

**A FRAMEWORK FOR CONTEXTUALIZATION OF
FAMILY CENTRED CARE IN THE MANAGEMENT OF
HOSPITALISED CHILDREN IN KENYA**

BY

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DECLARATION

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DEDICATION

This thesis is dedicated to my children Japheth, Emmanuel and Joseph, and to all children whose health I treasure.

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LIST OF ABBREVIATIONS

AAP: American Academy of Paediatrics

BScN: Bachelor of science Nurse

CRC: Convention on the Rights of the Child

DAN: Advanced Diploma in Nursing

FCC: Family - Centred Care

FGD: Focused Group Discussion

GCH: Gertrude Children's Hospital

GoK: Government of Kenya

IMAM: Integrated Management of Acute Malnutrition

IMCI: Integrated Management of Childhood Illnesses

IMNC: Integrated Maternal and Newborn Care

KDHS: Kenya Demographic Health Survey

KEPI: Kenya Expanded Programme on Immunisation

KNH: Kenyatta National Hospital

KRCHN: Kenya Registered Community Health Nurse

MDG: Millennium Development Goals

MO: Medical Officer

MOH: Ministry of Health

NCAPD: National Coordinating Agency for Population and Development

NAWSCH: National Association for the Welfare of Sick Children in Hospital

NCK: Nursing Council of Kenya

NHSSP: National Health Sector Strategic Plan

SPSS: Statistical Package for Social Scientist

UK: United Kingdom

UoN: University of Nairobi

WHO: World Health Organisation

WWII: World War II

IMCI: Integrated Management of Childhood Illnesses

ABSTRACT

Introduction: Family-centred care (FCC) is concerned with the professional support accorded to a sick child and his family in an interactive system with healthcare providers. The philosophy and principles of the approach have made it to be identified as “best practice” in paediatric hospitals. Modalities on how the approach can be implemented and actualised in the Kenyan set up have not been explored.

Purpose of the study: The overall goal of the study was to develop a framework for the contextualization of FCC in management of hospitalised children in Kenya.

Methodology: A descriptive cross sectional study using mixed methods was carried out in two phases at Kenyatta National Teaching and Referral Hospital and Gertrude’s Children’s Hospital, Kenya. The study population included healthcare providers, parents of hospitalized children and lecturers. The sample size for nurses and parents who participated in the study was calculated using Fisher’s formula and this was a total of 301 respondents comprising 160 parents and 141 nurses. The other respondents were purposively selected. Multi-stage stratified random sampling was used in selecting the respondents from each category. Data were collected by use of questionnaires and interview and focused group discussion guides. Quantitative data were analyzed by use of descriptive statistics aided by the Statistical Package for Social Scientists (SPSS) programme. Significance testing was done by use of Chi Square, independent t-test, logistic and multiple regressions at 95% significance level. Qualitative data were analysed using content analysis, were organized in themes and sub-themes.

Results: On family involvement in decision making, 54.6% of the parents were actively involved whereas 45.6% were passively involved. The healthcare providers mainly involved the hospitalised child's parents in carrying out daily routines (68.8%, n=99). The healthcare provider's parental status exhibited a statistically significant association with parental involvement ($X^2=3.916$, $P< 0.038$). There was a statistically significant association between the healthcare providers' knowledge of FCC and the level of parental involvement in decision making ($X^2=0.444$, $P<0.001$). The results further reveal that the parent's level of education and the institution of admission have a statistically significant association with their involvement in decision making ($X^2 = 17.13$, $P= 0.021$ and $X^2 = 15.01$ and $P <0.001$ respectively). On accompaniment of hospitalised children during procedures, both the healthcare providers and the parents acknowledged that it is important.

The study established that visiting of the hospitalised child by family members especially children is severely restricted particularly in the Teaching and Referral Hospital. Despite this, however, majority of the healthcare providers and the parents acknowledged the importance of the hospitalised children being visited by other children. The results indicate that 63.2% of the healthcare providers have heard about FCC and 74.7% (n=68) of them did practise it. The study further established that there were no documented policy guidelines in the two institutions on how the healthcare providers should work together with the sick child's family in the care of the hospitalised child.

Results of this study indicate that the healthcare providers face various challenges including difficult working conditions, delays from other members of the healthcare team, communication problems because of language barriers, large number of patients, the disease itself and parental ignorance among others. The paediatric nurses in their effort to practice FCC, experience challenges including lack of support, staffing and time limitations and parental ignorance.

Concerning the perspectives of partnership in care, both the healthcare providers and the parents explained that it entails the two parties working together in planning, implementing and evaluating care for the hospitalised child. This, the study established can be achieved through training and sensitization, review, establishment and documentation of childcare policies and implementation guidelines, improving of the work environment and attitude change both in the healthcare providers and the parents.

Conclusion: The study concluded that low level of knowledge of FCC by the stakeholders involved in the care of the hospitalised child is the main hindering factor in partnership establishment. It further concluded that with training and sensitisation, FCC can be implemented using the evolved framework.

CHAPTER ONE

1.0 INTRODUCTION

This chapter introduces the topic of study. The key areas presented include background to the study, problem statement, justification, study questions and significance of the study. The chapter ends by discussing the Paradigms applied in the study and the operational definition of terms.

1.1 Background to the Study

Family-centred care (FCC) is concerned with the professional support accorded to a sick child and his family in an interactive system with healthcare providers. The philosophy and principles of FCC have made it to be identified as “best practice” in paediatric hospitals (Eichner, 2002 - 2003). The approach clearly recognizes families as integral partners in the care of their sick children (Johnson et al 1992). According to Neff and Spray (1996), the approach was born out of the recognition that the emotional needs of hospitalised children were in most cases unmet, parents were not involved in the direct care of their children, children were often unprepared for procedures and tests and that visiting was severely controlled.

The American Academy of Paediatrics (AAP) describes FCC as an approach that is based on the understanding that the family is the child’s primary source of strength and support and that the children and family’s perspectives and information are important in clinical decision making. Family-centred practitioners are keenly aware that healthcare

experiences can enhance parents' confidence in their roles and, over time, increase the competence of children and young adults to take responsibility for their own healthcare, particularly in anticipation of the transition to adult service systems (Eichner, 2002 - 2003). In explaining the approach of FCC O'Malley (2008) raises three issues that are central to it. He points out that in practising FCC, care is provided to a person; not a condition. He adds that the patient is best understood in the context of his or her family, culture, values, and goals, and further that showing of honouring results in better healthcare, safety, and patient satisfaction.

In management of hospitalised children, the developed world has embraced the FCC approach with improved patient and family outcomes (Johnson, et al, 1992). The approach enjoys a long history of establishment. In Britain, for instance, the contemporary social construction of FCC began to emerge in the 1950s as a result of the recognition of the emotional needs of children (Coleman, 2002). Prior to the 1950s, the care in hospital was influenced by medical knowledge about infection control and strict child rearing theories which did not recognize the importance of parental presence. The concept has however progressed from parent involvement/participation to the current state whereby children and siblings are included as participants in care (Ibid.).

In the developing world, there is scarce documentation on the approaches used in the management of hospitalised children. A study conducted by Richter et al (2009) in South Africa observed that the ward atmosphere and care context was emotionally stressful to both the hospitalised children and their parents. Nursing staff were reluctant to become

involved with parents and children. They performed routine and other procedures, but otherwise left the children alone. On the other hand, a study conducted by Sodderback & Christensson (2007) into the care of hospitalised children in Mozambique found that nurses valued the mother's presence and their involvement in care to the extent that they stated that the child's bed is the mother's bed.

In Kenya, a study conducted by Orinda (1982) found that little thought is given to the role of the mother when her sick child is admitted to the paediatric ward and planning for the ward does not include the mother. Another study conducted by Makworo and Laving (2010) on parental involvement by nurses in the management of hospitalised children found that parents were mainly involved in giving information about their sick child and preparing the child for procedures but not in planning and implementing care.

1.2 Statement of the Problem

Appropriate management of hospitalised children is crucial to the recovery process. In relation to adult patients, management of sick children is unique because they are more often unable to communicate verbally and changes in their health status and determinants occur more rapidly. In this respect, sick children cannot be viewed in isolation of their families. Various studies on the care of sick children emphasize that parental involvement in shaping a child's response to illness is fundamental in the healing process and that their participation in preparing their sick child for hospital experiences is paramount (Hansberger, 1989; Lacovitti, 1992 and Hilary & Connie, 2003). Despite this vital role played by the parent and generally the family in the recovery process of a hospitalised

child, the situation in hospitals in Kenya is such that family involvement is highly restricted and visitation of the hospitalised child is limited to a few hours per day.

Child mortality rates in Kenya are still high despite the government's effort to ensure that they are lowered. According to the Kenya Demographic Health Survey (KDHS, 2008-2009), childhood mortality levels in Kenya are decreasing. Infant mortality was 52 deaths per 1,000 live births for the five year period before the survey compared with 67 deaths for the 5–10 year period before the survey. Under-five mortality levels have also decreased from 95 deaths per 1,000 live births to 74. The reduction in the mortality rates has been attributed to increases in child vaccination coverage and ownership and use of mosquito bed nets (Kenya National Bureau of Statistics and ICF Macro, 2010). These strategies are however community-oriented not in-patient. Despite the reduction in the mortality rate, the figures are still high and therefore there is need to put in place more child mortality reduction strategies. Such strategies are management oriented and are intended to empower families in order to further improve on the indices and thus reduce the disease burden among children, alleviate the care burden on healthcare providers, enhance parent participation in the care of their sick children while in hospital and eventually roll over into improved care at home.

Most healthcare providers in Kenya do not take care of sick children holistically, but rather treat them only for the presenting illness (National Co-ordinating Agency for Population and Development) (NCAPD) and ORC Marco, 2005). Wamae et al (2009) when explaining child healthcare in Kenya points out that the approach commonly used in the management of the children is Integrated Management of Childhood Illness

(IMCI). This approach has been tailored to the management of children aged below five years and for only specific conditions. Therefore, there are no clear guidelines for the management of other conditions not covered in the strategy and for the children aged above five years.

In view of the above, the question which comes to the fore and constitutes statement of the problem is, “What strategies can be put in place so as to enhance the practice of Family-Centred Care in the management of hospitalised children in Kenya?” A framework developed from the evolved strategies forms a platform for contextualization of the approach in Kenya.

1.3 Justification of the Study

The health status of children is an indicator of a country’s level of health. Childhood mortality rates are basic indicators of a country’s socio – economic level and quality of life. Ill-health is one of the principal reasons why households become poor and remain poor. Sick children require increased family expenditure because of hospital fees and out of pocket costs for both the patient and guardian (Jones, Steketee, & Black, 2003).

Datta (2009) summarizes the effects of childhood illness and hospitalization to both the child and family. He indicates that illness threatens both the physical and psychological development of children. Further, it causes pain, restraint of movement, long sleepless periods and restriction of feeds. Moreover, hospitalization results in separation from parents and home environment which may lead to emotional trauma. (Johnson, Jeppson, & Redburn, 1992). On the other hand, parents whose children have been admitted to the

hospital feel not only separation from their children but also have feelings of inadequacy as others (nurses, doctors) provide care for their children. Thus the parents experience feelings of anxiety, anger, fear, and disappointment, self-blame and possible guilt due to lack of confidence and competence for caring for the child in illness and wellness. This necessitates the need for care approaches that minimize these effects and FCC has been documented to have met this need (Johnson, Jeppson, & Redburn, 1992).

Family-Centred Care is a widely used model in paediatrics especially in the developed world, and is felt instinctively to be the best way to provide care to children in hospitals (Johnson, Jeppson, & Redburn, 1992). The historical background of FCC indicates that the approach was initially socially constructed in the UK. Conversely, in North America, it was constructed in social settings in which there were children with special needs. However, studies done by Coleman (2002) and Shields (2007) found that there has been a tendency to utilize the concept in other settings without always acknowledging that the needs of children and families may differ. These studies recommend that further evaluation of the concept should be undertaken, with regard to applicability in different settings to ensure that a more flexible approach is used to meet the needs of the client in each individual setting. Richter, Chandan and Rochat (2009), while discussing the hospital care of children in the developing world, acknowledge a limited existence of documentation on the approaches utilised. This study contributes substantially on shedding light on the status of family involvement in the care of the hospitalised children and how the approach can be contextualized in Kenya which is one of the developing countries.

The study was conducted at Kenyatta National Hospital (KNH) and Gertrude Children's Hospital (GCH). Kenyatta National Hospital is one of the National Teaching and Referral hospitals in Kenya. According to the Ministry of health, the national referral hospitals are centres of excellence and are charged with the responsibilities of providing leadership and high clinical standards and treatment protocols. This level of institutions further contribute in providing solutions to local and national health problems through research as well as to contributing to policy formulation (Muga et al, 2005). Gertrude Children's Hospital on the other hand is a private hospital and is the oldest and biggest private children's hospital in Kenya. The hospital is used for the training of nurses undertaking a higher national diploma in paediatric nursing and has adapted FCC in the child healthcare policies. According to Muga et al, (2005), private hospitals contribute forty percent of health services in the Kenya. Both institutions attract patients from diverse cultures and different socio-economic characteristics from all regions across the country and even neighbouring countries. It is in taking cognizance of the above factors that the study was undertaken in the two institutions.

Further, to contribute to the findings of studies that have had their focus only on nurses (Paliadelis et al, 2005 and Chuya, 2011), in this study, data were collected from the main stakeholders in the care of hospitalised children. These comprised paediatricians, medical officers, non-paediatric nurses, paediatric nurses, nurse managers, lecturers involved in teaching the paediatric component to healthcare trainees and parents.

1.4 Research Questions

The study set out to answer the following questions:

- i. What is the current status of family involvement in the management of hospitalised children in regard to policies and practices?
- ii. What challenges do healthcare providers encounter while managing hospitalised children?
- iii. What are the healthcare providers' and the parents' perspectives of partnership in the management of hospitalised children?
- iv. What strategies need to be put in place to facilitate implementation of FCC in the management of hospitalised children Kenya?

1.5 Objectives of the Study

1.5.1 Broad Objective

The broad objective of this study is to develop a framework for the contextualization of family-centred care in the management of hospitalised children in Kenya.

1.5.2 Specific Objectives

- i. To establish the current status of family involvement in the management of hospitalised children in regard to policies and practices
- ii. To explore challenges experienced by healthcare providers while managing hospitalised children
- iii. To explore the healthcare providers' and parents' perspectives of partnership in the management of hospitalised children
- iv. To explore facilitating factors for partnership establishment in the management of hospitalised children

1.6 Assumption of the Study

The study is embedded in the assumption that both the healthcare providers and parents are willing to work in partnership in the care of hospitalised children.

1.7 Significance of the Study

The study was designed with the realization that the mode of management of hospitalised children plays a crucial role in their recovery process. The researcher, noting that the concept of FCC and models of nursing have been mainly applied and evaluated in the developed world, has provided information on how the approach can be practised and how its implementation can be contextualized in Kenya. The information forms a basis for the revision and improvement of standards of paediatric and child healthcare in Kenya.

This study has explored the aspect of visitation an area that has had a paucity of data. This is particularly on the aspect of hospitalised children being visited by other children. The study has shed light on the perspectives of the healthcare providers and the children's parents. Further research on this subject needs to be done so as to explore the views of children on this aspect.

This study has shed light on the healthcare providers' and the parents' perspectives of partnership in care. In particular, no study has been done on the procedures that parents can do while in the ward. This study has identified a number of procedures both from the healthcare providers and the parents. This suggests another area of research to ascertain the uptake and outcome of such a practice.

The study has shed light on the status of FCC in the two hospitals, thus adding to other studies done in other Kenyan hospitals (Chuya, 2011). Findings of the study generate future research areas and in particular assessment of the applicability of the framework. It is hoped that implementation of the framework results in promotion of parent, child and healthcare provider satisfaction on the care provided to hospitalised children. Another benefit is a reduction of childhood morbidity and mortality as families are empowered on how to care for their children when sick or well through the sharing of health messages and provision of unbiased information. The framework enhances the building of child and family strengths, leads to decreased healthcare costs, and more effective use of healthcare resources.

1.8 Paradigms

Tuli (2010) identifies are two broad epistemological positions in research: positivism and interpretivism –constructivism. Positivism sees social science as an organized method for combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity. The nature of social reality for positivists is that: empirical facts exist apart from personal ideas or thoughts; they are governed by laws of cause and effect; patterns of social reality are stable and knowledge of them is additive. Researchers who work from this perspective explains in quantitative terms how variables interact, shape events, and cause outcomes. They often develop and test these explanations in experimental studies. On the other hand, an interpretivist-constructivist perspective, the theoretical framework for most qualitative research, sees the world as constructed, interpreted, and experienced by people in their interactions with each other

and with wider social systems. According to this paradigm the nature of inquiry is interpretive and the purpose of inquiry is to understand a particular phenomenon.

The researcher while considering the tenets of the two Paradigms and the scope and purpose of the study embraces hermeneutic phenomenology as the study's epistemological position. According to Bryman (2004), hermeneutic phenomenology is one of the philosophical heritages of interpretivism that is concerned with the question of how individuals make sense of the world around them and how in particular the philosopher should bracket out preconceptions in his or her grasp of that world. The goals of interpretive phenomenological research are to enter another's world and to discover the practical wisdom, possibilities, and understandings found there (Polit & Beck, 2012).

Phenomenology emphasizes that:

1. Social reality has a meaning for human beings and therefore human action is meaningful
2. It is the job of the social scientist to gain access to people's 'common sense thing' and hence to interpret their actions and their social world from their point of view.
3. The researcher's interpretations are further interpreted in terms of the concepts, theories and literature of a discipline.

The main focus of the study was to understand the participants' perspectives and experiences of partnership in the care of hospitalised children with intent of developing a framework for better partnership establishment. Hermeneutic phenomenology is well suited in meeting this goal.

1.9 Operational Definitions

Child: According to the World Health Organisation (WHO), a child as defined by the Convention on the Rights of the Child (CRC) is “Every human being below the age of 18 years unless under the law applicable under the child, maturity is attained earlier”. However, for purposes of this study, a child is any human being below the age of 12 years.

Healthcare provider: This refers to nurses and doctors who are involved in the provision of health care to children either directly (bedside) or indirectly (managerial level).

Bedside nurses: These refers to either the non-paediatric nurses or the paediatric nurses who are involved in the direct care of the hospitalised children

Non-paediatric nurses: These are the nurses working in the paediatric wards but have not undertaken a higher national diploma or masters degree in paediatric nursing

Paediatric Nurses: These are the nurses who have undertaken a higher national diploma or a master’s degree in paediatric nursing

Managers: these are the nurses and paediatricians working as administrators of the paediatric wards, departments, units and hospitals.

Parent: This refers to the person or persons responsible for the child’s well-being both in hospital and at home.

Family: In the context of the study this refers to the hospitalised child’s parents (as defined above) and the siblings

Acute cases: These are the children who are hospitalised for less than fourteen days

Chronic Cases: These are the children who have been in hospital for more than fourteen days without being discharged

Family-Centred Care: This is the professional support of a sick child and family through a process of involvement, participation and partnership underpinned by empowerment and negotiation.

Parental involvement: This refers to enabling of parents to be with their sick child at all times, involve themselves in basic care and to an extent decision-making. Fundamentally though, the healthcare provider remains in control of the family's involvement.

Parent participation: Is a situation where parents are involved by healthcare providers in decision making, delivery of care or just being consulted on their child's care. There is negotiation between parents and the healthcare providers with parents having the leeway to choose the level of participation. Parents are thus seen more as partners in care and able to take up more complex tasks.

Structure: This refers to the interrelationship between the key stakeholders involved in the care of hospitalised children.

Process: Refers to the changes expected to take place within the structure once training has taken place in order to have establishment of effective partnership between the healthcare providers and the child's family.

Outcome: Refers to the end result of the management process of the hospitalised child.

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter presents a critical synthesis of literature in regard to the concept of family centred care, trends in children's healthcare and theories in which the study is embedded. In selection of literature relevant to FCC surrogate terms are identified. Surrogate terms as defined by Rodgers (1989) are several terms that serve as manifestations of the concept. The surrogate terms included in the literature search were as follows:

- Family involvement in the care of the hospitalised child
- Parental involvement in the care of the hospitalised child
- Parental accompaniment of children during procedures
- Partnership in the care of the hospitalised child
- Partnership in paediatric care
- Family centred paediatric care

Further to understand the concept of FCC, an understanding of its attributes is deemed necessary. Identification of this attributes is guided by the following questions:

- What is family centred care?
- What are the characteristics of family centred care?
- How has family centred care evolved?
- What are the principles of family centred care?
- What are the elements of family centred care?
- What are the benefits of family centred care?
- What are the strategies of effective implementation of family centred care?

The theories guiding the study include; Casey's partnership Model, Farrel's model and Ahmann's family centred model. Other nursing theories also reviewed in this chapter include Peplau's interpersonal relationships theory and Leninger's Culture model. A critical synthesis of these theories results in a conceptual framework that guides the study.

2.1 Trends in Child Healthcare

Throughout history, major health problems for children have resulted from poverty. In addition, overcrowded, unsanitary and substandard living arrangements have been identified as critical factors in child health (Moules and Ramsay, 2008). It is in taking cognizance of these factors that before the 1970s, visiting of hospitalized children even by mothers was restricted as they were seen as the means of introducing potential life threatening infections. The prevalent view of doctors and nurses was that children were better of removed to hospital and away from their poor unsanitary homes and mothers who were unable to provide the care and treatment they required (Davies, 2010). In the developed world and Britain in particular, nursing care of children is described as having moved from care by families in the home, to care by professionals in the hospital and finally to care in the home or hospital by family and healthcare professionals (Coleman, 2002).

In tracing the historical development of children's nursing in the UK between 1920 and 1970, Jolley and Shield (2009) indicate that children did not have access to their parents and that the staff were construed as being non-human. The nurses cared about the children and about their anxieties but hid the affection they had for the children.

Datta (2009), when describing the development of paediatric nursing in India, notes that remarkable changes have occurred in recent years due to changing needs of society, medical and technological advancements, political interests and changing trends within the nursing profession. This has also been occasioned by consumer demands, increased public awareness and greater understanding of child problems along with psychological aspects of illness and hospitalization. Datta further emphasizes that acceptance of FCC requires that nurses work in liaison with the health team and family to prepare mutually developed plan of care to minimize psychological trauma in relation to a holistic approach to child care.

Davies, (2010), describes the shift in children's care as being from exclusion to toleration and parental participation in the care of the hospitalised child. He indicates that in 1956, the Ministry of Health (MoH) in Britain set up a committee chaired by Sir Henry Platt to look at the welfare of children in hospital. The committee was mandated to make a special study of the arrangements made in hospitals for the welfare of ill children as distinct from medical and nursing treatment and to make suggestions which could be passed on to hospital authorities. Before then, parental visiting of hospitalised children was limited to few hours per week. The Platt report has been instrumental in changing the profession's attitudes and relationships with parents in the UK. This, alongside other trends at national and international levels, has led to increasing participation by parents in the care of their hospitalised children. In Britain, Canada and USA, between 1850 and 1910, the Children's hospitals were established by volunteers to take care of the poor and visiting was restricted to avoid cross-infection. Babies and small children were not

allowed because they required more nursing care and were more costly to care for than older children. As the 19th century progressed, the exclusion policy was waived and hospitals were reluctantly accepting admission of babies and small children. The Platt report recommended that:

- Children should not be admitted to hospital if it could be possibly avoided.
- Parents should be allowed to visit their child whenever they can, and to help as much as possible with the care of the child.
- Consideration should be given to the admission of mothers with their children, especially if the child was under five years of age.
- Children and adolescents should not be nursed on adult wards.
- The sister in charge of the ward should be a Registered Sick Children's Nurse, as well as a State Registered Nurse
- The emotional needs of children should be stressed in refresher courses for ward sisters.

After the Platt report, between 1959 and 1980, most hospitals in the developed world tolerated parents. Nurses still felt it was better to have the children alone than with their parents. In the 1960s, parents themselves formed the National Association for the Welfare of Sick Children in Hospital (NAWSCH) whose charter is that children have the right to have their parents with them at all times, provided this is in the best interest of the child. Accommodation should therefore be offered to all parents and they should be helped and encouraged to stay (Coleman, 2002, and Davies 2010).

Throughout history, children's nursing has thus shifted from the medical model of care to one of partnership in care with the child as the central focus and the parents and the nurse as partners in caring for the child through negotiation and empowerment. This has allowed the potential for change in control from the nurse to the child and family. It has also encouraged nurses to explore the effect of the child's illness on the family and thus the practice of FCC (Casey, 1995).

2.2 Child Healthcare in Kenya

Child health care in Kenya is offered at all levels from level one to level six government facilities, non-governmental facilities and private institutions. The key approach in the management of children in Kenya is the Integrated Management of Childhood Illness (IMCI) (Wamae, 2009)). According to the Division of Child Health, Kenya, other approaches that have been adopted include Integrated Management of Acute Malnutrition (IMAM) and Integrated Maternal and Newborn Care (IMNC).

The IMCI strategy is applied to children aged below five years with the aim of reducing infant and child morbidity and mortality by implementing three main components: improving health workers' skills in case management; improving the health systems; and improving family and community childcare practices. Kenya's child survival programme includes immunization through the Kenya Expanded Programme on Immunization (KEPI), enhanced nutrition through growth monitoring, and intensified efforts to combat malaria through promotion of insecticide-treated bed nets (Wamae et al, 2009)

2.3 Family-Centred Paediatric Care

Family-centred is a philosophy of care that recognizes the centrality of the family in the child's life and inclusion of the family's contribution and involvement in the plan of care and its delivery (Potts and Mandleco, 2012). The concept is a multifaceted and has evolved over time to become a central tenet of children's nursing. The concept has progressed from parental presence to parental involvement and participation and to partnership (Coleman, 2002 and Jolley & Shields, 2009). The concept was developed initially in the economically advantaged countries as a result of increased social awareness, which focused particularly on the importance of meeting the psychosocial and developmental needs of children, with an emphasis on the role of families in promoting the health and wellbeing of their children. FCC in paediatrics is based on the understanding that the family is the child's primary source of strength and support and that the child's and family's perspectives and information are important in clinical decision making (Mantovani, 2009). Thus the concept works in contrast to the medical model in which health professionals are directed to assume the roles of evaluator and controller of treatment interventions resulting in child and care giver dependence on healthcare providers (Potts and Mandleco, 2012).

Family-centred care strives to support families in their natural care giving roles and promotes patterns of living at home and in the community. Finally, parents and professionals are viewed as equals in a partnership committed to excellence at all levels of healthcare. In healthcare settings that have FCC philosophy, families are given

choices, provide input, and are provided with information that is understandable by them. The family is respected and its strengths are recognized (Moules and Ramsay, 2008)

2.3.1 Evolution of Family-Centred Paediatric Care

Jolley & Shields, (2009) describe the evolution of FCC as having been catalyzed by the effects of the Second World War (WWII) and the works of two British theorists and investigators, Bowlby and Robertson. Bowlby studied the effects of separation anxiety and grief and Robertson developed films on the effects of hospitalization on children. Parents as consumers of healthcare services have also been noted to have greatly influenced the development of FCC. This influence was through formation of associations like the NAWSCH of UK, Association for the Care of Children's Health in the USA which was later disbanded and the Institute for Family-Centred Care formed in 1992, the Australian Association for the Welfare of Children's Health of 1975, Children in Hospital Ireland 1970 and the European Association for Children in Hospital 2006.

In 1991, the UK in line with most of the world ratified the United Nations Convention for the Rights of the Child of 1989 in which emphasis was that children should not be separated from their parents. This led to the continued promotion of FCC (Davies, 2010).

The contemporary social construction of FCC began to emerge in Britain in the 1950s as a result of the recognition of the emotional needs of children. The NAWSCH was formed in 1961 by parents to advocate parental visiting. Prior to the 1950s the care in hospital was influenced by medical knowledge about infection control and strict child rearing theories which did not recognize the importance of parental presence. At the same time

children were often unprepared for procedures and tests and visiting was severely controlled (Coleman, 2002). Various studies that have been carried out on the approach have led to its continued evolvement from parent involvement or participation to include children and siblings as participants in care, that is, family participation (Neff and Spray, 1996 and Coleman, 2002).

2.3.2 FCC Practice Continuum

Smith, Coleman, and Bradshaw, (2002) while analyzing the evolution of FCC, realized that FCC is practised at different levels depending on parental needs and the abilities on the part of the healthcare provider to negotiate and be partners in care. Based on these findings, they developed the FCC practice continuum which indicates the various levels in which FCC can be practised based on the range of parental input. The levels thus range from being nurse-led at the lowest, to sharing equal status and being parent- led which is the ultimate goal of FCC. Where the nurse or parent is located on the practice continuum may vary with each admission, contact or according to the ability of the nurse to facilitate that part of the continuum. What is most crucial throughout the continuum is open communication as it is essential to the facilitation of the relationship between the healthcare provider and the parent. The practice continuum enables healthcare providers to facilitate any aspect within the range according to individual need rather than a blanket approach for all patients.

The FCC practice continuum thus provides clarity and flexibility to truly meet the needs of families and children. It can also be used as a tool to grade the level of practice of FCC

by the healthcare providers and the parents/ families. The continuum is as illustrated in figure 2.1.

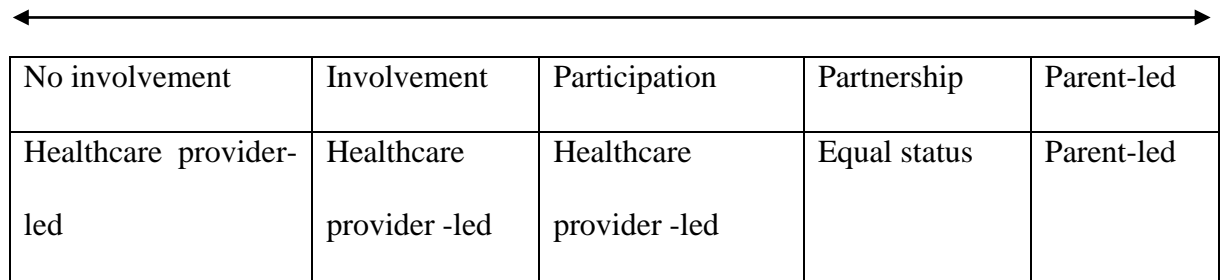


Figure 2.1: FCC Continuum

(Adapted and modified from Smith, Coleman, and Bradshaw, (2002)

2.3.3 Principles of FCC

The AAP Committee on Hospital Care (Eichner, 2002-2003) has outlined the principles that guide collaborative relationships between the children’s healthcare providers and families as follows:

1. Respecting each child and his or her family
2. Honouring racial, ethnic, cultural, and socioeconomic diversity and its effect on the family’s experience and perception of care
3. Recognizing and building on the strengths of each child and family, even in difficult and challenging situations
4. Supporting and facilitating choice for the child and family about approaches to care and support
5. Ensuring flexibility in organizational policies, procedures, and provider practices so that services can be tailored to the needs, beliefs, and cultural values of each child and family
6. Sharing honest and unbiased information with families on an ongoing basis and in ways they find useful and affirming
7. Providing and/or ensuring formal and informal support (such as family-to-family support) for the child and parent(s) and/or guardian(s) during pregnancy, childbirth, infancy, childhood, adolescence, and young adulthood

8. Collaborating with families at all levels of health care, in the care of the individual child and in professional education, policy making, and programme development
9. Empowering each child and family to discover their own strengths, build confidence, and make choices and decisions about their health
10. Celebrating successes.

2.3.4 Key Elements of Family Centred Care

The elements of FCC recognize each family's uniqueness, acknowledge the influence of a family as a constant in the child's life and emphasize the importance of providing services that demonstrate the value of collaboration between the health care provider, the child and the family. It is based on the premise that a positive adjustment to a child's level of health and well-being requires the involvement of the whole family. Bowden (1998) identifies the following key elements in FCC:

1. Incorporating into policy and practice the recognition that the family is the constant in a child's life, whereas the service systems and support personnel within those systems fluctuate.
2. Facilitating family professional collaboration at all levels of hospital, home and community care of an individual child, program development, implementation, evaluation and evolution, and policy formation.
3. Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.
4. Incorporation into policy and practice the recognition and honouring of cultural diversity, strengths, and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational, and geographic diversity.

5. Recognizing and respecting different methods of coping and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial support to meet the diverse needs of families.
6. Encouraging and facilitating family-to-family support and networking.
7. Ensuring that hospital, home and community services and support systems for children needing special health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs.
8. Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health.

2.3.5 Strategies for an Effective Family-Centred Care

Communication has been underscored by various researchers as an integral component for the effective implementation of FCC. A research conducted by Shields and King (2001) in Thailand, Indonesia, Australia and UK, found the need for communication between parents and staff. This has also been emphasized by Ahmann (1994) and Casey (1995).

Harrison (2009) explains the prerequisites for effective implementation of FCC. He states that “to provide FCC professionals must have an attitude and practice of respect, collaboration and support, and health care systems must provide support for staff,

adequate facilities, innovative and accessible services and opportunities for family participation.”

Langton (2000) underscores the importance of negotiation in the establishment of partnerships in the management of hospitalised children. She emphasizes the need for nurses to empower parents to negotiate through communication, information and support. Langton further indicates that nurses must possess the knowledge, attitudes and skills in order to be able to negotiate with parents and children and develop a practice of partnership in care.

According to Mckinney et al (2000), FCC is achieved when health care professionals can create partnerships with families, recognizing that the family is essential to the child and that the family has the right to participate fully in planning, implementing and evaluating the child’s care plan. Commitment to FCC means that the nurse respects the family’s culture, educational and socio-economic variations and can use the strengths of these variations. It also means that the nurse truly believes that the child’s care and recovery are greatly enhanced when the family fully participates in the child’s care. FCC therefore requires that the nurse establishes rapport with the family, identifies the family’s needs and expectations, is available and open to questions, provides family education and empowerment, gives and gets feedback from children and families and, manages conflict effectively.

Mantovani, (2009) has also outlined strategies for an effective family-centred care in hospital and private practice as follows:

1. Conducting or attending physician rounds (that is, patient presentations and rounds discussions) in the patients' rooms with the family present should be standard practice. This will facilitate the exchange of information between the family and other members of the child's health care team and encourage the involvement of the family in the decisions that are commonly made during rounds.
2. Invite parents and guardians to be present with their child during medical procedures and offer support before, during, and after the procedure. Working with families in decision making and information sharing in all practice settings should always take into account the older child's and young adult's capacity for independent decision making and right to privacy and confidentiality.
3. Promote the active participation of all children in the management and direction of their own health care, beginning at an early age and continuing into adult health care. During their work in collaboration with families and other health care professionals, healthcare providers should also examine systems of care, individual interactions with patients and families, and patient flow and should modify these as needed to improve the patient's and family's experience of care.
4. Share information with children and families in ways that are useful and affirming in every health care encounter.

5. Encourage and facilitate family-to-family support and networking, particularly with families of similar cultural and linguistic backgrounds or families who have children with the same type of medical condition.
6. Invite the families to collaborate in paediatric research programs. Families should have a voice at all levels in shaping the research agenda, in determining how children and families participate in research, and in deciding how research findings should be shared with children and families.
7. Create opportunities for children and families to serve as advisors in family advisory councils, committees, and task forces dealing with operational issues in hospitals, clinics and office-based practices; as participants in quality improvement initiatives; as educators of staff and professionals in training; and as leaders or co-leaders of peer support programs.

2.3.6 Benefits of FCC

According to Eichner (2002-2003), where FCC approach has been embraced, there is improved patient and family outcomes, increased patient and family satisfaction, building of child and family strengths, increased professional satisfaction, decreased health care costs, and more effective use of health care resources. Also as observed by Richter, Chandan and Rochat (2009) in their study on “Improving Hospital Care for young children in the context of HIV/AIDS and Poverty” in South Africa, actively engaging caregivers (parents) in the care of their children mitigates the care burden on hospital staff and improves young children’s experience of hospitalization.

Researches done in UK, Canada, Ireland and Wales indicate that when FCC is practised, there are shorter hospital stays representing an economic saving to hospitals as well as meeting the emotional needs of the child. The studies further affirm that care by parents works well for the children because they spend less time alone and have most of the care from a familiar person as compared to unaccompanied children who are cared for by a series of nurses and spend more time alone and crying (Davies, 2010).

The Institute of Family-centred care, has identified the following as the benefits of FCC to health care professionals, patients and families:

- Introducing health professionals and trainees to family-centred concepts during their training fosters lasting attitudes and practices.
- Families and patients benefit by knowing that their stories and experiences can serve as a catalyst for change or an affirmation for those who instinctively practise family-centred care.
- The experience of teaching can be empowering to patients and families.
- Patients and families appreciate the opportunity to give back.
- Patient and family faculty programmes strengthen an institutional commitment to family-centred care.

2.4 Theoretical Frameworks

Before 1988, there were no models developed specifically for the nursing care of children. The first model was published by Casey in 1988. The work focuses on the notion of partnership and how that is practised particularly with children and their

families while the child is sick. The model sees the child as the client (Moules and Ramsay, 2008).

Casey's theory underscores the importance of nurses working in partnership with children and their families. Her model comprises five key concepts which include the child, family, health, environment and the nurse. She recognizes the child as the client and emphasizes that the nurse should recognize that good health is shared with families. The nurse should therefore provide teaching and support to children and families to enhance partnership formation and promote the right of children to have parents accompany them during hospitalization and treatment. Thus the paediatric nurse complements parental care by doing those things for the child or his parents to meet the child's needs. The process of nursing is therefore carried out in partnership with the child and his or her family. The partnership model aims to establish a relationship of equality between the professional carers and parents. The success of the model depends on the parents' and the staffs' attitudes, enthusiasm and willingness to work together.

In considering the applicability of Casey's theory in the care of hospitalised children, her propositions are relevant as children cannot be cared for in isolation from their parents. Despite its applicability in paediatric nursing, in light of the current study, the theory falls short of explaining the position of other members of the healthcare team, health system managers and the other members of the sick child's family like the siblings. Despite the shortfalls, it is applied in this study as family centred care is all about partnership establishment in the care of the hospitalised child.

Clarke and MacDonald developed their model in 1988 while working at the Royal Manchester Children's Hospital. Their theory identifies factors important for the life of the child. These include: maintaining a safe environment, breathing, communicating, eating and drinking, eliminating, personal cleansing and dressing and controlling body temperature. The child will also need to be able to have understanding / education, rehabilitation, mobilizing, working and playing, expressing sexuality, sleeping, thinking and feeling, worshiping and that the child will eventually experience dying. She underscores the effect of the social and environmental factors in the child's life (Clarke & MacDonald, 1988).

Clark's theory focuses on key elements for the sustainability of children's life and development and can be applicable both to the sick and well children. The theory however does not stipulate who is responsible in ensuring the elements are available for the child. In light of the current study, whose focus is on healthcare providers and parents, the theory is not applicable as it does not consider the position of the key stakeholders in the practice of FCC, which ensures the child's basic needs as stipulated are met.

A theory based on the concept of FCC was developed by Ahmann in the USA (Ahmann, 1994). She defined the family as a constant in a child's life and emphasized the importance of family involvement through family- professional collaboration by creating room for communication, dialogue, active listening, awareness and acceptance of differences and negotiation. She further identified nursing strategies to promote

collaboration and include listening, explaining, acknowledging, recommending and negotiating. According to the theory, the nurse should establish a caring atmosphere, elicit and focus on parental goals and aspirations ascertain parents' perception of the child's condition and encourage parent participation by eliciting suggestions for care and negotiating disagreements about the plan of care (Ahmann, 1994). This is the theory that guides the current study.

Farrel (1992) also developed her partnership model based on Casey's model. She emphasizes the importance of partnership between the child, the family and the nurse. She specifies the role of the nurse to include care for the child and family, support teaching and referral. Because the theory emphasizes the idea of partnership and spells out the nurse's roles, these variables are applied in this study.

A theory on interpersonal relationships was developed by Hildegard Peplau in 1952. The theory looks at the patient as a partner in the nursing process rather than an object. She also describes nursing as a significant, therapeutic interpersonal process, an educative maturing force that aims to promote forward movement of creative, constructive, productive, and personal and community living. She identified the nurse as being a teacher, resource, counsellor, leader, technical expert and surrogate. She emphasizes that when a client seeks help, the nurse must first discuss the nature of the problem and explain the services available. She further identifies four phases in the nurse-patient relationship which include orientation, identification, exploitation and resolution. This relationship is influenced by both the nurse's and the patient's values, culture, race,

preconceived ideas, beliefs, past experiences and expectations (Belcher and Fish, 2002; Tomey and Alligood, 2002). Although this theory was first developed for psychiatric patients, it is applicable in paediatric healthcare and in this study as the researcher strongly believes that establishment of interpersonal relationship between the healthcare providers, the child and the parents enhances formation of partnership in care and practice of FCC.

Madeleine Leninger's theory of 1985 focuses on trans-cultural nursing and human care. The theory is based on comparative study and analysis of different cultures and subcultures in the world with respect to their caring values, expression and reaction to illness beliefs and pattern of behaviour. Leninger defines nursing as a learned humanistic and scientific profession and discipline that is focused on human care phenomena and activities to assist, support, facilitate or enable individuals or groups to maintain or regain their well-being (or death) in culturally meaningful and acceptable ways or to help people face handicaps or death (Tomey and Alligood, 2002). Assumptions to Leninger's theory include that nursing, as a trans-cultural care discipline and profession, has a central purpose to serve human beings in all areas of the world; that when culturally based, nursing care is beneficial, healthy and contributes to the wellbeing of clients. The theory further states that nursing care is culturally congruent or beneficial only when the clients are known by the nurse and the client's patterns, expressions, and cultural values are used in appropriate and meaningful ways by the nurse with the clients. It is further assumed that if clients receive care that is not at least reasonably culturally congruent, the client will demonstrate signs of stress, non-compliance, cultural conflicts and/or ethical

or moral concerns (George, 2002). This theory is applicable in this study as one of the key elements of FCC is that the healthcare providers ought to respect the patient's culture which makes the child's family have confidence in them. In the long run, both the healthcare providers and the child's family will establish effective partnerships in the care of the hospitalised child.

2.5 Conceptual Framework

The researcher acknowledges the fact that the theories, models and the FCC approach as discussed above have all been developed, implemented and evaluated in the developed world. From the review of literature, the theories of children's nursing and FCC have not been systematically implemented in Kenya and there is no framework that has been developed to guide their implementation.

From the theoretical framework, it emerges that each of the theories has concepts that are relevant in coming up with a framework for contextualization of FCC. As such, this study is guided by a conceptual framework built on variables that cut across the theories. In this regard, for FCC to be effectively implemented, the healthcare providers should appreciate the child's family as constant in the child's life (Ahmann's theory), respect and appreciate the family's culture (Leninger's theory), be aware of and perform their roles (Farrel and Peplau's theory) which lead to establishment of working partnership with the child's family. The conceptual framework is as demonstrated in figure 2.2.

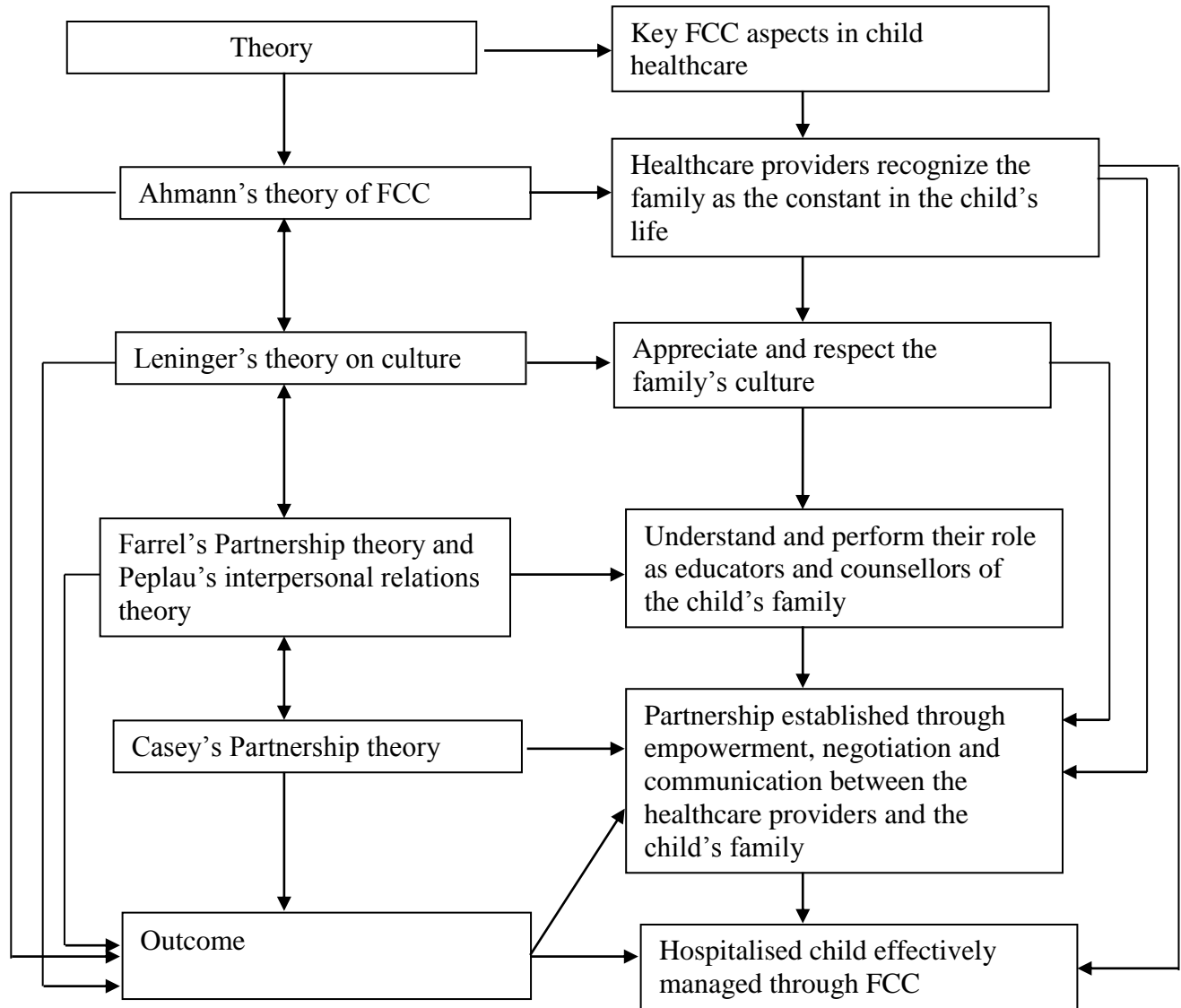


Figure 2.2: Conceptual Framework.

Source: Author, 2013

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

This chapter presents the methodology that was employed in the study. Central to it is study design, sampling methods, data collection procedures and analyses and ethical considerations that were employed and limitations.

3.1 Study Design

This research adapted a descriptive cross sectional design that utilised mixed qualitative and quantitative methods so as to obtain rich data required in developing the framework.

3.1.1 Mixed Methods Research

Leech and Onwuegbuzie (2007) defines mixed methods research as research that involves collecting, analyzing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon. Mixed research methods is further defined by Polit and Beck (2012) as research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry. Two methods of mixed methods study are identified, that is partially mixed and fully mixed. Fully mixed methods involve the mixing of quantitative and qualitative techniques within one or more stages of the research process or across these stages. In partially mixed methods, both the quantitative and qualitative elements are conducted either concurrently or sequentially in their entirety before being mixed at the data interpretation stage (Leech and Onwuegbuzie, 2007).

Mixed research designs are further classified in three dimensions based on the level of mixing (partial versus fully mixed), time orientation (Concurrent versus sequential) and emphases on the approaches (equal status versus dominant status). These are further classified into eight designs namely; partially mixed concurrent equal status designs; partially mixed concurrent dominant status designs; partially mixed sequential equal status designs; partially mixed sequential dominant status designs; fully mixed concurrent equal status designs; fully mixed concurrent dominant status designs; fully mixed sequential equal status designs; and fully mixed sequential dominant status designs (Leech and Onwuegbuzie, 2007).

In the current study, the researcher adapts the partially mixed sequential dominant status designs whereby the qualitative study followed the quantitative study. The essence of the quantitative study was to enable the researcher have an informed appreciation of the status of care of the hospitalised child. This enabled the researcher to formulate the questions that guided the in-depth interviews and the focused group discussions. The data obtained from the qualitative study helped explain why the status of care and how improvements can be effected in form of a framework.

3.1.2 Implementation of the Mixed Methods in this Study

The mixed methods were carried out both concurrently and sequentially in two phases. Phase one of the study was quantitative dominant and concurrent whereby some of the closed ended questions were followed by an open ended question that required the respondent to explain his/her choice of response. Phase two of the study was carried out after analysis of phase one data and was purely qualitative hence the sequential bit of the

study. Phase one was a baseline survey that generated data which aided the researcher to gain an understanding of the status of care of the hospitalised children and generated the variables that were investigated further in the second phase of the study. The essence of the second phase was to enable the researcher obtain detailed data from the participants concerning partnership in care of the hospitalised child and an explanation of the reasons behind the current practice as revealed in phase 1. This is consistent with stipulation in explanatory sequential design of the mixed research methods whereby the qualitative findings help to interpret or contextualize quantitative results (Driscoll et al 2007; Leech & Onwuegbuzie, 2009). The researcher was therefore convinced that this was the best way to come up with the intended framework. The two phases of the study are summarized in the flow diagram below:

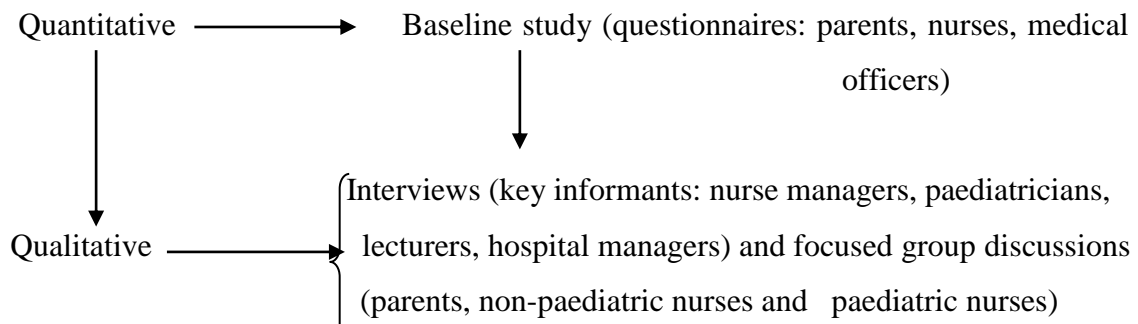


Figure 3.1: Summary of the two phases of the study

Whereas the objectives of the study are interrelated, each had a distinctive focus and therefore called for a distinctive design. Table 3.1 shows the linkage between each objective and the corresponding study design.

Table 3.1 Linking objectives to study design

Objective	Study design
To describe the current status of family involvement in the management of hospitalised children in Kenya.	Descriptive cross-sectional study (mixed design, quantitative dominant)
To explore challenges experienced by the healthcare providers while managing hospitalised children.	Descriptive cross-sectional study (mixed design, qualitative dominant)
To explore the healthcare providers' and the parents' perspectives of partnership in the management of hospitalised children.	Qualitative study
To explore facilitating factors for partnership establishment in the management of hospitalised children.	Qualitative study

3.2 Study Area

The study was conducted in two hospitals; Kenyatta National Hospital (KNH) and Gertrude Children's Hospital (GCH), both of which are located in Nairobi City. KNH is the oldest hospital in Kenya. Founded in 1901 with a bed capacity of 40 as the Native Civil hospital, it was renamed the King George VI in 1952. It was renamed Kenyatta National Hospital after Jomo Kenyatta following independence from the British in 1963. The hospital's mandate as stated in Legal Notice No.109 of 1987 is to provide specialized healthcare, facilitate training and research and participate in National Health Planning and Policy for the benefit of the nation and the region at large. KNH has grown from its humble beginnings since 1901 to become the largest (2,000 Bed capacity) teaching and referral hospital in the East and Central African region. The Hospital's Vision is "to be a world class referral hospital in the provision of innovative and specialized healthcare", and its mission is "to provide accessible specialized quality healthcare, facilitate medical

training, research, participate in national health planning and policy. The hospital's healthcare structure is divided into various divisions including surgical, medical, oncology and paediatrics among others. The focus of the study was in the paediatric division. The paediatric division is further divided into medical, surgical, oncology, emergency and newborn care. The study is conducted in all these areas except the emergency department.

GCH is a private children's hospital in Kenya. It is situated at Muthaiga in Nairobi and is the oldest and largest children's hospital in the country. The hospital was founded in 1947, with the donation of some land by Colonel Ewart Grogan, pioneer extraordinary, in memory of his beloved wife, Gertrude Edith initially as a home for destitute children. The mission of the hospital is to benefit humankind by providing health services, fostering good health, carrying out research and teaching healthcare professionals. The hospital, just like KNH, receives patients of diverse cultures from all regions across the country and even neighbouring countries. The hospital's aim is to be the preferred healthcare provider for East and Central Africa's children using the Family Centred approach. GCH has six general wards, an ICU, emergency department, outpatient department and satellite clinics within various estates in Nairobi and its environs. The study is conducted at the main hospital.

3.3 Study Populations

The study populations comprised healthcare providers involved in the management of hospitalised children, the sick children's parents and key informants. Healthcare providers consisted of nurse managers, bedside nurses, paediatricians and medical

officers. Further, key informants were drawn from nurse managers, paediatricians, paediatric nurses; non paediatric trained bedside nurses, lecturers and parents.

3.4 Sampling

Macnee (2004) observes that research is rarely able to include in one study all the cases that may be affected by the research question but rather a representative population which is the sample is chosen. In this regard, sampling was applied in this study as the populations were large.

Sampling as defined by Polit and Beck (2012) is the process of selecting cases to represent an entire population so that inferences about the population can be made. The process thus allows the researchers to achieve statistical conclusion, validity and to generalise their results. In order to achieve these key tenets in this study, before the sampling of the nurses and parents was undertaken, the inclusion and exclusion criteria for the study subjects was set as outlined in section 3.7 and a reconnaissance survey of the hospitals was carried out with a view to establish the population of nurses and paediatric beds. The number of paediatric beds in each ward is used to indicate the corresponding population of parents in the ward. The survey revealed that there is an estimated paediatric bed capacity of 275 (200 at KNH and 75 at GCH) with nursing population of 241 (175 at KNH and 66 at GCH). These respective populations defined the sampling frame for nurses and parents (table 3.2).

Table 3.2: Nursing staff and bed capacity in the Paediatric wards in KNH and GCH

KENTATTA NATIONAL HOSPITAL				GERTRUDE CHILDREN'S HOSPITAL			
3A Bed capacity : 32 Nurses: 22	3B Bed capacity : 32 Nurses: 23	3C Bed capacity: 32 Nurses: 23	3D Bed capacity : 32 Nurses: 24	Mimosa Bed capacity: 10 Nurses: 5	Jean Bed capacity : 10 Nurses: 9	Susan Bed capacity : 12 Nurses: 9	Felicity Bed capacity : 21 Nurses: 16
4A Bed capacity : 16 Nurses: 15	NBU Bed capacity : 32 Nurses: 38	1E Bed capacity: 12 Nurses: 5	9A Bed capacity : 12 Nurses: 15	Jacaranda Bed capacity: 12 Nurses: 9	Edna Bed capacity : 12 Nurses: 10	George Drew Bed capacity: 8 Nurses: 8	

In deciding the sample size for the various categories of respondents, due consideration was accorded to the sample's representativeness and size as recommended by Polit and Beck (2012). This was guided by the questions proposed by Macnee (2004) that guide determination of a study sample. These questions are as follows:

- Does the population of this study reflect the types of patients or situations that am interested in understanding?
- Does the sample in the study reflect or fit with the population of interest?
- Does the approach taken to choosing the sample limit how much I can use the results of the study?

3.4.1 Sample Size Determination for Bed- side Nurses and Parents

The sample size for the bed-side nurses and parents was calculated using Fisher's formula documented in Mugenda and Mugenda, (2003). This formula is as follows:

$$n = \frac{z^2 pq}{d^2}$$

Where; n = the desired sample size (if target population is greater than 10,000)

z = the standard normal deviate at the required confidence level (1.96)

P = Family involvement in the management of hospitalised children in (50 %)

q = 1-p

d = the level of significance set [0.05 (confidence limit at 95% confidence interval)]

As the target population was less than 10000, the following formula was used to calculate the final sample size:

$$nf = \frac{n}{1 + (n/N)}$$

Where: nf = the desired sample size (when the target population is less than 10,000,)

n = the desired sample size (when the target population is more than 10,000 [384 in this case])

N = the estimate of the population size (275 for the parents and 241 for the nurses)

The estimated sample size for the bed-side nurses and parents using the above formula was as follows:

- Nurses – 141 (GCH: 38 & KNH: 103)
- Parents – 160 (GCH: 50 & KNH: 110)

The techniques of sampling parents and nurses in each hospital ward are presented in sections 3.5.2.1 and 3.5.2.2 respectively.

3.4.2 Sample Size Determination for Medical Officers

For medical officers, the study set a purposeful sample of 14. In this regard, one medical officer is selected from each of the 14 paediatric wards in the two hospitals. The technique for sampling medical officers in each hospital ward is presented in section 3.5.2.3.

3.4.3 Sampling of Key Informants

The study populations under key informants comprised nurse managers, paediatricians, paediatric nurses, non-paediatric nurses, lecturers and parents. The sample size of these respondents was not set as data were collected until saturation was reached, that is, a level where no new information was forthcoming. This is in line with the recommendations by Polit and Beck (2012) that saturation is the principle most often used to make decisions about when sampling in qualitative research can stop.

3.5 Sampling Techniques

3.5.1 Sampling of Hospitals

Mugenda and Mugenda (2003) and Polit and Beck (2012), recommend that purposive sampling is a good approach in multi-stage sampling in which case sites are sampled purposively and people are sampled in some other fashion. In view of this, the hospitals where the study was conducted were purposively selected. This was based on the fact that the two hospitals had cases that had the required information with regard to the objectives of the study.

3.5.2 Sampling of Phase 1 Populations

Multistage stratified random sampling was used in the selection of respondents from populations in phase 1. According to Mugenda and Mugenda (2003) and Polit and Beck (2012), stratified random sampling achieves desired representation from the various subgroups in the study population. After stratification, because of the differences in size across the strata, probability proportionate sampling to size was used for the selection of nurses and parents so that each stratum was given a chance of selection proportionate to its size. This is in accordance to the recommendations by Leedy, (1997), Bryman, (2004), Babbie, (2010), and Polit and Beck (2012).

The first stage of sampling was at the hospital level whereby each paediatric ward formed a stratum. At the second level, the respondents were stratified into two categories consisting of healthcare providers and the hospitalised children. At the third level of stratification, the healthcare providers were stratified into two categories, that is, nurses and doctors, whereas the children were stratified into the acute (short stay) cases and chronic (long stay) cases. The short stay cases comprised the children who had been hospitalised for three days to fourteen days. The long stay cases comprised the children who had been hospitalised for more than fourteen days without being discharged. The parents who participated in the study were selected from the stratum of hospitalised children whereas the healthcare providers were selected from the stratum of doctors and nurses. The process of sampling is illustrated in figure 3.2

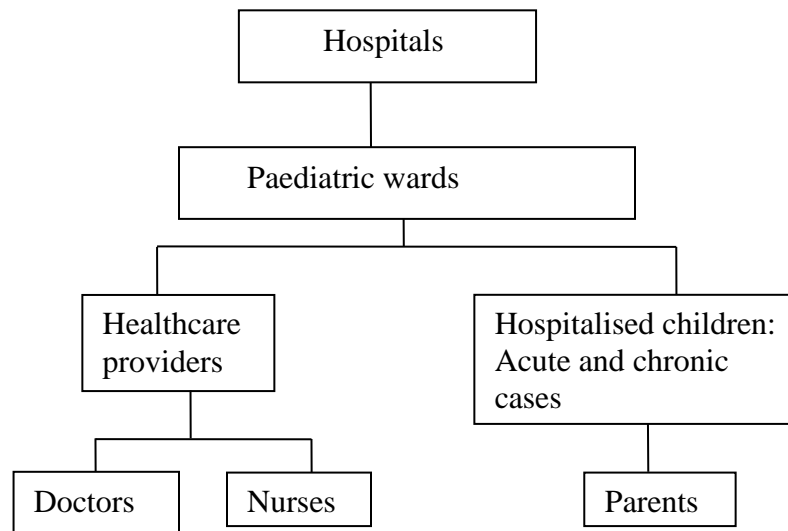


Figure 3.2: Flow chart demonstrating stratification of the study population for phase 1

3.5.2.1 Sampling of Parents

The parents were selected based on the in-patient register of their children. The record books for each ward were scrutinized separately in order to select the children who met the inclusion criteria. Children who met the criteria for each ward were listed separately for the acute and chronic cases because of their differences in hospital experience and then using random numbers generated by a computer, the required sample was selected for each ward. The sampling was done proportionate to size for the acute and the chronic cases. Random numbers are generated separately for each category of parents. After selecting the children, their parents were requested to participate in the study.

3.5.2.2 Sampling of Nurses

Non probability sampling was used in the selection of nurses who participated in the study whereby whoever was on duty and accepted to participate was recruited. This was done until the required sample was obtained.

3.5.2.3 Sampling of Medical Officers

The medical officers were purposively selected whereby one medical officer was selected from each ward. Whoever was on duty during the data collection period and accepted to participate was given the question to fill. Once the researcher got a respondent from a given ward then she did not request the other medical officers working in the ward.

3.5.3 Sampling of Phase II Populations

This phase of the study sought to generate qualitative data from key informants by engaging them in in-depth interviews and focused group discussions. The key informants for the in-depth interviews included nurse managers, paediatricians and lecturers. There were three sets of focused group discussions in each hospital whereby each comprised paediatric nurses, parents and nurses. Participants in each focused group discussion and in-depth interviews were purposively selected. Polit and Beck (2012) recommend purposive sampling when a sample of experts is required. In view of this, the selection of the participants was based on the fact that they had the required experience, knowledge and were able to articulate their experience. This is further consistent with the recommendation by Hycner (1985) that part of the control and rigor in qualitative research emerges from the type of participants chosen and their ability to fully describe the experience being researched on.

3.6 Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were set before the selection of the study subjects. The essence of setting this is to ensure that the data collected is able to answer the study questions. In view of this, these criteria were set based on the duration of experience that

the expected respondents had in care of hospitalised children either as healthcare providers or as the hospitalised children's parents.

The respondents included in the study were as follows:

- All non-paediatric nurses, paediatric nurses and nurse managers working in the paediatric wards/departments and had worked there for at least three months.
- The medical officers working in the paediatric wards and had worked there for at least three months.
- The paediatricians working in the paediatric wards/departments and had worked there for at least three months.
- Parents whose children had been in the hospital for a period not less than three days.
- Lecturers involved in teaching paediatric principles and concepts

The respondents that were excluded from the study were as follows:

- Nurses working in other departments but occasionally deployed in the paediatric wards when there is high demand for nursing services.
- The parents who did not consent to participate in the study.
- Parents whose children had been in the hospital for less than three days. These were excluded because they wouldn't have had enough experience in the hospital to meet the expectations of the study.
- The healthcare providers who did not consent to participate in the study.
- Healthcare providers and parents that participated in the pre-testing of the study instruments.
- Lecturers not teaching the paediatric principles and concepts

3.7 Study Variables for Phase 1 of the Study

Variables for phase 1 of the study included both dependent and independent variables.

3.7.1 Dependent Variables

Dependent variables in the study revolve around the current status of family involvement in the management of hospitalised children. The scope of the study on these variables was to determine whether these practices are done or not. Hence the dependent variables are dichotomous or binary. These are as follows:

- Parental involvement in decision making on the management of the hospitalised child.
- Parental accompaniment of the hospitalised children during procedures
- Visitation of hospitalised children by other children
- Healthcare providers' practice of FCC
- Modes of practice of FCC
- Views about the implementation of FCC in Kenya

3.7.2 Independent Variables

These are the factors that affect the mode of management of hospitalised children. It is against these factors that the dependent variables were correlated to establish whether there exists a significant relationship between them. This was done by use of Chi square test, logistic regression and multiple regressions. The independent variables include:

- Healthcare providers' knowledge of FCC
- Healthcare providers' source of information on FCC

- Working institution
- Profession
- Healthcare provider's parental status
- Parent's level of education
- Parent's age
- Parent's actual relationship with the hospitalised child
- Hospitalised child's age

3.8 Selection and Training of Research Assistants

The principal researcher worked with the aid of two research assistants whereby one was selected from each institution. The choice of the assistants was in consideration that they were familiar with the hospital environment and therefore would aid in identifying who was eligible to participate in the study. These were Bachelor of Science Nurses (BScN) working in the institutions under investigation. The research assistants were orientated on the subject of research for one day and then further orientation was undertaken during the pre-testing of the research instruments.

3.9 Study Instruments

The study employed three instruments in data collection, namely, questionnaires, in-depth interview and focused group discussion guides (appendices 3-9).

3.9.1 The Questionnaires

Two types of questionnaires with both closed ended and open ended questions were used in the first phase of the study. Each closed ended question was followed by an open ended question requiring the respondent to provide an explanation for the response in the

structured part. One questionnaire was for the nurses and medical officers and the other was for the parents. The questionnaires were developed by the researcher after extensive literature review. The questionnaire for the healthcare providers is divided into four parts comprising socio-demographic data, parental participation in care, factors affecting delivery of healthcare and knowledge and practice of FCC. The questionnaire for the parents was also in four parts comprising the socio-demographic data, participation in decision making, readiness to participate in the care of the child while in hospital and visitation.

3.9.2 In-depth Interview and Focused Group Discussion Guides

In-depth interviews and focused group discussion are part of the methods used for data collection in qualitative research (Polit and Beck, 2012). The two methods were chosen because of their advantage in exploratory research as compared to the closed ended questions in quantitative research. Their advantage is to the fact that by use of open-ended questions and probing gives participants the opportunity to respond in their own words, rather than forcing them to choose from fixed responses, as quantitative methods do. Further open-ended questions have the ability to evoke responses that are: meaningful and culturally salient to the participant, unanticipated by the researcher and rich and explanatory in nature. The questions included in the interview and focused group discussion guides were developed after the analysis of data collected using the questionnaire in phase I of the study. The guides were semi-structured and comprised two parts. Part one was on the participant's socio-demographic data and part two comprised the questions to guide the discussion. The main focus was on policies guiding the

management of hospitalised children and FCC practice, challenges and implementation strategies (Appendixes 5-9).

3.10 Pre-testing of the Study Instruments

The study instruments were pre-tested at KNH on 10 percent of the study sample consisting of 14 nurses, 16 parents, one medical officer, and one paediatrician. The pre-testing helped to clarify the questions outlined in the questionnaires. It also served as an orientation programme for the research assistants. The pre-testing exercise was done for a period of five days. The terms that were not easily understood by the respondents during the pre-testing were substituted with surrogate terms that they were able to understand. In this instance the question that was asking about approaches to child care were replaced with parental involvement in decision making and parental accompaniment of their children during procedures. A question on policies on child care was moved to interview as was recommended by a majority of those that participated in the pre-testing. The data collected during the pretesting exercises was used in refining the study instruments and was not included during the analysis of the data collected in the main study.

3.11 Data Collection

The data collection exercise was conducted in two sequential phases took thirteen months from March 2011 to April 2012. Phase I was first conducted and the data collected were analysed before the commencement of phase II. The steps followed in each of the phases are described in the following sub-sections.

3.11.1 Phase 1

During this phase of the study, data were collected from bedside nurses, medical officers and parents of the hospitalised children by use of questionnaires. This was carried out in both institutions concurrently both to the healthcare providers and the parents. The main aim was to obtain data on the current status of family involvement in the management of hospitalised children. This was done for six months (March 2011 to August 2011).

The questionnaire for the healthcare providers was self-administered whereas the one for the parents was researcher administered. Before administration of the questionnaires, the nature of the study was explained to the respondents. They were provided with a detailed information sheet and a written consent form which they signed in duplicate. The healthcare providers who consented to participate in the study were given the questionnaires to fill at their convenient time with an indication as to when a member of the research team would pick them. A total of one hundred and seventy four questionnaires were distributed but only one hundred and forty four were returned thus giving a response rate of 82.8 percent. On the part of the parents that consented to participate in the study, the questionnaire was filled by a member of the research team resulting in the return of all the one hundred and sixty one questionnaires that had been distributed meaning the response rate was 100 percent. To avoid introduction of bias in the researcher filled questionnaires, the researcher and the research assistants had an orientation on how to ask the questions as outlined in the questionnaire during the pretesting exercise and the responses were written in the respondents' own words. The principal researcher further kept a close check on how the research assistants were filling

the questionnaires. At the end of every day all the filled questionnaires were checked for completeness by the principal researcher and stored under lock and key for data analysis. The locked questionnaires were only accessible to the principal researcher.

3.11.2 Phase II

Data collection in this phase was done after analysis of the data collected in phase 1. The data that had been collected from both the healthcare providers and the parents was analysed and the key issues that had arisen from the responses especially to the open ended questions were enumerated and used to develop the interview and focused group discussion guides. In-depth interviews and focused group discussions were conducted with a view to obtain further information on the policies guiding the management of hospitalised children, visitation of hospitalised children by other children, challenges faced in the management of hospitalised children and the perspectives of healthcare providers and parents on partnership in care. The steps followed in the collection of data using these two methods are described in the following sub-sections.

3.11.2.1 Interviews

In-depth interviews were conducted with key informants comprising nurse managers, paediatricians and lecturers involved in teaching paediatrics. The principal researcher identified the key informants from the various paediatric wards and departments, explained to each of them individually the nature and purpose of the study and requested them to participate in the interview. They were further informed that the interview was to be recorded using a voice recorder which was shown to them at that instance. Those that

accepted to participate in the interview were requested to book an appointment with the interviewer at a time that was convenient to them. The interviews were conducted by the principal researcher and they were held at the key informants' offices/ workplace.

Prior to administration of the interview tool, the respondents were given a written consent to sign and a form to fill their socio-demographic characteristics. Each interview lasted 45 minutes to one hour. Each participant was interviewed once. At the end of the interview, the researcher summarized the key findings to the respondent and sought their clarification on any of the issues that were not clear. The recorded information was also played back to them to confirm that it is their voice and information that had been recorded. The researcher then thanked the respondent for participating before departing from the interview venue.

The interviewing process continued for all the key informants until when a point of saturation was reached. This was determined when there was no new information that was volunteered from two subsequent interviewees besides what had been said by the preceding interviewees.

3.11.2.2 Focused Group Discussions

Morgan (1998) explains that in collection of qualitative data, focused group discussions exhibit three main strengths: exploration and discovery, context and interpretation. Therefore, by conducting the focused group discussions for the key stakeholders in the management of hospitalised children, it was possible to understand the participants'

experiences and perspectives. The researcher utilized the three steps outlined by Morgan (1998) to organize for the focused group discussions. These steps include planning, recruitment and conduction of the discussions.

Planning for the focused group discussions entailed outlining questions to be discussed by each group, identifying and training a researcher assistant from each institution and identifying the venues where the discussions would be held. Identification of a research assistant from each of the institutions was in consideration that he would help in identification and organization of the venues.

Recruitment of the participants was done purposively. This was based on their experiences and ability to articulate issues as recommended by Hycner (1985). Before the participants were recruited, the researcher and the research assistants visited all the paediatric wards, explained to the parents the nature of the research and asked whoever was willing to come and participate. The nurses were explained to individually and those that accepted were called together for a short meeting to agree on the time when the discussion would be held. The decision on the day and time was based on when a majority of them indicated they would be available.

Six focused group discussions were conducted, that is, two for parents, two for paediatric nurses and two for non-paediatric nurses. Each group comprised 5-8 participants. Constitution of the groups was done at each institution. The constitution of the groups was in accordance with the observation by De Vos (2002) that when participants are

fundamentally similar, they spend less time explaining themselves to each other but instead focus on the topic at hand.

A focused group discussion guide was used in conducting the focused group discussions. Formulation of questions in the guide was based on the format recommended by De Vos (2002), namely; introductory, transition, key and ending questions. Before the commencement of the discussions, the participants were explained the nature of the study, the data collection procedures, the role of the research assistant and were given a consent form to sign. The participants were also given a socio-demographic data sheet to fill before embarking on the discussions. Data were recorded using a voice recorder and also field notes were taken by both the principal researcher and the research assistants.

3.11.2.2.1 The Focused Group Discussion Sessions

The focused group discussions were conducted on schedule as agreed between the research team and the participants. This was carried out in six days that were not sequential but dependent on the availability of the members of the research team and the participants. On the day of the discussion, the principal researcher and the research assistant arrived at the institution an hour before the scheduled time for the discussions. This enabled us to organise the room where the discussion was to take place by ensuring that it was clean and there were enough seats for all the participants, the chairs were arranged in a circular order and a table for placing the materials needed during the discussion and also where tea and snacks would be served from. After organisation of the

room we then contacted the participants either by phone for the nurses or by visiting the wards for the parents to remind them about the time and venue for the discussions.

After reminding the participants, the principal researcher and the research assistant proceeded to the venue for the discussion so as to be there at least ten minutes before time. This was in a bid to ensure that as the participants arrived, we were there to receive them. As the participants arrived, they were ushered in and asked to sit wherever they liked as the seats were not arranged in any particular order. Upon arrival of all the participants, the principal researcher opened the session by thanking them for coming, explaining to them the essence of the meeting and the protocols that were to be observed and observing each other's confidentiality even after the session. The participants were informed that they needed to agree on the order of responding to the questions either starting with the person seated to the right or left of the principal researcher. The agreements on this were different in the various groups. Based on the agreement the respondents were assigned numbers by the members of the research team as earlier agreed but for purposes of confidentiality the respondents were not informed who was assigned what number. The entire sessions were facilitated by the principal researcher.

Before starting the sessions, the researcher checked the voice recorder to ensure that it would capture the participant's responses and had sufficient clarity and volume to be used later for data analysis. During the discussions, the participants were asked the questions as outlined in the guide. The language used in each group dependent on what the participants were comfortable with. On the part of the discussion groups for the

nurses, English was used whereas for the parents, the questions were read in English and then translated to Kiswahili as some did not understand English. To ensure consistence in translation and avoid introduction of bias, the translation was done by the principal researcher only. Prior translation was not done as this was just a guide and many more issues arose during the discussion. Each participant had the opportunity of responding to the question asked before another question would be asked. In the process of the discussions, probing questions were asked as need arose. At the end of the session, the principal researcher gave a summary of the discussions, asked the respondents if there was any issue that needed clarification or discussion, checked the recording in the voice recorder by playing back for one minute and ended the session with a vote of thanks. The discussions lasted an average duration of one and half hours and were conducted once for each group.

3.12 Data Analysis

3.12.1 Quantitative Data

Upon completion of the data collection exercise, the data were coded and entered into a computer and analyzed using descriptive statistics aided by the Statistical Package for Social Scientists (SPSS) programme. Socio-demographic data and responses for structured questions were expressed in frequencies and percentages. Cross tabulations were done to relate some of the socio-demographic characteristics with the responses given for some of the questions. The results are presented using tables, bar graphs and pie charts generated by Excel and SPSS programs.

Testing of statistical relationship between the dependent and independent variables is done by use of Chi Square and independent sample t-test at 95 percent confidence level. During the statistical analysis using Chi Square, for the 2x2 tables, the value is taken from the continuity correction row and where the where the minimum count of five in the cells is not met or less than 80 % of the cells meet the minimum count, Fisher's Exact test is used (Pallant, 2005).

The predictability of the independent variables on the dependent variables is estimated using logistic regression for the dichotomous variables and multiple regressions for the continuous variables. Dichotomous variables as defined by Pallant (2005) are the variables with only two responses. In this study the dichotomous variables had either a "yes" or a "No" as the response. As recommended by Pallant (2005) and Hinton et al. (2004), the coding for the variables is as follows: Yes = 1 and No = 0. This is applied to both the dependent and the predictor dichotomous variables. The dichotomous variables include parental involvement in decision making; healthcare providers allowing children to be accompanied during procedures, practice of FCC, important for hospitalised children to be visited by other children and FCC implementation in Kenya. The continuous dependent variable is the level of parental involvement in decision making.

The dependent variables included in the multiple regressions though categorical are treated as dummy variables and regressed against continuous independent variables. Boslaugh and Watters (2008) explain the application of multiple regressions with categorical variables especially in social research. They indicate that building up

regression models is very useful for understanding what causes changes in a dependent variable. In both the logistic and multiple regressions, the forward method of data entry is applied. The forward method as defined by Hinton et al (2004) is whereby the researcher decides on which variables to enter into the model. The variables entered in this study are those that exhibited significance association on Chi Square test. P-values less than 0.05 were considered significant. A summary of the method used in data analysis per objective is presented in table 3.3.

Table 3.3: Summary of data analysis method per objective

Objective	Analysis
To describe the current status of family involvement in the management of hospitalised children	Descriptive statistics, chi square, Logistic regression and multiple regressions aided by SPSS version 16.0 and qualitative content analysis.
To explore challenges experienced by the healthcare providers while managing hospitalised children	Descriptive statistics aided by SPSS version 16.0 and qualitative content analysis.
To explore the healthcare providers' and the parents' perspectives of partnership in the management of hospitalised children	Qualitative content analysis
To explore facilitating factors for partnership establishment in the management of hospitalised children	Qualitative content analysis

3.12.2 Qualitative Data

Analysis of qualitative data was the most challenging bit of the study as the data were overwhelming. This was done separately for the two phases of the study. The qualitative data obtained from the open-ended questions in phase I was transformed, quantified and analyzed concurrently with the quantitative data from the closed-ended questions as recommended by Driscoll et al (2007). Quantifying data helped the researcher to

understand the extent of family involvement in the management of the hospitalised and the magnitude of the various practices. The qualitative data obtained from phase II of the study was analysed by use of content analysis. Polit and Beck (2012) explain qualitative content analysis as the analysis of the content of narrative data to identify prominent themes and patterns among themes. It involves breaking down data into smaller units, several stage coding and naming the units according to the content they represent and grouping coded material based on shared concepts. Interpretivism is employed as the epistemological stance in the analysis of the qualitative data. In this regard the researcher initially made meaning from the respondent's perspectives and lived experiences. This is then followed by further interpretation in terms of concepts, theories and literature on FCC leading to development of the framework.

In analysing the qualitative data obtained from the in-depth interviews and focused group discussions, the guidelines by Hycner (1985) were applied. According to these guidelines, there are specific set steps to be followed in the analysis of qualitative data, namely; transcription, listening to the interview to make a sense of the whole, delineating units of general meaning (coding), delineating units of meaning relevant to the research question, verification of the units of relevant meaning by independent judges, eliminating redundancies, clustering units of relevant meaning, determining themes from clusters of meaning, writing a summary for each individual interview, identifying general and unique themes for all the interviews, contextualization of themes and making a composite summary. The steps that were followed in the analysis of the qualitative data in this study are explained in the following sub-sections.

3.12.2.1 Transcription

In this step, recorded data is transcribed using the respondent's own words. The process commenced immediately after the first interview. This is important as it enabled the researcher to conceptualize the issues arising from the preceding interview so as to include them in the next interview. As the transcription of each interview was done, identification of the respondent was indicated using numbers so as to ensure anonymity and confidentiality of the respondent. Similarly transcription of the FGDs was undertaken on a daily basis as they were conducted. The responses were labelled for each respondent using the secret numbers assigned during the discussions. This ensured the confidentiality and anonymity of the respondent.

The process of transcription was carried out by the researcher herself to ensure that no information was left out. As the recorded data were being transcribed, cross checking was done with the field notes taken by both the principal researcher and the research assistants during the interviews and focused group discussions as a way of confirming what was being transcribed. The data were transcribed verbatim taking note of pauses in speech, intonation, dialect, turn taking, laughs, crying, context and responses. Punctuating of the sentences in the process of transcription was based on the rhythm and pace of the verbal speech of the respondent. This was in a bid to ensure that no essential information and opportunity is missed out in case selective transcription was to be done. The data were transcribed by hand and later typed into the computer using the Microsoft word programme. The whole process was carried out by the principal researcher herself. This helped her to be close with the data. To ensure confidentiality, the hand written

documents were kept under lock and key and the typed document was protected by a pass word. This data will be kept for a period of 5 years.

3.12.2.2 Listening to the Interview for a Sense of the Whole

The aim of this step is to get a sense of the whole interview. It entailed listening to the entire recorded information and reading the transcriptions many times. Besides listening to the words, the researcher took note of the tone of the voice, emphases and pauses as expressed by the respondents. The listening was done for each interview and focused group discussion separately with some interval of relaxation in between to allow time for internalization of the information. This was done in the morning hours between 3 a.m. and 6 a.m., a range of time the researcher found convenient with no interruptions. The key questions that guided the researcher in this process include:

- Do I understand what is going on here?
- What should I have asked to find out more about this?
- What is surprising me about my data?

3.12.2.3 Delineating Units of General Meaning (Coding)

This was done by reading over and over through every word, phrase, sentence, paragraph transcribed in order to elicit the participants' meanings. The respondents' information was eventually crystallized and condensed using their literal words. The codes were derived from the respondent's own words or from the researcher's interpretations of the respondent's response. The key essences of their expressions were written at the margins

of the typed and printed transcriptions. Codes emerging from early interviews were explored in subsequent interviews and developed and extended.

This process was guided by the following questions:

- What is going on here?
- What do I understand about this data?

3.12.2 .4 Delineating Units of Meaning Relevant to the Research Question

At this stage, the researcher correlated the units of general meaning to the respective research questions. In the process, the general units of meaning that were not relevant to the research questions were eliminated.

3.12.2.5 Verification of the Units of Relevant Meaning

This step is important as a reliability check in order to verify the findings. The researcher identified two independent qualitative research analysts. They were each given the recorded and transcribed data and asked to come up with their own units of general meaning. This took them two weeks. After the two weeks, they had a meeting with the principal researcher in which comparison of the units generated was conducted. It emerged that most of the units were the same. For those that were different, they discussed and arrived at a consensus.

3.13.2 .6 Eliminating Redundancies

This entailed removal of any unit of relevant meaning that was redundant. Before elimination was done, the researcher read through the units to confirm that they had similar meaning with the ones rendering them redundant.

3.13.2. 7 Clustering Units of Relevant Meaning

This is the point in which the units of general meaning that have similar essence are clustered together. The researcher read over the units of general meaning after eliminating redundancies so as to understand the subject matter being brought out by each of them. The units that had similar subject matter were then collapsed, merged, refined, verified and the relationship between them was established. This process was aided by Microsoft word programme. The following question guided the process of clustering:

- How does this relate to the other instances?

3.12.2.8 Determining Themes from Clusters of Meaning

This is the stage where the themes are derived. At this point, all the codes (clusters) that were related were brought together. The researcher interrogated all the clusters of meaning to determine the central themes which expressed the essence of these clusters. The central themes are then linked to the various units of general meaning which are presented as sub-themes and the main themes. The themes, presented in chapter four of this study, were determined from the essence that each cluster brought out.

3.12.2.9 Writing a Summary for Each Individual Interview

This entailed attaching the themes to each of the interviews. The researcher read through each interview and focused group discussion and attached the themes to the expressions that had brought out the theme. Some of these expressions are quoted in the results as the themes are presented.

3.12.2 10 Contextualization of the Themes

This is the point at which the qualitative data was integrated with the quantitative data. Further, the themes were placed within the overall context of the FCC framework that has been developed by this study.

3.13 Securing Approval for the Field Work

Before implementation of the study, approval was sought from the School of Nursing Sciences and the Board of Post-graduate Studies, University of Nairobi. Permission to conduct the research was granted by the Ministry of Higher Education (Research Authorisation letter No. NSCT/RRI/12/1/MED/235/5), KNH-UoN Research and Ethics Committee (Approval No. P222/07/2010, dated 11/11/2010), GCH Research and Ethics Committees (Approval letter dated 24/1/2011) and the Deputy Director Clinical Services, KNH (Approval letter dated 24/1/2011). Copies of the approval are covered in appendix 10.

Before approaching the intended participants in the study, the researcher reported to the nursing officer's in-charge of the various paediatric wards. The researcher presented copies of the ethical approvals for the study and briefed them on the nature and purpose of the study and the subjects. The ward in charges gave the researcher permission to

access the admission registers and to approach nurses, doctors and parents so as to request them to participate in the study.

3.14 Ethical Considerations

The participants were explained the nature of the research and its significance and assured of confidentiality before being given the consent form to sign for acceptance to participate. The participants were further explained that the information they provided was purely for research purpose and in the process of analysis and report writing their identity would not be revealed. Further, the participants were asked not to indicate their names on either the questionnaires or the socio-demographic data sheets. The participants were provided with an information sheet describing the study (Appendix 1), a consent form to sign in duplicate (Appendix 2) and a copy of the signed consent. Further to ensure confidentiality during report writing, the data that is stored in the principal researcher's personal computer is protected by a password known only to her. Whilst quotes are used in the results, the results are aggregated to ensure the individual respondents are not identified.

3.15 Study Limitations

The main limitation of the study was in relation to the nature of the participants. The researcher had assumed that the participants would be easily available so that the set timelines would be met, but this was not the case. Some of the participants had busy schedules, which made the study to take longer than had been anticipated for phase II. This was particularly in regard to meeting the key informants as some would give appointments but due to work schedules, they would not honour the appointments. To

obtain the required data, patience was exercised, rebooking was done and the duration extended until saturation was reached.

CHAPTER FOUR

4.0 RESULTS

This chapter presents results of the data obtained from both phase 1 and 2 of the study. The study being a mixed method design, the results from both phases that are about a similar variable are integrated. The results are presented using narratives, tables, bar charts and pie charts. The response rate for each of the study questions is variant as the participants were free not to respond to any question that they were not comfortable to (appendix 1). The chapter starts with the socio-demographic data of the respondents followed by results as per the study questions.

4.1 Socio-Demographic Characteristics of the Participants in Phase I

The participants of phase I of the study consisted of healthcare providers and parents of the hospitalised children. Healthcare providers comprised nurses and medical officers (doctors). Their socio-demographic characteristics are described in the following sections.

4.1.1 Healthcare Providers' Socio-Demographic Characteristics

A total of 144 healthcare providers, 112 from KNH and 32 from GCH, participated in the study. This was out of the anticipated 174 respondents thus implying a response rate of 82.8 percent. On sex, majority (87.1%, n=122) were females. About their age, 46.9 percent (n=67) were aged between 31 – 40 years. Concerning their profession, 85.3 percent (n=122), were non-paediatric nurses, medical officers comprised 9.1 percent (n=13) whereas paediatric nurses accounted for 5.6 percent (n= 8). On their marital and

parental status, more than half (71.3%, n=102) were married and most (80.4%, n=115) were parents. These are presented in table 4.1.

Table 4.1: Healthcare providers' socio-demographic characteristics

CHARACTERISTIC	FREQUENCY	PERCENTAGE
Sex		
Male	18	12.9
Female	122	87.1
Total	140	100.0
Age		
<30	31	21.7
31-40	67	46.9
>40	45	31.5
Total	143	100.0
Profession		
Non-paediatric nurses	122	85.3
Doctor	13	9.1
Paediatric nurse	8	5.6
Total	143	100.0
Religion		
Christian	140	97.2
Muslim	4	2.8
Total	144	100.0
Marital status		
Married	102	71.3
Single	35	24.5
Others	6	4.2
Total	143	100.0
Parental status		
Parent	115	80.4
Not a parent	28	19.6
Total	143	100.0

4.1.2 Healthcare Providers' Work Experience

Table 4.2 presents the healthcare provider's work experience as a health professionals and the specific experience in paediatrics. About half, (50.7%, n=72) had worked as health professionals for less than nine years. Concerning their experience in paediatrics, only 37.5 percent (n=39) had worked in the paediatric department for less than two years.

Table 4.2: Health care providers' age, work experience and paediatric experience

CHARACTERISTIC	FREQUENCY	PERCENTAGE
Work experience as healthcare professionals (Years)		
<9	72	50.7
10-19	47	33.1
>20	23	16.2
Total	142	100
Paediatric experience (years)		
<2	39	37.5
3-5	35	33.7
6-8	15	14.4
>9	15	14.4
Total	104	100

4.1.3 Socio-Demographic Characteristics of the Parents

A total of 161 parents participated in phase I of the study. Out of these, 106 were from KNH and 55 from GCH. They were drawn proportionately from all the paediatric wards in the two hospitals. Table 4.3 presents the socio-demographic characteristics of the parents. About half (55.3%, n=89) of the parents were aged between 25 and 35 years. Majority of the parents, comprising 88.2 percent (n=142), were females whereas 11.8 percent (n=19) were males. On their level of education, 41.9 percent (n=67) had attained secondary school level of education. On marital status, 87 percent (n=140) were married

whereas 11.2 percent (n=18) were single. Almost all (99.4%, n=160) were of the African race and Kenyans. The Kenyan tribe from which the patients came included: Kikuyu - 35.6 percent (n=53), Luo 17.4 percent (n=26), Kamba 12.1 percent (n=18), Meru 9.4 percent (n=14) and Kisii 4.7 percent (n=7). Other tribes represented by less than five respondents included Taita, Somali, Turkana, Giriama, Borana, Kalenjin, Maasai, Teso and Indian. Majority of the parent's religious affiliation was Christian (93.8%, n=151) and the rest were Muslims (6.2%, n=10).

Table 4.3: Socio-demographic characteristics of the parents

CHARACTERISTIC	FREQUENCY	PERCENTAGE
Age (years)		
15-25	42	26.1
26-35	89	55.3
>35	30	18.6
Total	161	100.0
Sex		
Male	19	11.8
Female	142	88.2
Total	161	100.0
Level of education		
No education	2	1.3
Primary school	39	24.4
Secondary school	67	41.9
College	25	15.6
University	27	16.9
Total	160	100.0
Marital status		
Married	140	87.0
Single	18	11.2
Others	3	1.8
Total	161	100.0
Race		
African	160	99.4
Caucasian (Indian)	1	0.6
Total	161	100.0
Nationality		
Kenyan	160	99.4
Other	1	0.6
Total	161	100.0

The parents whose religion was Christian were asked to indicate their denominations. Out of the one hundred and fifty one parents who were Christian, one hundred and thirty four indicated their denominations as indicated in table 4.4. Most (64.2%, n=86) were protestants comprising Presbyterian Church of East Africa (PCEA), Pentecostal, Africa

Independent Pentecostal Church of Africa (AIPCA), Holy Ghost, Anglican, Methodist, Christian fellowship, Pentecostal Assemblies of God (PAG), Full Gospel, Hopehood, Deliverance, Africa Inland Church (AIC), Gospel church, Baptist, Discipline Temple, Emmanuel Fellowship, Gospel Revival Centre, Vision Centre, Assembly of God, Jubilee Celebration Centre, Salvation Army and Redeemed.

Table 4.4: Parents' Denomination

Denomination	Frequency	Percentage
Protestant	86	64.2
Catholic	37	27.6
SDA	10	7.5
Jehovah's witness	1	0.7
Total	134	100

4.1.4 Socio-Demographic Characteristics of the Hospitalized Children

Majority (70.8%, n=114) of the children whose parents participated in the study were aged less than three years (figure 4.1). The most common conditions leading to their admission included pneumonia (32%, n=32), cancer (21%, n= 21%), meningitis (17%, n=17) and malnutrition (10%, n=10). Other conditions included asthma, gastroenteritis, hernias, respiratory distress, neonatal sepsis and prematurity, among others. Slightly more than half (58.4%, n=94) of the children had never been admitted to hospital.

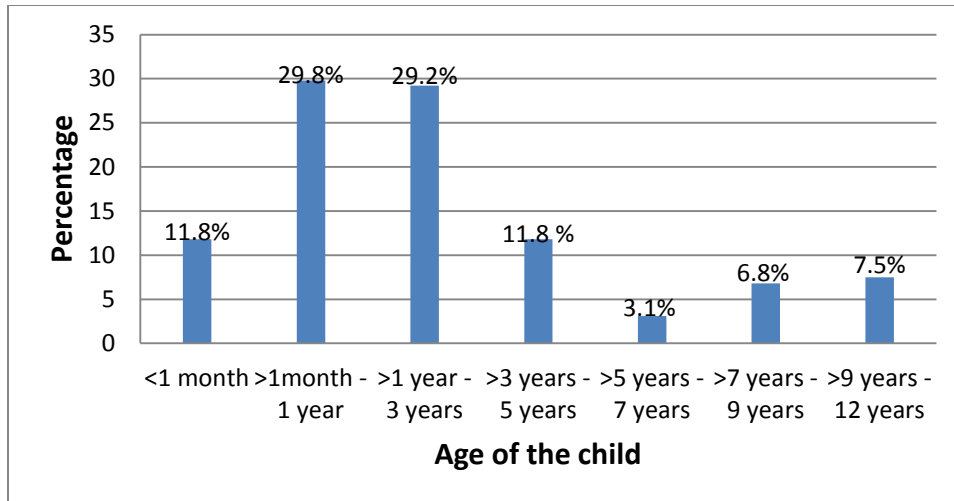


Figure 4.1: Age of the children whose parents participated in the study

4.1.5 Caretaker's Actual Relationship with the Child

Although most of the hospitalised children were taken care of by their mothers or fathers, some were taken care of by people who were not necessarily their parents. As displayed in figure 4.2, 84.5percent (n=136) of the caretakers staying with the children in the ward were the children's mothers.

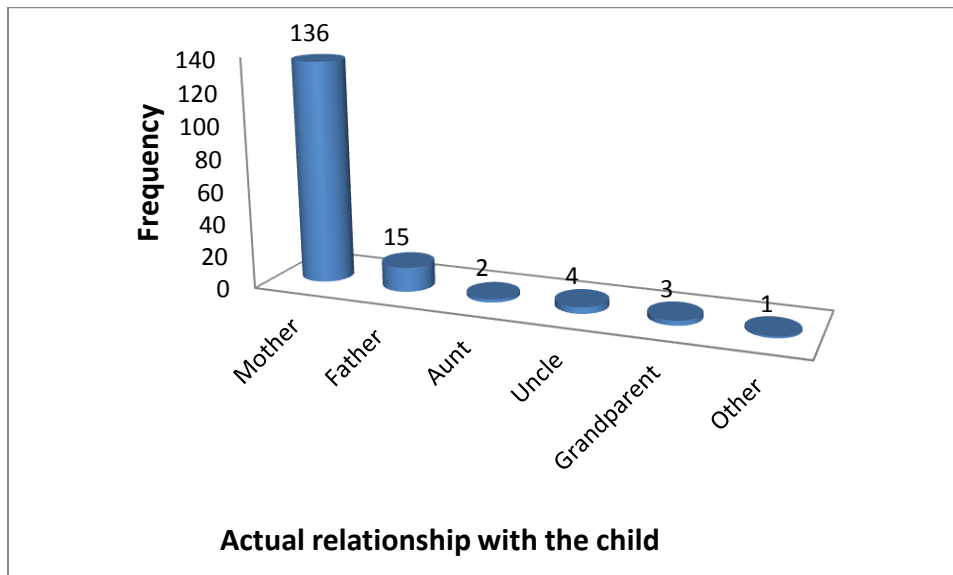


Figure 4.2: Parent's actual relationship with the child

4.2 Socio-Demographic Characteristics of the Participants of Phase II of the Study

This section presents socio-demographic characteristics of the respondents who participated in the focused group discussions and in the in-depth interviews.

4.2.1 Socio-Demographic Characteristics of the Parents

A total of 13 parents, 7 of whom were from KNH and 6 from GCH, participated in the discussions. Majority (84.6%, n=11) of the participants were females with each group comprising one male participant. The majority (76.9%, n=10) of the parents were married, aged less than 30 years (53.8%, n=7), had attained college level of education (53.8%, n=7), and had business as their occupation (38.5%, n=5). On their actual relationship with the child, 76.9% (n=10) of the participants were the children's mothers. These characteristics are presented in table 4.5.

Table 4.5: Socio-demographic characteristics of the parents in the FGDs

Socio-demographic characteristic	Frequency	Percentage
Age		
<30	7	53.8
31-40	3	23.1
41-50	2	15.4
>50	1	7.7
Level of education		
Primary	3	23.1
Secondary	3	23.1
College	7	53.8
Occupation		
None	4	30.8
Business	5	38.5
Farmer	1	7.7
Employed	2	15.4
Student	1	7.7
Relationship with the child		
Mother	10	76.9
Father	2	15.4
Grandmother	1	7.7

In order to get the parents' hospital experience, they were asked to indicate the duration of the child's hospitalization. Most (38.5%, n=5) of the parents indicated that their child had been in the hospital for less than one week. For 30.8 percent (n=4) of the parents, their children had been hospitalized for more than five months whereas for 30.8 percent (n=4), the hospitalization period was between one week and five months.

4.2.2 Socio-Demographic Characteristics of the Non-Paediatric Nurses

Table 4.6 presents the socio-demographic characteristics of the non-paediatric nurses who participated in the focused group discussions. A total of 11 nurses, 6 of whom were from KNH and 5 from GCH, participated in the discussions. Majority (81.8%, n=9) of the participants were females with each group comprising one male participant. The majority (72.7%, n=8) were married, aged 31-40 years (63.6%, n=7), were trained at diploma level (81.8%, n=9) and had a work experience of less than 9 years (63.6%, n=7).

Table 4.6: Non-paediatric nurses' socio-demographic characteristics

Socio-demographic characteristic	Frequency	Percentage
Age (years)		
<30	2	18.2
31-40	7	63.6
41-50	2	18.2
Total	11	100
Level of training		
Certificate	1	9.1
Diploma	9	81.8
Degree	1	9.1
Total	11	100
Experience (years)		
< 9	7	63.6
>9	4	36.4
TOTAL	11	100

4.2.3 Socio-Demographic Characteristics of the Paediatric Nurses

A total of 13 paediatric nurses, 6 of whom were from KNH and 7 from GCH, participated in the discussions. Majority (84.6%, n=11) were females with each group comprising one male participant. The majority (76.9%, n=10) were married, aged below 40 years (61.5%, n=8) and had worked as paediatric nurses for more than 2 years (53.8%, n=7). These are presented in table 4.7.

Table 4.7: Paediatric nurses' socio-demographic characteristics

Socio-demographic characteristic	Frequency	Percentage
AGE (years)		
<40	8	61.5
>40	5	36.5
Work experience (years)		
< 9	5	38.5
10-19	5	38.5
>20	3	23.1
Experience as a paediatric nurse (years)		
<2	6	46.2
>2	7	53.8
Total	13	100

4.2.4 Socio-Demographic Characteristics of the Managers

A total of 11 managers, 6 of whom were from KNH and 5 from GCH, were interviewed. The managers comprised ward in-charges, paediatric unit in-charges and hospital in-charges. Majority (90.9%, n=10) were females and married. The other socio-demographic characteristics are presented in table 4.8.

Table 4.8: Socio-demographic characteristics of the managers

Socio-demographic characteristic	Frequency	Percentage
Age		
<30	2	18.2
31-40	5	45.5
41-50	4	36.3
Level of training		
BSc. N	3	27
PHD	1	9
postgraduate diploma	2	18
KRCHN	2	18
BSc Child health	1	9
DAN	1	9
MSc nursing administration	1	9
Managerial level		
Hospital	2	18.2
Ward	8	72.7
Paediatrics	1	9.1
Work experience (years)		
0 – 9	1	9.1
10 -19	2	18.2
20-29	5	45.5
>29	3	27.3
Managerial experience (years)		
0-2	1	9.1
3-5	2	18.2
6-8	3	27.3
>9	5	45.5
Total	11	100

4.2.5 Socio-demographic characteristics of the Paediatricians

A total of 6 paediatricians, 3 from each hospital, were interviewed. Majority (77.7%, n=4) were males. Almost all (83.3%, n=5) were married and had practised as paediatricians for less than nine (9) years. Their age distribution is indicated in figure 4.3.

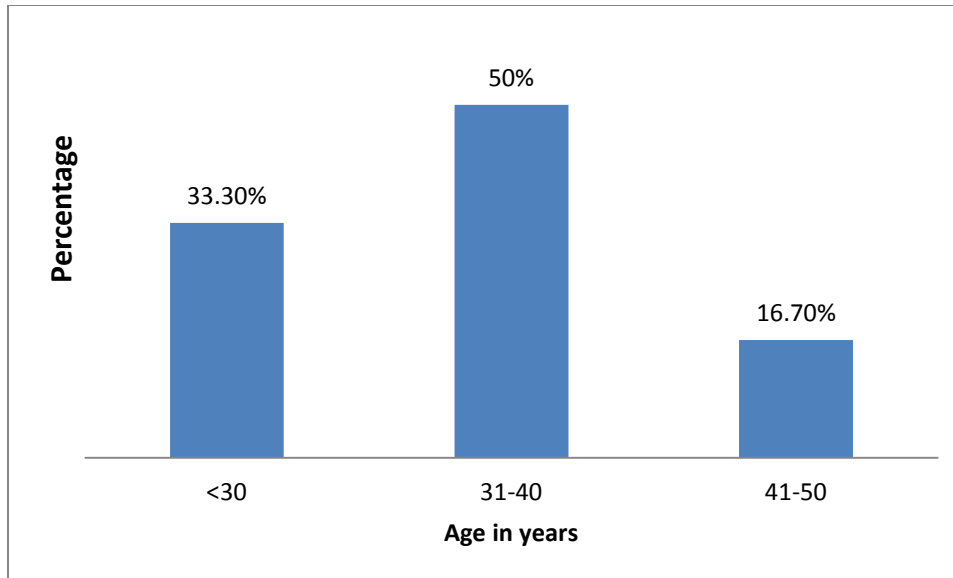


Figure4. 3: Age distribution of the paediatricians

4.2.6 Socio-Demographic Characteristics of Lecturers

In-depth interviews were conducted for 3 lecturers. Each interview lasted about 45 minutes to one hour. Two of them were males but were all married. Two had attained a masters level of training whereas one had a Ph.D. On their age, one lecturer was aged between 31 and 40 years whereas two were aged over 50 years. On work experience, one had an experience of less than 9 years, another between 10 and 19 years and the other one more than 29 years.

4.3 Status of Family Involvement in the Management of Hospitalised Children

The variables describing the status of family involvement in the management of the hospitalised child include: parental involvement in decision making, parental accompaniment of children during procedures, healthcare providers' knowledge and practice of FCC, visitation of the hospitalised child, and the policies guiding the management of hospitalised children.

4.3.1 Parental Involvement in Decision Making On the Management of the Hospitalised Child

4.3.1.1 Healthcare Providers' Responses

Almost all the healthcare providers (98.6%, n=141) indicated that that they did involve the parents in decision making on the care of the sick child. Two of the healthcare providers indicated they didn't. About half (49.6%, n=70) did this sometimes as indicated in figure 4.4.

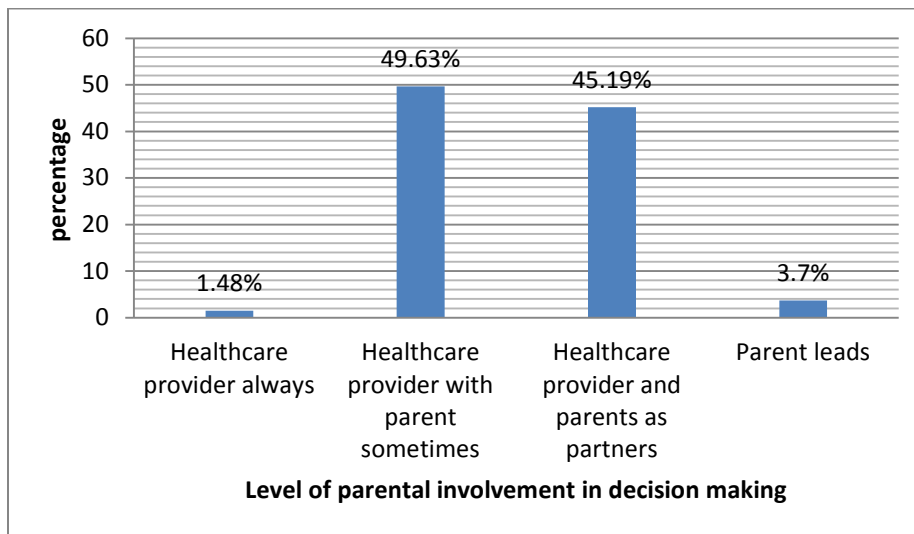


Figure4.4: Level of parental involvement in decision making

The healthcare providers were asked to indicate the various ways in which they involved the parents in decision making. This elicited multiple responses as outlined in table 4.9.

Table 4.9: Modes of parental involvement

Mode of involvement	Frequency	Percentage
Performing daily routines/procedures	99	68.8
Giving the child's history	11	7.6
Being explained to and counselled	55	38.2
Giving consent	15	10.4

Cross tabulation is done to determine the number of healthcare providers from each of the categories that responded to the various levels of involvement. On Chi Square test, there was no significant association between the healthcare provider's profession and the level of parental involvement in decision making (table 4.10).

Table 4.10: Profession by Level of decision making cross tabulation

Profession	Levels of decision making				X ²	P
	Healthcare provider always	Healthcare provider and parent sometimes	Healthcare provider and parents as partners	Parents lead		
Nurse	2	57	49	4	0.199	0.508
Doctor	0	5	8	0		
Paediatric Nurse	0	2	3	1		
Total	2	64	60	5		

4.3.1.1.1 Association between the Healthcare Provider's Socio-Demographic Characteristics and their Involvement of the Parents in Planning Care for the Hospitalised Child

Association is determined between the healthcare provider's socio-demographic characteristics and their involvement of the parents in planning care for the sick

hospitalised child. Cross tabulations reveal that all the healthcare providers who are parents involve the parents in planning care for the hospitalised child as compared to those that are not parents. On Chi square test, the healthcare provider's parental status exhibited a statistically significant association with their involvement of the parents in planning care for the hospitalised child whereas the work experience, paediatric work experience and having heard of FCC had no significant association (table 4.11).

Table 4.11: Parental Status by Involvement of Parents in Planning Cross-tabulation

			Involvement of parents in planning		Total	Fisher's Exact Test
			Yes	No		
Parental status	Parent	Count	114	0	114	0.038
		% within parental status	100.0%	.0%	100.0%	
		% of Total	80.3%	.0%	80.3%	
	Not a parent	Count	26	2	28	
		% within parental status	92.9%	7.1%	100.0%	
		% of Total	18.3%	1.4%	19.7%	
Total	Count	140	2	142		
	% within parental status	98.6%	1.4%	100.0%		
	% of Total	98.6%	1.4%	100.0%		

Association is further determined between the healthcare provider’s working institution and their involvement of parents in planning care for the hospitalised child. Cross-tabulation reveals that a bigger percentage of the healthcare providers working in KNH involve the parents as compared with those working in GCH. On Chi square test the working institution exhibited a statistically significant association with their involvement of the parents in planning care for the hospitalised child whereas the work experience, paediatric work experience and having heard of FCC had no significant association (table 4.12).

Table 4.12: working institution by Involvement of parents in planning Cross-tabulation

			Involvement of parents in planning		Total	Fisher’s Exact Test	
			Yes	No			
working institution	KNH	Count	112	0	112	0.046	
		% within working institution	100.0%	.0%	100.0%		
		% of Total	78.3%	.0%	78.3%		
	GCH	Count	29	2	31		
		% within working institution	93.5%	6.5%	100.0%		
		% of Total	20.3%	1.4%	21.7%		
	Total		Count	141	2		143
			% within working institution	98.6%	1.4%		100.0%
			% of Total	98.6%	1.4%		100.0%

The predictive ability of the set of independent variables that exhibited a significant association (parental status and working institution) on the dependent variable (involvement of parents in planning care for the hospitalised child) is established by

regression while controlling for and marital status. Multiple regressions reveal a significant correlation between parental involvement in decision making and the healthcare provider's parental status and the working institution.

As shown in table 4.13, model 1 shows no significance for the controlled variables; sex and marital status. Model 2 takes on sex, marital status and working institution and indicates the working institution to be a significant predictor. Model 3 takes on sex, marital status, working institution and parental status. According to model 3 both the working institution and parental status are significant predictors with the working institution being the most significant predictor. Multicollinearity is checked for models 2 and 3. The tolerance values for each of the models is more than 0.1, the values of the variance inflation factor (VIF) is less than 10 and the condition index (CI) is less than 30 hence no multicollinearity.

Table 4.13: Regression models for the healthcare provider's parental status and working institution on their involvement of parents in planning care for the hospitalised child

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	1.077	.061		17.736	.000		
	Sex	-.047	.030	-.134	-1.588	.115	.998	1.002
	marital status	.018	.015	.106	1.249	.214	.998	1.002
2	(Constant)	1.003	.065		15.555	.000		
	Sex	-.052	.029	-.147	-1.787	.076	.995	1.005
	marital status	.019	.014	.109	1.319	.189	.998	1.002
	working institution	.067	.023	.236	2.869	.005	.997	1.003
3	(Constant)	.965	.067		14.50	.000		

)					7			
Sex	-.050	.029	-.143	-1.756	.081	.994	1.006	
marital status	.008	.015	.047	.544	.588	.876	1.142	
working institution	.056	.024	.197	2.357	.020	.943	1.060	
parental status	.053	.026	.180	2.020	.045	.837	1.194	

The proportion of parental involvement score for each model is established. Model with the working institution explains 8.9% of the variance whereas model 3 with both the working institution and the healthcare provider's parental status explains 11.3 % of the variance. It is clear that the proportion explained by each of the models is less than 30 %, hence a poor fit (table 4.14).

Table 4.14: Significant predictors for involvement of parents in planning care for the hospitalised child: Model fit Statistics

Model	R	R Square	Adjusted R Square	Std. Error	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.175 ^a	.031	.016	.11688	.031	2.140	2	136	.122
2	.294 ^b	.086	.066	.11389	.056	8.232	1	135	.005
3	.337 ^c	.113	.087	.11262	.027	4.082	1	134	.045

In model 2 and 3, the healthcare provider's working institution and parental status has a direct relationship with their involvement of parents in planning care for the hospitalised child. This would mean the healthcare providers who are parents or have children they are parenting appreciate the importance of involving parents in planning care for the hospitalised child more than those that are not.

Further, an independent t-test was conducted to compare the level of parental involvement scores for the two hospitals. There was a significant difference in the scores for KNH (M=2.45, SD=0.58) and GCH (M=2.72, SD=0.59; $t(133)=-2.2$, $p<0.03$). The magnitude of the difference in the means was large (eta squared = 0.78).

4.3.1.2 Parents' Responses

Slightly more than half (67.1%, n=108) of the parents acknowledged being involved whereas 32.3 percent (n=32) indicated that they are never involved. The parents who indicated that they were involved were further asked to explain how they were involved in making the decisions. From their responses, two dimensions of involvement emerged, that is, actually being part of the decision makers (54.6%, n=59) or taking instructions and or orders from the healthcare providers (45.4%, n=49). Some of the explanations given in the questionnaires in response to the open ended questions on this aspect are; *"We agree on the course of action to be taken being given the choices"* or *"I am told to ensure the intravenous line is not out"*.

The parents' reasons for non-involvement in decision making were in two perspectives: some felt they were ignored by the healthcare providers in the process whereas others thought it is not necessary. One of the explanations that brought out the aspect of being ignored was as follows: *They just decide themselves without informing me. In most cases, I don't even know what they are doing even if I ask them"* and one that depicted it not

being necessary is: *“If I am the one who brought the child, how can they ask for my opinion? “Why should the doctor ask my opinion, yet I am not a medical person?”*

The parents were further asked whether they thought it is important for them to be involved in planning care for their hospitalised children. Majority (87.6%, n=141) indicated it is important, whereas 11.8 percent (n=19), thought it is not important. Those that thought it is important gave the reasons indicated in figure 4.5.

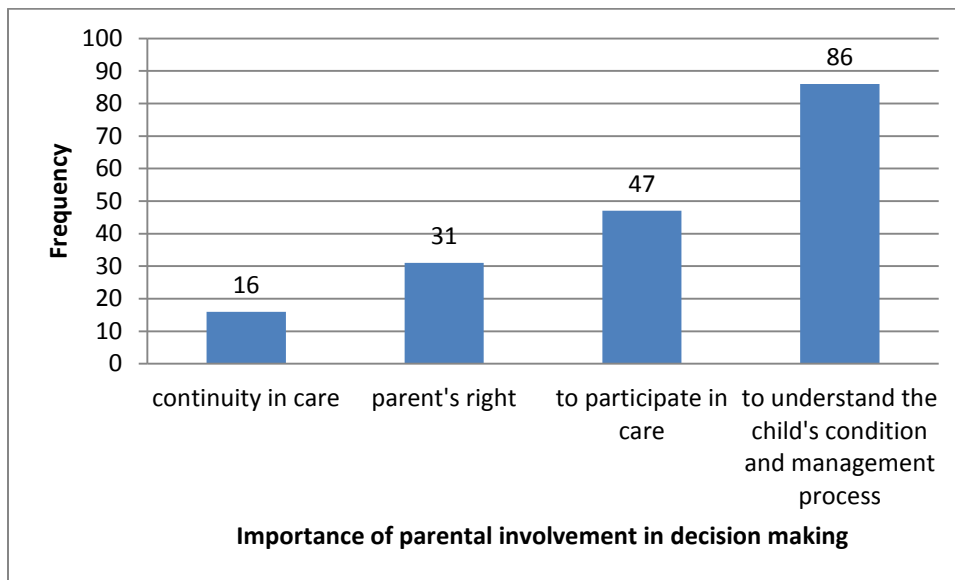


Figure4.5: Importance of parental involvement in decision making

The majority of the parents responding that being involved in decision making will enable them understand the child’s condition and management process is a clear indication that they have more expectations from the healthcare providers than just the child’s recovery from the disease. Their understanding will in the long run enable them be active participants in the management process of the child.

Those that felt that it is not important on the other hand explained that either they are not experts (41%, n=8), it is not necessary (42%, n=8) or this would delay the process of managing the child (17%, n=3). This responses display ignorance on the part of the parents on their rights to information and their roles when their children are sick and hospitalised.

4.3.1.2.1 Association between the Parent's Socio-Demographic Characteristics and Involvement in Decision Making

Association is determined between the parents' socio-demographic characteristics and their involvement in the decision making process on the management of the hospitalised child. Cross tabulations reveal that a bigger percentage of those with college and university education are involved in decision making as compared to those with lower levels of education. Further, on Chi square test, the parents' level of education exhibited a statistically significant association with involvement in decision making whereas their sex and age had no significant association (table 4.15).

Table 4.15 Level of education by Involvement in decision Cross-tabulation

			Involvement in decision		Total	X ² 6	P-value 0.002
			Yes	No			
Level of education	No education	Count	1	1	2		
		% within Level of education	50.0%	50.0%	100.0%		
		% of Total	.6%	.6%	1.3%		
	Primary	Count	18	21	39		
		% within Level of education	46.2%	53.8%	100.0%		
		% of Total	11.3%	13.2%	24.5%		
	Secondary	Count	43	23	66		
		% within Level of education	65.2%	34.8%	100.0%		
		% of Total	27.0%	14.5%	41.5%		
	College	Count	22	3	25		
		% within Level of education	88.0%	12.0%	100.0%		
		% of Total	13.8%	1.9%	15.7%		
	University	Count	23	4	27		
		% within Level of education	85.2%	14.8%	100.0%		

		% of Total	14.5%	2.5%	17.0%		
Total		Count	107	52	159		
		Expected Count	107.0	52.0	159.0		
		% within Level of education	67.3%	32.7%	100.0%		
		% of Total	67.3%	32.7%	100.0%		

Cross tabulation is done for the institution of admission and parental involvement in decision making. The results reveal that a bigger percentage (87.6%) of the parents whose children are admitted in the private hospital are involved in making decisions concerning the management of their hospitalised child as compared to those in the public hospital. Further on Chi square test, the institution of admission exhibited a statistically significant association with involvement in decision making whereas their sex and age had no significant association (table 4.16). The difference in the two institutions would be explained by the parents' socio-demographic characteristics and the patient populations as brought out in the focused group discussions.

Table 4.16: Institution by Involvement in decision Cross-tabulation

			Involvement in decision		Total	X2	P value
			Yes	No			
Institution	KNH	Count	60	45	105	15.011	0.001
		Expected Count	70.9	34.1	105.0		
		% within Institution	57.1%	42.9%	100.0%		
		% of Total	37.5%	28.1%	65.6%		
		Count	47	7	54		

	GCH	Expected Count	36.4	17.6	54.0		
		% within Institution	87.0%	13.0%	100.0%		
		% of Total	29.4%	4.4%	33.8%		
Total		Count	108	52	160		
		Expected Count	108.0	52.0	160.0		
		% within Institution	67.5%	32.5%	100.0%		
		% of Total	67.5%	32.5%	100.0%		

The predictive ability of the set of independent variables (level of education and actual relationship with the child) on the dependent variable (involvement in decision making) is established by regression controlling for sex and previous admission. Multiple regressions reveal significant correlation between the parent's involvement in decision making and the level of education and actual relationship with the child (table 4.17).

As shown in table 4.17, model 1 shows no significance for the controlled variables; sex and previous admissions. Model 2 takes on sex, previous admissions and level of education and indicates the level of education to be a significant predictor. Model 3 takes on sex, previous admission, level of education and actual relationship with the child. According to model 3 both the level of education and actual relationship with the child are significant predictors with the level of education being the most significant predictor.

Multicollinearity is checked for models 2 and 3. The tolerance values for each of the models is more than 0.1, the values of the variance inflation factor (VIF) are less than 10 and the condition index (CI) is small hence no multicollinearity.

Table 4.17: Regression models for the healthcare parent's level of education and actual relationship with the child on involvement in decision making

	Unstandardized Coefficients	Standardized Coefficients			Collinearity Statistics
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Model		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	1.222	.235		5.193	.000		
	SEX	.051	.119	.035	.427	.670	.960	1.041
	Previous admission	.005	.078	.005	.064	.949	.960	1.041
2	(Constant)	1.748	.259		6.743	.000		
	SEX	.058	.113	.040	.513	.608	.960	1.041
	Previous admission	-.047	.075	-.049	-.623	.534	.933	1.072
	Level of education	-.142	.035	-.314	-4.057	.000	.971	1.030
3	(Constant)	2.180	.317		6.881	.000		
	SEX	-.077	.126	-.053	-.608	.544	.754	1.326
	Previous admission	-.062	.074	-.065	-.827	.409	.926	1.080
	Level of education	-.146	.035	-.324	-4.229	.000	.968	1.033
	Relationship with child	-.109	.047	-.199	-2.309	.022	.762	1.312

The proportion of involvement in decision making score for each model is established. Model with level of education explains 9.7% of the variance whereas model 3 with both the level of education and actual relationship with the child explains 12.7 % of the variance. It is clear that the proportion explained by each of the models is less than 30 %, hence a poor fit (table 4.18)

Table 4.18: Significant predictors for involvement in decision making: Model fit Statistics

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.036	.001	-.011	.47254	.001	.103	2	156	.902
2	.312	.097	.080	.45074	.096	16.456	1	155	.000
3	.35	.127	.105	.44457	.030	5.331	1	154	.022

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4.3.1.2.2 Association between the Parent’s Socio-Demographic Characteristics and Importance of Involvement in Decision Making

Association was determined between the parents’ socio-demographic characteristics and their view on the importance of being involved in the decision making process on the management of the hospitalised child. On Chi square test, the parents’ level of education, the institution of admission, sex and age exhibited no significant association with their view on the importance of being involved in decision making.

4.3.2 Parental Accompaniment of Children during Procedures

Both the parents and healthcare providers were asked whether the parents are allowed to stay in when procedures are being performed to the children. Majority (90.1%, n=128) of the healthcare providers indicated they do allow, whereas 9.9 percent (n=14) don’t. Majority (87.6%, n=141) of the parents indicated being allowed to stay in during the procedures whereas a few (11.8%, n=19) indicated not staying in during the procedures. One parent gave no response to this question.

The parents were further asked whether they thought it was important they be allowed to stay in during the procedures. Almost all (96.3%, n=155) thought it was important whereas 3.6 percent (n=6) thought otherwise. The key reasons derived from the healthcare providers’ and the parents’ responses for supporting child accompaniment by parents during procedures included: comfort, assist in procedures, confirmation of what is

being done on the child, allaying of anxiety in the child and parent, and continuity of care (Figure 4.6). Trauma experienced by parents when the procedures are done was the main reason for not supporting parental accompaniment.

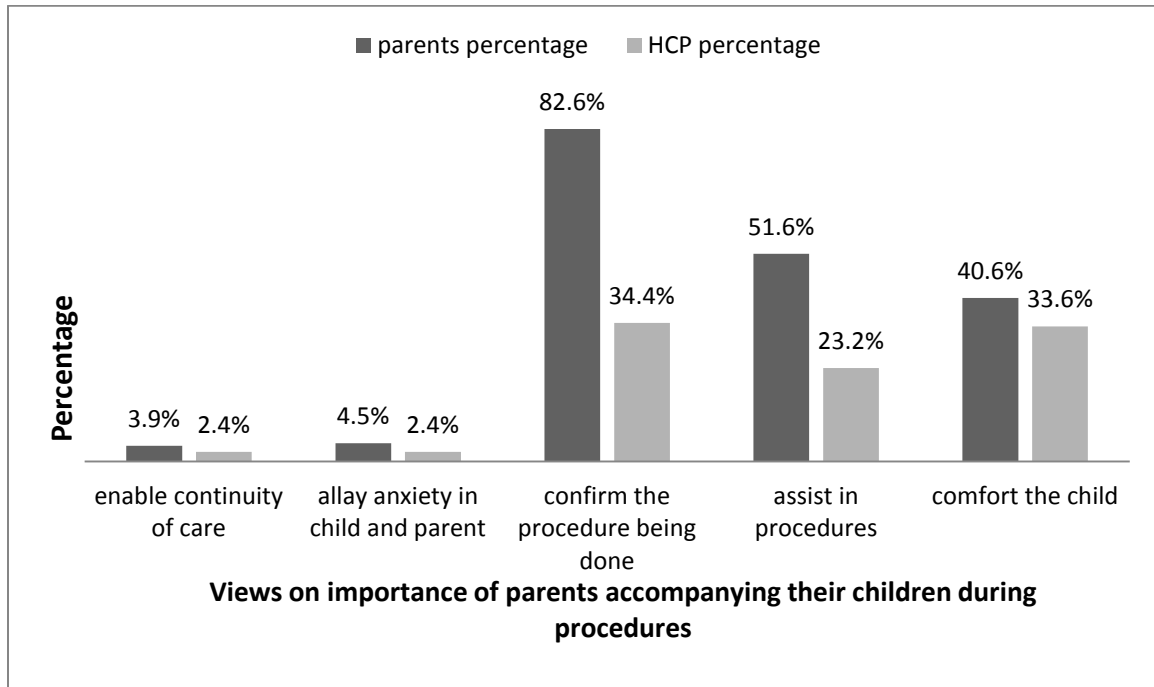


Figure 4.6: Parents' and healthcare providers' views on importance of parents accompanying their children during procedures

The results reveal that for the majority of the parents and the healthcare providers the main reason for children being accompanied during procedures is for the parent to confirm the procedure being done. This responses exhibit an attitude of mistrust on the part of the parents and lack of knowledge about atraumatic care on the part of the healthcare providers.

4.3.2.1 Association between the Healthcare Provider's Socio-Demographic Characteristics and allowing of the Parents to stay in during the Performance of Procedures to the Hospitalised Child

Association was determined between the healthcare provider’s socio-demographic characteristics and whether they allow parents to accompany their children when they are undergoing procedures. On Chi square test, the healthcare provider’s practice of FCC exhibited a statistically significant association at 95 percent confidence level whereas their profession, parental status, working institution, work experience, and paediatric work experience had no significant association (table 4.19).

Table 4.19: practice of FCC by parents stay in during procedures Cross-tabulation

			Parents stay in during procedures		Total	Fisher’s Exact test (P Value)
			Yes	No		
Practice of FCC	Yes	Count	71	3	74	0.029
		Expected Count	67.9	6.1	74.0	
		% within practice of FCC	95.9%	4.1%	100.0%	
		% of Total	65.1%	2.8%	67.9%	
	No	Count	29	6	35	
		Expected Count	32.1	2.9	35.0	
		% within practice of FCC	82.9%	17.1%	100.0%	
		% of Total	26.6%	5.5%	32.1%	
		Count	100	9	109	

Total	Expected Count	100.0	9.0	109.0
	% within practice of FCC	91.7%	8.3%	100.0%
	% of Total	91.7%	8.3%	100.0%

The predictive ability of the independent variable (practice of FCC) on the dependent variable (allowing parents to stay in during performance of procedures to their children) is established by logistic regression. Logistic regression reveals that the practice of FCC significantly explains 4.4 to 10.2 percent of the variance in the dependent variable allowing parents to accompany their children during procedures. The Odds ratio reveals that the odds of the healthcare providers allowing parents to accompany their children during procedures is 4.89 times higher among those that practice FCC than those that don't practice. The regression model is displayed in (Table 4.20)

Table 4.20: Regression model for the healthcare provider's practice of FCC on their allowing parents to accompany their children during procedures

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
								Lower	Upper
Step 1 ^a	Practice of FCC	1.589	.741	4.600	1	.032	4.897	1.147	20.909
	Constant	-3.164	.589	28.816	1	.000	.042		

N = 109, R²1 = 0.044, R²2 = 0.102

Where:

; B = Coefficient of Constant (the intercept); S.E = standard error around the coefficient for the constant; Wald = Chi Square value; df = degrees of freedom; Sig = significance of the Model (P value), Exp (B) = Odds Ratio, N = Number of cases included in the

analysis, $R^2_1 = \text{Cox \& Snell R Square pseudo R-square}$; $R^2_2 = \text{Nagelkerke - pseudo R-squares}$

The regression model reveals that for every unit increase in the practice of FCC among the healthcare providers, there is a 1.589 increase in their tendency to allow children be accompanied by their parents during procedures.

4.3.3 Visitation during Hospitalization

Concerning visitation, the parents were asked whether the other family members visited the child while in hospital any time they wanted. Majority (79.5%, n=128) indicated that they did not with only 19.9 percent (n=32) indicating they did. The main reasons for not visiting any time they wanted included: hospital policies with strict visiting hours, distance from the health facility and commitments such as work for those that are employed (Figure 4.7).

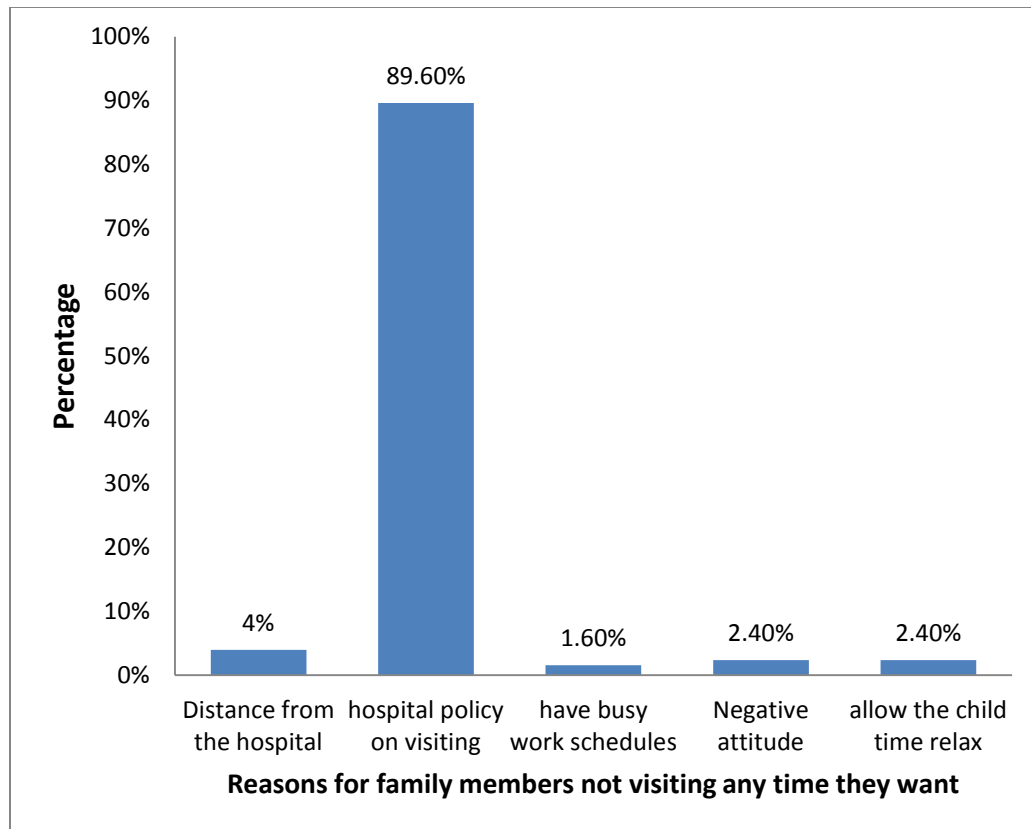


Figure 4.7: Reasons for family members not visiting any time they want

The parents were further asked whether they have other children at home and whether the children visit the one who is hospitalised. Most of them (69.6%, n=112) had other children at home with majority of them (81.3%, n=91) indicating that the children didn't visit the one in hospital and only 21.4% acknowledging that they did come visiting. As indicated in figure 4.8, they did not visit mainly because the hospital does not allow (60.7%, n=55), they stay far from the hospital (26%, n=24) and fear by the parents that the child may acquire infection (5.2%, n=5).

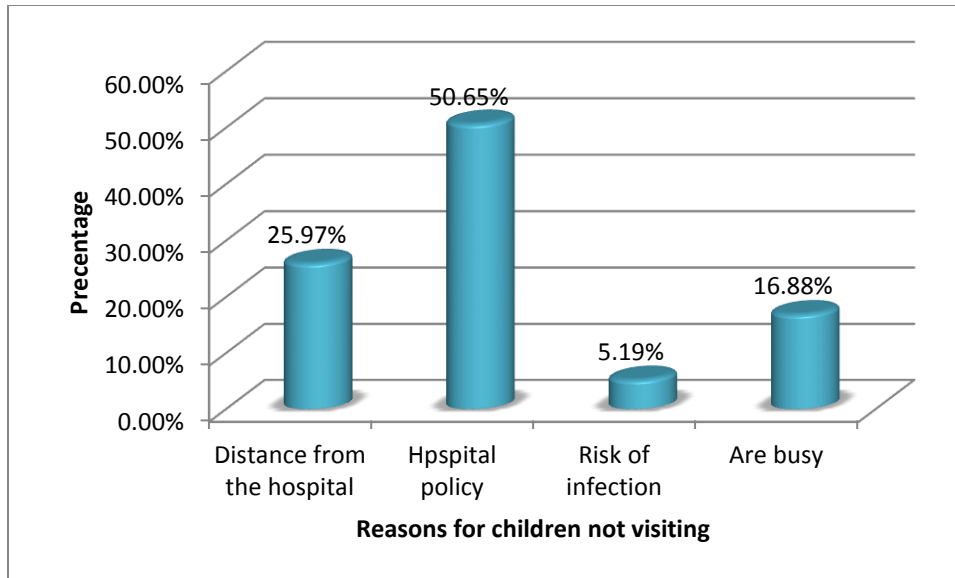


Figure4.8: Reasons for children not visiting

The high response rate for hospital policy as the key reason for family members not visiting any time they want signifies that the emotional needs of both the hospitalised child and the family members are ignored by the hospital management. This is contrary to the tenets of FCC that there should be restricted visiting.

In responding to the open ended question in respect to the hospitalised child being visited by other children, an example of the explanations given was as follows:

“They can acquire infection. The child came and was instructed never to visit again since she/he would contract infection. I don’t want them to acquire infection because diseases can spread easily to the kids”.

The study sought the parents’ views on children visiting the ones in the hospital. Majority (70.2 %, n=113) thought it was important whereas 29.2 percent (n=47) thought it wasn’t. Psychological satisfaction for the sick child and promotion of healing were among the

key reasons for supporting the idea (Figure 4.9).

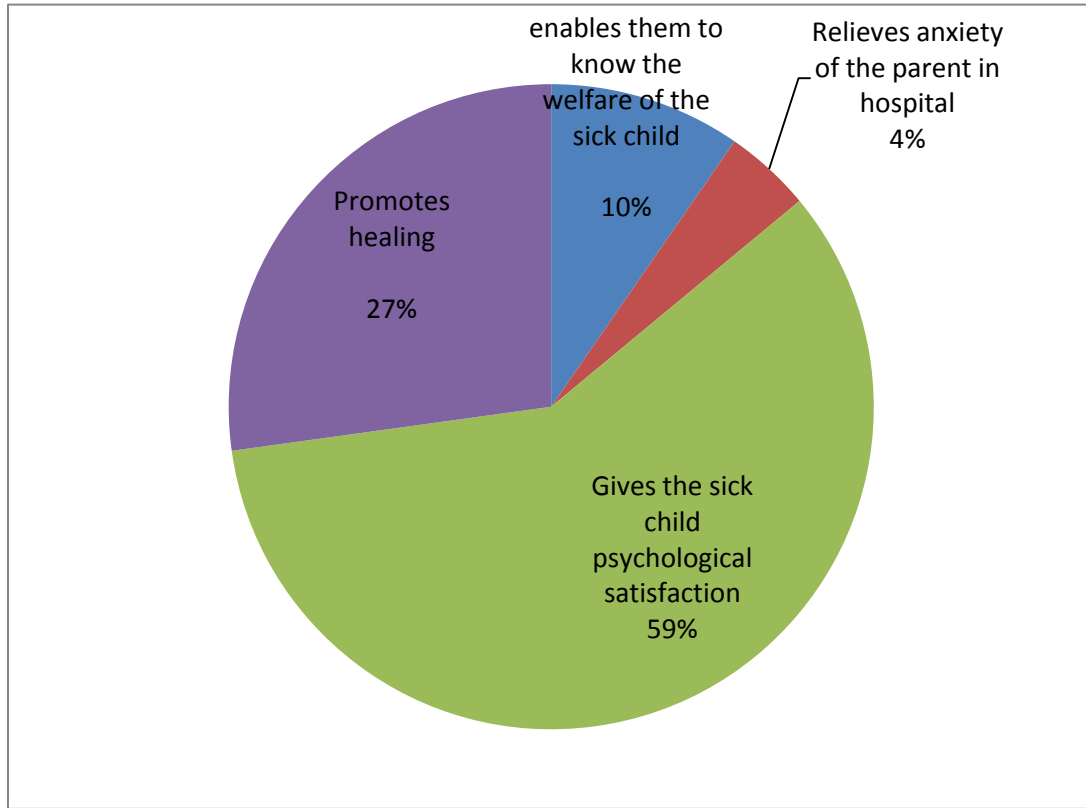


Figure 4.9: Parents' views on other children visiting the one in Hospital

Those that thought it is not important for children to visit gave acquisition of infection and psychological trauma as the main reasons (table 4.21).

Table 4.20: Parents' reasons for not supporting other children visiting the one in Hospital

Reason	Frequency	Percentage
May acquire infections	32	69.6
Causes psychological trauma	10	21.7
is not necessary	4	8.7

4.3.3.1 Association between the Parent’s Socio-Demographic Characteristics and Importance Other Children Visiting the Hospitalised Child

Association was determined between the parents’ socio-demographic characteristics and the importance of the hospitalised child being visited by other children. On Chi square test, the parents’ age exhibited a statistically significant association with their view on the importance of hospitalised children being visited by other children whereas their sex, level of education and institution of hospitalisation had no significant association (table 4.22).

Table 4.21: AGE by Important for other children to visit Cross-tabulation

		Important for other children to visit			X ²	P value	
		Yes	No	Total			
Age	15-25 YEARS	Count	26	16	42	9.47	0.009
		Expected Count	29.7	12.3	42.0		
		% within AGE	61.9%	38.1%	100.0%		
		% of Total	16.1%	9.9%	26.1%		
	26-35 YEARS	Count	60	29	89		
		Expected Count	63.0	26.0	89.0		
		% within AGE	67.4%	32.6%	100.0%		
		% of Total	37.3%	18.0%	55.3%		
	>35 YEARS	Count	28	2	30		
		Expected Count	21.2	8.8	30.0		
		% within AGE	93.3%	6.7%	100.0%		
		% of Total	17.4%	1.2%	18.6%		
		Count	114	47	161		
		Expected Count	114.0	47.0	161.0		

Total	% within AGE	70.8%	29.2%	100.0%		
	% of Total	70.8%	29.2%	100.0%		

4.3.3.1 Key informants' views on children visiting the ones in Hospital

Almost all the key informants were in support of children visiting the ones in hospital. The data collected from the key informants, comprising paediatricians, nurse managers, non-paediatric nurses, paediatric nurses, lecturers and parents, generated two main themes as follows:

Theme 1: Current practice

In regard to children visiting their hospitalized sibling, the private children's hospital upheld the practice acknowledging that it yielded multiple benefits. The national teaching and referral hospital, on the other hand, advanced a divergent view that did not support the practice. Two sub themes brought forth this theme:

Sub- theme 1: Categories of visitors

There are of two categories of visitors depending on their age. The first category are the adult visitors who mainly come to visit the adult accompanying the child hence not of benefit to the sick child. The second category of visitors is the children visitors. These are beneficial to the child as they meet his or her psychological, emotional and social needs. In explaining why they allow other children to visit the hospitalized children, one of the respondents from the private hospital explained as follows:

“We do allow, because you realize most adults who come, they come not to see the child but the parent. There is so much interaction with the parent rather than the sick child, but if the other siblings come to see or other friends from

school, you realize the child cheers up and comes up quickly when they see the other children”. (GR04)

Sub theme 2: Fears for Children visiting

Infection transmission is the main fear on the subject of children visiting the hospitals. Whereas the fear is experienced in both the public and the private hospital, the two institutions have adopted different strategies to prevent the problem. The public hospital has adapted restricted visiting for the children below the age of twelve years. This is brought by the responses given by the key informants like:

“From 12 years and below they cannot come in, they are restricted by the security officer so the parent comes and picks the other child and then comes back. The aim of refusing is because they feel they will abscond in the pretext that this is not the sick child and also because they can pick infections from the hospital”. (KR02)

Restriction of children from visiting is part of the one of the policies in the teaching and referral hospital. However, the practice is not evidenced based. This is expressed as follows:

“Hospital policy – no visiting by children so as to protect them from nosocomial infections and also to prevent them from bringing in infections for example we have been admitting children with malaria and they end up getting measles, chicken pox, other infections in the ward because another child came with that because of exposure. So we are protecting the children inside and also the children from outside. This is a varied reason but it can be reviewed because no research has been done”. (KR04)

To prevent infection to the visiting children, the private hospital has adapted the infection prevention practises like hand hygiene and room restriction. Further, due consideration is

given on the nature and duration of illness of the hospitalised child. In this regard, for the acute and infectious conditions, restriction is exercised in the wards but the children's siblings or friends are allowed in the hospital compound and play grounds. This is implied in the following responses:

“Being family-centred, it is our desire to have siblings visit, but we have to balance that against the risk because the child whom they are visiting may not be having a contagious illness, but other children in the ward may be, but when a child is admitted for long we do make arrangements for them to visit quite frequently. Acute problems or short stay we only allow the parents. This is meant to protect the well child but we would not have a problem having them in the compound, play grounds but not in the ward where they are at risk”. (GR03)

Theme 2: Views about Children Visiting Other Children in Hospital

Concerning children visiting their hospitalised siblings, the study sought the views of paediatricians, nurse managers, non-paediatric nurses, paediatric nurses, lecturers and parents. Two sub themes brought forth this theme. These are as follows:

Sub theme 1: Children Should Visit

Majority of the key informants supported the idea that hospitalised children should be visited by other children. The main reasons for their support are to the fact that it is part of treatment, hastens the process of recovery and shortens the duration of hospitalization. Child visitation further reduces the negative effects of hospitalization like anxiety in the hospitalised child, the accompanying parent and the visiting child. One of the paediatricians gave the following response:

“They should come because they are anxious, the parent or sibling is not there for some time and then they get the sad news that the sibling has died and they have not seen them for 2-3 months – this brings a negative impact on them. The sick child brightens up when they see their siblings”. (GP02)

Another reason for supporting the idea is that the adult visitors do not benefit the child as much as other children do. The children get emotional and social satisfaction on interacting with the other children. In regard children visiting their hospitalized siblings the following observation was made by one of the paediatricians:

“Children cheer up when they see other children but adults can never”. (KP04)

Another importance of children visiting is that it serves as a learning experience for the visiting children in particular if the hospitalised child is suffering from the effects of engaging in wrong habits or risky behaviours. This is hoped to enhance behaviour change and taking of necessary precautions in their activities and interactions.

“It is also good to know that children can get sick, they can take caution like playing in a stupid way”. (KNM02)

In considering rationale for restricted visiting by children, the importance of children visiting and the hospital environment one of the lecturers expressed that allowing them to visit still outweighs the other factors. This he explained as follows:

“We want children to keep in contact with one another. If the worry is that the child will be infected, what happened before the child came to the hospital? My role is to ensure that as they come, they should not get infected. Preventing them from coming to visit others does not help the situation. Put in place measures to protect them from getting infected but not preventing them from really coming to visit - look at the WHO definition of health”. (L02).

All the parents embraced the idea of hospitalized children being visited by other children.

Their expressions, hospital experiences and suggestions were as follows:

“It is very healthy to allow siblings, schoolmates, church-mates to visit. The healthcare providers should understand the distress parents go through may be there be a place where they meet”. (GPR02)

One of the parents from the teaching and referral hospital explained her scenario as follows:

“It is good to come and see because like me, I have been here for the last seven months; I will have loved her to come”. (KPR01)

One of the parents whose child had been in the ward for more than five months expressed himself as follows:

“It is important because as we talk on phone, they enquire so much about each other. Like the one in the ward was asking, how is my sister, why doesn't she come home? It is important the family has to interact, like me, if I see my wife and children together playing, that is my joy”. (KPR02)

Allowing children to visit will avert some of the negative effects of restriction that some of the parents are experiencing. One such effect is that the children left at home particularly those aged less than three years tend to forget their parents. One of the parents who had such experience tearfully stated:

“At least they allow because they forget the other children or the parent who is in the ward because like me(crying) when I go home my child does not see me as her mother, she tells me, “bye, we'll see you”, she calls me aunt”. (KPR07)

In emphasizing the negative effects of restricting children visiting their siblings in the ward, another parent gave her experience with her children as follows:

“Me, I will be very happy if they come because my daughter tells me, she has missed the child, and she is stressed and always asks, ‘How can my mother and sister leave me?’ Let them create somewhere”. (KPR05)

To prevent the negative impacts of children visiting the ones in hospital the respondents fronted the following prerequisites:

- Have a controlled environment where the children's safety is ensured
- Exercise caution
- Consider the nature of the illness that a child is hospitalised of

"I don't believe that children should not visit, dependent on the cases. For things that are not scary, that will not give them nightmares, they should come and see. For highly infectious or scary states, that they can be barred. Otherwise they need to visit and play with them". (KP01)

- Review hospital policies on visitation

"We need to encourage the hospital management to change their views and also the operating environment within the hospital". (KP04).

- Put in place modalities and logistics for children visiting to include designated areas or specific days of the week

Sub theme 2: Children should not visit

A minority of the respondents did not support the idea of children visiting the one in hospital. The main reason for their position was to the fact that the visiting children can acquire infection or get psychological trauma upon seeing the sick sibling. One paediatrician who did not support children visiting explained as follows:

"I have passion for infection control, so I will not encourage. Children are risky and vulnerable due to their low immunity and practices like touching the floor and they will be our next clients. If the child is very sick, then the family will actually understand that psychologically even for the younger children, it is not very healthy to see their sibling ill. They can support in terms of talking to them on phone, writing to them but only be allowed to interact when the other sibling is able to interact with them". (KP03).

4.3.4 Healthcare Providers' Knowledge and Practice of FCC

The study set out to determine the healthcare providers' level of knowledge about FCC and whether those that have the knowledge apply it in their practise.

4.3.4.1 Healthcare Provider's Knowledge of FCC

Slightly more than half (63.2%, n=91) of the healthcare workers had heard about FCC. The source of information included training (27.5%, n=25), Continuing Medical Education [CME] (49.5%, n=45), read about it (6.5%, n=6) and others including hearing from colleagues and internet sources (16.5%, n=15). The distribution of the various categories of healthcare providers with regard to source of information is as illustrated in table 4.23.

Table 4.22: Source of information of FCC for the various professionals in healthcare

Source of information on FCC	Nurse	Doctor	Paediatric nurse
Training	20	3	2
CME	40	2	3
Read about it	6	0	0
Other	11	4	1
Total	77	9	6

When asked to state their understanding of FCC, the healthcare providers who had heard about it gave different meanings whereby majority (85.1%, n= 86) of the respondents' definitions depicted possession of the right information whereas a few (14.9%, n=15) displayed a lack of understanding of the concept. The following are some of the definitions they came up with:

1. Definitions indicating possession of the right information about FCC:
 - Caring of the sick child and involving the parent at every stage (in all aspects).

- Provision of healthcare through participation by all, that is, family (parents & siblings), patients and healthcare providers.
- Is where you involve the other members of the family to care for the sick family member and also within their means.
- Involving the whole family in the care of the patients so that they are supported fully socially, physically, psychologically & spiritually and also offer best continuum of care at home.
- Where the family plays a leading role in decision making concerning the care of the child.
- Is where the family life is continued in the care of the child – the family habit is continued, for example, eating time, sleeping time and type of food.
- Prioritizing care based on family needs and should be specific, supported and encouraged by creating mutual understanding and partnership with parents in the care of a child.
- All family members participate in decision making, delivery of care at every stage; it is family initiated care, doctors just give direction.
- Care that is family initiated and maintained.
- Care involving the family in ways they can manage within resources available to them. Their informed word has lots of input.
- 3 concepts in FCC, that is ,
 - Enablement: enabling parents to display their abilities in care of their child.

- Empowerment: where you make the family have a sense of control over their family.
- Partnership: where the nurse and the parent work together and have equal role in deciding what is good for the child and family as a whole.
- It is care that involves the whole family with special emphasis on the child but also caring for the mother or father and considering the family as a unit. When a child falls sick, the whole family is affected psychologically, socially, mentally, and physically so these needs must be catered for in the care.

2. Responses indicating a lack of knowledge about FCC:

- Where the family caters for their own patient at home and involving relatives in the patient's care.
- It is the care given to a family (nuclear) like home-based care where you give services and advice.
- It is where the nurse cares for the patient and also the family.
- Encouraging good family health for a healthy community (society at large).
- A centre designed to address the health challenges facing families in a holistic way.
- This where a patient is taken care of by the family in a home set up.
- An institution that provides information to families or provides care to families who are undergoing some difficulties.
- Caring for the family and involving the parents and the community.
- Where family members are being taught how to take care of their families.

- Care given at reach of family or relatives.
- The care of a sick child extended in home environment especially with chronic illnesses.

4.3.4.2 Practice of FCC

Slightly more than half (52.1%, n=75) of the healthcare providers acknowledged that they did practise FCC. Among the healthcare providers that have heard of FCC, 74.7 percent (n=68) apply the approach in their practice. Association was determined between the healthcare provider's socio-demographic characteristics and their practice of FCC while caring for the hospitalised child. On Chi square test, the healthcare provider's having heard of FCC exhibited a statistically significant association with their practice of FCC in caring for the hospitalised child ($X^2 = 6.379$, $P < 0.012$) whereas their profession, parental status, work experience, paediatric work experience and source of information on FCC had no significant association (table 4.24).

Table.4. 23: Heard of FCC by Practice of FCC Cross-tabulation

			Practice of FCC		Total	X2	P value
			Yes	No			
Heard of FCC	Yes	Count	68	23	91	6.379	0.012
		Expected Count	62.9	28.1	91.0		
		% within heard of FCC	74.7%	25.3%	100.0%		
		% of Total	61.8%	20.9%	82.7%		
	No	Count	8	11	19		
		Expected Count	13.1	5.9	19.0		
		% within heard of FCC	42.1%	57.9%	100.0%		
		% of Total	7.3%	10.0%	17.3%		
Total	Count	76	34	110			
	Expected Count	76.0	34.0	110.0			
	% within heard of FCC	69.1%	30.9%	100.0%			
	% of Total	69.1%	30.9%	100.0%			

The predictive ability of the independent variable heard of FCC on the dependent variable (practice of FCC) is established by regression. Logistic regression reveals that the healthcare provider having heard of FCC significantly explains 6 to 9 percent of the variance in the practice of FCC. The odds of practising FCC by the healthcare providers is four times higher among those that have heard about FCC than those that haven't. The results further reveal that one unit increase in the knowledge of FCC increases the chances of practicing FCC 1.4 times (table 4.25).

Table 4.24: Regression model for the healthcare provider's having heard of FCC and their practice of FCC in the care of the hospitalised child

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I.for EXP(B)	
								Lower	Upper
Step 1 ^a	Heard of FCC	1.402	.524	7.176	1	.007	4.065	1.457	11.343
	Constant	- 1.084	.241	20.196	1	.000	.338		

N = 109, R²1 = 0.064, R²2 = 0.090,

Where:

B = Coefficient of Constant (the intercept); S.E = standard error around the coefficient for the constant; Wald = Chi Square value; df = degrees of freedom; Sig = significance of the Model (P value), Exp (B) = Odds Ratio, N = Number of cases included in the analysis, R²1 = Cox & Snell R Square pseudo R-square; R²2 = Nagelkerke - pseudo R-squares

Analysis was done to compare the profession of the healthcare provider and the practice of FCC. A higher percentage of the paediatric nurses practised FCC as compared to the doctors and non-paediatric nurses. The results as indicated in table 4.26.

Table 4.25: profession by Practice of FCC Cross tabulation

		Practice of FCC			
		Yes		No	
		Frequency	%	Frequency	%
Profession	Nurse	62	66.7	31	33.3
	Doctor	7	77.8	2	22.2

	paediatric nurse	6	85.7	1	14.3
Total		75		34	

Further analysis is done to compare the working institution of the respondents and their practice of FCC. The results obtained revealed that the approach is practised by a bigger percentage (84.5%) of those working in GCH as compared those working in KNH (62.3%). On significance testing by Chi square, there was a significant relationship between the working institution and the healthcare provider's practice of FCC ($X^2 = 4.727$; $P < 0.030$). The results are as displayed in table 4.27.

Table 4.26: working institution by Practice of FCC Cross tabulation

		Practice of FCC		X^2	P value
		Yes	No		
Working institution	KNH	50	30	4.727	0.030
	GCH	26	5		
Total		76	35		

4.3.4.2.1 Modes of Practice of FCC

The common modes of practice of FCC, as indicated in table 4.28, included allowing parents to participate in giving care (52.9%, n=36) and empowering them through education and counselling (32.9%, n=22).

Table 4.27: Modes of practice of FCC

Modes of practice of FCC	Frequency	Percentage
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Parents participate in giving care	36	52.9
Education, counselling and empowerment	22	32.9
Allow the family to visit	2	2.9
The children are accompanied in the ward	8	11.8
Total	68	100

4.3.4.2.2 Reasons of Non-Practice of FCC

As indicated in figure 4.10, a large patient population and lack of stipulation of the concept in policy were the key reasons for non practice of FCC.

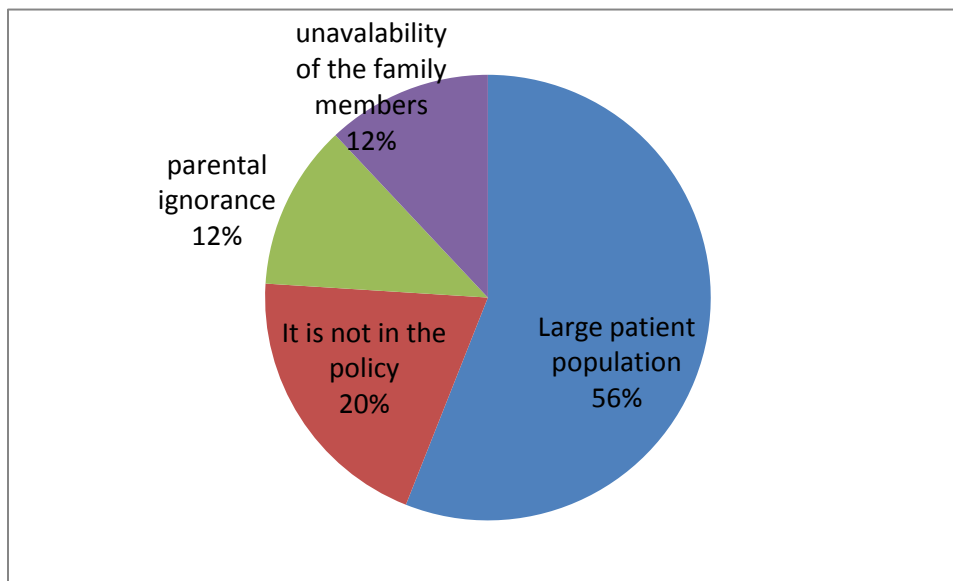


Figure 4.10: Healthcare Providers' Reasons for not Practicing FCC

4.3.4.4 Paediatric Nurses' Practice of FCC

In the focused group discussions, the paediatric nurses were asked to narrate their experiences in the practice of FCC. Their expressions brought out two themes as regards

to the practice of FCC. These are the FCC practice strategies and the reasons for practicing FCC.

Theme 1: FCC Practice Strategies

The FCC practice strategies are the ways in which the paediatric nurses ensure they apply the principles and elements of FCC in the care of the hospitalised child. These include:

- Encouraging the parents to be with the child in the process of examination and treatment. In explaining this point one of the paediatric nurses from the public hospital explained that though the hospital has not adapted the approach in its child care policies, in her unit she has embraced it. She explained as follows:

“FCC has been embraced; it starts immediately when the child has been brought to the unit. We encourage both parents to be there and we find it being applicable because they assist one another when the child is sick in caring. We encourage them to be with the child at every point”. (KPN01)

- The paediatric are zealous about the application of the concept whether adapted in policy or not. This is by ensuring they orientate and encourage their colleagues on the benefits of the approach

“It is self initiative but it is not documented”. (KPN01, 2)

- Sharing information with the sick child’s family and explaining to them the child’s condition and management process
- Allowing the children to be accompanied by their parents throughout the period of hospitalization
- Teaching and allowing some parents to perform or assist in the performance of some procedures

- Not restricting children to the hospital food. This is upheld in the public hospital whereas it is not upheld in the private hospital.
- Allowing the accompanying parent to participate in the ward round when the child is being reviewed

“They are allowed to participate even during the ward round”. (KPN 05)

Theme 2: Benefits of Practicing FCC

The paediatric nurses, expressions on the practice of FCC brought forth the benefits that they have realised. The benefits extracted from their expressions include:

- When both parents are present they assist and support one another in the management process. For example due to the distress caused by the child’s illness, one parent may forget some aspects of the child’s illness, the other parent supports by bringing out the forgotten aspect.
- When the parents are involved in the care of the hospitalised child, coping is easier
- The healthcare providers find it easier to care for the child when they involve the parents

“When you involve them, caring is easy”. (KPN02)

- The parents get empowered to care for the child even after discharge. This is particularly so if they are involved from the first day of admission.

“Most of the time when we involve the parents, they feel empowered and confident to manage the children even on discharge, especially those with chronic illnesses”. (KPN 08)

- The child’s home routines and practises are not adversely disrupted as they used to be before the adoption of FCC particularly in the children’s hospital. One of the respondents narrated her experience as follows:

“I remember when I came here in 2002, I was in an open ward, at 2’oclock, the children were given a cup of milk, the curtains were closed and they were all told to sleep so as to wake up at 4.00 but now we are not doing that, the child will sleep as they sleep at home”.(GPN04)

4.3.5 Policies guiding the management of hospitalised children

Data concerning policies guiding care of the hospitalised children was collected from the managers during phase II of the study. Analysis of the data generated 2 themes in regard to the policies.

Theme 1: Existing policies

The interviews revealed existence of some policies guiding management of hospitalised children. However, it emerged that some of the managers were not aware of the existence of such policies especially in the teaching and referral hospital. Some of the policies are not documented and the policies are not all inclusive especially in regard to healthcare provider-parent involvement. This is depicted by the responses given that included the following:

“Do we have any written policies? Not really. But we have a policy which says, children who are below 5 years should stay with their mothers and children above five years should only stay with their mothers when they are very sick. It may not be documented, but a child who is more than six years and is critically ill we can allow the mother even though she is not in hospital to come anytime and see the child”. (KNM05)

In responding to the issue of policies one of the paediatricians stated the following:

“For some common conditions there is the paediatric protocols from the Ministry of Health but not for every ailment and they address the under fives and not the caretakers. We have basic paediatric admission forms”. (KP02)

Theme 2: Key informants’ awareness about the policy guidelines in their hospital

While enquiring about policies, the key informants were asked to explain whether the policies clearly stipulated the role of the healthcare providers and the parents in the care of the hospitalised child. From the information provided by the respondents from the teaching and referral hospital, there was a discrepancy on this. Whereas the lower level managers indicated that there was no existence of a policy in this respect, those in top management indicated there was. One of the top managers stated the following:

“We have guidance for both the caretakers and the healthcare providers. The day post admission, there is an orientation for the caretakers of the children on which they are given guidance on our expectation when they are in the ward; What we expect them to do for the child, what we don’t expect them to do and schedules of the hospital like ward round, treatment and visitation. There is also guidance for the healthcare providers of the children who are with the caretakers that we expect you to do ‘ABCD’ and guide the caretakers to do ‘abcd’”. (KP03)

This was in contrast to responses by the lower level managers, one of whom said the following:

“There are no written policies which indicate that we involve the mother although when we are overwhelmed, we can talk to the assistant chief nurse and say those things the mothers can do so that we can let them do like feeding, bathing, changing, straightening the bed – but there is no policy in place. It is very necessary to have a policy because some of these things we are doing in fear because if the managers find you, you will be asked as it is not documented”.
(KNM02)

When the top manager was further asked whether the guidelines are given in writing to the healthcare providers in the ward and to the parents, it was indicated they are not given.

The responses given by the participants from the private children’s hospital revealed that both the top and lower level managers were aware of the policies that guide the management of hospitalised children in the hospital. The following are responses from a lower level manager and a top manager respectively:

“We encourage the parents to take care of their children as much as possible-feeding, bathing, and oral medication under the supervision of the nurse when they are in the ward”. (GNM01)

“In this hospital we practise family-centred care whereby we encourage partnership in care. We allow parents to stay with their children no matter the age and regardless of the condition. We also allow parents to take care of some of the needs of the children. The only things that we’ve not been able to share with parents are technical skills but activities of daily living, whatever the parent is willing to take up, we allow”. (GNM05)

When further asked whether they explained to the parents what they mean by family-centred care, they indicated that this was not done as a routine unless a parent asked to be explained to.

4.4 Challenges Experienced by Healthcare Providers in the Care of Hospitalised Children

The study set out to establish whether healthcare providers faced any challenges while caring for hospitalised children. Almost all (97.2%, n=140) healthcare providers from the two institutions acknowledged experiencing a number of challenges while caring for hospitalised children. This being an open ended question, the respondents gave multiple responses. The challenges are presented in table 4.29.

Table 4.28: Table 4.29: Common challenges experienced by the healthcare providers

Challenge	Frequency	Percentage
Difficult working conditions	95	66.0
Delays from other team members	11	7.6
Family factors	49	34.0
Language barriers	11	7.6
Large number of patients	25	17.4
Lack of positive motivation	27	18.6
The disease, its outcome & child's reaction	17	11.8

Some of these challenges are further are further described below:

Difficult working conditions

The healthcare providers from both hospitals felt that their working environment was in most cases not very supportive. Most of the respondents from the teaching and referral hospital enlisted the following in regard to difficult working conditions: relatives in the

ward who are a bother to health workers in the delivery of care; lack of essential drugs and equipment; no beds for relatives; congestion in the rooms; heavy workload; lack of motivation of staffs (no promotions, low pay, for the night staffs, long working hours with no snacks or meals to sustain them); lack of structures for the fathers (for example, no kangaroo room, wash rooms and changing room for the fathers/male caretakers); no hot water for children to bathe; overstaying of the discharged patients in the ward and a dirty environment. The healthcare providers' view that relatives in the ward are a bother is portrays a lack of knowledge on the propositions of FCC and a further negative attitude. This would be a hindering factor to working together with them in partnership for the care of the hospitalised child.

Delay from other healthcare team members

There was a general feeling that some of the delivery of care for the children is delayed by other members of the healthcare team or other departments. One of the explanations given to the open ended questions in the questionnaire on this aspect was as follows:

“Other staffs take too long to attend to the patients, there is delay in getting results and procedures like CT scan due to lack of money”.

Family factors

The healthcare providers indicated that there are various family factors that pose a challenge in their care delivery processes. These include factors like: religious beliefs and practices; socio-economic factors; cultural factors; lack of cooperation from the family; very stubborn family members; low level of education for the parents; the parents are uncooperative during assessment; non-adherence to medication; attitude of the parents;

abscondment; needy families; anxiety in the family because of the child's sickness; overprotective parents; very prominent and very economically stable families; when parents decline planned procedures for example cannulation; when clients themselves refuse to have treatment; high tempered parents; rigid parents; difficult clients (parents) who can never appreciate despite what you do. The various family factors enlisted by the healthcare providers suggest a lack of understanding and appreciation of the weaknesses and strengths of individual families and their coping mechanisms.

4.4.1 Challenges Experienced by the Key Informants

The key informants comprising nurse managers and paediatricians were also asked to indicate the challenges they experienced while working in paediatric wards/departments. This was done in order to corroborate their responses with those of the bedside healthcare providers. The challenges that they verbalized were similar to those stated by the respondents in phase 1 (table 4.18). These challenges are as follows:

The Disease Itself

The healthcare providers cited the diseases that the children present with as another challenge.

“The illness itself like balancing the needs of the child and those of the parents which are not necessarily synonymous”. (GP3)

In regard to this challenge, one of the key informants explained as follows:

“It is a challenge caring for terminally ill children (psychological pain). It is hell after I have admitted this child I know for sure I might not make it, I might not win the battle and you know after you've become friends and you are attached, she is part of my family and she goes, that is a nightmare. Sometimes I don't want

to see the parent and what do I tell the other children? I ring and inform the parent that the child is very sick please come and they don't come and this child is crying, 'mama, niitie mummy' ('mum, call for me my mother'). This puts me in an awkward situation. I don't know what to tell this child and by the time the parent comes, the child is already gone and I don't know what to tell him/her – it is a challenge". (KNM 01)

Communication problems

Communicating with the child and the parents was frequently cited as a challenge. This is especially in situations where the parents do not understand the national languages which are English or Kiswahili. One of the respondents pointed out the following:

"Stating clearly what is happening without using much jargon so that they can understand as they have different levels of education". (GP2)

Parental ignorance

Parents are ignorant in regard to the management of the child when in hospital. This is more evident on their expectations when some protocols like blood transfusion are to be instituted. In explaining this challenge, one of the nurse managers made the following remark:

"Parental ignorance, for example, in an instance where blood transfusion is required, the parents come with a donor; they expect that once the blood has been donated the blood should be given immediately". (KNM01)

Whereas parental ignorance is seen as a challenge to the healthcare providers, the researcher strongly feels that they should take that opportunity to educate and empower them as brought out by the paediatric nurses.

Parental fear and anxiety

In explaining this challenge, one of the nurse managers made the following remark:

“Parents fear the sick child, so the child belongs to the nurse. It is upon the nurse to involve her and encourage her”. (KNM02)

In regard to this challenge, the researcher observes the healthcare provider’s lack of knowledge on the effects of childhood illness and hospitalisation to the parents. Possession of such knowledge enables the healthcare provider realize that this is one of the normal reactions by parents. This enables them take the opportunity to counsel and educate them rather than viewing it as a challenge.

Parental refusal to participate in care

In this scenario, parents refuse to participate in the performance of some procedures, like changing of the child, on grounds that they are paying. So it is the responsibility of the healthcare providers. This is brought out in the quote below:

“Some feel why should I do it and am paying? It is your work!”. (GNM01)

From my own perspective and that of the parents, parental refusal to participate in care delivery is dependent on the approach used by the healthcare provider and the interaction they have. The parents if well orientated on admission and if communicated to in a respectable and understandable way they will not refuse to participate. This was brought out by the parents during the focused group discussions.

Bothersome parents

Contrary to the stipulations of FCC that the healthcare providers and the parents should work in partnership, some of the healthcare providers view the parental presence in the children's ward as a bother. In their view parental presence makes them take a longer time in doing a procedure as compared to when the child is alone. This is because they have to explain to the parents whatever they are doing and why.

“On the side of the nurse, once the child is in the ward with the parent, they feel the parent is a bother, they want to do their procedures quickly but now they have to explain to the parents which is like wasting their time., then they want to take the child, do the procedures and take off”. (GNM02)

The above scenario is a further justification for the need for training on FCC.

Family disintegrations

Some families separate once the child is diagnosed of a chronic or genetic condition

“baba ameenda kabisa. haonekani tena” (‘the father has gone completely; he is nowhere to be seen’) he doesn’t come to see the child again”. (KNM01)

4.4.2 Challenges of working with parents

The data obtained in the focused group discussions with the non-paediatric nurses and in-depth interviews yielded four main challenges in regard to working with parents. These are described below:

I. Parental expectations and demands

The respondents indicated that parents, especially in the private children's hospital, have high expectations and demands for the healthcare providers. One of the participants from the private children's hospital made the following comment:

“Parents are demanding when they are around. If you are not strong, they may really push you around, some to the extent that they show you that you don’t know what you are doing”. (GGNR01)

II. Children’s reactions to the healthcare providers when parents are present

The respondents indicated that parental presence makes some of the children refuse to cooperate with the healthcare providers. One of the respondents made the following observation:

“Some of the children cry all the time because the parents pamper them too much until you are not able to carry out the procedure confidently”. (GGNR03)

III. Parents’ views about the payments they make to the hospital

The issue of making payments to the hospitals was cited as one of the factors that caused a challenge in working in partnership with parents in the provision of care to the hospitalised child in the two institutions. One of the respondents made the following remark:

*“Parents feel they pay a lot of money so they want you to do everything”.
(GGNR03)*

IV. Parental unavailability

Some parents, especially those whose children are admitted in the private hospital, were said to be unavailable for consultation with the healthcare providers. One of the respondents made the following remark:

*“No enough time – children are left with the caretakers – parents are too busy”.
(GGNR02).*

4.4.3 Challenges faced by the paediatric nurses in the practice of FCC

The challenges faced by the paediatric nurses in the practice of FCC while providing healthcare to children and their families included the following:

I. Lack of support

The paediatric nurses working in the Teaching and Referral Hospital expressed lack of support from the hospital management and other staffs who are not trained on the concept. Due to differences in awareness about FCC, a disparity exists on how the healthcare providers handle the parents. This makes it difficult to work with the parents because they are made to have a negative attitude toward the healthcare providers as the majority have not been trained on the concept. One of the respondents gave the following explanation:

“Nurses imagine that parents are know-it-all due to their access to internet information. So the challenge to the health personnel is, why is the parent doing my work? Like I remember a nurse asking a mother why she had a thermometer and yet they have been educated and they have them at home. So fear of the nurses on mothers taking over their work, you find a mother bathing the baby and you ask, ‘kwa nini unafanya kazi yangu’ (why are you doing my work)”? (KPN01)

II. Parental behaviour due to cultural influences

They cited cultural influence on the approach parents take in the presentation of their sick child to the hospital. One of the respondents gave the following scenario:

“Parents due to culture like fathers staying a distance away and yet when the mother leaves the doctor’s room they start questioning them, did you explain about this properly”? (KPN01)

Culture as a hindrance to partnership establishment is a clear indication that the healthcare providers need to be trained culture appreciation and incorporation in care.

III. Space, staffing and time limitation

The paediatric nurses from the teaching and referral hospital cited space constraints and the overwhelming number of patients which makes it difficult to practice FCC properly. Lack of essential facilities, like beds for the parents, makes some of them opt to go home leaving the child alone in the hospital. Here is a comment by one of the respondents:

“Facility – environment, the parents have no space to sleep or even a blanket to use so the parents feel that since the child sleeps alone at home, she can as well leave her”. (KPN 05)

Another respondent, in emphasizing the same point, explained that they handle a large number of patients which makes them experience time constraints in individualizing patient care. For instance, instead of conducting individualized patient education, they opt for group education.

IV. Parental fear of witnessing some of the procedures

Some parents fear accompanying their children during some procedures especially if they are traumatic. Thus they opt to stay away leaving the child alone with the nurse. In this instance, it becomes difficult to practise atraumatic care. One of the respondents explained as follows:

“Some parents not wanting to be with the children during some of the procedures like resuscitation, lumbar puncture because they find them to be rather traumatic, so they will want to be away and trying to pull them back sometimes is hard”.
(KPN03)

V. Parental commitments

The respondents indicated that the parents have a number of commitments and other social responsibilities to attend to. These limit their availability to be with the hospitalised children. This is expressed in the following scenario:

“Single parents – this parent has some other children at home and one has been admitted so she finds it difficult to coordinate between home and here. So, as much as we would want to practise FCC, as a hospital we cannot cater for the children who are at home and here. Parents might go, there is fear and anxiety in the parent on what is going to happen to the other children and what is happening to this one”. (KPN04)

VI. The impact of the history of hospital care in the country

One major challenge was in the way hospital care for children have been carried out in the past. The parents have been encultured that once the child is in the hospital, it is the responsibility of the healthcare providers to decide and implement care. This makes them to be bystanders rather than active participants in the planning and implementation of care for their hospitalised child. This is reflected in the comment below:

“We have lived in the old time that the healthcare provider is the one who knows it all; so long as the child is in the hospital, we should take care. We have not erased it from the parent”. (KPN05)

VII. Influence of parents on one another

Parents share experiences in the ward and in the process they sometimes influence each other wrongly. This challenge is reflected in the following remark:

“They influence one another and children may not be having the same problem but they interact and influence one another – pick wrong concepts regarding care”. (GPN01)

This challenge was further explained by another participant as follows:

“You want to involve the family in the care; sometimes especially relatives get too involved or are problematic. Those who think they know sometimes come with their own ideas making the parent to follow their idea more than the one from the healthcare providers. Sometimes you find what they want for the child is not what the parents or healthcare providers want”. (GPN03)

4.5 Perspectives of Partnership in Care

On this aspect, the study sought the healthcare providers’ views concerning involving or working with parents in the planning and implementation of the child’s care while in the hospital. The parents’ views were also sought on how they would be involved in the care of their children while in hospital. Data collection was done by focused group discussions and in-depth interviews. The findings are presented in sections 4.6.1 and 4.6.2 respectively.

4.5.1 Healthcare providers’ perspectives of partnership in care

This was evaluated in terms of their understanding of partnership in care, the procedures that they can allow the parents to assist in performing and whether they think FCC is the way to go.

4.5.1.1 Healthcare providers’ understanding of partnership in care

Information was obtained from various categories of healthcare providers. They explained that partnership in care with the parents generally means involving them in the care of their child while unwell. Four themes were derived from the explanations given.

Theme 1: Allowing the family members to carry out some of the responsibilities pertaining to the care of the child.

The respondents affirmed that for them to work in partnership with the child's parents, they have to allow the parents to carry out some of the responsibilities in the ward. One of the respondents explained his understanding of partnership in care as follows:

“You are sharing in the care, by them assisting us in controlling some of the conditions at home, medication administration”. (GMN01).

Another respondent explained partnership to mean the care provided by the healthcare providers and the children's care takers beyond the hospital set up. This means that the healthcare providers appreciate that they will not be always with the child but the child's family members are always there for the child. The respondent's response supports the key element of FCC that states “the family is the constant in the child's life where as the service and support systems fluctuate”. The respondent stated the following:

“Would mean that I am giving medicine to the children to cure them, but that medicine is dependent on other people helping me because, for example, I will not be there to give the drugs myself at all times. So I rely on the mother if she is at home or the caretaker of the child to follow the instructions I will give if they are going home, and to the nurses if they are inpatients so as to ensure that whatever I prescribed to them is actually given and if there is any counselling, then we do counselling”. (GP0 2)

Theme 2: Involving parents in planning, implementing and evaluating care

Partnership in care was also defined as care in which the healthcare providers involve the parents in planning, implementing and evaluating care including discharge planning. One of the respondents explained the meaning of partnership in care as follows:

“Partnership in care means involving the parents in the care of their children when they are in the ward, how the disease has developed, what can be done and how to prevent it when they are at home. We also involve them in feeding, drug administration so that the drugs can be given well. Incorporating them in the care we are giving so that they don’t just act as onlookers as they have been before, to be partners with us and at the same time not compromising on the professional ethics”. (KGNR04)

Theme 3: Empowerment

Some of the healthcare providers indicated that by working together with the parents, the parents get empowered in terms of the disease condition, its management and prevention.

“It is empowering the parents and guardians in the care of the ill child while in the hospital and home which is beneficial to the hospital and parents.”(KGNR07)

Theme 4: Considering the effects of the child’s illness on the other members of the family and incorporating them in care

Partnership in care was defined as care that looks at the effects of the sickness on the entire family instead of just looking at the sick child. This was explained as follows:

“When an individual is unwell, it will affect the family – emotionally, financially. So you need to incorporate the feelings of the people around them and what is happening”. (GP02)

4.5.1.2 Procedures the parents can perform on their children while in the ward

The healthcare providers were asked to indicate the procedures they thought the parents can be allowed to do while in the ward. They identified various procedures but noted that it will be dependent on the patient's condition and the willingness of the parent to be demonstrated to and perform them under the observation of the healthcare provider. The procedures that they agreed during the discussions included: Observations especially temperature; assisted feeding – naso-gastric tube (NGT); bed making; personal hygiene; oral and rectal medication administration; suctioning; wound care; ORS preparation and administration; turning of the child in bed; blood sugar testing; nebulisation; Kangaroo mother care for the pre-term babies; top tailing in the newborn unit (NBU); preoperative care – shaving, starving; post-operative care – checking the surgical site for bleeding; colostomy care; anal dilatations; insulin administration; and peritoneal dialysis.

On application of topical medications, one of the respondents gave the following scenario:

“A mother was allowed to apply damazine. She gained confidence until she would ask, ‘where is the damazine?’”. (GNM01).

4.5.1.3 Healthcare providers' views on implementation of family-centred care in Kenya

This was established from the respondents both in the first and the second phases of the study.

Phase 1

Among all the healthcare providers who participated in phase 1, 115 participants responded to the question with a majority (92.2%, n=106) indicating that the approach can be implemented. Those that felt that the approach cannot be implemented comprised

7.8 percent (n=9). They felt it is not practical because of lack of essential drugs and equipment and also lack of time due to the large patient populations.

Association between the Healthcare Providers’ Socio-Demographic Characteristics and Their View on the Implementation Of FCC Kenya

Association was determined between the healthcare provider’s socio-demographic characteristics and their view on the implementation of FCC in Kenya. On Chi square test, the healthcare providers who had had heard of FCC exhibited a statistically significant association with the view on its implementation whereas their profession, parental status, work experience, paediatric work experience and source of information on FCC had no significant association (table 4.30).

Table 4.30: heard of FCC by FCC implementation in Kenya Cross-tabulation

			FCC implementation in Kenya		Total	Fisher’s Exact test
			Yes	No		
Heard of FCC	Yes	Count	87	4		0.016
		Expected Count	83.8	7.2	91	
		% within heard of FCC	95.6%	4.4%	91.0	
		% of Total	76.3%	3.5%	100.0%	
	No	Count	18	5	79.8%	
		Expected Count	21.2	1.8	23	
		% within heard of FCC	78.3%	21.7%	23.0	
		% of Total	15.8%	4.4%	100.0%	
Total	Count	105	9	20.2%		
	Expected Count	105.0	9.0	114		
	% within heard of FCC	92.1%	7.9%	114.0		
	% of Total	92.1%	7.9%	100.0%		

The predictive ability of the independent variable that exhibited a significant association (heard of FCC) on the dependent variable (their view on implementation of FCC in

Kenya) is established by regression. Logistic regression reveals that the healthcare provider having heard of FCC significantly explains 5 to 12.2 percent of the variance in the healthcare provider’s views on the implementation of FCC in Kenya. The odds of supporting the implementation of FCC in Kenya are six times higher among the healthcare providers who have heard of FCC than those that have not (table 4.31).

Table 4.31: Regression results for the healthcare provider’s having heard of FCC on the implementation of FCC in Kenya

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
								Lower	Upper
Step 1 ^a	Heard of FCC	1.799	.719	6.257	1	.012	6.042	1.476	24.730
	Constant	-3.080	.511	36.269	1	.000	.046		

N = 114, R²1 = 0.05, R²2 = 0.122, sig = 0.014

Where:

B = Coefficient of Constant (the intercept); S.E = standard error around the coefficient for the constant; Wald = Chi Square value; df = degrees of freedom; Sig = significance of the Model (P value), Exp (B) = Odds Ratio, N = Number of cases included in the analysis, R²1 = Cox & Snell R Square pseudo R-square; R²2 = Nagelkerke - pseudo R-squares

Phase II

While recognizing that implementation of FCC in Kenya had been recommended by majority of the healthcare providers who participated in phase I of the study, further views on the same were sought from the key informants. They were all in agreement that it can be implemented. One of the respondents, a lecturer, in considering the effects of hospitalised children not being accompanied by their family members explained as follows:

“It is the way to go – you cannot suddenly withdraw a child from the family just because they are unwell. This is a time they are uncomfortable, they are in pain and you want to withdraw them because you are the professional and there are things you want to do for them, no”! (L3)

Another respondent, on affirming the same, said the following:

“Any time, yes, because you have a mother who has a whole 24 hours sitting there doing nothing. At the end of the day, the care of this child is not now but will continue. The good thing is that they master and this will minimize hospitalizations”. (GNM05)

Despite the general feeling of all the respondents that family-centred care or partnership in care is the way to go, those from the private hospital thought it can be actualized in the public hospitals whereas those from the teaching and referral hospital thought it can easily be implemented in the private hospitals. One of the participants from the private hospital said the following:

“The public institutions practise more than the private because the mothers are more than willing to participate in care”. (GPN05).

This is in contrast to the views of some of the respondents from the public hospital whereby they thought it can be actualized in the private hospitals. For instance, one of them pointed out as follows:

“Public sector set up, no. It is overwhelmed and there is severe staff shortage. However, if we had several centres, it would. Private sector set up, yes”. (KP02)

4.5.2 Parents’ Perspectives of Partnership in Care

The study sought views of the parents as pertains partnership in care. They were asked to discuss how they think they should be involved in the care of their hospitalized children and the procedures they felt they can perform given the necessary guidance. Two main themes arose out of their discussions:

Theme 1: Involvement in Care

The parents from the two hospitals in their respective discussion groups, underscored the importance of being involved in all aspects of care. This, they said, should be right from the time a doctor is making diagnosis to the ordering of investigations and medications and also in the provision of nursing care in the ward. They pointed out that this will enable them own up and feel accountable for their children. One of the parents gave the following explanation:

“On general management, the parent who is taking care of the baby should be actively involved; be made to understand all procedures. So, if it is taking the child to theatre, we say, ‘we decided’; me, the nurse and the doctor. If am asked how the baby is fairing on, I say, oh! We decided to take the baby to theatre because of this and that, so that I can own up”. (GP2)

The parents also felt they should be involved so as to avoid some of the management problems that they have encountered before with their children. This was backed up by some their experiences that they each narrated. Some of the narrations were as follows:

“This is my second baby. I have a daughter (older) and she got admitted and she became sickly. I came to realize that her immunity is so low because she was started on very strong antibiotics so every now and again you are admitted until the nurses know you. I didn’t want the same thing to happen to my second one, so like yesterday, I was struggling with the nurse who was attending to us because I didn’t want them to use very strong antibiotics on him. You see what happened to the sister, I went to the village, she got ill and I went to the pharmacy and clinics there and whatever medicine they gave her she did not respond. So I had to travel to Nairobi so that she would be given the strong antibiotics. So yesterday I was asking that this being the first time the child is being admitted, can you begin with something mild, so that he can build his immunity? So that doctor was like, you know when it comes to antibiotics there are various categories and you know am an armature in the area so I don’t know the strength of various drugs. So I think if we are involved we will make appropriate decisions so you don’t end up visiting the hospital every now and again“. (GPR1)

Another parent, in reacting to the above scenario, said the following:

“On the idea of medication, the child should not be given very strong drugs. Especially there is one they always prescribe every time the child is sick and then you wonder, if the child is not very sick and is given that, won’t he develop resistance? As the doctor prescribes, it is good to explain and listen to the guardian of the baby so as to enable them understand why that has to be given”.

(GPR2)

To emphasize further on the importance of parents being involved in the entire process of management of their children, another parent whose child developed complications after treatment narrated her experience as follows:

“They should involve us because like my son here, drugs like amoxil will not work because he was started on very strong antibiotics and they eroded all the intestinal lining so he was admitted in ICU for one and half months because of

enterocolitis. I have to pressurize to know what is affecting him because of the fever he has. Today is when I was told there was infection, that is, giardiasis, but from day one I have been insisting because they took blood in casualty for full haemogram and again they came to take blood for the same so I was anxious because the last time I was here I used around three million so I am curious of every step they take. I should be told, like I saw they have started today antibiotics because the nurse came and told me the doctor has added some drugs for the child. I have not met the doctor to ask him, "last time the antibiotics eroded the intestines though it was not a mess of here but another hospital", so I will like to know why they have started on zinacef and flagyl and they were the same drugs that eroded the intestines. My worry is, why they have started the antibiotics". (GPR05)

On commenting on the issue of medications and the need for the healthcare providers ascertaining the medicines that a child has been taking, one parent made the following observation and recommendation:

"Previously in the city council clinics, we used to be told to carry all the medicines or containers of medicines that we have used at home when we come to the hospital so that they would know all the medicine the child has used. Nowadays they don't do that and yet it was important". (KPR07)

The experiences shared by the parents in the focused group discussions are a clear indication that the healthcare providers do not involve the children's parents in deciding the mode of management. The experiences further exhibit the negative impacts that arise from the healthcare provider's non-involvement of the child's parents and further a failure to explain to them the likely adverse effects that the child might experience. The parents in the long run have mistrust on the healthcare providers. This explains why the majority of the parents in phase one of the study indicated that they accompany the

children during procedures so as to confirm the procedures being performed on their children.

Theme 2: Procedures Parents Feel they can Participate in Performing

The parents who participated in phase 1 and those that participated in phase II of the study were asked whether there are procedures that they feel they can participate in performing given the necessary guidance. It emerged that there are various procedures. The responses from phase 1 of the study are indicated in table 4.32.

Table 4.32: Procedures parents can participate in performing

Procedure	Frequency	Percentage
Oral medication administration	147	91.3
Giving injections	27	16.8
Measuring temperature	143	88.8
NGT feeding	77	47.8
Physiotherapy	114	70.8
Making the child's bed	151	93.8
Checking the child's blood sugars	48	29.8
Nebulization	69	42.9
Weighing	143	88.8
Suppository drug administration	108	67.1

Those who participated in phase II concurred with the procedures that were given by the parents in phase 1. These procedures are similar to those indicated by the healthcare providers so long as they are taught on how to do them. They further explained that if they can be allowed to perform them, then some of the problems that are experienced in

the ward will not be there anymore. One parent from the teaching and referral hospital gave the following example:

“Boiling water in the ward we group ourselves in the rooms and get one mother to take the responsibility. Linen is scarce; mothers carry a lot as they get opportunity, they grab, and if we are given we will maintain cleanliness and tidiness in the ward”. (KPR07)

A parent from the private hospital, in emphasizing on procedures, stated that:

“If we can be shown how to make those beds, it is very easy; we can do it on our own. Like now the child had diarrhoea and so was soiling the clothes all the time. If the changing materials are in the room, I will change instead of just waiting. We will be very much comfortable”. (GPR02)

The parents from both hospitals exhibited a willingness to participate in the performance of procedures and routines in the ward. This contradicts the healthcare providers' view that parents are not willing to do anything for their children because they are paying. The discrepancy therefore calls for a change of attitude on the part of the healthcare providers on their perspectives on the parents. This signifies the need for training and policy review to include FCC.

4.6 Suggestions for Enhancement of Partnership Establishment

The study aimed at coming up with suggestions to aid partnership formation between the healthcare professionals and the parents of hospitalised children. These suggestions were obtained from key informants comprising nurse managers, paediatricians and lecturers involved in teaching paediatric concepts. Further, the suggestions were obtained from focused group discussions composed of paediatric nurses, non-paediatric nurses and parents with each category forming their own group.

Before discussing the suggestions for enhancement of partnership establishment, the key informants were asked to discuss the factors that hinder partnership establishment.

4.6.1 Factors Hindering Partnership Establishment between the Healthcare Providers and the Child's Family

Nine key factors emerged from the discussion on the factors hindering partnership establishment between the healthcare providers and the child's family. These were as follows:

Parental Ignorance

The healthcare providers expressed parental ignorance in the processes required in the implementation of some interventions in the hospital. This causes conflict or misunderstanding between the parents and the healthcare providers. One of the respondents gave the example of blood transfusion as follows:

“For example, blood transfusion, they come with the donor and expect that once the blood has been donated the blood should be given immediately”. (GNM01)

Another respondent, in explaining about ignorance, gave the example of the expectations in terms of improvement in health status as follows:

“Some come with children and expect them to improve immediately. So, after like two days they see the child is not improving, they sneak in their herbal medicine when we are still giving the conventional medicine”. (KNM02)

Fearful Parents

Another hindering factor was to the fact that some parents fear handling their sick children. This makes them leave the child to the healthcare provider to handle them alone. One respondent explained it this way:

“Parents fear the sick child, so the child belongs to the nurse”. (GNM04)

Parental Attitudes to Participation in Hospital Care of the Child

Some parents have the attitude that since they are paying for the services, they should not do anything for the child apart from keeping the child company or just coming to visit them.

Cultural Beliefs and Practices

Some cultural beliefs and practices impact negatively on the child’s health. One of the paediatricians explained one cultural practice as follows:

“The practices people have in their culture such as cutting of the uvular”.
(GP01)

Another respondent, in alluding to the issue of culture in regard to health seeking behaviour, gave the following scenario:

“Some feel the disease should not be managed in the hospital because they feel it is not natural; ‘ni urogi’ (‘is witchcraft’). So they go back home for the grandmother to intervene”. (KNM02)

Language Barrier

This was raised mainly by the paediatricians. Most of them expressed communication with parents as big problem especially those who do not understand English or Kiswahili.

One of the informants voiced experience of difficulties in explaining medical terms in a manner that the parents can understand as follows:

“Stating clearly what is happening without using much jargon so that they can understand as they have different levels of education”. (GP2)

Another respondent also expressed language difficulties as follows:

“Trying to explain complex ideas you have about a disease process to a parent especially people who have not completed basic education. There is also language barrier so we have to talk through two different communicators”. (KP 1)

Coordinating with Parents Who Are Not at the Hospital/The Unaccompanied Children

In the wards, where the policy does not allow the children to be accompanied while in the ward, a problem of coordinating with the parents at a distance was voiced.

Parental Mistrust of the Healthcare Providers

Contrary to the expression by parents as having trust on safety of their child with the healthcare providers, the key informants raised parental mistrust of the healthcare providers as one of the key factors hindering partnership establishment. In explaining this, the following scenario was given by one of the nurse managers:

“Some of the parents don’t trust the caregivers; they feel, if you argue with them, you can harm their children. Like we had a certain father who said, he can’t stay

in a given ward because the caregivers there are from a certain tribe so we had to look for an alternative ward to take him”. (KNM03)

One of the paediatricians also gave the following example:

“Sometimes the parents are adamant; they move from doctor to doctor but they are all the time referred to me and by the time they come it is too late – we have to explain to them but we don’t blame them”. (KP 04)

Socio-Economic Demands on the Parents

Sometimes the parents’ socio-economic responsibilities do not allow them time to be with the child in hospital. This was explained as follows:

“Financial or job related pressures, “you want a child admitted for a few days and the parent says, I am the only caretaker, I don’t want to lose my job”. That becomes an issue for them”. (KP04)

Shortage of Supplies and Equipment

Lack of some essential supplies and equipment, especially in the public hospital, influences the parents’ reactions to the healthcare providers. In explaining this, one of the managers in the teaching and referral hospital gave the following explanation:

“Being a public health institution, not everything is available. So the parents get agitated and are at conflict with the healthcare providers and the healthcare providers are also human beings so they will not treat the caretaker very well. This leads to tension”. (KP03).

4.6.2 Suggestions for Enhancement of Partnership Establishment

4.6.2.1 Suggestions from Phase 1 Respondents

The healthcare providers from phase 1 of the study indicated that for the approach to be actualized, the following factors have to be put in place: training of all stakeholders;

staffing issues be addressed; review of child healthcare policies and improvement of the physical structure. The thrust of the responses, in terms of percentages, is illustrated in figure 4.11 below.

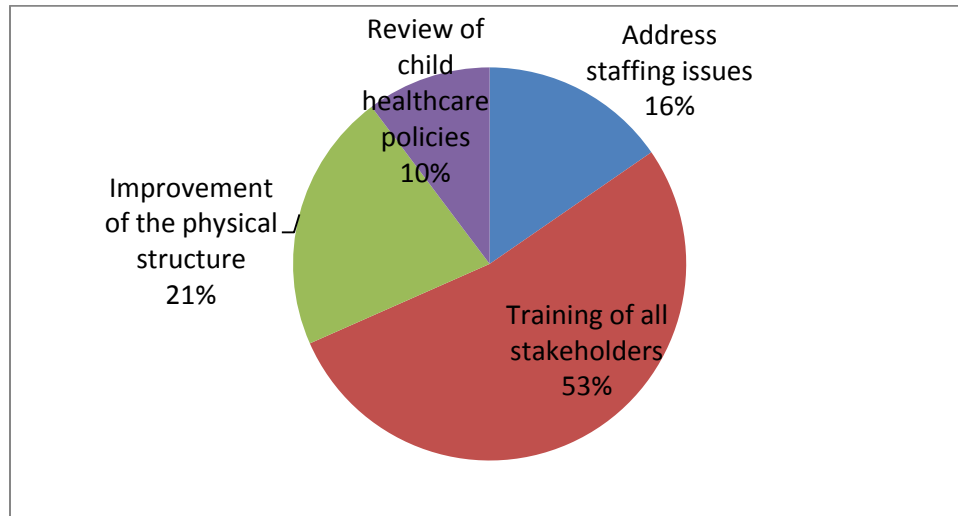


Figure 4.11: Factors to be put in place to aid the implementation of FCC in Kenya

4.6.2.2 Suggestions from Phase II Respondents

All the respondents had virtually similar views on how partnership establishment can be enhanced. The following themes were derived:

1. Training and Sensitization

All the healthcare providers who participated in the in-depth interviews and focused group discussions indicated that paediatric care concepts, such as FCC, should be included in the training curriculum of all cadres and categories of healthcare providers. They also indicated that these concepts should be included in the continuing medical education programmes for those who are already in service, including sensitizing the top managers. One of the key informants involved in training said the following:

“During training, students should be exposed more to outpatient counselling services where involvement is more than the inpatient teaching alone because in

many times we are just taught at the bedside with inpatient cases but outpatient and clinics and going to the community is very poor". (L3)

Training plays a key role in determining the kind of attitude that the healthcare providers have toward patients and their families. The effect is supported by the views of the ward managers as expressed earlier that the nurses who are trained on FCC are better different in their practice from those that have not been trained. One of the respondents in emphasizing the importance of training either in school or in continuing medical education programmes, made the following statement:

"Sometimes nurses have an attitude. When a parent tells you 1,2,3, you say, 'it is me who went to school, you, you don't know what you are telling me", yet the parents have checked in the internet. So if they are sensitized, they can have change of attitude and the mother cannot feel, 'when I tell them this I am just put off'". (GN06)

Training was recognized to have a great impact on partnership establishment and general management of hospitalised children. One of the nurse managers, in comparing the nurses that have been trained on FCC during their paediatric nursing training and those that are non paediatric trained, made the following observation:

"The nurses who have done paediatric nursing are different from those that have not done". In view of this, these nurses are assigned other nurses to mentor". (GNM04)

Besides training of FCC, the healthcare providers need to be trained on communication. This will enable them have a better way of communicating with the children and their families. Further, with proper communication, the parents will change their attitude and be open to them. One of the lecturers, in emphasizing communication, said the following:

“The worst communicators are doctors because they are not trained on how to communicate – they are not taught at all; they are very poor. Therefore communication should be included in their training curriculum”. (L3)

The problem of communication was also echoed by the parents in their discussion and emphasized that it should be checked and rectified. This is what one of the parents said:

“What contributes to misunderstanding is that there is no communication. The parent is the one who understands the status of the child. When you come you try to explain to the doctor, he leaves you with the in charge. ‘Unajaribu kumwambia hivi, naye anakuambia hivi’ (‘You try to tell him this, he tells you that’). (KNP07)

In summary, the aspects that need to emphasis in training include the concept of FCC, the effects of childhood illness and hospitalization on the child, the parents and the siblings and effective communication.

2. Client Involvement and Appreciation

Both the parents and the healthcare providers asserted that for effective partnership establishment in the management of hospitalised children, the parents and child should be fully involved. The process of involvement should be from the first time of contact with the healthcare system and all the children should be admitted with parents. One of the lecturers said this,

“We are emphasizing on other things like the nursing process. We should also emphasize FCC from the beginning when the mother is pregnant so that they have courage to be involved in the care of the child because whoever is doing it is doing blindly”. (L2)

Another respondent also said the following:

“Involve the parents in care; not only when the child is sick but at all times. Let’s not leave the parents in whatever we are doing; our roles are intertwined because the problem is how we train the people like the parents have to be there. Incorporate them in the management of the child from the time they come to the hospital from the beginning. Stop abusing the parent, ‘you are dressed very well but your child is malnourished’! The fact that the mother has brought the child to the hospital is enough for us to thank them, ‘thank you for bringing the child to the hospital’. Not, ‘it is dawa time, tengeza Mtoto’ (‘it is time for medication administration, prepare the child’.) They are never told why the procedures or investigations are being done – explanations are hardly there”. (L3)

The parents were emphatic about being involved in care at all stages as can be realized from what they said:

“The doctor will come and prescribe and move on, now you don’t know anything. By the time you finish explaining or before you finish, you are given a prescription. It is important to involve the parent and the baby”. (KP06)

The parents stressed the importance of them being involved during the ward rounds when their children are being reviewed. Their view concurs with that of the paediatric nurses. In regard to the issue of being considered during the ward rounds, one of the parents made the following remark:

“The consultants should ask the parents how the child is doing; not just asking other doctors alone”. (KNP05)

Further, on the issue of involvement, the parents are aware of the key stakeholders in the care of the hospitalised child. The parents understand their position, rights and responsibilities. In contrast the healthcare providers in their practice either have no understanding of the same or if they do, they omit it in their practice. One of the parents made the following observation:

“We are three parties here; the patient, the guardian and the healthcare provider. Coordination should be there because the parent is the one who is close to the child. At times, say when the nurse comes around, when you ask for medicine for example, she can delay or tell you that drug has not been prescribed for the child. She doesn’t recognize the guardian. It is like the doctor and the nurse, the doctor passes information to the nurse, then the nurse goes directly to the child and the guardian is excluded and it is not good because the parent is the one who has information about the patient”. (GP2)

3. Establishment and Documentation of Clear Policies and Implementation Guidelines

All the healthcare providers echoed the importance of having clearly documented policies and guidelines aiding implementation of FCC. Existence of such policies is important as they spell out the responsibilities and expectations of both the healthcare providers and the parents. One of the lecturers gave the following recommendation:

“Have it in policies and standards of care like those ones from the Nursing Council of Kenya (NCK)”. (L1)

In explaining the same point, one of the paediatricians said the following:

“Have standard operating procedures which are provided. While parents are, in the ward, they should be given guidelines (booklets/brochures) indicating their limits”. (KP2).

4. Awareness Creation in the General Public

Both the healthcare providers and the parents indicated that for proper establishment of partnership in care, the general public needs to be informed about their rights as patients or clients and their role when in hospital. One of the paediatricians gave the following explanation:

“People need to understand their rights; it is constitutional. You actually involve

the parent in planning – pick from them ‘what would you like best for you so that you can take care of your child while in the hospital?’ so that in a way you can get their expectations. What do they have in place in accordance to the law? so that you don’t bridge the laws that are there so as to protect the interest of an institution, laws that govern human rights so that you don’t deny them their rights like the right to participate in the care of their child in any way so as to make the child feel better”. (GP3)

5. Improvement on Communication

Doctors and nurses should use proper communication techniques when dealing with parents and their children. One of the parents explained this by saying:

“Doctors and nurses to have a good language of asking questions because if you fold your face and talk arrogantly, a parent who is fearful will fear even the more”. (KNP2).

Another parent, in adding to what her colleague had said, expressed the following:

“There is a language they use here, there are those who assume or talk badly and this makes parents to continue fearing such that even if the child has a problem like a convulsion, they will not say. So, there is need to change language and approach to communication”. (KNP5).

The parents further indicated that they should be given all the information concerning their children and they should have access even to the child’s records.

“The file is written “private”, so they are the only ones who know, they don’t tell us. ‘sasa file ya mtoto wako, ukienda kuichungulia, wewe!!’, ,na mtoto ni wako’ (‘even the file of your child, when you peruse, you are shouted at, “you”! and yet this is your child), so we are excluded. Even the drug your child is on, you don’t know. You are asked, ‘does your child have a line or is there medicine in the fridge’? You fear to ask because you don’t know how you will be responded to”. (KNP07)

6. Provision of a Conducive Work Environment

Both the health workers and the parents underscored the importance of providing a conducive work environment and improving on staffing especially in the public hospitals. One of the parents, on alluding to this, expressed her displeasure for the number of patients assigned to one nurse by saying the following:

“The number of patients a nurse is assigned to may be more than 10. This makes them stressed and irritable; they vent out to parents. Increase the number of nurses to be like 2 per room, for example, like in our ward today, we had two nurses, so you find medicine is delayed. It pains me”. (KNP7)

7. Attitude Change

Following the data obtained from phase one of the study, the parents indicated they are not involved in care because the healthcare providers think they are the experts and the parents don't know anything. The data also revealed that the healthcare providers view the parents as being stubborn. For effective partnership establishment, there is need for change of this kind of attitude. The participants of the focused group discussions came up with the following strategies for attitude change:

- I. Identify and deal with barriers to partnership formation with the parents in care.
- II. Improve on interpersonal relationship through proper communication.
- III. Recognize and appreciate the parents' level of knowledge on the child's condition. One of the paediatric nurses made the following observation:

“It is a big challenge as most of the caregivers are enlightened. They have access to internet. We should incorporate them, be much open and let them know why we are doing what we are doing. In case of fear of the legal implications, nurses should be enlightened on medical-legal issues”. (KPN2)

One of the paediatric nurses, in reacting to the comment about the parents' level of knowledge, made the following recommendation:

“Be ready to learn and be challenged even from parents as they may have researched on the child’s condition”. (KPN5)

- IV. The healthcare providers to put themselves in the parents’ shoes. In emphasizing this point, the following observation was made by one of the paediatric nurses:

“Nurses are very fussy when they are patients; when you come down you realize the patients are very patient. For example, there is a time a patient asked me, ‘what is your name’? I felt challenged because I was not ready to give out my name. When the patient wants to know your name you brand them as being rude. Also nurses should educate and encourage parents to do the procedures.” (KPN4)

One of the paediatric nurses, in reacting to that comment, made the following recommendation:

“Understand own personality trait and that of others. Put yourself in the patient’s shoes and this will lead to change of attitude. Treat patients equally; not according to ranks or social class”. (KPN6)

- V. The healthcare providers to make time to talk to the patients/caregivers so as to appreciate their stress. This can be done even in the course of performing procedures to the children. In making this suggestion, one of the respondents made the following remark:

“We don’t have time to talk to the patients. When the parent wants to talk to the nurses, the nurses are irritable because of the things they have to do. You brand the parent as being rude or fussy; it becomes very hard for the parent to operate in the ward. You tell other nurses about the parent, ‘is this and this’, and so the patient’s life in the ward becomes uncomfortable”. (KGN04)

- VI. The healthcare providers to recognize the rights of the patients and the parents as partners. One of the paediatric nurses from the teaching and referral hospital came up with the following recommendation:

“Realize that parents are key stakeholders in delivery of quality care, dwell on quality and not quantity as nurses do. Procedures will be done in time than when the nurse struggles to do alone”. (KPN05)

VII. Nurses to strive to improve the image of nursing in the parents. This was suggested as follows:

“Fight the prejudice – nurses are very bad and rude. Make a difference and prove that nurses are not bad. Work pressure may make them seem rude – explain even if later. Where you are not sure about a condition, refer to the right person so as to avoid contradictory views from doctors and nurses”. (KPN06)

VIII. Sensitize both the healthcare providers and the parents to enable them change their attitude to each other.

Other Suggestions for Partnership Establishment

Other suggestions that were given in enhancing partnership establishment between healthcare providers and parents include:

- Paradigm shift in thinking and being open to change
- Advocacy
- Lobbying up to the highest level – to increase budget allocation and improve infrastructure
- Orientation for parents and new staffs
- Listening to the parent’s side of the story
- Learning the experiences from those that have already embraced and implemented the approach and including the challenges they have experienced

- The hospital, either once per month or every three months, to facilitate interactive meetings between parents and healthcare providers so as to share views

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents a discussion of the results that are presented in chapter four. The discussion is undertaken on the basis of the study questions. The findings of this study are related to the existing literature on similar studies that have been carried out elsewhere. The discussion is concluded with the development of the framework for the

contextualization of FCC in the management of hospitalised children in Kenya. The framework has been developed based on the key findings of the study, presented in chapter four and information obtained from critical review of literature. The chapter ends with a presentation of the conclusions and recommendations of the study.

5.1 Discussion

5.1.1 Socio- Demographic Characteristics of the Respondents

In terms of the parent's socio-demographic characteristics, the study revealed that more mothers (n=136) than fathers (n=15) stay with their children in hospitals, thus reflecting that mothers remain the primary caregivers of their children even when sick. This scenario is similar to that established in a study by Lam (2005) in China in which out of nineteen parents who were with their children in hospital, sixteen of them were mothers. The result also concurs with the findings in a study by Sodderback and Christensson, (2007) in Mozambique whereby they established that 89 percent of the care givers accompanying hospitalised children were mothers.

The parents had a low level of education. This is similar to findings in Mozambique by Sodderback and Christensson (2008) whereby they established that family members of hospitalised children had low level of education and they were hardly informed of anything to do with hospitalisation.

The study further established that most of the parents were Christians who belonged to various denominational affiliations with majority of them being protestant and catholic. The majority are Christian and this is consistent with the religious composition of the Kenyan population whereby most (78%) are Christian (Gonza, 2009). The study further

established that the patients were from 17 out of the 52 ethnic groups in Kenya with majority of them belonging to the Kikuyu community. This would be because Central province where the Kikuyu community comes from is nearer to Nairobi as compared to other provinces. These findings are similar to those obtained by Mwenda (2012), in her study of substance dependent patients in rehabilitation centres in Nairobi. Establishment of the patient's ethnic, religious and denominational affiliation is important because it gives a bearing on a people's culture. Culture has been underscored as one of the key elements of FCC (Bowden, 1998).

On the healthcare provider's socio demographic characteristics, the study established that most of the nurses caring for the hospitalized children in the two hospitals are not trained in paediatric nursing. This is similar to the findings by Chuya (2011), in her study on nurses' knowledge, practice and attitude of FCC at the paediatric ward in Moi District Hospital, Voi, Kenya, in which out of a total of 20 nurses who participated in the study, only one was a paediatric nurse. The study established that most of the healthcare providers had heard of FCC but majority of them, except the paediatric nurses, had not been formally trained on the concept.

5.1.2 Current Status of Family Involvement in the Care of the Hospitalized Child

Several studies have established that parental involvement in the care of the hospitalized child decreases stress in the child and parent, provide opportunity for parents to improve their skills of caring for the sick child and increase their awareness of their child's condition (Kawik, 1996; Hughes, 2002; Roden 2005 and shields & Pratt, 2006). In the current study, this was looked at under various aspects including: parental involvement in

decision making, parental accompaniment of their children during procedures, family visitation of the hospitalised child and healthcare providers' practice of FCC. Each of these variables is discussed in the following sub-sections.

5.1.2.1 Parental Involvement in Decision Making

Working with families in decision making on the management of hospitalised children has been underscored to be of great benefits (Mackinney, 2000 and Mantovani, 2009). In this study, the question on participating in decision-making elicited mixed reactions. Some of the parents felt that they were not the experts and therefore they should not be involved. This is similar with the findings of a study by Sodderback and Christensson (2007) in which majority of the parents in Mozambique felt they should not be involved. However, this contrasts a study by Callery (1997) in which parents were recognized to be in possession of greater knowledge about their child's condition. The finding is also in contrast to that by Hallstrom (2012) in which though parents felt they do not want to make the final decision on the management of their hospitalised child, they do want to be involved in the decision making process .

The study findings indicated that some of the parents felt totally neglected in the decision making process. This concurs with results in a study in Mozambique by Sodderback and Christensson, (2008) in which family caregivers had experiences of being neglected. The finding is also in tandem with the documentation by Potts and Mandleco (2012) who in describing the medical model indicate that it directs health professionals to assume the roles of evaluators and controllers of treatment interventions hence rendering the child and family to be dependants. The study established that the parent's level of education

and the actual relationship with the child had a significant association with the level of involvement. The actual relationship exhibited a direct relationship with involvement whereas the level of education exhibited an inverse relationship. Parental neglect in decision-making contravenes the family centred care element which stipulates that there should be exchange of complete and unbiased information between the healthcare providers and the child's family (Bowden, Dickey, and Greenberg, 1998).

Majority of the healthcare providers in this study indicated that they did involve parents in decision making. This was however at different levels with majority of them involving the parents sometimes. The healthcare provider's parental status and working institution had a statistically significant association with their involvement of the parents in planning care for the hospitalised child. This would be because those who are parents have an understanding on what parents go through when their child is unwell and also because of the hospital policies guiding the care of the hospitalised child. The modes of involvement included involvement in performance of procedures, asking them to give the history of the child, asking for their consent or explaining to and counselling them on the condition of the child. The level and modes of involvement indicate that the healthcare providers were still in control of the decision making process about the care of the hospitalized child. This finding concurs with that of a study by Paliadelis, et al (2005) in which a culture of hospital resistance to incorporating the patient and family into decision making is expressed.

5.1.2.2 Accompaniment of Children by their Parents during Procedures

Studies done in various settings indicate that parental accompaniment of their children in hospital and during procedures are of great value (Ygge, 2004; Lam, 2005; Mantovani, 2009; Gonzalez et al, 2010; Abdulbaki et al, 2011). This realization concurs with findings of the present study. Five reasons were given for allowing parents to accompany the children: comforting the child, assisting in procedures, confirmation of what is being done on the child, psychological satisfaction/allaying of anxiety in child and parent, and continuity of care. This concurs with findings by Mangurten et al (2006) and Gonzalez et al (2010), and suggestions advanced by Potts and Mandleco (2012) while discussing the methods of providing atraumatic care to children.

Trauma experienced by the parents, especially during invasive procedures, was cited as the key reason for not allowing parents to accompany their children during procedures. This concurs with findings established in studies by Paliadelis et al (2005) and Gonzalez et al (2010) whereby they identified three main reasons: interfering with the professional's work, not being a calming influence on the child and suffering greater anxiety. This however contrasts the findings by Daneman and Macaluso (2003) in which the parents and healthcare providers supported parental accompaniment of the child during painful procedures.

The study established that the healthcare providers' practice of FCC had a direct relationship with their allowing parents to accompany their children during procedures. This implies that those that practice FCC appreciate the importance of the child being with a familiar person during procedures than just being with strangers which causes stranger anxiety (Potts and Mandleco, 2012). The study further established that the

child's age had a significant association with the parent's views on importance of accompanying children during procedures with a higher percentage of the parents' whose children were younger indicating that it is important to support their children. This further concurs with the developmental considerations in the assessment and care of sick children which indicate that for those below three years they are better assessed and cared for when held by their parents or familiar persons (Potts and Mandleco, 2012).

5.1.2.3 Visitation during Hospitalization

The study established that visitation of the hospitalised child by other family members was highly restricted by hospital policies. It further established that this was more severe on children visiting, especially in the teaching and referral hospital. This indicates that in the Kenyan set up, the status of care of hospitalised children is at the level of the pre-FCC period of the developed world whereby restriction of visiting was practised (Datta, 2009; Jolley and Shields, 2009; Davies, 2010).

Despite majority of the parents and healthcare providers supporting the idea of children being visited by other children, some of them felt this should not be the case as the visiting children will be at risk of acquiring infections from the hospital. These results concur with those by NewYorkers for Patient and Family Empowerment (2012). In this study, the parent's age and actual relationship with the child exhibited a statistically significant association with the importance of other children visiting ($p < 0.001$). The actual relationship with the child displayed a direct relationship implying the closer the relationship to the child the more they recognize the importance of the child interacting with other children. The age of the parents displayed an inverse relationship, whereby the

younger parents felt it was important that other children visit the hospitalised child than the older parents. This would be because the younger parents might have left younger children at home and were also missing them as expressed during the focused group discussions as compared to the older parents.

The restriction for visiting was more for children aged below 12 years who were totally not allowed in especially in the teaching and referral hospital. The main reasons for restricting children included fear that they are at risk of acquiring infections from the hospitals and that the hospitals are scarely hence causing psychological trauma to the children. This concurs with the findings by NewYorkers for Patient and Family Empowerment (2012) whereby, in their study of 99 hospitals in New York, they established that 43 percent of the hospitals had restrictions for children. The restrictions were indicated to be there throughout the year and in all types of wards. This is different from other hospitals in the developed world. For instance, at Ontario, restriction is only during the outbreak of severe acute respiratory syndrome (Rogers, 2004) whereas at Robert Wood Jonson Medical Centre, children are restricted in the acute wards because of swine flu but are allowed in the oncology wards (<http://parenting.blogs.nytimes.com/2009/12/8/the-ban-on-children-visiting-hospitals>).

Some of the healthcare providers and parents felt that the restrictions are baseless. This concurs with the statement by the American Academy of Critical Care Nurses (AACN) as reported by the NewYorkers for Patient and Family Empowerment (2012). All respondents suggested the need for review of the policies on visitation. This is congruent with the suggestions given by the NewYorkers for Patient and Family Empowerment (2012). Some of the suggestions given in this study included: Children be allowed to visit

but be accompanied by adults and the hospitals to either have specific days when children visit or they set aside other places, besides the wards, where the children can visit.

5.1.2.4 Practice of FCC

The current study established that slightly more than half of the healthcare providers have heard about FCC with majority of them exhibiting right understanding of the concept. The study further established that the approach is practised more in the private hospital than in the teaching and referral hospital where it is not documented in policy. On significance testing, the study established that there is a statistically significant association between the healthcare provider having heard of FCC and the working institution and the practice of FCC ($P < 0.005$ and $P < 0.030$ respectively). This implies that possession of knowledge about a concept plays a key role on it being practiced. The practice of FCC in the private hospital is adhered to because it is documented in their policies and is emphasized in their continuing medical education programmes. This concurs with findings in a study by Eckle and Maclean (2001) in which they found that support for FCC was most consistent in departments with specific competencies, educational programmes and practices that were inclusive of the family.

In comparing the practice of FCC among the various cadres of healthcare providers, the study established that a higher percentage of paediatric nurses did practice the approach than the doctors and nurses not trained in paediatric nursing. This indicates that training on the approach in the paediatric nursing programme has a relationship with its practice in the hospital. This is in tandem with the findings by Mandell and Murray (2009) in

which they established that those with a higher understanding of FCC are likely to practice it more than those without.

The healthcare providers explained that they practise FCC by allowing the children to be accompanied by a family member for 24 hours or by practising unrestricted visiting hours for the family members. This however, as explained by Mantovani et al (2009), does not necessarily mean so because if the staffs are not equipped to meet the family's needs, it would ultimately have unfavourable consequences. This is already evident in the current study as some of the parents felt ignored by the healthcare providers despite the fact that they were staying with their children in the ward.

5.1.2.5 Policies

There exist policies for the management of hospitalized children in the two institutions. However, there are no clear guidelines on how some of the policies should be implemented. There is no documented policy on how the healthcare providers should interact with the parents of hospitalised children and what roles the parents should play while in the wards. This concurs with the finding in Australia by Paliadelis et al (2005). The finding, however, is contrary to the stipulation by the Convention of the Rights of Children which stipulates that policies should acknowledge that parents are partners in the caring team and should be involved in the treatment of children. The unavailability of policies, especially as pertains to parental presence during procedures, has also been documented in a study by Eckle and Maclean (2001).

The study further established that clients are never represented in the formulation or review of policies. This is contrary to the element of FCC which advocates for facilitation

of family-professional collaboration at all levels of hospital; home and community care of an individual child; programme development, implementation, evaluation and evolution; and policy formation (Bowden, Dickey, and Greenberg, 1998)

5.1.3 Challenges Experienced by the Healthcare Providers in the Care of the Hospitalised Children

The healthcare providers cited a number of challenges that they experience while providing care to the hospitalized child. These were mainly from the work environment and the child's family. One challenge that was overly cited, especially in the teaching and referral hospital, was that of caring for children in a non-conducive environment. This contravenes one of the stipulations on the right of children to health which states that children should be admitted to an environment that is adapted to the needs of children of different ages and stages of development. In relation to the work environment, workload and large number of patients were enlisted as key challenges experienced in the care of the hospitalized children. This finding is congruent with those realized by Paliadelis et al (2005) and Abdalbaki et al (2011).

The study also established that formation of partnerships between the healthcare providers and the parents was a major challenge. The paediatric nurses explained that this was a result of lack of knowledge on FCC among the managers, healthcare providers and parents and also due to inadequate facilities. This finding concurs with findings in other studies (Bruce & Ritchie, 1997; Paliadelis et al, 1997; Bruce et al, 2002; and Roden, 2005).

The paediatric nurses cited a number of challenges that they experience in their endeavour to practise FCC. These challenges included: lack of support from the institutional managers and other healthcare providers; parental behaviours due to cultural influences; space constraints due to congestion of patients; understaffing; limited time to be with each patient; and parental fear to witness some of the procedures performed to their children. These challenges are similar to those established by Espezel and Canam (2003) in their study on parent - nurse interactions in the care of hospitalised children. They also concur with those of Paliadelis et al (2005) in their exploration of paediatric nurses' beliefs and practices of FCC.

5.1.4 Perspectives about Partnership in Care

The concept of partnership between healthcare providers and the family of a hospitalised child was introduced by Casey in 1988 when she developed her model of paediatric nursing (Moules and Ramsay, 2008). In the current study, the healthcare providers explained partnership in care to mean: allowing the child's family members to carry out some of the responsibilities pertaining to the care of the child; the healthcare providers and the child's family working together in planning, implementing and evaluating the care; empowering the child's family, considering the effects of the child's illness on the other members of the family and incorporating them in care. Both the healthcare providers and the parents indicated a number of procedures that parents can perform for the child either on their own or with the healthcare providers. These included procedures like feeding; either orally or via naso-gastric tube; bathing the child; administration of oral medications; observation of the vital signs such as temperature; and bed making.

This concurs with findings by other studies (McCubbin, 2001; Paliadelis et al, 2005; and Abdulbaki et al, 2011).

Although most of the healthcare providers in the current study were in support of parents participating in the performance of most of the procedures, some of the nurses felt that the technical skills, such as medication administration and nasogastric tube feeding, should be left to the nurses alone. This is similar to findings by other studies conducted elsewhere (Keatings and Gilmore, 1996; Maxton, 1997; and O'Haire and Blackford, 2005).

Both the paediatric nurses and the parents who participated in the current study expressed their support for parental accompaniment of the children during all aspects of care. This is in line with the findings in a study by Melnyk & Alpert-Gillis, (2004). The parents further expressed their desire to accompany their children during their painful and stressful moments. This current finding is similar to that established by Scott (2007) in the systematic review of literature on parental presence during complex invasive procedures and cardiopulmonary resuscitation. The parents further indicated that they can perform most of the procedures provided they are given the necessary guidance. This concurs with the findings by Hallstrom, Rumesson, and Elander, (2002).

5.1.5 Factors Hindering Partnership Establishment between the Healthcare Providers and the Child's Family

In order to come up with suggestions on how partnership establishment can be enhanced between the healthcare providers and the child's family, it was imperative to ascertain the existence of any factors that could be a hindrance to the process. This is in recognition of

the fact that by coming up with suggestions on how the hindrances can be dealt with, partnership enhancement would have been realised. The healthcare providers came up with nine key factors that hinder partnership establishment with the family of the hospitalised child. These included: parental ignorance; fearful parents; parental attitudes towards participating in the care of the child when they are paying for the services; cultural beliefs and practices; language barrier affecting communication between the parties; parental unavailability; parental mistrust of the healthcare providers; social demands on the parents; and shortage of supplies and equipment making the parents to be in conflict with the healthcare providers.

Staff shortages and a large number of patients lead to a heavy workload on healthcare providers. This in turn leads to their lack of time to teach and discuss with the parents. This finding is similar to that established by Espezel and Canam (2003) and paliadelis et al (2005).

5.1.6 Suggestions for Enhancement of Partnership Establishment

The study sought suggestions from all participants on how partnership establishment can be facilitated between the healthcare providers and the parents in order to have the realisation of FCC. The suggestions that were advanced touched on all the stakeholders involved in the care of the hospitalised child. These stakeholders include: trainers, administrators, healthcare providers and the child's family. The suggestions included:

5.1.6.1 Training and Sensitisation about FCC to all the Stakeholders

This was cited as the key factor for the realization of partnership establishment. The respondents expressed the need to have the concept included in all curricula of the various healthcare training programmes. Further, they suggested inclusion of the concept in modules for in-service training, such as in the training of IMCI, and that all the hospital managers and policy makers be trained on the concept so that they can offer the much needed support that was identified as missing for those already trying to implement the concept. The training should be extended to the general public to make them aware of their rights and responsibilities when they have a sick child admitted to the hospital. This suggestion has also been stated in a study by Karani (2001) and Eden and Callister (2010).

The training is to be conducted to all healthcare providers comprising those already in practice and those undertaking health courses. The focus of training on FCC is on the principles and elements of FCC, the FCC implementation strategies and its benefits. Sensitization on the other hand is conducted to the healthcare managers and administrators through seminars and to the public through use of various means of communication like mass media, internet, public gatherings like churches and development and distribution of brochures. Evaluation of the training is done through formulated questionnaires for the parents and through assessment of the management of the hospitalised child.

5.1.6.2 Client Involvement and Appreciation

The participants reiterated that involvement of the child's family immediately on first contact leads to establishment of good working relationship with the healthcare providers. Most of the parents indicated that accompanying their children and participating in their care should be unconditional. They further expressed the need for communication and emotional support during their participation in the care of the child. Communication is underscored as a key strategy in the establishment of partnerships and effective practice of FCC by various authors including; Ahmann (1994), Casey (1995), Shields and King (2001), Lam et al (2005) and Mantovani (2009)

The suggestion on involvement of parents is in tandem with recommendations by Muga et al (2005) in their preamble to the Kenya Service Provision Survey (SPA) 2004. Their recommendation is to the effect that future planning needs to recognize that reversing trends cannot be achieved by the government sector alone. Active involvement and partnership with other stakeholders in the provision of care is needed.

5.1.6.3 Establishment, Documentation and Review of Policies and Guidelines

All the healthcare providers emphasized the importance of having in existence clearly documented policies and guidelines aiding the implementation and evaluation of the concept. This is similar to suggestions by Huffman (2012) which point out that policy review and development is vital in decision making by healthcare providers with regard to the level of parental involvement in the care of children. Huffman further explains that

adoption of a family policy will decrease idiosyncratic decision making among staff. This has also been emphasized by Duran et al (2007). .

5.1.6.4 Communication

This was pointed out as a key factor in the establishment of partnerships between the healthcare providers and the sick child's family. This is similar to the findings by Eden and Callister (2010) that existence of good relationships and communication between healthcare providers and parents builds trust and eases stress placed on parents in making decisions about the care of their infants. The importance of communication is also underscored by Casey in her partnership model (Casey, 1995) and in the element of FCC that stipulates about exchange of unbiased information (Lee, 2007).

5.1.6.5 Provision of a Conducive Work Environment

According to the findings of this study, a conducive work environment is fundamental in the establishment of healthcare provider- parent partnerships. This concurs with the finding by Eckle and Maclean (2001) and Harrison (2009) which points out that implementing an FCC approach requires significant environmental changes.

5.1.6.6 Attitude Change

Attitude change by both the healthcare providers and parents was established to play a key role in the effective establishment of partnership between the healthcare providers and the parents. Each of the parties has to change its attitude towards the other. This is similar to the documentation by Lee (2007) that attitude has an influence on partnership

in care and Harrison (2009) who indicates that to provide FCC, health professionals must have an attitude of respect, collaboration and support.

5.1.7 The Framework

Establishment of a framework for the contextualization of FCC entailed looking at the key FCC aspects in the management of hospitalised children, the current status of practice as realized in the study, the practice gap identified through comparison of the study results and the documented literature, and the proposed suggestions for contextualization of FCC (table 5.1).

Table 5.1: Summary of the key findings and the suggestions for the framework

Key FCC aspect	Current status of practice	Practice Gap	Suggestions for the framework
Possession of knowledge on FCC	27.5% have been trained on FCC	Inadequate knowledge about FCC	Training of Healthcare system administrators and providers on FCC

Parental knowledge of their rights and roles when their child is hospitalised	Parental ignorance	Parents are not informed on their rights and responsibilities when the child is hospitalised	Sensitization and empowerment
Inclusion of FCC in the childcare policies	The private hospital has included FCC in their policies but in the public hospital it has not been adopted	FCC not included in policies	Review child healthcare policies to include FCC
Documented guidelines indicating how the healthcare providers should relate with the child's family	There are no guidelines on how the healthcare providers should relate with the parents	There are no documented guidelines	Develop policy implementation guidelines
The healthcare providers and the parents should be willing to work together in partnership	Healthcare providers ignore the parents and some parents do not trust the healthcare providers	Lack of knowledge, both for the healthcare providers and the parents, on the importance of working together in partnership	Training and sensitization
Open and free communication between the healthcare providers and the sick child's family	Healthcare providers filter the information they give to the sick child's family	Healthcare providers are poor communicators	Healthcare providers be trained on communication skills
Recognition and respect of culture	Culture is seen as a major challenge by the healthcare providers	Healthcare providers lack knowledge about culture	Be trained on the importance of accepting and respecting the diverse cultures of patients
A conducive working environment	The wards are open hall and congested; privacy is inadequate whereas it is critical for partnership establishment	No room for privacy and maintenance of confidentiality	Healthcare system management to provide a conducive working environment
Unrestricted	Strict visiting hours and	Restricted	Review policies

visitation	children below 12 years not allowed to visit	visitation	on visitation
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The framework for the contextualization of FCC in Kenya, as advanced by this study, takes cognizance of the low level of knowledge about the concept amongst the key stakeholders involved in the care of hospitalised children. Knowledge of the concept has an impact on the structures that need to be put in place, the process of implementation of the concept and the outcome. In view of this, the framework embraces structure-process-outcome approach. These concepts of the framework are described below:

Structure: This refers to the interrelationship between the key stakeholders involved in the care of hospitalised children. These are the sick child’s family, the healthcare providers who are involved in direct care of the sick child and the healthcare administrators who are responsible for the development of child healthcare policies and ensuring that all the necessary equipment and supplies are available. According to this framework, for FCC to be effectively implemented, all the stakeholders should be in possession of the right knowledge of FCC. This is achieved through training and sensitisation. The training and sensitisation takes cognizance of the knowledge gaps realised in the findings of this study. This is achieved through inclusion of FCC in all training curricula for the various cadres of healthcare providers, inclusion of FCC in ongoing in-service courses such as IMCI; in continuing medical education programmes; community sensitization programmes that use diverse approaches such as media; and conducting seminars and workshops especially for the healthcare system managers. Training and sensitization empowers all the stakeholders to have similar expectations in

the care of hospitalised children. Besides, it creates avenues for effective exchange of information among them.

Process: This, as defined by the Oxford Advanced Learner's dictionary (Hornby, 2000) is a series of things that are done in order to achieve a particular result. According to this framework, process refers to the changes expected to take place within the structure once training has taken place in order to have establishment of effective partnership between the healthcare providers and the child's family. The healthcare system administrators review the child healthcare policies to include FCC, develop guidelines on how FCC should be practised and provide a conducive child healthcare environment. The policies are availed to all healthcare providers and sick children's families. The healthcare providers and the parents on the other hand embrace FCC, exhibit change of attitude and good communication amongst themselves.

Outcome: According to the Oxford Advanced Learner's dictionary (Hornby, 2000) outcome is the result or effect of an action or event. Outcome, as used in this framework, is the end result of the management process of the hospitalised child. In this regard, management process includes partnership establishment and the quality of care provided to the hospitalised children. Effective partnership establishment is evidenced when the healthcare providers, the sick child and family work together in planning, implementing and evaluating care. The partnership results in empowerment of the sick child's family on how to care their children both in sickness and in health.

5.1.7.1 Operational Framework

For FCC to be practised effectively in the management of hospitalised children, three key players come to the fore, namely; the institutional management, sick child's family and the healthcare providers. In the operational framework advanced by this study, the institutional management should have clearly documented policies on the care of the hospitalised child. It should specify that FCC is to be applied in the management of hospitalised children and a policy document on the same be readily accessible to the healthcare providers and availed to the child's family on admission. The institutional management should give room for evaluation of the policies by both the healthcare providers and the child's family in form of feedback. There should be exchange of information between the child, his/her family and the healthcare providers for development of a working partnership on the care of the hospitalised child. Thus, both formative and summative evaluation is done and the final outcome of the care is evaluated based on the elements and principles of FCC. If the outcome is satisfactory, the practice is maintained and strategies for further improvement are put in place following the feedback received. When the outcome is not satisfactory, the process is evaluated and strategies put in place to aid implementation of the strategy.

For FCC to be effectively practised, the child's family should be empowered to participate actively in the care of their hospitalised child. On the other hand, healthcare providers should:

1. Be aware of themselves professionally and culturally in order to appreciate the needs of hospitalised children and their families.

2. Have insight into the setting at which they are delivering care and the policies guiding their practice.
3. Be aware of the cultural diversity of their clientele in order to provide care that is culturally congruent.
4. Create an atmosphere of trust with the child and family.
5. Communicate assessment findings to the child and family in a language they can understand.
6. Empower the family in order to enable it realize its strengths and weaknesses.
7. Allow the child and family to participate in the assessment, planning, implementation and evaluation of care.
8. Have the ability to accommodate and care for children and families of diverse characteristics.
9. Evaluate the process of care delivery and give feedback to the health facility management.

5.1.7. 2 Conceptual Framework

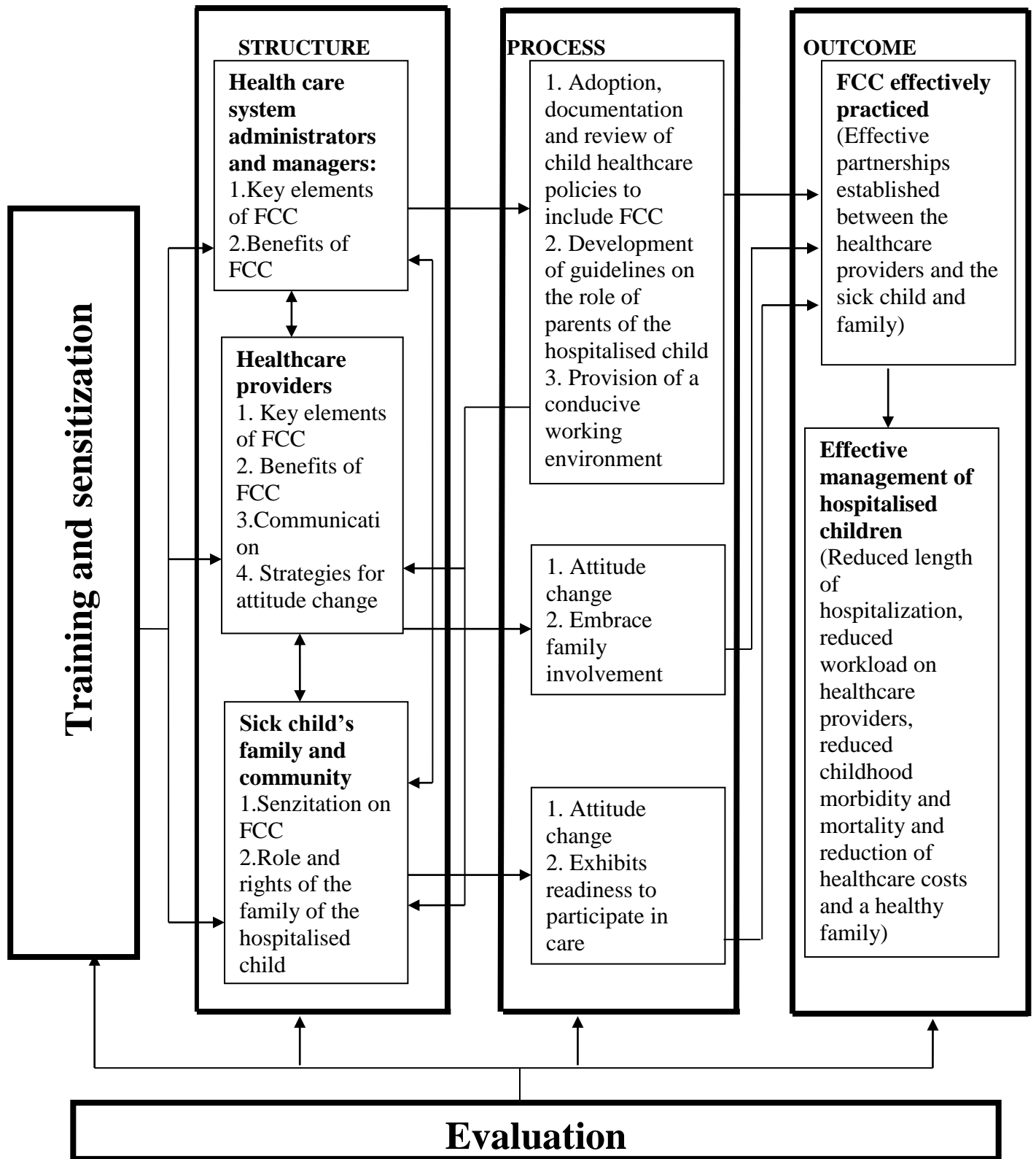


Figure 5.1: Moke's framework for the contextualization of FCC

5.2 Conclusions

The researcher came up with the following conclusions based on the study findings:

On socio-demographic characteristics of parents who participated in this study, it was established that the two hospitals receive patients from diverse ethnicities and religious backgrounds. This implies that their cultural composition is also diverse. The study realized that children are mainly accompanied by their mothers during hospitalisation.

In regard to family involvement in the management of the hospitalized child, the following conclusions were drawn:

- The healthcare providers take the lead in deciding about the management of the child. About half of the parents are actively involved with the remaining half being passively involved. Majority of the parents acknowledge the importance of being actively involved at all stages of decision making.
- Parents are allowed to accompany their children during most of the procedures. Both the parents and the healthcare providers appreciate the importance of children being accompanied by a family member during procedures. Parents would like to accompany their children in all procedures, be they traumatic or non-traumatic.
- Family visiting of the hospitalized children is restricted to specific hours and children aged twelve years and below are not allowed to visit, especially in the teaching and referral hospital, for the main reason that they are likely to acquire infections from the hospital. The study however established that all the

stakeholders acknowledge the importance of hospitalised children being visited by fellow children.

- Slightly more than half of the healthcare providers have heard of FCC mainly through CME and only 27% of the healthcare providers are trained on FCC.
- There is a significant relationship between the working institution and the practice of FCC whereby FCC is more practised where it has been adapted in policy than where it has not.
- The healthcare providers that have been trained on FCC have embraced it in their practice even in the institution where it is not documented as a child healthcare policy.
- There are in existence documented and undocumented policies on the management of hospitalised children in the two institutions. However, the policies do not specify how the healthcare providers should work together with the sick child's family as they provide care for the hospitalised child.
- Where FCC has been adapted in policy, there are no documented guidelines on how it should be practised.

The study further concluded that:

- The healthcare providers face various challenges emanating from the sick child's family, the healthcare providers themselves and the work environment while providing care to the hospitalized children.
- Both the healthcare providers and the parents of the hospitalized children view partnership in care as a situation where they work together in planning, implementing and evaluating care for the sick child, including discharge planning.

They both acknowledge that there are procedures that parents can be trained on and assist to carry out for the child while in hospital.

- FCC can be implemented in Kenya using the suggestions given in this study as expressed in the innovated framework.

5.3 Recommendations

The researcher proposes the following recommendations to training, practice, policy and research on FCC:

- There is need to include cultural studies in the training of healthcare providers to enable them appreciate the diverse cultures that they encounter while attending to their clientele.
- The government and other organisations need to keep up women empowerment campaigns, especially with regard to education, in order to enable them participate actively in the care of their hospitalised children.
- The hospital administration should review its policies on visitation so as to allow for unrestricted visiting of patients. In particular, it should put in place modalities to allow children to visit sick children and especially those with prolonged hospitalisations.
- FCC should be included in all the basic and post-basic training curricula of all healthcare providers, in the in-service training programmes and continuing medical education programmes.
- Child healthcare policies need to be reviewed to include FCC and guidelines be developed on how it should be implemented. The respective hospital management should put in place mechanisms for frequent evaluation of the challenges

experienced by the healthcare providers and work together with them in addressing the challenges.

- The hospital management, in conjunction with the healthcare providers and parents, should come up with a list of procedures that parents can be allowed to perform for their children while in the wards. It is also important for the hospital management to come up with guidelines on how parents should undertake these procedures.

5.4 Areas for Further Research

- This study has focused on the approach of FCC in relation to hospitalised children in Kenya. There is need for research on its applicability to other developing countries.
- Culture is one of the key elements of FCC. There is need for research to be carried out to determine the health-seeking behaviours of various ethnic and religious denominational groupings in order to enable healthcare providers be responsive to culture in provision of care.
- Children are part of the key stakeholders in the practice of FCC in paediatrics. There is need for research to determine their perspectives of partnership in provision of healthcare to sick children.

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APPENDICES

- Appendix 1: Information Sheet for Participants
- Appendix 2: Consent Form
- Appendix 3: Healthcare Providers' Questionnaire
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APPENDIX 1: INFORMATION SHEET FOR PARTICIPANTS

Title of Study

A framework for the contextualization of Family Centred Care in the management of hospitalised children in Kenya

Investigator

Drusilla G.M. Makworo, PhD Student, School of Nursing Sciences, University of Nairobi

Cell phone: 0721262355

Purpose of the Study

The purpose of this study is to develop a framework to guide the implementation of the concept of Family Centred Care in the management of hospitalised in Kenya. This approach has been practiced and evaluated in the developed world with many benefits but so far there is no documentation on how it can be implemented in the Kenya.

Description of the Research

I am kindly inviting you to participate in this study. The study will be conducted in two phases but you may not participate in all the phases. Phase 1 will entail use of questionnaires to ascertain the status of family involvement in the care of hospitalised children. The questionnaires will take proximately 30 minutes. Phase II will include use of interviews and focused group discussions on strategies that can be used in developing the framework. Each interview will last approximately 45 minutes whereas the focused group discussions will last 1 hour.

Access to Research Information

The data collected will be kept in safe custody and will not be accessed by any unauthorized persons. The information will only be accessed by the research team comprising of the principle researcher, the supervisors and the examiners. The filled questionnaires and voice recorded information will be locked up for a period of five years after the study before being destroyed.

Potential Harm, Injuries, Discomforts or Inconvenience

This being a non-experimental research, you will not be exposed to any harm, injuries or discomforts. There may be some inconvenience in terms of time but I request you to bear with it.

Potential Benefits

You may not benefit immediately from participating in this study as the benefits will be experienced after the framework is developed, accepted and implemented.

Confidentiality

- Confidentiality will be respected and no information that discloses your identity will be released or published without consent unless required by law.
- For Focus Group discussions, confidentiality of information is guaranteed but I can't promise that the other participants will observe each other's privacy.

Participation

Participation in research is voluntary. If you choose to participate in this study you may withdraw at any time. If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will you be victimized.

Contact:

If you have any questions about this study, please contact:

Makworo Drusilla G. M,
School of Nursing Sciences
University of Nairobi
P.O Box 19679- Nairobi
Cell phone: 072126235

OR

Dr. Grace Omoni
School of Nursing Sciences
University of Nairobi
P.O Box 19679- Nairobi
Cell phone: 0727466460

If you have questions about your rights as a research participant, you may contact:

The Chairperson,
KNH/UoN Research and Ethics Committee,
P.O Box 20723,
Nairobi.
Tel.726300-9

APPENDIX 2: CONSENT FORM

Please tick as appropriate

By signing this form, I agree that:	YES	NO
The study has been explained to me		
All my questions were answered		
Possible harm and discomforts and possible benefits (if any) of this study have been explained to me		
I understand that I have the right not to participate and the right to stop at any time		
I understand that I may refuse to participate without consequence		
I have a choice of not answering any specific questions		
I have been told that my personal information will be kept confidential		
I understand that no information that would identify me will be released or printed without asking me first		
I understand that I will receive a signed copy of this consent form		

I hereby consent to participate in this study:

Initials of Participant: _____

Signature: _____

Date: _____

Name of Researcher: _____

Signature: _____

Date: _____

APPENDIX 3: HEALTHCARE PROVIDERS' QUESTIONNAIRE

Instructions

- Please put a tick (✓) in the box next to the right response
- Where no choices are given, please write /fill in the appropriate answer

DEMOGRAPHIC DATA

001. Sex M..... F.....

002. Profession: Nurse Doctor Paediatrician
Paediatric nurse

003. Age? <30 31 – 40 41 – 50 >50

004. Religion: Christian Muslim Hindu Other (Specify).....

005. Marital Status: Married Single Divorced Other (Specify).....

007. Parental status: Parent Not a parent ther (Specify)

008. Working institution KNH Gertrudes Ward.....

009. Work experience in years: 0-9 10 – 19 20 – 29 > 29

010. Paediatric Specialist experience in years: 0-2 3-5 6 - 8 > 9

Parental participation in care

011. When planning the care of the child in hospital, do you involve the parents?

Yes No

If yes in what aspects do you involve them?

.....
.....
.....

If no, why don't you involve them?

.....
.....

012. Do you allow the child's parents to stay in when performing procedures on their child?

Yes No

If yes, why should they stay in?

.....
.....
.....

If no, why shouldn't they stay in?

.....
.....
.....

Factors affecting delivery of healthcare

013. Does the layout of the ward in which you are working affect your delivery of care to hospitalized children? Yes No

If yes, how?

.....
.....
.....

014. What do you think should be done to the layout so as to facilitate better delivery of health care to hospitalized children?

.....
.....
.....

015. Are there family factors that affect your delivery of care to hospitalized children?

YES NO

If yes, state the factors

.....
.....
.....
.....

016. Are there challenges that you face when caring for the hospitalized children?

Yes No

If yes, state the challenges

.....
.....
.....

Knowledge and Practice of Family Centred Care (FCC)

017. Have you ever heard of Family Centred care? Yes No

018. If yes, how did you get to know about it? In training

CME Read about it Other (specify).....

019. Explain your understanding of Family Centred Care

.....
.....
.....

020. While providing health care to hospitalized children, do you practice Family Centred Care? YES NO

If yes, explain how you practice family centred care.

.....
.....
.....

If no in 20 above, explain why?

.....
.....
.....

021. Do you think Family Centred Care can be implemented in the Kenyan set-up?

YES NO

If yes, what should be put in place to aid in its implementation?

.....
.....
.....

If no, why

.....
.....
.....
.....

The table below indicates the levels of decision making on care of the hospitalized child. Please tick one appropriate column on the level at which you practice.

Healthcare provider makes the decision always	Healthcare provider makes the decision with the parents sometimes	Healthcare care provider and parents work as partners in decision making	The parents play the leading role in decision making

THANK YOU FOR YOUR PARTICIPATION

APPENDIX 4: PARENTS' QUESTIONNAIRE

SERIAL NO.

Definition of parent: according to this study, a parent is defined as the person or persons responsible for the child's well being both at the hospital and at home.

Instructions

- Please put a tick (√) in the box next to the right response
- Where no choices are given, please write /fill in the appropriate response

DEMOGRAPHIC DATA

A. Parent

001. Age: 15-25 26-35 >35

002. Sex: Male Female

003. Level of education: No education Primary Secondary
College University

004. Marital status: Married Single Divorced
Other (specify).....

005. Occupation.....

006. Relationship with child: Mother Father Aunt Uncle
Grandparent Other (Specify).....

007. Religion: Christian Muslim Hindu other (specify).....

008. If Christian please indicate your denomination.....

009. Race: African Caucasian Asian
Other (Specify).....

010. Nationality: Kenyan Other (Specify).....

011. If Kenyan please indicate your cultural (ethnic) background.....

012. Institution KNH Gertrudes

013. Ward -----

Information about the child

014. Age: ≤ 28 days 1 month – 1 year 1-3years 3 – 5 years
5-7 years 7- 9 years 9-12 years

015. Diagnosis.....

016. Date of admission.....

017. Has this child been admitted to any hospital before?

Yes No

Participation in decision making

018. Are you involved in making decisions together with the health care providers on the management of your child while in the hospital?

Yes No

If yes, how are you involved?

.....
.....
.....

If no, why are you not involved?

.....
.....
.....

019. Do you think it is important for the child’s family members to be involved in deciding on how the child should be cared for while in hospital?

Yes No

If yes, why should they be involved?

.....
.....

If no, why shouldn't they be involved?

.....
.....
.....

Readiness to participate in care

Which of the following technical aspects of healthcare do you feel if empowered you can participate in performing to your child while in the ward?

	Yes	No
020. Giving oral medications	<input type="checkbox"/>	<input type="checkbox"/>
021. Giving injections	<input type="checkbox"/>	<input type="checkbox"/>
022. Measuring temperature	<input type="checkbox"/>	<input type="checkbox"/>
023. Naso-gastric tube feeding	<input type="checkbox"/>	<input type="checkbox"/>
024. Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
025. Making the child's bed	<input type="checkbox"/>	<input type="checkbox"/>
026. Checking the child's blood sugars	<input type="checkbox"/>	<input type="checkbox"/>
027. Nebulization	<input type="checkbox"/>	<input type="checkbox"/>
028. Weighing	<input type="checkbox"/>	<input type="checkbox"/>
029. Suppository drug administration	<input type="checkbox"/>	<input type="checkbox"/>
030. Other specify.....		

031. Do you always stay in when procedures are performed to your child?

Yes No

If no, please explain why.

.....
.....

032. Do you think it is important for the child's parents to stay in when procedures are being performed on their child?

Yes No

If yes, why should they stay in?

.....
.....

If no, why shouldn't they stay in?

.....
.....

Visitation

033. Do the family members visit your child any time they wish to?

Yes No

If no, why?

.....
.....

034. Do you have other children? Yes No

If yes do they visit come to visit this one who is hospitalized? Yes No

If they don't visit please explain why?

.....
.....
.....

035. Do you think visitation by other children is important? Yes No

If yes, please explain why?

.....
.....

If no, please explain why?

.....
.....

THANK YOU FOR PARTICIPATING

APPENDIX 5: INTERVIEW GUIDE FOR THE LECTURERS

Demographic data

001. Sex: M..... F.....

002. Age group: <30 31 – 40 41 – 50 >50

003. Highest Level of training:

004. Marital Status: Married Single Divorced Other (Specify).....

005. Working institution

006. Work experience as a lecturer in years: 0-9 10 – 19 20 – 29 > 29

1. What concepts/approaches of child healthcare do you embrace in your teaching?
2. How do you collaborate with the healthcare institutions to ensure that the students acquire the required skills and competences on child healthcare approaches?
3. What is your view about the applicability of the FCC approach in the Kenyan set-up?
4. What strategies can be put in place to enhance the practice of FCC?
5. What are your views about hospitalised children by other children?

APPENDIX 6: INTERVIEW GUIDE FOR THE NURSE MANAGERS AND PAEDIATRICIANS

Demographic data

001. Sex M..... F.....

002. Age group: <30 31 – 40 41 – 50 >50

003. Highest Level of training:

004. Marital Status: Married Single Divorced Other (Specify).....

005. Working institution KNH Gertrudes

006. Ward:

007. Managerial level:

009. Work experience in years: 0-9 10 – 19 20 – 29 > 29

010. Duration of experience as a manager: 0-2 3-5 6 - 8 >9

1. What policies does your hospital have on management of hospitalized children?
2. What is your understanding of partnership in care of the hospitalised child?
3. How family is centred care practiced in your hospital/department/ward?
4. What challenges does your hospital/unit/ward experience in the practice of FCC?
5. What factors hinder the practice of FCC/partnership establishment in your hospital/unit/ward?
6. What do think should be put in place to enhance the practice of FCC in your hospital/unit/ward?
7. What are your views about hospitalised children being visited by other children?

APPENDIX 7: FOCUSED GROUP DISCUSSION GUIDE FOR NON – PAEDIATRIC NURSES

DEMOGRAPHIC DATA

001. Sex M..... F.....

002. Age? <30 31 – 40 41 – 50 >50

003. Level of nursing training: Certificate Diploma Degree

004. Marital Status: Married Single Divorced Other (Specify).....

005. Working institution KNH Gertrudes

006. Work experience as a nurse in years: 0-9 10 – 19 20 – 29 > 29

007. Ward -----

1. What is your understanding of partnership in care?
2. What challenges do you face while working with parents in the care of hospitalized children?
3. What should be put in place to enhance the partnership between the healthcare providers and the sick child’s family?
4. What are your views about hospitalised children by other children?

APPENDIX 8: FOCUSED GROUP DISCUSSION GUIDE FOR PAEDIATRIC NURSES

Introduction

Hospitalization of children is challenging to the children, parents and healthcare providers. In a bid to overcome these challenges there is need to come up with strategies that can enhance partnership between the hospital and families. The purpose of this discussion is to come up with the strategies.

DEMOGRAPHIC DATA

001. Sex M..... F.....

002. Age? <30 31 – 40 41 – 50 >50

003. Marital Status: Married Single Divorced Other (Specify).....

004. Working institution KNH Gertrudes

005. Work experience as a nurse in years: 0-9 10 – 19 20 – 29 > 29

006. Paediatric Specialist experience in years: 0-2 3-5 6 - 8 9

007. Ward

1. How do you implement FCC in your practice?
2. What challenges do you face in your practice of FCC?
3. What should be put in place to enhance the practice of FCC?
4. What benefits will the practice of FCC bring?
5. What are your views about hospitalised children by other children?

APPENDIX 9: FOCUSED GROUP DISCUSSION GUIDE FOR PARENTS

Introduction

Hospitalization of children is challenging to the children, parents and healthcare providers. In a bid to overcome these challenges there is need to come up with strategies that can enhance partnership between the hospital and families. The purpose of this discussion is to come up with the strategies.

Demographic data

001. Sex: M..... F.....

002. Age group: <30 31 – 40 41 – 50 >50

003. Level of education: None Primary Secondary
College University

004. Marital Status: Married Single Divorced Other (Specify).....

005. Occupation:.....

006. Religion: Christian Muslim Hindu Other (Specify).....

007. Relationship with the child:

008. Institution KNH Gertrudes

010. Ward:

011. Duration of hospitalization

1. What roles do you play in the care of your child while in hospital?
2. What procedures do you feel you can be able to perform on child child while in hospital?
3. FCC aims at establishment of partnership between the healthcare providers, the child and the family, what do you think can be done to realize this aim?
4. What are your views about hospitalised children by other children?

APPENDIX 10: APPROVAL LETTERS

- Ministry of Higher Education - Authority letter No. NSCT/RRI/12/1/MED/235/5
- KNH-UoN Research and Ethics Committee - Approval letter No. P222/07/2010, dated 11/11/2010)
- GCH Research and Ethics Committees - Approval letter dated 24/1/2011)
- The Deputy Director Clinical Services, KNH - Approval letter dated 24/1/2011