PAEDIATRIC HOSPITAL VISITING POLICIES IN CAMEROON: THE EXPERIENCES OF NURSES AND PARENTS

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Abstract

This study explored the experiences of parents and nurses caring for hospitalised children with the parents either living-in or having only visiting rights. The participants were parents with children hospitalised for a minimum of three days and nurses working in the paediatric ward for a minimum of six months. A qualitative approach using semi-structured interviews and participant observation was used to collect the data and Burnard's (1991) thematic content analysis to analyse the data. Six themes were identified of which two (one from the nurses and one from the parents) are main themes. The main theme from the nurses relates the nurses' aim of meeting the children's need and getting them ready for discharge home. The main theme from the parents relates the parents' satisfaction with the care they receive and the difficulties they have as parents not always being able to be with their child at will.

The roles of parents and the nurses with regards the cares of children are relatively distinct in the hospital. The parents' role seemed quite limited due to the poor information received from the nurses although they (nurses) had a better understanding of what these roles could be. It could be noted that attitudes and opinions of nurses and parents about the way children are cared for in hospitals are different. For some parents, living-in and carrying out basic cares such as bathing, changing, feeding and comforting the child is just normal. Others felt it is the nurses' responsibilities, hence were reluctant to do it.

Nurses also had divided views with regards to providing this basic care for the children added to their nursing/medical cares. As well there were few nurses to provide the care. Despite the differences, the nurses and parents have a common goal of getting the child ready for discharge home. On the whole the nurses are happy to have parents live-in and parents are happy to stay, although some parents feel living-in is an obligation not a choice. Unlike the parents of the older children that are happy to live-in, the neonatal parents are not given that privilege to live-in and that is distressing to them. The different concepts of care in paediatric wards are examined and not all of the concepts can be applicable in the Cameroon context. The study suggests a possible concept of care to be used in the hospital after a review by the authorities. This study provides a base for future research in this domain.

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> *"I am only one, but I'm still one. I cannot do everything, but I can do something. And because I cannot do everything, I will not refuse to do something that I can do"(author unknown).*

Dedication

I dedicate this work that culminates my sojourn in New Zealand to my family:

To my father and father-in-law for your encouragement and love when you people were alive. Father, although I miss you so much I know you are with me always.

To my uncle Chief S.C. Kimbi and his family for you have made me what I am today.

To my mother, thanks for all the prayers, teachings and advice though physically being thousands of kilometres apart. My sisters: Meekness, Phoebe, Eni and Mercy; and my brothers: George and Clifford for your support and prayers.

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TO GOD BE THE GLORY

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Chapter One: Introduction and Background

1. Introduction

In most countries all over the world, Cameroon inclusive, children are a major concern to the parents, family, community and the government, confirming the common saying that 'children are the future of a nation'. According to the Bureau Central des Recensements et des Etudes de Population (BCREP) (1998), 46.4% of Cameroon's population is made up of children aged 0-14 years. Children are seen in Cameroon as the most vulnerable group with regards to their health status. About 151 out of every 1000 children die before their fifth birthday (BCREP, 1998). A child's admission to the hospital is therefore a major concern, considering this alarming situation.

When a child is sick and taken to the hospital, nurses and parents are involved in the care of the child. Parents try to maintain the continuity of the family despite the health condition of the child. Likewise nurses feel it is their responsibility to see that the child receives adequate treatment and care, recovers and is discharged home as soon as possible. Many studies have been done on hospitalised children, the parents and the nurses in developed countries but seemingly, little on the care of children in hospitals in developing countries. Where it exists, it is mostly on mortality and/or morbidity of certain disease conditions (BCREP, 1998). In the literature there appeared to be issues for both parents and nurses with regards to hospital visiting policies. In this research there are also issues for children, although children are not included or interviewed.

1.1 My interest in this area and the aims of the study

I am a Cameroonian and I have been practising as a registered nurse since 1981 and have nursed in medical, surgical, obstetrics and gynaecological wards. The greater part (9 years) of my nursing career has been in the paediatric ward. During my experience in paediatric nursing, a policy of restricted visiting for parents was in operation. In 1993 I went to Israel on an exchange program for two months to appreciate the nursing of children in a hospital and the community. My experience there changed my view and appreciation of the system I was used to for so long. I saw parents living-in with their hospitalised children and felt very impressed with the shared care. Unfortunately, my report on return could not influence much of a change since both the nurses and the doctors working in the paediatric ward then seemed to feel comfortable working without the parents present. As well no literature on any study done in Cameroon was available and access to foreign literature in Cameroon was almost impossible. There was therefore nothing to justify any need for change. With the opportunity to further my education and write a thesis, this was an appropriate time to venture into research in the area of the experiences of nurses and parents in a paediatric ward with regards to visiting policies.

The aims of this research are:

- To explore the experiences of parents (those living-in and those with visiting rights) who have children in the hospital.
- To explore the experiences of the nurses working in the paediatric ward where parents either have restricted visiting rights or can live-in.

Of the 15 parents interviewed, 14 were mothers and 1 was a father of a hospitalised child. For the nurses, I interviewed 6 registered nurses, 2 of whom had postgraduate nursing qualifications. The data were collected between October and December 2000.

2. Justification of the research

The policy of restricting visitors was introduced in the early 1980s and parents were not allowed to live-in in some hospitals, mostly in the capital city (Yaounde). In reviewing the research on visiting policies in paediatric wards, there appear to be none completed in Cameroon. Hence, the need for a critical examination of the effects of policies related to restricted visiting and living-in parents in Cameroon. The viewpoint of the participants with the experience of each type of visiting policy was therefore the focus of the study. A descriptive and exploratory design was appropriate to gain the perspectives of both parents and nurses.

A qualitative research approach was chosen as suitable for this study as my wish was to analyse the natural, everyday aspects of a certain situation (Holloway, & Wheeler, 1996) that embraces the wholeness of humans, focusing on their experience in naturalistic settings (Liehr, & Marcus, 1994). This involved the use of semi-structured interviews (Burnard, 1991) and participant observation to enrich the data (Denzin & Lincoln, 1994). Since this study was done in Cameroon, it is useful to situate the country of Cameroon to better understand the study and/or the reasons behind certain actions taken.

3. Cameroon

Cameroon is located in West Central Africa and is bounded on the West by the Federal Republic of Nigeria; on the East by the Republics of Central Africa and Chad; and on the South by the Republics of Congo, Gabon and Equatorial Guinea. On the Southwest is the Atlantic Ocean (figure.1). The total surface area of Cameroon is estimated at 475,440 km2 with a population estimate of 13.6 million (Ministry of Economics and Finances (MINEFI/DSTAT), 1996). It is often referred to as 'Africa in miniature' because of its rich geographic, climatic, ecological, tribal, linguistic, religious and economic diversity reflecting a vast range of experiences typical of many other African countries. Cameroon was colonised by Germany up till the First World War when it became a trusteeship territory to both the British and the French, and this explains the use of two official languages (French and English) in the country in addition to the many tribal languages.

Economically Cameroon depends primarily on agricultural products, tropical wood and petroleum. Cameroon has a Gross National Product (GNP) per capita of $820 (United Nations Development Programme, (UNDP) 1996) and is therefore classed in the low-income group of countries. The economy was expanding steadily until 1986 when a significant drop in economic growth set in due to a sharp fall in the price of the primary products at the world market.

3.1 The health system in Cameroon

The pyramidal health care structure in Cameroon rises from the primary level (village health post, dispensaries and health centres) to the Sub-divisional Hospital, the Divisional Hospital, and the Provincial Hospital and up to the Referral Hospital. At the primary level, it is the village health workers who provide first aid services, and staff the village health post. Dispensaries provide basic treatment. Health centres offer, in addition to the basic treatment, mother and child health care and first line referral, in-patient, and obstetric services. A midwife assisted by an enrolled nurse, usually heads a health centre. A consulting nurse or a nurse/midwife heads the larger institutions. These are developed health centres with a visiting medical doctor (general practitioner) making routine visits to the centres. These centres organise immunisation campaigns. The more technical and medical treatments are dealt with at the hospital level. Medical doctors usually head these.

3.2 Hospital visiting in Cameroon

Traditionally in Cameroon mothers lived-in with their sick children in hospitals and if the mother needed to go home the father or an extended family member came to stay with the child. Other visitors were allowed to visit three times during the day with each patient not having more than two visitors at a given moment. Each visiting time was spread over a period of two hours to permit everybody coming to visit to take turns if a patient had more than two visitors. Although the mothers were allowed to live-in in the paediatric wards, that was not the case in the neonatal units. The mothers of babies in the neonatal unit only visited at specific times but they were allowed more visits to permit breast-feeding. This policy of having the mothers live-in originates as far back as when modern medicine and hospitals were introduced into Cameroon.

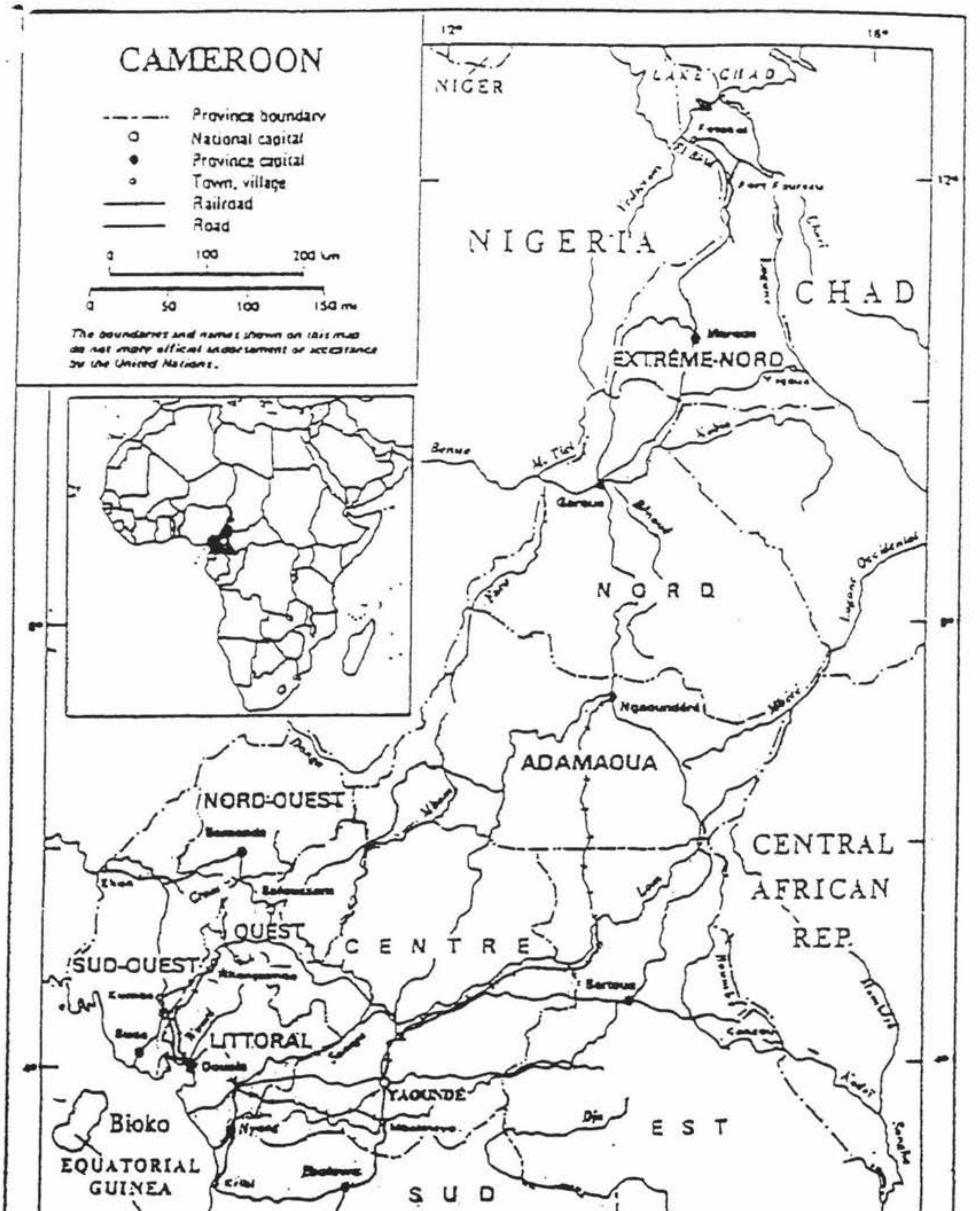

Figure. 1. The Location of Cameroon

3.3 Change of policy and reasons

According to a paediatrician who was heading one of the Paediatric wards in Yaounde, the policy of not having parents live-in was introduced in the early 1980s. Parents and other visitors only had visiting rights, visiting at specific times. The following were the main reasons why he and his colleagues (paediatricians) introduced this system:

- There was not enough space to have the mothers and their children stay in the same ward, as the rooms were over-crowded with mothers and their belongings, which made movement within the ward difficult.
- The hygiene of some mothers was potentially detrimental to the wellbeing of the child. For example three children died in a ward within one week due to septicaemia. According to the paediatricians the mothers were the origin of the septicaemia.
- Some mothers were bringing alternative treatments (traditional drugs) from home and giving these to children, alongside the drugs given in the hospital. This combination of drugs is thought to have been affecting the children.

It was therefore decided that instead of having mothers live-in, that they should visit only, thereby limiting their contact. Getting the finances was a major threat to their proposed plan, as a lot of building restructuring had to be done. The then First Lady (wife of the President) and retired midwife Jeanne Irene Biya, who had previously made known her interest in the care of hospitalised children, supported the plan. The Paediatricians (policy makers) held a meeting and discussed the problems they were having and with the First Lady's willingness to assist them, they decided to write a report of the proposed changes and their rationale and to take this to her. Mrs Jeanne Irene Biya, being a health professional, understood their difficulties. She accepted their reasons and was ready to support whatever policy they choose to work with, provided it improved on the care given to the children.

With the support from the First Lady, the parents (mothers) of hospitalised children were no longer allowed to live in the wards and the care of the children was left with nurses who were not only nursing but also assumed the role of proxy parents. The parents of hospitalised children were allowed to visit their children from 6 a.m. to 8 a.m., 12 noon to 2 p.m. and 6 p.m. to 8 p.m. Only mothers of children aged 0-3 months had subsequent visits in addition to the normal visiting times, because they had to breast-feed the babies or express milk and leave in feeding bottles for the nurses to feed the babies as required.

The policy makers' assumption in the introduction of this policy was to provide a better environment for the health professionals to practice. Secondly it was believed that it would be beneficial to the mothers because it would reduce their stress. Mothers could now stay home to take care of the other family members, knowing that the sick child was being cared for, while their husbands went to work.

To effectively provide the care that parents previously had, more nurses had to be posted to the paediatric wards. They were educated on what to do and the First Lady gave financial motivation to all the staff working in the ward (extra payment every three months). The parents with children in the hospital at that time had to be educated on what they were expected to do as care for their child when they visited. Secondly the public had to be sensitised to the new approach using the radio and television to create a better awareness and understanding of the new policy. This changed parents' rights and responsibilities when they had a child admitted to the hospital. Some other hospitals (including the hospital used for this study) in the capital city also introduced this policy in their paediatric wards in their own way.

The policy of not having parents living-in with their hospitalised children was gradually abandoned in most of the hospitals (that were restricting parents living-in due to various reasons). In the hospital where this study was conducted parents live-in with their hospitalised child with the exception of the neonatal unit.

4. Study setting

Previously this hospital was not opened to the public as only referral cases from other hospitals or centres were received there. No patients were admitted directly from home. It is one of the most expensive hospitals in the country. Only those who are financially viable go there. It is not easily accessible to all. This may explain why in 1999 the total number of children admitted into the paediatric service was comparatively low.

> *567 children were admitted in 1999 and among these, were 291 medical cases, 91 surgical cases and 185 neonatal cases with the most common diagnoses being malaria, anaemia and gastro-enteritis (Field notes).*

The average duration of stay is three days for medical cases, excluding cases such as cerebral malaria, or children on IV antibiotics. For surgical and neonatal cases it depends on the individual conditions. In the year 2000 there may have been fewer patients admitted because major road construction work and the politico-social events at the time, made access to the hospital difficult.

4.1 The general layout of the paediatric ward used in the study

Table 1 Layout of the ward

Room 1	6 beds	Medical cases
Room 2	6 beds	Medical cases
Room 3	6 beds	Surgical cases
Room 4	6 cots	Neonatal cases
Room 5		Ward charge's office
Room 6	1 bed	Isolation (can be used as a single room if required by parents).
Room 7		Office
Room 8	1 bed	Isolation (can be used as a single room if required by parents).
Room 9	1 cot	Neonatal intensive care
Room 10	3 beds	Medical cases

There is a general nursing station used by nurses and most often doctors (general practitioners) and student doctors to write up their notes after ward rounds. The Paediatricians have their offices in the administrative block. There is also a treatment room next to the nursing station where children are taken for certain procedures, a kitchenette and staff toilet. Each room has its own toilet adaptable to the age of the children although they were not admitted to rooms based on age. There is a large playroom for the children with few toys.

4.2 Chapter layout and overview

Chapter two provides a brief overview of literature relating to parenting, research on the historical trends of hospitalising children including the hospital visiting policies, the exclusion (or restriction) of parents from the hospital, the changes of visiting policies and the reasons for the changes and the impact of that changes.

Chapter three describes the method used in collecting and analysing the data in this study. The first section describes the use of the qualitative approach, more specifically semi-structured interviews and participant observation and the strengths and limitations in using these methods. The second section describes the methodological review in related studies, difficulties researching in developing countries and using semi-structured interviews and participant observation in this setting. The ethical issues are also discussed.

In **Chapters four and five** the results of the data analysis from the nurses and parents is presented. The data were analysed using thematic content analysis as suggested by Burnard (1991). Six themes emerged from the data; three from the nurses' interviews and three from the parents' interviews are discussed.

In **Chapter six** the discussion of the findings linking together data from chapters four and five and looking specifically at the impact of visiting policies on care provided by parents and nurses is presented.

In **Chapter seven** the research is summarised, the different concepts of care in children's wards discussed, recommendations, the implications for nurses and the limitations of the study are presented.

Chapter Two: Literature Review

1. Introduction

As described by Burnard (1991) in his outline of the method of thematic content analysis, the review of literature is an on-going process starting from proposal to final write-up. The literature is taken as a source of data. As Burnard suggested the findings are linked to the literature on the topic and comparisons and contrasts made. Thus the purpose of the review of literature at this stage is to review previous knowledge on this topic, different designs used and where the studies were done.

To better understand how or why separating a child from the parents is detrimental, an understanding of parenting is necessary. Parenting can be viewed from several perspectives. Literature reveals that parents had a very strong influence in the introduction of change of hospital visiting policies in the Western world.

2. Parenting

Understanding the nature of being a parent helps make more comprehensible the experiences of the parents especially when their child is sick and has to be admitted to hospital where the parents may or may not be allowed to live-in. Parenting has been seen differently by different people.

According to van Manen (1990) it is necessary to know the etymological origins of the word 'parenting', which refers both to "'giving birth' and 'bringing forth' and it has connotations of origin or source. To parent is to originate, to be the source, the origin from which something springs" (p.59) and "parents give and teach the very young something without which growing up or even the living of a life becomes quite impossible" (p.60). The parents make the children feel safe in the world, and develop their own personality; thus they nurture, shelter and provide protection for the child. Parenting therefore "is something primordial which defies literal language and precise definition" (van Manen, 1990, p.61).

According to Palmer (1993) being a parent encompasses certain duties, obligations and rights. She also observes that parenting differs from one culture to another. In an article written by Harvey, (1997, p.1693-1694) in Canada, he noted that, "parenting is the key to our future as a nation and a society". Harvey, like van Manen, sees the principles of parenting as the need for attachment, nurturing and structure, applied to all children. These needs change dramatically as the children grow and develop. No specification is given as to whom a parent is.

Looking at the etymology of parenting, Anderson (1998) on the other hand does not see parenting only as 'giving birth and/or bringing forth' because there are others like grand-parent, step-parent, adoptive parent or a parent's partner. These people get involved in a child's life, contributing to the nurturing and socialisation of the child. According to Anderson (p.936) parenting therefore "is framed in terms of rights. It encompasses the custody and companionship of the child, opportunities to influence the child's values and moral development through religious training, and important education and health care decisions".

Therefore with the understanding of parenting if a child is sick and is to be hospitalised, this may cause stress on the parent and child. In a ward where the parents are not allowed free access to their child, the situation may worsen as, the need to parent is not something that can be suspended because the child is ill and hospitalised (Hardgrove, & Roberts, 1989). Depriving a parent of this role has the potential to be detrimental to both the child and parents or family as a whole (Darbyshire, 1993; Hardgrove, & Roberts, 1989; Robertson, 1970). Therefore, it is accepted that parents, (mothers in particular) should be able to live-in with their sick child in the hospital to counter the effects of separation.

3. The Historical context

This section reviews literature on the introduction of children's hospitals or specific children's wards in hospitals. Reasons for the exclusion (or restriction) of parents from the hospital are discussed, as are the changes of visiting policy to having parents live-in and the impact organisations and groups had on the change of policy.

Miles (1986) wrote a historiographic account on the emergence of sick children's nursing in the United Kingdom (UK). She noted that the first dispensaries were founded at the instigation of Dr Armstrong in the UK between 1719 and 1789, with the first dispensary taking effect in April 1769. These dispensaries, Dr Armstrong claimed, were charity instituted to bring relief to sick children. The purpose was to give advice and medicine to the children of the "industrious poor" (p.83). Dr Armstrong was totally against the admission of children into a hospital, which explains why he started dispensaries instead. His reason was that it was not convenient for the mothers to stay in the hospital to take care of the sick child. Secondly, the mothers and the nurses were "constantly going to be at variance" (p.83) with each other if mothers were allowed to live-in. According to Dr Armstrong, "if you take a sick child away from the parents, you break its heart immediately" (Miles, 1986, p.83). This implies that the psychological effects of separation on a child were known as early as 1769.

Contrary to Dr Armstrong's reasons for not wanting a hospital, Miles (1986) notes that Dr Charles West, who was a London physician at the time, was convinced of the need for a hospital to provide in-patient care. Dr West's experience while working at the Royal Universal Dispensary convinced him that outpatient treatment was not sufficient. He noted that the insufficiency of the outpatient treatment was more of a problem than the psychological trauma of separation and the danger of infection associated with admission to hospital. This was because the children were mostly from poor families and the unhygienic conditions and malnutrition prolonged the periods of illness, then increased the danger of infection. The first hospital for sick children in London (Great Ormond Street Hospital) was opened in February 1852.

According to Miles, (1986, p.83) Dr West's aims for opening the hospital were:

- To provide the reception, maintenance and medical treatment for children of the poor...
- To prompt advancement of medical science... and
- To disseminate among all classes of the community, but mostly among the poor, a better acquaintance with the management of children during illness.

These aims were adopted by the majority of the children's hospitals established following the opening of the Great Ormond Street Hospital.

Historically, hospital visiting policies have changed over time as discussed in relation to the development of dispensaries and children's hospital. Hospitals then were for the poor and the rich families who could afford home care never took their sick children to the hospital (Antice, 1970). The policy then was that when the mother took her child to the hospital, the child was handed over at the gate to the nurses, doctors and other health professionals (Antice; Shields, 1998). The mother went back home and was believed to be grateful that parting with her child was a price she had to pay for the child to get better. Antice also noted that the practice of separating a sick child from its mother was common only in the 'advanced' countries, which might explain why this policy was introduced in some paediatric wards in Cameroon only in the 1980s, and only in the capital city. Unfortunately by the time it was being introduced in some hospitals in Cameroon many Western countries were on the verge of wiping out this policy.

Robertson (1970) noted that historically in Western cultures sick children of the very wealthy were usually cared for in nursing homes and private wings of hospitals where their families had unrestricted visiting. This implies that these families and hospitals acknowledged that sick children were not to be separated from their mothers but such privileges were given only to the very wealthy. Therefore the poor who could not afford to pay for a private wing never had the privilege of staying with their sick child and had to suffer the effects of separation from their children.

In Third world countries such as Cameroon traditionally mothers were not allowed to leave their sick children alone in the hospitals, they took care of the child's other needs while the doctors and nurses dealt with the illness (Robertson, 1970). In contrast, in the Western world parents staying with their children and participating in their care in hospitals has been a relatively recent happening. Until the 1950s, parents had very little contact with their hospitalised children and were only allowed to visit once a week (Young, 1992). For example in Great Britain changes only started after the publication of the Platt Report in 1959.

The Platt Report

The Ministry of Health and the Central Health Services Council, London appointed a committee to write the 'Welfare of the Children's Report (known as Platt Report) on the 12th of June 1956. This committee was appointed as a result of the call for change by parents who were not happy with the policy of separating hospitalised children from their mothers and other issues surrounding children's admission into hospitals. The Ministry felt there was a need for the psychological and emotional wellbeing of the children in the hospital to be reviewed. The purpose of this committee was "to make a special study of the arrangements made in hospitals for the welfare of ill children as distinct from their medical and nursing treatment and to make suggestions which could be passed on to hospital authorities" (Platt Report, 1959, p.1). The recommendations made by this committee included alternatives to in-patient treatment for children; the admission of children to a children's ward; nurses be trained specifically to care for children; preparation of both children and parents for admission; the development of play and recreational activities, and lifting of restrictions on visits by parents.

3.1 The hospital visiting policies

Thomsen (1999) in a study done in New Zealand on 'making family-centred care a reality' noted that in the 1950s the children received skilled medical and nursing care when hospitalised but had very little contact with family members because visiting was seen as upsetting to the children. Restricted visiting policies varied from one country to another or one hospital to another. For example Moran (1963) noted that in some paediatric wards in United States, the hospital administration set visiting hours from 10 a.m. to 8 p.m. but allowed parents to visit their children at any time, to stay overnight if they wished, but no additional facilities were provided for the parents. This made it difficult for the parents to consider living-in. In some hospitals parents were allowed to visit their children only twice a week while in others they were allowed to visit daily but during certain hours only. In Cameroon the hospitals restricting visitors allowed parents to visit twice or trice daily and only during specific hours.

3.2 Reasons for the introduction of restricted visiting policies

In the majority of the studies done, very little has been said about parents who would rather stay at home than stay in the hospital with their hospitalised children. In Meadow's (1964) study some mothers did not want to live-in with their hospitalised child even though a bed was provided for them. Reasons included having other children at home; that they could not leave their husbands; that their husbands would not allow them stay in the hospital; fear of hospital and personal inadequacy. Some saw no reason to be in the hospital because they believed staying away caused no harm to the children as the children needed to be encouraged to be independent.

As mentioned above going to the hospital was considered a special privilege and in the best interests of the child since the children were most often from poor families. Hospital care was seen as a charity for the poor. Therefore there was no necessity for parents to be present as the hospital provided all that the parents could not provide for the child (Antice, 1970). The following were some of the reasons as to why the presence of parents was not welcomed in the hospitals.

3.2.1 Hindrance to treatment of the child

Antice (1970) and Thomsen (1999) noted that it used to be the general belief that separation of a child from its mother allowed the child to settle quicker, preparing him/her for treatment. The presence of the mother was believed to be a disturbance, obstructing the work of the ward and the children were difficult to manage in the presence of their mothers. The mother's presence was even seen as dangerous to the child as the nurses and doctors considered themselves better caregivers than the mothers (Robertson, 1970; Young, 1992). Visiting by parents was believed to unsettle the children and the mothers' visitation was seen as "sentimental and selfish" (Antice, 1970, p.1514). With all the good intention of the staff wanting to provide good care for the children in an undisturbed environment, nothing was known as to how this separation affected the child during or after discharge from the hospital.

Fagin and Nusbaum (1978) did a survey study exploring 'parental visiting privileges in paediatric units' in selected hospitals all over the United States of America (USA). They sent out questionnaires to 1,154 randomly selected hospitals and their findings showed that sixty two percent of the sampled parents indicated that they were permitted twenty-four hour visiting in paediatric units. In relation to unit size, census, age of children, diagnosis, or length of stay, there were no differences between hospitals that did and those that did not permit twenty-four hour parental visiting. But hospitals with highly qualified physicians and nurses were the ones most likely to restrict visiting on paediatric units.

3.2.2 Preventing cross infection

Hardgrove, in carrying out a study in 1971 for the World Health Organisation entitled 'examining family inclusive policies in England, Sweden, and Denmark' (Hardgrove, & Roberts, 1989, p.249), went to the children's ward of Great Ormond Street Hospital. This ward was one of the world's finest paediatric hospitals at the time. Mothers were seen sitting on rocking chairs, carrying their children, or playing with the children. This created a positive atmosphere in the ward but this positive atmosphere was gone just within ten years. The children were then restricted in their beds and mother's visits restricted. Asking why the mothers were now excluded from the wards she learnt that it was done in an attempt to "prevent the spread of contagion and to maintain discipline and quiet" (Hardgrove, & Roberts, p.249).

The maintenance of strict infection control was important for health professionals as it limited the spread of infection. This was seen as providing a good reason for keeping parents out since the hospital was seen as a "sterile" environment and any visitors coming in were seen as potential source of infection (Young, 1992).

The knowledge of contagion and antisepsis saved lives but the new dangers caused by separation became apparent. According to Reed and Zurakowski (1996, p.34), Nightingale in her nursing days "was vehement in her disbelief of the 'germ theory', and regarded 'contagion' as a word borrowed from poets that was connected 'with no end of absurdities'". In Nightingale's concept of nursing, clean air, sunlight, and quiet in a person's environment promoted health thus the chattering of visitors fatigued the patient and unnecessary contact with a patient's bed was a 'painful annoyance' (Reed, & Zurakowski, 1996). Therefore the idea of restricting mother's visiting seems to have originated from Nightingales' principle of quietness and that less contact promotes health and faster recovery. Despite the positive effects of having mothers live-in with their hospitalised children or have unrestricted visiting, there seemed to be an assumption that mothers do not disturb their own children

3.2.3 Disturbance to health professionals

Despite the many studies on separation and the negative effects on a child especially after discharge, the need for change had its own difficulties due to the way the health professionals and some parents viewed the change. Mahaffy (1964) noted that Wessel in his article 'why can't mothers stay in hospitals with their children' in 1963 commented that living-in parents were a problem to nurses, but they were beneficial to children. Mahaffy validated Wessel's comment after a small study of two children and their mothers in an effort to identify criteria for effective nurse-parent relationships. According to the findings some of the problems encountered when mothers were allowed to live-in with their sick children were the conflict of expectations. The conflict was between the nurse and the parent as they both felt connected to the child in a special way. Some nurses felt that encouraging parents to undertake more of their child's care was a shift of power. Although satisfying to parent and child, it was alienating and exclusive to the nurses. Darbyshire later confirmed this in his study done in 1994.

Seidl (1969) used a Likert-type attitude scale to examine the attitudes of 231 nursing personnel at a New York hospital toward parent participation in the childcare. The findings showed that the nurses with a higher ranking position (in the hospital), higher levels of education and those with younger children in their homes were the only ones who had more accepting attitudes towards parents. In this study there seemed to be a correlation between rank or qualification and behaviour.

Nine years later Fagin and Nusbaum (1978) presented findings contrary to Seidl. Their American survey showed that, "the lowest percentage of hospitals permitting twenty-four hour visiting on paediatric units was found in the Northeast Region. This region had the greatest percentage of highly educated physicians and nurses and the oldest traditions in both fields" (Fagin, & Nusbaum, p.24). Therefore Fagin and Nusbaum found that the higher the staff qualification the less contact parents had with their children when hospitalised.

Robinson and Thornes (1984) did a study in British Colombia examining the phenomenon of family interference in the health care of a sick family member. They noted that the background to the problem was that nurses saw parents as people "who demanded undue attention, criticised every care, complained about conditions, sabotaged the patient's compliance, and generally, made a nuisance of themselves" (Robinson, & Thornes, p.597). Some nurses viewed the families as "troublesome" and described family interference as "disruptive" to the orderly flow of ward routine, demanding precious time and energy rightfully belonging to the patient" thus frustrating the efforts of the nursing staff (p.597).

Hardgrove and Roberts (1989) also confirm that the presence of parents was seen as disruptive to the orderly flow of routine nursing practice, thus frustrating nursing efforts to give the best possible care. As Darbyshire (1992) noted, no thought seemed to have been given as to how the nurses and parents would experience this policy of having parents live-in or have unrestricted visiting rights. Little attention seemed to have been given as to what would be expected of the parents with regards to the care of the child and the nurses with regard the nursing practises when the child was admitted.

Despite the Platt Report of 1959 and the many studies done into the effect of separation of a child from its mother, Darbyshire observed as late as 1993 in Glasgow, Scotland that, in the relationship of nurses and live-in parents which developed after the 'post-Platt era', some nurses "tolerated" (p.1674) the parent's presence rather than actively encouraging them to stay with their child. Some nurses resented the presence of parents so much so that they used words to describe the parents such as, "thick mother", "lazy mother", and "troublemaker" (Darbyshire, 1993, p.1674).

3.3 The revision of policies in paediatric settings

Hardgrove and Dawson (1972) in a study done in the United States of America noted that many hospitals responded negatively to change. Hall (1978) in his study done in Swansea, Wales noted that difficulties do occur when the underlying reasons for change are either not known or not accepted. The author noted that the implementation of the Platt Report was slow as a result of too much emphasis on the psychological effects separation had on the child, while ignoring the sociological implications of hospitals as institutions, and the difficulty in effecting changes within such a place.

Hardgrove and Roberts (1989) discussed the history of family involvement with hospitalised children. They presented some early studies on the negative effects of separation on the child and the family as a whole. The knowledge about the need for family support during a hospital stay and the dangers of separation moved institutions and parents to change. Despite the slow take off, parents are eventually allowed to live-in.

According to Young's (1992) case study done in Toronto examining changing attitudes towards families of hospitalised children from 1935 to 1975, he noted that some hospitals introduced living-in of parents because power was passed from the physicians to the hospital for administration of paediatric services. Young holds that the need to improve public relations rather than the impact of psychological research led to the acceptance of family presence on the wards.

Darbyshire (1993) noted that the change to unrestricted visiting rights and allowing parents to live-in came as a result of recognition of the lasting psychological and emotional effects separation had on the children. Despite the decline of infectious diseases because of improved housing and hygienic conditions and the introduction of antibiotics and technological advancement, these factors seem to have had very little influence on the pressure for change.

The struggle for change of policy in paediatric settings has been like many other social movements, which have taken place in the course of time. In spite of the recognition of child-parent separation anxiety as the major cause for change, other factors such as introduction of surgical procedures and techniques; health education; ambulatory care and home care; parents wanting to live-in, consumer rights and the introduction of antibiotics all had their influences on the change of policy.

In Cameroon the policy of not having parents' living-in with their hospitalised children has gradually been abandoned in most of the hospitals that were not allowing parents live-in due to various reasons. For example the hospital where the present study was done now allows parents to live-in with their hospitalised child, with exception of neonatal unit where the parents only have visiting rights.

3.3.1 The effects of separation on the child and parents (Separation anxiety)

Separation anxiety is seen as one of the major reasons for the change of hospital visiting policy. Bowlby (1995) noted that when a child is deprived of maternal care over a period of time, the child's physically, intellectually and socially development is retarded and the child may manifest symptoms of mental illness. An example given was the war orphans and refugees where children of all ages were separated from their families taken from around Europe to be cared for in Switzerland. This separation had tragic effects on the children who were being separated from their loved ones. Some of the symptoms the children manifested were, "a feeling of emptiness, bedwetting, stealing and inability to make relations and aggressiveness" (Bowlby, 1995, p.44). Based on what Bowlby observed he described three stages of separation anxiety, which the children went through: protest, despair and detachment.

According to the Platt Report (1959), there is more than one form of separation and not all types of separation are harmful to either the parent or the child. Hospitalisation of sick children alone, contrary to other forms of separation, has been recognised as a stressful experience especially for children and their parents (Caty, Ritchie, & Ellerton, 1989; Darbyshire, 1993). This form of separation appears to be more detrimental to both mother and child, causing more anxiety and fears than any other separation.

Mahaffy (1964) in a small study of two children and their mothers identified that separation brought about failure to thrive in the child and recovery from any health condition was slow. Despite the small sample used his findings were similar to other studies done later using a larger sample such as Fagin and Nusbaum's (1978) study done using 1154 hospitals all over the United States of America. Fagin and Nusbaum discovered convincing evidence that the "presence or absence of the mother figure is itself a condition of the greater significance in determining a child's emotional state" (p.24). Therefore, a mother present in anxiety-provoking situations gives a child additional confidence and can increase favourable outcomes.

Palmer, a Staff Nurse with the adolescent unit of Bristol Royal Hospital for Sick Children did a study on the care of sick children by parents. The findings showed that "maternal deprivation and separation anxiety expressed by children are detrimental to a child's recovery in hospital" (Palmer, 1993, p.185).

According to Whitis' (1994) study examining visiting hospitalised patients, the most prevalent visiting hours were 7 a.m. to 9 a.m. and somewhat less frequent were the spans 8 a.m. to 8 p.m. and 10 a.m. to 9 p.m. Only 16% of hospitals allowing visits to paediatric wards all through the day or night. Nurses, according to Whitis were the professionals who implemented such policies and often made decisions to grant exceptions to the policies. The hospital-visiting policies that limited time spent by the family with a hospitalised family member, increased the stress experienced by parents.

According to Bar-Mor (1997) children perceive hospital as a place with difficult and unpleasant trials, which are forced on them, and they are compelled to experience and cope with the difficulties. Furthermore some children see their sickness as punishment for a sin committed so treatment is just a punishment method (Bar-Mor) therefore hospitalising them without their mother confirms their fears.

Clatworthy, Simon and Tiedeman (1999) noted in their study that children get very anxious when hospitalised, unfortunately the degree of anxiety experienced is not known although behaviours such as crying, aggression, anger, withdrawal, bed wetting and sleep disturbance have been recorded, similar to Bowlby's (1995) findings.

3.3.2 Change of attitudes by health professionals

The change from restricted visiting to unrestricted visiting and a live-in situation has come a long way. Many health professionals have recognised the positive effect of having parents live-in with their sick children.

Webb, Hull and Madeley, (1985) in Nottingham, noted that the paediatric wards that had live-in parents were more economical to manage, the children were less disturbed, the confidence and competence of parents reinforced, and fewer nursing staff were needed. In this ward the nurses and medical staff carried out the procedures requiring skills and knowledge while the mothers gave the daily cares needed by the child. Because of the increased awareness of the importance of parents' influence on recovery of a sick child, many paediatric wards, especially in the Western world, have moved from restricted parental visiting to a liberal system where parents either live-in or visit at will (Darbyshire, 1993).

Darbyshire (1994a) in his study done in Glasgow, using interpretive phenomenology to explore the experiences of parents and nurses living with a sick child in the hospital noted that nurses previously saw encouraging parents' involvement in the care of their sick child as handing over what was traditionally nurses' responsibility to parents. Now the idea of perceiving parents negatively or as someone taking over their responsibilities had changed and parents are seen as partners in care. Some nurses, as Darbyshire notes, feel comfortable now with parents in the ward.

3.3.3 The effects of the knowledge of infection and advanced procedures on change

As discussed previously one of the reasons for restricting mothers visiting when their children were hospitalised was the belief of the risk of cross-infection. Pickerill and Pickerill (1946) gave an account of the practise in their surgery clinic, during a five years period and its effect in reducing cross-infection. According to the authors when the babies and their mothers were both admitted this kept the baby and mother happy in their room. In this situation the possibility of cross-infection was very reduced because the child was isolated from other children but happy with its mother. Because of the reduced contact with others there was reduced cross-infection.

Darbyshire (1992), in reviewing literature on parents, nurses, and paediatric nursing, noted that infectious diseases diminished in prevalence as a result of the introduction of antibiotics. The use of antibiotics reduced the rate and length of treatment of infections (Cleary, 1992; Cleary, et al., 1986). Children's admissions into hospitals reduced and when they did get admitted, their length of stay shortened hence the isolation or exclusion of parents was no longer needed. Also the rationale for keeping parents out on the basis that they would introduce infection could no longer be applied. Although the decline of infection due to the introduction of antibiotics was not recognised in the many studies done in effecting change in visiting policies in paediatric settings it has reduced the inconveniences of hospitalisation for parents.

The work of Louis Pasteur on bacteriology (Burnett, 1981) and others on the causes and spread of disease, made hospitals a place where people got better rather than died. Immunisation programmes made great advances against infectious diseases and with these advances some pioneers discovered that there was a place for mothers in the hospitals with their children (Cleary, 1992) therefore influencing the change in visiting policies. The advances in technology have made possible for procedures such as radiology, transfusions and infusions, surgery of blood vessels, thoracic surgery, cardiac surgery, neurosurgery, orthopaedic surgery, urology, abdominal surgery, transplantation and plastic surgery.

The effects of health education on change

Health education has had a positive effect on change of policies as, not many children are being admitted into hospital. Even when they are admitted it is for a shorter time. In New Zealand for example, the community nurses including public health nurses and Plunket nurses have done a lot in improving the health of the children thus reducing their admission rate to hospitals (Department of Health, 1985).

3.3.5 The rationale of parents wanting to live-in and its effect on change

Mahaffy (1965) studied the effects of hospitalisation on children admitted for tonsillectomy and adenoidectomy. He identified some problems such as "the coolness and aloofness of hospital environments" (Mahaffy, 1965, p.12) as being very upsetting to parents. Some parents felt that the staff were not interested in their child therefore they needed to be present for their child. Secondly nurses were skilled at providing physical care but not emotional care. Because the parents felt the emotional needs of their child were not being met, they were unhappy and this resulted to hostility towards the staff. Thirdly the behaviour of the doctors and nurses did not permit open communication with the parents because they always seemed busy. This made the parents feel as though there was little concern for the child's fear of procedures or separation from the mother.

Darbyshire (1992) used interpretive phenomenology to explore the experiences of parents living-in with their hospitalised children and their relationships with paediatric nurses. Some of the reasons parents gave for wanting to live-in with their children when hospitalised were that parents travelled from very far and going between their home and hospital was very expensive. They felt the need to be with their child to provide daily cares or to breast-feed and to be available in case there was a need to consent for any treatment. They felt being present protected the child from any possible effects of hospitalisation. For some parents the decision to live-in was almost automatic (Darbyshire).

Imai (1997) did a study in the Japanese Red Cross Medical Center using Leininger's ethnonursing method to explore the views of Japanese mothers attending hospitalised children. Six mothers who were with their hospitalised children, fourteen staff members including nurses, physicians and nurse aides were contacted for the study. According to Imai, the reasons why mothers wanted to live-in with their hospitalised child included the desire for mothers to be continually with their children, some mothers wanted to be there to do everything because they thought the nurses were too busy therefore they could not leave their child alone, and others were there as assurance of life for their children. Despite the different periods and countries between Darbyshire (1992) and Imai's (1997) study, they had similar findings as to why mothers wanted to live-in with their hospitalised children.

Consumer's rights

Swanwick (1983) noted that most of the parents who formed the National Association for the Welfare of Children in Hospital (NAWCH) were parents with previous bad experiences in hospitals. Their aim, apart from monitoring the implementation of Platt Report, was also to work in a constructive and reconciliatory way with the hospital. According to Hardgrove and Roberts (1989), in some paediatric wards in USA changes have come about because of pressure from consumer groups, especially mothers, who felt frustrated at the care given to children in the hospitals. One of the groups formed to fight for change was an organisation called Children In Hospitals (CIH) whose main aim originally was the concern for breastfeeding mothers, and later included all interested mothers. Swanwick (1983) and Darbyshire (1992) noted that the group NAWCH formed in 1961 now called Action for Sick Children, developed as its aim to monitor and report on how the Platt Report was being implemented.

According to Thomsen (1999) one of the motivating factors for the struggle for their rights was that the parents wanted a high quality and accessible health service at the least personal cost. A lot of changes have taken place in paediatric wards because of the struggle of parents fighting for their children. Hospitals or wards that had restricted visiting policies were being criticised because it was believed they ignored the negative effects separation had on the child and even the parents. Many studies were being published and many parents in different countries also formed groups to fight against this policy.

4. The introduction of parents and their experiences as living-in parents

Meadow's (1964) study showed that neither social class nor the age of the child was found to be a relevant factor in the decision by a mother to live-in but the more children the mother had, the less likely she was to accept hospital accommodation for herself. Mahaffy identified that the mother was seen as the one who cared for the child, assisting in the performance of those activities that contribute to the child's health or recovery. The mother, therefore, considered herself capable of being an active participant in the child's care in any situation, therefore being in the hospital was a necessity not a choice.

Four years later Meadow (1969) did another study in London, over a period of two and a half years. Using a qualitative survey approach he explored the experiences of mothers, medical and nursing staff from three different hospitals. The aim of the study was to find out how mothers felt about staying in the hospital with their sick child and at the same time medical and nursing staff were asked for their views. 130 mothers were interviewed and 60 of them were subsequently reinterviewed.

The findings showed that wards provided limited accommodation for mothers and no privacy or any means of entertainment such as television was provided. The mothers complained of boredom, of being the sole company for the child, and of looking forward to discharge to end what looked like "a long prison term" (p.363). Some felt worried about household affairs, lack of information about investigations and procedures done on their child and that they feared to ask questions because of the "authoritarian structure of the hospitals" (p.364). Some mothers felt themselves to be on trial, guilty and responsible for their child's sickness and often hesitated to touch their child and felt bad because they were sometimes "criticised as being lazy, untidy or leaving all the nasty things for the nurses to do" (p.364).

Meadow (1969) also noted that despite all the difficulties some of the live-in mothers faced in the wards they usually gained confidence later on and their children reported a better post hospital adjustment on their return home. Mothers of children in the same ward made friends and supported each other especially if a child was very ill or dying. On the other hand it could be detrimental being in the same ward when a child was dying or having just died with a similar disease to their child (Anstice, 1970).

According to Elfert and Anderson (1987) a hospital is a complex environment and encouraging parents to live-in with their child tends to minimise the implications, for both parents and paediatric nurses. Therefore as Hall (1978) noted, "the process of opening wards, where children are nursed, to parental visiting is still incomplete" (Hall, p.25). According to Hall the policy of accepting unrestricted parental visiting was good but it was not the sole answer to children's distress in hospital. Although parents were allowed to live-in or have unrestricted visiting some problems still existed in paediatric units.

Some parents in the hospital found themselves confused, uncertain, reluctant to interfere, helpless, feeling lonely and guilty, feeling threatened and inadequate when confronted with the complex nature of their child's condition and were often unaware of what was happening (Darbyshire, 1994a; Nielsen, 1990). They did believe that if they were well informed they would play a better part (Webb, et al., 1985). Some parents stated that being a parent of a sick child changed their whole lives and that only a parent who had a similar experience could truly understand what it meant (Hayes, & Knox, 1984).

Historically some studies identified that parents could cope better with their children's hospitalisation if they were prepared on admission and they were better able to help their children through the hospital experience as is evidenced by the children's reaction (Mahaffy, 1964; Moran, 1963; Seidl, & Pilliteri, 1967). Parents wanted to be useful within the professional team, because as one parent observed in Nielsen's (1990, p.19) study "working with parents can lessen those difficulties, help the parents and improve the care of the child".

The nursing profession had recognised the importance of the children's psychosocial needs as well as their physical care; the greatest of these needs being to maintain close contact with their families, whose presence was expected and welcomed (Cleary, 1992). Parents were being encouraged to participate in the care of their children while in the hospital. It was recognised that the most essential aspect to successful non-damaging hospitalisation was in involving parents (Cleary).

5. Conclusion

This chapter has reviewed literature in relation to studies done on the care of a hospitalised child. Most of the literature available is from the Western world; access to literature from developing or Third world countries was limited. But looking at the available literature, there seem to be issues in both systems (restricted visiting and open visiting) common to the developed as well as developing countries. My study examines the parents and nurses' experiences in paediatric ward in a hospital in Cameroon where some parents live-in and some only have visiting rights as there seem to be no studies on a similar topic done in Cameroon. The next chapter outlines the method used, the raison d'être for the choice of method and the difficulties of doing research in a developing country, specifically Cameroon.

Chapter Three: Research Method

I. Introduction

Since the aim of the research is to explore the experiences of parents and nurses, a qualitative design would gain the perspectives of both parents and nurses as qualitative research is concerned with humans and their environment in all their complexities (Polit, & Hungler, 1989). Qualitative research encompasses a variety of designs and methods. These designs and methods share similar features such as: recognition of human realities, focusing on human experiences, the researcher maintaining contact and getting involved with the people in their natural environment, and the data producing rich descriptive, usually narrative information of the people living through events in various situations (Munhall, & Boyd, 1993).

The method used in this study involved the use of semi-structured interviews and participant observation to help enrich the data (Holloway, & Wheeler, 1996). According to Rountree and Laing (1996) the use of more than one technique for collecting data is useful to improve credibility of the research. Taking of photographs was another technique that was going to be used for collecting data as photographs provide the visual images of experience and visual knowledge about various human conditions (Hagedorn, 1994). Unfortunately this ran into some difficulties as will be explained later.

This chapter gives a description of the research method used and its justification. The chapter also presents the techniques of collecting data, the strengths and limitations of using these techniques, a review of methods used in previous studies and the process used for collecting data. The data collected have been analysed using thematic content analysis as outlined by Burnard (1991). The ethical issues involved are also discussed.

2 Methodology Review in related studies

In the research world today different researchers use different research approaches to achieve their objectives and this depends mostly on their interest and question. The most commonly used approaches are either quantitative or qualitative although some choose to use both. Polit and Hungler (1995, p.15) note that "there is no single right way to understand our complex world". Using both methods can contribute to the improvement of nursing practice. According to Polit and Hungler (1989, p.312):

> A debate has emerged in recent years about whether qualitative or quantitative studies are better suited for advancing nursing science, but there is a growing recognition that both approaches are needed. The most balanced perspective seems to be that the degree of structure a researcher imposes should be based on the nature of the research question.

Meadow (1964) used interviews to find out reasons why some mothers refused the offer of a room in the hospital with their sick child. Meanwhile, Hayes and Knox (1984) used a qualitative research design in Canada to explore parent's experience of stress. Caty, et al. (1989) used an exploratory descriptive method to explore mother's perceptions of coping behaviours in hospitalised pre-school children. Miles and Frauman (1993) did an exploratory study on the nurses' and parents' negotiation of care roles in USA. Darbyshire used interpretative phenomenology (1994a) to explore experiences of parents living with sick children and nurses in UK and a mini-ethnonursing method was used by Imai, (1997) in Japan to explore the views of Japanese mothers with hospitalised children.

Other researchers used a quantitative approach to meet their objectives. Fagin and Nusbaum (1978) used a survey method where they distributed questionnaires to randomly selected hospitals in the USA to identify the extent of unlimited visiting for parents in paediatric services. Whitis (1994) also used the survey method to find out how visiting policies affected patients and their families in USA.

Dearmun (1992) on the other hand chose to use both descriptive and survey approaches to compare the perception of parents and nurses towards the parents' contribution to the care of their children in hospital in UK. Shields (1999) used both methods also to do a comparative study of the care of children in hospital in developed and underdeveloped countries. She used Australia and Britain as the developed countries and Indonesia and Thailand as the underdeveloped countries.

Qualitative methods seem to have been used in most of the studies as can be seen above, the simple reason being that most of the studies done were descriptive or exploratory in nature. A qualitative approach, as stated earlier, is most suited when researching in a naturalistic situation and it is suitable because it can be used to best describe the phenomenon.

3. Justification of method

This study used semi-structured interviews and participant observation as methods of collecting data and thematic content analysis to analyse the data. Qualitative research is based on the belief that knowledge is socially constructed (Holloway, & Wheeler, 1996) and that "knowledge about humans is not possible without describing human experience as it is lived and as it is defined by the actors themselves" (Polit, & Hungler, 1989, p.312). The researcher develops understanding of human experiences. For health professionals this understanding is important because in their work they focus on caring, communicating and interacting with people (Holloway, & Wheeler, 1996), therefore focusing on the whole person (holistic view).

Unlike quantitative methods or surveys, the process of qualitative interviews used in this study permitted the participants to describe their experiences better given the high level of illiteracy of the participants. Language errors linked to reading and understanding questions in their context and providing responses was avoided as the researcher had personal contact with the participants.

When using a qualitative method, the researcher tries to examine the experiences, feelings and perceptions of the participants and aim to uncover the meaning people give to their experiences. Thus only participants who are experiencing the phenomenon of interest are selected (Holloway, & Wheeler, 1996). This study aim was to analyse the natural, everyday lives of my participants in the hospital setting as Holloway and Wheeler suggests focusing on their experiences. This aim could therefore be better met using a qualitative approach to data collection and analysis.

3.1 Interviews

Using interviewing as a means of data collection is often justified in terms of several qualities. In qualitative research the use of interviewing allows the participants to speak in their own words, and not in the words of the researcher (Sarantakos, 1998). Interviews encourage subjectivity and intensive dialogue between the researcher and the participants, overcoming some barriers. To know how people understand their world and their life, the best way is to talk to them. In an interview the researcher listens to what people themselves tell about their lived world, hears them express their views and opinions in their own words (Kvale, 1996). Silverman (1993, p.114) notes that "interviews share ... an involvement in moral realities. They offer a rich source of data which provides access to how people account for both their troubles and good fortune". An interview, according to Kvale, (1996, p.2) "is literally an 'inter view', an inter change of views between two persons conversing about a theme of mutual interest".

3.1.1 Strengths of using interviews

There are many advantages of using interviews as a means of data collection. Interviews can be flexible because the researcher can adjust the format to meet diverse situations and this may produce new insights and awareness (Bailey, 1978; Kvale, 1996; Sarantakos, 1998). This research technique attracts a high response rate since the researcher makes personal contact with the participants. Interviews can be used to reach those people who may normally be unreachable with other sampling techniques such as the rich and secluded people, or the very poor (Bailey, 1978; Polit, & Hungler, 1989; Sarantakos, 1998; Seaman, 1987). This was an added advantage for this study as I was there to explain and answer questions, or doubts before the scheduled time of interview.

Interviews are easy to administer since it does not require the participant to be able to read or handle complex documents. Therefore it can include children, blind and the very elderly (Polit, & Hungler, 1989; Sarantakos, 1998). This was particularly good for my participants since some of them were not able to read or write. Furthermore, because it was easy to administer, it is less intimidating.

Using interviews provides the opportunity to observe non-verbal behaviour and the opportunity to record spontaneous answers (Polit, & Hungler, 1989; Sarantakos, 1998). Some participants use body language more when trying to express themselves, therefore interviewing permits the interviewer to get this aspect of the data, which is missed if questionnaires are used. For example it was easy to note how certain points were emphasised and the pauses and duration. As well most often when a question is asked, answers are given spontaneously. The interview gives a better chance to get this type of spontaneous answers. Interviews are less prone to misinterpretation by the participants because the interviewer is present and can determine whether the question was misunderstood or not and a better clarification to the question can be given if needed (Polit, & Hungler, 1989).

3.1.2 Limitations of using interviews

Despite the advantages, interviewing has its limitations. Interviews can be costly and time-consuming (Bailey, 1978; Kvale, 1996; Polit, & Hungler, 1989). It takes more time and resources to prepare for the interviews, carry out, and transcribe and analyse the interviews. This was a problem encountered in this study as all the interviews were undertaken in French and transcribed into English, thus using more time than estimated. As well interviewing in a different language and transcribing in another language could be a problem as different words carry different meanings in different languages. Bulmer (1993a, p.12) notes that the meaning of words is seldom identical across cultures, for example, 'friend' in English, 'amie' in French and 'amigo' in Spanish all have different meanings.

Another disadvantage is that the participant and the interviewer may develop 'stage fright' (Field, & Morse, 1985). Some participants may feel threatened by the use of tape recording and vulnerable by the type of questions asked. The researcher may have problems settling into the first interviews and also feel frightened asking certain questions. This was evident in my first interview as a participant was very willing to take part in the study but when I mentioned audio-taping she was a bit withdrawn. I had to go over the conditions for her participation again to gain her confidence and willingness to participate.

Interviews offer less anonymity than using questionnaires since the interviewer may know the identity, and sometimes the residence, family conditions and other personal details of participants (Bailey, 1978; Polit, & Hungler, 1989; Sarantakos, 1998). This was not much of a problem, as the participants wanted to be interviewed in the hospital, not their home, and asked me not to mention their names in the report before they would participate.

Interviews might be less effective when sensitive issues are discussed because some people prefer to put their sensitive issues in writing (Sarantakos, 1998). This was not a problem as the participants saw me as one they could confide in and discussed their personal feelings since I was neither one of the staff nor a family member. They felt I could understand their feelings. Again some could not write, as they were illiterate.

In collecting qualitative data, interviewing is considered the main source of data collection but there are limitations. To reduce these limitations and further enrich the data other methods are used. For this study, semi structured interviews as well as participant observation were used.

3.2 Participant observation

In using this method the researcher, according to Byerly (1969), becomes an instrument. In the research participant observation allows the researcher to study people in their natural environment with less potential impact on their behaviour as a result of the presence of the researcher. It provides detailed and rich information about a particular group or situations in an open and flexible way. When doing observation certain things that are taken for granted and information that cannot be given verbally can be discovered (Langley, 1994).

Byerly (1969, p.236) notes that the process of participant observation:

> Involves a sensitive awareness of the behaviours of the persons being observed, similar insight into the investigator's own actions and reactions, a careful and complete recording of these events, and retrospective evaluation and analysis of the data. The professional nurse researcher, who recognises and makes use of the multiple facets of the participant observer role, can engage in behavioural research concerning members of her own nursing profession and maintain the objectivity and integrity which such research demands.

3.2.1 Strengths of participant observation

The advantages of participant observation include that participant observation yields a deeper and richer understanding of human behaviours and social situations than is possible with structured procedures because of the ability to "get inside" (Polit, & Hungler, 1989, p.208) a particular situation and understand its complexities.

Participant observation provides information against which to cross check all other data collected throughout the period of the research (Byerly, 1969; Mahr, in Sarantakos, 1998). As I observed the nurses and parents through the time I was there, I could see how busy the nurses were running between patients and rooms, and how disgruntled or happy some parents were. This either challenged or confirmed the information obtained from the interviews.

When involved in participant observation the researcher approaches reality in its normal or natural structure, seeing first-hand a wider range of information without relying on the reports of others, due to the close interpersonal relationships that, may develop between the researcher and the participants (Byerly, 1969; Mahr, in Sarantakos, 1998). By being present and observing what was going on, I was able to get data from one nurse and one parent (a grandfather of one of the hospitalised children) who were not taking part in the study which enriched my data. For example this nurse made this observation in my presence:

> *I feel sorry for the mothers who have to leave their babies here and go home because they feel embarrassed and uncomfortable telling the neighbours who come to visit the new baby where the baby is. So you see the problem actually has to do with visitors coming to their home every now and then. That is not easy in our type of society where immediately neighbours hear you have a baby they rush to your house (Field notes).*

The grandfather said:

> *I don't know why this people [the staff] in this hospital want to keep my grandson here. You see his father could not bear staying at home with his baby here so he came in yesterday and threatened them [staff] until they had to let him sign out his baby [laugh]. Interestingly just when he was about signing, they discovered that he still had a bill to pay and that made him angrier as he could not understand why they were keeping his baby and now wanted him to pay a bill when actually his baby was not sick (Field notes).*

This data re-emphasises some of the issues raised in the interviews. This nurse viewed keeping mothers out of the neonatal unit differently from some of her colleagues. She viewed it from the mothers' perspective living out in the community without a baby after just giving birth.

3.2.2 Limitations of using participant observation

Participant observation cannot be employed when studying large groups because research participation tends to increase, it takes time and energy, and therefore significant items may be overlooked (Byerly, 1969; Mahr, in Sarantakos, 1998).

Observer's bias, selective perception and selective memory affect participant observation since the observer is part of the situation being observed. The findings from participant observation cannot be generalised (Byerly, 1969; Mahr, in Sarantakos, 1998).

4. Method and process

There are no strict rules for sampling size in qualitative research but the sample size should be enough to meet the aim of the study and help in the understanding of the research problem (Polit, & Hungler, 1999). Therefore an information-rich data source is necessary to better understand the phenomenon under study. In this research the participants were parents who have or have had a child hospitalised in the paediatric ward for at least three days and nurses who have worked in the paediatric ward for at least six months. Participation was voluntarily after the explanation of the conditions of participation. The conditions included audio-taping the interviews. All participants were informed of their rights to refuse to answer any question or withdraw from the interview and study at any time.

4.1 Study setting

A setting suitable to get enough information from participants was chosen. Participants were accessed from one hospital. The participants were parents with restricted visiting rights only, parents (most often the mother) living-in with the hospitalised child, and the nurses.

4.2 Data collection

In this study two techniques (semi-structured interviews and participant observation) were used for collecting the data to improve credibility and further enrich the data (Rountree, & Laing, 1996).

4.2.1 Difficulties doing research in a developing country (Cameroon)

According to Bulmer (1993b), a researcher researching in a developing country faces difficulties because the activities and the role of researchers are not widely recognised and very little is known about research. In addition the problem of limited resources, illiteracy, geographical and cultural differences between the population renders the average citizen ignorant of the activities of a researcher or interviewer. Therefore asking people to participate in an interview necessitates a lot of time for explanation. This may be due to misunderstanding, especially with regards to the purpose of the interview by the participants.

Peil (1993) notes that in carrying out research in a developing country, getting permission to access participants often takes a long time and that is because the "governments or gatekeepers" (p.73) must be convinced the project does not threaten their position or conflict with their interests. At times it may need intervention from influential persons. It may be more difficult if the researcher is of a lower status. Furthermore few bureaucrats or leaders have any training in research hence are less likely to see the results as of much potential benefit to themselves. They see academic researchers as people not providing support for the government initiatives. Researching in a developing country can be very time consuming.

In carrying out research in all countries, the researcher has to be aware of certain difficulties such as the sensitivity of the people he/she is researching. Some questions may be offensive or embarrassing to the participants and they may be reluctant to answer (Bulmer, & Warwick, 1993). For example asking some women their age, their marital status and how many children they have may be embarrassing for them in some cultures.

Problems encountered

After obtaining ethics approval from the Massey University Human Ethics Committee, a letter was sent to the Director of the hospital proposed for this study. A reminder letter was sent a few months later as no reply was received. A second reminder was sent four weeks before my date of departure from New Zealand. There is a general belief in Cameroon that 'silence means acceptance'. With that concept in mind I decided to proceed, planning to obtain official consent on arrival if necessary.

I arrived in the capital city (Yaounde) on Saturday and on Monday I went to the hospital to see the Director and announce my arrival. Unfortunately for me on that Monday, the nurses (supposedly all over the country) were on strike. The Director came in late as he was busy trying to convince the nurses of his service not to join their colleagues in the strike. The secretary told him I was waiting and I was asked in. I introduced myself and talked to him about my research.

We had a long discussion and he said he was not sure how my research was going to benefit the service. I explained once more the aim of the study and that they were going to be given a copy of the report written after the study was completed and that might be used as an evaluation tool or as they wished. All my explanations given were in vain as he told me I could not collect data in the service. I tried to inquire why he did not send me such a reply earlier so that I could make alternative arrangements but no reason was readily available. I took time to explain to him once more about my study, my interest in the topic and the justifications. He told he was going to contact me after discussing my study with his paediatricians. Unfortunately I waited for a week and nothing was forthcoming. I unsuccessfully tried to contact him.

Having travelled all the way to Cameroon I had to start other arrangements to be able to collect my data. Through personal contacts, I went to the Director of another hospital. He very willingly let me collect my data in the hospital. On the spot he gave a verbal consent and asked me to proceed to the ward while the secretary was preparing written consent for me to collect later.

The hospital I had chosen previously is open to people of all social classes as financial and geographical access to that hospital is easy. According to my research proposal, I was supposed to use three methods to collect data, that is interviews, participant observation and photos. Having worked in that service, I knew using the three methods was possible and I was certain of the rich data I could get using those methods. Unfortunately I had to change to a new setting where access is relatively difficult as only the financially viable are able to take their children there. Unlike the other hospital, parents are required to pay for services and treatment.

The parents, although pleased to share their experiences with me, were not willing for me to take any photos of their children. Due to the financial cost, my participants were mostly of a higher socio-economic class. The less privileged majority that could not afford to take the children to this hospital were not given the opportunity to take part in the research.

4.2.2 Accessing participants

The first two days in the field were set aside for contacts with the Director, the head of service of the paediatric service and the ward charge, to familiarise them about the intended research and also to visit with the parents.

After making initial contacts, parents who had sick children in the hospital for at least three days were asked if they would like to participate. Those who were willing to participate were invited on the basis that they had a story to tell since they had been there for a number of days and knew a little more of what was going on around them. Paediatric nurses who had worked in the ward for at least six months were asked if they would like to participate. For those that accepted the invitation to participate, appointments were made at convenient times. The interviewing was not initially planned to take place in the service but the participants requested it to be done there. The interviews with the parents were done mostly in the evenings when there were no visitors around and the children were asleep. For the nurses it was done either when they had finished a shift or just before they started the shift in order not to disrupt the normal activities of the service.

All the interviews with the parents were completed before starting with the nurses. This was to give assurance to parents that their participation had no consequences on the care of their child. An explanation of the intended study was given to the parents first and then the nurses since I started interviewing the parents first.

The information prompt sheet (see appendix A) was used to make sure that the information needed was covered and verbal consent was obtained and audio-taped. The reasons were that some of the parents could not read or write so giving them the information sheet could have been embarrassing to them. As well the nurses did not have the time to read and understand the information sheet due to their busy work schedule so a prompt sheet was time-saving and appropriate.

The data collection was over a period of two months and I interviewed twenty-one participants of whom six were nurses and fifteen parents. The following methods were used to collect the data: interviews and participant observation.

4.2.3 Interviews

After obtaining verbal consent, we mutually agreed on a time and place for each interview. For the parents it was either the room where they were in with their children when it was not full or the children's play room. For the nurses it was mostly in the nursing station or the kitchenette. The interviews were all in French, as there was no child of English-speaking parents hospitalised at the time the study was conducted. Cameroon has French and English as official languages and I am fluent in both. During the interview I was observant to note how the participants were coping so that I could stop when the participants seems bored or tired and uncomfortable. For two of my participants I had to stop the interview for a while as the participants were in tears. Therefore the length of the interviews was determined by the way the participants were coping as the interview went on. This explains why some of the interviews were not as long as expected, about 30 minutes, while others went over 60 minutes.

I started the interviews by asking the parents about their experience of going to the hospital with their child for admission. The interview was geared towards supporting the parents in the exploration of their feelings, perceptions and thoughts (Holloway, & Wheeler, 1996). I used prompt questions, listened to them without interruption and let them ask any questions they wanted to, or challenge anything they felt like.

4.2.4 Participant observation

As Bailey (1978) observes, participant observation may be a continuum with the researcher involved in the activities being observed with his/her role not generally known to the other participants. At the other end of the continuum the researcher may not participate in the setting and may just observe and which is what I did. I sat or moved around observing the nurses, parents and the general setting or what was going on in the ward.

I checked on the notice board in the nursing station and also with the ward charge to see the total number of nurses in the service, the number of nurses running each shift and the nurse/patient ratio. The service had 18 State Registered nurses, two Nurse Aides and three doctors (two paediatricians and one general practitioner). There were three nurses on permanent morning duty (including the ward charge). They work from 7.30 a.m. to 3.30 p.m. They oversee the running of the service and take care of the documentation. There were two groups of nurses running the shifts. There were only two shifts, that is the shift that starts at 7 a.m. and finishes at 5 p.m. and the next shift starts from 5 p.m. and finishes at 7 a.m. the next day. Three nurses were rostered on each shift.

I observed how the nurses did 'handing over'. It was done mostly in the nurses' station with the nurses going to the rooms only when there is a new patient or a patient that had some concerns during the shift.

The mothers living-in attended to the children. They fed, washed, played and read to their children and the nurses went to a child most often only when there was a treatment to be administered or to check or inquire something from the mother. Children aged 2 years and above who were well enough to run around, played with the few available toys while the mothers watched them. Most of the children wore their own clothing.

In the paediatric ward the mother's bed is next to the child's. Although the mothers were provided with beds, the rooms were never full. As one parent confirmed, this might be due to the fact that it is very expensive bringing a child to the hospital. As well it is at the outskirts of the town where access is difficult. The children were fed but not the mothers' living-in. They had to feed themselves. The service has a kitchenette but mothers are not allowed to use it. They can only go there to put or take feeding bottles. Each room has a toilet but there is no place for a shower.

Most of the interviews with the mothers living-in were conducted when the child was sleeping. On one occasion the child got up and was crying so we had to stop and the mother resettled the child before we could continue. As for the mothers of the neonatal unit, some came from home and we had the interview in the children's play room and for those mothers still in the maternity service, I went there in the evening and we had the interview in their rooms. Each bed in the maternity service is screened so there is no direct contact with other mothers.

The children seemed very relaxed with the mothers present. With no specific person to regulate visitors, some of the nurses were very busy during visiting hours, as they had to go round the rooms often to check the number of visitors and send some out if there were more than two visitors per child. On the whole the parents and nurses seemed to have a good relationship. There were some parents who were always asking questions and some nurses though always busy, tried to answer and explain things to those parents. The observation occurred over the two months period of data collection.

4.3 Data analysis

The purpose of data analysis is to impose some order on the large body of information collected so that some general conclusions can be reached and communicated in a research report (Polit, & Hungler, 1999). The method used in analysing the data collected was Burnard's (1991) thematic content analysis.

4.3.1 Thematic content analysis

Content analysis came into being as a journalistic tool used to analyse large amounts of information and Max Weber first proposed this in 1911 (Krippendorff, 1980). It did not gain popularity then so quantitative newspaper analysis was introduced in order to meet the high demand for empirical standards and the notion of scientific objectivity (Krippendorff).

A second phase of 'intellectual growth' of content analysis started firstly because the new and more powerful electronic media of communication could no longer be treated as an extension of the newspaper. Secondly, many social and political problems were considered by the mass media to have been caused by the economic crisis; and thirdly the issue of empirical methods of inquiry in the social sciences. What distinguished content analysis from quantitative newspaper analysis was the background of the many social scientists that became involved. They brought with them theoretical frameworks, concept development and better statistical tools to bear on the analysis especially of psychological experiments and the content analysis data became part of a larger research efforts (Krippendorff, 1980).

Content analysis became well known during the Second World War and the method spread to many other disciplines after the war. "In psychology content analysis found three primary applications: analysis of verbal records... use of qualitative data gathered...and processes of communication in which content is an integral part" (Krippendorff, 1980, p.18). By the year 1955 many more disciplines such as anthropology, history, psychology, political sciences, literature and linguistics had started using content analysis.

Content analysis is therefore used to put the many words used in a text into fewer content categories with each category consisting of words or phrases with similar meanings. These similarities may be based on grouping synonyms or words sharing similar connotations, for example grouping together several words implying 'wealth or power' (Weber, 1985). The organised information allows conclusions to be made about the characteristics and meaning of written and otherwise recorded material (United States General Accounting Office, 1982).

Ely, Vinz, Downing and Anzul (1997, p.206) see thematic analysis as "sorting and lifting," "as a seamstress lifts threads with a needle". A theme therefore is "a statement of meaning that runs through all or most of the pertinent data or one in the minority that carries heavy emotional or factual impact" (Ely et al., p.206).

Polit and Hungler (1989, p.325) note that "although content analysis is a method of handling narrative, qualitative material, it is a procedure that typically involves quantification". To start analysing the data, all the recorded data must be transcribed. Qualitative data analysis is done alongside data collection. Thus data collection and analysis interact for they are linked from beginning to end of the research (Holloway, & Wheeler, 1996).

4.3.2 Transcribing

This involves writing out the interviews. I did all the transcribing as the data, although collected in French, were transcribed into English. The initial data analysis was done on a continuous basis, with the transcribing done immediately after each interview. It gave me an opportunity to better familiarise myself with the data. As well where the tape was not clear it was easy to remember what was said.

4.3.3 Data analysed using Burnard's thematic content analysis

"Thematic content analysis has been adapted from Glaser and Strauss' grounded theory approach and from various works on content analysis" (Burnard, 1991, p.461). Burnard notes that the data collected are organised according to the themes. A theme addresses the issues raised during the interviews and links the themes and the interviews together under "an exhaustive category system" (p.462). According to Burnard (1991) data analysis using thematic content analysis involves fourteen stages.

Stages one, two and three involved making notes after each interview on what was discussed, reading through the transcripts to better understand the content and making notes on the general themes within the transcripts. In the course of reading the transcripts, headings that described all of the aspects of the content are made and written down. Unrelated issues to the topic from the interview are noted separately.

These first three stages were time consuming, as I was new to this process. I went through the transcripts many times looking at each sentence closely. I then wrote down headings that seemed to describe the issues discussed initially. The lists of the headings were almost as long as the transcripts.

Stages four and five involves grouping together similar headings under one broad heading, re-categorising, putting sub-headings and removing similar headings in order to come up with a final reduced list of main themes.

Stage six involves enhancing the validity of the method and guarding against researcher bias (Burnard, 1991). This stage may be done by inviting someone who is familiar with the method but not involved in the research to generate a category system list independently. Then a general discussion is held based on the lists generated and the researchers' list before any eventual adjustments made. In my case I used my supervisor, who is familiar with the research, and also with the method used. She followed me closely as I generated the categories as suggested by Burnard (1991). Constant suggestions and feedback reduced the possibility of bias.

Stages seven and eight involves re-reading of the agreed list of categories and sub-headings and making adjustments if necessary, working through the list of headings and sub-headings according to the list of category headings. The feedback I got from my supervisor at this stage indicated that I had come out with topics instead of themes. I had findings from the nurses and parents' perspective and three main topics from both perspectives, which I thought were themes and several sub-headings. I needed to go back to the data and look for themes.

Table 2. Preliminary themes

Findings from the nurses' perspective	Findings from the parents' perspective
The hospital policy and its effects on the care the nurses provide	The effects of change of policy in the general paediatric ward
The nurses' views of paediatric nursing	Practice in neonatal unit and its effects
The practice in the neonatal unit and its effects on the mothers	Contradiction in perspectives in relation to the parents views of care

After going back to the transcripts and re-reading them, while asking myself what exactly the participants were saying and not what I thought they meant, I came out with two main themes from the nurses and parents' perspectives. Six sub-themes emerged from the two themes. All the themes and sub-themes were phrases used by the participants.

Table 3. Final themes

Meeting the children's needs and readying them for discharge home (Nurses)	**I am satisfied with the care although I am not always allowed to be with my child at will (Parents)**
We did not need parents but now we do	At first mothers were not allowed to stay
Meeting the children's needs and readying them for discharge home	The babies in neonatal unit have no right to having their mothers live-in
Visiting in neonatal unit is strictly for biological parents and mothers are not allowed to do anything	I am satisfied with the care although I am not always allowed to be with my child at will

Stages nine and ten involves taking out of the transcripts and collecting together all items of each coded section of the interviews while keeping a complete transcript for reference. Following Burnard's (1991) suggestions, I made copies of the transcripts and preserved complete copies and with the others, cut out grouped items under similar themes and put them together.

Stage eleven involves taking the main themes to some of the participants and asking them to check if it represents what they said or meant and making some adjustments if necessary. In this study, this was not possible as only the preliminary analysis was done in Cameroon and given the distance between Cameroon and New Zealand, the limited time and finances available allocated for the study.

Stage twelve involves filing together all the sections and keeping the complete transcripts where they can be easily accessed for reference when writing up. This was done as suggested by Burnard (1991) and all the files have been kept according to the different themes apart from the complete transcripts that are kept separately.

Stages thirteen and fourteen involves the writing up process, starting with the first section and working through to the last section, selecting examples and comments and linking them to the literature. While working through the sections, verbatim quotes were referenced to the original transcripts. The writing up has been done under the themes while returning always to the original transcripts to make sure what was written was not taken out of context. Burnard (1991) suggests that findings could be presented alongside with the existing literature, which is what has been done in this study. This has produced two main themes that are used as chapter titles as they carried more emphasis and cover more of what the participants said.

4.4 Ethical considerations

Ethical approval is to protect the researcher and participants. Ethical approval for the study was obtained from Massey University Human Ethics Committee and permission was obtained from the hospital authority for the access to the participants and hospital setting before starting the data collection.

4.4.1 Access to participants

Due to the change of venue, I had to take my application to the Director of the hospital personally. He gave his accord and sent me to the head of service of the paediatric ward, then to the ward charge. After introducing myself and giving the ward charge the information about my study (Appendix A), I was taken for a brief introduction around the service. I later visited the service on my own. I met with the mothers living-in and introduced myself. I then talked to them about the study (appendix A) and ask them if they were willing to participate. I explained to them the conditions of participation and their rights and then asked them to think about it, promising to return the following day for the reply.

I visited the nurses in the nursing station, introduce myself, talked briefly about the study (appendix A) and asked them if they wanted to participate. I explained to them the conditions of participation and their rights and asked them to think about it while I come back the next day for their reply.

Under other circumstances I would have let somebody else access the participants on my behalf but the only people that were readily available to access the participants were the nurses. In order that the nurses did not know the parents participating in the study, I invited the parents myself. I made sure that they knew that their participation was voluntary and that the care of their child would not be affected.

4.4.2 Informed Consent

Verbal consent rather than a written consent was sought because in this setting it is more appropriate. I discussed the study and participation (Appendix A) so that the participants were fully informed. All participants accepted all the conditions, including the audio-taping.

4.4.3 Anonymity and Confidentiality

All identifying features were removed from the data at analysis. Any information transferred through on-line communication paths such as e-mail was done in a manner that concealed any identification and this communication was only between my supervisor and I. No references were made to the participant's names or hospital where the study took place. Only the researcher and supervisor have access to the raw data. Pseudonyms have been used where necessary.

4.4.4 Potential Harm to Participants

It was anticipated that there was unlikely to be any harm to participants participating in this study. All the same some mothers were very distressed because of the condition of their child and telling me about their experiences was stressful. Some could not bear it and had to break down in tears. With one, I had to stop the interview and pray with her, as she was a Christian, to raise her spirits. I reminded her once more of her rights and asked if she wanted me to suspend the interview but she chose to continue. I interviewed all the parents first and then later interviewed the nurses.

5. Credibility and trustworthiness

As stated above the use of qualitative or quantitative approaches to collect data is determined by the researchers' interest and the question asked. According to Sandelowski (1986) qualitative methods are frequently viewed as failing to achieve or to make explicit the rules for achieving reliability, validity and objectivity criteria of adequacy in scientific research. Polit and Hungler (1995) note that the central issue underlying the concepts of reliability and validity is the reflection of truth in the data collected and qualitative researchers are as eager as quantitative researchers to have their findings reflecting the true state of human experience. "Validity refers to the extent to which a question or variable accurately reflects the concept the researcher is actually looking for" and "reliability refers to consistency" (Davidson, & Tolich, 1999, p.31-32). Because this is a qualitative study the terms validity and reliability will not be used instead credibility and trustworthiness will be used.

Credibility according to Polit and Hungler (1995, p.362) "refers to confidence in the truth of the data" and "trustworthiness or dependability refers to the stability of the data over time and over conditions". Sandelowski (1986, p.31) notes "credibility can be obtained in a qualitative study when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognise it from those descriptions or interpretations as their own". As well the descriptions or interpretations should be presented in a way that other researchers or readers can recognise the experience when confronted with it or just from reading about it in the study.

As acknowledged previously the difficulties researching in a developing country meant that some strategies for maintaining credibility could not be respected. In this study the time constrain was a big issue thus this had to be taken into consideration even in the choice of the method used. Therefore using semi-structured interviews and participant observation to collect data and using Burnard's (1991) thematic content analysis to analyse seemed the best for this study. Only two months could be set aside for data collection. With such limited time, revisiting the participants with the main points was not possible. As well some parents were too stressed by the condition of their child to be able to talk about the interview again. For example I met one of my participants whose child had been discharged two days earlier and immediately she saw me coming in she said:

> *If you are coming to see me for more discussion, please do not bother because I am not in any mood to talk today (Field notes).*

I was not going in to discuss the interview but just to say hello, as I was surprised seeing her son back after being discharged two days earlier.

Before going to the field for data collection, I did a pilot interview to improve my interview skills and to be prepared for situations such as going off the topic or doing more of the talking than the participants. Having a supervisor who was very knowledgeable with the methods was an added advantage. The decisions made throughout the data collection period and the steps used for the analysis were done as indicated by the method chosen. Because the steps are clear enough, the readers can audit the events, influences and actions of the researcher as Koch (1994) suggests. Credibility has been maintained by constantly returning to the raw data (transcripts) and field notes.

Summary

The first part of this chapter focused on describing the qualitative research method, interviews and participant observation used in this study. The raison d'être for choosing these methods in collecting and analysing the data is also discussed. The difficulties in carrying out research in a developing country and more specifically the difficulties I encountered as a researcher collecting data in Cameroon have been briefly stated. Accessing participants, the process of collecting the data, a brief discussion of the philosophical underpinning of thematic content analysis, the process of data analysis followed by the ethical issues, credibility and trustworthiness are discussed in the second part of the chapter. The results of the data analysed using thematic content analysis according Burnard (1991) are presented in the next two chapters. This framework provides a means of interpreting the data in a way that can be audited.

Coding

Verbatim:	Verbatim quotes from transcripts will be in italics and indented from the margins.
Pseudonyms:	Are used to maintain participants' anonymity
[ ]	are used when translating a word, clarifying something said or explaining a comment.
...	Pause in participant speech and omitted name (for confidentiality reasons)

Parents=would most often refer to mothers in this study

According to Callery (1997a, p.993), "there is a danger that this gender neutral term 'parent' disguises the important differences between the experiences of mothers and fathers". Because of this observation, it is necessary to state that in this study the parent who stayed in the hospital with the child was mainly the mother and in the situation where a father was involved, specific mention of his role as father has been made. As well traditionally in Cameroon, the care of children is mostly the mothers' responsibility as the fathers carry out other duties such as working to provide for the family.

Chapter Four: Meeting the children's needs and readying them for discharge home

1. Introduction

This chapter presents the views of nurses working in the paediatric unit in relation to parents living-in or parents who only have visiting rights. While the data obtained from the nurses is very rich, there are variety of views and opinions expressed. An attempt is made here to systematically and honestly present the thoughts and feelings of the nurses, as Burnard (1991) suggested. Three themes emerged from the data analysis of the nurses' interviews. These are:

- We did not need parents but now we do.
- Meeting the children's needs and readying them for discharge home.
- Visiting in neonatal unit is strictly for biological parents and mothers are not allowed to do anything.

In the first section of the chapter views from the nurses when the paediatric service restricted parents' visiting, the effects it had on the care rendered at the time, the changes that took place, the reasons for change and the effects that change has had on the care are related. The second theme relates the nurses' goals of meeting the children's needs and readying them for discharge home. The third theme brings out the practice in neonatal unit where visiting is restricted to the biological parents only and the mothers are not allowed to care for the children when they go in to visit.

2. We did not need parents but now we do

According to Mosby's Medical, Nursing and Allied Health Dictionary (Anderson, Anderson & Glanze, 1998, p.1286) policy is a "principle or guideline that governs an activity and that employees or members of an institution or organisation are expected to follow". The hospital visiting policy therefore is a guideline put in place in the hospital (written or verbal) that informs all patients, families and friends of the visitation guideline to the hospital. Hospital visitation is either open or restricted and who provides the information or what is given to the families with regards the hospital visiting policies varies in different hospitals. For example, in a study done by Flint and Walsh (1988) examining parents' perception of visiting policies in paediatrics, the majority of parents stated that the nurses told them verbally about the visiting policies. In that hospital parents were allowed to live-in if they chose to but some parents were not given the opportunity because nobody talked to them about the visiting policy of the ward.

In this hospital there were no documents on hospital policy. The regulation of the hospital policy was done through service notes, which were not assembled into any document after each implementation. The hospital became functional in 1990 as a joint project of the Belgian and Cameroon governments. It was initially for referral cases only and only selective or special cases from other health centres or hospitals were treated there, thus it had a small number of patients.

2.1 We did not need parents around because we could do without them

When a patient was hospitalised, nothing was expected from the family because the hospital was well equipped to meet the patients' needs (drugs, food, clothing, bed and linen and toiletries). In the paediatric ward there was a playroom with assorted toys for the children. The hospital was well staffed to take care of the needs of the patients. In the paediatric ward, parents came only to visit their children. They were not allowed to care for their child while they were visiting and the parents only had to pay a bill when the child was discharged. The nurses had double role; they were proxy parents and nurses to the children, as Paul states:

> *The old system involved taking complete charge [responsibility] of the children when they arrived here. We didn't need the parents around because the hospital was well equipped and we could take complete charge of any child that was brought to us. Then, the children were not many because the hospital was not opened to everybody. So we had very selected cases or special cases that we took complete care of (Paul: Interview 18, p.2).*

The service had specific visiting hours. Visiting in the general paediatric ward was from 12 noon to 2 p.m. and 6 p.m. to 8 p.m. Since every hospital has its visiting policy, the health personnel (nurses) and or the health consumers (patients and their families) feel the effects of this policy. It is generally accepted that when a member of a family is sick and hospitalised, there is a need for the rest of the family to be with their sick person to maintain the continuity of their family. For some people the set roles and regulations such as times for visits became an issue while with others it was not. These policies influence the care rendered to or received by patient as is developed later.

The ward was clean and we circulated freely

It was the policy of the hospital not to allow parents to live-in since all physical comfort, drugs and feeding, were provided for the children. In this case the administration and the nursing staff did not see the need for parents to be present. Viewing caring for the sick child through the perspective of some paediatric nurses in this hospital, not all aspects, which contributed to the child's health, were considered important. For example some nurses viewed the importance of free circulation and cleanliness of the ward to be paramount as James elucidates below.

> *When we were working without parents there were some positive points noted such as, the service was clean and we didn't have problems concerning space. We circulated freely and carried out procedures with ease. One just needed to be organised and all went on well (James: Interview 20, p.2).*

The policy of restricting parents' visiting, according to the policy makers, was also to provide the physical comfort to the parents taking care of the hospitalised child. In this case since there would have been over-crowding making circulation difficult, it was better for the parents to stay at home.

When the hospital could not meet the needs of the patients, such as the regular supply of drugs, some of the nurses felt they could still do without the parents as they could manage to procure drugs for the children. Neolla relates below how they managed to procure drugs for the children when the mothers were not around.

> *When the mothers are not there, we do everything. If a drug is prescribed that needs to be administered immediately and we see that another parent has it we take to save the life of that child. Immediately the mother of that child comes we tell her to buy and replace what we used. For the mother whose drug was taken we tell her it was taken to save another child's life. When there is nothing, we sign out the drug from the pharmacy, that is you sign out the drug in your name accepting the responsibility to pay for it (Neolla: Interview 17, p.5).*

2.2. Financially we could not maintain the standards

In 1993 the Belgians left the complete management of the hospital to the Cameroon government and their share of financial support was cut off. The few patients in the hospital could not contribute enough for the running of the hospital. According to the participants the hospital could not maintain its standards and had to open its doors to the public.

> *But things have changed because of the negative evolution. First of all, when the Belgians left, the hospital could not keep up or meet the complete needs of all its patients. Secondly it became costly to run, so the hospital was open to the public and we started receiving all types of patients (Paul: Interview 18, p.2).*
>
> *From the beginning, everything was okay, maybe not perfect but the caring, the environment, the working spirit and relationship, interaction and co-operation between the personnel and the administration was okay. We never had problems with our salary or our bonuses, and we had all the necessary working equipment. So we were working at ease. That was the period of the creation of the hospital up till 1993 when the last Belgians left here. When they went, Cameroonians took over complete management and the hospital started falling progressively, progressively until 1997 when it was really catastrophic (John: Interview 19, p.2).*

A change in policy was therefore imminent to cope with the change in management and funding. This change would be noticed in a number of domains.

We need parents to buy drugs

It was the policy of the hospital to take total responsibility of their patients no matter the age and at the time of discharge a bill was made available for payment. In the paediatric ward the nurses did not see the necessity to have parents live-in. For some nurses they thought that parents needed to live-in as the hospital could no longer meet its needs and patients were expected to buy their own drugs. According to these nurses this was a major reason for introducing parents in the ward.

> *And before then the nurses had wanted the system of having parents live-in because the hospital was not capable of meeting its needs like supplying of drugs or taking complete charge of the patient as it was done previously. Now we have a system in place, which permits patients to buy their drugs. There is the need for* **"garde malade"** *[patient caretaker] by the child so that if there is any prescription they buy the drugs and we don't wait for long. This is my opinion and I think it is the opinion of most of my colleagues that this is the most important reason for having parents stay (John: Interview 19, p.3 - 4).*
>
> *But afterwards the hospital had problems and the pharmacy was no longer able to continue with its responsibility, so we started with the system of giving prescriptions to parents. That is the first reason to have someone staying next to a sick child. We could need a drug urgently and if it is not available and no parent around we are forced to wait till visiting hours for the parents to come and buy. This could pose problems as regards the follow up of patients (James: Interview 20, p.2).*

According to some nurses, after Cameroonians took over complete management, the development of the hospital started changing. Furthermore with the acknowledgement of the importance of the presence of a parent beside the hospitalised child, the hospital changed to accepting parents live-in in 1999. This change of policy has had lots of consequences on the nurses, the management and the parents as the nurses discussed in their interviews. For example some nurses note that the pharmacy is considered a different service, as it is not working in collaboration with other hospital units. According to these nurses the pharmacist knows and takes care of all the procurement of drugs independently of the nurses.

Drugs are no longer supplied to the wards as was the case previously and parents have to buy drugs for their children either from the hospital pharmacy or go to town when they are not available in the hospital pharmacy. Their responsibility as nurses is to administer the drugs when available. Although it is not the nurses' problem, it may significantly affect the child's treatment and recovery.

> *I am not saying we have a complete pharmacy but that is the problem of organisation. The pharmacy is another service on its own, the chief of service of the pharmacy, organises things the way he wants. But the ideal could have been that we have all the necessary drugs on the spot. Since they are managing it like a private pharmacy where they are free to have Chloroquine today and tomorrow they don't have glucose, well that is their problem, it doesn't concern us. It is the problem of the organisation of the pharmacy service (James: Interview 20, p.4).*

2.3 We need parents because others say it is important

After the hospital opened its doors to receiving all sorts of patients, the visiting policy, especially in the paediatric ward, was changed. The present visiting policy of the paediatric ward allows parents (mothers) to live-in with their hospitalised children. The mothers of babies in the neonatal unit are allowed open visits but not to live-in and visiting is still restricted only to the biological father and mother. This visiting policy has been changed partly because of the partnership the hospital made with the Italians.

> *Yes, the change of the practice was done this year 2000 when the Italians became a partner with us. To accept the partnership they explained to us how they operate in their country. They said the new system now is mother and child [together] because it is not good to separate the child from its mother. The separation can worsen the state of the child and can create very serious problems (Neolla: Interview 17, p.2).*

This practice was also apparently acceptable for a paediatrician who had worked in other places and knew the importance of having parents live-in with their hospitalised children. He had started talking about it to the staff prior to its implementation.

> *Well, the parents were not accepted here in the rooms since the creation. I think the system [of letting mothers live-in] was introduced when Dr ... started working here. Yes he is the one who first talked about this idea because I remember we had discussed this idea during the service meeting. He gave his point of view of the importance of having a parent stay with the hospitalised child. He was taking the example of USA where he was trained and has worked and from everywhere he has been of the important role mothers' presence plays even in the treatment of the child (John: Interview 19, p.4).*

2.4 We want them to stay but there are no facilities to meet their needs

Some nurses note that mothers are allowed to live-in with their children but there are limited facilities available to the parents and only the patients are provided with food.

> *They [mothers] don't have anything except the bed. We provide only the bed and bedding for them because normally they were not supposed to sleep here. When this hospital was constructed, it was not for mothers to stay with their children in the hospital and for a long time since the beginning, we were functioning on that basis, mothers were not allowed in. Nothing has been put in place for the mothers. Absolutely nothing. Normally they pass the night here and in the morning they go home to have a shower. As for feeding when they are here during the day they struggle and eat whatever they get around. They buy from the road or ask the family to bring them something to eat (Marie: Interview 21, p.3).*

Meadow (1969) a house physician did a survey over a period of two and half years in London looking at living-in mothers. Contrary to the findings of this study where mothers have beds by their children but no place for showers and no food, the mothers of Meadow's study had limited accommodation and food was provided free. These mothers even expressed surprise that no charge was made for the meals they were provided and felt like contributing if it would improve amenities for future mothers. Meadow's study was done 31 years ago and although the situation in that hospital in London and many other hospitals in the Western world are not the same at present, comparisons with this hospital approach to parents can be made.

2.4.1 We have specific visiting hours for the other family members, to avoid overcrowding

Although mothers are now allowed to live-in, only the mother and two other visitors are allowed with each child and visiting is from 12 noon to 2 p.m. and 6 p.m. to 8 p.m. According to some nurses, this practice of limiting visitors is to avoid overcrowding. Contrary to this view, Cleveland (1994) in a study looking at 'ICU visitation policies, notes that restricted visiting hours isolate the patients from their families yet, "the world created for a person by his family... can be a powerful force in recovery from illness" (p.80a). According to Cleveland, restricted visiting prevents the nurse from meeting the needs of family members and also, forces nurses to try to meet needs which the family can, such as "parenting".

> *We are strict [with the visitors] in order to avoid overcrowding especially during treatment, that is why we have specific visiting hours for the other family members. The visiting hours are from 12 noon to 2 p.m. and 6 p.m. to 8 p.m. in the evening. We don't authorise more than two visitors per patient. Excluding the parent that stays with the child; two others can come to visit. If they are say six, the two will stay for a little while and go out before two others come in, and they continue like that until they all take their turns (Paul: Interview 18, p.10).*

According to some nurses, they have problems restricting visitors as more than the required number of people come in to visit at a time. Most often in Cameroon when somebody is hospitalised, friends and relatives see visiting that person as an obligation. At times they come in a group and this creates a problem to the nurses who are trying to restrict the visitation according to hospital regulations. Some nurses believe that fellow colleagues also create more problems as they come in at will with many visitors. These situations can be seen as an inconvenience for the nurses and they try to remedy the situation by spacing out the visitors.

> *In the paediatric section, visiting hours have been distributed, that is from 12 noon to 2 p.m., and from 6 p.m. to 8 p.m., that is four hours of visits a day. Excluding the parent by the child we admit two visitors and I tell your it is not easy. We have tried to be strict but it is not easy especially with us Africans. It is not easy. Yes it is not easy, for example, we will say two visitors per patient but you enter a room and find out that the room is full with people. Like*

> *earlier on in room three, I went there to tell them that there were so many visitors and some needed to go out and wait for a while. It is difficult to know who came to visit which child. At times in a room with four patients there are more than ten visitors and the room gets very hot and people are almost suffocating (James: Interview 20, p.13).*
>
> *If there are many people to see a child the others wait outside. That is what is recommended. It is even written and pasted outside on the door, two visitors per patient. Normally that is how it is supposed to be but we are in Africa and at times many of our colleagues are the ones disobeying these regulations. These are some of the difficulties we have because our colleagues are the first to go against these regulations, they come with four or five visitors and when you remind them of the regulation they become annoyed. The personnel are the ones who boycott the regulations put in place. The others try respect the regulations (John: Interview 19, p.9).*

2.4.2 We restrict visitors to limit infection

Despite the change of visiting policy some of the nurses believe that visitors introduce infection to the children, therefore visiting has to be limited. No patient is allowed more than two visitors at a given time. This practice, according to some of the nurses, prevents the children from contracting another infection.

> *Positively it [visiting] is good because the child needs to see the family. It gives him/her that affection, that joy that people are thinking of him/her. Even when the child does not speak he/she knows that this or that person visited when he/she was in the hospital, but despite the positive aspect of visitation we limit the number of visitors and the time. We limit visitors for therapeutic reasons, that is to limit infection. For example if a visitor that come to visit is having tuberculosis, he/she just need to cough once, and sends out a great number of bacilli that the child, apart from their normal condition, can contract. That is the problem. It is mostly for therapeutic reasons so that the child apart from his/her problem that brought them to the hospital doesn't get some other condition (John: Interview 19, p.10).*

Maintaining strict infection control is a central concern for health professionals. As well Young (1992) notes that this provided a good reason for not letting parents live-in since the hospital was seen as a "sterile" environment and any visitors coming in were seen as potential source of infection.

Contrary to the above views, hospitals are not sterile and cross infection often occur as a result of health professional contact rather than parents or visitors. In 1954 Pickerill and Pickerill, plastic surgeons of Wellington Hospital in New Zealand, confirmed that keeping mother and baby together prevented cross-infection. According to Pickerill and Pickerill, it was universally acknowledged that nurses convey infection. At this time they commented "if many persons do many things for many patients, cross-infection seems inevitable" (p.425) but the 'modern day' practices of universal precautions are designed to stop this.

2.5 We want them to stay but we are having some problems with them

According to some nurses, the presence of some parents (mothers) in the ward is disturbing either because they are very demanding or do not understand what they are told. As well there are some nurses who do not know how to deal with parents and this brings conflicts. John talks of the minor conflict they have with the mothers.

> *We have small, small quarrels with parents who don't understand well what they are told. They are certain parents that are very demanding; especially parents that have stayed long here and they know they are having a big bill to pay. They become very demanding and say all sorts of things. It is on both sides. There are also some colleagues that don't know how to deal with parents. When they are asked a question, instead of answering well or orienting the parents they take it differently (John: Interview 19, p.10).*

Some of the nurses remark that living-in parents are disturbing and demanding as they ask too many questions. Similarly, Frank (1952) a nurse in USA in an article entitled 'Parents and the paediatric nurse', noted that the nurses working in single rooms with parents living-in complained that those rooms were the most difficult to work in. The nurses complained about the mothers either being negligent or doing too much for a child and would complain immediately a treatment was delayed slightly.

Others found the presence of parents in the ward a hindrance to their nursing care because they were not able to carry out certain procedures conveniently. They had to either take the child out of the ward for treatment or send the parent out of the ward as Neolla and Paul recount.

> *If we notice that there are any inconveniences attending to a child in the presence of the mother, we take the child to the treatment room, otherwise when we have some parents disturbing us we just do what we are supposed to do and go away. For example we have the whites, especially the Americans, that disturb us a lot. With such parents, we take the child to the treatment room for any treatment (Neolla: Interview 17, p.8).*
>
> *Generally, when we are carrying out a procedure that is traumatising we ask the parent to go out. We carry out such procedures without the parents. But if it is a simple procedure we do it in the presence of the parent since many parents want to be present when we are treating their children (Paul: Interview 18, p.10).*

Lovell-Davis (1986), director of NAWCH in the UK, examined a survey of selected European countries done by Stenbak for the World Health Organisation. Stenbak's findings showed that some nurses viewed parents as interference and people who understood little of the emotional needs of the child. In Callery's (1997a) study in England, he notes that parents were allowed to care for their children during unpleasant procedures and this was distressing to the parents. Although unpleasant procedures can be distressing to the parents, the practises of taking the children out or letting the parents stay out when performing a traumatising or unpleasant procedure seem to contradict the purpose of parents being present in the hospital with their hospitalised children. On the contrary in New Zealand, children are taken to treatment rooms for treatment, especially unpleasant ones, so that their bed is seen as a 'safe haven' and also so that other children do not get distressed.

In this hospital, previously when a child was hospitalised, the nurses did everything for the child including washing, feeding, all observations, administering medical and nursing treatment and being at the child's disposal whenever there was a need. With the change in policy, some nurses assumed caring for the child would be a shared responsibility between mother and the nurse. According to Marie, the child was left at times with the basic needs not met because of confusion as to whether the mother or the nurse was responsible.

> *As well the problem of toileting the child, the nurses were doing all that but now there are certain mothers who knew that at first it was the nurses' responsibility to do everything so when they are sitting there by the child they do nothing. The nurses don't do it because they know that the parents will do that. Some children stay till 12 noon with nothing done as regard toileting them. When you ask the mother she says she thought it was the responsibility of the nurses and the nurses also say the mothers are there, why should they do the toileting (Marie: Interview 21, p.8).*

Similarly, studies done by Elfert and Anderson (1987) and Darbyshire (1994b) noted that some nurses expected the mothers to carry on with the daily cares of their children such as washing or feeding but that was never said clearly to them. Providing daily cares, according to some nurses, was the main reason for parents' living-in although some parents felt uncomfortable about what they could not do, especially in the foreign environment of a hospital.

Although open to the public now, this hospital is not easily accessible because only the financially viable go there. According to James, when people pay for hospitalisation, they tend to behave poorly and want everybody to be at their service or do what they want.

> *We are in a very expensive hospital as the parents declare. Our people think that when they pay money in the hospital everybody there should be at their disposal. I will take a small example with the ward maid who cleans the floor always. When she comes to clean the floor, she has to empty the rubbish bin and most often the rubbish bin is empty while the rubbish is all over the floor, it is horrible. She takes the time to clean the floor and when she is cleaning they are moving in and out. She can clean the floor three times a day but if you did not see her cleaning you will not believe that she has touched it. And she cannot talk to a mother because the mother will say, "what is it, I am paying my money here and I have been authorised to stay (James: Interview 20, p.6 - 7).*

The society or the parents themselves label some parents as 'well to do' and such parents are difficult according to some nurses. The concept of 'well to do' would mean people of the middle class who are rich, educated, and have a high life standard. These people most often would employ housemaids, nannies or boys who serve them at home. They do not assist their children while in the hospital because that is always somebody else's responsibility.

> *You see there are many categories of parents that come here. There are parents who maybe consider themselves well to do or whatever and don't touch their child at home. When a child does anything it becomes the responsibility of somebody else to come and take care of that which the child has done. This type of parent when they are here, whenever the child is soiled, they have to call out for a nurse (Elias: Interview 13, p.6).*

2.6 It is difficult to keep an eye on everybody at the same time, with few nurses running each shift

The change of policy (opening up to the general public) also had its effect on the staffing and workload with many nurses leaving because they cannot cope or they are not willing to work in the ward any more. As well the administration did not recruit more nurses to the ward as the other nurses resigned from working in paediatrics. The ward now has, at most, three nurses running each shift, covering the general paediatric ward and neonatal unit. These observations are confirmed by what Elias, Paul and Neolla say.

> *There can be inconveniences especially now that the groups are having fewer nurses in each group. It is difficult to put an eye on everybody at the same time. You can be very busy on the other side and the ones on the other end are having a problem. One [child] might mistakenly remove a drip and start bleeding profusely without you knowing because you were spending some time on the other. If we were many while some are busy there the others are checking on everybody and all possible happenings (Elias: Interview 13, p.6).*

> *There are problems as regard the functioning of the service because when we started here everything was almost technical and as time went by the machines that were helping us a lot broke down and they were never replaced so our workload became heavier. Working here when it all started was very much at ease. As well we had nurses that did paediatric nursing as a*

> *speciality but more than half of them have gone and were never replaced. As well the number of staff has reduced greatly and we are forced at times to make do with students. For example we were two today with 15 patients, excluding the neonatal unit with 5 babies. We could not constantly be with all the children (Paul: Interview 18, p.11).*

> *We are supposed to be three but since the groups are reducing regularly due to ill health or what not and some who cannot continue working in paediatrics because they have back pain are transferred to other services, we are just two today. These types of people are not easily replaced because no nurse wants to be in similar situations (Neolla: Interview 17, p.9).*

2.7 They are of great help to us

Despite the inconveniences caused by the change of policy to letting mothers live-in, some nurses get a lot of assistance from the mothers as their presence in the ward greatly reduces their workload, permitting them to nurse better.

> *The new system of having parents stay is good for us because the mothers help us a lot. Their help is great. We can now work well in the neonatal unit. When the old system of not having parents was in place, the work was not done well. For example if you are working in room 4 and there is a cardiac arrest in room 1 you cannot see or know. Now we can concentrate in a room and the mothers know that they can come and call us from there (Neolla: Interview 17, p.9).*

> *We used to be very occupied when there were no parents but now we are disengaging ourselves from certain things. We let them do certain things such as to clean and feed their children but we administer the drugs, take the weight etc. In general we do all the treatment (Elias: Interview 13, p.5).*

> *The mothers staying with their children are helping us a lot especially as regards the observation of the children. They are of great help to us. They change their children when they soil themselves. For example when we were two with as many as fifteen patients, we could not be constantly with all the children. When we cannot be there, the parents replace us observing the children and in case of any abnormalities they call us immediately. As well when the child does not have any complicated treatment the mothers do the toileting if they are able but when there are complicated treatments like drips or any other connections we do all the cares. The mothers*

> *feed their children also if there are no technical aspects like tube feeding involved (Paul: Interview 18, p.9).*
>
> *The mother being there can help us with the changing of the child if the child is soiled, when we are occupied for example in the neonatal unit. When her child in the paediatric unit wet or soils his/herself, the mother can change him/her and she watches her child closely because there are certain children who climb over their beds. The mother's presence helps a lot for they also inform us if the glucose drip is almost finishing so that we can replace it, if it is flowing by the side, she calls us and we arrange it. In general when there is a problem in the room she tells us and we can intervene (John: Interview 19, p.6).*

Some of the nurses see the mothers' role as helper, not as someone doing her normal duties of parenting. According to these nurses they greatly appreciated the mothers' presence in the ward because of the help the mothers are giving them. Lloyd (1955) a Paediatric Supervisor at Hunterdon, New Jersey did a study at Hunterdon Medical Center. She noted that the paediatric nurses who took part in the study acknowledged and welcomed the parent's presence, as it was good for the patients and a great help to the nurses. As well Webb, et al. (1985) in their study in Nottingham, UK examining the care by parents in hospital, acknowledged that parents were playing a greater part in providing the daily cares for their children in hospital while nurses and medical staff performed those procedures requiring special knowledge or skills.

The benefit of the presence of parents during paediatric hospitalisation has been acknowledged in literature (Fagin, & Nusbaum 1978; Hall, 1978; Mahaffy, 1965). In this hospital, this aspect has also been acknowledged and that is why mothers are allowed to live-in with their sick children. Apart from parents being of great help to the nurses, their presence provides a friendly and welcoming environment for the children thus promoting recovery as John describes below.

> *When the mother is present, the child being in the hospital does not feel lonely in this strange environment and feels happy and cheerful since there is continuity of the family relationship and this aspect plays an important role in the child's treatment (John: Interview 19, p. 4).*

Nurses are most often concerned with the nursing treatment of the children and ignore the mothers' or parents' parenting role. As well they believe they know and understand the mothers so they let some mothers do more cares than others because they are seen as 'enlightened'. Being enlightened is seen as an elevated status and there are responsibilities that go with that.

> *Mothers that are enlightened like Andrew's mother can give her child the drugs. She knows how to control the time and at times when it is time for her child's injection she comes to remind us so when the mother is enlightened we can let her do that (Neolla: Interview 17, p.7).*

According to Miles and Frauman (1993), parents who were not viewed as competent were not offered as many opportunities to give care. Similarly only the mothers considered enlightened were given opportunities to administer oral medications. Therefore carrying out certain procedures is seen as a privilege for a mother.

In contrast Darbyshire (1994b) examined parental participation and involvement of parents in the care of their hospitalised child. His findings included that some parents were very happy carrying out only the child's basic cares and leaving the more technical cares to the nurses, while others had learned some technical skills, such as nasogastric feeding, so that they could do this for their child. Therefore all the parents were given equal opportunity to carry out procedures (and even technical procedures).

Since some mothers were considered not knowledgeable, the nurses taught them the administration of oral drugs before their child was discharged home, thus sharing certain responsibilities with the parents only when the child was going to be discharged from hospital.

> *We feel that the mother cannot know the quantity to be taken to give the child if we let her administer any drugs. For example if she is allowed to give, lets say a cough syrup, she will be giving the child every time the child coughs. The giving of all the drugs is planned. But when the child is discharged and they are going home we reduce the frequency, for example we do not let*

> *the mothers give six hourly drugs because they might not control the time (Neolla: Interview 17, p.6).*
>
> *If there is a mother who wants to administer a treatment and it is an easy one we let her do it because they are discharged home always with a prescription. But we always teach them what to do and then let them do it because we will not be there to administer the treatment for them at home (Elias: Interview 13, p.5).*

According to Meadow (1969) mothers living-in were being criticised for being "lazy" and or "untidy" (p.364). A nursing sister in the same study made this remark to a mother, "you're learning quickly, mother, you changed his nappy well; if you do as well tomorrow I'll let you help me take his temperature" (p, 365). It could be noted that for this nursing sister the mother was being appreciated for a job well done, therefore, a reward was necessary which was letting the mother take the temperature. Some of the mothers in this study, like those of Meadow's study, were not always considered knowledgeable. Mothers are only allowed to administer oral drugs after proof of knowledge as taught by the nurse.

3. Meeting the children's needs and readying them for discharge home

Different people view nursing differently. According to Orem (1995) a nurse must be someone who is knowledgeable, insightful, and skilled enough to know the events, conditions, and circumstances characterising persons in their care. Orem (p.20) views nursing as a "specialised helping service". Peplau (1988, p.5) views nursing as an "interpersonal" and "therapeutic" process in that it is on-going and goal-directed, demanding certain steps, actions, operations, or performances that occur between the individual who does the nursing and the person who is nursed. Paediatric nursing, on the other hand, involves every aspect of child and family growth and development. Thus (nursing) functions vary according to regional job structures, individual education, experience and personal career goals (Wong, 1999). Paediatric nursing focuses on protecting children from illness and injury, assisting them to attain optimal levels of health regardless of health problems, and rehabilitation (Ball, & Bindler, 1999) and this can be achieved when the paediatric nurses relate meaningfully to the children and their families.

3.1 We have the knowledge and skills to look after these children

The nurses see themselves as professionals with the confidence and the nursing ability to nurse the children. Some have developed distinctive roles and responsibilities for parents and nurses with relation to the care of the hospitalised child. These distinctions are made because they are trained professionals who are knowledgeable.

> *That is why we are taught how to receive a patient. When you receive a patient or a mother well, even if the child ends up dying, everything will be all right. Since that is what I was taught when I was doing my training as a Technicien Superieur en Soins Infermiere [Advanced Nursing Education Certificate] that the reception of a patient could treat a patient, I try to do it well (Neolla: Interview 17, p.4).*

Although the mothers in the paediatric unit are allowed to do certain things because they live-in, the nurses assume the greater part of the cares as they believe they know what is good for the child. In some circumstances the mothers are allowed to do certain things only because of the limitations of the nurse, as it is the nurses' role. In acknowledging their limitations, the mother is viewed as a necessary collaborator. Rowe (1996), a lecturer in Griffith University examined the nurse-parent relationship. The findings showed that nurses were understood as initiators, engaging with parents in the course of their practice and determining, to some extent, the practices of the parents. Therefore parents were seen only as relieving the nursing work burden by being there. The nurses made comments such as "one less child to feed and wash and all that" (p.103). Parents, according to the nurses were considered as useful relievers and this left the parents in a position of bystanders as they were excluded in the decisions concerning their children. The parents felt marginalised and the important role of parenting undermined as "the nurses fixed every problem and displayed the trophy to demonstrate the success" (p.104). These findings are similar to the findings of the nurses of the paediatric service in this study.

> *This is my opinion; the mother is here to do for the child what I am not able to do. The maternal love; for me even if I can flatter the child, I cannot replace the mother. The mother is there to complete my work. What I cannot do she does it and together we do what we can to contribute to the healing of the child (James: Interview 20, p.5).*

> *When the child is admitted here, it is the nurse who receives the child first and installs the child in the treatment room. The nurse checks the medical prescription and administers it. Generally in paediatrics all children admitted here are placed on an IV line and the nurses do that. When the treatment is administered the child is installed in the ward and instructions are given to the mother concerning what she is to do on the child such as how to hold the hand having the drip and if there is a problem she calls us using the intercom. We do all the observations as need be. That is the role of the nurse (John: Interview 19, p.6).*

According to some, as paediatric nurses, they have specific goals, which are centred on the child recovering and going back home. They are prepared to work with whichever visiting policy as long as that meets their goal.

> *Well personally I will say we are trying this new system [having mothers live-in]. At first we could not say we were trying because we knew that was the internal regulation and we were supposed to apply it as we met it. If they [administration] have decided to change, that is fine, but if later on they discover that there are inconveniences I am sure we will go back to the old system. I think all we want here is what gives us the best results or contributes to a speedy recovery of the children. All we need is what will benefit the child, that is why I say, (laugh) we can do this or that. Every institution has their way of doing things for example in ...or ... the parent can stay by the child there and all goes well but somewhere else it might not work out well (James: Interview 20, p.3).*

As well Miles and Frauman (1993) in their study looking at 'barriers and bridges of nurses and parents in the negotiation of care-giving roles', noted that nurses and mothers shared many responsibilities for the infant but the official roles were clearer for the nurses than the mothers. The nurses had ongoing responsibility for the care and wellbeing of the infant. They were responsible for treatment, medications, ongoing monitoring of symptoms and also for the infant's bathing, diapering and feeding. Despite the mother's important role of being with their infants, their ability to implement cares was limited because of the limited knowledge of the infant's health problems and treatments. These mothers were not allowed to hold the baby but only to look at it.

3.2 Being a paediatric nurse is about knowing how to look after children

According to some nurses they let the mothers live-in only because the mothers can satisfy some of the children's needs that cannot be met by the nurses.

> *The children feed well when their parents feed them than by an unknown [nurses] feeding them, especially when they see us in this white uniform; they are very afraid of it. But I don't think the problem is actually because of the uniform. It is that with children they recognise people easily. For example, on admission the administration of their treatment is almost forcefully and so whenever they see that nurse who inflicted them pain even in the midst of others they know. They know that among all these people wearing white uniform you are the one that injected him/her on that first day (Paul: Interview 18, p.9).*

> *There is this problem of maternal love; the children are very much attached to their mothers so much so that certain children become very rebellious when the mothers are not around. They cannot accept the absence of their mothers easily and at times they even refuse to eat and cry all through the evening when the father or mother is going back home. This type of behaviour is seen more with the older children and not new-born babies (James: Interview 20, p.3).*

As mentioned above, children feed better when their mothers are feeding them. Lloyd (1955) noted that children refused food and fluids when left alone in the hospital and their appetite improved greatly when their mothers were present to feed or assist them. Although children know those who inflict pain on them, some nurses acknowledged that by being friendly, loving and attending to their needs some children could easily forget and adjust to their environment. Others see caring for children as enjoyable.

> *When a child is born, even if the mother is not alive, if you manipulate the child well, by taking good care of the child, show him/her that you who is present is the mother. Later in life if they don't tell that child about the biological mother, he/she will never know that you were not the mother (James: Interview 20, p.9).*

> *I have always loved paediatrics so much so that I don't feel at ease in another service. And what I can say is that if you can treat a child, you can treat any other person because if you can understand somebody who doesn't speak then for those who can speak you can treat them easily (Neolla: Interview 17, p.9).*

> *Working in paediatrics is great, it is wonderful world of its own. A world that is not difficult, that is to say you are the one that pose the problem instead. For example after you have just administered a treatment, maybe an injection, inflicting pains on he/she, you come back few minutes later he/she has forgotten and you people become friends again and are playing. Unlike adults who first of all insist on everything and they don't let off things easy. Nothing for them [adults] is taken lightly. They shout at you and what not and things don't go easy as with the children (Elias: Interview 13, p.8).*

The nurses see giving of information to the parents of sick children as the responsibility of the nurses, although all the other health personnel can also give information as needed. Therefore whoever receives the mother and admits the child gives her all the necessary information.

> *Generally giving of information to patients or mothers is part of the role of the nurse wherever. When you as a nurse receives a patient no matter where, you have to reassure the patient, and tell him/her what you intend to do on him/her concerning his/her condition. They may not be okay with what you are doing, but they are supposed to know (James: Interview 20, p.12 - 13).*

> *We do not have a particular person or document that gives all necessary information to parents, but actually we are all responsible for giving any information to mothers from the paediatrician to the nurses and even the ward maids. Everybody is responsible for giving information to patients or their mothers (John: Interview 19, p.8).*

Some of the nurses acknowledge that some parents miss out being informed and knowing what to do becomes difficult as they are in a strange environment.

> *No, we don't have anybody uniquely for receiving parents but we work here on rotation basis so there is always somebody in the group working who receives people. Anyway everybody is expected to receive parents when they arrive. So whoever receives the child takes care of all the*

> *information. But there are two reasons that can explain why some mothers miss out getting information. Firstly if the child was brought and the nurse who received the child got very busy and somehow had no time to give the information necessary to the parent; secondly when the nurse finished with what he/she was doing, it was the place of the parent to ask questions if they needed to know something. So because the nurse was busy and the parent never asked any questions and when this group handed over, those taking over assumed they were all informed (Paul: Interview 18, p.7).*

> *For questions we encourage the mothers to ask questions. It is not bad to ask to know. I was just talking to the other lady, her child spent three to four days here and she didn't know why the child was hospitalised because it was the grandmother who was staying with the child in the hospital. How will she follow up the child then? If it was a condition that necessitated her avoiding certain things how would she do it not knowing what was even wrong with her child. That is why we like questions, for when a parent asks questions it is to know. We explain what is there and what is to be done (Elias: Interview 13, p.6).*

Knafl, Cavallari and Dixon (1988) carried out a study on parent participation in USA hospitals and found that most parents received information from the nurses or whoever was at the nurses' desk and also any available person. Some parents even received information from security guards. Therefore in most instances, no one person or classification of personnel is seen as an information source. Because parents rely on health personnel for information, they may not actively seek it out but rather wait to be informed. Since the parents of my study were acting on this principle (waiting to be informed) some of them missed out.

When we can do things right the child goes home faster

Some of the nurses viewed themselves as being there to shorten the stay of patients in the hospital. Occasionally mothers were seen as prolonging the child's stay because of their actions.

> *I am sure there are certain children that stay here longer than expected because of the parents. It is not because they come often but it is that when they come they want to do whatever, disturbing the child in the name of talking with the child. I am not in support that the number of days a child spends in the ward is more because of the mother. That makes me feel very bad. I don't*

> *tolerate this type of behaviour but please don't misunderstand me, I am not here to separate the family. I will like the child to be cared for within the family circle but the problem that brought him/her here is more important (James: Interview 20, p.10).*

> *Although I am a nurse, if I put myself in the place of a parent, if my child is sick and it necessitates hospitalisation, if there was a possibility for me to arrive the hospital and the sickness is removed immediately and I go home, I think I will prefer that, likewise most parents (James: p.14).*

Mahaffy's (1964) study confirms the impression that some mothers prolong their child's stay in the hospital. Nurses who participated in his study remarked that, "mothers are not equally capable of giving appropriate care to their children. Some even hinder their children's progress" (p.56).

On the other hand some nurses work as a team to achieve their aims that are all geared at shortening the length of hospital stay, as there is much to do and not many nurses to meet the workload. Although these nurses work as a team, the mothers are not included in the teamwork and this leaves one to question why exactly mothers are present when they are not seen as able to assist in any way.

> *There is much work, so when there is a problem somewhere we all rush there and solve the problem fast. For example if it is to place a drip we do not let one person do that, we all go there, one person holds the child's hand or to give plaster while the other one is placing the drip. That is how we function and that makes things easier and faster for us (Elias: Interview 13, p. 4).*

4. Visiting in the neonatal unit is restricted to biological parents and mothers are not allowed to do anything

In the neonatal unit, visiting has always been restricted. Only the biological parents are allowed to visit, although the mother is allowed more visits to breast-feed the baby. The siblings and extended family are not allowed to visit but they can come as close as the glass doors to see the baby.

4.1 We do not see the necessity for parents in the neonatal unit but we have problems keeping some parents out

As it is the policy of the hospital not to let mothers live-in and visiting is not open to siblings or other relatives, there is a lot of controversy among the nurses concerning this policy. While some see the usefulness of this practise, others see it as a problem. According to some nurses like James, visiting in the neonatal unit should be restricted because this permitted easy movement in the ward.

> *Looking at the work we do, this is a busy unit and if they are going to let everybody in we will have so much problems. We cannot leave people in all through the day, it cannot work. For me I will say in the neonatal unit, the visiting should be restricted whether we are talking of affection or not (James: Interview 20, p.8).*

Contrary to the above practise of not letting siblings or other relatives visit in the neonatal unit, Thornes (1984) found that 86% of the units surveyed allowed daily visiting by siblings as the staff enjoyed the children coming in and out and it helped family relationships.

According to some of the nurses not having the mothers live-in with their children in neonatal unit is appropriate, as the parents' assistance is not needed. They (nurses) do everything and mothers have almost nothing to do when they visit since the children's needs are limited. For these nurses, they take complete responsibility over all the children in the unit and give instructions to the mothers on what to do for their children. For example in neonatal unit the mothers are to express breast-milk and give it to the nurses to do the feeding because according to the nurses, they (the mothers) will not know what to observe when feeding the child.

> *We [the nurses] take complete care of the children in neonatal unit; that is, when we arrive we try to make sure that the child is in a clean condition. We weigh the child to see the evolution of the weight; we observe the vital signs and how the child swallows when we are feeding in case of any problem. We check on the children's elimination and every other thing to avoid any*

> *problem apart from the medical treatment that we give. We also make sure that all the equipment is functioning well because that is very important (Paul: Interview 18, p.5).*
>
> *We ask the mothers to express breast-milk before going home and we preserve it fresh and during treatment or when necessary we give the child. The nurses feed the child not the mothers, because during feeding we control to see if the child is digesting well or not. There are lots of dangers involved in feeding such children and the mothers cannot know what to observe (John: Interview 19, p.6).*
>
> *In the neonatal unit the parents don't stay there because there is no space and the parental cares are not needed there. We don't see the necessity of their presence. The work there is easy because we have children whose only need is to eat and to sleep. So they don't disturb us at all. When they cry it means they are hungry or they are wet and that is making them uncomfortable. You don't have unnecessary calls that this or that is wrong. Working there is not disturbing. Everything goes on easily and since we know that there is nobody by the children we are at their service constantly (Elias: Interview 13, p.2).*
>
> *The mother does not do anything even when she is around; her role is just to extract milk for her baby. For those mothers whose babies can suck, they breast-feed the babies directly. They can observe their babies when they are around, for example those babies on phototherapy, if a mother notices that the plaster is blocking the nostrils she can come and tell us what is happening and we arrange it. If the drip finishes she can tell us and we replace it or remove it if that was the last one. When the baby is in the incubator, she doesn't touch the baby (Neolla: Interview 17, p.5).*

Some nurses do not let the mothers participate in any care giving as they assume the mothers will not know what to do or what to observe when caring for the baby since these babies are very fragile. In a study by Griffin, Wishba and Kavanaugh (1998) on 'Nursing interventions to reduce stress in parents of hospitalised pre-term infants' in Chicago, they note that it is beneficial for parents to participate in care giving activities early as early participation offers the parents the chance to help their infant. As well the most severely ill infants are more likely to die and this may be the parents' only opportunity to parent the infant.

Others feel that it is not necessary to have mothers live-in in neonatal unit because the children there do not manifest their love openly like older children.

> *As for the neonates, not to deceive you, it is not necessary for the mothers to stay in because these babies don't manifest their affection openly like the older children (John: Interview 19, p.6).*

In the neonatal unit since the hospital policy does not encouraged mothers to be there at will, some nurses see the importance of their presence only just to provide the things the nurses could not offer such as breast-feeding and mother-child communication.

> *The parents have visiting hours and that is when they come and communicate with their babies. The babies need the maternal warmth, that is why we insist on asking the mothers to supply much milk because this same milk is food and a facilitator. It facilitates exchange of communication between mother and baby (Elias: Interview 13, p.2).*

Added to this not having mothers in neonatal unit is a big issue that causes lots of discomfort to both the mothers and the staff. Some mothers do not feel comfortable leaving their children in the hospital. They may not be able to go back home, and therefore stay around the hospital. This behaviour is disturbing to some of the nurses.

> *We are confronted with very serious problems when a mother is at home and she arrives in the morning to be told the baby died in the night. If the previous day she left her child breathing normally and was not told of anything serious, though it could have been existing by then but not noticed. If she were around saw the condition changing for the worst it could be easier. Me for example I was attacked by some parents whose child died in their absence. The parents were at home and they came back around midnight to see how the child was progressing. Unfortunately when they arrived they were told the child died around 11pm. They molested us till 3am, we were unable to do anything and they could not even allow us treat any other patient. They were eight and were following us everywhere. It created panic among the other patients and there was no means even to call the security. We were very scared of them (Neolla: Interview 17, p.4).*

> *There are some mothers that cannot stay at home while their babies are here, they come and stay here throughout the day and it is disturbing to us because we know they need to rest. These mothers stay sited here all through the day with no place to rest and that is tiring for them (Marie: Interview 21, p.6).*

4.2 We try to explain and convince the mothers to leave their babies with us

Some of the nurses acknowledge their role and responsibilities and the control they have over the parents. They view themselves as people capable of handling all situations as Neolla explains below what she does to help a mother having difficulties leaving her child in the hospital.

> *On admission we convince the mother to accept the situation [in the neonatal unit]. Convincing the mother is one of the roles of the nurse. We have to convince the mother since there is no place here specifically for her to stay. But in the night when we see that it is very difficult for her to leave her child here and go home, we let her spend the night. For example we had an Anglophone lady here when we asked her to go home, she told us she could not leave her child here alone with us. We did all to convince her to no avail. Later this lady went and sat out on the corridor she started sweating profusely. We saw that if we don't let her something bad could happen to her. She couldn't understand why we were separating her from her child. When I went to talk with her later she explained to me that her husband died leaving her with the pregnancy of this child. Now she doesn't have a husband and giving birth to her child we want her to leave her child with us and go home because he is sick. She asked us to put ourselves in her place and see if it is easy to understand. I explained the situation to my colleagues and we decided to let her stay all through the period of her child's admission (Neolla: Interview 17, p.4).*

Some nurses help parents cope with separation from their children by trying to gain their confidence. They make the parents see that they empathise with them and are ready to do their best for the child.

> *For me when I spend time talking with the mothers, some of my colleagues see my behaviour as abnormal but since I was taught what a good reception means to a patient or their family I try to spend time with the mothers when they arrive. At times the way I talk to a mother convinces her to leave her child and go home. I tell them to have confidence in us and we will do our best*

> *and leave the rest to God to decide and they accept, they confide in us and go home (Neolla: Interview 17, P.4-5).*
>
> *When we see a mother looking lost or sad [because she has to leave her baby behind and go home] we take time to talk and explain things to her and this makes her have confidence in us (Marie: Interview 21, p.5).*
>
> *When the mothers come we explain to them whatever problem their child is having and why we have to separate them. After explaining things to them if they accept to leave their children with us that is okay but if they insist on taking the children home, we let them do so after signing that they have taken their child home against medical advice (James: Interview 20, p.11).*
>
> *We try to let the mothers know that it is the situation of the children that has made us separate them from their children. We take time to reassure them when explaining the situation and make them understand the necessity for the separation (Paul: Interview 18, p.7).*

Griffin, et al., (1998) note that the mothers felt sad leaving their infants in the hospital and going home when they were discharged. In recognition of the sadness of the mothers, the Chicago nurses called on regular times to update the mothers of the infants' condition and that was very reassuring to the mothers. In a situation where the mother was unable to visit from her hospital room, these nurses took pictures of the infant and visited this mother with her infants' pictures and also gave the mother information about the infant's appearance.

We inform parents when they arrive

Informing parents, according to the some nurses, depends on who receives the patient at the time and there is no written document that is given to the parents. For parents who can read there is a small note behind the door of the neonatal unit informing them of the visiting hours. On the contrary in Thornes' (1984, p.17) article a sign with a picture of a baby and bold print writing states: "Welcome to the neonatal unit. Please come and visit your baby as often as you can". It is pasted on the main entrance to the unit. This information is what the parents need at the time and it makes them feel very welcome there but it is the contrary in this study.

> *It is the responsibility of the nurses to inform the parent when they arrive. But the problem is that in the neonatal unit the baby arrives first with no mother or father. They receive the baby and the mother is still lying there in the maternity and when she arrives afterwards, they forget that they had not given her any information since the baby was brought down with no parent accompanying. They start immediately by asking her to bring this or that, that is lacking not knowing that they had not explained things to that mother. At times when the parents arrive they meet a different group and that group assumes that the group that received the child explained everything to the mother. That is what causes all such problems (Marie: Interview 21, p.3).*

4.3 Wearing of gowns protects the children from exterior contact limiting infection

Some nurses assume that mothers introduce infection to the children therefore the mothers are expected to put on a gown and shoes provided when they are going into the neonatal unit.

> *Yes it is because we are trying to protect the environment where these premature children are staying so we have adopted the system of wearing the gown and changing of shoes and these things are used only in the neonatal unit. When they [parents] are coming in they wear these things and take them off when they are going out to avoid contamination (Paul: Interview 18, p.4).*
>
> *The first problem is infection. In a service like neonatal unit, the more you let visitors come in the more you run the risk of major problems. It is specified that visiting here is for the mother and father only but there are some people who sneak in when the nurses are busy somewhere else and not looking, visit the baby and rush out. Since they rush in, open the incubator and see the baby before somebody comes, there is no time to respect other roles like washing the hands and whatever: In such a situation anything can happen (James: Interview 20, p.10).*

The policy of parents putting on gowns and washing hands before approaching the baby is seen as protecting the baby. They (nurses) let the mothers do that often hoping they will learn some practical lessons and continue when at home after discharge.

> *You know that observation is a second school and constant practice makes perfect. While here we don't permit them to touch the child anyhow, and at home the mothers will do the same thing. When a mother enters here the first thing we tell her is to put on one of the gowns provided which is hanging outside the ward and wash her hands before coming to touch the baby. You see if they spend a week here doing that when they arrive home it will be a reflex and she will continue doing it though she might not have a specific gown to put (Elias: Interview 13,p.4).*
>
> *We tell the parents that when they get home after they are discharged from hospital, they can only take out the baby from its cot to feed, bath or change him/her. That is all, nothing else, not to go with the baby to the living room for anything sake because the baby is very fragile and do not need too much disturbance (John: Interview 19, p.9).*

Since some nurses assume that mothers are possible sources of infection, they monitor the mothers closely. For example only the mothers seen as 'clean' are allowed to extract breast-milk at home and bring to the hospital for the feeding of their babies.

> *At home if the breast is full, the mothers can extract and throw away but the mothers that are clean and have feeding bottles at home can extract the milk and put inside the bottle and bring in the evening when they are coming for visit (Neolla: Interview 17, p.6).*

4.4 Conclusion

The data collected from the nurses has been analysed using Burnard's (1991) thematic content analysis and three themes emerged from the data. These were: we did not need parents but now we do; meeting the children's needs and readying them for discharge home; visiting in neonatal unit is restricted to biological parents; and mothers are not allowed to do anything. From these themes were developed sub themes. 'Meeting the needs of children and readying them for discharge home' has been used as the main heading for this chapter because it seemed to stand out clearly from all the nurses' interviews that this is their main goal.

A lot of contradictions exist in the data from the nurses' perspectives. For example there was a general acknowledgement of the visiting policy change that took place.

Some say the procurement of drugs was the main reason for the change to accepting parents live-in while others say they were just following the change of events that have taken place in other hospitals. The nurses viewed having parents live-in differently, some were pleased with their contribution while others felt uncomfortable in their presence. The next chapter presents the data from the parents.

Chapter Five: I am satisfied with the care although I am not always allowed to be with my child at will

1. Introduction

According to Bowlby (1995) what is believed to be important for the mental health of an infant or young child is the experience of a warm, intimate and continuous relationship with the mother or mother-substitute in which both find satisfaction and enjoyment. The child needs to feel he/she is an object of pride to the mother. The mother needs to feel the child is an expansion of her own personality. Therefore "mothering a child is not something that can be arranged by roster, it is a live human relationship which alters the characters of both partners" (Bowlby, 1995, p.67). Any hospitalisation of a child is likely to be stressful for the child and family. The family going to the hospital has a lot of fears, such as fear of loss of control, fear of bodily injury and pain, stress of family separation and uncertainty of the outcome (Ladebauche, 1992).

This chapter presents the experiences of parents who live-in with their child or parents who may only visit hospitalised children in the paediatric ward. The experiences and feelings of the parents in the study are presented under the following 3 themes, which emerge from the data analysis.

- At first mothers were not allowed to stay but now we are.
- The babies in neonatal unit have no right to have their mothers live-in.
- I am satisfied with the care although I am not always allowed to be with my child at will.

The first section introduces the visiting policy changes as acknowledged by the parents and its consequences in the general paediatric ward. The second section brings out the practice in the neonatal unit and its effects on the parents. The third section brings out the variance of ideas as expressed by parents.

2. At first mothers were not allowed to stay but now we are

Changing the visiting policy of the hospital had many consequences on both the health care providers and the patients and their families. In this section some parents acknowledge the change and its effects on the care received. Although the staff of the hospital would better record a change in hospital policy, since patients are most often temporary, some parents of the hospitalised children acknowledged cognisance of the previous and present practices (visits only and living-in). The parents' knowledge of the change came about by either previous visits to this paediatric unit or they had heard from other people. Previously parents (mothers) were not allowed to live-in but, as well as other family members, had only visiting rights. One parent is now allowed to live-in with the hospitalised child.

> *At first mothers were not allowed to stay here, there was no bed for the mother. It is just recently that they discovered that there are certain children who would not stay without their parents around (Susan: Interview 7, p.2).*
>
> *When my son was born here five years ago, parents were not allowed to stay with their children so I was going back home always and coming back in the morning (Comfort: Interview 16, p.5).*
>
> *Compared to not living-in, as was the practise at first, I never will choose to stay at home. I would never leave my child here alone. No it will never happen to me (Helen: Interview 4, p.6).*

The parents advanced various reasons for the change in policy as well as personal experiences as dealt with in the following sections.

2.1. We buy drugs for the treatment of our children from the hospital pharmacy or in town and it can be dangerous at night

Given that parents pay for services, hospitalising a child in this paediatric ward is seen as a financial burden, especially for those parents with low incomes. The financial burden increased with the policy change from not having parents live-in to having parents live-in. Now the parents have to pay for services as well as travel to town for drugs for their children. This requires spending money on taxi fares or fuel for the car. Their safety is potentially endangered especially when they have to go out to other pharmacies in town at night in search for drugs for their child. This search for drugs results from the supply policy change. The hospital pharmacy does not operate in collaboration with the other hospital units.

> *Normally we buy the drugs here but if they don't have them, we go out to get them. If it is in the night, then it is worse. They should arrange to have all the necessary drugs here and always check their stock so that when it is finishing they buy more instead of compelling patients to go looking for drugs out of the hospital (Grace: Interview 15, p.4).*
>
> *I thought everything was provided here in the ward and only included in the bill but they write a prescription and I have to go to the pharmacy to buy. At times it is not available in the pharmacy and I have to go and buy it in town. And when it is getting late in the night it is unsafe. Worse still, you arrive with a child and are given a prescription to go out and buy. The security of the parent is not guaranteed. And for the patient it is not good because no treatment is given until the drugs arrive (Helen: Interview 4, p.6 - 7).*
>
> *One needs money especially when your child is having meningitis, because whenever there is a prescription you have to run to the pharmacy. If you do not have money it will be terrible. They take good care of their patients, though expensive. That is the most important thing. If you don't have [money] there is nothing that can be done (Joan: Interview 3, p.2).*

In this hospital, the parents did not expect to go searching for drugs since they paid for the services. They felt dissatisfied that the hospital did not supply the important drugs, and they had to leave their sick children alone to go looking for them. Parents who did not have the money to buy the drugs found that no treatment was given to their child. No matter the urgency of a condition, the commencement of treatment was delayed until the parents brought the drugs and this could be problematic. In Cote-d'Ivoire, the situation is similar as access to drugs depends on whether parents can afford to pay them. The doctors write the prescriptions and the patients' families then have to go and buy the drugs from the hospital pharmacy before they can be administered (Kone, 1998).

2.2 It is difficult for a mother who has other children at home to stay in the hospital

According to Meadow (1964) in his study mothers were given beds to stay with their hospitalised children but most of the time the rooms were empty with the mothers staying at home. In trying to understand why, 400 women with sick children in the hospital were interviewed. The findings showed that mothers with other children at home under the age of 15 years were more likely to refuse living-in. Social class and the age of the sick child had no relevance. As well, some mothers felt that there was no need for their presence as nurses were trained to look after children. Others did not believe that leaving a child alone in the hospital did any harm to the child as they felt "children should learn to stick up for themselves" (p.814). With regards to employment outside the home, that was no reason since very few mothers then had jobs and for those with jobs taking time off was no issue. Although this study was done in 1964, about 36 years ago these findings were similar with the way some mothers of the children of this hospital felt.

Some of the mothers had experienced both systems and did not all want to live-in with their hospitalised children. These mothers did not want to live-in because they had other responsibilities or felt that the nurses needed to take complete responsibility of the children whilst in the hospital, similar to Meadow's (1964) findings above. As well, for some, living-in was not an option as some mothers were asked to stay with their children by the medical staff and so they were obliged to stay. This increased their burden of housekeeping and care for other children. They would have preferred, as Comfort and Mercy relate below, to live-out and visit.

> *Well I think there are many things the nurses don't look at again because the mother is there. For me I think it is not normal because the child is in the hospital at their disposal. Normally I think it is for them to take care of everything. It is difficult for a mother who has other children at home to stay in the hospital. I would have preferred that they take complete care of the child within the few days that the child is here (Comfort: Interview 16, p.5).*

> *Well I will prefer to be home because I need to take the other child to school and back. I am here because the doctor says I should be here. If he says that I should go home I would go. For now I am staying here even if it is inconveniencing to me because he also needs my assistance, especially going to the toilet (Mercy: Interview 12, p.5).*

According to some mothers although they had accepted living-in with the sick child, they were faced with other situations such as having to bring two children to the hospital.

> *I came with my baby because he is one month ten days old and he is strictly on breast milk so I could not leave him at home. If I left him at home I will not feel comfortable staying here, neither will I leave this sick one here and feel at ease at home. But I must accept that it is not easy being in the hospital with two children (Helen: Interview 4, p. 2).*

Some of the parents had to abandon work to be able to live-in with their hospitalised children. In some instances both parents were living-in. One stayed with the child while the other ran around for whatever was needed. This disturbed their work as Susan and Thomas relates below.

> *I did not take lectures this year because he has been sick since.... He was hospitalised in.... He is a sicklier. He had malaria crisis just when schools were re-opening. I spent all of the month of ... in the hospital. I didn't take up any teaching for this academic year so my lectures were given to another person. This year I will just roam around. My boss knows that I have a child handicapped by sickness (Susan: Interview 7, p.3).*
>
> *We are obliged to be present so that if they need a drug at any time there is always somebody to run and get it. It disturbs my work. I am forced to be here at least twice a day (Thomas: (father) Interview 15, p.4).*

As well some mothers were obliged to depend on the other children at home to care for themselves and manage their businesses.

> *I have a big girl, 14 years old, so she takes care of her junior sister who is 10 years. I call and give instructions on what to cook, or do, and advice on locking the doors and windows before sleeping and any other thing. As for my business I am forced to have confidence on the people*

> *working for me and I ask the girl to collect money from the workers every evening and to let them write the amount of money given and sign (Elisabeth: Interview 1, p.6).*
>
> *I have five other children in the house and he is the sixth. I am a high school tutor. I am not happy being here because of the other children at home, though I have big girls that I taught how to manage the house and take care of the younger ones (Susan: Interview 7, p.2).*

Some extended family members knew the difficulties of having a child in the hospital and were readily available to share responsibilities. They worked together as a unit, supporting each other. For example when a mother was to go home for one thing or another the father, if he was available, or an extended family member came to be with the child. This caused a lot of disruption in the normal functioning of the family. The parents shared responsibilities or support from the family while in the hospital with the sick child to reduce some of the difficulties.

> *I stay the night here and go home in the morning to come back in the evening. When I go home his father comes to stay with him (Patricia: Interview 12, p.3).*
>
> *My mother is at the house. I was lucky that she was visiting when my daughter became sick so she takes care of the others at home (Lois: Interview 8, p.2).*
>
> *Yesterday I went to work and my junior sister stayed with him. Most often I spend the night and my junior sister stays with him during the day (Comfort: Interview 16, p.2).*

2.3 We have to be here always because the nurses need us

Staying in the hospital has been seen as a necessity. According to some mothers their presence was very important given that reduced staffing had limited the attention given to patients. These parents saw their children as being vulnerable and needing close supervision and assistance, which the nurses could not do as they (nurses) were not readily available for their children.

> *I have to be by him always. He has constant pains [he has sickle cell anaemia] so I need to be massaging him. The nurse has to take care of other patients and not permanently him alone since the nurses are not many. I have to be here in the night and in the day, when he is having pains at the joints I massage him, when he needs to go to the toilet I take him there. In short I*

> *need to take care of him in all aspects and report to the nurses when the drip infiltrates, or I stop it (Susan: Interview 7, p.3).*
>
> *No, I will stay with him even if it were disturbing to me because when he needs to go to the toilet he needs help as, he cannot walk (Patricia: Interview 12, p.4).*
>
> *It is not easy for a mother to be out of the ward when the child is sick. It is not even safe because a nurse cannot come and stay by my child all through the day. If I am there I watch over my child and call them if there is a problem. If the mother is not there and the nurse goes to their nursing station or to do something else before coming back, the child might be in problems with nobody around to call their attention (Mercy: Interview 11, p.5).*

As mentioned in chapter one, the neonatal unit is included in the paediatric service and there are only three nurses on duty at a given time covering the service. Some of the mothers acknowledged that with only three nurses, the workload got heavier when the neonatal unit had many babies.

> *If there was a possibility I will like that the administration thought of adding the nursing staff. Instead of three in a shift let them put at least five. For example when there are many babies in the neonatal unit with some in the incubator, more time is needed there. When one has a problem here, the nurses are taken up there and cannot come fast enough (Susan: Interview 7, p.5).*

According to others the change of policy had been influenced by the staff shortage, although they had no knowledge of what was happening before the policy change.

> *I am wondering how they were managing at first when parents were not allowed to stay. I am sure they now accept parents to stay because of reduced staffing (Thomas: Interview 15, p.4).*

Darbyshire (1992) noted that parents wanted to live-in in order to help their child in practical ways. The sort of help these parents gave their children was in doing things such as taking the children to the toilet, as the nurses were so busy. Being present and able to assist the child was considered as "one less for the nurse to look after" (p.71). Similarly most of the parents in this study were happy living-in with their hospitalised children to help the children meet their needs and reduce the workload of the nurses.

2.4 Personal experiences as a living-in mother

Hospitalisation is invariably a stressful situation for the patient and family. The mothers of the hospitalised children in the paediatric ward, although pleased to be able to care for their children, had many personal issues surrounding their being in the hospital with their sick children.

2.4.1 They want us here but there are no facilities to meet our needs

The hospital does not provide facilities for mothers to meet their own basic needs. Therefore accessing basic needs such as food or taking a shower involved a lot of inconveniences to the mothers themselves and others directly or indirectly involved with the sick child. These mothers may be forced to leave their child alone to meet their own needs.

> *There is a toilet there but no shower. I go back home to take a shower (Mercy: Interview 11, p.3).*
>
> *Food here is provided for the children only. If I want to eat I either go out of the hospital to get something or my family brings me food. And to take a shower I always go home and do that before coming back (Grace: Interview 15, p.3).*
>
> *I have been given a bed but no food. When food is brought, they specify it is for the child. It is bad to feed the child and not the mother. It can happen that one does not have a family here or anybody to help and is here alone with a child. If you do not eat here where will you get food to eat? The other problem for me is shower; they refuse us meeting our needs. You can't get up in the morning to take a shower. Somebody like my neighbour stays very far, she cannot get up in the morning to take a shower at home as I do. If there was a shower room that we can use when we are here with a child that will be better (Janet: Interview 5, p.3).*
>
> *Having somewhere to take a shower is the big problem. When I just arrived I spent two days without taking a shower. Yes, it is disturbing a lot especially for us not coming from Yaounde, what are we supposed to do (Lois: Interview 8, p.3)?*

Although other parents said they were not fed while living-in with their hospitalised children, one mother remarked that the mother could be fed if she paid an additional fee each day for her meals. According to Helen, the money could be paid but the quantity and quality of the food was not always as expected.

> *Mothers are not given food but a mother can be given food if she pays an extra fee each day for her meals. The sad thing is that you cannot eat what you want; you are forced to eat only what you are given or you will die of hunger, except supplementary food is brought from home. The quantity is also not much but we are obliged to make do with what we are given to be able to have strength. I must eat to be able to take care of my two children here (Helen: Interview 4, p.3).*

Callery (1997b) did a study in Manchester, England exploring the costs of parents' involvement in their children's care in hospital. Callery noted that the costs could be financial, social and personal. Parents experienced difficulties providing themselves with adequate and affordable food and drinks while in hospital and some had to involve relatives to bring them food. Despite all the inconveniences as noted above, the mothers were pleased being in the hospital with their sick children as they worried less, mainly because they saw the child getting better.

Mothers express their concern for their sick children in different ways. Although not being provided with food was an issue for some mothers, their child's condition sometimes made them feel so low that eating did not matter much to them as their greatest wish at the time was for the child to get well. Others got distressed after knowing the diagnosis of the child.

> *Well my greatest wish is for my child to get well. The problem of food, it is just in the past days that I managed to eat. When she was very sick I could not even eat. I had no appetite (Lois: Interview 8, p.3).*
>
> *I was afraid because I know that meningitis is a sickness that does not pardon people always. A mother with a sick and hospitalised child is worried; she is troubled, she is afraid because anything can happen. When I arrived here that is how I felt. I cried here like a mad person. That is to say when a child becomes sick the mother is actually not alive because she does not sleep, she is worried and she thinks of everything especially bad things (Joan: Interview 3, p.2).*

2.4.2 We try to occupy ourselves while in the hospital

Some parents may not be fully occupied caring for the child during hospitalisation; therefore they use their time in the hospital with their sick child in different ways. Some occupied themselves reading while others, if the child felt a bit better, taught the child so that he/she did not miss out on schooling.

> *I spend my time reading novels most often (Lois: Interview 8, p.3).*
>
> *When he is feeling better like now we work together. I teach him so that he does not miss out a lot from his schoolwork. He has all his schoolbooks here. We work together. The doctor said I should not push him too much so when he is tired, I let him stay and I do crossword puzzles and reading. I read a lot (Susan: Interview 7, p.4).*
>
> *I read if I have newspapers when I am idle (Comfort: Interview 16, p.3).*

The idea of mothers seeing themselves as being either idle or bored while in the hospital with their sick children has been noted earlier by Meadow (1969). He was the house physician and he carried out a survey over the period of two and half years to find out what mothers felt about their stay in the hospital. Some mothers remarked that they were bored living-in with no house chores to do and were forced to stay in an uncomfortable room with their child for twenty-three hours a day. Similarly the mothers in this study found themselves idle at times and resorted to reading or doing other things just to occupy themselves.

2.4.3 We need spiritual and psychological support

In times of crisis many individuals look for support in different ways. According to some of the mothers they spent time looking for spiritual support when there was nothing else to do for the child. They prayed to God for their children's' recovery or thanking him for healing.

> *When I finish cleaning or feeding him since he eats and sleep only, I pray to God to help him and help all of us to go through this stage (Mercy: Interview 11, p.3).*
>
> *Well I say thank you to God because I did not know if I would see my child again. When I look at him now I give thanks to God only (Patricia: Interview 12, p.2).*

> *Being here now I give thanks to God because his hand of grace has touched me for I can see now that he is out of danger (Joan: Interview 3, p.1).*

Others turn to the nurses for moral support as Janet explains below.

> *Psychologically, I need a lot of moral support. I talk with the nurses a lot and they reassure and comfort me. I feel at peace and able to go on after talking with them (Janet: Interview 9, p.4).*

Some of the mothers got reassurance and comfort from talking with the nurses. Similarly in Miles and Frauman's (1993) study, parents indicated that the nurses encouraged them and helped them overcome their fears.

2.5 My being here reassures my child

Despite the inconveniences of living-in as mentioned above, some mothers were happy being by their children and they acknowledge the effects of their presence on the child.

> *What is sure is that though my child does not speak he somehow feels my love. At times when I speak to him, he smiles as if he understands what I am saying. That is how God created children, I can not explain but I know that my presence uplifts him. I am sure he can feel my presence somehow (Mercy: Interview 11, p.5).*
>
> *I think my presence here uplifts him a bit because as he sees me by him he feels at ease and I think it is influencing his recovery. It gives him a speedy recovery (Grace: Interview 15, p.2).*
>
> *Psychologically my presence here is good for her. I am sure that if I leave her here alone she will be angry and crying always (Helen: Interview 4, p.2).*
>
> *I am here because it is good for him. He needs that affection. My presence here reassures him since he is afraid of people he is not familiar with. When he sees someone entering he thinks they are coming to harm him but when I am here I assure him that there is no problem and that they are not going to harm him. I think it is necessary for a mother to stay by her child (Comfort: Interview 16, p.3).*

Some mothers acknowledge the effect of their presence on their children emotionally or psychologically. For example some mothers noted that their presence was comforting and reassuring and promoted a fast recovery since the child felt safe and secure. In Darbyshire's study in 1992, he notes that parents wanted to live-in to prevent the negative effects their absence had on their children. The most important reason for these parents wanting to live-in was for the emotional wellbeing of their child. Coyne's (1995) study in London, looking at partnership in care, notes that parents felt their presence was necessary to relieve the fear of hospitalisation, provide reassurance for their child and help the child recover quickly from their illness. As well some parents felt the nurses were too busy to provide consistent care for their child.

3. The babies in the neonatal unit have no right to have their mothers live-in

In this hospital the neonatal unit is part of the paediatric service. The parents of children in the neonatal unit are not allowed to live-in and other family members are not allowed visiting, but could view children from a distance. This practice has been maintained since the creation of the hospital. Others see this practice as an irony as the parents of older children live-in and not parents of neonates. According to Janet the mothers of neonates are needed more.

> *Where you see the mothers with their children, the mothers are allowed to stay, I don't know why. There, the children have the right to having somebody beside the child but not here. My premature baby does not have the right of having his mother by him. This for me does not seem right because I think my baby needs me more (Janet: Interview 9, p.4).*

3.1 They say the room is 'sterile'

In a situation where a mother has a normal delivery and goes home immediately with her baby, the risk of hospital-acquired infection is limited. When the baby has to be taken to the neonatal unit either because it was pre-term, or sick, or for observation because the mother had a caesarean section, the risk of infection becomes an issue. Parents are not allowed to come into the unit without covering up with a gown and changing shoes for fear they will infect the children. Furthermore, visiting in this unit is strictly for biological parents, although some fathers were not allowed in, and sometimes their visit was very limited.

> *No, we don't have the right to enter at will though one nurse told me, the father and the mother have the right to enter. I was left to stay in as long as I wanted to but a student nurse came and told me after a while that I had to go out. She said staying in I could soil the room and the children will be infected since the room is sterile (Elisabeth: Interview 1, p.3).*
>
> *Family members are not allowed to enter. They only see the child through the glass doors because it is a sterile room with other premature babies. The father is also not allowed to enter. He only sees the child through the glass doors. They say that he is not sterile. We as mothers, put on uniforms and shoes before going in (Ann: Interview 2, p.4).*
>
> *They are sterile things; we are not supposed to enter into the room dressed anyhow. They have sterilised them because the babies in there are delicate. With the dresses from outside it is good to cover them a bit, as they are not sure of our dresses (Pauline: Interview 9, p.6).*
>
> *Arriving in front of the room I change my shoes with the ones at the entrance, I put on a gown over my dress before entering. They say that the gown protects. For example, if the dresses you are wearing are infected, the gown protects the baby. The shoes are not used out of the room so they are clean not to pollute the air where the baby is staying (Beatrice: Interview 10, p.4).*

Others know that a 'sterile room' means it is free of any living micro-organisms.

> *When they say the room is sterile, it means it is not accessible to microbes. For me it is an image they want to create in the head of those entering the room that the baby is in an environment clean and sterile and we are not supposed to be afraid. If you have your baby in this room you are not suppose to be afraid the child may inhale any microbe because the room is sterile. Well, though I see it as an impression, I am happy knowing that my child is in a safe environment as I see that it is very clean. When I get home, I will make sure I maintain high hygienic standards for his sake. I know when something is clean; there is at least 50% chance of not having micro-organisms around (Beatrice: Interview 10, p.5).*
>
> *For me I accept the idea that the room is sterile especially for those coming from outside. I think they are right. Someone like my husband is working at … [a town out of Yaounde] and with all difficulties he faces on the way with all the dust should not just come and enter a room with delicate new-borns (Ann: Interview 2, p.3).*

Parents (mothers) of neonatal unit babies in this hospital seem to believe the rooms were sterile and safe for their babies and intended to respect this practise while at home.

3.2 Upset about being without my baby

When a child is hospitalised in the neonatal unit, that child is separated from his/her parents. This separation always affects the relationship (bond) with those involved directly or indirectly in many ways. Some mothers, after giving birth, were separated from their babies because of ill health. The babies had to be taken to the neonatal unit for observation and possible treatment. The mother was not allowed to live-in with this child. Some of the parents (mothers) of neonates missed that opportunity to bond to their baby. This may be prolonged if the baby was premature and put in the incubator. These mothers were worried about the separation, their babies' condition and the need to get to know their new babies. These mothers expressed their worries in different ways.

> *When you give birth you want to have your child with you but if the child is somewhere else that is disturbing and painful. I miss my child a lot. The pains I feel are not physical but pains at heart. I can't be with my child when I want to. That is very painful. It is not easy; imagine all what goes on in my head. I know I do not have to worry too much because it might result into depression. I am forced to be brave (Elisabeth: Interview 1, p.8).*

> *...[pause] It is disturbing to me because I cannot see him at will. When I want to see him I have to go down there and this is disturbing to me. Actually I am not at peace. If he was down there for observation or to gain some weight only as he is a premature baby, that will be fine. But apart from separation he is sick. That is a double shock. When I go there to visit him...[pause] I forget that he is there because he is sick. I forget everything and just enjoy being by him at that moment (Agnes: Interview 14, p.2).*

> *I am very, very stressed; I don't know how to express it. I am not at peace at all. I think a lot of my baby. I am not at peace. I prefer to come and stay here next to him because when I am at home my mind is in the hospital and I don't sleep (Pauline: Interview 9, p.4).*

These feelings expressed by mothers were similar with the feeling of inadequacy expressed by the mothers who were separated from their premature babies in a study done by Seashore, Leifer, Barnett and Leiderman of Stanford University (1973) on 'the effects of denial of early mother-infant interaction'. Their findings showed that the denial of early mother-infant interaction had a negative effect on maternal self-confidence.

Kasper and Nyamathi (1988) conducted a study on 'parents of children in the paediatric intensive care unit'. Their results showed that being with their child was the most important need identified and the greatest stressor was the disruption of parental role in the neonatal intensive care unit. As well in Miles and Frauman's (1993) study the mothers expressed a desperate need of being a mother, carrying, changing diapers or bathing their baby. These mothers in my study were deprived of that also.

For others, in addition to stress and feeling of distress, they felt dispossessed when other children cried as that reminded them of their own babies' absence.

> *I feel emptiness. It is emptiness for a mother who has just given birth, who wants to carry her baby in her hand, feel him, sleep in the night knowing that at a certain time you will get up to breast-feed the baby. Not going home with him creates emptiness; more so when one is put together with mothers who have their babies with them. Hearing the children crying in the night reminded me that I also had a child but it was not by my side (Beatrice: Interview 10, p.4).*
>
> *...[Pause for about three minutes] You are a mother and when a child cries near you it is painful especially when your own child is not around you. You are always thinking of her. You cannot sleep and you keep wondering how your child is. At times the cries of the other children makes my heart beat as if it were my child. I don't sleep at night; I only start sleeping in the mornings (Regina: Interview 6, p.5).*

In this hospital the practise is that immediately after a caesarean section the baby is taken to the neonatal unit for at least 48 hours. This separation is to permit the mother to recover from the surgery while a series of investigations are being done on the baby. After the investigations, if the baby is cleared from any defects or infection, he/she is then taken to be with the mother. On the other hand if all is not well with the baby, then the mother has to be brought down to the neonatal unit to see and if possible breast-feed her baby. According to some mothers it was very difficult staying away from one's own child immediately after delivery. Ann relates how she could not recognise her child.

> *It is not easy; it is really not easy for me staying here without my baby. I saw my child three days after when I went down to breast-feed her. The nurses kept telling me, 'oh you gave birth to a beautiful baby with so much hair'. With that excitement when I arrived in the ward I found two children next to each other and both having much hair. I had to start thinking, which of them was mine, as I approached the beds. You see how you can see your child and you don't recognise her and she is there just by you (Ann: Interview 2, p.3).*

3.3 Not being able to care for my baby when I want to is not normal

Since the children were in the neonatal unit, the nurses did most of the cares with the mothers left with almost nothing to do. Some mothers missed that aspect of mothering their children because the system in place did not let them there at will. As well some fathers were not able to see their children because of the limited strict visiting hours.

> *The nurses feed and clean my baby. I want to carry my child and talk to her. I want to dress her myself. I want to take care of her for this is my first child. I want I want…[pause] It is very disturbing. I am just a few steps away from my child but I do not have the right to touch my own child, I can only see my child at times through the glass door. It is very distressful. Yesterday I cried here the whole day. The father is not staying here in town. He can't see his child when he wants. Can you imagine that since I gave birth he has not seen his child? When he comes late, they say that it is not visiting time (Elisabeth: Interview 1, p.4).*

> *For me not being able to be with my child when I want to is not normal. I was thinking that since I can get out of bed now, I can leave here in the morning and go and stay there throughout the day and I come back when I am tired in the evening to sleep. But that is not the case because I am not allowed to be there at will (Agnes: Interview 14, p.3).*

In addition to not being able to care for their babies some mothers do not know what is happening or what is being done on their babies.

> *Worst of all they are still closing her eyes with a bandage [as the baby is on phototherapy]. I have not even seen her face. I asked why they were doing that and my brother-in-law told me that is their job and that is what is to be done (Regina: Interview 6, p.5).*

The mothers of Meadow's (1969) study were worried because very little information was provided to them as regards their children's condition, for example one mother said, "I wish they would tell me why he has a temperature"(p.363). Similarly Regina expressed worries as her child's eyes were bandaged but she had no idea why that was done. Furthermore Miles and Frauman (1993) note that the severity of the infant's condition reduced the ability to respond to parental attempts to develop a relationship. The equipment on or around the child and the child's treatment were additional barriers to parenting as described previously by Regina.

3.4 I am compelled to be strong if I need to see my child

With the neonatal unit some distance away from the maternity ward where the mothers were left to recover, visiting their children demanded great efforts to withstand the physical discomfort. Despite the discomfort they were compelled to visit their children.

> *Now I am here at the maternity and my child is down there in the paediatric service. With a bandage on my stomach [post caesarean section] it is not easy going down to see the child. I don't have the strength. It is rather very painful, very, very painful. When I turn around and my child is not by me, I am compelled to be strong if I need to see my child. You know that if you are limping and hear there is an accident or a house is collapsing you will walk; I was forced to walk to see my child (Elisabeth: Interview 1, p.2).*
>
> *I go down on my own now, but the first day I was taken there in a wheelchair to breast-feed the child. But I was told that after a caesarean section walking is recommended. The second day I walked down to see my baby and slowly the pains disappear. Despite the pains when one thinks of the child one has to put in all efforts (Ann: Interview 2, p.3).*

> *It is very uncomfortable for me to leave here and go down to visit him. I feel pains. I was told I needed to rest because I was operated upon. I know it is necessary for me to rest and I am making an effort (Agnes: Interview 14, p.3).*

Others had to visit the hospital every day to be able to be with their children. They acknowledge how inconveniencing and burdensome it was travelling to the hospital. To stay healthy the mothers saw that they needed to look after themselves.

> *For my health, I take iron tablets because coming here is very tiring. One has to accept that it is very difficult and exhausting, I did not even have a day of rest after giving birth. I try to continue taking my iron tablets to prevent falling ill also. I try to take my drugs and feed well every morning before coming here (Pauline: Interview 9,2).*

4. I am satisfied with the care although I am not always allowed to be with my child at will

Sometimes the issues raised by the mothers contain contrasting perspectives within the same interview, and between views shared by other mothers. For example some mothers talk of being satisfied with the care while at some stage what they said denoted a feeling of powerlessness. Their views seem to agree on one thing – being compelled to bear the situations.

4.1 I am very satisfied with what I see them doing on my child

According to some of the mothers, they were impressed with the care their children received in the hospital as they noticed their children's condition improving. The extracts below explain the different ways the mothers appreciated the quality of care their children were receiving.

> *I appreciate the care given to my son. This is not my first time coming here with a sick child. Every time I am here I feel satisfied. When I was bringing this child here, I was really worried about the way he looked but seeing him now, I am very pleased. They [the nurses] take good care of the children here (Janet: Interview 5, p.4).*

> *I am very satisfied with what I see them doing on my child. Since he arrived here, I see him changing day by day. This is not the same child who entered here last Thursday with oxygen and all sorts of things connected on him. Now all what was connected has been taken away. He does not need oxygen again and all is going on normally. So I am satisfied (Pauline: Interview 9, p.4).*
>
> *I think they take good care of children here. He is responding very well to treatment. He is getting better. They don't do trial and error; they do lab tests and on the basis of the results, they diagnose and treat (Grace: Interview 15, p.3).*
>
> *When I go somewhere else I do not get the impressive results I get here. Here they [the doctors] take time to analyse everything. They don't rush to treat immediately and the nurses take good care of the children. At times some parents get impatient because they want immediate treatment. I feel it is not good to rush into treatment without assurance of what one is treating. They give treatment for the exact problem (Susan: Interview 7, p.4).*
>
> *They are very welcoming here and they take good care of their patient but you need money (Joan: Interview 3, p.4).*

Some mothers felt satisfied being in this hospital as the doctors and nurses had distinctive roles and together they met their needs. For these mothers, the satisfaction with the care came also from seeing many doctors working on their child. According to them the many doctors can treat any problem, giving them reassurance.

> *What I noticed is that many doctors follow up the child, I am sure some are student doctors but they are many taking care of her. When they finish with her they discuss the diagnoses and the treatment. This gives me assurance so many doctors on a patient, I think arrest even death. When the doctor prescribes the nurses are the ones that administer the treatment and err…they do all of what they are supposed to do. Yes, they are regular with their care (Helen: Interview 4, p.5).*
>
> *As for me even now I don't go to nurses for treatment. I believe that a nurse is somebody who administers a treatment and the doctor is one who examines and can determine exactly what is wrong. So I need to be besides the doctors always (Comfort: Interview 16, p.4).*

With three nurses on duty at a given time, the workload was heavy especially with babies in the neonatal unit as mentioned previously. Some mothers sympathised with the nurses because of the nurses' workload.

> *I am obliged to sympathise with the nurses seeing what they do as work (Elisabeth: Interview 1, p.6).*

4.2 They are motherly, they empathise with the mothers and the children

Others perceived the nurses as motherly as well as having compassion for the mothers. According to these mothers, the nurses cared for their children as their (nurses) very own. That made them pleased as Ann, Mercy and Beatrice relate below.

> *They are good. I am very satisfied with the treatment here. They are motherly. At times the nurses feel their absence when some children are going home. It is worse when a child dies for they talk with so much concern about the way the dead child's mother was caring for the child … They are really compassionate (Ann: Interview 2, p.4).*
>
> *Thanks to God I came here. Compared to other hospitals or centres, it is very nice here. Yesterday for example I met a nurse working on my child and she looked so devoted and I just could not stop thanking her. She took care of the child as if it was hers and that gave a good feeling in my heart (Elisabeth: Interview 1, p.6).*
>
> *Here in the paediatric service, I see that those working here, are people who have empathy for the mothers and children. They are people with children, like us, and are sensitive (Beatrice: Interview 10, p.7).*

Some of the parents, as mentioned above, were satisfied with care as a result of the improvement of their child's condition, a reduction of all the technical connections, the method of treatment, the welcoming, empathising and compassionate attitudes of the staff and having many doctors available to their child. Avis, Bond and Arthur (1995) noted that the high levels of patient satisfaction recorded in most standardised surveys related to the services. Most of the patients judged themselves to be satisfied when care met their expectations.

4.3 Going home and leaving my child in the hospital is annoying but what can I do, I am forced to accept

Despite being happy with the care their children were receiving, some mothers (of babies in the neonatal unit) were feeling powerless with the situation they found themselves in. These mothers saw themselves as forced to accept everything since they could do nothing to change the situation.

> *Well I have accepted it like that, even if I have to go home leaving him in the hospital. It annoys me but what can I do, I am forced to accept. After spending two nights up there at the maternity, I have tried to adapt to the absence because I know that I cannot do anything. If I decide to take him home, they will let me take him. But if something happens afterwards, they will say it is because I took him home when they had not finish with the investigations and treatment. So I am forced to accept despite the pain of not being able to go back home with him (Beatrice: Interview 10, p.6).*
>
> *Yesterday when the father came back from town with the results of a test he had to do, they let him in but were scolding at him because he was late. He is the father; it is not normal that they scold at him like that. I wish the nurses would put themselves in the place of parent. It is not that we can solve any problem or want to show that we know what to do or that we want to be nurses, but that they should try to understand us. I feel that some nurses are not polite with parents. I will like that the rude nurses try to be polite so those parents do not find themselves in a depressed mood (Elisabeth: Interview 1, p.6 - 7).*
>
> *I would prefer to be here often to visit my child, but that will depend on the nurses. If they tell me to come four times a day I will come (Regina: Interview 6, p. 3).*

Some were not only feeling powerless but also tried to be convinced that they were not guilty of any wrong doing that put their children in this situation.

> *For me as an individual, I know I do not have any fault because I know that throughout my pregnancy, I took every precaution needed. This situation occurred at the last minute when I least expected, and I have confided in God that his will be done. I am just accomplishing his will (Beatrice: Interview 10, p.3).*

The extracts above explain how powerless some mothers felt having to go home without their babies, as they had to be kept in the neonatal unit for treatment or observation. Though feeling powerless, a mother was happy, as she felt no guilt. Seashore et al. (1973) in their study, showed that early separation of mother and infant did not only affect the mothers negatively in their self-confidence but that the mothers felt inadequate as the paediatric nurses knew their infant better and they felt responsible for everything wrong with the infant.

4.3.1 I am dissatisfied in certain aspects

Some mothers were disappointed with the doctors because they felt their care fell below their expectations although they had to accept the situation, as they could do nothing.

> *He does not talk. What is disturbing me now is that I am some how disappointed with the doctors telling me that there is nothing they can do as regards his speech. I have tried to ask if they can try abroad and they tell me it is difficult. So I am obliged to accept the situation as it is and I leave everything in Gods' hands (Comfort: Interview 16, p.2).*
>
> *This hospital has lost some of its qualities. It is only the old nurses who have real concern for the children, the new ones do not have time, and they do not even want to work. For example I went to see a nurse that my child was having a problem and she told me she was taking her dinner and she could not do anything then. She was not worried at all. I offered my excuses and left. The old staff are perfect but these new ones are not worth as much (Comfort: Interview 16, p.5).*
>
> *I am very angry because I was not expecting this. If everything went on well, I would not have been here now. I spent long hours in labour. I am covered by my insurance, and did not know that I would be asked to pay cash again though I had some money on me. When I arrived, I was asked to buy a few things, which I bought but when the money got finish it was late. I could not send my junior sister home at 3 a.m. to bring more money. I asked the doctor if he could help me with the drugs or lend me his personal money to buy these drugs and I will refund it in the morning but he refused. My labour was then prolonged while my membranes ruptured long before then. I had the baby at 8 a.m. in the morning but it was too late, the baby had taken in water already. I reminded the doctor later that he was responsible for my child being here*

> *because of the few injections that he refused to provide when I ran out of money. Now it will cost me much (Beatrice: Interview 10, p.3).*

Some patients or parents believe that the medical personnel could satisfy all their needs when they were in the hospital. In the above extracts, Comfort seemed dissatisfied because the doctors could do nothing for her child and some nurses did not see the care for her child as a priority. For Beatrice going to the hospital to have her baby turned out to be burdensome in many aspects. All her expectations were destroyed. In her example above, there were many issues involved. Financially she was prepared for any eventuality since she was covered by her insurance but she was unaware that immediate cash may have been needed although she took some with her. She later ran out of money and the safety of her sister was at stake if she had to send her home at night to get some more money for things needed. This put the unborn baby's health at risk. The situation of the hospital where there were no emergency drugs rendering the doctors unable to help, increased the baby's risk further. This example confirms what some nurses said in chapter four that the child's condition could worsen when there were no drugs to commence the treatment.

4.3.2 They are the nurses, they know what they are doing

Some of the mothers saw nurses as all-knowledgeable (knowing) therefore whatever they said was accepted. They felt that what the nurses were doing was for the benefit of their children. These mothers did not see the need to express a contrary idea to what the nurses said. Others felt that expressing themselves would have meant trying to change a system in place.

> *...[Pause] yes, that is what they said, are we supposed to argue with them? How do I start to argue about it? That is what we were told, so I also wear it [the gown before entering] as every other person (Pauline: Interview 9, p.6).*
>
> *No, I did not ask, I felt that they have their reasons and I cannot change a system I met in place (Lois: Interview 8, p.4).*

> *They are the nurses. They know what they are doing. I cannot go against what they say if it is for the safety of my child and maybe others as there are other children also. I do not contradict health. I will persevere. I do not have a choice since I want my child to regain her health. All the same I will prefer that they let me enter even just to see her (Elisabeth: Interview 1, p.4).*
>
> *I do not know why I have to put a gown over my dress but I do only what I am told to do. I am sure they know why (laugh) (Regina: Interview 6, p.3).*
>
> *I would have loved to go home with her but since they want her to stay in the hospital, I cannot refuse for it is their profession. They know what they are doing. I am obliged to leave my baby and go back home (Regina: Interview 6, p.6).*

Some of the mothers accepted whatever the nurses told them and were comfortable with the nurses doing most of the cares, as they believed the nurses were more knowledgeable. Miles and Frauman (1993) note in their study that some mothers trusted the health care professionals and viewed them as the experts. These mothers wanted to take up their parenting roles only when the child came home.

In Cameroon challenging or arguing with a nurse is seen as an abnormal behaviour since it is believed that patients (parents) are ignorant. Similarly in an article written by Akiwumi (1994) a senior lecturer in the Department of Nursing, University of Ghana, notes that in Ghana the patient is expected to be ignorant about health problems and treatment. Being ignorant, the patient therefore is submissive and co-operative to the health provider, and is not expected to challenge instructions given. If not he/she is considered non-conformist and uncooperative.

Some mothers did not consider the nurses as all knowing so they had to be present to monitor what was done on their children. Others were able to note the behaviours of individual nurses with regard to their children.

> *My main aim of being there is for him to feel my presence. But when I am there, I watch to be sure that he is well fed and takes his treatment. Since I am the one who has to buy the drugs that are prescribed for his treatment I have to be there for that (Pauline: Interview 9, p.2).*

> *I ask them a lot of questions because I like to know whatever is being done on my child (Janet: Interview 5, p.4).*

According to Pauline and Janet, they observed the care given or ask questions for reassurance and to know what was being done on their child. Similarly the mothers, according to Miles and Frauman (1993), stayed closer to the bedside to monitor cares being given by the nurses especially when they were not confident in a particular nurse caring for their child. Callery and Luker (1996) noted that some mothers' reasons for staying with their children were for the child's emotional wellbeing and mother's reassurance. According to these mothers their presence ensured that their child was adequately supervised and cared for.

5. Conclusion

Data from the parents has been analysed using the same method as data from the nurses in the previous chapter. Three themes emerged from the data which were: At first mothers were not allowed to stay but now we are; the babies in the neonatal unit have no right to having their mothers live-in; and I am satisfied with care although I am not always allowed to be with my baby at will. Sub themes were also developed from these themes.

In the first two themes, the parents were expressing their feelings and thoughts in a consistent way but the third theme contains a lot of contradictions. The third theme brings together the first and the second themes. From the data one could gather that some parents were pleased with the change in policy while others were not and would prefer the previous policy where parents did not live-in. As well the parents of babies in the neonatal unit seemed to be very dissatisfied with the visiting policy but were obliged to accept the situation. There are lots of contradictory ideas within particular interviews and within different interviews. For example some mothers were happy with the care their child was receiving and at some stage were very dissatisfied with certain situation. One could conclude that although this contradictory idea, the parents (mothers) were generally satisfied as their expectations (recovery of their child) was met. As can be drawn from the data, in Cameroon (and some other African countries), challenging or arguing with a nurse or any medical personnel is seen as being uncooperative as they (hospital staff) are considered experts and so the parent had to be submissive.

The next chapter links together the data from nurses and parents, looking specifically at the impact of visiting policies on the care provided by the parents and nurses. It also discusses the aim of the nurses and parents and what they do together or separately to achieve this aim.

Chapter Six: Discussion

1. Introduction

This chapter discusses the issues arising from the six themes from nurses and parents, linking them together where possible while looking specifically at the hospital visiting policies in the paediatric ward.

2. Discussion relating to major themes identified

The two main themes that emerged from the data analysis were:

- Meeting the children's needs and readying them for discharge home (nurses).
- I am satisfied with the care although I am not always allowed to be with my child at will (parents).

2.1 The purpose of having parents present in the paediatric ward from the perspectives of the nurses and parents

In order to discuss the issues arising from the above-mentioned themes and link them where possible, there is a need to outline nurses' and parents' perspectives of the purpose of having parents present in the paediatric ward. Looking at the list in *Table 4*, there were similarities and differences between the nurses' and parents' views with regards to why the parents were present in the ward. Both groups acknowledge that parents were living-in to assure a constant supply of drugs for their children and to relieve the nurses of the workload. On the other hand for the parents their presence was to comfort and reassure the children and monitor the care. For nurses, parents were there to do for the children what the nurses could not do, and because others said that it was good to let parents live-in. Although some differences exist as to why parents were present in the ward, the nurses and parents had a similar goal, getting the child ready for discharge home. How both groups achieved this goal is developed later.

Table 4 Different views of having parents present in paediatric ward

Nurses' perspectives	Parents' perspectives
We need parents to buy drugs for their children	We are present in the ward to buy drugs for our children
We need parents because others say it is important	Our presence reassures and uplifts our children, facilitating their speedy recovery
We need parents to do for the child what we cannot do	We are present to monitor the care given to our children
We need parents because they are of great help to us as they assist us, reducing our workload	We are present to relieve the nurses from their workload as there are few of them

2.1.1 The nurses and parents are both working towards the child being sent home well but they have different roles in the process

In this study parents and nurses have relatively distinct roles with regards to meeting the child's needs in the hospital. The parents' role could be seen as a social role while the nurses' role is a professional role.

The parents' role (social role)

As outlined in the literature review chapter parenting "encompasses the custody and companionship of the child, opportunities to influence the child's values and moral development through religious training, and important education and health care decisions" (Anderson, 1998, p.936). The parents make the children feel safe in the world, and develop their own personality, thus parents nurture and shelter the child (van Manen, 1990).

In this study there were two groups of parents, parents of older children who were living-in and parents of neonatal babies who only had visiting rights. Although both groups of parents aimed at meeting the children's needs they had different experiences. For example the mothers of the older children had an average of three days stay in the hospital if the child's condition was not chronic or cerebral malaria while the mothers of the neonatal babies most often stayed longer. Ironically these mothers (of neonates) who just had their babies were given limited opportunity to bond with their babies if the babies were sick and had to be taken to the neonatal unit where they most often stayed for a week or more. The negative effects of separation as expressed in this study were with regards to the neonatal mothers, as the other mothers were not routinely separated from their children. Despite the inconveniences their experience was short-lived.

> *The mothers of the older children sat with, washed, fed, talked, read and played with the child. The children were never without the parents unless for few minutes if the mother had to rush to toilet or to get something. (Field notes).*

The mothers, in carrying out the above mentioned activities were caring for the child, thus parenting. Therefore the mothers shared the care of the child by providing the daily cares while the nurses and medical staff performed the procedures requiring more skills, similar to the findings of Webb, et al. (1985). The authors observed that hospitals where parents were living-in and providing basic cares for their children were more economical and the children were less disturbed. Also the confidence and competence of parents was reinforced and they could manage well with fewer nursing staff. The nurses and mothers met the needs of the child in respective ways; therefore their presence in the ward was a necessity as they took care of the physical and psychosocial needs of the child.

The mothers knew and understood the child's needs. It is clear from the data then that mothers were also in control. Here the mother, although not having the power to take certain decisions, was in control of the child's wellbeing in the hospital as she was with the child doing what was necessary to contribute to the child' health.

The nurses role (professional role)

The nurses concentrate on meeting the child's physical needs by administering medical/nursing treatment and readying them for discharge home as soon as possible. McFarlene (1977) has identified a range of nursing activities including assisting, helping and servicing aspects where the nurse helps another person to do things he normally would do for himself. Nursing is committed to a unique task providing 24-hour, 7-day a week service to people. This makes it different from other professions. Both the previous visiting policy and the present policy have a historical effect on the nurses. Despite the change in policy the major concerns for the nurses were still to provide appropriate treatment for the child and this influences their practice and their relationship with the children and their parents (those living-in and those with visiting rights only). The nurses seem to find themselves torn between carrying out the policy of restricting visitors (to please the administration) and yielding to the demands of parents.

The parent's main focus was also to see the children improve and to take them home as soon as possible. Therefore the nurses and the parents, although they have distinct roles, have similar aims to meet the hospitalised child's needs. Since both the nurses and the parents meet the child's needs by caring for the child, it is important to look at the different views of caring to be able to identify the components of caring.

According to Dawson-Wright (1997), caring has been likened to love, as love is a critical element of caring. Caring involves support, comfort, compassion, empathy, helping behaviours and activities relating to the maintenance of health (Leininger, 1981). Caring is a moral obligation where the end is protecting, enhancing and preserving human dignity (Watson, 1985). Caring is a feeling of dedication to other people (Bevis, 1981). The carer possesses appropriate knowledge and skills that help in performing those caring activities directed to meet the physical, mental and emotional, needs of the one being cared for (Kitson, 1987).

Caring and nursing seem to share the same attributes, which are "commitment, knowledge and skills and respect for persons" (Kitson, 1987, p.164). Therefore parenting and nursing are also similar in certain aspects but it is important to note that there were clear distinctions between what the nurses and parents did with the children in this study. With the limited number of nursing staff, the nurses concentrated on getting the task done, which was saving the child's life, with little time for the psychosocial aspects while the parents mostly take care of the psychosocial aspects.

In the Western countries nursing incorporates a wide range of activities, including the medical/nursing treatment and the psychosocial needs of the patients, but in

Cameroon the nurses, probably due to the limited number of staff, do more of the medical/nursing treatment only. As well the doctors influence most decisions including cares because they hold most of the administrative positions of the hospital and wards. For example the head of service of the paediatric service was a doctor. The nurses provide care as instructed by the doctors.

According to some nurses in this study, they let parents carry out cares for their children. This idea of letting parents may have been influenced by the fact that parents had always paid for services in this hospital but when they paid previously nurses had a dual role. They nursed and were seen as proxy parents to all children admitted to the hospital, as parents were not living-in. With the change of policy to having parents live-in, the nurses still saw a parent parenting the child as doing what they have been permitted.

The difficulties seemed to be that there was no clear negotiation between the two parties (mothers and nurses) as to who was responsible for what. This lack of negotiation created conflicts between the nurses and the parents regarding the different expectations from both parties. Since parents pay for services rendered, some expected the nurses to take total responsibility for their child including feeding, changing and cleaning the child on the ward. Very limited information seemed to be given to parents with regards to their role or responsibility for the child. The nurses assumed the parents present in the ward would carry out the physical cares such as cleaning, changing and feeding. As for the mothers, not being certain as to what to do seemed to be an added stress. As well, being usually unfamiliar with the environment and trying to adapt to their new role, coupled with the anxiety about the child's hospitalisation, was stressful enough. Despite the conflicts, the nurses acknowledged that the parents were of great help to them. The conflicts resulting from the different expectations from parents and nurses have been an ongoing debate in other children's wards or hospitals as Elfert and Anderson (1987) and Darbyshire (1994a) confirm in their respective studies.

Parents looked to the nurses for instructions on what to do and gave no cues as to how they wanted to be involved. The parents waited for nurses to tell them what to do, as that seems to have been the practice before and they appeared to be unable to carry out any cares without instructions.

This is an aspect of acceptance by parents of the powerful position of health personnel in the hospital. According to Pfeffer (1981, p.3) "power is having something that someone else wants or need and being in control so that the person in need has very little or no alternative means of obtaining what is needed". The parents' accepting of instructions most often from the nurses, with very little contribution indicated that there was a power imbalance, with regards to nurses (or all the health personnel). The nurses did not specifically tell the mothers what to do while with the child in the hospital, but the mother's care giving was limited to the basic needs. Allowing the mothers to carry out these basic cares, according to the nurses, was because there were fewer nurses, and not the policy of the hospital.

As cited in the literature review, since the publication of the Platt Report in England in 1959, much has been written on the psychosocial benefits to hospitalised children and their parents when close contact between them was maintained (Coyne, 1995; Darbyshire, 1993; Palmer, 1993; Young, 1992). Despite the literature, in this study the mothers provided limited cares (especially in the neonatal unit) thus limited contact while the nurses did most of the cares including the medical/nursing treatment of the child.

Letting parents live-in seemed to be a disputed practice. However, some nurses saw it as good for the child and the nurses as the mothers carried out some of the cares, reducing the workload of the nurses. The nurses saw parents as helpers or as filling the gap for the shortage of nursing staff. These mothers were not considered partners in care but helpers and they were doing something they were good at. Studies done in other hospitals also showed that nurses viewed parents as their helpers (Lloyd, 1955; Webb et al., 1985).

The presence of the mother is important if all of the sick child's needs are to be met, as it is not possible for the nurses to meet all the needs. Therefore mothers should not be considered as being there to fill the gap only. Some saw their being in the hospital not as an option but an obligation due to the shortage of nurses. This is similar to Rowe's (1996) finding as stated previously.

Although the mothers were made to believe that they were there just to fill the gap, they actually took a greater percentage of the care of the hospitalised child since they spent more time with the child and knew the child's needs better. The nurses most often were very busy and only got to a child's side to administer treatment or when a mother called their attention. Because the nurses were rarely with the children, some children saw them only when they came to perform treatment (sometimes unpleasant). Some of these children reacted very negatively by crying or screaming when they saw some nurses pass by. On one occasion a nurse entered a room and as he approach a child's bed, the child started to cry and clung to the mother. The mother cuddled the child reassuringly and saying:

> *Don't worry I am here, he [the nurse] will not hurt you, he is just coming to see how you are doing (Field notes).*

This showed that the child felt more secure being with the mother in the hospital and the nurse was the outsider. This child saw that nurse as an intruder. Therefore parental participation in their child's care should not be seen as help. It reduces the disruption the sick children and their families experience during hospitalisation, and improves the quality of care the child receives in the hospital (Callery, & Smith, 1991; Keatinge, & Gilmore, 1996).

Some mothers were given the opportunity to do more than just cleaning or feeding their child because they were considered 'enlightened' and could do more. Such mothers had a better relationship with the staff and the staff could rely on their judgement. On the contrary some mothers considered 'well to do' could not do anything for their child because it was normally someone else's responsibility. While in the hospital these parents did not want to touch the child. Nurses seemed not to establish a good relationship with such parents and found it difficult dealing with them.

2.1.2 Mothers in the neonatal unit

Although the mothers of the older children played a great part in the care of their child in the hospital because they were living-in, the mothers of the neonates had very limited responsibilities with regards to parenting their babies when they visited as they were not allowed to live-in.

> *The mothers never took babies out of the incubators but put their hands in and touched the babies. Mothers only changed the diapers of their baby if they were breast-feeding the baby and noticed that the baby was soiled (if the baby had no drips or any other connections) (Field notes).*

In the neonatal unit the nurses identified the importance of mothers' presence only with regards to the needs the nurses were unable to meet, like breast-feeding. Mothers were allowed more visits to breast-feed the babies but did nothing else to their baby. Despite this, there were controversial views among nurses with regards to restricting visits, (not letting mothers live-in) and mother's care for their babies when they visited.

Some nurses held that there was no need for mothers in the neonatal unit, as the babies' needs were limited. Despite the frequent visits, mothers there only watch their babies while the nurses did most of the cares since it was assumed mothers would not know what to do. Therefore nurses felt they could concentrate better on the baby and help them recover faster without being distracted by the mothers. This supports literature from the nurses' perspective that nurses felt a high level of responsibility towards the child, and lacked trust in the parents' abilities (Brown, & Ritchie, 1990; Keatinge, & Gilmore 1996).

Some neonatal unit mothers, although feeling frustrated for not being able to care for their babies, agreed with the nurses that their babies were fragile and they intended to continue similar practices such as limiting contact with the babies when they get home. But this practice contradicts the idea of helping a family relationship or giving the parents an early opportunity to parent their baby (Griffin, et al., 1998; Thornes, 1984).

Although some nurses did not see the need of the mothers' presence in the neonatal unit, others noted the mothers' emotional trauma resulting from the separation of a child from the mother, and would prefer the mothers to live-in if that were possible. Despite the goodwill of these nurses to have mothers live-in, the infrastructures in place would not permit the mothers to live-in, as the rooms were small with only enough space to take six cots and with no spare rooms for mothers.

Ironically the mothers of the older children were allowed to live-in while those of neonatal babies not, despite the evidence about the negative effects of early separation of a mother from her baby (Bennett, & Slade, 1990; Field, 1977; Seashore, et al., 1973). In Cameroon it is the policy of the government that when a woman is pregnant, she takes maternity leave (for the working mothers) of 14 weeks (6 weeks before the due date and 8 weeks after). This enables the mother to be with the baby on regular basis during the first few weeks of life. Some mothers found the idea of leaving the baby alone in the hospital difficult to comprehend, as it did not seem right. It seemed to contradict even the government policy.

> *Where you see the mothers with their children, the mothers are allowed to stay, I don't know why. There, the children have the right to having somebody beside the child but not here. My premature baby does not have the right of having his mother by him. This for me does not seem right because I think my baby needs me more (Janet: Interview 9, p.4).*

This mother acknowledged the abnormality of this policy but found herself in a situation where she felt unable to do anything to change things. Although the nurses and parents had similar goals of meeting the child's needs, in the neonatal unit the mothers were not able to contribute much in attaining this goal. They waited and watched the nurses do most of the cares on their babies.

2.2 Limited facilities for living-in mothers, low parental participation

In many hospitals that have changed visiting policies to allow parents to live-in, it seems that parents were allowed to live-in because it was common practise, without much consideration as to the availability of appropriate facilities (Callery, 1997b; Platt Report, 1959; The Consumers' Association, 1981). In addition to the staff attitude these limitations could be interpreted as the result of resistance to change or a means to deter the parents from living-in.

It is difficult to judge if the administration, the medical staff and the nurses of the hospital were too busy with the workload and did not have the time to think of the child's emotional, developmental and physical needs since nothing was put in place for the living-in parents. Mothers had to arrange for their food as well as a shower. Although the mothers generally liked living-in, they seemed dissatisfied with the struggle to meet their basic needs similar with the mothers of Meadow's (1969) study. Despite being a hospital of high standards in Cameroon, meeting the needs of parents was not a priority as there was an overworked staff with limited resources.

In as much as having facilities was important, when and how they were used should be taken into consideration as this seemed to be a short-term inconvenience and both parents and hospital staff could make do with what was available. The priority for the hospital with limited resources may not have been to provide facilities as there were many other priorities such as more staff and the need to provide emergency drugs. Furthermore, the average stay of children in the hospital was three days since the common conditions were malaria, anaemia and gastro-enteritis. With an average stay of three days, mothers somehow could manage.

The limited facilities to meet the needs of living-in mothers did not seem to be the main worries of the mothers as with an admitted child, the mother's priority would be to see the child recover. Some mothers did not want to leave the child's side even for a minute.

> *Despite the beds provided, when the child's condition was critical, some mothers did not lie down to sleep as they could be seen sitting up holding the child's hand. Some were talking to the child, others were praying on the child while others were holding the child's hand but looking so involved in their thoughts (Field notes).*

Meeting their own needs did not seem to be an urgent necessity for the mothers. Some mothers only thought of themselves when they saw the child improving as one mother confirmed that she spent the two days without taking a shower, and only realised it as a problem after noticing the improvement of the child. Others talk of loss of appetite as the child lies in a critical condition.

2.3 Live-in as cultural practice in continuity or modern practice

Traditionally in Cameroon young children are always with their mothers or within a familiar family circle. It is unusual for young children to be left in an unfamiliar environment especially when the child is sick. In most of the hospitals in the country, mothers stay with the sick child in the hospital. Keeping out parents when a child is sick and admitted in a hospital could be seen as a foreign practice or an imported culture. Darbyshire (1987), in his article on how patient's relatives are treated in the hospitals, made this observation, "separating patients from their families is a feature of our culture which would not be acceptable in other parts of the world and would be thought to be very strange behaviour indeed" (p.23). Despite being a strange behaviour in Cameroon, the policy was embraced hesitantly as a sign of 'modern' standards.

This, according to Tipps (1973, p.206), therefore respects "the modernisation paradigm which is a celebration of Western civilisation, a proclamation of the self-confidence of ethnocentric achievement". This concept of modernisation sees the West as superior to the other countries in all social, political and economic aspects. Therefore the scientific revolution that has permitted Western "mastery" (Hulme, & Turner, 1990, p.35) of the environment must be adopted by the underdeveloped countries if they are to achieve the privileged status of being modern.

"Modernisation thus becomes synonymous with Westernisation" (Hulme and Turner, p.35).

Since what is Western is seen as desirable, other countries are aspiring to be modern or Western so they embrace things from the West. Cameroon is a developing country and some ideas from the West, at face value, seem to be the best and embraced. All the same it is puzzling as to why this hospital, which opened in 1990 embraced an out-dated policy instead as most hospitals in the Western world then were not restricting parents from the children's units.

3. Conclusion

Despite the difficulty parents experienced being in the hospital with their hospitalised child, the main focus seemed to be seeing the child improving and going home. This focus ties with the nurses' aim also of meeting the children's needs and readying them for discharge home. The difficulties seemed to be on short-term basis only and the parents would readily accept as they had little control. As well, limited sharing of information made it difficult for the parents to have a clear understanding of their role in the hospital. On the whole they were satisfied that the child received appropriate care as satisfaction was measured only on expectations met. Other studies have also shown that patients judge their satisfaction based on their expectations and the reduction of equipment on their child (Avis, et al., 1995; Bennett, & Slade, 1990; Williams, 1994).

Meeting the needs of the sick children and readying them for discharge home through physical treatment to save life was the nurses' focus while parents cared for the psychosocial aspects for older children. This was achieved despite the limited staff and facilities. Although no study was available on the effects of just saving life and leaving the other aspects of cares to the parents, the children looked happy having the family continuity. The issue might be with regards to the nurses' job satisfaction, as it seemed that little in the way of interpersonal relationships were created with the patients or family. Satisfaction could only be judged also in relation to improvement. This might not be applicable to the neonatal unit as the mothers felt that the nurses bonded more with their children for in addition to providing nursing/medical cares they provided basic cares.

In Cameroon health personnel are powerful and this power influences the way the patients and or the family (parents) deal with the hospital staff. This is not only noticeable in Cameroon as Shields (1999, p.237) confirms in her study that "health is seen as a powerful force in most countries and does not operate in isolation of community norms and values".

Chapter Seven: Conclusion and recommendations

1. Introduction

In this study, the parents and the nurses had relatively distinct roles with regards the care of children in the hospital despite the apparent limited sharing of information by the nurses to involve the parents. Despite the distinctive roles, the main aim was of meeting the children's needs and readying them for discharge home. In their respective roles they were achieving their aim. On the whole the parents and the nurses seemed satisfied with the care given to the children, although satisfaction here implied the improvement of the children's condition.

The effects of the change of hospital visiting policy were multifaceted and the parents and nurses gave various reasons for having parents present in the paediatric ward. According to some of the nurses, with limited space the mothers of the neonatal unit could not be allowed to live-in. As well, not enough space for mother and child was one of the reasons the policy makers opted to restrict visiting policy in the paediatric ward.

Mothers who were seen as capable were given more responsibilities. Mothers of the neonatal unit who were considered "clean" were allowed to express breast-milk into a feeding bottle and bring to the unit while others were to express and throw it away. This also supports the policy makers' reasons for the introduction of restricting visiting policy as stated in chapter one that it was believed that some mothers' standard of hygiene was potentially detrimental to the wellbeing of the children.

All through the data from the nurses and parents, no mention is made about some mothers bringing alternative treatment (traditional drugs) to the hospital and administering to the children alongside the hospital drugs. This could be an issue in other hospitals where access of people of all social classes is made easy. In this hospital, because of its reputation as a hospital of high standards, people may feel embarrassed or intimidated taking or talking about any traditional drugs in the hospital. Hence, this motive does not come out to be as important to back up policy changes as professed by the paediatricians in chapter one.

2. Different concepts of care in paediatric nursing

With parents and nurses sharing the care of the hospitalised child but in different ways, it is necessary to examine the different concepts of care that can be used as models to guide practice and policies in the paediatric setting. In examining the best approach to care for hospitalised children, many studies have been done on the different concepts of care of paediatric patients. Some concepts developed include family centred-care, partnership with parents, parental participation in care, parental involvement in care, shared care and ambulatory care. These are all theoretical concepts that have been studied, developed and applied mostly in Western countries in an attempt to improve the care given in a paediatric setting.

Coyne (1996) notes that there seem to be confusion in the use of these concepts as some are used interchangeably and indiscriminately. Hutchfield (1999) used Cahill's (1996) hierarchy approach of the relationship between concepts, beginning with parental involvement at the lowest level and progressing through participation to partnership between parents and health professionals as the base of family-centred care at the highest level. According to Coyne (1996, p.739), family-centred care provides a "strong conceptual foundation for the enhancement of care for the child in the family context". Hutchfield suggests that the hierarchical framework "could be applied to all children and families. The lowest level could be said to represent the minimum that any family could expect of the nursing profession" (p.1186).

2.1 Parental involvement in care

Hierarchically this is the lowest approach of the different concepts of family-centred care. In this concept although the nurse leads interactions with parent and child, the main focus is on respecting the parents and family. They are constantly in the child's life therefore know the child better. The parents act as advocate as well as provide emotional supports for the child. The nurses give medical/nursing care;

help parents give basic cares and acts as advocate for the family. Therefore the parents feel involved in what is happening to their child and their normal roles are maintained where appropriate (Hutchfield, 1999).

2.2 Parental participation in care

In this approach the main focus is collaboration between the nurses and parents working as partners. Knowledge is shared, and the parents are made aware of the importance of their role. The parents participate in the normal (basic) caregiving and may undertake nursing care if they wish. Thus participation is negotiated and voluntary with the nurse as the "gatekeeper" (Hutchfield, 1999, p.1185). The nurses ensure all cares are given, undertake care that parents do not want to provide and teach parents how to care for their child.

Another form of parental participation in care is shared care. According to Keatinge and Gilmore (1996) this approach reduces parents' anxiety, improves communication between parents and health professionals, facilitates a smooth transition from hospital to home for families and empowers parents to make better family health decisions. The main focus is to identify the needs of the children and parents and to negotiate with parents about delivery of care. The nurses determine the guideline of shared care and parents' potential involvement.

2.3 Partnership with parents

Within this approach the aim is a relationship of equal status and the concern is family wellbeing. The roles are negotiated and support is given where the need is identified. The parents and family are acknowledged as primary caregivers, knowledgeable and skilled. The nurses support, advise, facilitate, ensure that the parents get a rest and acknowledge that the sick child is not only the family's concern (Hutchfield, 1999).

2.4 Family-centred care

Family-centred care is an approach that focuses the child's care around the child and their family including as much normal "homelike" activity as is possible in hospital and therefore is a holistic approach. Nurses are seen as "facilitator" for the parents to care, the "enabler", not always the "doer" (Stower, 1992, p.68). In family-centred care, parents do more and some are involved in what otherwise may be seen as nursing skills, such as giving intravenous drugs and applying dressings. The nurses educate, teach, encourage, and provide support for parents caring for their children. Hutchfield (1999, p.1185) sees it as a "parent-led" approach with the nurses' role, that of a consultant or counsellor. For Thomsen (1999), family-centred care is a partnership between the health care team and the parents with the parents being the principal caregivers.

The ideal seems to be family-centred care. As an alternative to the family-centred care, Turner (1998) recommends ambulatory care. Ambulatory care as defined by Turner, is "any treatment or nursing intervention that does not take place during an overnight stay in hospital" (p.12). Therefore the emphasis here is on ambulatory care as opposed to in-patient care and the reasons being that it is cost-effective and the child is best supported through the illness by his/her loved ones in the home environment.

All of these concepts are reliant on visiting policies, which support the presence of parents.

3. Recommendations

As mentioned above there seems to be confusion in the use of the different concepts as some people use them interchangeably. Shields (1999) observed that some of the above stated concepts were written for use in Western cultures. In these societies, health services are similar and have adopted aspects of paediatric care that were originally from the Platt report of 1959. According to Hutchfield (1999) concepts such as family-centred care cannot be applied where it will not be workable either because the resources are limited or just inappropriate, as it may create the development of unnecessary stress for the children, parents, families and health professionals instead.

- It is recommended that: the parents of older children continue to be able to live-in while their children are admitted in the paediatric ward.

- Facilities that would support live-in parents are considered. This could include access to a shower for parents and a restaurant or somewhere within the hospital where the parents can purchase food.

- Consideration is given to allowing mothers with babies admitted to the neonatal unit to live-in if resources permit.

- Consideration is given to relaxing the visiting restrictions on biological parents in the neonatal unit, so that mothers and fathers can spend more time with their infants.

- Consideration is given to actively involving parents in the care of their sick child or neonate. The models or concepts of paediatric care, discussed previously, could be adapted to the context and used as a framework to clarify the roles of parents and health professionals, in particular nurses. Increasing the parents' participation in care has benefits for the child, parent and nurses, as demonstrated in the literature review and throughout the data chapters. These benefits occur during the admission and following discharge home. Consideration would need to be given to which concepts are most appropriate in the specific context, how they would need to be adapted, to be cognisant of the cultural values and resources available, and the process of implementation. Nurses, who would be most involved in the implementation of any new concept of care, would need to be comfortable with assessing parents' skills and willingness to learn new skills, supporting parents in caring for their child or baby, and communicating the benefits of increased involvement and participation to parents. In the main, these activities would be developments and extensions of those already undertaken by the nurses. Therefore successful implementation would require careful analysis of the staffing levels available.

- Parents should be made to feel and know they are partners in care by being given information on their role and responsibility as parents. For example they could be informed that their parenting is not going to be interrupted while the child is in the hospital. An information sheet or someone constantly available to inform the parents on arrival at the ward could be considered.
- One of the aims for introducing restricted visiting policy was the mothers' standard of hygiene, which was seen as potentially detrimental to the child's wellbeing. In this study, some mothers of the neonatal unit were not allowed to express their breast-milk at home and bring to the unit because they were seen as dirty. Parents could therefore be educated on basic hygiene of their children and family to limit infection in the hospital or at home.
- In this study, the nurses and parents made mention of staff shortage and the inconveniences it caused. The hospital administration could review the staffing, as it seems to be an issue in this ward.
- The findings from nurses and parents indicate that accessing medications especially out of hours, was an issue. The hospital administration could review the process of obtaining medication.

4 Implications for nursing

In a multi-cultural setting such as Cameroon, the nurses care for children and parents from a diverse range of cultural backgrounds. It is therefore often difficult to provide an environment where a balance is easily reached to be able to provide the best care. Communication between parents and the nurses is hence important. Nurses should be aware of the differences that exist and try adapting their care to suit those differences. This could be done through education on communication and cultural awareness for the nurses, parents and if possible all health personnel. The nurses should be able and willing to provide support for the parents while in the hospital with their children, as the whole family requires assistance to meet their needs.

5. Limitations of the study

The constraints of conducting research within the timeframe of completing an academic degree meant things had to be rushed. In addition collecting data in Cameroon, a developing country with limited resources and means of communication made contact with my supervisor in New Zealand more difficult during the data collection period. As well, not being able to carry out the research at the initially proposed hospital (due to reasons explained in chapter three) disrupted the data collection as not all the methods intended were used.

This is a localised study and the findings are not generalisable. As well the findings from this study are not a representation of all the hospitals in Yaounde. The politico-social events of the time would also have an influence on the result of the study as this made accessibility to the hospital difficult.

6. Summary of the study

This research explored the experiences of the parents and nurses in a paediatric ward in Yaounde, Cameroon where some parents live-in and some only have visiting rights. The participants were parents who have or have had a child hospitalised in that ward for a minimum of three days, and nurses who have worked in the paediatric ward for the minimum of six months.

Semi-structured interviews and participant observation were used as approaches to collect data and the data were analysed using thematic content analysis as suggested by Burnard (1991). From the data analysis, two themes emerged: one from the nurses and one from the parents. These were; meeting the children's needs and readying them for discharge home, and I am satisfied with the care although I am not always allowed to be with my child at will. The findings showed that nurses and parents had relatively distinct roles with regards to meeting the child's need and readying them for discharge home but there seemed to be limited sharing of information about the different roles. The parents seemed not to have a good understanding of their role as parents in the hospital. The change of the visiting policy affected the way nurses and parents care for children in the paediatric ward.

Appendices

Appendix A

Massey University
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Information Sheet

Researcher's Name	Patience Y. Njeba
Qualification	Master of Arts (Nursing) student
Address	School of Health Sciences, Massey University, Palmerston North, New Zealand Phone (646) 3569099 ext. 7381
Supervisor	Ms Lesley Batten
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Research Topic

Sick children in the hospital in Cameroon: Hospital visiting policies: The experiences of parents and nurses.

Reasons for doing this research

A lot of changes have taken place in children's wards all over the world with regards to parents visiting. The changes have included shifting from policies allowing parents to live-in with their sick child, to not having them present, except for restricted visiting rights at particular times, and back to having parents live-in. In Cameroon two systems operate, that is in some paediatric wards parents live-in with their sick child and in others parents only have restricted visiting rights.

No study has yet been done in Cameroon with regard to the effect of these visiting policies on the children, parents and the nurses. The researcher has worked as a paediatric nurse in the then Beaudelogue (paediatric ward) in Cameroon for nine years and developed an interest in the topic.

Parents only

I am inviting parents who have or have had a sick child in the hospital for at least three days to take part in two interviews with the researcher. The first interview will be to talk about your experiences of having a sick child in hospital and visiting them. This interview will last for approximately 30 - 45 minutes. The second interview will be shorter and during this I will discuss the main ideas that I have summarised from our first interview. This will enable us to check my initial interpretation of what you said. With your permission I will audio-tape both interviews and will type the transcripts myself.

Nurses only

I am inviting nurses who have worked in the paediatric ward for at least six months to take part in two interviews with the researcher. The first interview will be to talk about your experiences of nursing children in a paediatric ward with either the parents living-in or having restricted visiting rights. This interview will last about 30-45 minutes. The second interview will be shorter and I will discuss the main ideas that I have summarised from our first interview. This will enable us to check my initial interpretation of what you said. With your permission I will audio-tape both interviews and will type the transcripts myself.

Parents and Nurses

I would also like to use some photos in my research. You can decide whether or not you want to take photos. If you do you can decide what the photos would be of, but I would like you to take the photos of things that you think show the effects of visiting policies. If you don't know how to use a camera, I will take the photos of what you tell me to. If you take photos (or I take them for you) I will give you a copy to keep. We will discuss the photo at the second interview.

I will also spend some time observing the ward and hospital environment and will take some notes about the things that I see.

- I will ask for your permission before starting the interviews or taking photos. Even if you agree to take part in this study you have the right to:
- Withdraw or refuse to answer any question at anytime and decline to participate in the interview at anytime.
- Refuse to answer any particular questions during the interview.
- Withdraw from the study at anytime until after our second interview is completed.
- Ask any questions about the study at any time.

I will not use any information that you have given me or that I observe in a way that would identify you. If I use direct statements made by you I will remove identifying information and use a pseudonym instead of your name. The tapes will be used only for research purposes and will be destroyed after the completion of the study. The transcribed messages and the photos will be stored securely by the researcher. The photos will be used only for analysis and only photos of buildings or the environment with no people will be used in the thesis if necessary.

Parents only

Participating in the research will not change the care given to your children, or affect you in any way. The nurses caring for your child will not know you are taking part in the research because I will not disclose your identity to them and I will finish interviewing parents first before interviewing any nurses.

Parents and nurses

I will make available a copy of the final research report to the hospital authorities and a copy will also be placed in the Massey University library. Articles written from the thesis will be published in nursing and academic journals and presented in conferences.

I will visit this ward again tomorrow and ask you if you would or would not like to take part in this study.

Appendix B

Massey University Human Ethics Committee
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Massey University

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20 April 2000

Ms Patience NJEBA
PG Student
Health Sciences
TURITEA

Dear Patience

Re: Human Ethics PN Protocol – 00/18
Sick children in hospital in Cameroon: Hospital visiting policies

Thank you for your letter dated 13 April 2000 and the amended protocol.

The amendments you have made and explanations you have given now meet the requirements of the Massey University Human Ethics Committee and the ethics of your protocol are approved.

Yours sincerely

Sylvia Rumball.

Professor Sylvia V Rumball
Chair
Massey University Human Ethics Committee: Palmerston North

cc Ms Lesley Batten
Health Sciences
TURITEA

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