THE EXPERIENCES OF MOTHERS WITH CHILDREN HOSPITALISED IN A CHILDREN’S EMERGENCY UNIT, GHANA

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ABSTRACT

The main purpose of the study was to explore the experiences of mothers during their stay with their children when admitted to the Children’s Emergency Unit (CEU). An exploratory, descriptive and qualitative design was used to determine the experiences of mothers who stayed in hospital with their children while they were hospitalised. Ten (n=10) mothers were purposively selected from the CEU. Semi-structured, audio-taped interviews using a general interview guide was the method of data collection. The method used to analyse the data was content analysis. The findings revealed that the majority of mothers tried remedies to treat their children at home and sought professional health care as a last resort. While in hospital, the mothers were obliged to observe and care for their children. Being a cash and carry system, mothers had to pay for almost every service obtained. Stress increased as they stayed with their children. Analysis of factors that increased their stress indicate that financial issues, cost of drugs and food, inadequate facilities, and crowded environment were prominent. The mothers were constantly anxious and worried about their children’s condition. These mothers were often ill, especially as the length of stay increased. They coped by accessing various forms of support, such as from family members, friends, one another and their relationship with God.

Keywords: mother, child care, stress, anxiety, nursing interaction, emergency unit
INTRODUCTION

Involvement in the care of hospitalised children can affect the wellbeing of parents especially mothers who stayed with their children while hospitalised. To understand the extent of the effect of hospitalisation, knowledge of the individual experiences of the mother is essential. Even though the stay by mothers at the hospital may be stressful, the importance of positive therapeutic effects of parental involvement in a child’s recovery cannot be over emphasised.

Certain needs of mothers have been identified whilst involved in the care of their children in hospital. Ward (2001) found that mothers want to be informed about the condition of their children and want honest answers to their questions. They also want nurses to listen to their fears and expectations and assist them to understand the responses of infants to hospitalization. Yui & Twinn (2001) also reported 8 categories of needs that influence parental experiences during their children’s hospitalization. These included the need for recognition of their reactions, support, financial assistance, household help, personal time and parenting skills.

Several authors have identified strategies that enhance coping capabilities in mothers during their children’s hospitalization. Some of these are family support (Wilson 2001) and educationally driven programs. Carnevale (1990) in his study examined systematically how parents coped with the critical illness of their children He identified 34 different themes grouped into 5 categories which are related to coping strategies of mothers. These he named cognitive (things you think about), interpersonal (actions directed toward other people), social support (drawing on support from others), direct action (things you do) and drawing from environment. Much of the literature on this topic stem from developed countries and such studies have undoubtedly helped in the design of physical structures that would minimize stresses for mothers but also enhance their roles in expediting recovery of their hospitalised children. On the other hand such studies are grossly lacking in developing countries such as Ghana.

PROBLEM STATEMENT

Mothers face many difficulties while caring for their children in hospital. They have to stay with their children all the time. This means that the mothers need to sacrifice much including proper rest and self-care, and being with other children at home, and may be confronted with financial problems among others. There is little research in Ghana on the impact of the hospital environment on a mother’s role in her child’s recovery during hospitalisation. For this reason, a study of Ghanaian mothers’ experiences in children’s emergency was needed. Such research would contribute to improving nurses’ support for mothers.
PURPOSE OF THE STUDY

The purpose of this study is to obtain information on mothers’ experiences during their stay in hospital while their children were hospitalised.

DEFINITION OF TERMS

Experience: defined here as what mothers do, see and feel. It also includes the problems they face while participating in the care of their children.

Mother: defined as either biological or surrogate.

Children’s Emergency Unit (CEU), which is the unit where referrals of paediatric emergencies are detained until admitted to the wards or discharged.

RESEARCH METHODOLOGY

Design

A qualitative, exploratory and descriptive design was used to explore the experiences of mothers who stayed in hospital with their children while they were hospitalized.

Population & Sampling

Sampling was done purposefully in that all mothers who were interested and willing to participate were selected. Before actual data collection started, the mothers were approached, and the research procedures explained to them including potential benefits for the mothers and children, if recommendations emanating from the survey could facilitate mothers’ future stays with their children in the CEU.

Semi-structured interview schedule

As part of the interview data, various demographic variables of the mother were collected, including: mother’s age, educational background, marital status, religion, occupation, place of residence, number of children and their ages, length of stay in hospital, and number of times a mother had a child admitted to hospital. As well, events that led to the child’s admission to hospital, mothers’ actions while staying with the children, the challenges they faced while interacting with hospital system, their perception of staff, and their feelings about the experiences and how they coped with the challenges were explored. A pilot interview was done with two participants prior to the actual data collection to test and improve the interview schedule.
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Data collection

Data collection followed the procedures outlined by Mayan (2001). It was collected in the form of feelings, behaviour, thoughts, insights and actions. The information was acquired directly from the mothers who went through the experiences of looking after their children in the unit. Face to face interviews with the participants were conducted and tape recorded and documented immediately after the interview. An interview guide enabled the researchers to obtain information about the mothers’ experiences.

Data analysis

All aspects of the data including interviews, field notes and diary entries were analysed to provide a rich description of the experience of the mothers. Data analysis was done concurrently with data collection using latent content analysis Mayan (2001). The information was coded and grouped according to the emerging themes and concepts (Polit & Hungler, 1995). By coding the data and categorizing them to similarities, the meaning of the data emerged, giving an understanding of mother’s experiences of having a child in an emergency unit.

Trustworthiness

The conversations with the participants were documented immediately after the interview to capture the emotions and mood and describe the setting. This was done to minimise distortion in the meaning. There was member checking in that the researcher went back to the participants two or three times to review findings and clarify misunderstandings so as to increase credibility of the findings. Direct quotes from the participants and description of the setting in which the phenomenon was described were used so that interested persons could determine whether these findings might apply to other similar contexts.

Ethical considerations

Prior to the study, ethical approval was obtained from the Ethics committee of the Noguchi Memorial Research Institute, University of Ghana Medical School, Accra, Ghana. If a mother was willing to participate in the research, a consent form was signed.

RESEARCH FINDINGS

The research results will be presented according to the specific themes that emerged from the data analysis. Where appropriate, direct quotations will be supplied as expressed by the participants.
Biographical profile of participants

The ages of mothers ranged from 24 to 45. All but one participant attained some level of formal education. Eight out of the ten mothers were married. All of them were Christians. All mothers were self-employed. The number of children of each mother was between 1 and 8 and the ages of their children ranged from three months to 22 years. The average length of stay in CEU was five days, ranging from two days to two weeks. Four of the mothers had previous admissions of their children to hospital, for the rest this was their first time to have their child admitted.

Thematic findings

Seven key themes emerged from the data. These included: seeking care; being there; challenges of “being there”; interaction with hospital system; perception of CEU staff; mothers’ feelings about experiences; and support facilitating “being there”. As outlined in Table 1 many of these themes had sub themes, as outlined in the subsequent discussions. Some of the mothers’ responses are presented verbatim to further illustrate the theme.

**TABLE 1**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub theme</th>
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<tbody>
<tr>
<td>Seeking Care</td>
<td>• noticing the signs and symptoms</td>
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<td>• deciding what is abnormal</td>
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<td>• taking action</td>
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<td>Being There</td>
<td>• watching over</td>
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<td></td>
<td>• providing physical care and emotional care</td>
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<td>• getting supplies and medication</td>
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<td>• understanding the child’s illness</td>
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<td>• caring for the rest of family</td>
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<td>Challenges of Being There</td>
<td>• securing sufficient money</td>
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<td></td>
<td>• maintaining personal health (physiological, psychological and social needs)</td>
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<td>Interaction with the Hospital System</td>
<td>• hospital policy</td>
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<td>• working environment</td>
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<td>Perception of staff</td>
<td>• Perception of Doctors</td>
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<td>• Perception of Nurses</td>
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<td>• Perception of Orderlies</td>
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<td>Feelings about the experiences</td>
<td>• Psychological Experiences</td>
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<td>Support, facilitating being there</td>
<td>• Support from Family and others</td>
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<td>• Support from Religion</td>
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SEEKING CARE

In order for care to be sought a mother needed to notice and recognise that the signs and symptoms her child was experiencing signify an illness and that care was required. The mothers’ comments outlined how mothers became aware that their children needed medical treatment

Noticing the signs and symptoms:

Mother: Sunday to Monday she (her daughter) was not able to sleep at night. She was vomiting and complaining of headache ... she was very hot.

Deciding what is normal or abnormal:

Mother: ‘... for the past 3 days the body was getting hot (fever) but when I administered paracetamol syrup, she became all right ... then ... I noticed one of her (daughter) ... hand was shaking ... eyes rolled backwards ... I poured cold water over her but she didn’t cry ... she did not like cold water ... that was when I noticed that all was not well with her...’

Taking action and type of action: Mothers frequently decided to seek guidance first from family, neighbours or traditional healers

Mother: ‘The sickness started with a cough. People (neighbour and friends) claimed it is because the ‘hole’ in front of her head (anterior fontanel) was not properly ‘closed’, that was why she was coughing. So we did native treatment for a long time...and also she has sores in the mouth, and her stomach... she has been scratching her legs... she is often not able to eat well. From time to time the body becomes hot. All these started about two months ago... people claimed that if the fontanel is not properly closed, it is not the “type of disease” to be treated at hospital...so I kept her for home treatment…’

By the time those mothers who did not first seek professional care decided to bring their children to hospital, the child was often seriously ill and the mothers frightened. As a consequence they came unprepared with no idea of what to expect.

Mother: ‘if your child was ill and you would panic, you will not even know what you did. Perhaps you were running fast before arriving at the hospital. You would even forget to take a cloth because it was an emergency situation. You do not prepare...that you are coming to hospital...’

BEING THERE

The predominant theme throughout the study was “being there”. Mothers stayed with their children throughout his or her stay in hospital. Mothers left the bedside only when it was very necessary such, as a visit to the toilet or getting supplies and medication. Mothers saw “being there” for their children as their obligation and responsibility. The
following described the typical responses and the activities of mothers while staying with their children.

**Watching over:** One mother notes the importance of attending to her child.

Mother: ‘Sometimes you (mother) may leave him and by the time you return he (child) is dead, but that if you are there, and you can monitor your child’s condition and if the child is warm you can wipe the body’.

**Providing physical care:** Day to day care for the child was carried out by the mother. This caring is outlined by one participant:

Mother: ‘When I sit by, when he goes to toilet I clean him and change him... I change his napkins more than 8 times. In the night he passes a lot of urine so the moment he is wet I change him, I smear vaseline between the thighs so that the stools do not stick onto the skin.’

**Providing emotional care:** Not only did mothers meet the physical needs of their children but they tried to meet the emotional needs as well.

Mother: ‘When I sit by I talk to him and make him happy....’

**Getting supplies and medications:** Leaving the child for needed supplies required planning in order to ensure that one’s child was looked after.

Mother: ‘If a fellow mother is nearby then you can ask her to watch your child so that you can go to obtain prescriptions for your child and quickly return and sit by him.’

**Understanding child’s illness:** Mothers tried to find meaning in their child’s illness.

Mother: ‘sometimes you see the skin changing colour, first black, then white as if something is poured on it ...you try to make sense of what is happening.’

**Caring for the rest of family:** Being there for one’s child did not negate the obligation of attending to the welfare of the family at home. Mothers who had other children at home were concerned about the family and home and struggled to balance their responsibilities. Most of the participants made arrangements to care for the rest of the family.

Mother: ‘Oh! they (the younger children) are with their brothers and older sister’.... when the child became ill I asked her (older daughter) to come and stay with the rest ... the two small ones.

Mothers who had no mature persons at home to care for their children were constantly worried about their children’s welfare.
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Mother: ‘... the other one (2nd twin) is also left at home for children (younger sister) to look after ... Hmm (expression of sorrow)! I myself I am sick because I have been thinking ... about the one here, and the one at home ... because there is no grown up at home to look after the other one.’

“Challenges” of being there

Two distinct challenges emerged. One is securing sufficient money and the other, maintaining their personal health.

Securing sufficient money: Lack of money was a very worrying experience for mothers and many comments were made about it.

Mother: ‘... you buy drugs. Everything you have to buy; drip (IV fluids), drugs, and food. You give food to the child, you buy your own food, and you will pay before you take a bath, if you pass urine you will pay, if you visit the toilet you will pay. If you finish (discharged) the bill that will be given you, if you don’t take care you will not have money to pay ... you pay for everything...’

Maintaining personal health: Mothers met their physiological needs of rest, sleep, elimination and nutrition with difficulty. The following comments reflect this difficulty.

Physiological needs

Mother: ‘...you don’t feel fine. Your child is not well ... you also don’t get any place to sleep and you cannot also sleep. For about 4 days now I have been at one place. So since yesterday I realized that I was ill...’

Mothers complained of the long distance between toilet facilities they were allowed to use and the unit, (120 meters). They also complained about the number of toilets (4) and bathrooms (2), which serve all mothers (over 200) with children admitted to Child Health Department. They paid before they could use any of the facilities or services. NB authors please clarify; previously you referred to the CEU – how is that different from the Child Health Department; NB if possible consistently refer ONLY to the CEU otherwise your readers, who might be totally unfamiliar with Uganda, will get confused.

Mother: ‘... as for that place (bathrooms) it is good but if there is someone there before you go, you will have to wait for the person to finish before...’

They also complained about food. Food was not available, poor in quality, or expensive.

Mother: ‘Here ... there is no place to get food. A certain woman comes to the hospital to sell Banku (a meal prepared from corn dough) with okro soup. The okro is too thick and
some of us feel that if we eat that food and breastfeed, the children will have diarrhoea. If you want food, you have to walk a long distance to look for it ... There is a canteen here but the food is expensive...’

Psychological and social needs

Mothers tried to meet their own psychological and social needs, in part, through recognition that care they were giving was important. Indeed, mothers were happy to provide nursing care

Mother: ‘He (the son) thought I was going to leave him so did not want to sleep, but I stayed by him and he slept on my lap till daybreak. I am happy that I carried him throughout the night.’

Mothers interacted among themselves, encouraged and assisted one another as much as possible.

Mother: ‘...as for us (mothers) here (CEU) we are all thinking about our children. We have sympathy for one another and we encouraged one another and think about one another and help one another.

INTERACTION WITH THE HOSPITAL SYSTEM

The interaction of mothers with the health care system often led to concerns and issues.

Hospital policy

According to the policy of the Child Health Department, a child could be admitted to the Children’s Emergency Unit only with, a referral letter from a polyclinic. The admission nurse often sticks to the policy.

From the mothers’ perspective once the child was seriously ill, the child must be admitted

Mother: ‘...but when we arrived, the nurse said because there was no referral letter accompanying her, the child would not be accepted for the doctor to see. In fact I begged her and other people also begged her but she said no and insisted on what she was saying...’

The ‘cash and carry’ system which was operated at the time of this study meant that drugs and laboratory services were paid for upfront. The following is how mothers perceived the ‘cash and carry’ system.
Mother: ‘They (pharmacist) said unless we have money, the drug will not be supplied... they insist that they will have to ‘see’ money before the drug is given...what we have(money) when it is finished, then that is all’

**Working environment:** The participants complained about inadequate space and furniture such as lack of chairs, beds and cots. In addition the unit was overcrowded.

Mother: ‘eh! as for chair to sit on you cannot talk about it...if someone is sitting on one and the person gets up then you go for it otherwise you will have to stand by until you get one to sit on.’

Mother: ‘The beds are not enough for the children; they are shared one bed for about three children...’

**PERCEPTION OF STAFF**

Mothers had varying perceptions of staff and talked often about their interaction with physicians, nurses and orderlies.

**Mothers’ perceptions of doctors**

Mothers’ perceptions of doctors were positive. They saw doctors generally as friendly and ready to answer their questions. Mothers also compared them with nurses all the time.

Mother: ‘The Doctors are good. They are more sociable than nurses.......’

**Mothers’ perceptions of nurses**

Throughout the emergency unit experience, mothers perceived nurses as performing certain kinds of roles such as giving treatments and taking temperatures. They described the interaction between nurses and mothers as limited

Mother: ‘The nurse comes only when it is time to give treatment. When the time is up to give treatment they come and after that leave’.

Some nurses were perceived as being friendly, while other nurses were not easy to approach. One mother reflected: ‘...some of them (nurses) are friendly…but some too give you ‘pressure’ (they scare)…’

**Perceptions of orderlies:** Mothers thought that too much power was vested in the orderlies, resulting in some orderlies talking or behaving rudely to them. Mothers were scared to challenge them.
Mother: ‘...some of the workers here too do not speak well...like the tall man who is working here (one of the cleaners)...he talked to me harshly...' 

MOTHERS’ FEELINGS ABOUT THEIR EXPERIENCES

The challenges that confronted the mothers in the unit, their experiences of being with their children and the problems associated with them generated all kinds of feelings such as despair, helplessness, anxiety, fear, anger, constant worry and self-pity.

Mother: ‘...you are a mother, and you are sitting by your sick child and see dead ones being carried by,...you will be troubled...' 

SUPPORT FACILITATING BEING THERE

Mothers tried to cope with the many difficulties they encountered during their stay in the emergency unit by using various forms of support. Such support came from the other mothers in the unit, families, friends, money and prayer.

Support from family and others:

Support from mothers: Mother: ‘...I don’t go anywhere. I stay here and carry other people’s children for them...if the child is crying I have to carry her.

Support from friends and relations: Mother: ‘...at times when visitors are coming to visit they bring you food’Mother: ‘...when this friend of mine came, she stayed by the child for me...’

Money as source of support: Mother: ‘...if I haven’t had some money...from Monday to Thursday where would I have got this money which is over 1,000,000 Cedis ($100.00)...if I am somebody who has no money then what will I do then?...’

Support from religion:

Prayer as source of support: Mother: ‘...I was frightened when I came here and saw that somebody’s child was dead. My heart beat very fast for a long time. So it takes prayers...that is what I do.’

SUMMARY OF FINDINGS

While in hospital, mothers vigilantly watched over their children and were not willing to leave them for fear of losing them. They were involved in every aspect of their care. 

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Mothers went through a lot of stress as they stayed with their children. The problems the mothers faced affected them psychologically in that they experienced hardship. Physiologically, they were often ill. They were able to cope through the use of various forms of support.

**DISCUSSION**

Only a few mothers contacted professional health carers immediately after their children became ill. All mothers tried various remedies when their children first fell ill and only sought professional care when these remedies were ineffective. When illness occurs, professional health care often might be the last resort for rural dwellers. In addition, when professional help was required, mothers were often unprepared for the subsequent hospitalization.

In the hospital, mothers were always with their children constantly watching over them. While mothers watched their children, they engaged in various activities such as feeding and maintaining personal hygiene. They also carried out advanced nursing care. For example, they sponged their children when their temperature was high, observed them critically and reported any unusual findings to the nurse or doctor. These findings support those of Garcia de Lima, Rocha, Scochi, and Callery (2001) who found in their study that mothers actively participated in the care of their children and were taught to do advanced procedures like postural drainage and medication administration.

Mothers had several environmental challenges as they participated in the care of their children. The physical space of the emergency department was inadequate. There was no proper place to rest. Mothers sat for long hours at their children’s bedside with no proper place to rest. Due to these inadequate facilities, mothers were not able to maintain their personal health and were often ill. The adverse effect of this was that a mother might not have been able to care for her child properly, especially if the stay was prolonged. It was also observed in the study that mothers had insufficient money to meet their needs during their stay. For example, mothers needed money to buy food for themselves and their children. Food was expensive and not everybody could afford more than one meal per day. Food was also not available all the time and poor in quality. Inadequate nutrition may increase the risk of maternal illness.

Mothers also needed money to buy drugs and have laboratory investigations undertaken. The lack of money adversely affected access to prescribed medication, posing challenges to both the families of the sick children as well as hospital authorities. In special cases of long admissions of children to hospital, the mothers often were absent from their jobs with the consequences of losing their pay for the period. A vicious cycle is created where the mother’s limited funds to acquire drugs lengthens the child’s admission to hospital, prolonging the period of absenteeism from work for the mother and this decreased the opportunity to earn money to pay for treatment. Perhaps this problem may be addressed with the introduction of the “National Health Insurance Scheme”. In this Scheme, while
people are healthy, they contribute to the cost of health care services. In the mean time, policies need to be developed that will reduce the financial burdens of the mothers at the time of hospitalisation.

It was evident that mothers’ comfort was not met during the admission of their child to the hospital. Invariably, toilet facilities were limited and cash-strapped mothers were required to pay extra for use of such facilities. Lack of money could threaten the dignity of mothers who stay at hospital while their children were hospitalised. These facilities are also far away from the unit. Since mothers were always with their children, it is necessary to have a rest room in close proximity. Mothers wanted basic amenities such as comfortable chairs to sit on. Their children were crowded in beds and cots, which may increase cross infection and may complicate their illness. Some of these needs were also identified by Ward (2001), who found that primary care givers in CEU needed a place to sleep near the unit, a bathroom near the waiting room and comfortable furniture in the waiting room.

Mothers appeared to have greater confidence in the doctors’ abilities to care for their children than they did in nurses’ abilities to do so. They commented on doctors’ friendliness, hard work, and willingness to communicate with them. On the other hand they identified two opposing sets of nursing behavioral characteristics, which either facilitated or inhibited their confidence. Those things mothers described as facilitative were few, including friendliness and carrying out of expected duties on time. Those that inhibited an effective relationship with nurses were unfriendliness and limited interaction with mothers. These findings support the work of Fenwick, Barclay, and Schmied (2000) who found that the mother’s relationship with the nurse is the single most important influence on the woman’s experience of mothering in the nursery. This aspect requires further investigation since interaction in the nurse-patient-family relationship is a very important aspect of nursing care.

It is necessary that medical and nursing professionals who provide care in the CEU avoid instillation of negative attitudes, and recognize that admission to the emergency unit is a signal to attend not only to physical needs of the children but also to the interpersonal and communication needs of mothers. Negative attitudes of the professionals may aggravate mothers’ anxieties during crisis situations. As a result, mothers in the emergency unit were often afraid to interact, approach, or ask the nurses any questions relating to their children.

Mothers tried to cope with the difficulties they encountered in the unit through various forms of support. These mothers received support from family members, friends, and from fellow mothers on the unit. Mothers also prayed constantly for their children and they viewed their relationship with God as a powerful source of help and hope during their children’s recovery. This was similar to findings described by Wilson and Miles (2001). Mothers adopted these coping strategies to give them strength to face all the difficulties they encountered.
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The challenges that mothers in the CEU faced while caring for their children are similar to those found in other studies. However, the findings in this research reveal that lack of communication skills of nurses, high level of maternal participation in care of child, inadequate facilities, inadequate rest, and financial difficulties, made conditions worse.

LIMITATIONS OF THE STUDY

Some of the interviews were conducted in the unit because of the unwillingness of the mothers to leave their children. This resulted in a lot of interruptions which perhaps threatened maternal privacy. However, because the mothers were willing to share their experiences they gave the researcher necessary information.

CONCLUSIONS

Nurses are health workers who are closest to and interact more often with mothers of children admitted to the unit. Nurses need to have skills and knowledge to communicate proper instructions on procedures that the mother is expected to perform, and ensure that mothers are relieved for bathroom breaks, meals and rest. For effective nursing care, nurse educators need to ensure that student nurses are able to give compassionate, competent care from the onset of training. Also, nurses in practice need to fully understand the demands made on mothers and how these can be managed in an overstretched health care system.

RECOMMENDATIONS

The findings may also be useful for hospital administrators who plan the physical facilities in hospitals. Invariably, only the patient is provided for but as shown, the speedy recovery of hospitalised child also depends on the role of the mothers who reside in the hospitals during admissions. The administrators must also communicate to policy makers the need to improve upon the general condition of the unit and provide the necessary equipment like adjustable chairs that could be reclined so that the mother can sleep when necessary. Food could be provided for mothers at least once a day and the cost added to the discharge fee. This might alleviate some of the nutritional problems and ease mothers’ fears about needing to leave their children. The unit may be expanded to ease congestion.

Since parental participation has become an accepted concept in child hospitalisation, it would be worth the while to study the appropriate level of parental participation in the unit. A survey on the challenges of maternal involvement in care of hospitalised children is needed to determine the scope, depth, and prevalence of these challenges. More work is required if we are to provide quality care to mothers and children. National Health Insurance Scheme is needed to take the place of the ‘cash and carry’ system.
Policy makers of the hospital must improve on infrastructure and provide necessary equipment. The media can be used to educate mothers about health care. In-service education is needed for nurses and the entire staff.

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