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.

To my children: Lois, Bryan, Beryl, Bianca and Bruna. Lois you were not around but I know you have always been thinking and praying for me. For the rest, at your tender ages, you took my place when I was too busy to run the home; and prepared hot meals for me when I got home so tired. Thanks for everything. I know you missed me a lot during the period of study, I promise to be there for you always, God willing.

To my beloved husband Kenneth, despite your multiple preoccupations at the time, you supported me giving me your time and energy in the realisation of this work. I must acknowledge it was not easy working together at times but by God's grace we are through at last.

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.

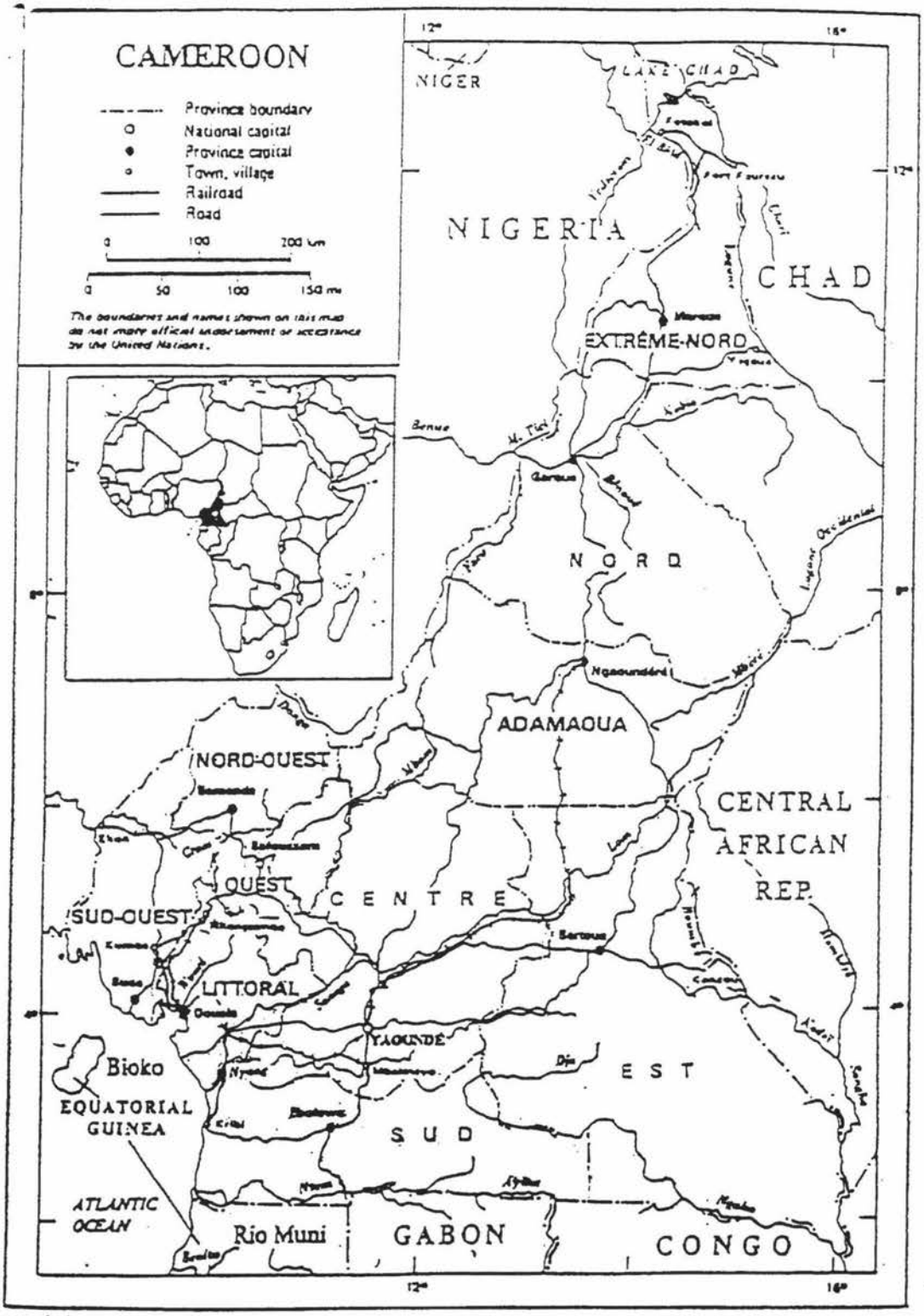

Figure. 1. The Location of Cameroon

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.