group dynamics, and adaptation of relaxation techniques, especially for the development of competencies related to communication, self-care, or management of complex situations. For virtual instances, some resources could be virtual classrooms, videos, forums, gamified platforms, collaborative whiteboards, blogs, collaborative workshops, or peer assessment, among others, always focusing on promoting permanent interaction, even if it is not in person (González, 2015.)

The internship is a key moment to put what has been learned into practice, and includes the support of a supervising teacher. In this format, the teacher may be present with the student synchronously during the internship, but asynchronous support may also be provided through tutorials and discussion groups to rethink and plan the approaches. The supervising teacher also encourages and supports moments of introspection that provide spaces for self-assessment, including, among other options, the written record of experiences.

The methodologies stated are closely related to the PCA approach, because they foster the construction of educational environments based on addressing real, everyday situations, which facilitates the applicability of learning in each student's field of work. They also promote motivation and the acquisition of significant learning in caregivers. Many of these methods are recognized as the strategies that generate the most and best results in people who have received training, as we have seen in the section on good practices worldwide.

Methodological transformation also involves assessment. Learning processes through active methods entail considering both summative and formative assessment. The former involves collecting information that allows for a reliable measurement of the degree of consolidation of a certain learning. This type of evaluation is key, for example, when validating technical competencies that demonstrate the ability to apply protocols based on criteria of quality, suitability and risk control. Some resources that can be used for this type of assessment are questionnaires, oral presentations, or participation in forums.

Formative evaluation ensures continuous follow-up of each student's learning process, in order to adjust teaching strategies and identify key areas for improvement. It requires follow-up and feedback from students in their day-to-day classwork, which allows them to analyze their strengths and weaknesses, and facilitates the achievement of learning. For this type of evaluation, checklists and performance rubrics are essential tools that allow students to know, from the beginning, which competencies they are expected to develop throughout their training, and enabling them to monitor their performance, and receive feedback from both peers and teachers.

Finally, the training courses should be taught by an interdisciplinary educational group who share a common approach and who are familiar with and able to mainstream the PCA proposal. In the survey conducted, we observed a wide variety of professional profiles and teaching backgrounds among course trainers and --in some cases- little knowledge of the PCA approach. To overcome this challenge, it is recommended to implement training workshops for trainers and to train in PCA and teaching competencies, mainly in competence-based planning, teaching strategies, and accreditation and formative assessment.

7. Conclusions

A commitment to the professionalization of the care sector and the generation of a solid care economy means making firm progress in developing training strategies for current and future caregivers. In this study we analyze and compare, for the first time, training policies, curricula, approaches, content, and methodology in Latin America and internationally.

One of the main findings is that the PCA approach is present at a discourse and policy level and in different documents in Latin America and the Caribbean. However, this is not aligned with organizational practices and structures where some traditional elements of healthcare approaches are predominant during the rendering of care services (establishing routines, guaranteeing safety, standardizing times and procedures, etc.) Promoting the PCA approach represents a paradigm shift, which entails understanding that care transcends the application of techniques and protocols, as it is mainly based on the quality and strength of the bond generated between caregivers and those who require care. In order to really change the quality of care based on what is deemed principles of good treatment, it is essential to train caregivers with a curriculum that mainstreams the PCA approach and allows for constant reflection of current practices.

Another added value of this study is that, based on the lessons learned from regional and international good practices and the challenges of competencies that caregivers have identified as needed, we propose four training courses with a PCA approach, including competencies to be developed, contents, and methodology. These four training courses are for people: 1) who already work in the caregiving field, 2) without previous experience, 3) who wish to specialize in caregiving in high dependence situations and 4) who coordinate caregiving services and are decision makers.

The proposed training courses seek a methodological transformation, from a memoristic and passive learning process that prioritizes contents, to a more interactive, practical and experiential one, which favors the progressive building of competencies. The suggested training model is hybrid: it combines synchronous and asynchronous instances, both in-person and through virtual learning environments. Hybrid models make it possible to respect the in-person preference of most caregivers and also help reconcile work, training and family time. The training load for people with no previous experience is 300 hours and the training for experienced caregivers is 240 hours. This training load seeks to balance, on the one hand, the need to cover basic competencies and professionalize the role and, on the other hand, the availability of time, the educational level of the intended trainees, and the countries' budgetary constraints.

For the implementation of the training proposals, we recommend government leadership to unify a training model, set content, approach and timetable, and to institute the certification of competencies to perform these occupational activities.

The intention is to build a specific professional identity for this group, which can be promoted and demanded for labor practice. Along the same lines, it is recommended that Training 2, aimed at people with no previous experience in care, be included in each country's public technical education system, and thus legitimize the professionalizing profile of this educational path.

The leadership of the public system to organize care based on professionalism and knowledge does not mean that the provision of training should be the sole responsibility of the public sector. Partnerships between the State, civil society, the market and families are key to generate conditions that allow those interested in training to have access to it throughout a country, and sustain it over time.

The complexity of the role of the caregiver requires training, but it is also necessary to assign value (economic and symbolic), visibility, and social relevance to the work of caregiving, recognizing it as a task that sustains life (UN Women, 2018.) In this vein, it should be noted that although in some countries there are policies that seek to incentivize training through better salaries, the current average compensation for the task is low. In addition, gender biases still persist in the care sector. As a society, it should be understood that care is not a female task by default, and it should be mainstream that care corresponds to everyone, which entails accepting that it is both a right and a duty of the community as a whole and that, as such, care practices demand reciprocity.

The present study has limitations. On the one hand, the survey of caregivers corresponds to a limited and non-representative sample of workers in the care sector. In addition, our sample does not include any Caribbean countries. It will be necessary for future research to study the challenges and conditions of paid and unpaid caregivers in several countries in Latin America and the Caribbean with a larger and more representative sample, which should also include home-based care.

On the other hand, training is still unavailable for those who perform unpaid care tasks at home and within the framework of family relationships. The training proposals presented in this document can be a good basis for thinking about such training, but they will have to be adapted to the challenges and specifics of the home context. It is also necessary to develop devices that allow caregivers to share and contrast their practices with both experts and peers, building networks of emotional support and professional development that transcend the training instances. Caring for the caregiver is an issue to be highlighted, and consequently, it is necessary to have a team that can identify, respond to and provide support in situations of occupational stress, which would reduce absenteeism, labor turnover, and cases of abuse and/ or neglect.

Caring must be an ethical option for all stakeholders, including governments, which should be first to provide care to their caregivers. The ultimate goals of the curricular proposals presented in this study are collaborating in the construction of quality and supportive labor and social relations, enabling personal and professional development, and encouraging participation in training that allows to discover and nurture personal vocation.

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9. Annexes

Annex A. Caregiver Survey Results

TABLE A1. Educational level of caregivers

	Frequency	Percentage	Cumulative percentage
Less than 6 years	3	2.8	2.8
Up to 6 years	23	21.1	23.9
Up to 9 years	43	39.4	63.3
Up to 12 years	19	17.4	80.7
More than 12 years	21	19.3	100
Total	109	100	

Source: Developed by authors, based on surveys of caregivers. Number of observations: 109.

TABLE A2. Definition of caregiving as practiced by caregivers

	Frequency	Percentage
Definition focused on needs	14	13.0
Person-centered definition (PCA)	79	73.1
Definition focused on addressing BADL	15	13.9
Total	108	100.0

Source: Developed by authors, based on surveys of caregivers. Number of observations: 109.

TABLE A3. Areas of training interest as perceived by caregivers

		Frequency	Percentage
Care for physically dependent persons	No	54	49.5
	Yes	55	50.5
Nursing techniques	No	47	43.1
	Yes	62	56.9
First aid	No	34	31.2
	Yes	75	68.8
Addressing mental health-related pathologies	No	48	44
	Yes	61	56
Palliative and end-of-life care	No	44	40.4
	Yes	65	59.6
Cognitive, social, and motor stimulation.	No	40	36.7
	Yes	69	63.3
Relationships and communication with older people	No	41	37.6
	Yes	68	62.4
Working with families	No	51	46.8
	Yes	58	53.2

Source: Developed by authors, based on surveys of caregivers. Number of observations: 109.

TABLE A4. Training needs for specific tasks perceived by caregivers.

		Frequency	Percentage
Hygiene and dressing	No	73	67
	Yes	36	33
Mealtime assistance	No	79	72.5
	Yes	30	27.5
Transfer techniques and postural changes	No	56	51.4
	Yes	53	48.6
Cleaning of rooms and common areas	No	85	78
	Yes	24	22
Planning and execution of leisure activities	No	46	42.2
	Yes	63	57.8
Interviews with family members	No	60	55
	Yes	49	45
Emotional assistance and support	No	27	24.8
	Yes	82	75.2

Source: Developed by authors, based on surveys of caregivers. Number of observations: 109..

TABLE A5. Preference of caregivers: duration of training.

	Frequency	Percentage
Short course, up to 100 hours	33	30.6
Long course, up to 200 hours	5	4.6
Professional technical training with degree	51	47.2
University training, 2 to 4 years	19	17.6
Total	108	100.0

Source: Developed by authors, based on surveys of caregivers. Number of observations: 109.

TABLE A6. Preference of caregivers: type of training

	Frequency	Percentage
Fully in-person	34	31.2
Virtual Synchronous	31	28.4
Virtual asynchronous	8	7.3
Hybrid	36	33.0
Total	109	100.0

Source: Developed by authors, based on surveys of caregivers. Number of observations: 109.

Annex B. Comparative table of good training practices at worldwide

	Italy	Finland	Spain	France	
Training diploma	Socio Sanitary Operator	Practical nursing.	Caregiver of dependent people in institutions. Geriatric assistant	Nursing assistant.	Educational and social support worker.
National Qualifications Framework	Yes	Yes	Yes	Yes	Yes
Target groups	People with psychological and/or physical needs.	Older persons, children and youth, people with substance abuse and people with disabilities	Dependent persons.	Older and/or dependent persons.	Children and youth, adults, older or disabled persons.
Areas of intervention	Healthcare, community, and domestic frameworks	Healthcare, social- health, educational, housing, frameworks, etc.	Institutional.	Healthcare (including hospital), domestic and housing frameworks.	Educational, social and housing frameworks.
Training duration	1000 hours 550 theoretical hours 450 practical hours	Between 2 and 4 years.	450 hours 370 theoretical hours 80 practical hours	1540 hours 770 theoretical hours 770 practical hours	1365 hours 24 weeks of practice
Care model	PCA	PCA	PCA	PCA	PCA
Main contents	Sociocultural, institutional and legislative Psychological and social Healthcare Technical and operational	Encouragement of growth and social inclusion. Promotion of wellbeing and functional capacity. Promotion of health, safety and wellbeing. Maintenance and promotion of functional capacity.	Support in the organization of interventions at the institutional level. Care intervention for hygienic and nutritional care in institutions. Intervention in social and health care in institutions. Psychosocial support, relational and communicative care in institutions	Support in the organization of interventions at the institutional level. Care intervention for hygienic and nutritional care in institutions. Intervention in social and health care in institutions. Psychosocial support, relational and communicative care in institutions	Assisting persons in activities of daily and social life. Assessment of clinical status and appropriate collaborative care. Information and support to individuals, their families and other professionals. Quality/risk management teamwork.
Methodology	Theoretical and practical training	Theoretical and practical training	Theoretical and practical training	Theoretical and practical training	Theoretical and practical training
Assessment	Final exam, of a written and a practical test, generally conducted in the classroom.	Practical tasks in authentic work.	Assessment after each module.	Assessment of competencies acquired in practical training.	Assessment of each completed module Practice assessment. Written, oral assessment and/or project (depending on each module.)

Source: Developed by authors

Annex C. Comparative table of current training in Latin America and the Caribbean

	Uruguay	Colombia	Costa Rica	
Training diploma	Course on Assistance to Dependent Persons	Basic Care of Functionally Dependent Persons at the National Learning Services	Comprehensive care for Older Persons at the National Learning Institute	Comprehensive Assistance for older persons at Comprehensive Family Counseling
National Qualifications Framework	No	No	Yes	Yes
Target groups	Dependent persons throughout the life cycle (not only older persons)	Older persons and people with disabilities	Older Persons	Older Persons
Areas of intervention	Centers and homes	Homes	Centers and Homes	Centers and Homes
Training duration	152 hours	1296 hours	700 hours	750 hours
Care model	Social and health care, with some elements of the PCA approach.	Social and health care, with some elements of the PCA approach.	Socio-sanitary. We did not observe PCA elements	Social and health care, with some elements of the PCA approach.
Main contents	Biopsychosocial characteristics of aging, law and gender perspective, social vision of old age. Hygiene-comfort care, related to activities of daily living, first aid. Humanization of care. Prevention of violence and abuse. Leisure and free time management. Communication with families. Self-care and rights of the caregiver.	Care and assistance related to basic daily activities and degree of autonomy, strategies for emotional and spiritual support, health care activities, self-care, effective and efficient communication, ethical principles for building a culture of peace, environmental protection practices, occupational safety and health.	Contextualization of care for older people, application of biosecurity protocols, attention to risks and emergencies during care, mobilization, transfer and human movement, and cognitive stimulation. In addition, the training is complemented with a food-handling course and a course on cultural recreation for older people.	Introduction to gerontology, social elements of caregiving, psychological elements of caregiving, biological elements of caregiving, spiritual elements of caregiving and caregiver self-care.
Methodology	Theoretical and practical training	Theoretical and practical training	Practical exercises are present during the courses, but there isn't an established final practice	Practical exercises are present during the courses, but there is no established final practice.
Assessment	Accreditation at the end of each module or at the end of the whole program, integrating theoretical and practical contents.	Continuous assessment throughout the process, including internships.	Continuous assessment throughout the process, including internships.	Continuous assessment throughout the process, including internships.

Source: Developed by authors

Annex D. Competencies of the four training curricula developed.

TABLE D1. Training 1 aimed at people already working in care: general and specific competences

Name of the program. Update for caregivers: PCA in the care of older people in long-term and day centers.	
General competence	To develop skills for the assistance and care of older people from an ethical and welfare framework based on the principles of person-centered care, autonomy, good treatment, maintenance of a meaningful and significant life, self-care, and teamwork.
Specific competencies	1) To apply the person-centered care model in the daily practice of care, ensuring the development of a life project in accordance with the strengths, interests, needs and wishes of older persons.
	2) To understand the processes of aging and the diversity of old age from a lifespan perspective, with respect for a person's dignity, rights and experiences.
	3) To develop comprehensive care skills, strategies, resources and procedures, in accordance with the principles of PCA, which guarantee the wellbeing, self- determination and decision making of older people in the framework of daily life.
	4) To implement strategies and tools that promote meaningful activities, participation and social inclusion of older people.
	5) To choose and apply strategies that enable self-care and modification of occupational risk factors while exercising the role.
	6) To develop attitudes and strategies for teamwork, construction and implementation of projects that promote care.

Source: Developed by authors

TABLE D2. Training 2 for people with no previous experience: general and specific competencies

Name of the program. Basic technical training: Caring for older people from the PCA approach.	
General competence	To develop skills for the good care of older people, consistent with the ethical principles of the person-centered care approach.
Specific competencies	1) To apply the person-centered care model in the daily practice of care, promoting a meaningful daily life that ensures the continuity of the individual life project, based on the talents, strengths, interests, needs and desires of older persons in need of care.
	2) To understand the processes of aging and the diversity of old age from a lifespan perspective, with respect for a person's dignity, rights and experiences.
	3) To develop technical, personal and relational skills for the exercise of the role of expert professional in accordance with the principles of PCA, developing and proposing care plans together with the dependent persons and other professionals of the care team, prioritizing wellbeing and promoting autonomy and independence on a daily basis.
	4) To implement strategies and tools that promote the personalization of care and the implementation of meaningful and significant activities for people, with their effective participation.
	5) To choose and apply strategies that enable self-care and modification of occupational risk factors while exercising the role.
	6) To develop attitudes and strategies for teamwork, conflict resolution and the promotion of relational health, based on complementarity, appreciation, and emotional management.

Source: Developed by authors

TABLE D3. Training 3 for those who want to specialize in the care of people in highly dependent situations. General and specific competences

Name of the program. Specialized training: Care focused on highly dependent older persons in long-term and day centers.	
General competence	To develop skills for the good care of older persons in high dependence situations, consistent with the ethical principles of the person-centered care approach.
Specific competencies	1) To apply the person-centered care model in the daily practice of care, promoting a meaningful daily life that ensures the continuity of individual life project, based on the talents, strengths, interests, needs and desires of older people in a highly dependent situation.
	2) To understand the processes of aging and the diversity of old age from a lifespan perspective, with respect for a person's dignity, rights and experiences.
	3) To develop technical, personal and relational skills for the exercise of the role of professional of reference in coherence with the principles of PCA, developing and proposing care plans together with high dependence persons and other professionals of the care team, prioritizing wellbeing and promoting autonomy and independence on a daily basis.
	4) To implement strategies and tools that promote the personalization of care and the implementation of meaningful and significant activities for people, with their effective participation.
	5) To choose and apply strategies that enable self-care and modification of occupational risk factors while exercising the role.

Source: Developed by authors

TABLE D4. Training 4 for care service coordinators and decision-makers. General and specific competences

Name of the program. Leadership and management of centers for older people from the PCA approach.	
General competence	Add skills for the management and leadership of institutions and teams aimed at the care of older people in accordance with the ethical principles of the person-centered care approach.
Specific competencies	1) To understand the person-centered care model and to know the scope that promotes its advancement in long-term and day care centers for older people.
	2) To analyze challenges and add strategies for the implementation of proposals and environments in accordance with the PCA approach in the centers.
	3) To develop competencies to exercise positive leadership that promotes an organizational culture centered on the people involved in care; older people, people with emotional bonds, and professional caregivers.

Source: Developed by authors

Annex E. Technical, relational and self-care competencies in the proposed training.

TABLE E1. Technical competencies in the proposed training courses

Competition	General Description	Examples
To develop skills, strategies, resources and procedures for comprehensive care, aimed at preserving the dignity of individuals and promoting their autonomy and well-being, within the framework of daily life.	The provision of support and care is done from a human rights framework, in which the person cared for must perceive that their dignity and autonomy are guaranteed. To this end, training must be provided in the provision of quality care that includes both the necessary techniques and care procedures, as well as attitudes.	To support and assist in dressing and undressing, respecting identity, choices, intimacy and personal image. Carry out hygiene support tasks respectfully, in conditions of privacy, with no more people than necessary, attending to the person's opinions and promoting their involvement. Support in all activities of daily living, respecting people's time and promoting functional independence, avoiding overprotection.
To apply the PCA model in the daily practice of care, promoting a meaningful daily life that ensures the continuity of the individual life project, based on the talents, strengths, interests, needs and desires of older people in need of care.	Placing the person at the center of attention facilitates the understanding and knowledge of their talents and strengths. It is understood that entering the center entails supporting the development of the person's life plan, understanding that this is not interrupted in old age.	Agree verbally and in writing on how you want to be cared for. Respect their wishes when making decisions that affect them, such as changes in treatment, diet, etc. If this is not possible, enlist the help of family members or significant others. Use cognitive accessibility tools: simple language, pictograms (graphics that represent objects, spaces or actions) that facilitate communication and decision making, etc.
To understand the process of aging and the diversity of old age from a Lifespan perspective, and That each person is unique, respecting their life context and experiences.	Knowledge about the aging process and its associated changes, working from the perspective of the uniqueness of individuals. It is about understanding that the changes associated with aging are multidimensional and include both losses and gains. Each person is unique and has the possibility to build a life plan according to their experiences and expectations.	Working on the myths and beliefs associated with the health of older people on a physical, social and emotional level: "growing old is also about winning". Avoid treating all people in the same way, adapting the action procedures to the specific situation of each of them, humanizing the action protocols. Development of useful tools to manage complex behaviors in people with dementia. Providing the necessary support, avoiding reducing the person to the disease.
Implement strategies and tools that promote the personalization of care and the implementation of meaningful and meaningful activities for people, with their effective participation.	This is about knowing the different tools to get to know the person and assisting them in their daily life. Through the participation of the person in the development of a care and life plan, the person's preferences are known, personalization and the development of meaningful activities for each person are promoted (daily activities, activities associated with leisure, social networks, etc..)	Use communication tools and strategies and records that let you know the experiences and life story of the person and identify which activities are meaningful to them, assisting or supporting them when necessary. Ask family members or significant others when the person is unable to provide the information themselves (e.g., in cases of dementia.) To inquire about vital and current interests that can be developed in the framework of daily life (artistic, social, spiritual, etc.) To plan together stimulating and meaningful activities (watering the plants, collaborating in the kitchen, etc..)

Source: Developed by authors

TABLE E2. Relational competencies in the proposed training

Competencies	General Description	Examples
Recognize and integrate relational skills that promote the humanization of care and promote autonomy.	Affectionate treatment. Respect for the dignity and intrinsic will of older persons. Promotion of autonomy through decision making in daily life activities. Skills to know relational styles and eliminate violence and mistreatment towards older people.	Organize times to encourage the person to perform daily activities with independence and assisting their options and choices, thus fostering their autonomy (e.g., support in eating and in the choice of related issues, rather than feeding them.)
To develop social and relational skills, promoting dialogue and negotiation and agreement processes with older people, their environment, and team.	Identification and assertive management of emotions. Identification of verbal and non-verbal communication strategies for the practice of active listening and empathy. Promotion of the person's involvement in decision making in their daily life. Teamwork skills.	Facilitate dialogues that promote the expression and initiative of the older person. Identify care and communication practices that relegate the person to a passive position or infantilize them. To analyze similarities and discrepancies between the care provided and how we would like to be cared for, promoting empathic listening. Identify relational styles that tend to overprotection or mistreatment. Analyze factors that limit or strengthen teamwork and the definition of roles.
Add tools that allow the construction of life projects and integrate end- of-life support strategies	Meaning of life in old age, life project and interests at the end of life. Creation of spaces to talk about the end of life and project decisions that make this process. Assisting the person and family environment in the dying process. Self-care skills in the face of bereavement associated with caregiving.	To support the person spiritually so that they can discuss the fears associated with death and dying. Support and record decision-making in the context of assistance. Support and include the family in the decision-making process, in agreement with the older person. Management of professional distance or closeness in dealing with end-of-life situations.
To know non-pharmacological meditation and stimulation strategies, which can be flexible according to the interests of individuals and applicable in the context of daily life.	Music therapy. Spirituality applied to gerontological care and meditation. Artistic expression. Relaxation and massage. Physical activity. Reminiscence and reality orientation therapy	Use the benefits of music to provide calm and well-being to people, especially in the case of people with dementia. Propose therapeutic mediation resources that promote interaction according to the person's preferences and interests: for example, reminiscence in relation to their life experiences. Organize the activities proposed in the centers collaboratively with people based on their interests.
To understand the importance of a vision of care as co-responsibility between the older person, the family and the center, promoting positive synergies among those involved.	Promotion of the fundamental role of families in the care and preservation of the quality of life of older people. Reciprocal relationship between family and staff, with respect, trust and appreciation.	Enable family participation in meaningful activities for individuals. Include families in the intervention framework and share decision making in complex situations.

Source: Developed by authors

TABLE E3. Self-care competencies in the proposed training.

Competencies	General Description	Examples
Select and apply strategies that enable self-care and modification of occupational risk factors in the performance of the role.	Emotional management and identification of bonding and physical behaviors associated with overload syndrome. Knowledge of the professional role and the limits against abuses associated with the work practice.	Planning the use of free time, promoting the dedication of time to one's own projects or pleasurable activities. Mobilization and transfer techniques to avoid risks for the cared person and physical fatigue for the caregiver. Relaxation techniques to compensate or prevent stressful situations. Knowledge of the legal rights and conditions of the caregiver to identify possible abuses.
To develop attitudes and strategies for teamwork, conflict resolution and the promotion of relational health, based on complementarity, appreciation, and emotional management.	Knowledge of the importance of teamwork and the role of all team members in generating a good working environment that benefits caregivers and cared-for persons.	Team meetings as a good practice to review professional interventions, face complex situations, and resolve conflicts. Development of supervision and peer review groups as a way to socialize good practices and challenges of the task.

Source: Developed by authors

Annex F. Training curricula and methodological strategies

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