AN EXPLORATORY STUDY OF THE POTENTIAL ROLES OF CHILD AND YOUTH CARE WORK IN A HOSPITAL CONTEXT

Celest Castelina Heeralal

Date: 28 August 2020

Student number: 21430879

Submitted in fulfillment of the requirement of the Degree of Master of Health Sciences

FACULTY OF HEALTH SCIENCES, DURBAN UNIVERSITY OF TECHNOLOGY

Supervisor: Prof Raisuyah Bhagwan

DECLARATION

I, Celest Castelina Heeralal, declare that this dissertation is my own work, unless stated otherwise. All references have been cited in this study. This dissertation has not been submitted to any institution previously.

_____

Celest Castelina Heeralal

20/10/2020

Supervisor: Professor R Bhagwan (PHD)

Department of community Health Studies

Durban University of Technology

ABSTRACT

INTRODUCTION

A hospital can be regarded as a place of healing, that strives to offer holistic care to patients and the requisite support to families. Children who are faced with hospitalization encounter immense distress due to being separated from their parents and due to painful medical procedures. Equally important is the need to support parents who face the trauma of their child's illness or injuries. It is within this context that the need for helping professionals particularly child and youth care workers are crucial to supporting both children and their families.

This study explored how hospitalization affected children and family members but more importantly what support children and family members needed during this time.

PURPOSE OF THE STUDY

The purpose of the study was to explore then the challenges that children and their families face, when children are hospitalized as well as the psychosocial support that is needed during this time. The study also looked to explore the potential role of child and youth care workers in terms of providing developmental and therapeutic programmes in a hospital context and how child and youth care workers can work collaboratively with the multidisciplinary team in a hospital context.

METHODOLOGY

The study used a qualitative research approach. This was to secure rich and in-depth information with regards to the challenges children and their families faced during hospitalization and what support and other holistic therapeutic interventions could be used to support their recovery. It also helped the researcher to understand what therapeutic activities and interventions could be levelled, by social service professionals, in a hospital setting. The study was conducted at RK Khan Hospital which is a public hospital. Two samples were used, which included eleven health care professionals from RK Khan Hospital and ten senior child and youth care workers from the National Association of Child Care Workers. Participants were selected using non-probability purposive sampling techniques. The data collection method used for both samples were semi-structured interviews. The interviews for health care professionals took place at RK Khan Hospital and the interviews with the senior child care

workers were conducted at NACCW. Both settings were in the Ethekwini region. Data was then analysed using the process of thematic analysis. Themes and subthemes were then generated and the data discussed accordingly.

FINDINGS

From the data, three main themes emerged and fourteen subthemes. The main themes were inclusive of the hospitalization experience, nature of psychosocial support of children in hospital and their families and lastly, the roles of social service professionals in a hospital context. The study found that children and their families experience many challenges whilst they are hospitalized which included namely parent-child separation anxiety, fear of medical staff, difficulty understanding medical jargon, inadequate infrastructure and inadequate support services. These challenges created fear and anxiety in children during their stay at the hospital. Medical staff were found to try their best to minimize such effects but this was not adequate in terms of providing psycho-social care to children and their families. Data also reflected that children receive some psychosocial support in the hospital and that families are offered counselling although this is minimal and very superficially done. The need for social service professionals in the hospital context is beneficial. The study found the need for social service professionals to be present in the hospital environment so that therapeutic interventions could be undertaken with children and their families as well as such as group therapy, multidisciplinary teamwork, liaison with community stakeholders and spiritual support.

CONCLUSION

The need for social service professionals particularly child and youth care workers and social workers are crucial to provide a holistic health service within the hospital context.

DEDICATION

I dedicate this dissertation to all the child and youth care professionals out there, without much recognition but still strive to make lives of others better. I also dedicate this dissertation to all the individuals who have contributed to my success over the years.

ACKNOWLEDGEMENTS

The following acknowledgements and appreciation is sent out to the people who motivated me and helped me to accomplish this milestone. I would like to thank the following people:

Firstly, I give all praise and glory to my Lord and Savior Jesus Christ, for guiding me and helping me through this journey.

Professor Raisuyah Bhagwan, for all the guidance, motivation and support in helping me to complete my dissertation.

My mother, Kerin Heeralal, for all her support, motivation and prayer for me through my journey.

Kody Moodley, for all his motivation, support and sacrifices, to help me successfully accomplish my study.

Avenal Finely, for all her assistance during the writing of my dissertation.

R.K Khan Hospital for allowing me to conduct my research at the Hospital

NACCW for allowing me to use their premises for interviews.

All participants who have helped me during my interview, and who have made me feel comfortable whilst conducting my interviews.

I appreciate you all. May you continue to be blessed in the future.

TABLE OF CONTENTS

LIST OF APPENDECIES

ACRONYMS

NACCW – National association of child care workers

MDT – Multi-disciplinary team

CYC – Child and youth care

CCG – community caregivers

PWB – Psychosocial Well-being

CHAPTER 1:

INTRODUCTION

"Healing in a matter of time, but it is sometimes also a matter of opportunity".
– Hippocrates

1.1 PATIENT AND HOSPITAL IN CONTEXT

A gentle touch, a smile of warmth, honesty-based affirmations, and communication that is both respectful and non-verbal, are some ways that are little, yet meaningful to show caring within a healthcare setting (Krebs 2001:55).Health is an integration of physical, psychological and social factors. In fact "the practice of holistic healthcare accounts for the physical, environmental, mental, economic, emotional, social and spiritual aspects of human experience" (Ventegodt, Kandel, Ervin, and Merrick 2016:1936). Hence whilst many hospitals provide physical care for patients, little is done to address the psychological and emotional factors that accompany health difficulties. It is the psychological, emotional and spiritual resources however that play a crucial role in patient healing and recovery.

Moreover hospitals have acknowledged the relationship that is shared between the physical and patient outcomes and have worked towards focusing on developing safe and aesthetically pleasing physical spaces (MacAllister, Bellanti and Sakallaris 2016:119). Moreover, the hospital should have a range of healthcare professionals who work together towards achieving the goal of assisting the patient towards recovery. In this sense, hospitals can be seen as a place of healing. According to Abbas and Ghazali (2010:948), a healing environment is defined as the entire environment which includes both physical and non-physical aspects that are present to enable the recovery process. Hence in order to affect recovery and well-being health must be approached from a holistic perspective.

As such the hospital should not only offer medical services but should cater for psychological and spiritual dimensions of a person and provide psycho-social and spiritual care that will support a person's journey to recovery. Moreover, the patient should not be seen as a discrete entity that is isolated from their family when the crisis of illness or injury arises. They

too form an important part of the journey to recovery. Hence a holistic treatment plan should embrace the biopsychosocial and spiritual facets of the patient and should include the family system. In addition to this, the hospital environment itself is crucial. The hospital's physical environment is one of the interrelated areas that can maximize the patient's innate healing process. (MacAllister et al 2016:119). In fact, the hospital's physical environment influences healing and contributes to a better quality of life for patients, caregivers and health care workers (Abbas and Ghazali 2010:949).

1.2 CHILDREN IN THE CONTEXT OF THE HOSPITAL

When children become critically ill, it becomes a life-changing experience for the child, their family and caregivers (Curtis, Foster, Mitchell and Van 2016:330). Children may experience a range of illnesses and injuries that range from Human Immunodeficiency Virus (HIV), tuberculosis (TB), leukaemia, childhood cancer, asthma, traumatic brain injury and even epilepsy all of which may warrant hospitalization (Pufall, Nyamukapa, Eaton, Mutsindiri, Chawira, Munyati, Robertson, Gregson 2014:1; Marais and Schaaf 2014:1; Hunger and Mullighan 2015:1541; Koohan, Yousofian, Rajabi, and Zare-Farashbandi 2019:2; Trivedi and Denton 2019:1; Stanley, Bonsu, Zhao, Ehrlich, Rogers, and Xiang 2012:25; Minardi, Minacapelli, Valastro, Vasile, Pitino, Pavone, Astuto and Murabito 2019:1). It is during this time, that they encounter the hospital's milieu for the first time and are faced with an array of medical interventions that are daunting.

Despite the fact that the hospital is deemed a place for healing and recovery it may provoke untold stress and anxiety for children in particular (Koukourikos, Tzeha, Pantelidou and Tsaloglidou 2015:438). Anxiety may set in when these children are confronted with the environment and the associated medical processes that take place in a hospital (Li, Chung, Ho and Kwok 2016:1). This may influence their recovery as physical and psychological aspects are interrelated. The unfamiliarity of the hospital environment may cause the child to act out emotionally, creating an impact on the delay of important medical treatments and increasing the time and process of the treatment (Lerwick 2016:143-144).

Paediatric critical illness may not only disrupt the health of the child profoundly but also disrupts normal family functioning and well-being (Crow, Undavalli, Warner, Katusic, Kandel, Murphy, Schroeder, and Watson 2017:2). Usually, children and adults are different in ways that affect how they evaluate the quality of care given to them, as children rely mostly on their caregivers (Dackiewicz, Rodriguez, Irazola, Barain, Marciano, Fedrizzi, Gonzales, Elias-Costa, Almada Viola, Tonini, Zamberlin and Garcia-Elorrio 2016:676). As such children require a greater emotional amount of emotional care and support.

Parents and caregivers too also experience immense strain when their child is hospitalised. They endure feelings of helplessness over their child's pain and suffering. Research has shown that in a paediatric critical care setting, parents reported being highly stressed because of the illness that their child was facing and the treatment they received. This was found to play a role in the way parents perceived the information that they received and the way they made decisions in relation to the child's diagnosis and the way they function (Foster, Whitehead and Maybee 2016:8-9). By including care and support into the hospital plan, clinical care may be optimized and outcomes improved. Moreover, employee satisfaction and morale in addition to the satisfaction of parents is improved (Woo and Lin 2016:2). The introduction of social service professionals who can provide such emotional support may assist with supporting the hospital's overall care and recovery plans for patients and their families.

A "social worker in a medical team helps to solve social problems in individual patients and their families, and the interaction between the patient and the family is the main role of social workers in health care for patients in order to obtain their health" (Parast and Allai 2014:60). Hence, social service professionals like medical social workers and even child and youth care workers can help ease the strain experienced by children and families during a child's hospitalization.

Health social workers provide both concrete and clinical services (Carranza 2013:37). Carranza (2013:36-37) added that these concrete services relate to acting on the information and the activities that are referred from the medical staff, whilst the clinical services include dealing with interpersonal relations between the social worker, the patient and their family.

They can also help eliminate the child's fear and anxiety during hospitalization as well as that of family members.

The sub-sections that follow will contain aspects related to hospitalization in the South African context and the child and youth care context. Additionally, the problem statement and rationale for the study will be presented. The aim, objectives, research questions and the definition of the main concepts will be discussed. The theoretical framework that was used to guide the study will also be detailed. Finally, a brief overview of the research methodology and the structure of the dissertation will be presented to conclude this chapter.

1.3 THE SOUTH AFRICAN CONTEXT OF HOSPITALIZATION

South Africa is constitutionally obliged to deliver quality services in terms of health care to patients, and the government has launched programs to help improve this quality of health care (Maphumulo and Bhengu 2019:1). However, the country has experienced poor health outcomes due to its level of economic development (Pillay-van Wyk, Msemburi, Laubscher, Dorrington, Groenewald, Glass, Nojilana, Joubert, Matzopoulos, Prinsloo, Nannan, Gwebushe, Vos, Somdyala, Sithole, Neethling, Nicol, Rossouw and Bradshaw 2016:642). Poverty, poor living conditions as well as a lack of access to quality health care are some of the factors that have influenced poor health outcomes. The participants from this study emerge from a hospital within such a context.

In 1997, the South African government developed the Batho Pele campaign that aspired to enhance service delivery to the public (Frost, Jenkins and Emmink 2017:1). This campaign included access to health care, which was regarded as a basic human right in the National Health Insurance White Paper (Frost et al 2017:1). The healthcare system in South Africa consists of mainly two sectors, the private and the public sector. The public sector is government based and services patients through public hospitals. It treats roughly 82% to 84% of the country's population (Modisakeng, Matlala, Godman and Meyer 2020:3). This again is the scenario of the context of the hospital identified for this study.

Regardless of the 1994 health reforms, the burden of disease escalated from non-communicable diseases and chronic diseases to communicable diseases such as HIV/AIDS and sexually transmitted infections (STIs) (Hlafa, Sibanda and Hompashe 2019:2). Hlafa et al

(2019:2) added that violence and injuries caused increased mortality rates, resulting in the loss of healthy lives. The private sector, in contrast, treats approximately 16% of the population, servicing individuals who are covered by private medical schemes (Ranchod, Adams, Burger, Carvounes, Dreyer, Smith, Stewart and Biljon 2017:102).

Research has indicated that patients experience hunger problems at public hospitals as opposed to private hospitals. This includes long waiting times that lead to delayed consultations and delayed treatment whereas private sectors were found to be more expensive (Ranchod et al 2017:105).

South African public hospitals face many challenges such as staff shortages, heavy workloads and management failures. Their environments are more stressful, with the public health outcomes being poor (von Holdt and Murphy 2007:315). The private hospitals spending on health care is a lot greater in comparison to public hospitals which often leads to an unequal access to higher quality health care services and early prevention and care (Delobelle 2013:160).

“The health system faces a quadruple burden of disease characterised by HIV/AIDS and TB, maternal and child health issues, non-communicable diseases as well as trauma and violence” (Bresick, von Pressentin and Mash 2019:109). One of the biggest epidemics that South Africa has faced is the human immunodeficiency virus (HIV). Mayosi, Phil, and Benatar (2014:1345) wrote that “South Africa, with 0.7% of the world’s population, accounts for 17% of the global burden of human immunodeficiency virus (HIV) infection”.

Poverty is one of the aspects that is associated with illness and injuries in children. Child health in South Africa is challenged by poverty, the overburden of health care and infectious diseases (Isaacs-Long, Myer and Zar 2017:219). Many children are vulnerable to diseases and injuries in poverty-stricken homes which leads to increased hospitalizations especially at public hospitals. Children who are ill also live a distance away from health care facilities meaning that they do not get immediate health care when they first need it. In the year 2014, a study found that approximately 21% of children lived more than 30 minutes away from a hospital (Barnes, Hall, Sambu, Wright and Zembe-Mkabile 2017:30).

Language barriers are also one of the problems experienced in South African hospitals. There are eleven official languages spoken in South Africa and not all South Africans speak these different languages. IsiZulu is the most common language in South Africa, however, English is used primarily by healthcare staff (Benjamin, Swartz, Hering and Chiliza 2016:74). In a recent survey, parents reported that language and cultural barriers were the major barriers experienced, in relation to health care being provided to their children (Van den Berg 2016:230).

“The South African Government is moving towards national health insurance to provide accessible, quality health care to all” (Pillay-van Wyk et al 2016:642). In this context, the Government is endeavouring to make an effort to enhance the facilities and equipment within the hospital and the Department of Health and has developed an audit committee to assess the health facilities of the infrastructure and human resources (Owolabi, Mhlongo and Evans 2016:127). It is hoped that this will improve the health care service delivery to children and their families.

1.4 PROBLEM STATEMENT

“Hospitals provide highly specialized hospital care and are characterized by technical, economic, and financial autonomy” (Di Vincenzo 2018:2). They are responsible for facilitating the recovery of sick patients by providing specific care for their different injuries or illness. Garrick, Sullivan, Doran and Keenan (2019:48) added that hospitals can be grouped by the types of services they provide and these services include general acute care hospitals which are geared to offer both short-term medical and surgical care for a broad range of conditions and to provide diagnostic imaging, laboratory services, and emergency department services. Even though most public hospitals provides these wide range of services, what remains unknown is the nature of psycho-social support being offered to patients and their families. The latter, however, is crucial to patient well-being and recovery.

Children are hospitalised daily due to various illnesses and injuries. Literature shows that children who are hospitalised experience a great deal of stress during hospitalization (Bsiri-Moghaddam, Basiri-Moghaddam, Sadeghmoghaddam and Ahmadi 2011:206; Chung 2014:8-10; Rokach 2016:399). Being admitted to a hospital can induce anxiety and fear, which places

additional strain on both children and their family (Rokach 2016:399). As Lerwick (2016:144) said children usually report feeling afraid or anxious when they are placed in the healthcare settings with medical staff. This fear usually is associated with painful procedures that have to be performed by these medical staff as well.

When children are hospitalized they become fearful and the recovery process is disrupted, which causes an increased length in their healing process (Şahin and Topan 2018:1012). The stress induced through hospitalization may ultimately negatively impact on the overall health of the child, which suggests that they need more than just physical care (Conye 2006:344). However, most public hospitals do not make provision for psycho-social support and spiritual care that can help children transcend the difficult experience of illness, injury and hospitalisation.

Social service professionals that include both child and youth care workers and social workers are professionally trained to provide the support required to children and families facing any form of distress or trauma. Despite this, there remains a void in public health facilities, with regards to such social service professionals who can render supportive and therapeutic services to children and their families. A perusal of the literature indicates little scholarly work on this topic in South Africa. Several studies have however been conducted abroad (Temesgen 2016:3; Pandaya 2016:701; Parast and Allaii 2014:60; Zimmerman and Dabelko 2007:34; Allen 2012:184; Gehlert and Browne 2012:22-23) with regards to the salience and roles of social service professionals in a hospital context. Hence this study meets a scholarly gap in the field as it attempts to understand the challenges faced by children and their families at public hospitals and to make recommendations regarding the contribution of social service professionals in assisting children and their families.

1.5 RATIONALE OF THE STUDY

Health has been conceptualised by the World Health Organization as a state of total physical, mental, and social well-being and not the disease or infirmity being absent (Svalastog, Donev, Kristoffersen, Gajović 2017:432). There are five facets of health which include physical health, social health, emotional health, spiritual health and psychological health (Hawks, Smith, Thomas, Christley, Meinzer and Pyne 2007:321). Physical health refers to the way one

maintains a healthy body, followed by good physical health practice, proper nutrition and exercise, along with appropriate health care (Swarbrick and Yudof 2017:4). Khan and Qureshi (2018:586) explained that social health relates to an individual's ability to interact with others such as friends, family and society. The emotional aspect includes the ability to express emotions, be able to enjoy life, adjust to emotional difficulties, and deal with stress and traumatic experiences that an individual faces throughout life (Swarbrick and Yudof 2017:14). Spiritual health alludes to the connection with one's self (personally), other individuals (socially), the nature (environmentally) and God (transcendentally) (Ghaderi, Tabatabaei, Nedjat, Javadi,and Larijani 2018:2). Lastly, good psychological health refers to an individual being able to understand the potential, manage the general and normal life stressors, as well as being able to participate in the community, and the ability to work in an effective manner (Khan and Qureshi 2018:586).

Psychological well being (PWB) or mental health dimensions constitute important factors in health. "Various PWB dimensions are associated with subsequent chronic diseases and mortality, and potential mechanisms explaining associations, including stress-buffering effects and healthier behaviours" (Trudel-Fitzgerald, Millstein, von Hippel, Howe,Tomasso, Wagner and VanderWeele 2019:3). In many situations, patients are unable to manage life experiences, such as illness and they become depressed and helpless. In this regard, depression, anxiety, hopelessness and life satisfaction can be controlled through the dimensions of mental health (Guney, Kalafat and Boysan 2010:1210).

"Mental health promotion is defined as the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences" (Fusar-Poli, de Pablo, De Micheli, Nieman, Correll, Kessing, Pfennig, Bechdolf, Borgwardt, Arango and van Amelsvoort 2020:35). Mental health promotion aims to increase well-being, competence and resilience across the life-span of an individual (Fusar-Poli et al 2020:35). This is able to enhance positive mental health dimensions. Srivastava (2011:75) wrote that many psychological factors on the other hand are able to protect and support positive mental health and this can facilitate resilience to illnesses, lessen and delay the emergence of disabilities, as well as promote more rapid recovery from disease. Positive mental health dimensions are significant in a way that they promote resilience in patients and

help them to bounce back from adversities. Positive health relies on the ability to endure and cope with stress in an adaptive way (Srivastava 2011:75).

Child and youth care is a profession that is registered under the auspices of the South African Council for Social Service Professionals. Social work is also registered under this Council as a profession. Both disciplines share similar roles in relation to children and youth particularly. Research thus far has looked at the role that social service professionals, such as social workers, can play in the hospital context. These roles include discharge planning to ensure that the hospital stay is at the shortest period of time (Gehlert and Browne 2012:22). It also includes groupwork with patients enduring long term hospitalization, as well as engagement and collaboration with the medical team and the provision of information that can assist with effective decision making (Parast and Allaii 2014:64-65).

Social workers usually help support patients and their families within the complexities of health systems by providing patients with psycho-education on health and wellness and by addressing behavioural health issues (Zerden, Lombardi and Jones 2019:144-145). Their other roles include collaboration with medical teams, counselling and spiritual interventions.

Given the aforementioned aspects, child and youth care workers can play a salient role in most hospital environments, particularly the paediatric wards. Due to the daily admission of children at hospitals, it is crucial then to inquire what child care workers can do to alleviate the trauma faced by illness, injuries as well as the distress brought on by hospitalization for both children and their families. Most healthcare settings work on the premise of attending to the physical dimensions of care whilst neglecting the psychological, social and spiritual aspects. This makes it important to consider what child and youth can do to support a holistic plan of care and how they can work collaboratively with other disciplinary experts in paediatric settings. This is where the current study positions itself.

Most of the time it is the psycho-social aspects which seem to affect children and child and youth care workers are well equipped to provide therapeutic and developmental services to both children and their families. They have adequate educational preparedness to provide support and care to both children and their families. Moreover, they can design both developmental and therapeutic programmes to support children and families through the hospitalisation process. The study explores how this broad role can be used specifically within

the hospital context. No prior research has looked at this within a child and youth care context in South Africa.

1.5.1 The context of child and youth care

Child and youth care workers(CYCWs) are professionals who work in the child and youth care (CYC) field, which is another discipline that falls under the social service sector (Molepo and Delport 2015:149). Child and youth care work is seen as a brand that portrays a wide range of action-orientated and concrete activities as practitioners work with children using therapeutic play, problem-solving interventions and behaviour management (Gharabaghi 2008:146). These professionals develop therapeutic interventions to assist children with different aspects of their holistic being.

Child and youth care workers do not only work with children and youth but they work with the child's family as well as with the community that they live in. "The relationship developed between the family and worker is founded on a sense of safety that grows out of mutuality and a "non-expert" stance by the worker rather than the power relationship that occurs when a person goes to an expert to be healed" (Phelan: 2008: para. 13 lines 2).

The following 5 key characteristics underpin child and youth care work: (1) it concentrates on the development of both children and youth, (2) it considers their total functioning from (3) focuses on social competence perception, (4). the everyday life and context of children and youth, which is (5) anchored in the development of a therapeutic relationship with children and the people that places significance in their lives (MacArthur, Rawana and Brownlee 2011:7). These five characteristics can be used to nurture their possible roles in the hospital environment.

One of the main aspects of child and youth care, is to use a strengths-based approach. The strength-based approach provides ways to assess, treat and empower children and youth in order to help them achieve their highest potential (Racco 2009: para. 3 line 3-4). This approach has also been identified in social work practice and also has a history in child and youth care work, as a means of providing a holistic method of working with children and youth

(MacArthur et al 2011:7). It recognizes and takes advantage of strengths that are distilled from the daily functioning of the child (MacArthur et al 2011:7).

A strength-based approach increases the understanding and realization of strengths that children and youth possess, especially during various challenges and helps them to overcome their struggles (Racco 2009: para. 3 line 5-8). Child and youth care workers can use such a strengths-based approach to help children work through the challenges associated with recovery from illness and injury and hospitalization.

Moreover, some child care workers are community-based workers and provide support to children, particularly those without parents or who are HIV positive, by assisting with HIV prevention, referring them to other community health care workers, providing support psychologically, educating them on health issues and providing a link to help children receive a social grant (Thurman, Taylor, Nice, Luckett, Taylor and Kvalsvig 2018:1). Hence, child and youth care workers based at a hospital can provide such services post the hospital stay or within the community as well. Child and youth care work aims to build relationships with children, by developing a safe milieu to connect with children, whilst facilitating the best possible development that meets their capacity (Freeman 2013:100). Child and youth care workers also play a vital role in developing groups be it treatment centres or children's homes. They build relationships with these children and develop developmental and therapeutic activities for them (Krueger 2007:233) that have relevance to the hospital context as well.

Child and youth care workers reach out to the children who have been abandoned, orphaned, abused or are merely at "risk". They seek to provide care and facilitate the holistic development of such children socially, psychologically, behaviourally, emotionally and spiritually. This makes them a natural ally in the hospital context.

1.6. AIM

This study aims to explore the potential role of child and youth care work in a hospital context.

1.7. OBJECTIVES

1. To explore the challenges that children and their families may face during hospitalization.

2. To determine what psychosocial support children need when they are hospitalized.
3. To explore the potential role of child and youth care work in terms of providing developmental and therapeutic programmes in a hospital context.
4. To explore how child and youth care workers can work collaboratively with the multidisciplinary team in a hospital context.

1.8. RESEARCH QUESTIONS

1. What are the challenges that the child and their families may face during hospitalization?
2. What psychosocial support do children need during hospitalization?
3. What are the potential roles of child and youth care workers in terms of providing developmental and therapeutic programmes in a hospital context?
4. How child and youth care workers can work collaboratively with the multidisciplinary team in a hospital context?

1.9 DEFINITION OF CONCEPTS

The following sub-heading gives definitions of the key words used throughout the study.

1.9.1 Child

Chung (2014: 5) defined a child as an individual, determined by developmental and social maturity, that classifies them as children. This concept is given to people from the age's inception to 18 years old. According to the South African Department of social development (2006: 20), a child is a person that is under the age of 18 years old.

1.9.2 Hospital

According to Temesgen (2016: 8), a hospital is defined as a place in which the ill, receive medical treatment and assistance. A further definition of a hospital is a place that is able to provide care overnight and has qualified health care professionals such as physicians, nurses, and other care health care providers available
24 hours a day 7 days a week (Garrick et al 2019: 48).

1.9.3 Long-term hospitalization

This is a lengthy phase in which a person who is ill is admitted to the hospital for a prolonged period (Chung 2014: 5).

1.9.4 Health Care

Temesgen (2016:22) looked at health care to be a wide range of interventions and treatments that are provided to help any person who is ill.

1.9.5 Anxiety

Anxiety can be defined as an emotional state with psychological, social, and physiological aspects that seem to affect an individual at any point of their development (Gomes, Fernandes and da Nobrega 2016: 885). Additionally, Sukhodolsky, Bloch, Panza and Reichow (2013: 1342) wrote that subjective distress, and anxiety can bring about impairment in adaptive functioning.

1.9.6 Resilience

Resilience is a process in which individuals recover and thrive after facing adversity whilst adapting and trying to reach an optimal level of functioning (McNatt, Boothby, Wessells and Lo 2018:14). It “allows individuals to adapt to adverse conditions and recover from them” (Dantzer, Cohen, Russo and Dinan 2018:28).

1.9.7 Psychosocial support

Psychosocial support is a method that is used to assist in developing resilience among individuals and their families (Hansen 2009:25). This term can further be defined as the processes and actions that are used to enhance the holistic wellbeing of individuals in their social systems and aims to help people to recover from a crisis and to normalize their experiences in life after adversity (McNatt et al 2018:14).

1.9.8 Multi-disciplinary team

Mendelev, Mazumdar, Keefer and Gorbenko (2019:1) claimed that a multidisciplinary team works using different disciplines to help develop communication and also education so that it can improve the result of the patient's care.

1.9.9 Spirituality

"Spirituality refers to a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and to experience relationship with self, family, community, nature and the significant or sacred" (Soomar, Mthembu and Ramugondo 2018: 64). "Spirituality is expressed through beliefs, values, traditions, and practices" (van Leeuwen and Schep-Akkerman 2015:1347).

1.10 THEORETICAL FRAMEWORK: THE RESILIENCE THEORY

The theoretical framework that will be used to guide this study is resilience theory. Resiliency theory provides a conceptual framework for a strengths-based approach, in order to understand the child and adolescent's development and serves to inform intervention design (Zimmerman 2013:1). According to Van Breda (2018:3), this theory posited that resilience is seen as a process for a better outcome of adjusting well to any form of adversity.

Studies have shown that during adversity, some families appear to be more susceptible whilst others handle the same adversity better and recuperate faster (Masten 2018:13). Having enough knowledge of the process involved in resilience, it becomes plausible that resilience can be promoted by enhancing capacity for responding effectively to broad or specific challenges (Masten 2018:16-17). These challenges include hospitalization and facing illness and injuries.

Resilience theory provides the conceptual scaffolding for studying and understanding why some children and adolescents grow up to be healthy adults despite the risks that they were exposed to (Zimmerman 2013:1). Resilience includes the concepts of survival, recovery, and thriving and describes the stage at which a person maybe during or after facing adversity (Ledesma 2014:1). Moreover, Southwick, Bonanno, Masten, Panter-Brick and Yehuda (2014:2) explained that resilience has biological, cognitive, social and cultural aspects that

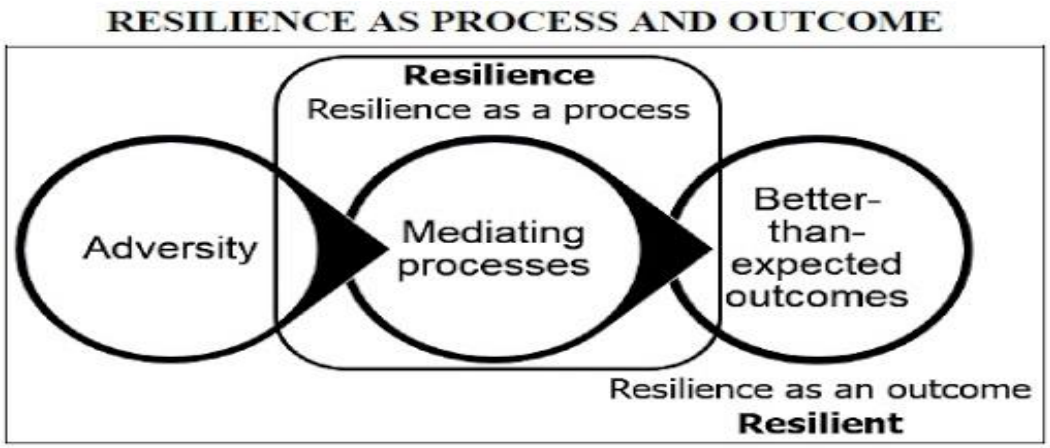
interrelate with each other to establish the response to these stressful events. This theory then postulates that since resilience is a process it, therefore, needs positive mediating factors to present a constructive result (Van Breda 2018:3-7).

During a child's hospitalisation, caused by illnesses or injuries, the latter is perceived as adversities that both children and their parents face. Hence despite being resilient, children and their families may be unable to withstand the stress of hospitalization of a child. There is a need for mediating factors that are able to contribute to the positive outcome and build resilience.

Such factors may include positive social relationships and support given to the child and their parents to work through this adversity (van Breda 2018:4). Child and youth care workers can act as a support system and offer therapeutic and developmental programmes to patients and their children thereby building resilience. Child and youth care workers can also use multiple interventions to build resilience in children and their parents and their families to obtain a better outcome of hospitalisation. Resiliency theory is a unified theme that can be useful for public health education since it assists to create a common language and analytic approach that cuts across the specific issue or domain being studied to enhance knowledge and use information-based practice by using a strengths based paradigm (Zimmerman 2013:3).

This framework is most appropriate as it will guide the researcher on what activities, interventions and factors may help to build resilience in the child and their families. Building resilience will also eliminate uneasiness during the event of hospitalisation. It will also provide insight as to how children are able to overcome or deal with the stage of illnesses that they experience.

Figure 1: Resilience as a process and outcome (Van Breda 2018:4).



1.11 OVERVIEW OF THE METHODOLOGY

A qualitative approach was used to guide the study. The reason for this was so that more in-depth and rich information could be collected with regards to the challenges parents and children faced during the hospitalization experience and what could be done to strengthen their well-being. The study was conducted using two samples and data was collected using semi-structured interviews. The first sample constituted an array of hospital medical staff and the second sample child and youth care workers. The interviews took place for the first sample at R.K Khan Hospital and the second sample at the Ethekwini office of the National Association of Child Care Workers. Data was recorded by the use of a voice recorder. All data was collected until saturation. The sampling method used was purposive sampling. Thereafter, data was analysed using thematic analysis.

1.12 STRUCTURE OF DISSERTATION

- Chapter 1 – Introduction
- Chapter 2 – Literature review
- Chapter 3 – Research Methodology
- Chapter 4 – Data analysis and discussion of findings
- Chapter 5 – Recommendations and conclusion of the study

1.13 CONCLUSION

This chapter provided an introduction that gave an overview and background of the study. Hospitalization within the South African context was discussed. This chapter also outlined the problem statement and the rationale of the study. Additionally, the context of child and youth care was explained. The aim, objectives, research questions, as well as the definitions of key concepts, was also presented. The theoretical framework that was used to guide the study was discussed. The chapter ended with an overview of the research methodology and the structure of this dissertation. The chapter that follows is the literature review chapter which focuses on relevant literature pertaining to the aim of the study.

CHAPTER 2:

LITERATURE REVIEW

"We see how early childhood experiences are so important to lifelong outcomes, how the early environment literally becomes embedded in the brain and changes its architecture." – Andrew S. Garner

2.1. INTRODUCTION

This chapter gives an overview of the literature pertaining to children and their families in a hospital context. According to Snyder (2019:333), a literature review can be defined as a method of gathering and synthesizing prior research. A literature review can also further be described as "a comprehensive overview of prior research regarding a specific topic" (Denney and Tewksbury 2013:218).

This chapter on the literature reviewed presents the global and national statistics related to the admissions of children in hospital over the years, for injuries and illnesses. It further goes on to discuss the impact that hospitalization has on children and their parents. Literature related to the psychosocial and spiritual interventions offered at hospitals and within the context of recovery is reviewed. Finally the interventions that social service professionals can implement to promote healing for hospitalized children and families are discussed.

2.2. STATISTICS RELATED TO HOSPITALIZATION INTERNATIONALLY AND NATIONALLY

Children are hospitalized for many reasons due to illness or severe injuries. A review of local literature reveals that many children are admitted to hospital due to various illnesses and injuries, and whilst literature focuses on the reasons for hospitalization, little exists on the actual statistics on children who have been hospitalised. Statistics for children who have been hospitalised in an international context are more prevalent in the literature. The following sub-sections will present statistics related to illnesses and injuries in both the international context and the national context.

2.2.1 International context

In the year 2012 around 5.9 million children were admitted to hospital in the United States (US), for various types of injuries and illnesses (Lerwick 2016:144). In terms of injuries, approximately 14,2 % of children, between the ages of 15 to 19 were reported to be admitted for transport injuries, in the US that warranted long-term hospitalization (Morgado, Jalles, Lobon, Abecasis and Gonçalves 2017:1).

More specifically 14 400 children, under the age of 19 were hospitalized for injury in road accidents (Mitchell, Bambach, Foster and Curtis 2015:1). Leventhal, Gaither, and Sege (2014:1) wrote that firearm injuries are one of the most common causes of injuries amongst American children. Approximately 21000 children were hospitalised for this type of injury in 2010. In Puapa New Guiene, in the years 2014 -2015, 107 children were screened and hospitalized for child maltreatment, 56% of which accounted for sexual abuse, of all the child-maltreatment admissions to paediatric wards. Thirty four percent and ten accounted for deliberate neglect and physical abuse respectively (Rero, Aipit, Yarong-Kote, Watch, Bolnga, Vei, Morris, Lufele and Laman 2016:284).

In West Australia, Duke, Rea, Boyd, Randall, and Wood (2015:905), revealed that approximately 35% of children under the age of 15 were hospitalized for accidental burn injuries. It is also documented that 382 children, younger than 4 years to those older than 15 years of age were hospitalized in Ethiopia in the years 2011-2015, for burn injuries (Alemayehu, Afera, Kidanu, and Belete 2020:4). Torio, Encinosa, Berdahl, McCormick and Simpson (2015:23) stated that just less than 59 000 children were hospitalised for self-mutilation globally, and within the years 2006 to 2011, there was a rapid increase of children admitted into the hospital for the same reasons.

In terms of illnesses, in a recent study in the year 2011, it was established that 182 122 children aged 1 to 17 years old were hospitalized for mental health issues in the United States (Torio et al 2015:23). According to Savina, Simon and Lester (2014:1) in the year 2009, more than 144 000 children and adolescents in the US, were admitted for mental health problems and roughly 95 500 children and adolescents were hospitalized for mood disorders such as depression and bipolar disorder.

In developing countries, roughly about 77% of children who were admitted to hospital was for childhood cancer (Lifson, Hadley, Wiles and Pillay 2016:1). A study done in Romania by Sasu, Ciutan and Musat (2019:18) showed that a total of 28 762 children were admitted in the years 2013-2017, for malignant tumours. Moreover according to the World Health Organization (WHO), a total number of approximately 550 000 children were infected with tuberculosis, globally (Graham, Cuevas, Jean-Philippe, Browning, Casenghi, Detjen, Gnanashanmugam, Hesseling, Kampmann, Mandalakas, Marais, Schito, Spiegel, Starke, Worrell and Zar 2015:179). In the year 2008, 34 million occurrences of respiratory syncytial virus caused children under the age of 5 years old to be hospitalised globally (Kyeyagalire, Tempia, Cohen, Smith, McAnerney, Dermaux-Msimang and Cohen 2014:1). These statistics provide a broad overview of the number of hospitalizations and a snapshot of the reasons warranting the hospitalization of children.

2.2.2 South African context

In South Africa, a study conducted between the years 2008 to 2010, found that approximately 522 patients were hospitalized for injuries that were not accidental. This included the physical abuse of children (Janssen, van Dijk, Al Malki and van As 2013:221). In the year 2013-2014, approximately 987 patients were hospitalized over a 12 month period for burn injuries at the Red Cross War Memorial Children's Hospital in Kwazulu-Natal (ter Meulen,Poley, van Dijk, Rogers,and Rode 2016:1120).

In the years 2007 to 2013, 75 children were hospitalized for drowning or near drowning incidents. In a study done in the year 2016, there were a total of 130 children admitted for brain injury, 50% due to pedestrian vehicle accidents, 33.8% involved a child as a pedestrian being hit by a car and 16.2% being a child as a passenger in the car (motor vehicle accidents) (Corten, van As, Rahim, Kleinsmith, Kleyn, Kwinana, Ndaba, Sillito, Smith,Williams and Figaji 2019:3).

In terms of illness, in the year 2013, approximately 3658 children were admitted for surgical procedures (Isaacs-Long, Myer and Zar2017:221). A study conducted in the year 2005 to 2008, in Gauteng, South Africa, found that the Human-Immunodeficiency virus affected 2,46% of children under the age of 15 years old (Dangor, Izu, Moore, Nunes, Solomon, Beylis, von

Gottberg, McAnerney and Madhi 2014:2). In total there was a sum of 215536 children admitted in Gauteng, in the years 2004 -2003.

In South Africa, many of the reasons for hospitalisation are related to tuberculosis and invasive pneumococcal disease (Dangor et al 2014:2).Chronic obstructive pulmonary disease (COPD) and bronchiectasis was documented as 167 admissions in the year 2013 (Isaacs-Long, Myer and Zar2017:221).

In the year 2016 to 2017 approximately 50 439 children under the age of 5 years old were admitted for pneumonia (Bamford, Barron, Kauchali and Dlamini 2018:34). In 2013 there were 1400 children admitted for diarrhoea, 371 for convulsions, 116 for poisoning and 128 for asthma. In the year 2014 to 2018, in the Limpopo province, 1424 children were hospitalized for severe acute malnutrition (SAM) (Gavhi Kuonza, Musekiwa and Motaze 2020:4). Having presented the statistics available in the literature, the following sub-sections looks at the impact of hospitalization on a child.

2.3. IMPACT OF HOSPITALIZATION ON A CHILD

Hospitalization is a difficult and stressful time for a child, seeing that the child has to adjust their usual lifestyle, such as their social life and the rules and routines that they are familiar with, to the new ways of the environment that they have just entered (Martins, da Silva, Fernandes, e Souza, Vieria 2016:3969). The hospital environment is unpredictable and disorderly for the young person because their routines and everyday activities aren’t practiced as normal (Conye 2006:328). Chung (2014:6) argued that most children, who are hospitalized, have very unsettling feelings about the medical environment. Moreover, some children have opportunities taken away from them such as socializing with peers because of facing frequent or long term hospitalization (Russell, Oh and Taylor 2019:2).

Hospitalisation of a child is often anxiety-provoking (Rokach 2016:399). When a child is hospitalized, it induces considerable fear and stress for them (Salmela, Salantera, and Aronen 2009:269). Stress can be defined as a relationship between an individual and the environment which is considered as taxing or exceeding the resources of an individual and causing a danger to their well-being (Andrade and Devlin 2014:125). This stress that children experience, further impacts on their health and they may have fewer mechanisms to eliminate the stress in a hospital environment (Bsiri-Moghaddam et al 2011:202).

Often children start to experience uneasiness as they begin to engage with medical staff in the hospital context (Lerwick 2016:144). The child may also experience feelings of exclusion, suspicion and fear if the medical care worker does not involve them in their communication regarding their situation Corsano, Cigala, Majorano, Vignola, Nuzzo, Cardinale and Izzi 2016:85). The way that hospital staff interact with the hospitalised child and the level of care that they provide to them, are factors that influence aspects such as their sleep (Vardar-Yagli, Saglam, Inal-Ince, Calik-Kutukcu, Arikan, Savci, Ozcelik and Kiper 2016:800). Children usually require more time and more specificity for their care, monitoring their parameters closely, personalized medicine and trained and compassionate care providers (Casamir 2019:4).

Stressful incidents for the child that is hospitalized for an illness, along with the family and the treatment provided by health care can cause emotional repercussions for everyone involved (Azevedo, Junior and Crepaldi 2015:3654). Being an inpatient, individuals experience loss of control over their lives and they are unable to decide what and when to eat and when to receive visitors and they do not have much chance of leaving the inpatient area or have a wide range of activities or control of the physical environment (Andrade and Devlin 2014:126).

2.3.1 The effects of hospitalization on a child

Children experience fear differently due to their developmental stages (Salmela et al 2009:269). The developmental stage of a child and their cognitive stage is restricted therefore children use their actions and behaviour as a form of expressing their feelings (Lerwick 2016:144). Children, who usually have special health care needs, are at risk of developing physically, developmentally and/or behaviourally, irrespective if it is a chronic or temporary illness. They require greater care that needs to be properly performed or else it affects the survival of these children (da Silva and Cabral 2014:936). Chronic illness impairs the sensory, physical, and mental aspects of achild, interferes with their daily functioning, and can be managed but very rarely cured (Shah and Othman 2013:1).

Children, who are admitted for chronic illnesses, require repeated or extended hospitalisation (Coquillette, Cox, Cheek and Webster 2015:2708). Lyu, Kong, Wong and You (2015:1959) argued that extended or reoccurring hospitalisation becomes an experience which is too stressful for a child. Research suggests that frequent hospitalizations in the short term, can

cause adverse effects on the welfare of the admitted child, and exposing them to various stressors, such as separation from the family, school and friends and unfamiliarity of the environment (Shah and Othman 2013:2). Emotional deterioration occurs when they leave their comfort zone which is their home and go to an unknown hospital environment (Gomes and de Oliveria 2012:166). The way children respond emotionally to the event of hospitalization fluctuates from 10% to 30% for psychological distress, to as much as 90% when children may get emotional or upset during hospitalization (Rokach 2016:400).

When a child is admitted to hospital for a longer period of time it causes problems in other areas of their life such as schooling which disrupts their holistic functioning (Bakri, Ismail, Elsedfy, Amr, and Ibrahim 2014:504). Stress and anxiety are present in a child irrespective if there is pain or not (Lerwick 2016:144). As a result of all of these factors and experience, the child's biological, psychological and social development is affected (Matziou, Vlachioti,Megapanou, Ntoumou, Dionisakopoulou, Dimitriou, Tsoumakas, Matziou and Perdikaris 2016:863). With regards to appetite changes, there are changes in eating habits and the illness triggers factors that compromise the nutritional status of the child (Gomes et al 2016:887).

"Children's cognitive development prohibits their capacity to define parameters of any event, specific to duration or intensity" (Lerwick 2016:145). Children usually rely on others emotionally and cognitively, in which they tend to become susceptible to coping with their trauma in hospital (Rokach 2016:399). Behaviourally, a child will show fear, aggressive actions and they do not try to cooperate (Lerwick 2016:144). Psychological problems that appear during the time the child hospitalized are usually called hospitalism (Crnkovic, Divcic, Rotim and Coric 2009:126).

Psychological care needs to be seen as important in the hospital context, because if it is not treated it may cause cognitive health issues, worsening the situation (Lerwick 2016:144). When a child is admitted to hospital, particular attention is paid to the improvement of the clinical symptoms of the illness and to reducing the psychological burden (Koukourikos,Tzeha, Pantelidou, Tsaloglidou 2015:438).

Hospitalized children may begin to feel helpless and fearful, which gives rise to anxiety, which may, in turn, have a negative impact on the health of the child (Li, Chung, Ho and Kwok 2016:1). It affects them holistically and impacts on their ability to heal (van Dijk 2017:4).The psychological burden that children experience, makes the procedures in hospital difficult to

effectively execute, and may impose medical risks (Wong, Yim, Kwok, Choi, Wah and Chan 2018:1).

2.3.2 The child's perceptions of hospitalization

Children usually get an impression of the hospital context from their visits to the hospital, to see other relatives or from watching television programs about the hospital (Conye 2006:331). The impression of the hospital environment also derives from information, based on what their parents tell them, therefore, resulting in feelings of fear and anxiety (Salmela et al 2009:269). According to psychologists, the hospital's physical environment is able to influence the treatment process and results (Woo and Lin 2016:2). When children lack appropriate information about a healthcare setting, any misconception regarding this leads to huger fears and acute distress.

According to Chung (2014:7), some children feel as if hospitalization is a form of punishment for their misdeeds. Salmela et al (2009:269), explained that some children feel like it's a form of parents abandoning them and causing them pain. "For children the hospital is like a foreign country to whose customs, language and schedules they must learn to adapt" (Rokach 2016:399).

One of the biggest fears of children is the pain that comes with hospitalization, such as surgical procedures and being injected (Conye 2006:327-331). Hospitalised children frequently undergo painful procedures associated with treatment, and they also experience pain related to their symptoms of disease or injury possibly resulting in distressful or negative memories (Vejzovic, Bozic, Panova, Babajic and Bramhagen 2020:2). During surgery children are also quite likely to resist sedation through intravenous injections due to associated pain (Chow, Van Lieshout, Schmidt, Dobson, and Buckley 2016:183). The pain that they experience, results in effects such as consuming lesser food, discomfort and feelings of fatigue (Matziou et al 2016:863). Additionally, the way that children show their pain and their ability to face it, is closely associated to their age and cognitive maturity (Silva, Pinto, Gomez and Barbosa 2011:318).

Moreover, children fear long-term hospitalization because they miss out on schooling activities and may deteriorate in their grades (Coyne 2006:330). This may also include the readmission of children. Usually, children who have complex chronic conditions are more likely than other

children to face readmission after an acute care hospitalization (Jurgens, Spaeder, Pavuluri and Waldman 2013:154). A study conducted by Cahayag (2020:13) found that after hospitalization there was deterioration in a child's school related work.

2.3.3 Parent-child separation anxiety

When a child is separated from his or her parent, they go through a phase of distress, which may be related to the child's cognitive aspect, which is referred to as separation anxiety (Stone, Otten, Soenens, Engels and Janssens 2015:3192). Most children who need hospitalisation become very attached to their parents (Gomes and de Oliveria 2012:166). Hospitalised children fear separation from parents, who are very important in their everyday lives (Bsiri-Moghaddam et al 2011:202).

Separation from parents results in a phase of separation anxiety and has a loss of control with regards to the amount of fear that they face (Vakili, Abbasi, Hashemi, Khademi and Saeidi 2015:594).Hospitalization causes separation induced anxiety, grief, fear of the environment that's new to them and anxiety, all of which can affect the psychological, cognitive and emotional state of patients (Shafiee, Gharibvand and Hemmatipour 2018:284).

When children show signs of separation anxiety, when they are away from parents during their hospital stay, it becomes very challenging (Stone et al 2015:3192). Children with separation anxiety start to feel nauseous and experience pain in their stomach and their head. These symptoms can take a toll on the child's health for the worst (Ehrenreich, Santucci and Weiner 2008:389). Decreasing child anxiety becomes a vital treatment method to help control emotions over the child's experience of pain (Fincher, Shaw and Ramelet 2011:952). Separation anxiety disorder is an imperative disorder that requires treatment because it affects the child's daily activities, routines and may cause other psychiatric disorders (Naldan, Karayagmurlu, Ahiskalioglu, Cevizci, Aydin and Kara 2018:764).

The previous sub-section detailed the impact of the hospitalization and the way hospitalization affects the child negatively. The following sub-sections will present the impact that a child's hospitalization has on their parent's well-being.

2.4 IMPACT OF HOSPITALIZATION ON PARENTS

Hospitalisation is a critical event that affects not only the child but their family members as well (Tehrani, Haghighi and Bazmamoun 2012:39). When a child is in hospital, the experience for the parent is nerve-wrecking (Vakili et al 2015:594). A hospital is also seen as a very intense, unpredictable and hostile environment to the family, which tends to make them nervous (Walker-Vischer 2014:6).

Hospitalized children need healthcare that focuses on their unique needs from the beginning to the end, and that includes the involvement of their parents (Casamir 2019:4). Franck, Ferguson, Fryda and Rubin (2015:433) acknowledged that the need for family care within hospitals has been identified over the years. Walker-Vischer (2014:6) stated that parents play a steady and important role in the everyday life of their child. In addition, parents are also seen as the primary agents in a child's life, with regard to their outlook on life and their behaviours that may affect their welfare (Commodari 2010:1).

When a child is hospitalised, it is important to understand how their parents are coping and the way they may be handling this situation (Gomes and de Oliveria 2012:166). Sometimes when a child is in hospital for a long time or repeatedly, it can cause greater distress and can upset their overall psychological well-being (Lyu, Kong, Wong and You 2015:1960). Families fear infections, they fear that the child's illnesses or injuries might worsen and they are afraid of their child not getting proper medical care (Gomes and de Oliveria 2012:166).

Challenges that parents face includes fear of the unknown that goes on with their child in the hospital, finding the way of the medical system, a feeling of anxiety, erratic feelings, and coping with the risk of their child's mortality (Kosta, Harms, Franich-Ray, Anderson, Northam, Cochrane, Menaham and Jordan 2015:1063). Yet at the same time it is a parent who understands their child well and plays the role of a mediator between the child and medical staff, whilst continuing to offer care to the child (Gomes and de Oliveria 2012:166).

2.4.1 Holistic effects of a child's hospitalization on the parent

The following sub-sections discuss the physical, psychological and financial aspects of how parents of hospitalized children are affected.

2.4.1.1 Physically

Parents tend to have disorientated sleep patterns, when their children are hospitalised, which results in overall minimal performance during this period of time (Vardar-Yagli et al 2016:800-801). Furthermore, previous studies have shown that not only do parents have reduced sleep, but they also have night time awaking and have trouble falling back asleep since they are constantly checking on their child (Stremler, Haddad, Pullenayegum and Parshuram 2017:37).

Some studies found that some parents who are allowed to stay over with their children at hospital have sleepless nights by the sound of hospital machines and other environmental factors that cause this (Nassery and Landgren 2019:266-270). Parents also experience physical difficulties such as digestive problems and pain as well (Commodari 2010:5).

2.4.1.2 Psychologically

Commodari (2010:1) stressed that parents need to be psychologically functional, in order for their children to recover physically and cognitively through their ill health and hospital stay. In this case, assessments also need to be conducted on parents of hospitalised children, so that they get the requisite psycho-social care, so that they do not struggle alone (Lyu et al 2015:1959).

Parents struggle to deal with the stress of helping their child to transition in hospital and also out of hospital and back to home (Beck, Solan, Brunswick, Sauers-Ford, Simmons, Shah, Gold and Sherman 2017:304). Parents of these children also seem to carry out overprotective behaviours, simply because they are lost in relation to how to handle the situation at hand (Matziou et al 2016:863).The way parents view pain that is experienced by their child, places a considerable strain on them (Matziou et al 2016:863).

Walker-Vischer (2014:6) elaborated on how parents struggle with the fact that strangers are caring for their children when they cannot. Parents tend to feel powerless at this time and lose their sense of control (Matziou et al 2016:863). Parents are also fearful of the situation and its outcomes and their coping is influenced by their experiences, knowledge about the situation and their ethics (Gomes and de Oliveria 2012:166).

One of the biggest fears parents endure is the fear of the death of their child who has been hospitalized, their child being injected with an intravenous drip and as well as the fear that the

same circumstances may occur with one of their other children (Tehrani et al 2012:41). Walker-Vischer (2014:10) also stated that parents fear that their children might not receive the necessary care when there are language barriers between children and nursing personnel.

2.4.1.3 Financially

Parents also experience stress due to financial issues (Tehrani et al 2012:40). Financial difficulties also surface when parents have to travel to and from the hospital and encounter a loss of their wages (Franck et al 2015:433). Parents also struggle economically, when their child is hospitalized, because they have to be absent from work, especially when their child is hospitalised for a lengthy period of time, thereby causing them to miss work and fall short on their wages (Parsapour, Kon, Dharmar, McCarthy, Yang, Smith, Carpenter, Sadorra, Farbstein, Hojman, Wold, and Marcin 2011:2).

Parents, who earn poor salaries and have to face a very high hospital bill, also experience high levels of stress, from both the child being ill and escalating medical costs (Coquillette et al 2015:2708). Some studies have shown that unforeseen hospitalization of children, has led to parents becoming highly stressed, particularly parents who are unemployed (Rodriguez-Rey, Alonso-Tapia and Colville 2018:150).

Having discussed the impact that hospitalization of a child has on the parent, the following sub-sections will outline the literature on the roles that social service professionals can play in the hospital and the interventions that they can offer which may benefit the hospitalized child and their families.

2.5. ROLES OF SOCIAL SERVICE PROFESSIONALS IN HOSPITALS

Literature from allied fields such as medical social work suggests that therapeutic work with children is an important aspect within the hospital setting. Medical social work entails many responsibilities within the health care setting (Limon 2018:9). Services rendered to a child in hospital need to be there to support the child and family and to eliminate the negative experiences during hospitalization making it a stable and positive experience (Vakili et al 2015:594).

The roles that a medical social worker plays, alters according to the needs that the family and the child require for the best possible functioning (Fonash 2018:112). According to Temesgen (2016:11), social workers are able to provide solid services such as counseling and advocating for the hospitalized child and family. In addition, social workers not only develop interventions to meet a child's developmental needs, but they also carry out case findings as well as conduct consultations with the child, to gain further information about their condition (Ruth and Marshall 2017:4).

In the following sub-sections aspects related to working in a multidisciplinary team, counselling hospitalized children and group therapy will be discussed as roles that social service professionals can play in assisting hospitalized children.

2.5.1 Working in a Multi-disciplinary team (MDT)

This term is seen to involve synchronized attempts between all specialists in multiple disciplines to help with the managing of a patient (Ugwumadu, Chakrabarti, William-Brown, Rendle, Swift, John, Allen-Coward and Ofuasia 2017:1-2). A hospital's MDT usually includes staff from all levels and they work more effectively than staff, that are randomly assigned to a unit (Epstein 2014:295). "Studies show that overall primary care clinicians believe that social workers are able to improve their ability to deliver comprehensive quality care to their patients" (Limon 2018:10).

Working in an MDT allows professionals to see to the overall needs of children and their families by providing security concerning their about their health. In addition, medical social workers may work within multi-disciplinary teams (MDT) in the hospital, to help other medical professionals work around the issue at hand, with the young person and to provide suggestions for the child's treatment within the decision-making phase. This is because social workers are able to communicate and work directly with both the young person and their family (Parast and Allaii 2014:60-65).

Working in a health care team, medical social workers can also take the initiative to give parents support as well as respect, when making decisions about the treatment for their child (Zimmerman and Dabelko 2007:37). Medical social workers have highly developed knowledge about obstructions people may face in the health sector and are well qualified to work with one on one patient involvement and by this, they are able to use motivational

interviews as one of the therapeutic methods (Allen 2012:184). The meetings that the multidisciplinary team has, ensures the quality of life and survival for the patient and influences decision making regarding the health of the child (Horlait, Baes, Dhaene, Van Belle and Leys 2019:159).

Studies have shown that medical social workers help to improve the life of the patient who may be dealing with a serious disease and also helped patients who have been suicidal or abusing drugs (Shrivastava, Shrivastava and Ramasamy 2014:131). In a previous study done, some roles of the social worker in an MDT included ensuring that care plans and discharge plans for the patients are grounded in the reality of the lives of these people by a representation of wider and contextual concerns that will have an impact on their lives (Giles 2016:30).

2.5.2 Counselling hospitalized children

Counselling has been defined as a professional relationship which empowers different groups of people, families and individuals to accomplish mental health, wellness and education, where a counsellor assesses, diagnoses and treats mental health, using evidence based interventions and also helps individuals who are unable to cope with life stressors (Beck and Kulzer 2018:92). One of the main reasons children fear the hospital is because it is an unfamiliar place. Children are assisted to understand the hospital environment and adapt to its routine (Vakili et al 2015:594). Medical social workers may also help children during their hospital experience, by providing counseling to help them live a more positive and healthier lifestyle (Allen 2012:184).

Medical social workers counsel children with regard to decision making about treatment and also their feelings and thoughts with regard to the hospitalisation experience (Limon 2018:9). Counseling enables social workers to show empathy and listen to children, as well as understand and empathize with their different conditions (Badger, Royse and Craig 2008:64-65). Health social workers are able to conduct adherence counselling, by assisting patients to adhere to taking their medication and treatment since this is vital with regard to positive health outcomes (Gehlert and Browne 2012:200).

A potential role can also include assessments with children that can be carried out so that their strengths can be ascertained, therapeutic goals designed, and therapeutic interventions

developed (Temesgen 2016:16). Writers have said that to determine the needs of children within a medical setting, specialists need to perform a psychological assessment to detect any possible stress, anxiety and coping abilities, to ensure that the interventions provided are age appropriate (Delvecchio, Salcuni, Lis, Germani and Di Riso 2019:2). Medical social workers are tasked to educate parents about the condition they are facing, unpack its complexity and attempt to teach them in the hospital about how to manage and handle a child with a particular illness (Fonash 2018:111).

A medical social worker is trained to play a role in providing counselling, in order to help the patient deal with their diagnosis and provide grief counselling for the loss that will be incurred because of the illness and also encourage their communication with a medical professional to maximize quality of life (Gehlert and Browne 2012:25). Social workers can also play a role by using education and counselling to prevent transmission of diseases between the patient's social networks (Gehlert and Browne 2012:166).

Social workers are often called in to provide support and counselling for patients who have had injuries and are experiencing disability for the first time such as spinal cord injuries and are unable to walk again. Hence they provide adequate time and a secure environment during such sensitive counselling sessions (Gehlert and Browne 2012:225-226). Social workers can also assist families in providing individual, family and support group counselling for these patients (Gehlert and Browne 2012:480). In addition, social workers provide a continuum of care for the patients and offer therapeutic interventions and support systems even after they are discharged (Parast and Allaii 2014:59).

2.5.3 Group therapy

Group therapy can be defined as treatment where individuals who face emotional distress are placed in a group for the purpose of assisting individuals in bringing change, improving social functioning and coping effectively through group experiences (Ezhumalai, Muralidhar, Dhanasekarapandian, and Nikketha 2018:541). Also having peer support groups where children share their experiences of hospitalisation, help them feel that they are not the only ones, experiencing such fear and anxiety (Madisha, Mabuela, Mohlabi, Shiba, Mabaso, Moodley, Tshitaudzi, Sithole 2016:22).

Hospital social workers usually run support groups for patients and their families to offer education and support concerning various health issues (Gehlert and Browne 2012:26). For patients who have critical illness such as cancer, social group work can be used to decrease isolation, build social support, share emotional concerns and provide a safe environment to manage the symptoms, cope with various changes and communicate with family and healthcare professionals (Gehlert and Browne 2012:510)

Social service professionals facilitate family groups, social support groups and peer support groups that are able to improve the quality of their life and health care (Gehlert and Browne 2012:203). Hansen (2009:30) wrote that psychosocial support can be provided over a period of time and uses different methods to address children in hospital and their families. This psychosocial impact can be decreased by the feelings and experiences of the child and their families being acknowledged and helping them to adapt to the event (Obaid 2015:77).

More group based therapies that can be implemented in the hospital are mindfulness meditation groups. Mindfulness is a type of awareness that involves one being attentive, on purpose, in the present moment, and without judgement (Ruskin, Gagnon, Kohut, Stinson and Walker 2017:3). The process and practice of mindfulness in Buddhist philosophy, is believed for a long time to decrease suffering that is experienced when the mind is focused on the past or future (Dove and Costello 2017:3). Mindfulness based interventions has been seen as a promising technique for this purpose given its emphasis on improved tolerance of uncomfortable physical and emotional experiences with adolescent chronic pain (Ruskin et al 2017:3).

Having reviewed the literature regarding the roles of social service professionals in a hospital context, the sub-section that follows below will outline the psychosocial and spiritual support and interventions that can be beneficial within the hospital context.

2.6. PSYCHOSOCIAL AND SPIRITUAL SUPPORT AND INTERVENTIONS

Psychosocial and spiritual support enables an individual to address their reactions to a critical situation, allowing them to adapt themselves and turn their situation into a possible opportunity for positive change (Hansen 2009:6). Psychosocial support helps children in

hospital to recuperate and heal themselves (Hansen 2009:25). It has been found that families who receive psychosocial support encounter less stress, anxiety, and trauma (Brysiewicz and Chipps 2006:69). Some of the psychosocial support interventions that will be discussed are play therapy, educating families about medical conditions and treatment, expressive art therapy, music therapy and spiritual support.

2.6.1 Play therapy

One of the most common types of psychosocial support in the hospital context is play therapy and it is important to implement this type of therapy for children during their stay at the hospital (Li, Chung, Ho and Kwok 2016:1). Kiran, Vithalani, Sharma, Patel, Bhatt and Srivastava (2018:412) defined play therapy as an interpersonal process in which a trained therapist uses the healing power of play to help patients overcome their psychological difficulties and help prevent future ones. Therapeutic play is a set of structured activities that is designed according to the child's age, cognitive level and health-related issues, to encourage emotional and physical well-being in hospitalised children (Wong, Yim, Kwok, Choi, Wah and Chan 2018:1).

"Play bridges the gap between concrete experience and abstract thought" (Pidgeon, Parson, Anderson, Stagnitti, and Mountain 2015:4). A child's ability to play during hospitalization constitutes a sign of health in a difficult environment, showing that the child is able continue their usual activities, or that there is some progress in the course of the illness (Koukourikos et al 2015:438).For children who are admitted to hospital, play is a powerful tool that can decrease their tension, anger, frustration, anxiety, help improve the way they cope, master capacities and their feelings of control as well as enhancing their communication with the health care workers (Ullan, Belver, Fernandez, Lorente, Badia and Fernandez 2012:274).

"Play therapy is a structured, theoretically based, approach to therapy that builds on the normal communicative and learning processes of children" (Drisko, Corvino, Kelly and Nielson 2019:1). Play facilitates verbal communication and allows the child to approach their emotional difficulties from a psychologically safe distance (Weil 2012:7).

Play is used as a routine type of activity, providing a familiar environment for children to express their anxiety and fear as well as master the way they cope, with how they feel towards the stress of medical events (Nabors and Kichler 2016:438). Play further assists a

child to express their feelings and creates a safer environment within the cold, unfriendly health care setting (Li et al 2016:2). Play acts as a distraction therapy and therefore can also be used to help nurses assess levels of pain that the child is going through (Reid-Searl, Quinney, Dwyer, Veith, Nancarrow and Walker 2017:445).

A study done by Li, Chan, Wong, Kwok and Lee (2014:38) for children who are undergoing surgery showed that therapeutic play intervention increased the children's sense of control by visiting the operation theatre as a way to increase their familiarity of the environment. According to He, Zhu, Li, Wang, Vehvilainen-Julkunen and Chan (2014:433), preschool children who engaged in therapeutic play during the pre-operative stage were significantly calmer, reported with low blood pressure and pulse rates as well as experienced fewer adverse behavioural changes, post operatively, rather than those children who received routine care. Play therapy was also seen to be effective in reducing the stress of a child after they underwent surgery (Ghabeli, Moheb and Nasab 2014:25).

Play therapy is one of the therapeutic interventions that are used to help a child deal with anxiety by distracting them from the pain and results in relaxation (Yati, Wahyuni, Pratiwi and Islaeli 2017:97). Play therapy with children, who have chronic illness, helps them to express their feelings, whilst creating a normalized medical experience during the hospitalization period (Russell et al 2019:3).

Selecting the proper toys for play therapy can assist in providing constructive, education, stimulating relaxation and bringing therapeutic value. Toys and games not only allow others to communicate with children but they assist medical workers to establish a relationship with children (Woo and Lin 2016:1). Play therapy uses cognitive behaviour therapy to focus on the emotions of a child and its association with a particular event in which children learn developmentally appropriate ways to cognitively recognize their emotions allowing them to cope better through the process of modelling and desensitization and by associating stressors with positive emotions (Burns-Nadar and Hernandez-Reif 2016:5).

Play is a crucial social work intervention and an applicable communicative tool in working with children. However, use of this type of play may be integrated differently within an inpatient hospital setting due to physical and emotional restrictions and the current medical model (Goodman 2009:8). Hospital-based play therapy includes preparation of medical procedures

or other experiences and also in assisting a child in dealing with their emotions towards hospitalization and illnesses (Nabors and Kichler 2016:438).

Having a playroom in a hospital is also important. Most hospitalized children receive play therapy together in a playroom, unless children are required to remain in their bed. Then only should play interventions be provided at their bedside (Li et al 2016:3). One of the purposes of a playroom is to create a less traumatized and more joyful hospital milieu, enabling better conditions of staying, recovery, helping the child to prepare for new situations and preserving their health, thereby ensuring a continuation of their development and discharge (e Sousa, De Vitta, de Lima, De Vitta 2015:42). The hospital playroom environment must be arranged by considering a child's physical and psychological needs (Kaytez 2018:613).

2.6.2. Providing appropriate education

Another important intervention is giving information and educating family about the child's condition and the upcoming medical procedures. The aim of educating the patient and family is to provide knowledge, skills, self-awareness and to encourage family health and empower children with chronic illness, as a result such that patients and their families can act in their own self-interest (Kelo, Martikainen and Eriksson 2013:71).

Receiving both information and clear communication concerning paediatric care is vital for both parents and children (Konstantynowicz, Marcinowicz, Abramowicz and Abramowicz 2016:1746). "The hospitalization of children requires improved communication to be established with parents and appropriate information to be provided, while the performance of care activities needs to be negotiated" (de Melo, Ferreira, de Lima and de Melo 2014:433).

Minimal information about the child's health causes anxiety, because parents often want to know about the health status of their children. Hence by informing them of the child's condition and providing sufficient knowledge it eases their mind and avoids any type of anxiety (Brysiewicz and Chipps 2006:69). This in turn influences how they may help a child psychologically as it can help them and their parents deal with their illness (Obaid 2015:77) "Research suggests that children facing surgery feel upset, angry and depressed when they are not provided with sufficient information" (Ramsdell, Morrison, Kassam-Adams and

Marsac2016:2). Parents need to also be educated about the diagnosis, treatment, and home management when the child is hospitalized because by informing parents, this can enhance coping, relieve uncertainty and help with the transition from the hospital back to home (Rodgers, Stegenga, Withycombe, Sachse and Kelly 2016:447).

Parents should also be notified earlier with information of details and instructions regarding the hospital's medical procedures and preparing the child for hospital (Litke, Pikulska and Wegner 2012:166). If children are undergoing surgery and are not informed or when their parents cannot give an explanation, this creates feelings of isolation and loneliness which may increase their preoperative anxiety (Litke et al 2012:167). Educating parents about the illness that their child faces, explaining the reason for the specific care that they have to take and teaching them how to take care of this child at home, will empower them as well (Panicker 2013:217).

Communication between the patient and the health care worker has a significant impact on the patient's experience and is one of the components of paediatric health care that is associated more strongly with overall ratings of parents (Matziou, Boutopoulou, Chrysostomou, Vlachioti, Mantziou and Petsios 2011:170). In a previous study done by Aarthun, Oymar and Akerjordet (2018:113-114), parents preferred receiving individually adapted information from healthcare workers about their child's health, their need and the healthcare system. Parents who received adequate information about the health of their child helped them to be actively involved in the decision making process. Caring for hospitalized children needs a concerted partnership between all stakeholders and the consideration of other types of knowledge concerning the child and family (de Melo et al 2014:437).

2.6.3 Expressive art therapy

Expressive art therapy is a therapeutic intervention that incorporates a variety of art modalities in the service of growth, development and healing and focuses on creative processes and exploration of deeper meanings of one's experiences (Siegel, Iida, Rachlin and Yount 2015:2). Expressive art can be used to meet the emotional needs of hospitalized children, by helping them to express their fears, anxiety, anger or sadness through open end art therapy (Bordonaro 2003:2).

“Expressive art therapies also lend themselves to a variety of environmental settings including psychotherapy, counselling, rehabilitation, or healthcare” (Brogdon 2011:19). Art therapy is sometimes used with children who are admitted in hospitals in order to help them cope with stress of medical treatment, resulting in increasing coping skills (Sanders 2013:10).

Studies found that by drawing there was an improvement of communication, learning to deal with their illness and diminishing pain (Metzl, Morrell and Field 2016:3-4). This type of therapeutic technique uses not only drawings but also uses imagination which can help children to process their emotions and reduce stress of both the child and their families (Yount, Rachlin and Siegel 2013:28). When an individual experiences trauma it stores in their somatic, sensory and imagistic memory and later into their narrative memory but when a child is physically creative, their somatic sensory function seems to improve, thus expressive therapy can positively affect and support the healing process by helping a child to access, process and incorporate traumatic material to encourage appropriate resolution (Siegel et al 2015:2).

2.6.4. Music therapy

“Music therapy is an evidence and art-based health profession which uses music experiences within a therapeutic relationship to address clients’ physical, emotional, cognitive, and social needs” (Stegemann, Geretsegger, Quoc, Reidl and Smetana 2019:1). Music therapy uses recorded or live music and is managed by someone who is professional or a music therapist; it is also a relational and interactional intervention between the therapist and the child (Uggla, Bonde, Hammar, Wransjo and Gustafsson 2018:1987). According to McCaffrey, Edward, and Fanon (2011:185), music is seen as a proven intervention that can benefit individuals suffering with mental health issues by improving social functioning, global and mental state.

Music therapy can have various psychosocial functions however it depends on the context and the needs of a patient (Yates, Beckmann, Voss, Anderson and Silverman 2018:2). In prior research it was found that music therapy improved pain levels of preoperative and post-operative patients, enhanced the increased play in children and promoted positive coping skills for paediatric patients diagnosed with cancer (Metzl, Morrell and Field 2016:4). When it comes to stress from being admitted to hospital, music can help in minimizing the stress, and can be used as a non-invasive therapeutic tool to decrease anxiety, increase relaxation and

reduce the blood pressure, pulse and respiration rate in a child (Kazemi, Kazemi, Ghazimoghaddam, Besharat and Kashani 2012:94).

Music therapy was seen to improve the mood of a child because it relates to a child's emotional level rather than others and is also viewed to encourage participation as well as movement and exercise (Hendon and Bohon 2007:141-142). This type of intervention can be very distracting, pleasing and a normalizing way to cope and explore feelings about illnesses (Colwell, Edwards, Hernandez and Brees 2013:250).

In a study done by Koolaee, Vazifehdar, Bahari and Akbari (2016:138) it was found that music therapy is a useful intervention that reduces anxiety and pain of sickness. For children with more serious life threatening illnesses such as cancer, techniques such as listening to music have been documented as non-pharmacological interventions to help these children cope with the pain (Sposito, Silva-Rodrigues, Sparapani, Pfeifer, de Lima, and Nascimento 2014:148).

2.6.5 Spirituality

Spirituality is a factor of humanity that shows how a person looks for and expresses purpose as well as how they experience their connection to themselves and other people (Vitorino, Lucchetti, Leao, Vallada and Peres 2018:1). Literature has also revealed the importance of spirituality in the hospital setting. Social workers may therefore use spiritual activities as an opportunity to assist the patient and family to cope (Pandaya 2016:701). "Spirituality is usually defined as a person's search for meaning of life and death, search for purpose, for connectedness to self, to others, to nature, and to the sacred or significant; it might also involve seeking transcendence beyond life" (Doumit, Rahi, Saab and Majdalani 2018:1). Spiritual care can be defined as providing interventions to the child and their families which can address their spiritual needs (Therivel and Shubb 2019:1). Research suggests that both religion and spirituality are associated with indicators of the well-being of children and adolescents (Kvarford and Herba 2017: 154).

Children look at spirituality and religion in different ways and to different extents whereas some children seek a higher meaning and connection in their lives whilst other children relate to their relationship with God (Drutchas and Anandarajah 2014:28). Patients who are highly stressed, have a disability or illness, or are facing end of life, usually have an interest in

spirituality and these are the same individual's encountered by the medical social worker (Gehlert and Browne 2012:266).

Social workers and other professionals have discovered that assessments and spiritual based interventions can be an effective way of helping clients through their treatment journey (Ramos and Chavez 2019:1). When social workers conduct spiritual care for children and their families they will need to carry out spiritual assessments, in order to discover if these individuals have any needs that have to be met and to listen to the family and promote a favourable environment for family bonding (Therivel and Shubb 2019:1). According to Drutchas and Anandarajah (2014:29) evidence suggests that spirituality and religiosity play an important role in the way children respond to chronic illness and this may have positive and negative effects on the welfare of the child.

Spiritual activities such as prayer, meditation and faith plays a vital role in many positive health outcomes such as a decrease in stress and blood pressure with an improvement in management of chronic pain and decrease in depression (Gehlert and Browne 2012 2012:171). Spiritual care ensures improved emotional and physiological results, lower levels of stress and emotional turmoil with regard to being sick and improving well-being of the child and their family (Therivel and Shubb 2019:2). "Integrating spiritual care into a child's plan of care is necessary when resolving crises and for optimal health" (Cudmore 2016:28). Spirituality can offer an outline for positive coping strategies, for instance, finding purpose and meaning in one's illness (Moore, Talwar and Moxley-Haegert 2015:259). The relationship that these children share with God is able to give them a different outlook on their illness so that they may feel better about it (Clayton-Jones, Haglund, Belknap, Schaefer and Thompson 2016:9).

Meditation is also a part of spirituality and can help with positive health outcomes. Many individuals use meditation to help with stress and stress related events to promote better health outcomes (Goyal, Singh, Sibinga, Gould, Rowland-Seymour, Sharma, Berger, Sleicher, Maron, Shihab, Ranasinghe, Linn, Saha, Bass and Haythornthwaite 2014:358). Van Dijk (2017:4) explained that meditation can help a child to remove themselves from negative thoughts of hospitalisation and feel at peace, and be removed from fear and anxiety. Research suggests that mindfulness meditation can help to alleviate negative emotions and can be used to reduce stress. It is based on the idea that physical, cognitive and emotional manifestation of stress leads to a healthy body and mind response to stress (Barrett, Hayney,

Muller, Rakel, Ward, Obasi, Brown, Zhang, Zgierska, Gern, West, Ewers, Barlow, Gassman and Coe 2012:338).

Spirituality can play an important part in the lives of children and their families by shaping their beliefs about their purpose in life and how they can cope with adverse events and their decisions with regard to treatment and internal and external resources that they can access (Therivel and Shubb 2019:2). Religion and spirituality are able to influence the development and course of a particular illness and psychological complexities across the life course (Gehlert and Browne 2012:276). Parents are usually faced with the duty of making medical decisions and may rely more on faith in God and use spirituality as a method of coping (Cudmore 2016:28). It is an example of spiritually based interventions.

2.7 CONCLUSION

This chapter reviewed the statistics related to children to children who were hospitalized for different illnesses and injuries both globally and nationally. It also highlighted the impact that hospitalization has on the child and their families. Moreover, literature was reviewed on the roles of social service professionals in a hospital context and the psychosocial and spiritual interventions that can be offered by the hospital. The next chapter gives an overview of the research methodology that was used to guide the study.

CHAPTER 3

RESEARCH METHODOLOGY

“Research is to see what everybody else has seen, and to think what nobody else has thought” – Albert Szent-Gyorgyi

3.1. INTRODUCTION

"Research is an original investigation undertaken to gain knowledge and understand concepts in major subject areas of specialization and includes the generation of ideas and information leading to new or substantially improved scientific insights with relevance to the needs of society" (Balakumar, Inamdar and Jagadeesh 2013:130). It is a method of gathering, analyzing and interpreting data so that one can understand a particular phenomenon (Williams 2007:65). It is believed that research is systematic when the objective is clear. In this chapter, the research design and methods will be discussed, the samples identified and recruited will be explained and the data collection methods and instruments used will be presented. Finally, the data analysis method used will be highlighted and the ethical issues involved in the study will be discussed.

3.2. RESEARCH DESIGN

Sileyew (2019:2) wrote that a research design delivers a suitable framework for a study and makes an important choice, regarding the research approach since it decides how data that is applicable for this study will be acquired. “A research design can be considered as the structure of research, as it is the “glue" that holds all of the elements in a research project together" (Akhtar 2016:68). This study used a qualitative research approach.

Sarantakos (2005:34) defined qualitative research as a methodology, in which the data is portrayed in words or sentences and gives the research a more detailed overview. The qualitative research paradigm produces more descriptive data that is written or spoken in the participants own words, showing the participant’s account of experience or perceptions (de Vos Strydom, Fouché and Delport 2011:65). Moreover, Kitto, Chesters and Grbich(2008:243)

added that “most commonly, qualitative research is concerned with the systematic collection, ordering, description and interpretation of textual data generated from talk, observation or documentation”. Qualitative research can also assist the researcher to gain access to the way participants think and feel (Sutton and Austin 2015:226).

This study was also exploratory in nature. The rationale for exploratory research is that it helps to search for new insights and to enquire what is occurring within a phenomenon (Rahi 2017:1). Exploratory research seeks to provide new explanations that may have been previously overlooked and it does so, through the active involvement of the researcher in the process of amplifying his or her conceptual tools, so as to allow him or her to raise new questions and provide new explanations, from different angles (Reiter 2017:144).

Qualitative research methods are used, to find out more about the experiences and views of the participant from their perspective (Hammarberg, Kirkman and de Lacey 2015:499). The qualitative research process is also viewed to be holistic and concentrates on the design, the way data is collected and the interpretations which may continue to change over time (de Vos 2011:64). According to Pathak, Jena, and Kalrak (2013:192) qualitative research looks to understand a research query, as a humanistic or idealistic approach.

Moreover, qualitative research serves as a vehicle to understand why people react to their emotions and thoughts in a certain way (Sutton and Austin 2015:226). This type of research uses a particular topic of interest to help participants to disclose events in their lives that may have affected them in relation to the study (Pathak, Jena and Kalra 2013: 192).

Qualitative research also uses data to discover a theme (Silverman 2005:18). It needs to be reflected upon, before the research can take place and after the research has been done so that it gives a better understanding of the context (Sutton and Austin 2015:226). In a qualitative study, the researcher and the participant have a more casual and comfortable relationship as opposed to that derived within a quantitative study (Pathak et al 2013: 192). Qualitative research is also known to give better insight into the development of social structures (Ritchie, Lewis, Nicholls and Ormston 2013:39).

The researcher opted to use qualitative research, as it helped to understand the challenges that families faced during the hospitalization of their children. It also helped them to understand what therapeutic activities and interventions could be levelled, by social service professionals, in a hospital setting. It provided rich and in-depth information on what problems

children and their families face during hospitalization and what support and other holistic therapeutic interventions could be used to support their recovery.

3.3. STUDY SETTING

There are many hospitals in the eThekwini region, however, the hospital that was chosen for this study was the R.K. Khan Hospital. It is located in Chatsworth. The researcher chose this hospital because it is a public health facility, and is based in a community, where young people are more vulnerable to accidents, trauma, and other illnesses, due to its poor socio-economic status.

This hospital is serviced to attend to as many as 550 patients of all ages, who have varied illnesses or injuries. The hospital is also staffed by 56 well trained health care professionals, who are qualified to attend to patients and their presenting medical conditions. At this chosen facility, many children are hospitalized daily, and many services are rendered to both children who are hospitalized and to those who come in for emergency care.

3.4. STUDY POPULATION

Brink, van der Walt and van Rensburg (2012:131) referred to a population, as the complete number of people within a group that meet the requirements of a particular aspect that the researcher is looking into studying. There were two populations, for this study. The first included all the medical personnel involved specifically in the care of children who were hospitalized. This included the doctors, nurses, and occupational therapists. The second population consisted of senior child and youth care workers, who are members of the National Association of child care workers in the eThekwini region.

3.5. STUDY SAMPLE

Sampling can be referred to as a portion of the population that you are interested in using, and using that portion, to represent the entire population (de Vos et al 2011: 193). Sampling also refers to using a small part of a population so that data from that group, can be used to represent the entire population itself (Sarantakos 2005:152). Two samples were drawn from

the populations mentioned in the preceding sub-section. The samples recruited and the sampling strategy used is discussed in the sub-sections that follow.

3.6 SAMPLING STRATEGY

The following sampling strategy was used for the study:

3.6.1 Non-probability strategy

Non-probability sampling is defined as the amount of aspects within a population that remains indefinite (Kumar 2005:177-178). It is also a process in which a deliberate selection of participants, are recruited to participate in the study (El-Masri 2017:17). Non-probability sampling method does not randomly select a sample; however, it includes the use of judgement (Showkat 2017:7). With non-probability sampling, the cases are sampled to deepen the knowledge that already exists about the sample, rather than getting to know more about the population (Uprichard 2011:3). It is also a process in which, a deliberate selection of participants are recruited to participate in the study (El-Masri 2017:17). In non-probability sampling, participants are therefore chosen in a particular way, which reflects that only certain members of the population are chosen (Elfil and Negida 2017:1).

For this study, the non-probability sampling strategy that was used was purposive sampling, for both the samples.

3.6.2. Purposive sampling

Purposeful sampling can be defined as a form of sampling that is based on the judgement of the person conducting the research, with a sample of people with the characteristics to represent the traits of the population to conduct a good study (de Vos 2011:202). Purposive sampling has also been described as judgemental sampling and is based entirely on the researcher's judgement (Sharma 2017:751; de Vos et al 2011:202). With purposive sampling, the researcher selects the participants for a particular study (Elfil and Negida 2017:2). The characteristics and attributes of purposive sampling form a better understanding of the chosen research topic and help the researcher to understand specific questions and themes (Ritchie, Lewis, Nicholls and Ormston 2013:112).

3.7 SAMPLES

The researcher chose purposeful sampling because it enabled the purposeful selection of individuals such as the doctors, nurses and occupational therapists at the hospital as well, as the senior child care workers at NACCW.

3.7.1. Sample 1

Sample 1 was a mixed group of health care professionals that consisted of 11 doctors, nurses, and occupational therapists. Although a minimum of two per profession was initially selected, data was collected until saturation. The following inclusion and exclusion criteria were utilized when selecting sample 1:

The inclusion criteria included:

- Registered health care professionals who worked at the said hospital, for more than 3 years.
- Registered health care professionals who worked with both inpatient children and their families admitted to the hospital.

The exclusion criteria used was as follows:

- Registered health care professionals, with less than 3 years of work experience at RK Khan Hospital.
- Registered health care professionals who worked only with outpatients at the hospital.

3.7.2. Sample 2

Sample 2 consisted of 10 senior child and youth care workers, who were based at the National Association of Child Care Workers (NACCW), in the eThekwini area. Data was collected until saturation and after the interviews, no further participants were recruited. The following inclusion and exclusion criteria were used for selecting sample 2.

The inclusion criteria were as follows:

- Child and youth care workers who were based at the eThekwini branch of NACCW.

- Child and youth care workers who were at a senior level.

The exclusion criteria used were as follows:

- Child and youth care workers who were not members of the NACCW within the eThekwini region.
- Child and youth care workers who had less than 5 years of experience.

3.8. DATA COLLECTION

In qualitative research, the most common way of collecting data is by conducting interviews (Jamshed 2014:87). An interview can be defined as a conversation with a participant, with the intent to gather information about the participant and to interpret and define the described phenomenon (Alshenqeeti 2014:40). “Qualitative data affords researchers opportunities to explore, in an in-depth manner, matters that are unique to the experiences of interviewees, allowing insights into how different phenomena of interest are experienced and perceived” (McGrath, Palmgren and Liljedah 2018:1). There are three major types of interviews that a researcher can use for data collection. These include structured interviews, semi-structured interviews, and unstructured interviews, each interview is however different (Ryan, Coughlan and Cronin 2016:310).

A semi-structured interview is a type of face to face interview, that can be carried out in any setting, and is more efficient with clear responses, which includes participants facial expressions (Walliman 2011:99). According to de Vos et al (2011:296), a semi-structured interview is used to collect information and insights about the participant with regards to particular phenomena and allows the researcher, to deviate slightly from the guide instead of sticking rigidly to the interview questions.

The semi-structured interview is also a mixture of structured and unstructured interviews (Sarantakos 2005:269). Semi-structured interviews usually include prearranged sections, with open-ended questions for the participant (Walliman 2011:99). Semi-structured interviews were used for both samples during this study.

Sample 1 was interviewed with the intent to explore how children and their families experience the hospitalization process and how child care workers could be beneficial to them. Sample 2

was interviewed with the intent to inquire about how child and youth care workers could help hospitalized children and their families during their stay at the hospital and post-discharge. All data collected was recorded using a recorder after permission was obtained from participants.

3.9 DATA COLLECTION PROCESS

The data was collected at RK Khan Hospital and also at the NACCW offices in Ethekwini, in respect of samples 1 and 2 respectively. A letter of information (refer to appendix 5) and a letter of consent (refer to appendix 6) was drafted and given to each participant in both samples. All participants had to provide consent before the interview took place. Before data collection could commence, ethical clearance was also secured from, Durban University of Technology, Institutional Research Committee, IREC (Ethical clearance number: IREC 010/19).

3.9.1 Sample 1

For sample 1, contact was first made with the Department of Health, with a letter requesting gatekeeper permission to conduct the study at R. K. Khan hospital (refer to appendix 1). Once the relevant permission was received from the Department of Health (refer to appendix 2), the researcher made contact with the research officer from R.K. Khan Hospital and sent a letter requesting further gatekeeper permission to conduct the study there (refer to appendix3). Once gatekeeper permission was received from the Chief Executive Officer (refer to appendix 4) and the research officer at R.K Khan Hospital, the study proceeded.

Before the interviews were conducted, the researcher had to liaise with the Head of Paediatrics through email, to set up the interviews with the doctors. The Head of Paediatrics thereafter referred the researcher to the Head of Nursing in the Paediatrics unit and Head of Occupational therapy, to set up interviews with their staff. These Heads were responsible for recruiting the participants, who all voluntarily agreed to participate.

Interviews for participants from sample 1, were set up at the hospital. A letter of information (refer to appendix 7) was given to all doctors, nurses and occupational therapists to read, for their understanding, of the nature and objectives of the study. A letter of consent (refer to appendix 8), was also given to them to sign once they understood what the study was about

in order for the data collection process to begin. Participants were also made aware of how the data was going to be collected and the outcomes of the process.

3.9.2 Sample 2

For sample 2, the researcher first made contact with the Head of NACCW in the eThekwini region. Gatekeeper permission was given to the researcher by the monitoring and evaluation officer of the organization and was secured before the interviews with senior child and youth care workers, from NACCW commenced. The organization was responsible for identifying and recruiting those who then voluntarily agreed to participate in the study.

Firstly, the researcher was introduced to the participants and each of them were provided with letters of information to read for a deeper understanding of the study before the interviews could commence. A letter of consent was given to each participant to sign before the interviews proceeded. The researcher explained the aim of the research and the objectives of the study. Participants were also made aware of how data was going to be collected and the outcomes of the process.

3.10. DATA COLLECTION TOOLS

The data collection tool that the researcher used was an interview schedule for both samples. The type of interview used to collect data was the semi-structured interview. An interview schedule was used to guide this process. Table 3.10.1 reflects the data collection tools for each sample.

Table 3.10.1: Samples and data collection tools used

Sample	Data collection tool
1. Health care professionals	Interview guide
2. Senior child care workers	Interview guide

3.11 INTERVIEW SCHEDULE

An interview guide (refer to appendix 9 and 10 for sample 1 and 2 respectively) is seen as a schematic representation of questions, which must be developed by the researcher (Jamshed 2014:87). An interview guide is often used to gather information from the participants which may be comparable (Doody and Noonan 2013:30). Qualitative interviews allow researchers to investigate profoundly the experiences of the participants being interviewed (Mcgrath et al 2018:1)

The interview guide should consist of sound questions so that the researcher can acquire enriched information from participants (Kallio, Pietila, Johnson and Kangasniemi 2016:2960).The interview guide then provides a valuable framework for the questions to be asked (Brayda and Boyce 2014:320). The researcher developed appropriate questions, according to the study objectives, so as to receive the necessary information from the participants. This was piloted with similar samples prior to data collection and refined accordingly.

3.12 INTERVIEW SETTING

The interviews for sample 1 and sample 2 took place as follows:

3.12.1 Sample 1: RK Hospital

The interviews with participants from sample 1 were conducted at RK Khan Hospital. The interviews with the doctors were conducted in a quiet room within the paediatric ward, nursery, or outpatient facility, as the doctors rotate working spaces. These rooms contained a desk and two chairs. The rooms were private, and it was an affable, non- hostile environment, in which the participant and the researcher were comfortable during the interview.

The interviews with the occupational therapists were conducted in the occupational therapy department, lunch room. The room was quiet and familiar to the participants. The nurses were interviewed in the paediatric unit, in their office. Although it was in the ward, it was a quiet place and was conducive to conduct the interview process.

3.12.2 Sample 2 – NACCW office

The interviews with sample 2 were conducted in a small office at the NACCW, at their Durban branch. The room was quiet and private, a space where the child and youth care workers could feel free and safe, in a familiar environment, to share their information with the researcher.

3.13 INTERVIEW PROCESS

The interview process was used for both sample 1 and sample 2. Before the actual interview could take place, the researcher liaised with people in charge of both the hospital and NACCW. Interviews provide researchers with very in-depth and rich data to understand the experiences of the participants and show them how meaningful the experiences are for the participants (Castillo-Montoya 2016:811).

For sample 1, the researcher visited the hospital at times most convenient to schedule appointments with the health care professionals. With sample 2 specific dates and times were given to the researcher to conduct the interviews.

Each interview lasted between 45 minutes to an hour with each participant, from both samples. All interviews were guided by the interview schedule (Refer to appendix 9 and 10 for samples 1 and 2 respectively) and recorded by using a voice recorder. Permission was given by the interviewee for the latter to occur.

3.14 DATA CAPTURING

In research, it is crucial to plan what information is needed and who the researcher wants to gain the information from (Bengtsson 2016:9). Before the data collection could take place, the researcher had planned for the recording of data in an organized way. For both samples, the researcher used a voice recorder during the interview, after consent had been given, by all participants. To obtain this, the researcher ensured that the participants were comfortable and were assured that the data collected would only be used for research purposes.

After each interview, the researcher labelled the recordings correctly, so that it was easier to access. Each recording for all the interviews was stored in encrypted files that only the

researcher could access. The researcher transcribed all interviews, verbatim, after listening to each recording and reading each transcript. This was to ensure that all data from the recordings were transcribed as accurately as possible. The researcher then familiarised herself with the data and this enabled the data analysis to commence.

3.15. DATA ANALYSIS

“Data analysis in qualitative research has been defined as the process of systematically searching and arranging the interview transcripts, observation notes or other non-textual materials that the researcher accumulates to increase the understanding of the phenomenon” (Wong 2008:14). The researcher chose to use thematic analysis to guide the analysis process.

Thematic analysis was defined by Brikci (2007:23), as looking through all information gathered by the researcher to recognize common concerns to generate a theme. The researcher chose thematic analysis, as a method because it is flexible and addresses the issues about the research by pointing out the concerns. The following process was applied in this study:

3.15.1. FAMILIARISATION WITH DATA

The researcher read the data repeatedly before beginning to code it, so that the researcher could become familiarised with the data. It is important that the researcher immerse oneself with the data in order to become familiarized with the content (Nowell, Norris, White and Moules 2017:4-5). According to Braun and Clarke (2012:60-61) making notes is a part of this step of familiarization and this is helpful when the researcher reads the words of the data actively, critically and analytically by thinking about what the data means. Significant notes were made and written down so that the researcher could refer back to them.

3.15.2 GENERATING INITIAL CODES

"Coding is the process of analyzing qualitative text data by taking them apart to see what they yield before putting the data back together in a meaningful way" (Creswell 2015:156). Nowell

et al (2017:5) explained that coding enables the researcher to make the data simpler whilst focusing on its specific characteristics. After becoming familiar with the data, the researcher used specific codes to label the data. The researcher used colour coding as a way of coding the data.

3.15.3 SEARCHING FOR THEMES

In this step, the researcher started to search for themes. Braun and Clarke (2012:63) suggested that searching for themes is regarded as an active process where themes are generated or constructed instead of discovered. Themes are recognized by bringing together ideas that are usually seen as meaningless when viewed alone (Nowell et al 2017:8).The researcher looked through the data that was colour coded and tried to determine common matters to generate and construct themes and subthemes.

3.15.4 REVIEWING THEMES

This step requires the developed themes to be reviewed with both the coded data and the whole set (Braun and Clarke 2012:65). The data of each theme must be read to ensure that the data does support the theme (Maguire and Delahunt 2017:3358). The researcher, in this phase, needs to review the data to deem if the pattern is coherent (Nowell et al 2017:9).

The data was reviewed to ensure that it made sense and determined is there were any signs of the data being distinct and coherent. The researcher ensured that there was sufficient data to support the themes. Any themes that the researcher identified to be similar and related were fitted together whilst other themes that were irrelevant were deleted.

3.15.5 DEFINING AND NAMING THE DATA

This step includes that the researcher chooses extracts that should be presented and setting a story around each one of the themes chosen (Braun and Clarke 2012:67). “It is important that, by the end of this phase, researchers can clearly define what the themes are and what they are not” (Nowell et al 2017:10). The researcher was able to define each theme and name them in relation to what was reflected in the data.

3.15.6 PRESENTING THE DATA

Presenting the data is the final step of thematic analysis. The write up of the thematic analysis ought to include a coherent, logical and non-repetitive account of the data that is found in the themes (Nowell et al 2017:11). The final write up must also be inclusive of the direct quotes from participants, which is essential (Nowell et al 2017:11). The report was then written up as a dissertation based on the findings that the researcher had established from the collection and analysis of data.

3.16. VALIDITY AND RELIABILITY

3.16.1 VALIDITY

Validity as defined by Silverman (2014:83) is ensuring that an interpretation of the data and findings are truthful. “The validity of its findings or data is traditionally understood to refer to the correctness or precision of a research reading” (Ritchie et al 2013:356).

3.16.2 RELIABILITY

Kumar (2005:156) explained that reliability was getting the same findings, in the same situation, using the same data collection tool, from more than one participant. The following aspects apply to qualitative studies.

3.17 TRUSTWORTHINESS

Trustworthiness aims to support the argument that the findings of a study are of value and significance (Elo, Kääriäinen, Kanste, Pölkki, Utriainen and Kyngäs 2014:2). To ensure that there is trustworthiness in this study and discard reactivity, research bias, and respondent bias, the following factors have to be considered namely credibility, dependability, conformability, transferability, and authenticity.

3.17.1 CREDIBILITY

Brink et al (2012:172) defined credibility as being confident that the information collected is real and that it is interpreted in a way that is authentic and believable to the people reading it. Credibility can also be said to be how the data and the methods of analysis are carried out such that no data is left out (Bengtsson 106:12).

The researcher ensured that the information given was correct by creating a trustworthy relationship between the researcher and the participant and through member checking. By doing member checking, this allows the researcher to determine the fit between the views of the participants and the researcher's representation of them (Nowell et al 2017:1). Member checking was done in groups with participants after data was collected.

3.17.2 DEPENDABILITY

This can be described as presenting evidence to ensure that similar conclusions were reached if the study was to be done again, with a similar population in a similar context. It is also described as stabilizing data over time (Brink et al 2012:172). With dependability, the researcher tries to explain the changes occurring to understand the environment (de Vos, Strydom, Fouché, Delport2011: 420 - 421).

To increase dependability, the researcher used an audit trail by accounting for all decisions and interpretations that had been made, as well as how the data was documented and analyzed. The code-recode strategy was also used in this study, where the same data was coded twice, between 2 weeks to check if the data was similar or if there was a difference between those two results.

3.17.3. CONFORMABILITY

"Conformability is largely an issue of presentation and refers to the objectivity and neutrality of the data (Bengtsson 2016:13). Brink et al (2012:172) described conformability as the possibility for the data to be similar in terms of accuracy and relevance. The researcher ensured that the data mirrored the participants, rather than the researcher's perceptions. To

ensure conformability, the researcher used the reflexive journal method, in which the researcher used a journal in which all activities were noted down and the researcher could reflect on. The rich excerpts from participants, from which the themes emerged, was also reflected upon.

3.17.4 TRANSFERABILITY

Transferability is the ability to use the findings to fit other settings and participants that may be used in future studies (Brink et al 2012:172). It is the responsibility of the researcher to ensure that they provide a rich description of both the participants and the research process so that the reader can evaluate if the findings are transferable to their setting (Korstjens and Moser 2017:3).The researcher used the method of providing a thick description of data to increase transferability, by gathering detailed information from the participants.

3.18 ETHICAL CONSIDERATIONS

Ethics are guidelines that all professions which includes their values and expectations, that they must uphold (Kumar 2005:210). Ethics plays a vital role in the relationship that the participant has, with the research and can build a secure relationship with (Jelsma and Clow 2005:3).

3.18.1. CONFIDENTIALITY

Confidentiality is the first ethical principle that was taken into consideration. Names were not used in the research and none of the participants identifying details were divulged. Hard copies of transcripts was safely stored and electronic data, was secured by a password that will be securely shredded and deleted after five years, respectively.

3.18.2. INFORMED CONSENT

Informed consent is the next important part of ethical considerations. Informed consent reflects that the participants know what information is to be gained from them, the way the information from them will be used and how they are likely to be affected by this procedure

(Kumar 2005:212). The participants for this study understood the objectives of the study and knew that they could withdraw from the interview whenever they wanted to without any consequences. The participants were given a letter of information to make them aware of what the study was about.

3.18.3. VOLUNTARY PARTICIPATION

Voluntary participation reflects that a participant should not be forced to take part in research (de Vos et al 2011:116). Participants should be assured that their participation is voluntary and that they are free to withdraw at any time without any negative effect on the relationship between them and the researcher (Bengtsson 2016:10). All participants were informed of the study purpose accordingly, and were given further information as to how the interviews were going to be recorded, so that they could decide about their participation voluntarily. The participants were also informed before the interview that their participation was voluntary and they could withdraw from the study at any time.

3.18.4. DECEPTION

This ethical issue refers to deceiving participants that have partaken in the study and concealing information or giving incorrect information to the participant in order for them to take part in the study (de Vos 2011:60). Honesty is vital when informing participants about the study. All accurate information regarding the study investigation was provided to the participants No form of deception was used when collecting the data.

3.18.5. AVOIDANCE OF HARM

This relates to causing harm to a participant, be it physically or emotionally. Instead, the researcher should protect the participant from any harm during the study (de Vos 2011:115). The research ensured that the questions asked were respectful and sensitive and the participants were not in danger of any trauma.

3.19. CONCLUSION

This chapter gave an overall view of the research methodology that was used to guide this research study. The research design was discussed as well as the samples selected. This chapter also looked at how the data was collected and analysed. Issues of trustworthiness and the ethical considerations were also discussed. The following chapter will present the data derived from the study and the findings made.

CHAPTER 4:

DATA ANALYSIS AND FINDINGS

4.1 INTRODUCTION

This chapter contains a presentation of the data and a critical analysis of the findings made. Data analysis has been described as a systematic process of examining and arranging transcripts from an interview or other forms of data collection and is accumulated by the researcher, to increase the way a phenomenon is understood (Wong 2008:14).This study explored the fears and anxieties faced by children and their parents during hospitalization and the potential roles that child care workers can play, to help support children and their families during their hospital stay. Data was collected from two samples namely medical professionals who treated children when they were in hospital and child and youth care workers. Data was analysed using a process of thematic analysis. The themes and subthemes derived from the data collected from both samples are presented holistically in the sub-sections that follow.

4.2 RELATIONSHIP BETWEEN THE OBJECTIVES AND DATA COLLECTION TOOLS

The relationship between the objectives of the study and the data collection tools used is presented in Table 4.2.1.

Table 4.2.1: Study objectives and data collection process

OBJECTIVES	DATA COLLECTION PROCESS
1. To explore the challenges that children and their families face during hospitalization.	a. Semi-structured interviews
2. To determine what psycho-social support families and their children need when children are hospitalized.	b. Semi-structured interviews
3. To explore the potential role of child and youth care work in terms of providing	c. Semi-structured interviews

developmental and therapeutic programmes in a hospital context.	
4. To explore how child and youth care workers can work collaboratively with the multidisciplinary team in a hospital context.	d. Semi-structured interviews

4.3 DEMOGRAPHIC PROFILES

Tables 4.3.1 and 4.3.2 below, reflect the demographic profiles of the participants. Table 4.3.1 reflects the number of interviews conducted and their place of employment. Table 4.3.2 reflects the participants' gender and their occupational background.

Table 4.3.1: Demographic profile: place of employment

Participants	Number of participants	Place of employment
1.Health care workers	11 (Total)	RK Khan Hospital
1.1 Doctors	4	RK Khan Hospital
1.2 Nurses	4	RK Khan Hospital
1.3 Occupational therapists	3	RK Khan Hospital
2. Senior child and youth care workers	10	National Association of child care workers (NACCW)

As can be seen in Table 4.3.1 there are 11 health care participants who were interviewed at R.K Khan Hospital. A further 10 child and youth care workers were interviewed at the National Association of Child Care Workers.

Table 4.3.2: Demographic profile: Occupation and gender

OCCUPATION	GENDER	PSEUDONYM
Paediatric doctor	Female	Participant 1 (P1)
Paediatric doctor	Female	Participant 2 (P2)
Paediatric doctor	Female	Participant 3 (P3)
Paediatric doctor	Female	Participant 4 (P4)
Occupational therapist	Female	Participant 5 (P5)
Occupational therapist	Female	Participant 6 (P6)
Occupational therapist	Female	Participant 7 (P7)
Nurse	Female	Participant 8 (P8)
Nurse	Female	Participant 9 (P9)
Nurse	Male	Participant 10 (P10)
Nurse	Female	Participant 11 (P11)
NACCW CYC Worker	Female	Participant 12 (P12)
NACCW CYC Worker	Female	Participant 13 (P13)
NACCW CYC Worker	Female	Participant 14 (P14)
NACCW CYC Worker	Female	Participant 15 (P15)
NACCW CYC Worker	Female	Participant 16 (P16)
NACCW CYC Worker	Female	Participant 17 (P17)
NACCW CYC Worker	Female	Participant 18 (P18)
NACCW CYC Worker	Female	Participant 19 (P19)
NACCW CYC Worker	Female	Participant 20 (P20)
NACCW CYC Worker	Female	Participant 21 (P21)

As reflected in Table 4.3.2, the sample was predominantly female of the total 21 participants interviewed, only 1 participant was a male. This reflects the gender bias of the caring professionals. CYC worker represents child and youth care worker.

4.4 THE PROCESS OF DATA ANALYSIS

Data was collected using semi-structured interviews for both samples. During the interviews, the researcher was able to detect patterns or similarities in the data. Once each interview was completed and recorded through the use of an audio recorder, the researcher transcribed the interviews. Data was then analysed using thematic analysis, using the process described in chapter 3. Each transcript was read several times to analyze the data thoroughly, so that the researcher could become familiar with the data and recognise meaningful excerpts. The researcher, thereafter, coded the data to depict relevant themes and sub-themes. The extracts identified were done in accordance with the objectives of the study. Using codes, themes were derived and thereafter categorized into broader sub-themes. Excerpts from each transcript were placed under the appropriate sub-theme and an interpretation of same was provided. The analysis of the data is presented in the sub-sections that follow.

4.5 DATA ANALYSIS AND FINDINGS

Table 4.5.1 below provides a list of the main themes and the subthemes derived from the data. Three major themes and 16 subthemes emerged from the data.

Table 4.5.1: Themes and subthemes derived from the data

THEMES	SUBTHEMES
1. The hospitalization experience	1.1. Parent-child separation anxiety 1.2. Fear of medical staff

	1.3. Difficulty understanding medical jargon 1.4. Inadequate infrastructure 1.5. Inadequate support services
2. Nature of psycho-social support for children in hospital and their families	2.1. Counselling 2.2. Group support 2.3. Play therapy
3. The roles of social service professionals in a hospital context	3.1. Salience of therapy 3.2. Group therapy 3.3. Family therapy 3.4 Working with an MDT 3.5 Liaison with the community 3.6 Spiritual support

Theme 1: The hospitalization experience

The first main theme reflects the hospitalization experience. The sub-themes derived from this theme are linked to issues of parent-child separation anxiety, fear of medical staff and issues related to hospital infrastructure.

- **Subtheme 1: Parent-child separation anxiety**

Participants gave their views on parent-child separation anxiety within the hospital context and shared their experiences as follows:

"We don't experience it first-hand… but I have seen kids lying there screaming… so there is that anxiety, but if you looked at our context, a lot of kids don't have caregivers with them

because their caregivers or parents can't afford to be away from work, so a lot of them are here on their own." [P6]

"Sometimes parents they live far, so also, they not always able to be there with the children… so it becomes very scary for the kids to be without family or sometimes they take turns and things but it's very scary." [P7]

"It's very frightening for the kids, we've noticed that we've picked that up that parents are not at all there and a child becomes afraid and they become clingy to the clinician or the health care worker….they want you to be by their side… they feel that they were abandoned but it's separation anxiety." [P7]

"That is a huge issue luckily for us, is that we do allow every mum to stay over, but in the case were the mums are working and they don't have family support, it is very stressful cause the children do get severe anxiety and they cry nonstop and a lot of the other mothers help as well to calm the children down, our nursing staff help, but the nurses as well are inundated with a lot of work and they can't always individualize their care to one specific child… so sometimes kids are left for a long period of time without their parents …. I'm sure they will appreciate some support, some care." [P1]

"Separation anxiety disorder is defined by developmentally inappropriate, excessive, persistent, and unrealistic worry about separation from attachment figures, most commonly parents or other family members" (Dabkowska, Araszkiewicz, Dabkowska and Wilkosc 2011:313). Most of the participants felt that parent-child separation anxiety was one of the biggest issues confronting parents and children during the hospitalization experience. The participants highlighted how children become traumatized and stressed, when separated from their parent, be it for a long period or a short period. Writers agree that when children are hospitalized, their emotional state often intensifies due to their being away from their families and their home (Gomes, Fernandes and Nobrega 2016:887).

As the excerpts reflect, even though the hospital allows for parents to stay over with their child, other issues such as absenteeism from work or the distance in terms of travel to the hospital prevents more frequent contact. This is especially true in more poorer socio-economic communities where transport costs pose a challenge. A study conducted by Roberts (2012:134) found that one of the reasons, why mothers could not stay with their child at hospital, was because they had to go to work to provide for their families and also because

parents of these children lived a distance away from the hospital that their child was in, and they had other children to take care of at home. When parents cannot stay over or do not visit frequently separation anxiety manifests. Moreover in public health facilities the lack of staff, especially nurses prevent children from receiving the reassurance and comfort they need.

Separation anxiety often leads to physical effects such as headaches or anxiety attacks and other symptoms such as clingy behaviour, nightmares and depression (Tyler, Wehby, Robbins and Damiano 2013:521). According to Stone et al (2015:3192), separation anxiety emanates more from the environment, which suggests that the hospital environment is both daunting and anxiety provoking for them. Hence although children, may have the best chance of healing under the care of their parents (Humphreys 2019:166), it is crucial that hospital caregivers provide greater support when parents cannot visit their children in hospital.

- **Subtheme 2: Fear of medical staff**

Participants identified fear of medical staff as follows:

"M*ost of them are on some kind of drip or something like that. So when they see the next person coming through then they think they also going to do something invasive to them." [P5]*

"A lot depends on the age of the child, so if you looking at very small children they don't register much so they don't have any reaction… Then you have an age group of roughly around a year just over, give or take till the time they about 4 or 5 years old then they scream, they cry, they scared…the child over 5 years who can talk and understand what's happening and if you speak to them, they are very co-operative." [P2]

"As soon as we put gloves on they are howling before we even touch them, it's difficult because for us we are not hurting them… I had a kid today with scabies, I had to put on gloves, as soon as he saw the gloves on, he thought I was doing something with his drip, so it's hard… We sometimes take up balloons or bubbles or something to distract them from the medical side of things." [P6]

"They're terrified…with regard to us who are constantly examining them, causing unintentional pain, but pain none the less, they are quite apprehensive toward us... Kids are very forgiving, they do tend to play with us in-between, but they are very stressed out." [P1]

"All of them are scared … if you do some procedure on them if you give them an injection or antibiotics…something that is going to traumatize them, they going to react differently." [P11]

Medical fear has been described as fear of any type of experience, that includes medical professionals or medical procedures that evaluate or modify one's well-being within a health care setting (Fox, Halpern, Dangman, Giramonti and Kogan 2014:1588). Healthcare professionals are there to prevent healthcare-induced trauma and reduce healthcare-induced anxiety. However, it has been found that children often feel afraid or traumatized when they have to deal with healthcare staff (Lerwick 2016:143-144). As reflected in the excerpts, children often experience heightened fear as they anticipate painful procedures being performed on them such as an intravenous drip or being injected. They associate staff with same and react fearfully whenever they approach them.

Studies have found that approximately 19% to 68% of children, were fearful of injections, needles and pain, with nursing procedures being the most common aspect, prompting fear amongst children (Salmela, Salentera and Aronen 2009:269).

- **Subtheme 3: Difficulty understanding medical jargon**

The subtheme that follows relates to the difficulties that parents and children face when speaking with medical professionals.

"We are guilty of falling into that trap of using medical jargon, we do try our best to minimize it, but there will be those times, when even the simplest medical terms can be confusing to parents." [P1]

"They do not understand, so if I go there and say what did the doctor say, do you understand what the doctor said, they will tell me no… I had a down syndrome kid today and the doctor was rattling on something about chromosomes and they have no idea what a chromosome is, so you have to break it down like, the baby is going to be slow in development, this is what you have to expect, so she kind of grasped the concept… It's hard both ways, hard for the patient not understanding and hard for the doctor with the caseload here." [P6]

"Medical jargon is a whole new ball game....they just nod and say yes, yes, yes but first of all the language is the problem… the doctors try and make it as simple as possible for them to understand." [P11]

Jargon is defined as the use of technical or specialized terms used by a certain profession and which is not understood by individuals who are outside of that particular profession (Berman, Aizer, Bass, Blanco, Davidson, Dwyer, Fields, Huang, Kang, Kerr, Kransnokutsky-Samuels, Lazaro, Schwartzman-Morris, Paget and Phillinger 2016:2094). Sound paediatric health care is premised on the health care professional and the parent being able to communicate effectively and for parents to understand medical terminology related to the child's condition and treatment. It includes firstly the health care professional's ability to converse in the patient's language. Secondly with regards to the use of medical jargon, it is crucial that parents understand same as it may impact on their understanding of the process of treatment (Links, Callon, Wasserman, Walsh, Beach and Boss 2019:1).

The data reflected the challenges that ensue, when medical jargon, is not properly understood by parents when their child is admitted. Whilst medical jargon may not be intentionally used by hospital staff, it is a more familiar form of language for them and as the excerpts reflected, some parents not only do not understand it, but are intimidated by hospital staff and are afraid of asking questions regarding its meaning.

Links et al (2019:2-3), wrote that when medical jargon is used extensively, it creates significant barriers to communication with staff and brings with it the risk of having parents whose children have chronic or severe medical illnesses, misinterpret what is being said to them. Apart from jargon being a problem, language barriers compound understanding of issues regarding treatment and diagnosis. Some staff may not understand the languages spoken by patients, such as isiZulu. These language barriers can be problematic when health care staff try to communicate with the family of a patient, hence staff need to ensure there is an interpreter who can communicate effectively with different cultural groups (Patriksson, Nilsson and Wigert 2019:1).

As scholars have said the "decisions about treatments or tests may be influenced by various communication factors including the medical terminology some clinicians may use to diagnose and describe conditions to patients" (Nickel, Barrat, Copp, Moyinhan and McCaffery 2016:1-10). Children rely primarily on their parents to communicate effectively with health care professionals, without language barriers being a concern (Jungner, Tiselius, Wenemark, Blomgren, Lutzen and Pergert 2018:1661). Hence issues around language must be dealt with

so that medical diagnoses and plans of treatment can be demystified to parents when they consult with doctors and other hospital caregivers.

- **Subtheme 4: Inadequate infrastructure**

Inadequate infrastructure also emerged as a subtheme as follows:

"Infrastructure is a major problem, you can see this is the only paediatric ward in this whole hospital and it houses all the different disciplines, and the problem is we don't even have enough space so our multidisciplinary team is outside of the hospital."[P11]

"Even though we allow the mums to stay in, we don't have proper lodging facilities or even amenities like a bathroom, or toilet, things that you take for granted… So proper mother or boarder mother facilities could help."[P2]

"I think a big issue is parents, they have to stay over, and there are no proper facilities for them so, they do stay over but it's not like ideal because they do sit up in a chair so there is like no sleeping facilities or accommodation facilities for them." [P7]

"I really feel sorry for the mothers as well… there is no bed or even decent chair for them to sleep on, and so they sleeping on the hard bench at night, sitting on their knees or sleeping on the mattress."[P5]

The excerpts above illustrate two important infrastructure issues. The first relates to the inability of the paediatric ward to accommodate other disciplinary professionals, in a way that holistic care can be provided to children and other infrastructure challenges that makes the ward uncomfortable. Infrastructure remains one of the most important aspects of promoting a more improved means of care, well-being and a better experience of health care for all patients (Luxon 2015:4-5). This is a challenge facing many public health facilities in South Africa.

As reflected in the data there is only one paediatric ward, in the entire hospital and hence insufficient space. There are also insufficient resources including a lack of beds for mothers who stay over with their children. Inadequate resources, such as a lack of adequate beds impacts negatively on the quality of service and patient care for both children and their families (Manyisa and Aswegen 2017:35-36). Given that parents of children who have been hospitalised have no proper beds to sleep on, may result in increased fatigue and stress. Sleep is important for one's health and studies have shown that when parents experience

disorientated sleeping patterns, it can result in poor decision making, which leaves them unable to cope appropriately with the illness of their child (Nassery and Landgren 2019:266). A family-centered care environment, which incorporates parent beds near the bedside of their sick child has demonstrated many positive benefits, which includes the reduction of parental stress (Smith, Hefley and Anand 2007:229).

- **Subtheme 5: Inadequate support services**

Inadequate support services such as a playroom and a shortage of staff at the hospital appeared as another subtheme.

"To have a psychologist available, not just on an adhoc once every 6 months or once in every 6 weeks... To have someone there if the need arises, if voices need to speak to somebody, somebody should be available."[P2]

"Our role is more geared at the moment in getting the child better physically. The mental and emotional aspects are neglected to a certain extent and it's not intentional, we do try our utmost best but the medical issues take precedence most of the time… Even if the environment here is good, it's not as best as the home environment, so we try our best but we do need more social workers, more youth care workers, volunteers, even more occupational therapists."[P1]

"It's always nice to have more regular staff, obviously we are very short-staffed across the board… and obviously a psychologist, our psychologist is running on one for the whole hospital."[P6]

"We don't have any counselling based people for the kids here themselves, we have for the parents from every angle via the social worker... but for the kids, there's nobody that comes and speaks to them themselves."[P11]

Many participants spoke about a shortage of staff at the hospital, and the lack of support services. This includes health care professionals such as psychologists, social workers, occupational therapists and a lack of staff in other multiple disciplines, which impacts the quality of care in health care settings. In Africa there are approximately, 57 countries which have a severe shortage of health care workers with an estimate of 817 992 shortage of health

professionals (Naicker, Plange-Rhule, Tutt and Eastwood 2009: 60). This reflects the scenario at most public health hospitals which do not function optimally, due to a shortage of health care staff.

In Africa, the shortages of health care workers, affects the quality of care provided to patients, particularly where poor staffing and the heavy workload together with insufficient time, becomes a stressor for staff when providing patients with care (Manyisa and Aswegen 2017:36). Staff shortages emanate from various factors such as underinvestment in training, poor incentive structures and poor mechanisms for health care workers (Miseda, Were, Murianki, Mutuku and Mutwiwa 2017:6). Medical social workers are trained professionals who can help bridge the gap where there are shortages of support staff, by using their knowledge to support other health care professionals.

Theme 2: Nature of psycho-social support for children in hospital and their families

The second theme emerging from the data related to the nature of psycho-social support that the hospital provides to sick children and their families. The subthemes that emerged from this included counselling, group support and play therapy, which are the most common forms of services available to children, by medical staff in the hospital.

- **Subtheme 1: Counselling**

Counselling emerged as a subtheme in relation to the nature of psychosocial support that is being given to children and families in hospital.

"We have social workers that come up and they mainly give advice to the caregiver or the parent, but if the child had a difficult experience traumatically and they have post-traumatic stress or fear, then they do offer the counselling… and they also follow up as outpatients as well."[P7]

"So, we have in place a social work department, and social workers assist us in counselling the mums and the children that are here for traumatic reasons or poor socio-economic circumstances, but their role is very limited, so they often consult the patients maybe one or

two times. If it's a really dire situation then they actually get community social workers involved, etc. but in the hospital itself, we, as doctors, do not have sufficient cover I would say to help children deal with these emotional issues. We, as doctors, do try but because of our clinical work supersedes that, we don't have enough time to give enough attention to that aspect of it."[P1]

"At the moment we don't have anything in place, previously we had a psychology service, so the psychologist used to help… If we identified children who had features suggestive of post-traumatic stress...Or whatever signs we could see, we would refer them to the psychologist, unfortunately, we don't have that available anymore… social workers are not so much for the trauma of hospitalization… The main service that our social work department provide here at R.K Khan is more in terms of counselling with accidental injuries and whether or not there's social circumstances at home that warrant their intervention so, if there's injuries at home, placement, maybe ill treatment of the children, malnutrition… then the social worker gets involved."[P2]

"It depends on the extent of the trauma as well constraints, if its minimum trauma then there's no intervention… but if you have further down the line, if it's a severe case, if the child is hallucinating, then we will probably ask for a psychologist consult but otherwise, there's nothing."[P11]

"Well, they have social workers that most of the paediatric ward kids see… if it's a traumatic case then the psychologist gets involved…that's most of the MDT that helps with counselling and support."[P6]

Counselling in a medical context has been defined as an active process of investigating, which includes interrelated systematic entities of the patient's variables, the counsellor's variables and what's going on between both variables, as well as listening directly about the experience of patients so that the process could be understood (Sackett, Lawson and Burge 2012:208).The data reflected that the hospital does have both social workers and psychologists, who do assessments and counselling, but this is still heavily under resourced. Given the latter, it was not surprising then that their roles have been very limited and that counselling is minimal due to high patient volumes and a dire shortage of counselling professionals.

According to Amanullah and Firdos (2018:23), counselling includes consideration of environmental factors, resources and psycho-education within therapy. The purpose of counselling a patient then is to help increase understanding of the situation and to discover the possibility of dealing with the condition of medical illnesses, all of which is crucial to recovery.

Illnesses and injuries cause huge distress and trauma. Children who are hospitalized experience tremendous anxiety. There is a fear of prognosis in terms of recovery amongst patients where there are more serious illnesses. Therapy is important to helping children deal with separation anxiety, fear of pain, and fear of the hospital. For both parents and children counselling can help them to understand the presenting medical condition and come to terms with the diagnosis and treatment plan.

The quality of counselling can be considered, excellent if it meets the information needs and expectations of patients and their family members and helps them to identify their resources and capabilities, and enable their control over the situation (Paavilainen, Salminen-Tuomaala and Leikola 2012:1). Social workers are trained to understand patients and their families in the social environment that they are in, whilst providing a range of psychosocial services including individual and family counselling (Gehlert and Browne 2012:567). The introduction of medical social workers into the hospital space, can therefore potentially bridge the gap between other medical staff and patients and their families. Whilst as the data suggests it is the psychologists who do the assessments for psychological disorders, it is the social workers who can do in-hospital counselling and also network with community social workers for ongoing help once children have been discharged.

- **Subtheme 2: Group support**

Participants that took part in the study gave their views with regards to group support as an intervention within the hospital.

“Our groups run once a week, once in two weeks, so it’s not ideal”[P6]

“Also used to be run by the psychologist so they used to have group therapy sessions on a particular day in the week, that age group of children would be put together, at the moment some of these roles have been taken over by the occupational therapy, so it’s more the allied services that are trying to overlap and help out where we lacking.” [P2]

"We don't usually have that structure in place, I'm sure as an outpatient they may have that… but inpatient, no group support at all." [P1]

"I know we do group therapy…for inpatients, its more stimulation we do in the paeds wards, we do stimulation groups."[P7]

"The hospital doesn't have anything in place as far as I'm aware, but our department has a stimulation program just for kids to get involved, and kids that are not referred to us for a specific reason, so if I have a CP child with neurological fallout, I'm not going to include that child in the stimulation group because of the different levels of the kids, the stimulation group is just to play and just to get them out of that institutionalization sort of thing, but we see those kids or the other kids individually." [P6]

"We do other kinds of caregiver education groups in the ward for like the severe acute malnutrition; we know there are groups of parents there, so we try to do education there just to prevent things like readmission."[P5]

The data reflected that group therapeutic programmes do not feature strongly within the hospital program as several have been discontinued. The types that exist though are stimulation groups for children and support groups for parents. This may be attributed to shortages in staff at public health facilities.

It was also found that the stimulation groups for children were not implemented as often as they should have been. Peer groups for adolescents infected with HIV are also, available to help them deal with the isolation and stigma attached, whilst allowing them to be free with one another and support each other whilst on treatment (Enane, Mokete, Joel, Daimari, Tshume, Anabwani, Mazhani, Steenhoff, Lowenthal 2018:10-11). A study done with children who have severe acute malnutrition, showed improvement in their mental and motor development and an increase in weight following stimulation groups (Nahar, Hamadani, Ahmed, Tofail, Rahman, Huda and Grantham-McGregor 2009:729). Support groups can also assist children in normalising their hospital stay (Gehlert and Browne 2012:511).

The data also reflected that there is a poor variety of groups being offered at the hospital. However the literature reveals various types of other support groups for parents. For example, those parents whose children have cancer can assist parents in feeling comfortable, expressing their feelings of concern and reducing stress (Racine, Smith, Pelletier, Scott-Lane, Guilcher and Schulte 2018:285-287). Support groups help parents who are burdened and

exhausted and offer continuity during transitions that may seem uncertain (Gehlert and Browne 2012:511).

Group support should not only be for children but also for the parents of hospitalized children as well. The goals of such group work therapy works in reducing negative feelings and poor motivation whilst it improves social functioning and interpersonal relationships(Ezhumalai, Muralidhar, Dhanasekarapandian and Nikketha 2018:515).

Occupational therapists were found to do most of the group work at the hospital in the present study. There is potential for social service professionals however to offer a range of other groups such as psychotherapeutic groups, counselling groups, support groups and psycho-educational groups (Van Hyussteen 2015:49-50). The workload and staff shortages, as discussed under the subtheme of inadequate infrastructure and support services, however, make it difficult to run groups.

Social workers constitute one of the largest groups of trained professionals who can provide evidence-informed behavioural health treatment. Moreover, the profession has grown in its expertise in integrated behavioural health (Zerden, Lombardi and Jones 2019:144). Hence they are adequately trained to provide group therapy programs with hospitalized children and parents of such children to help ease anxiety because of such training. The same can be argued for child and youth care practitioners.

- **Subtheme 3: Play therapy**

Play therapy is the last subtheme that emerged from theme 2.

"Another thing is to have available play areas, it also helps with their development and all of that."[P2]

"We need a set support structure, especially as an inpatient, we need a proper play area, we need a team that is specifically aimed at making the hospitalization process pleasant for the child, so I think that we lack that at the moment." [P1]

"There's a play area but it isn't the greatest and a little bit more supportive environment." [P6]

"We don't have a specific or designated area for play therapy or an area where the kids can basically, play with their toys or read or do whatever … in P5 we do have space that is available, however, it is not utilized properly so we do not have a set place in the ward."[P2]

“The occupational therapist does come here on a daily basis… so they take them up there and do play therapy with them.”[P11]

“We do have a play area in the ward, but it’s very small and it’s not very well equipped, so we don’t have enough stimulatory toys, charts, even like people that are available on a daily basis to do like group play therapy.” [P1]

“Play therapy plays a role, but it’s something that our OT’s usually get involved with but they also not as well staffed as us… so it is limited, I think that is where we would require you to come in.”[P1]

“The play therapy actually, you know they start to become comfortable with you, because you bringing out the toys, the balloons, they see all the toys, the balls, rattles and things, they start to open up a little.”[P5]

According to Mountain (2016:2), play therapy uses various theoretical paradigms and therapeutic relationship building that capitalises on the use of play to help reduce suffering and help facilitate optimum growth and development. Play therapy can further be defined as an interpersonal process that analytically uses the power of play therapy to reduce and prevent psychological complications (Shrinivasa, Ragesh and Hamza 2019:83). As reflected in the data, play therapy is important for children who are hospitalized, hence it is a feature of the paediatric wards. However it appears that the space is limited and the room is not adequately stocked with the requisite play equipment. Financial constraints at a public hospital may be a potential reason for this.

During the time of the child’s hospitalization, a playroom can be an environment to assist the child in disengaging from their physical pain and enabling them to express their emotions freely (Ramos 2014:149). Brown (2016:91) wrote that the play atmosphere should guarantee that the playroom assists a child in being playful and creates an environment where children can enjoy activities that are not serious. The context of the playroom should consider both physical and psychological aspects, to create a homely environment and be able to provide opportunities for therapeutic play for children who are hospitalized, as part of their emotional care (Burger, Kenke, Aucamp and Le Roux 2013:1-4).

One of the purposes of having a playroom in the hospital is to provide an environment which is happy and more positive, so as to offset the trauma of being in a ward at all times, thereby creating a better context for children to stay and recover in (De Sousa, De Vitta, De Lima and

De Vitta 2015:42). A playroom is therefore important and should be properly structured and resourced, to promote well-being and healing amongst children.

Play seeks to facilitate comprehension, improves the way a child copes and offers emotional support to children who are undergoing medical procedures (Huerga, Lade and Mueller 2016:402). It is crucial then that public health facilities endeavour to create well-resourced play areas for children who are ill. Play therapy has a positive transformative effect on children and helps to clear negative emotions children experience during hospitalization (Koukourikos et al 2015:439).

Play amongst children who are in hospital, helps to improve their social development and eases any anxiety, depression and fatigue that children with chronic illness may face (Nijhof, Vinkers, Geelen, Duijff, Achterberg, van der Net, Veltkamp, Grootenhuis, van de Putte, Hillegera, van der Brug, Wierenga, Benders, Engels, van der Ent, Vanderschuren and Lesscher 2018:425). As Kinjal, Suresh and Ravindra (2014:17) argued, play is vital in a child's care plan during hospitalization, as it promotes healing and helps children deal with stress and helps them to express their emotions.

One of the potential group therapy programs that can be introduced is playgroups. Playgroups can include new parents, engaging regularly with other parents and children that are 5 years or younger. This group can be a way of helping parents and young children to improve their social network and support (Hancock, Cunningham, Lawrence, Zarb and Zurbrick 2015:2).

Despite the fact that most play therapy activities, at the hospital are implemented by occupational therapists, other social service professionals such as child and youth care workers and social workers can implement play therapy as well. Child and youth care workers work in the life space of the child and can offer valuable therapeutic programmes in hospitals. "Life space intervention is a way of conceptualizing work with young people in the spaces where their lives unfold" (Gharabaghi and Stuart 2013:11) and can be effectively undertaken in hospital settings.

Theme 3: The role social service professionals can play in a hospital context

This theme shares insight into the roles that social service professionals like child and youth care workers and social workers can play in a hospital context.

- **Subtheme 1: Salience of social service professionals**

Participants identified salience of social service professionals as the following:

"The counselling for the parents is with the social worker like I'm saying all our non-accidental injuries have a social consultant,so all of them go via the social worker, they get a session with a social worker and if that social worker thinks it needs further investigation, then it is escalated."[P11]

"Most of the time these children don't divulge to us…, they scared of any nurse, any doctor whatever whereas you come as an outside person without poking them, that child will take to you better, than they would take to a doctor." [P11]

"They can provide the nurturance and the care in the absence of their parent which means holding their hand when they getting an injection, preparing them for the fact that you going to go into theatre… also the management of behaviour as well… it is one of our elements of scope of practice for child and youth care work."[P13]

"Just to be a listening ear for one, and two sometimes children just want to be heard or that's just a listening portion but even to play with the kids and things like that would help." [P2]

"One of the biggest roles that can be played by you is with children who have a chronic illness because they spend more time in the hospital, just for someone to be there, to play with them." [P5]

"If the parent or family were to see that this is the quality of the person that this child has access to, it will leave them less anxious when they not around and also the child and youth care worker can play that transitional role again of telling them what the child said when they weren't there or passing information about when they cried or what they said when they cried, or what they were asking for or calling for when they were in pain."[P13]

The excerpts above have grounded the importance of having social service professionals in hospital, along with the salience of therapy in the hospital context. Social service professionals such as social workers and child and youth care workers can help inpatient children by providing therapeutic and support services. The data revealed that play therapy and counselling are two crucial aspects of therapeutic work in the hospital environment.

As mentioned by the participants, counselling was important for the patient to understand their illness and to understand the importance of medical interventions, to be used as part of their treatment. A medical social worker is trained in particular to counsel and assist patients to deal with their medical diagnosis (Browne 2019:26).

As the data reflected, most children need someone who they can trust and talk to about their illness and the hospitalization experience. Social workers in the hospital context are well-positioned, to help with the trauma of being diagnosed with a terminal illness by, supporting a child whilst they are receiving treatment and by helping patients and families to cope with facing the end of life (Jones, Walsh and Phillips 2019:368). The presence of social workers or child and youth care workers provides a reassuring and comforting presence to the child, especially when family members are away.

Individual therapy as part of counselling can also address anxiety symptoms (Drisko et al 2019:7). Such interventions can also consist of taking a child for a tour of the operation room to prepare the child for surgery, which often has a reassuring impact on the child (Aranha, Sams and Saldanha 2017:2). Moreover, patients and their families need to understand better about what they are going through and need information regarding diagnoses and their prognosis. Social workers can provide such important information, especially when medical jargon is not understood. This includes explaining the illness to patients and their families and the treatment they are going to receive according to the language they speak, their developmental level and their literacy level (Browne 2019:26).

Music therapy may also prove beneficial with hospitalized children. Music therapy or also known as music medicine, if used to improve a patients wellbeing in a health care setting by using selected pre-recorded or live music that is managed by a professional other than a music therapist (Uggla, Bonde, Hammar, Wrangsjo and Gustasson 2018:1987). The data reflected that children who have chronic illness usually spend more time in the hospital. According to Stegemann et al (2019:3) apart from other clinical environments, music therapy is valuable for children and adolescents with other health related issues such as chronic illness.

Medical art therapy can be defined as the use of expression and imagery with patients who have physical illnesses, experiencing bodily trauma or those who have to go through medical procedures (Kinney and Mueller 2018:32). This can also be useful in a hospital context. The data reflected that children are fearful of medical staff. Art therapy such as clay work may

decrease the negative emotions in the health care setting and drawings can help children to cope with their illness whilst enhancing communication (Metzl, Morrell and Field 2016:3-4). Previous studies have found that children in a health care setting who participate in art therapy, helps to increase their hope, competence and self-esteem (Lopez-Bushnell and Berg 2018:1-2).

- **Subtheme 2: Group therapy**

Group therapy also emerged as a subtheme related to the type of groups that can be provided by social service professionals.

"Support groups would be nice for parents… I know the social worker intervenes individually but not as far as I know, support groups would be nice, better, a more kid friendly ward I suppose."[P6]

"They can form like support groups, you know with the support group it is easy for children to interact or discuss matters that are now concerning them and that also, peer support, the other children they learn from others… and also to motivate one another in terms of importance of treatment compliance." [P17]

"There's a whole lot of parent's staying over with kids in the ward, they can do something with the parents together, form a support team or group with mum's to offer support who share a similar experience."[P7]

Group therapy is another method of treatment, which includes placing troubled patients in groups to improve social development through group experiences and to assist them in dealing with any individual, group or community issue (Ezhumalai, Muralidhar, Dhanasekarapandian and Nikketha 2018:514). It, therefore, forms an important support service that can increase the efficacy of individual counselling in the hospital. As evidenced in the previous theme, group therapy has been done with children who were admitted to the hospital. This showed the need for greater therapeutic and support groups such as cancer support groups, HIV peer groups and groups to overcome substance abuse.

One type of group that can be implemented is family group conferencing. Family group conferencing is a group consisting of the patient and their social networks that come together to set goals and participate in daily activities, thereby promoting family-centred values

(Hillebregt, Scholten,Ketelaar, Post and Visser-Meily 2018:2). According to medical staff, implementing peer support groups in hospitals can also be beneficial. Peer groups assist in developing self-efficacy to achieve a particular behaviour through ways of group support, changing the norms of the groups, role modelling, and skill building. Social work, as well as public health intervention, focuses primarily on the oppressed, the vulnerable and at-risk groups such as addicts, abused and children with terminal illnesses (Gehlert and Browne 2012:64). Group therapeutic programmes can be effectively implemented with these groups of children in the hospital environment.

Medical social workers are well-positioned to develop support groups for both the patient and their families, which can provide education and the support that they need with regard to how their illness impacts their well-being (Browne 2019:27). Group therapeutic programmes can assist children who have chronic illnesses to talk about their illness and deal with negativity. Group therapeutic programmes, have also become crucial in helping people work through various psychosocial problems such as depression and aggressive behaviour (Douma, Joosten, Scholten, Maurice-Stam and Grootenhuis 2019:80).

- **Subtheme 3: Parental support**

Parental support was also seen as an important subtheme related to a role that social service professionals can play within a hospital.

"It's a limited service that we do have available, we do counsel every mother on admission… Sometimes even if they don't understand something, being scared of the medical staff, can make them apprehensive to ask questions so by having the child and youth care worker, they can help bridge the gap between the medical staff and them." [P1]

"If the news needs to be broken to the parent then equally so, the child and youth care worker can play the part of supporting the parent, if the medical staff feel that is appropriate, and if the parents actually are upset with that information, to comfort them before they come to see the child…managing feelings there's a whole lot of feelings from all sides that needs managing." [P13]

"I think keeping in contact with parents so that they will know of the progress of the child in hospital and maybe it will help them plan better for the child when she returns homeand I think

even encouraging visitations for the child, so the child and youth care worker can assist there as well, reunifying the family with the child." [P19]

Parents are often left unprepared for the anxiety and emotional stress which comes with a medical crisis and these parents need to feel supported and empowered so that they are better able to cope with the crisis of their child's condition (Lerwick 2016:144-146).

As evidenced in the excerpts above parents, can be offered various forms of support, whilst their children are in hospital. This ranges from individual counselling, providing clarity around their condition, providing comfort, and managing their feelings. Doupnik, Hill, Palakshappa, Worsley, Bae, Shaik, BS,Qiu, Marsac and Feudtner (2017:2) argued that these interventions are often designed to help support parents deal with their child's hospitalization period through communication, empathy, education and other ways to improve the health of the parent even after the hospitalization period.

As was evident in the excerpts parents are often afraid to ask questions about their child's condition, either out of fear for their condition or because they may not understand medical terminology. When there is effective communication between the parent and health care staff, parents feel less uneasy (de Melo et al 2014:437). A study done by Bry and Wigert (2019:8), revealed that parents wanted explanations as to why it was important for them to be present in the ward and they expected concrete services such as counselling, so that they could cope during the time of their child's hospitalization. Medical social workers are professionally trained to facilitate supportive counselling for families of patients, who are in hospital and also help families to understand how to manage the crisis for those living with chronic illnesses (Hassan 2016: 495-496). This supports the need for their presence within the hospital environment.

The provision of social support, during the admission of a child reduces stress amongst parents and increases their levels of comfort. As such parents have reported the need for support as well, particularly when they experience a lack of it during their child's hospitalization (Aftyka, Rozalska-Walaszek, Wrobel, Bednarek, Dabek and Zorzyeka 2017:2).

"Partnerships between families and the health care team are essential in paediatrics, where children are often unable to self-report symptoms or treatment preferences due to their developmental stage or health status" (Hill, Knafl and Santacroce 2018:22). A variety of

coping strategies, such as managing one's negative feelings, seeking social support and meaning-making may be beneficial to those parents who have to care for children who have a severe illness (Hill, Carroll, Snyder, Masarenhas, Erlichmean, Chavis, Putterson, Barakat and Feudtner 2018:454-455). Social workers can assist with the aforementioned issues and by alleviating parents feelings of doubt and uncertainty and by ensuring that there is a safe environment where parents can seek help and ask questions without fear of getting a punitive response (Jones, Walsh and Phillips 2019:370).

- **Subtheme 4: Working with a multidisciplinary team (MDT)**

Social service professionals working in a multidisciplinary team within the hospital emerged as another subtheme.

"It's always better to work in a MDT… it will be nice to have a child and youth care worker there as you have a better relationship with the family and you can provide them with more information that we have missed or that the family hasn't provided, because they do not feel comfortable. This will help better their prognosis."[P6]

"We have many different components to the multidisciplinary team… what we lack is a psychologist, we don't have psychologists at the moment in hospital, we do have a very limited service that is based on this recommendation by psychiatrists, it's only the very severe cases get referred to by psychologist and you know because of that we actually do need more child care workers because they have the experience of indulving into the emotional, psychological aspects of the child and children, sometimes all they need is a friendly person, a smile, for us to gain their trust."[P1]

"All of us are intertwined, like the doctor doesn't work separately from the nurse, separately from the physiotherapist, or separately from the occupational therapist. Everybody needs to be working as a team… the best way for you to join into the team would be to have a designated or an outline of what is expected… A structured scope or practice."[P2]

"I think they will play an integral role and be beneficial because they also come in with their own expertise and it will really be beneficial towards the whole multidisciplinary approach and enhance in terms of intervention and level of care."[P5]

"Obviously, they going to alleviate the burden that falls upon doctors and nurses because you can't be doing your work as well as other stakeholders work so it gives us more time to do our work and you'll can focus on the necessary things that you'll need to focus on." [P11]

A multidisciplinary team includes a group of care providers from multiple disciplines that all work toward a common goal to provide care for a patient (Pless, Van Hootegem and Dessers 2018:1). A hospital's multidisciplinary team usually involves different levels of staff. These teams are most effective and help to limit adversity and improve a patient's outcomes and satisfaction (Epstein 2014:295-296). Multidisciplinary team meetings are also there to improve communication between the different service providers and develop treatment plans for patients (Rosell, Alexandersson, Haggerberg and Nilbert 2018:1-2).

The MDT within a paediatric ward should therefore consist of those health care professionals who will work with the child according to the nature of their illness or injury for a better outcome. There are no professionals that can singularly provide the knowledge and skills to treat the complexity of a patient's health care needs so all team members contributions are important, namely the paediatrician, nurse, psychologist, occupational therapist, social worker, pharmacist, physiotherapist and even a dietician (Jennings and Astin 2017:78).

Primary care is patient-centred, so the various professionals who treat a patient, and the distribution of their roles change according to patient needs (Saint-Pierre, Herskovic and Sepulvida 2018:132). As reflected in the excerpts, participants shared their views on how child and youth care workers can be beneficial to the hospital's MDT, because of their knowledge and the way they work differently from other professional groups. Similarly "social workers can potentially contribute to both process skills for effective inter-disciplinary collaboration, and an understanding of the wider social, familial and cultural context for the ongoing assessment and care of the patient" (Giles 2016:26).

The social worker can also educate hospital staff with regards to the psycho-social needs of a child and communicate and collaborate with other health care workers (Australian Association of Social Workers 2016:5).They have relationship and rapport building skills which are important and also the competency to provide empathy, practical assistance and advocacy which are fundamental roles that medical social workers can play in an MDT (Schadewald, Kimall and Ou 2018:90).

- **Subtheme 5: Liaison with the community**

Liaison with the community emerged as another subtheme. Participants commented as follows:

"They are like playing that community role, like a community worker… for example, if the child has to go to a special school, maybe the child and youth care worker can get all the different resources, the human resources, like find out who gets involved, the different role players, like how can you get that child into that special school… or if the child needs further counselling for trauma…place of safety, if the child needs to be there because they can't go to their own home for some reason so they can play that role… liaise with everybody."[P7]

"The best way forward is to go through what we call community caregivers (CCG), there are CCG in every one of our districts provided by the government, these are people in the community who have volunteered their services…to ensure that children get their meds on time from the pharmacy, manage to pick it up from the hospital."[P2]

"Communicating with the community social workers and doing home visits… because home visits would be vital, what happens is that we lose communication with patients once they leave the hospital and we don't know what goes on until their next visit…if we have the child and youth care workers that can go to the house make sure the parents are coping, still compliant on medication… it would make life so much easier for the patient, the staff and ultimately the whole medical service that's being offered would be a better service and more effective."[P1]

"Home-based after discharge would be beneficial and then feedback to the medical facility that's how they could assist."[P6]

The aforementioned excerpts entrenches the role that social service professionals can play by liaising with community workers or ensuring ongoing care once a child has been discharged. A community caregiver can be defined as an individual who is the primary line of support between the community and the various governmental departments of health and social development, in which they provide community level interventions to vulnerable groups of people such as individuals with chronic illness (Koen, Ryke, Watson and Van Eeden 2017:318). These caregivers are crucial within the developing context of South Africa.

Participants reported that there are community caregivers in the community who attend to a child after discharge, to help by giving children their medication and helping with their recovery through support. However, as reflected in the excerpts above, child and youth care workers can also help by doing home visits and giving feedback to the hospital, upholding a continuum of care. In social work, home visits are an important part of the profession (Muzicant and Peled 2017:1) and are crucial to providing support post discharge of a child.

The hospital often loses contact with the patient until their next visit and does not know the patient's condition, both physical and emotional, between discharge and the next visit. De Regge, Pourcq, Meijboom, Trybou, Mortier and Eeckloo (2017:2) explained that it has therefore become necessary for hospitals to work together with community partners to do follow-ups with patients that have chronic illnesses to prevent continuous readmissions at hospitals. Both child and youth care practitioners and social workers can also assist by providing this service.

“Social workers provide care coordination services and advocacy for children and families in medical homes across the care trajectory, especially during the critical times of need such as the time of medical diagnosis, at hospital discharge, when a change in health status occurs, and during the transition to young adulthood”(Jones, Walsh and Phillips 2019:370). During hospitalization and post-discharge, a child would be missing out on school and may need additional support to help with school-based work and activities.

The link for hospital-school based transitional services is weak or sometimes non-existent at certain hospitals (Glang, Todis, Ettel, Wade and Owen 2018:1-2). In South Africa, it is even more scarce, due to a lack of funds at public hospitals. Medical social workers however have the knowledge to access secure community-based services and offer case management services and can refer the patient and their family to services and other available resources to meet their needs (Browne 2019:26). It is therefore crucial that medical social workers be available at public and private hospitals.

- **Subtheme 6: Spiritual support**

Spiritual support emerged as the last subtheme under theme 3.

"Spiritual support…maybe they have the expertise and they can create or develop a program during inpatient time, during their stay…they can build up a program and structure it age appropriately, culturally appropriately and to benefit the child… prayer and meditation is one of the good forms of relaxation and also to improve mental health… so they can use that but the children also come from different cultures so you have to be culturally sensitive."[P7]

"I think they would help a lot because the spiritual aspect here I think is never touched on at all… maybe emotionally and maybe physically and mentally but spiritually no and I'm sure that you have some sort of training in how to approach it, I don't know if you do techniques where the child can relax or meditate but they do need that, it would be very beneficial." [P1]

"I think with spirituality, it will affect older adolescent children…you do get to see children who have terminal illnesses and things like that and for them, I think the avenue or to being able to speak around spirituality will be very helpful because they are dealing with something that from a medical perspective we are not equipped or sometimes I think maybe we are too scared to see it because if death is coming a child must be able to talk about it and the older kids knows what's going."[P2]

Spirituality has been conceptualized "as the search for meaning in life, for a personal connection with transcendent realities, and interconnectedness with humanity" (Villani, Sorgente,Iannello and Antonietti 2019:2). Spirituality can be beneficial to help maintain an individual's physical and cognitive well-being as it, integrates both their physical and psychological being (Tabei, Zarei and Joulaei 2016:2). Participants expressed that spiritual activities are often carried out by the child's own family, but not by the hospital and the staff, itself. Participants mentioned that whilst the child received adequate physical care during hospitalization, spirituality or spiritual care was not included in patient care at the hospital.

Burkhart, Bretschneider, Gerc and Desmond (2018:2) defined spiritual care as a purposeful method of helping individuals to tap into their spirituality, especially during stressful situations. Those using spiritually based interventions, such as nurses or other social service professionals, can do same, by listening to patients and allowing them to talk about the fears and anxieties that they face (Bhagwan and Chandramohan 2016:7). It is important then to integrate spirituality and spiritually base care into hospital care particularly with children and their families.

Medical social workers can become involved in providing spiritually based interventions. Spiritual care interventions can include providing access to spiritual books, movies and music (Therivel and Schub 2019:4), as well as the use of prayer, meditation and visualization (Kvarfordt and Sheridan 2010:392). These activities can easily be introduced into the hospital context to support counselling and recovery.

Nita (2019:1605) explained that there is a well-established connection between spirituality and healing, and shows that religion and spirituality can be seen as an important means of coping. According to Koenig (2012:4), approximately 344 studies done during the year 2000 to 2010, showed how religion and spirituality helped people to cope with illness and adversities which included general illness and also chronic illness.

Social workers can also be sensitive to patients during the end of life experiences (Colon and Wladkowski 2019:632). Most children and their families may encounter many challenges including spiritual challenges through the course of the child's terminal illness (Adistie, Lumbantobing and Maryam 2020:258). Coping with an illness is finding meaningfulness despite the suffering, having faith when it seems pointless and having hope in the face of death (de la Porte 2016:7). Moreover, spirituality and religion, which are interpreted as mental health and religious practices by some individuals, overlap in the sense that they both offer frameworks where an individual can understand the meaning, goal, and high values of their life (Atashzadeh and Zakaryaee and Fani 2018:1319).

Positive spiritual coping has been found to be "associated with lower emotional distress in youth with asthma, cystic fibrosis and diabetes" (Reynolds, Mrug, Hensler, Guion and Madan-Swain 2013:543). Positive religious and spiritual coping usually includes approaches such as seeking spiritual support as well as making benevolent religious reappraisals and are sometimes linked to high levels of well-being (Park, Smith, Lee, Mazure, McKee and Hoff 2017:2). Spirituality then is of great significance as a means of coping with illnesses and during a period of crisis (Nascimento, Alvarenga, Caldeira, Mica, Oliveira, Pan, Santos, Carvalho and Vieira 2016:2). Social workers can play a valuable role in assisting patients to develop their personal spirituality and by contacting clergy in the community and through the social worker acting as an intermediary linking the patient and the clergy (Wolfer 2018:278).

The excerpts also reflected that prayer and meditation are useful spiritually based activities that can be a good form of relaxation during hospitalization. Prayer is deemed an imperative intervention, when implementing spiritual care with those who are suffering (Simaro, Caldeira and de Carvalho 2016:2). Prayer has been conceptualized “as a religious practice and/or means of communicating with God” (Hamilton, Kweon, Brock and Moore 2020:1687). Whilst patients expect to find healing through medical interventions, many patients believe that their prayer plays a role in controlling pain (Gehlert and Browne 2012:612).

Meditation is a technique that has been used to enhance an individual’s awareness of themselves and their spirituality (Troyer, Tost, Yoshimura, LaFontaine and Mabie 2012:154) and can be an important intervention during recovery from illness. Various types of meditation activities have been seen to result in both psychological and biological changes that are related to improved health (Andrade and Radhakrishnan 2009:247). Both prayer and meditation can be described to deliver various positive health improvements which include reduced stress, reduced blood pressure, chronic pain management and a decrease in depression (Gehlert and Browne 2012:171). Social service professionals should therefore become professionally prepared in terms of incorporating spirituality into their care activities within the hospital context.

4.6 CONCLUSION

This chapter reflects the data that emerged from the study and a discussion of the findings made. Both the main themes and subthemes highlighted the experience of hospitalization for both the child and their families, the nature of psycho-social support available for children and their families and the roles that social service professionals can play in a hospital context. The chapter ends with an exploration of the importance of spirituality in the care of patients. The final chapter that follows focuses on the conclusions made and the recommendations for further research.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The major aim of the study was to explore the potential role of child and youth care work in a hospital context. The objectives that guided the study were namely, (1) to explore the challenges that children and their families may face during hospitalization, (2) to determine what psychosocial support children need when they are hospitalized, (3) to explore the potential role of child and youth care work in terms of providing developmental and therapeutic programmes in a hospital context and lastly (4) to explore how child and youth care workers can work collaboratively with the multidisciplinary team in a hospital context. The data presented in chapter four contained a thorough discussion of the three main themes and fourteen subthemes that emerged from this study. Moreover, it gave a critical analysis of the findings made.

The study was conducted at RK Khan Hospital and found that children and their families face significant stress and challenges within the hospital environment. Due to the shortages of staff and poor hospital infrastructure as discussed, the hospitalization experience, becomes more challenging and difficult for those within the paediatric ward. The lack of psycho-social support offered to children and their families was a significant finding made and pointed to the need for more therapeutic services to be offered to ease the experience of illness, treatment and recovery for children. It was also essential to provide supportive services to family members particularly the parents of children who were hospitalised.

Given that child and youth care falls within the social services professions, findings were discussed in relation to social work. Social work is an allied social services professional group and scholarly work relevant to medical social work in particular was relevant to the findings made. This was necessary given the lack of literature in the child and youth care field.

R.K Khan Hospital is one of the largest public health facilities in Durban that deals with various paediatric cases. For many years the hospital has provided a paediatric service which is a branch of medicine that involves the medical care of infants, children and young people. Children are treated for a wide array of illnesses, injuries and psychological issues. Moreover,

the hospital provides a multidisciplinary team that assists with the diagnosis and treatment in a way that meets the holistic needs of children. However as indicated in Chapter four, there remains a need for greater psycho-social support to aid children's healing and recovery and support for parents when children are hospitalised. This is where the study found that the contribution of the child and youth care worker and medical social workers could be valuable. These professionals are crucial as they work closely with a child and this can prove beneficial to both the child's health outcome and their experiences of hospitalization.

Resilience theory was used as a framework to guide this study. This theory was particularly useful as it illuminated how through the psycho-social support resilience may be built and children will be able to transcend difficulties and recover from adversities. The variety of supportive and therapeutic interventions that emerged in the data provided a diverse number of ways that children can be supported through their recovery whilst in hospital. Interventions that can be implemented by social service professionals for parents were also highlighted in Chapter 4.

This final chapter therefore presents the major findings made and discusses how the objectives of the study were met. It gives a preview of the main themes and the subthemes that were previously mentioned in chapter four. This chapter also details the recommendations for further research.

5.2 MAJOR FINDINGS OF THE STUDY

The three main themes and fourteen subthemes that were taken from the data that was from the interviews are as follows:

THEMES	SUBTHEMES
1. The hospitalization experience	1.1. Parent-child separation anxiety 1.2. Fear of medical staff 1.3. Difficulty understanding medical jargon 1.4. Inadequate infrastructure 1.5. Inadequate support services
2. Nature of psycho-social support for children in hospital and their families	2.1. Counselling 2.2. Group support 2.3. Play therapy

3. The roles of social service professionals in a hospital context	3.1. Salience of therapy 3.2. Group therapy 3.3. Family therapy 3.4 Working with an MDT 3.5 Liaison with the community 3.6 Spiritual support

The discussion that follows presents the major findings made within the context of the objectives of the study.

5.2.1 Challenges children and their families face during hospitalization

The first objective of the study was to explore the challenges that children and their families face during hospitalization. The data revealed that children and their families experience several challenges within the hospital environment once the child is admitted to hospital. Challenges include separation anxiety, fear and anxiety, and emotional trauma amongst children and parents. The parents reported enduring financial strain, an inadequate hospital support structure and difficulties with understanding medical jargon. These issues placed a huger burden on families who were already experiencing strain.

One of the most significant findings was the huge levels of separation anxiety both children and parents faced when they had to leave their children overnight and be unable to stay with them. Although hospital health care workers encourage parents to be involved in paediatric hospital care (Nassery and Landgren 2019:266), work related commitments especially amongst poor socio-economic families, as is the case in the present study, often prevents

parents from remaining with their children overnight. The hospitalisation of a child also brings financial difficulty. Parents have the added financial stress of having to pay hospital bills and travelling long distances to hospital which can increase their financial costs. Writers have said an added burden of economic impact is posed, with regard to the cost of hospital and the possible loss of future earnings, as well as potential legal implications (Brysiewicz and Chipps 2006:68).

The data further revealed the huge lack of a support structure for children and their families who endure emotional strain. The hospital was found to lack a psychologist or other social service professionals who could offer comfort, support and counselling for inpatients and families when needed. Whilst social workers were available at times to offer counselling to families, there remained inadequate support and such services were not extended to the parents. Health social workers are trained to provide psychosocial counselling to patients and caregivers and to make referrals for appropriate financial, social, psychological, and community services. They also can provide proper discharge planning if the child is hospitalized (Gehlert and Browne 2012:395). Collectively these are meaningful services that can provide salient support as parents and other medical staff enable the recovery of children.

5.2.2. The psychosocial support children are given when they are hospitalized

The second objective was to explore the nature of psychosocial support given to hospitalized children. The study found that there was minimal support offered to children and their families. Children are provided with medical attention during their hospital stay. However what was found to be lacking were therapeutic services that could assist in their adaptation to the medical environment and associated procedures. Such therapeutic services could also provide comfort during the time of children's illness and recovery. Moreover support groups can be offered to parents when children have a prolonged hospital stay. Whilst the study found that the hospital had previously offered stimulation groups for children have been discontinued. These need to be resuscitated. Also, the everyday play therapy offered by occupational therapists, were found to be an important intense therapeutic intervention.

It has been argued that children who are hospitalized would benefit from play therapy because illness and the experience of hospitalization constitutes a crisis and brings overwhelming stress in a child's life. Hence play helps children to play out the fear and anxiety

that they feel in order to deal with this stress (Davidson, Satchi and Venkatesan 2017:441). Although occupational therapists may assist hospitalized children to overcome their fear through the use of play therapy, other professionals such as child and youth care workers and medical social workers.

Another form of psychosocial support that was uncovered in the study was that of counselling. Data showed however that whilst parents of these hospitalized children are offered some counselling, the children are not offered much counselling. This counselling for parents is implemented by social workers at the hospital, since there are no available psychologists. The main purpose of counselling is to assist an individual bring a change within themselves (Ray, Mahapatro and Kar 2011:118) and hence it is crucial to helping children through the diagnosis and treatment of their medical condition.

Social service professionals are trained and equipped to do counselling with these children and their families. Drobot (2013:1) supported the notion that social workers could provide counselling for such individuals as they are professionally trained for same. In particular, a health social worker can empathize with children, and provide counselling that is supportive and helps the child to deal with one's treatment (Browne 2012:25).

5.2.3. Potential role of social service professionals in terms of providing developmental and therapeutic programmes in a hospital context

The third objective of this study was to explore the potential role of social service professionals, in terms of providing developmental and therapeutic programmes in a hospital context. As evidenced in the data social service professionals can offer group therapeutic services. The study found a lack of same possibly due to financial constraints in terms of infrastructure.

There are several therapeutic groups that can be implemented by social service professionals that are potentially valuable for the hospital milieu. These include family group conferencing, mutual aid group, peer support group and even substance abuse groups (Metze, Abma and Kwekkeboom 2015:168; Hyde 2011:44-45; Shilling, Morris, Thompson-Coon, Ukoumunne, Rogers and Logan 2013:602; Lander, Howsare, and Byrne 2013:194). They are trained

professionals and have a place within the hospital to carry out interventions to ensure healthy development and discharge of a child. Social service professionals can also ensure that a child is taken care of after hospitalization by a continuum of care. The data reflected that social service professionals can help these children and families with counselling, by offering spiritually based interventions and referrals to social support and financial systems where appropriate.

5.2.4. Child and youth care workers collaboration with the multidisciplinary team in a hospital context

The final objective of the study was to explore how child and youth care workers could collaborate with the hospital's MDT. Just like other social service professionals, child and youth care workers can work efficiently in an MDT. Thesen (2014:74) wrote that child and youth care workers who work in a MDT are more likely to feel satisfied, be committed and work efficiently. The current study found that child and youth care workers currently do not exist in the hospitals multi-disciplinary team. However, they have the potential to richly contribute in a team made up of doctors, nurses, occupational therapists, social workers and psychologists.

It is clear that children are more open to talk to people that they have a relationship with and people who are willing to listen. In this regard, medical participants supported the notion that child and youth care workers can enhance the MDT with knowledge and recommendations for intervention that can support the child's recovery. By working closely with the parent and family they can bring additional information to the team meeting regarding social and emotional factors in relation to the child's illness. More importantly, they can formulate psycho-social interventions that support the medical plan and child's care which will enable their recovery.

Social service professionals such as medical social workers and child and youth care workers as members of MDTs can therefore contribute to an understanding of the expansive social, familial and cultural context for the assessment and care of the patient (Giles 2016:24). Children and families have specific socio-emotional needs that must be prioritised when they are faced with the crisis of a child who is ill and such needs can be attended to only if the

hospital sector provides attention to bringing child and youth care workers and medical social workers into the milieu of the hospital.

5.3. CONCLUSION

The healing and recovery ill and injured children are paramount within a hospital environment. Although medical interventions support physical recovery, in order to offer a truly holistic approach to understanding illness and supporting recovery, psycho social aspects should also be prioritised. This study highlighted the huge levels of distress and anxiety faced by children and their families during the hospitalization process and found that such needs required attention alongside the medical interventions that were put into place. As such a huge gap was uncovered in the hospital system which supported the need for greater psycho-social and spiritual support for children and their families. This strengthened the need for both medical social workers and child and youth care workers alongside medical professionals.

5.4. RECOMMENDATIONS FOR FURTHER RESEARCH

The following recommendations can be made for further research based on the findings of the undertaken study.

5.4.1 Lack of research on the need for child and youth care work in hospital

There is no empirical research that exists in the child and youth care field and other disciplines that support the need for child and youth care workers within a hospital context. Hence quantitative surveys across hospitals nationally and the child and youth care workforce will shed light on their need within such an environment. It will be important for other studies to explore how children feel during the hospitalisation experience and what support they require to enable well-being and recovery.

5.5. OTHER RECOMMENDATIONS

Other recommendations made for the study, include the following:

5.5.1 Enhanced therapeutic group work

Whilst the hospital was found to provide some group support for children and their families in hospital, they are minimal in nature. Moreover, the study found that such groups were primarily for outpatients. Hence one of the recommendations should be to provide group work support and therapeutic programmes for children and their families. This could be to support the recovery journey of patients and offer solace and comfort to those families whose children are critically ill.

5.5.2 Lack of spiritually based care and interventions in the hospital

The study found a huge gap with regards to spiritually based care and support and that spiritually based therapeutic interventions were minimal. The literature reflects that various spiritually based interventions such as meditation, listening to spiritual music and referrals to hospital chaplains were important components of supporting children and families during illness.

Whilst the literature shows that most hospitals internationally have a hospital chaplain, these services do not appear to be available at public hospitals. It is here that both medical social workers and child and youth care workers can play a significant role on offering spiritual therapeutic interventions like meditation exercises, music therapy and reflective writing (Bhagwan and Chandramohan2016:2-3). This type of care is crucial when children are faced with critical illness or terminal illness and life threatening injuries.

5.5.3 More child and youth care workers placed at hospitals

The study found that social service professionals such as child and youth care workers and medical social workers had a huge role to play in the hospital sector. The hospitals need to create a space within their infrastructure to include such professionals especially in paediatric wards. This can ensure a more enhanced and holistic approach to care and also strengthen the interventions within the hospital's MDT. Child and youth care workers can enable healing and support using many of the interventions evidenced in the literature review.

5.6 LIMITATIONS OF THE STUDY

Even though the study made important findings with regards to its objectives there were a few limitations as follows:

- The study used very small samples. This can be offset by the fact that qualitative inquiries seek information richness through their inquiries.
- Moreover, the study concentrated on one region and one hospital only. Here again, in qualitative inquiries generalisability is not crucial. However future studies can extend studies to other hospitals.

“The experience of hospitalization in children can be considered as a process of effort for returning to health and, on the whole, the regaining of the individual’s status of the world” (Bsiri-Moghaddam, Basiri-Moghaddam, Sadeghmoghaddam and Ahmadi 2011:207).

REFERENCE LIST

Aarthun, A., Oymar, K. A. and Akerjordet, K. 2018. How health professionals facilitate parents' involvement in decision making at the hospital: A parental perspective. *Journal of Child Health Care*, 22(1):108 – 121.

Abbas, M. Y. and Ghazali, R. 2010.Healing environment of pediatric wards.*Procedia - Social and Behavioral Sciences*, 5: 948-957.

Adistie, F., Lumbantobing, V. and Maryam, N. 2020. The Needs of Children with Terminal Illness: A Qualitative Study. *Child Care in Practice,* 26(3): 257-271.

Aftyka, A., Rozalska-Walaszek, I., Wrobel, A., Bednarek, A., Dabek, K. and Zorzyeka, D. 2017. Support provided by nurses to parents of hospitalized children: cultural adaptation and validation of Nurse Parent Support Tool and initial research results. *Scandinavian Journal of Caring Science*, 31(4): 1-10.

Akhtar, I. 2016. Research design. In: *Research in social science: interdisciplinary perspectives*, 68-84.
Available: https://www.researchgate.net/publication/308915548_Research_Design (Accessed: 12 January 2020).

Alemayehu, S., Afera, B., Kidanu, K. and Belete, K. 2020.Management Outcome of Burn Injury and Associated Factors among Hospitalized Children at Ayder Referral Hospital, Tigray, Ethiopia. *International Journal of Pediatrics*, 2020: 1-9.

Allen, H. 2012. Is There a Social Worker in the House?: Health Care Reform and the Future of Medical Social Work. *Health Social Work*, 37(3):183-186. Available: https://pubmed.ncbi.nlm.nih.gov/23193733/ (Accessed: 14 September 2018).

Amanullah, S. and Firdos, S. 2018. Counselling Psychology: Concept, trend and medical Setting.*International Journal of Psychology and Counselling*, 10(3): 22-28.

Andrade, C. C and Devlin, A. S. 2014. Stress reduction in the hospital room: Applying Ulrich's theory of supportive design. *Journal of Environmental Psychology*, 41: 125-134.

Andrade, C. and Radhakrishnan, R. 2009. Prayer and healing: A medical and scientific perspective on randomized controlled trials*. Indian Journal of Psychiatry*, 51(4): 247–253.

Alshenqeeti, H. 2014. Interviewing as a Data Collection Method: A Critical Review. English Linguistics Research, 3(1): 39-45.

Aranha, P. R., Sams, L. M. and Saldanha, P. 2017. Preoperative preparation of children*.International Journal of Health & Allied Sciences*, 6(1): 1-4.

Atashzadeh –Shoorideh, F., Zakaryaee, N. S. and Fani, M. 2018. The barriers and facilitators in providing spiritual care for parents who have children suffering from cancer.*Journal of Family Medicine and Primary Care*, 7(6): 1319–1326.

Australian Association of Social Workers. 2016. *Scope of social work practice: hospital social work*. Melbourne: AASW.

Azevedo, A. V. S., Junior, A. C. L. and Crepaldi, M. A. 2015. Nursing team, family and hospitalized child interaction: an integrative review. Ciência and Saúde Coletiva, 22(11): 3653-3666. Available: https://www.scielo.br/pdf/csc/v22n11/en_1413-8123-csc-22-11-3653.pdf (Accessed: 5 January 2020).

Badger, K., Royse, D. and Craig, C. 2008. Hospital Social Workers and Indirect Trauma Exposure: An Exploratory Study of Contributing Factors*. Health & social work*, 33(1): 63-71

Bakri, M. H., Ismail, E. A., Elsedfy, G. O., Amr, M. A. and Ibrahim, A. 2014.Impact of sickle cell disease in young children with repeated hospitalization.*Saudi Journal of Anesthesia*, 8(4): 504-509.

Balakumar, P., Inamdar, M. N. and Jagadeesh, G. 2013. The critical steps for successful research: The research proposal and scientific writing: A report on the pre-conference

workshop held in conjunction with the 64th annual conference of the Indian Pharmaceutical Congress-2012. *Journal of Pharmacology and Pharmacotherapeutics*, 4(2): 130-138.

Bamford, L., Barron, P., Kauchali, S. and Dlamini, N. 2018. Inpatient case fatality rates improvements in children under 5: Diarrhoeal disease, pneumonia and severe acute malnutrition. *South African Medical Journal,* 108 (Suppl 1): S33-S37.

Barnes, H., Hall, K., Sambu, W., Wright, G. and Zembe-Mkabile, W. 2017. Review of Research Evidence on Child Poverty in South Africa: 30. Available: http://childrencount.uct.ac.za/uploads/publications/Child%20Poverty%20Review%20update%20010 617.pdf (Accessed: 20 May 2020).

Barrett, B., Hayney, M. S., Muller, D., Rakel, D., Ward, A., Obasi, C. N., Brown, R., Zhang, Z., Zgierska, A., Gern, J., West, R., Ewers, T., Barlow, S., Gassman, M., and Coe, C. L. 2012. Meditation or exercise for preventing acute respiratory infection: a randomized controlled trial. *Annals of family medicine*, *10*(4), 337–346. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392293/ (Accessed: 14 August 2020).

Beck, A. F., Solan, L. G, Brunswick, S. A., Sauers-Ford, H., Simmons, J. M., Shah, S., Gold, J. and Sherman, S. N. 2017. Socioeconomic status influences the toll paediatric hospitalisations take on families: a qualitative study. *BMJ Quailty and Safety,*26: 304–311. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5503124/ (Accessed: 14 January 2020).

Beck, K. and Kulzer, J. 2018. Teaching Counseling Microskills to Audiology Students: Recommendations from Professional Counseling Educators. *Seminiars in Hearing*. 39(1): 91-106. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5802983/ (Accessed: 22 July 2019).

Bengtsson, M. 2016. How to plan and perform a qualitative study using content analysis.*Nursing Plus Open*, 2: 8-14. Available: https://www.sciencedirect.com/science/article/pii/S2352900816000029 (Accessed: 12 August 2019).

Benjamin, E., Swartz, L., Hering, L. and Chiliza, B. 2016.Language barriers in health: Lessons from the experiences of trained interpreters working in public sector hospitals in the Western Cape. *South African Health Review*, 2016(1): 73-81.

Berman, J. R., Aizer, J., Bass, A. R., Blanco, I., Davidson, A., Dwyer, E., Fields, T. R., Huang, W. T., Kang, J. S., Kerr, L. D., Krasnokutsky-Samuels, S., Lazaro, D. M., Schwartzman-Morris, J. S., Paget, S. A. and Pillinger, M. H. 2016. Fellow use of medical jargon correlates inversely with patient and observer perceptions of professionalism: Results of a rheumatology OSCE (ROSCE) using challenging patient scenarios. *Clinical Rheumatology*, 35 (8): 2093-2099.

Bordonaro, G. P. W. 2003. Art Therapy with Hospitalized Pediatric Patients.*Doctorate*, The Florida State University. Available: https://diginole.lib.fsu.edu/islandora/object/fsu:169030/datastream/PDF/download/citation.pdf (Accessed 21 May 2019).

Braun, V. and Clarke, V. 2012.Thematic Analysis. In: Cooper, H., Camic, P. M., Long, D. L., Panter, A .D., Rindskopf, D. and Sher, K. J. eds. *APA handbook of research methods in psychology, Vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological*. 3rd ed. Available: https://www.researchgate.net/publication/269930410_Thematic_analysis/stats (Accessed 20 November 2018).

Brayda, W. C. and Boyce, T. D. 2014.So You Really Want to Interview Me?: Navigating "Sensitive" Qualitative Research Interviewing. *International Journal of Qualitative Method*, 13(1): 318-334.

Bresick, J., von Pressentin, K. B. and Mash, R. 2019. Evaluating the performance of South African primary care: a cross-sectional descriptive survey.*South African Family Practice*, 61(3): 109–116.

Brikci, N. 2007.A guide to using qualitative research methodology. Medecins Sans Frontieres: 1-30.

Brink, H., van der Walt, C. and van Rensburg, G. 2012.Fundementals of Research Methodology for Healthcare Professionals. 3rd ed. Cape Town: Juta and Company.

Brogdon, N. L. 2011. The use of expressive arts by social workers as an intervention with children.*Masters*.California State University. Available: https://pdfs.semanticscholar.org/3651/7bba4c0884eb963b06dac3c84a7ae305d5c1.pdf (Accessed: 13 December 2018).

Browne, T. 2019. Social Work Roles and Healthcare Settings. In: Gehlert, S. and Browne, T. eds. *Handbook of health social work*. 3rd ed. Hoboken: John Wiley & Sons.

Browne, F. 2016. The Healing Power of Play: Therapeutic Work with Chronically Neglected and Abused Children. In Navidi, U. eds. *The Role of Play in Children's Health and Development*. Basel: MDPI.

Bry, A. and Wigert, H. 2019. Psychosocial support for parents of extremely preterm infants in neonatal intensive care: A qualitative interview study. *BMC psychology*, *7*(1): 1-12. Available: https://bmcpsychology.biomedcentral.com/articles/10.1186/s40359-019-0354-4 (Accessed: 17 January 2020).

Brysiewicz, P. and Chipps, J. 2006. The effectiveness of in-hospital psychosocial intervention programmes for families of critically ill patients: a systematic review. *SAJCC*, 22(2): 68-76. Available: https://www.ajol.info/index.php/sajcc/article/view/35534 (Accessed: 16 September 2018).

Bsiri-Moghaddam, K., Basiri-Moghaddam, M., Sadeghmoghaddam, L and Ahmadi, F. 2011. The Concept of Hospitalization of Children from the View Point of Parents and Children.*Iranian Journal of Pediatrics,* 21 (2): 201-208.

Burger, Y., Kenke, M., Aucamp, N. and Le Roux, M. 2013. Design aspects of a hospital playroom to aid the well-being of hospitalised oncology children – A case study.*Interim: Interdisciplinary Journal*, 12(4) : 1 –18.

Burkhart, L., Bretschneider, A., Gerc, S. and Desmond, M. E. 2019.Spiritual Care in Nursing Practice in Veteran Health Care.*Global Qualitative Nursing Research*, 6: 1-9. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6505241/ (Accessed: 17 January 2020)

Burns-Nadar, S. and Hernandez-Reif, M. 2016.Facilitating play for hospitalized children through child life services. *Children's Health Care*, 45(1):1-21.

Cahayag, V. 2020. Hospitalization and Child Development: Effects on Sleep, Developmental Stages, and Separation Anxiety. *Senior Theses*, Dominican University of California. Available: https://scholar.dominican.edu/nursing-senior-theses/17/ (Accessed: 30 July 2020).

Carranza, C. M. G. 2013. *Social Work in the Hospital Setting Interventions*. North America: Trafford Publishing.

Casamir, G. 2019. Why Children's Hospitals Are Unique and So Essential. *Frontiers in Pediatrics*, 7:1-5.

Castillo-Montoya, M. 2016. Preparing for Interview Research: The Interview Protocol Refinement Framework.*The Qualitative Report,* 21(5): 811-831.

Chandramohan, S. and Bhagwan, R. 2016. Utilization of Spirituality and Spiritual Care in Nursing Practice in Public Hospitals in KwaZulu-Natal, South Africa. *Religions*, 4(3): 1-13.

Chow, C. H., Van Lieshout, R. J., Schmidt, L. A., Dobson, K. G., and Buckley, N. 2016. Systematic Review: Audiovisual Interventions for Reducing Preoperative Anxiety in Children Undergoing Elective Surgery. *Journal of pediatric psychology*, *41*(2), 182–203.Available: https://academic.oup.com/jpepsy/article/41/2/182/2579890 (Accessed: 23 April 2019).

Chung, A. 2014.Long-term Hospitalization and the Impact on Emotional Well-being of a Child.Honors, University at Albany. Available: https://scholarsarchive.library.albany.edu/honorscollege_sociology/2/ (Accessed: 8 June 2018)..

Clayton-Jones, D., Haglund, K., Belknap, R. A., Schaefer, J. and Thompson, A. A. 2016.Spirituality and Religiosity in Adolescents Living With Sickle Cell Disease.*Western Journal of Nursing Research*, 38(6): 1-18.

Colon, Y and Wladkowski, S. P.. 2019. End-of-Life-Care. In: Gehlert, S. and Browne, T. eds. *Handbook of health social work*. 3rd ed. Hoboken: John Wiley & Sons.

Colwell, C. M., Edwards, R., Hernandez, E. and Brees, K. 2013. Impact of Music Therapy Interventions (Listening, Composition, Orff-Based) on the Physiological and Psychosocial Behaviors of Hospitalized Children: A Feasibility Study. *Journal of Pediatric Nursing*, 28(3): 249-257. Available: http://www.sciencedirect.com/science/article/pii/S0882596312002709 (Accessed: 21 October 2018).

Commodari, E. 2010. Children staying in hospital: a research on psychological stress of caregivers. *Italian Journal of Pediatrics,*36(40): 1-9.

Conye, I. 2006.Children's experiences of hospitalization.*Journal of Child Health Care,* 10(4): 326-336.

Coquillette, M., Cox, J. E., Cheek, S. and Webster, R. A. 2015.Social Work Services Utilization by Children with Medical Complexity. Maternal Child Health Journal, 19: 2707–2713.

Corsano, P., Cigala, A., Majorano, M., Vignola, V., Nuzzo, M., Cardinale, E. and Izzi, G. 2016.Speaking about emotional events in hospital: The role of health-care professionals in children emotional experiences. Journal of Child Health Care, 19(1): 84–92.

Corten, L., van As, A. B., Rahim, S., Kleinsmith, J., Kleyn, A., Kwinana, T., Ndaba, N., Sillito, E., Smith, J. T., Williams, N. and Figaji, A. 2019. Physiotherapy in children hospitalized with traumatic brain injury in a South African tertiary paediatric hospital. *Physiotherapy Research International*: 1-9.

Creswell, J. 2015. *30 essential skills for the qualitative researcher*. Los Angeles: SAGE.

Crnkovic, M., Divcic, B., Rotim, Z. and Coric, J. 2009.Emotions and experiences of hospitalized school age patients. *Acta Clinica Croatica*, 48(2): 125-135.

Crow, S. S., Undavalli, C., Warner, D. O., Katusic, S. K., Kandel, P., Murphy, S. L., Schroeder, D. R. and Watson, R. S. 2017.Epidemiology of pediatric critical illness in a population-based birth cohort in Olmsted County.*Pediatric Critical Care*, 18(3): 1-17.

Cudmore, C. D. 2016. Parental Spiritual Coping with a Chronically Ill Child.*Masters*, East Carolina University. Available: https://thescholarship.ecu.edu/bitstream/handle/10342/5358/CUDMORE-MASTERSTHESIS-2016.pdf?isAllowed=y&sequence=1 (Accessed: 29 January 2019).

Curtis, K., Foster, K., Mitchell, R. and Van, C. 2016. Models of Care Delivery for Families of Critically Ill Children: An Integrative Review of International Literature. *Journal of Pediatric Nursing*, 31(3): 330-341.

Dabkowska, M., Araszkiewicz, A., Dabkowska, A. and Wilkosc, M. 2011 Separation Anxiety in Children and Adolescents.*Different Views of Anxiety Disorders* , September: 313-338.

Dackiewicz, N., Rodriguez, S., Irazola, V., Barani, M., Marciano, B., Fedrizzi, V., Gonzales, C., Elias-Costa, C., Almada, A., Viola, B., Tonini, S., Zamberlin, N., Garcia-Elorrio, E. 2016. Patient experience assessment in pediatric hospitals in Argentina. *International Journal for Quality Health Care*, 28(6): 675-681.

Dangor, Z., Izu, A., Moore, D. P., Nunes, M. C., Solomon, F., Beylis, N., von Gottberg, A., McAnerney, J. M. and Madhi, S. A. 2014.Temporal Association in Hospitalizations for Tuberculosis, Invasive Pneumococcal Disease and Influenza Virus Illness in South African Children.*Plos One*, 9(3): 1-7.

Dantzer, R., Cohen, S., Russo, S. J. and Dinan, T. J. 2018. Resilience and immunity.*Brain, Behavior, and Immunity*. 74: 28–42.

da Silva, L. F. and Cabral, I. E. 2014. Cancer Repercussions on Play In Children: Implications For Nursing Care. *Texto & Contexto - Enfermagem*, *23*(4), 935-943.

Davidson, B., Satchi, N. S. and Venkatesan, L. 2017. Effectiveness of Play Therapy upon Anxiety among Hospitalised Children.*International Journal of Advance Research, Ideas and Innovations in Technology,* 3(5): 441-444.

de la Porte, A. 2016. Spirituality and healthcare: Towards holistic people-centred healthcare in South Africa. *HTS Theological Studies*, *72*(4): 1-9.

Delobelle, P. 2013. The health system in South Africa.historical perspectives and current challenges. In: Wolhuter, C. C. eds. *South Africa in Focus: Economic, Political and Social* Issues. Nova Science Publishers, Inc., 159-204.

Delvecchio, E., Salcuni , S., Lis, A., Germani, A. and Di Riso, D. 2019. Hospitalized Children: Anxiety,Coping Strategies, and Pretend Play. *Frontiers in Public Health*, 7:1-8.

de Melo, E. M. O. P, Ferreira, P. L., de Lima, R. A. G. and de Melo, D. F. 2014. The involvement of parents in the healthcare provided to hospitalized children. *Revista Latino-Americana de Enfermagem*, 22(3): 432-439

De Regge, M., De Pourcq, K., Meijboom B, Trybou J, Mortier E, Eeckloo K. 2017. The role of hospitals in bridging the care continuum: a systematic review of coordination of care and follow-up for adults with chronic conditions. *BMC Health Services Research*, 17(1): 1-24. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5551032/ (Accessed: 30 January 2019).

Denney, A. S. and Tewksbury, R. 2013. How to Write a Literature Review, Journal of Criminal Justice Education, 24(2): 218-234

de Vos, A. S, Strydom, H., Fouché, C. B. and Delport C. S. L. 2011. *Research at Grassroots: For the social science and human service professions*. 3rd ed. Cape Town: Van Schaik.

de Vos, A. S, Strydom, H., Fouché, C. B. and Delport C. S. L. 2011. *Research at Grassroots: For the social science and human service professions*. 4th ed. Cape Town: Van Schaik.

Di Vincenzo, F. 2018. Exploring the networking behaviors of hospital organizations.*BMC Health Services Research*, 18(1): 1-10

Doody, O. and Noonan, M. 2013. Preparing and conducting interviews to collect data. *Nurse Researcher*, 20(5): 28-32.

Douma, M., Joosten, M. M. H., Scholten, L., Maurice-Stam, H., & Grootenhuis, M. A. 2019. Online cognitive-behavioral group intervention for adolescents with chronic illness: A pilot study. *Clinical Practice in Pediatric Psychology, 7*(1): 79–92. Available:https://www.researchgate.net/publication/331666474_Online_cognitive-behavioral_group_intervention_for_adolescents_with_chronic_illness_A_pilot_study (Accessed: 18 February 2020).

Doumit, M. A., Rahi, A. C., Saab, R., and Majdalani, M. 2019. Spirituality among parents of children with cancer in a Middle Eastern country.*European Journal of Oncology Nursing*, 39: 1-24. Available: https://laur.lau.edu.lb:8443/xmlui/handle/10725/11369 (Accessed: 4 November 2018).

Doupnik, S. K., Hill, D., Palakshappa, D., Worsley, D., Bae, H., Shaik, A., Qiu, M., Marsac, M., and Feudtner, C. 2017. Parent Coping Support Interventions During Acute Pediatric Hospitalizations: A Meta-Analysis. Pediatrics, 140(3): 1-18

Dove, C. and Costello, S. 2017. Supporting emotional wellbeing in schools: A pilot study into the efficacy of a mindfulness-based group intervention on anxious and depressive symptoms in children.*Advances in Mental Health,* 15(2): 1-22. Available: https://www.researchgate.net/publication/312342532_Supporting_emotional_well-

being_in_schools_A_pilot_study_into_the_efficacy_of_a_mindfulness-based_group_intervention_on_anxious_and_depressive_symptoms_in_children (Accessed 17 August 2019).

Drisko, J., Corvino, P., Kelly, L., and Nielson, J. 2019. Is Individual Child Play Therapy Effective?.*Research on Social Work Practice*, 30(7): 1-9

Drobot, L. 2013. Social Work Counselling. In: Runcan, P., Rata, G. and Cojocaru, S. eds. *Applied Social Psychology:* Cambridge Scholars. Available: https://www.researchgate.net/publication/299392441_Social_Work_Counselling (Accessed: 30 July 2020).

Drutchas, A. and Anandarajah, G. 2014. Spirituality and Coping with Chronic Disease in Pediatrics. *Rhode Island medical journal*, 97(3): 26-30

Duke, J., Rea, S., Boyd, J., Randall, S. and Wood, F. 2015. Mortality after burn injury in children: A 33-year population-based study. *Pediatrics*. 135 (4): 903-910.

Ehrenreich, J. T., Santucci, L. C. and Weiner, C. L. 2008. Separation anxiety disorder in youth: phenomenology, assessment, and treatment. *Psicol Conductual*, 16(3): 389–412

El-Masri 2017. Terminology101: Non-probability sampling. *The Canadian Nurse, May/June*: 17. Available: https://www.google.com/search?q=Terminology101%3A+Non-probability+sampling&rlz=1C1AFAB_enZA493ZA509&oq=Terminology101%3A+Non-probability+sampling&aqs=chrome..69i57j69i58.457j0j4&sourceid=chrome&ie=UTF-8 (Accessed 30 May 2018). Pg no

Enane, L. A., Mokete, K., Joel, D., Daimari, R., Tshume, O., Anabwani, G., Mazhani, L., Steenhoff, A. P. and Lowenthal, E. D. 2018. "We did not know what was wrong": Barriers along the care cascade among hospitalized adolescents with HIV in Gaborone, Botswana. *PLoS One*, 13(4): 1-15. Available: https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0195372&type=printable (Accessed 14 October 2019).

Elfil, M., and Negida, A. 2017.Sampling methods in Clinical Research; An Educational Review. *Emergency (Tehran, Iran)*, *5*(1): 1-3

Elo, Kääriäinen, Kanste, Pölkki, Utriainen and Kyngäs. 2014. Qualitative Content Analysis: A Focus on Trustworthiness. SAGE Open, January-March: 1-10. Available: https://journals.sagepub.com/doi/pdf/10.1177/2158244014522633 (Accessed 8 July 2020).

Epstein, N. E. 2014. Multidisciplinary in-hospital teams improve patient outcomes: A review.*Surgical Neurology International*, 5 (Suppl 7) : S295 – S303

e Sousa, L. C., De Vitta, A., de Lima, J. M. and De Vitta, F. C. F. 2015. The act of playing within the hospital context in the vision of the accompanying persons of the hospitalised children.*Journal of Human Growth and Development*, 25(1): 41-49

Ezhumalai, S., Muralidhar, D., Dhanasekarapandian, R., Nikketha, B. S. 2018.Group interventions.*Indian J Psychiatry*, 60 (Suppl 4): S514-S521.

Fincher, W., Shaw, J. and Ramelet, A. 2011.The effectiveness of a standardised preoperative preparation in reducing child and parent anxiety: A single-blind randomised controlled trial. *Journal of Clinical Nursing*, 21(7-8): 946-955

Fonash, A. 2018.The Role of the Medical Social Worker in a Pediatric Aero-Digestive Program.*Current Problems in Pediatric and Adolescent Health Care*, 48(4): 111-112

Foster, M., Whitehead, L. and Maybee, P. 2016. The parents', hospitalized child's, and health care providers' perceptions and experiences of family-centered care within a pediatric critical care setting: A synthesis of quantitative research. *Journal of Family Nursing*, 22(1): 6–73

Fox, J. K., Halpern, L. F., Dangman, B. C., Giramonti, K. M. and Kogan, B. A. 2014.Children's anxious reactions to an invasive medical procedure: The role of medical and non-medical fears. Journal of Health Psychology, 21(8): 1587–1596

Franck, L. S., Ferguson, D., Fryda, S. and Rubin, N. 2015. The Child and Family Hospital Experience: Is It Influenced by Family Accommodation?.*Medical Care Research and Review ,* 72(4): 419–437

Freeman, J. 2013. The Field of Child and Youth Care: Are We There Yet?.*Child and Youth Services*, 34:100–111

Frost, L., Jenkins, L. and Emmink, B. 2017.Improving access to health care in a rural regional hospital in South Africa: Why do patients miss their appointments?.*African Journal of Primary Health Care and Family Medicine*, 9(1): 1-5.

Fusar-Poli, P., de Pablo, G. S., De Micheli, A., Nieman, D. H., Correll, C. U., Kessing, L. V., Pfennig, A., Bechdolf, A., Borgwardt, S., Arango, C. and van Amelsvoort, T. 2020. What is good mental health?: A scoping review. *European Neuropsychopharmacology*, 31:33-46

Ghabeli, F., Moheb, N. and Nasab, S. D. H. 2014. Effect of Toys and Preoperative Visit on Reducing Children's Anxiety and their Parents before Surgery and Satisfaction with the Treatment Process, *Journal of Caring Sciences,* 3(1): 21-28

Ghaderi, A., Tabatabaei, S. M., Nedjat, S., Javadi, M. and Larijani, B. 2018. Explanatory definition of the concept of spiritual health: a qualitative study in Iran. *Journal of Medical Ethics and History of Medicine*, 11(3): 1-7.

Gharabaghi, K. 2008. Professional Issues in Child and Youth Care.*Child & Youth Services*, 30(3/4): 145-163

Gharabaghi, K. and Stuart, C. 2013. Life-space Intervention: Implications for Caregiving. *Scottish Journal of Residential Child Care*, 12(3): 11-19

Garrick, R., Sullivan, J., Doran, M. and Keenan, J. 2019.The Role of the Hospital in the Healthcare System. In: Ltifi, R. eds. The Modern Hospital: Springer Nature Switzerland, 47-61

Gavhi, F., Kuonza, L., Musekiwa, A. and Motaze, N. V. 2020.Factors associated with mortality in children under five years old hospitalized for Severe Acute Malnutrition in Limpopo province, South Africa, 2014-2018: A cross-sectional analytic study. *Plos One*, 15(5): 1-13

Gehlert, S. and Browne, T. eds. 2012. *Handbook of health social work.* 2nd ed. Hoboken: John Wiley & Sons.

Giles, R. 2016. Social workers' perceptions of multi-disciplinary team work:
A case study of health social workers at a major regional hospital in New Zealand.*Aotearoa New Zealand Social Work,*28(1): 25–33.

Glang, A., Todis, B., Ettel, D., Wade, S. L. and Yeates, K. O. 2018. Results from a randomized trial evaluating a hospital-school transition support model for students hospitalized with traumatic brain injury. *Brain Injury*, 32(5): 1-9

Gomes, G. C. and de Oliveria, P. K. 2012.Family experience in the hospital during child hospitalization.*Rev Gaúcha Enferm*, 33(4): 165-171.

Gomes, G. L. L., Fernandes, M. G. M and da Nobrega, M. M. L. 2016. Hospitalization anxiety in children: conceptual analysis*. Revista Brasileira de Enfermagem*, 69(5): 884-889

Goodman, C. E. 2009. Clinical social work and the medical model : use of art and play therapy interventions. *Masters*, Smith College School for Social Work.

Goyal, M., Singh, S., Sibinga, E. M. S. Gould, N. F., Rowland-Seymour, A. Sharma, R., Berger, Z., Sleicher, D., Maron, D. D., Shihab, H. M., Ranasinghe, P. D., Linn, S., Saha, S., Bass, E. B. and Haythornthwaite, J. A. 2014. Meditation Programs for Psychological Stress and Well-being: A Systematic Review and Meta-analysis. *JAMA Intern Med*., 174(3): 357–368

Graham, S. M., Cuevas, L. E., Jean-Philippe, P., Browning, R., Casenghi, M., Detjen, A. K., Gnanashanmugam, D., Hesseling, A. C., Kampmann, B., Mandalakas, A., Marais, B. J., Schito, M., Spiegel, H. M. L., Starke, J. R., Worrell, C. and Zar, H. J. 2015. Clinical Case

Definitions for Classification o fIntrathoracic Tuberculosis in Children: An Update. *Clinical Infectious Diseases*, 61, (Suppl.3): S179–S187

Guney, S., Kalafat, T. and Boysan, M. 2010. Dimensions of mental health: life satisfaction, anxiety and depression: a preventive mental health study in Ankara University students population. *Procedia Social and Behavioral Sciences*, January: 1210-1213.

Hammarberg, K., Kirkman, M. and de Lacey, S. 2015. Qualitative research methods: when to use them and how to judge them. *Human Reproduction*, 31(3): 498–501

Hamilton, J. B., Kweon, L., Brock, L. B., Moore, A. D. 2020. The Use of Prayer During Life-Threatening Illness: A Connectedness to God, Inner-Self, and Others. *Journal of Religion and Health*, 59(4): 1687-1701.

Hancock, K. J., Cunningham, N. K., Lawrence, D., Zarb, D. and Zubrick, S. R. 2015. Playgroup Participation and Social Support Outcomes for Mothers of Young Children: A Longitudinal Cohort Study. *PLoS One*, 10(7): 1-15. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504708/pdf/pone.0133007.pdf (Accessed: 20 June 2019).

Hansen, P. 2009. *Psychosocial interventions : a handbook*. 2009. Copenhagen : International Federation Reference Centre for Psychosocial Support, International Federation of Red Cross and Red Crescent Societies.

Hassan, S. M. 2016. Medical Social Work: Connotation, Challenges and Prospects. *Pakistan Journal of Social Sciences (PJSS), 36(1): 495-504*

Hawks, S. R., Smith, T., Thomas, H. G., Christley, H. S., Meinzer, N. and Pyne, A. 2007.The forgotten dimensions in health education research.*Health Education Research*, 23(2): 319:324.

Hendon, C. and Bohon, L. M. 2007. Hospitalized children's mood differences during play and music therapy. *Child: care, health and development*, 34(2): 141-144

He, H. G., Zhu, L., Li, H. C., Wang, W., Vehvilainen-Julkunen, K. and Chan, S. W. 2014. A randomized controlled trial of the effectiveness of a therapeutic play intervention on outcomes of children undergoing inpatient elective surgery: study protocol. *Journal of Advanced Nursing*, 70(2): 431-442. Available: https://onlinelibrary.wiley.com/doi/abs/10.1111/jan.12234 (Accessed: 29 January 2019)

Hill, D. L., Carroll, K. W., Snyder, K. J. G., Masarenhas, M., Erlichmean, J., Patterson, C. A., Barakat, L. P. and Feudtner, C. 2018. Development and Pilot Testing of a Coping Kit for Parents of Hospitalized Children.*Academic Pediatrics*, 19(4): 454-463

Hill, C., Knafl, K. A. and Santacroce, S. J. 2018. Family-Centered Care From the Perspective of Parents of Children Cared for in a Pediatric Intensive Care Unit: An Integrative Review. *Journal of Pediatric Nursing*, 41: 22-33.

Hillebregt, C. F., Scholten, E. W. M., Ketelaar, M., Post, M. W. M. and Visser-Meily, J. M. A. 2018.Effects of family group conferences among high-risk patients of chronic disability and their significant others: study protocol for a multicentre controlled trial. *BMJ Open*, 8(3): 1-13. Available: https://pubmed.ncbi.nlm.nih.gov/29523560/ (Accessed: 30 April 2019)

Hlafa, B., Sibanda, K. and Hompashe, D. M. 2019. The Impact of Public Health Expenditure on Health Outcomes in South Africa.*International. Journal of Environmental Research and Public Health*, 16(16): 1-13

Horlait, M., Baes, S., Dhaene, S., Van Belle, S., and Leys, M. 2019. How multidisciplinary are multidisciplinary team meetings in cancer care?: An observational study in oncology departments in Flanders, Belgium. *Journal of multidisciplinary healthcare*, *12*: 159–167. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6389011/ (Accessed 8 March 2020).

Huerga, R.S., Lade, J. and Mueller, F. 2016. Designing Play to Support Hospitalized Children.*CHI PLAY*, October: 401-412

Humphreys, K. L. 2019. Future Directions in the Study and Treatment of Parent–Child Separation, *Journal of Clinical Child & Adolescent Psychology*, 48(1): 166-178

Hunger, S. P. and Mullighan, C. G. 2015.Acute Lymphoblastic Leukemia in Children.*The new England journal of medicine*, 373(16): 1541-1552

Hyde, B. 2011. Mutual Aid Group Work: Social Work Leading the Way to Recovery-Focused Mental Health Practice. Social Work With Groups, 36(1): 43-58.

Isaacs-Long, Y., Myer, L. and Zar, H. J. 2017.Trends in admissions, morbidity and outcomes at Red Cross War Memorial Children's Hospital, Cape Town, 2004 –2013.*South African Medical Journal*, 107(3): 219-226

Jamshed, S. 2014. Qualitative research method-interviewing and observation.*Journal of Basic and Clinical Pharmacy*, 5(4): 87-88.

Janssen, T. L., van Dijk, M., Al Malki, I. and van As, A. B. 2013. Management of physical child abuse in South Africa: literature review and children's hospital data analysis. *Paediatrics and International Child Health*, 33 (4): 216-227

Jelsma, J. and Clow, S. 2005. Ethical issues relating to qualitative research. South African Journal of Physiotherapy, 61(1): 3-6. Available: https://sajp.co.za/index.php/sajp/article/view/165 (Accessed 3 October 2019)

Jennings, C. and Astin F. 2017.A multidisciplinary approach to prevention. *European Journal of Preventitive Cardiology*, 24(Suppl 3) :77-87. Available: https://journals.sagepub.com/doi/10.1177/2047487317709118?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed (Accessed: 4 November 2018).

Jones, B. L., Walsh, C. and Phillips, F. 2019. Social Work With Children and Adolescents With Medical Conditions. In: Gehlert, S. and Browne, T. eds. *Handbook of health social work*. 3rd ed. Hoboken: John Wiley & Sons.

Jungner, J. G., Tiselius, E., Wenemark, M., Blomgren, K., Lutzen, K. and Pergert, P. 2018. Development and evaluation of the Communication over Language Barriers questionnaire (CoLB-q) in paediatric healthcare.*Patient Education and Counseling,* 101(9) :1661–1668. Available: https://www.sciencedirect.com/science/article/pii/S0738399118301861?via%3Dihub (Accessed: 23 February 2019).

Jurgens, V., Spaeder, M. C., Pavuluri, P. and Waldman, Z. 2013. Hospital Readmission in Children With Complex Chronic Conditions Discharged from Subacute Care. *Journal of the American Academy of Pediatrics*, 4(3): 153-158

Kallio, H., Pietilä, A.M., Johnson, M. and Kangasniemi, M. 2016. Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, 72(12): 2954-2965. Available: https://onlinelibrary.wiley.com/doi/abs/10.1111/jan.13031 (Accessed 4 September 2018)

Kaytez, N. 2018.Child and Game in Hospital. In: Alexandrova, E., Shapekova, N. L., Ak, B. and Ozcanaslan, F. eds. Health Science Research in the globalizing world. Sofia. St. Kliment Ohridski University Press
Sofia. Page no

Kazemi, S., Kazemi, S., Ghazimoghaddam, K., Besharat, S. and Kashani, L. 2012. Music and Anxiety in Hospitalized Children.*Journal of Clinical and Diagnostic Research*, 6(1): 94-96

Kelo, M. Martikainen, M. and Eriksson, E. 2013.Patient Education of Children and Their Families: Nurses' Experiences. *Pediatric Nursing*, 39(2):71-79

Khan, R. and Qureshi, M. S. H. 2018.The Three Dimensions of Health and Well Being.*Journal of Community Medicine and Health Education*, 8(1): 586

Kinjal, P., Suresh, V. and Ravindra, H.N. 2014.A study to assess the effectiveness of play therapy on anxiety among hospitalized children.*Journal of Nursing and Health Science,* 3(5): 17-23

Kinney, H. and Mueller, E. 2018.Medical art therapy .*Masters*, Loyola Marymount University and Loyola Law School.

Kiran, S. D. P., Vithalani, A., Sharma, D. J., Patel, M. C., Bhatt, R. and Srivastava, M. 2018. Evaluation of the Efficacy of Play Therapy among Children Undergoing Dental Procedure through Drawings Assessed by Graphological Method: A Clinical Study. *International Journal of Clinical Pediatric Dentistry*,11(5): 412-416

Kitto, S. C., Chesters, J. and Grbich, C. 2008. Quality in qualitative research: Criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia. *Medical Journal of Australia*, 188(4): 243-246

Koen, V., Ryke, E. H., Watson, M. J., and Van Eeden, E. S. 2017.Community caregivers' perspectives of community well-being in a mining community.Health SA Gesondheid, 22: 316-324. Available: https://www.researchgate.net/publication/324638241_Community_caregivers'_perspectives_of_community_well-being_in_a_mining_community (Accessed: 5 September 2020).

Koenig, H.G. 2012. Religion, Spirituality, and Health: The Research and Clinical Implications.*International Scholarly Research Network Psychiatry*, 2012: 1-33.

Konstantynowicz, J., Marcinowicz, L., Abramowicz, P. and Abramowicz, M. 2016. What Do Children with Chronic Diseases and Their Parents Think About Pediatricians? A Qualitative Interview Study.*Maternal and Child Health Journal*: 1745–1752

Koohan, E., Yousofian, S., Rajabi, G. and Zare-Farashbandi, F. 2019. Health information needs of families at childhood cancer: A qualitative study. *Journal of Education and Health Promotion*, 8(1): 1-10

Koolaee, A. K., Vazifehdar, R., Bahari, F. and Akbari, M. E .2016.Impact of painting therapy on aggression and anxiety of children with cancer.*Caspian Journal of Pediatrics,* 2(2): 135-141

Korstjens, I. and Moser, A. 2017.Series: Practical guidance to Qualitative research: Part 4: Trustworthiness and publishing. The European journal of general practice 24(1):1-5

Kosta, L., Harms, L., Franich-Ray, C., Anderson, V., Northam, E., Cochrane, A., Menaham, S. and Jordan, B. 2015.Parental experiences of their infant's hospitalization for cardiac surgery. *Child: care, health and development*, 41(6): 1057-1065

Koukourikos, K., Tzeha, L., Pantelidou, P. and Tsaloglidou, A. 2015.The Importance of Play during hospitalization of children. *Mater Sociomed*, 27(6): 438-441

Krebs, K. 2001. The spiritual aspect of caring- an integral part of health and healing. Nursing Administration Quarterly, 25 (3): 55-60

Krueger, M. 2007. Four Areas of Support for Child and Youth Care Workers. *Families in Society: The Journal of Contemporary Social Services,* 88(2): 233-240

Kvarfordt, C. L. and Herba, K. 2017. Religion and Spirituality in Social Work Practice with Children and Adolescents: A Survey of Canadian Practitioners. *Child and Adolescent Social Work Journal,* 35(2): 153-167

Kvarfordt, C.L. and Sheridan, M. J. 2010.Understanding the pathways of factors influencing the use of spiritually based interventions.*Journal of Social Work Education*, 45(3): 385-405

Kyeyagalire, R., Tempia, S., Cohen, A. L., Smith, A. D., McAnerney, J. M., Dermaux-Msimang, V. and Cohen, C. 2014.Hospitalizations associated with influenza and respiratory syncytial virus among patients attending a network of private hospitals in South Africa, 2007 2012.*BMC Infectious Diseases*, 14:1-10 http://www.biomedcentral.com/1471-2334/14/694 (Accessed: 24 May 2018)

Kumar, R. 2005. *Research Methodology: A step-by-step guide for beginners.* 2nded. London: SAGE Publications Ltd

Lander, L., Howsare, J. and Byrne, M. 2013. The Impact of Substance Use Disorders on Families and Children: From Theory to Practice. *Social Work Public Health*, 28(0):194-205

Ledesma, J. 2014. Conceptual Frameworks and Research Models on Resilience in Leadership.*SAGE Open*, July-September: 1–8. Available: doi: 10.1177/2158244014545464 (Accessed: 16 August 2020)

Lerwick, J. L. 2016. Minimizing pediatric healthcare-induced anxiety and trauma.*World Journal of Clinical Pediatrics,* 5(2): 143-150.

Leventhal, J. M., Gaither, J. R. and Sege, R. 2014.Hospitalizations Due to Firearm Injuries in Children and Adolescents.*Pediatrics*. 133 (2): 219-225

Li, W. H. C., Chan, S. S. C., Wong, E. M. L., Kwok, M. C. and Lee, I. T. L. 2014. Effect of therapeutic play on pre- and postoperative anxiety and emotional responses in Hong Kong Chinese children: a randomised controlled trial. *Hong Kong Medical Journal*, 20 (Suppl. 7): 36-39

Li, W. H. C., Chung, J. O. K., Ho, K. Y. and Kwok, B. M. C. 2016. Play interventions to reduce anxiety and negative emotions in hospitalized children. *BMC Pediatrics*, 16: 1-9.

Lifson, L. F., Hadley, G. P., Wiles, N. L. and Pillay, K. 2016. Nutritional status of children with Wilms' tumour on admission to a South African hospital and its influence on outcome. *Pediatric Blood and Cancer*, 64(7): 1-8

Limon, E. 2018. Challenges medical social workers face that lead to burnout. Masters, California State University. Available: https://scholarworks.lib.csusb.edu/cgi/viewcontent.cgi?article=1740&context=etd (Accessed 1 May 2019)

Links, A. R., Callon, W., Wasserman, C., Walsh, J., Beach, M. C. and Boss, E. F. 2019.Surgeon Use of Medical Jargon with Parents in the Outpatient Setting, 102(6): 1-19

Litke, J., Pikulska, A. and Wegner, T. 2012. Management of perioperative stress in children and parents: Part I - The preoperative period. Anaesthesiology Intensive Therapy, 44(3): 165–169

Lopez-Bushnell and Berg, 2018.Effects of Art Experience on Hospitalized Pediatric Patients. Mathews Journal of Pediatrics, 3(1): 1-8

Luxon L. 2015. Infrastructure - the key to healthcare improvement. *Future hospital journal*, *2*(1): 4–7.

Lyu, Q., Kong, S. K. F., Wong, F.K.Y., and You, L. 2015. Validation of Hospitalization Impact Scale among families with children hospitalized for cancer treatment. *Journal of Advanced Nursing*, 71(8): 1958–1969.

McGrath, C., Palmgren, P. J. and Liljedah, M. 2018. Twelve tips for conducting qualitative research Interviews. Medical Teacher, 41(9): 1-6

McNatt, Z., Boothby, M., Wessells, N. and Lo, R. 2018. Psychosocial Support: Facilitating psychosocial wellbeing and social and emotional learning. New York. INEE

MacAllister, L., Bellanti, D., and Sakallaris, B. R. 2016.Exploring Inpatients' Experiences of Healing and Healing Spaces: A Mixed Methods Study.*Journal of Patient Experience*, 3(4): 119-130

MacArthur, J., Rawana, E. P. and Brownlee, K. 2011. Implementation of a Strengths-Based Approach in the Practice of Child and Youth Care.*Relational Child and Youth Care Practice,* 24(30): 1-16

McCaffrey, T., Edward, J. and Fanon, D. 2011. Is there a role for music therapy in the recovery approach in mental health?.*The Arts of Psychotherapy*, 38(3): 185-189. Available: https://www.sciencedirect.com/science/article/abs/pii/S0197455611000438?via%3Dihub (Accessed: 30 September 2020).

Madisha, L., Mabuela, B., Mohlabi, R., Shiba, A. D., Mabaso, N., Moodley, V., Tshitaudzi, G. and Sithole, J. 2016. Psychosocial support (PSS) for children and adolescents infected and affected by hiv: 1-23. Available: https://www.childlinesa.org.za/wp-content/uploads/psychological-support-for-youth-infected-and-affected-by-hiv.pdf (Accessed: 15 September 2019).

Maguire, M. and Delahunt, B. 2017.Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars.*AISHE*, 3:3351-33514

Manyisa, Z. M. and van Aswegen, E. J. 2017. Factors affecting working conditions in public hospitals: A literature review. *International Journal of Africa Nursing Sciences*, 6: 28-38.

Maphumulo, W. T. and Bhengu, B. R. 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1): 1-9

Marais, B. J. and Schaaf, H. S. 2014.Tuberculosis in Children.*Cold Spring Harbor Perspective in Medicine*, 10(8): 1-21

Martins, A. K. L., da Silva, R. G., Fernandes, C. M., e Souza, A. M. A., Vieria, N. F. C. 2016. Effects of clown therapy in the child's hospitalization process.*Journal of Research Fundamental Care*, 8(1): 3968-3978

Masten, S. 2018. Resilience theory and research on children and families: Past, present and promise. *Journal of family theory and review,* March: 12-31.

Matziou, V., Boutopoulou, B., Chrysostomou, A., Vlachioti, E., Mantziou, T. and Petsios, K. 2011. Parents' satisfaction concerning their child's hospital carej.*Japan Journal of Nursing Science,* 8(2): 163–173

Matziou,V., Vlachioti, E., Megapanou, E., Ntoumou, A., Dionisakopoulou, C., Dimitriou, V., Tsoumakas, K., Matziou, T. and Perdikaris, P. 2016. Perceptions of children and their parents about the pain experienced during their hospitalization
and its impact on parents' quality of life. *Japanese Journal of Clinical Oncology*, 46(9): 862–870

Mayosi, B. M., Phil, D. and Benatar, S. R. 2014.Health and Health Care in South Africa - 20 Years after Mandela.*The New England Journal of Medicine*, October: 1344-1353.

Mendelev, E. M., Mazumdar, M., Keefer, L. and Gorbenko, K. 2019. Physicians as Advisors Not Leaders of Multidisciplinary Teams: A Qualitative Study of an Innovative Practice. *Crohn's & Colitis 360* , 1 (3): 1-6.

Metze, R. N., Abma, T. A. and Kwekkeboom, R. H. 2015. Family Group Conferencing: A Theoretical Underpinning. *Health Care Analysis,* 23:165–180

Metzl, E., Morrell, M. and Field, A. 2016. A Pilot Outcome Study of Art Therapy and Music Therapy With Hospitalized Children (Étude pilote des résultats de l'artthérapie et de la musicothérapie auprès d'enfants hospitalisés). *Canadian Art Therapy Association Journal,*29(1): 3-11. Available:

https://www.tandfonline.com/doi/full/10.1080/08322473.2016.1170496 (Accessed: 3 May 2020).

Minardi, G., Minacapelli, R., Valastro, P., Vasile, S., Pitino, F., Pavone, P., Astuto, M. and Murabito, P. 2019. Epilepsy in Children: From Diagnosis to Treatment with Focus on Emergency. *Journal of Clinical Medicine*, 8(1): 1-10

Miseda, M. H., Were, S. O., Murianki, C. A., Mutuku, M. P. and Mutwiwa, S. N. 2017. The implication of the shortage of health workforce specialist on universal health coverage in Kenya.*Human Resources for Health*, 15(1): 1-7

Mitchell, R. J., Bambach, M. R., Foster, K. and Curtis K. 2015. Risk factors associated with the severity of injury outcome for paediatric road trauma. *International Journal of the Care of the Injured*: 1-9.

Modisakeng, C., Matlala, M., Godman, B. and Meyer, J. C. 2020.Medicine shortages and challenges with the procurement process among public sector hospitals in South Africa, findings and implications. *BMC Health Services Research*, 20(1): 1-10

Molepo, L. and Delport, C. S. L. 2015. Professional challenges experienced by child and youth care workers in South Africa. *Children and Youth Services Review*, 56: 149-160

Moore, K., Talwar, V. and Moxley-Haegert, L. 2015. Definitional ceremonies: narrative practices for psychologists to inform interdisciplinary teams' understanding of children's spirituality in pediatric settings. *Journal of Health Psychology*, 20(3): 259-272. Available: https://www.researchgate.net/publication/273467202_Definitional_ceremonies_Narrative_practices_for_psychologists_to_inform_interdisciplinary_teams'_understanding_of_children's_spirituality_in_pediatric_settings (Accessed: 12 January 2020).

Morgado, M. A., Jalles, F., Lobon, S., Abecasis, F. and Gonçalves, M. 2017.Road Traffic Injuries and Road Safety Measures-Can We Do Any Better?.*Pediatrics and Therapeutics*, 7(2): 1-5

Mountain 2016.Play Therapy – respecting the spirit of the child. *International Journal of Children's Spirituality*, 21(3-4): 1-10

Muzicant, A. and Peled, E. 2017. Home Visits in Social Work: From Disembodiment to Embodied Presence.*British Journal of Social Work*, 48(3): 1-17

Nabors, S. and Kichler, J. eds. 2016. *Handbook of Play Therapy.* 2nd ed. Hoboken: John Wiley & Sons

Nahar, B., Hamadani, J. D., Ahmed, T., Tofail, F., Rahman, A., Huda, S. N. and Grantham-Mcgregor, S. 2009. Effects of psychosocial stimulation on growth and development of severely malnourished children in a nutrition unit in Bangladesh. *European Journal of Clinical Nutrition*, 63(6):725-731. Available: https://www.researchgate.net/publication/23238979_Effects_of_psychosocial_stimulation_on_growth_and_development_of_severely_malnourished_children_in_a_nutrition_unit_in_Bangladesh (Accessed 15 February 2019).

Naicker, S., Plange-Rhule, J., Tutt, R. C. and Eastwood, J. B. 2009.Shortage of healthcare workers in developing countries--Africa. *Ethnicity and Disease*.19(Suppl 1): S1-64. Available: https://pubmed.ncbi.nlm.nih.gov/19484878/ (Accessed: 3 February 2019).

Naldan, M. E., Karayagmurlu, A., Ahiskalioglu, E. O., Cevizci, M. N., Aydin, P. and Kara, D. 2018. Is surgery a risk factor for separation anxiety in children?.*Pediatric Surgery International*, 34: 763–767

Nascimento, L. C., Alvarenga, W. A., Caldeira, S., Mica, T. M., Oliveira, F. C. S., Pan, R., Santos, T. F. M., Carvalho, E. C. and Vieira, M. 2016.Spiritual Care: The Nurses' Experiences in the Pediatric Intensive Care Unit. *Religions*, *7*(3): 1-11

Nassery, W. and Landgren, K. 2018. Parents' Experience of Their Sleep and Rest

When Admitted to Hospital with Their Ill Child: A Qualitative Study. *Comprehensive Child and Adolescent Nursing*, 42(4): 265-279.

Nickel, B., Barrat, A., Copp, T., Moyinhan, R. and McCaffery, K. 2016.Words do matter: a systematic review on how different terminology for the same condition influences management preferences. BMJ Open, 7(7): 1-12

Nijhof, S. L., Vinkers, C. H., van Geelen, S. M., Duijff, S. N., Achterberg, E. J. M., van der Net J., Veltkamp, R. C., Grootenhuis, M. A., van de Putte, E. M., Hillegers, M. H. J., van der Brug, A. W., Wierenga, C. J., Benders, M. J. N. L., Engels, R. C. M. E, van der Ent, C. K., Vanderschuren, L. J. M. J. and Lesscher, H. M. B. 2018. Healthy play, better coping: The importance of play for the development of children in health and disease. *Neuroscience and Biobehavioral Reviews*, 95: 421 -429. Available: https://www.sciencedirect.com/science/article/pii/S0149763418305116 (Accessed 1 November 2019).

Nita, M. 2019. 'Spirituality' in Health Studies: Competing Spiritualities and the Elevated Status of Mindfulness. *Journal of Religion and Health* , 58(5): 1605–1618

Nowell, L. S., Norris, J. M., White, D. E., and Moules, N. J. 2017. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16:1-13.

Obaid, K. B. 2015. Psychosocial Impact of Hospitalization on Ill Children in Pediatric Oncology Wards.*IOSR Journal of Nursing and Health Science,* 4(3): 72-78.

Owolabi, A. K., Mhlongo, T. P. and Evans, N. 2016.The status and challenges of clinical informatics development in South Africa.*Inkanyiso, Journal of Human and Social Sciences*, 8(2): 125-135

Ritchie, J., Lewis, J., Nicholls, C. M. and Ormston, R. eds. 2013 *Qualitative research practice: a guide for social science students and researchers*. London: SAGE.

Paavilainen, E., Salminen-Tuomaala, M. and Leikola, P. 2012. Counselling for Patients and Family Members: A Follow-Up Study in the Emergency Department.*International Scholarly Research Network Nursing*, 2012:1-7. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3447345/ (Accessed: 3 February 2019).

Pandaya, S. P. 2016. Hospital Social Work and Spirituality: Views of Medical Social Workers. *Social Work in Public Health* 31(7): 700–710

Panicker, L. 2013.Nurses' perceptions of parent empowerment in chronic illness.*Contemporary Nurse*, 45(2): 210–219.

Parast, S. M. and Allaii, B. 2014.The Role of Social Work in Health Care System.*Journal of Social Science for Policy Implications, 2(2): 59-68.*

Park, C. L., Smith, P. H., Lee, S. Y., Mazure, C. M., McKee, S. A., and Hoff, R. 2017. Positive and Negative Religious/Spiritual Coping and Combat Exposure as Predictors of Posttraumatic Stress and Perceived Growth in Iraq and Afghanistan Veterans, *Psycholog Relig Spiritual*. 2017, 9(1): 1-19.

Parsapour, K., Kon, A. A., Dharmar, M., McCarthy, A. K., Yang, H., Smith, A. C., Carpenter, J., Sadorra, C. K., Farbstein, A. D., Hojman, N. M., Wold, G. L. and Marcin, J. P. 2011. Connecting Hospitalized Patients with Their Families: Case Series and Commentary. *International Journal of Telemedicine and Applications,* 2011: 1-7. Available: https://www.hindawi.com/journals/ijta/2011/804254/ (Accessed: 5 May 2019).

Pathak, V., Jena, B. and Kalra, S. 2013.Qualitative research. *Perspectives in Clinical Research*, 4(3): 192-192. Available: http://www.picronline.org/article.asp?issn=2229-3485;year=2013;volume=4;issue=3;spage=192;epage=192;aulast=Pathak (Accessed: 15 March 2019)

Patriksson, K., Nilsson, S. and Wigert, H. 2019. Immigrant parents' experiences of communicating with healthcare professionals at the neonatal unit: An interview study. Journal of Neonatal Nursing, 25(4): 1-6. Available: https://www.sciencedirect.com/science/article/abs/pii/S1355184118301340 (13 July 2018).

Phelan, J. 2009. Child and youth care family support Work. *CYC-Online*, February. Available: https://www.cyc-net.org/cyc-online/cyconline-feb2009-phelanchapter.html (Accessed: 22 June 2020).

Pidgeon, K., Parson, J., Mora, L., Anderson, J., Stagnitti, K. and Mountain, V. 2015.Play Therapy.In: Noble, C. and Day, E. eds. *Psychotherapy and Counselling: Reflections on Practice*. Australia: Oxford University Press

Pillay-van Wyk, V., Msemburi, W., Laubscher, R., Dorrington, R. E., Groenewald, P., Glass, T., Nojilana, B., Joubert, J. D., Matzopoulos, R., Prinsloo, M., Nannan, N., Gwebushe, N., Vos, T., Somdyala, N., Sithole, N., Neethling, I., Nicol, E., Rossouw, A., and Bradshaw, D. 2016. Mortality trends and differentials in South Africa from 1997 to 2012: Second National Burden of Disease Study. *Lancet Global Health*, 4: 642–653

Pless, S., Van Hootegem, G. and Dessers, E. 2018. Advancing a Systemic Perspective on Multidisciplinary Teams: A Comparative Case Study of Work Organisation in Four Multiple Sclerosis Hospitals.*International Journal of Integrated Care*, 18(3): 1–10

Pufall, E. L., Nyamukapa, C., Eaton, J. W., Mutsindiri, R., Chawira, G., Munyati, S., Robertson, L. and Gregson, S. 2014. HIV in Children in a General Population Sample in East Zimbabwe: Prevalence, Causes and Effects. *Plos One*, 9(11): 1-7

Racco, A. 2009.What is strength-based child and youth care anyway?.*CYC-Online*, September. Available: https://www.cyc-net.org/cyc-online/cyconline-sep2009-racca.html (Accessed: 22 June 2020).

Racine, N. M., Smith, A., Pelletier, W., Scott-Lane, L., Guilcher, G. M. T. and Schulte, F. 2018. Evaluation of a Support Group for Parents of Children Hospitalized for Cancer and Hematopoietic Stem Cell Transplantation. *Social Work with Groups*, 41(4): 276-290. Available: https://www.tandfonline.com/doi/full/10.1080/01609513.2017.1356799?scroll=top&needAccess=true (Accessed: 11 October 2019)

Rahi, S. 2017. Research Design and Methods: A Systematic Review of Research Paradigms, Sampling Issues and Instruments Development. *International Journal of Economics & Management Sciences*, 6(2): 1-5

Ramos, N. and Chavez, J. 2019. Factors of resistance: spirituality and religion in Social Work Practice. *Masters*, California State University. Available: https://scholarworks.lib.csusb.edu/cgi/viewcontent.cgi?article=1979&context=etd (Accessed 29 January 2020)

Ramsdell, K. D., Morrison, M., Kassam-Adams, N., & Marsac, M. L. 2016. A Qualitative Analysis of Children's Emotional Reactions During Hospitalization Following Injury. *Journal of trauma nursing : the official journal of the Society of Trauma Nurses*, 23(4): 1-13.

Ranchod, S., Adams, C., Burger, R., Carvounes, A., Dreyer, K., Smith, A., Stewart, J. and van Biljon, C. 2017. South Africa's hospital sector: old divisions and new developments. *South African Health Review*, 2017 (1): 101-110.

Ramos, S. R. T. S. 2014. Toys in playrooms as a source of pathogenic microorganisms for hospital infections (Toys from hospital playrooms as a source of pathogens in nosocomial infections). *Revista paulista de pediatria: official body of the Sociedade de Pediatria de Sao Paulo* , 32 (3): 149–150. Available: https://www.scielo.br/pdf/rpp/v32n3/en_0103-0582-rpp-32-03-0149.pdf (Accessed: 8 June 2019).

Ray, R., Mahapatro, S. and Kar, S. S. 2011.Adolescent Counseling.*Indian Journal of Clinical Practice,* 22(3):117-119. Available: https://www.researchgate.net/publication/277892824_Adolescent_Counseling (Accessed: 12 March 2020).

Reid-Searl, K., Quinney, L., Dwyer, T., Vieth, L., Nancarrow, L. and Walker, B. 2017. Puppets in an acute paediatric unit: Nurse's experiences. *Collegian*, 24(5): 441-447. Available: https://www.sciencedirect.com/science/article/pii/S1322769616300920 (Accessed: 8 June 2019)

Reiter, B. 2017.Theory and Methodology of Exploratory Social Science Research. *International Journal of Science and Research Methodology*, 5(4): 129-150

Rero, A., Aipit, A., Yarong-Kote, T., Watch, V., Bolnga, J. W. Vei, R., Morris, R., Lufele, M. and Laman, E. 2016. The Burden of Child Maltreatment Leading to Hospitalization in a Provincial Setting in Papua New Guinea.*Journal of Tropical Pediatrics*, 62: 282–287

Roberts, C. A. 2012. Nurses' Perceptions of Unaccompanied Hospitalized Children.*Pediatric Nursing,* 38(3): 133-136

Reynolds, N., Mrug, S., Hensler, M., Guion, K. and Madan-Swain, A. 2013. Spiritual Coping and Adjustment in Adolescents With Chronic Illness: A 2-Year Prospective Study. *Journal of Pediatric Psychology*, 39(5): 542-51

Rodgers, C. C., Stegenga, K., Withycombe, J. S., Sachse, K. and Kelly, K. P. 2016. Processing Information After a Child's Cancer Diagnosis—How Parents Learn: A Report From the Children's Oncology Group. *Journal of Pediatric Oncology Nursing,*, 33(6): 447–459

Rokach, A. 2016.Psychological, emotional and physical experiences of hospitalized children. 2(4): 399-401.

Rodriguez-Rey, R., Alonso-Tapia, J. and Colville, G. 2018.Prediction of parental posttraumatic stress, anxiety and depression after a child's critical hospitalization.*Journal of Critical Care*, 45:149-155

Rosell, L., Alexandersson, N., Haggerberg, O. and Nilbert, M. 2018. Benefits, barriers and opinions on multidisciplinary team meetings: a survey in Swedish cancer care. *BMC Health Services Research*, 18(1): 1-10

Ruskin, D. A., Gagnon, M. M., Kohut, S. A., Stinson, J. N. and Walker, K. 2017. A Mindfulness Program Adapted for Adolescents With Chronic Pain: Feasibility, Acceptability, and Initial Outcomes. *Clinical Journal of Pain*, 33(11): 1-18

Russell, B., Oh, S. and Taylor, D.D. 2019. Integration of Adlerian Play Therapy in Pediatric Hospitals.*Journal of Child and Adolescent Counseling*, 5(1): 1-13

Ruth, B. J. and Marshall, J. W. 2017.A History of Social Work in Public Health.*Public Health Then and Now*, 104(Suppl. 4): 1-7

Ryan, F., Coughlan, M. and Cronin, P. 2016. Interviewing in Qualitative Research: The one-to-one interview. International Journal of Therapy and Rehabilitation, 16(6): 309-314

Sackett, C., Lawson, G. and Burge, P. 2012. Meaningful Experiences in the Counseling Process.*The Professional Counselor*, 2(3): 208–225

Saint-Pierre, C., Herskovic, V. and Sepulvida, M. 2018.Multidisciplinary collaboration in primary care: a systematic review. *Family Practice*, 35 (2): 132–141

Salmela, M., Salantera, S. and Aronen, E. 2009. Child- Reported Hospital Fears In 4 to 6-Year-Old Children.*Pediatric Nursing,* 35(5): 269-303.

Sanders, J. 2013. The Use of Art in Therapy: An Exploratory Study.*Masters*, St. Catherine University and the University of St. Thomas. Available: https://sophia.stkate.edu/cgi/viewcontent.cgi?article=1259&context=msw_papers (Accessed: 30 August 2018).

Sarantakos, S. 2005. *Social Research*. 3rded. New York: Palgrave Macmillan

Sasu, C., Ciutan, M. and Musat, S. 2019.The most frequent hospitalization episodes in children with tumors, in romania, in the last 5 years. Management in health, 23(1): 17-25. Available: http://journal.managementinhealth.com/index.php/rms/article/viewFile/535/1331 (Accessed: 27 March 2019).

Savina, E., Simon, J. and Lester, M. 2014. School Reintegration Following Psychiatric Hospitalization: An Ecological Perspective*. Child Youth Care Forum*, 43(6): 1-18

Schadewald, A., Kimball, E. and Ou, L. 2018.Coping Strategies, Stress, and Support Needs in Caregivers of Children with Mucopolysaccharidosis. In: Morava E., Baumgartner M., Patterson M., Rahman S., Zschocke J., Peters V. (eds) JIMD Reports. Berlin, Heidelberg: Springer.

Sileyew, K. J. 2019. Research Design and Methodology.In book: Research Design and Methodology. Intechopen: 1-12

Silva, M. S., Pinto, M. A, Gomez, L. M. X. and Barbosa, T. L. A. 2011.
Pain in hospitalized children: nursing team perception. *SciELO*, 12(4): 314-20

Shafiee, S. M., Gharibvand, S. S. and Hemmatipour, A. 2018.The Effectiveness of Storytelling on Separation Anxiety in Hospitalized Children with Chronic Diseases.*Journal of Research in Medical and Dental Science*, 6(5): 284-290

Shah, A. A. and Othman, A. 2013.Hospitalization, Later Onset of the Disease, and Psychological Problems of Chronically Ill Children.*Sage*, October-December: 1–10

Sharma, G. 2017. Pros and cons of different sampling techniques.*International Journal of Applied Research*, 3(7): 749-752

Şahin, O. O. and Topan, A. 2018.Investigation of the Fear of 7–18-Year-Old Hospitalized Children for Illness and Hospital.*Journal of Religion and Health*, 58(3): 1011-1023

Shilling, V., Morris, C., Thompson-Coon, J., Ukoumunne, O., Rogers, M. and Logan, T. 2013. Peer support for parents of children with chronic disabling conditions: a systematic review of quantitative and qualitative studies, *Developmental Medicine & Child Neurology, 55(7): 602-609*

Showkat, N. and Parveen, H. 2017. *Non-probability and probability sampling*. Available: https://www.researchgate.net/publication/319066480 (Accessed 8 April 2019)

Shrinivasa, B., Bukhari, M., Ragesh, G. and Hamza, A. 2019.Therapeutic intervention for children through play: An overview. Archives of Mental Health, 19(2): 82-89

Siegel, J., Iida, H., Rachlin, K. and Yount, G. 2015. Expressive Arts Therapy with Hospitalized Children: A Pilot Study of Co-Creating Healing Sock Creatures. Journal of Pediatric Nursing, 31(1): 1-7

Silverman, S. 2014. *Interpreting qualitative data* 4th ed. Great Britain: SAGE Publications Ltd.

Silverman, S. 2005. *Doing Qualitative Research*.4th ed. Great Britain: SAGE Publications Ltd..

Smith, A. B., Hefley, C. G. and Anand, K. J. S. 2007. Parent Bed Spaces in the PICU: Effect on Parental Stress. Pediatric Nursing, 33(3): 215-221

Simao, T. P., Caldeira, S. and de Carvalho, E. C. 2016.The Effect of Prayer on Patients' Health: Systematic Literature Review. *Religions*, 7(1):1-11

Snyder, H. 2019. Literature review as a research methodology: An overview and guidelines. *Journal of Business Research*, 104: 333-339.

Soomar, N., Mthembu, T. and Ramugondo, E. 2018.Spirituality in occupational therapy.*South African Journal of Occupational Therapy*, 48(3): 64-65

South Africa, Department of Social Development. 2006. No. 38 of 2005: Children's Act, 2005. Government Gazette 28944: 19 June. Cape Town. Available: https://www.gov.za/sites/default/files/gcis_document/201409/a38-053.pdf (Accessed: 3 July 2018).

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C. and Yehuda, R. 2014.Resilience definitions, theory, and challenges:Interdisciplinary perspectives. *European Journal of Psychotraumatology*, 5(1): 1-14

Sposito, A. M. P., Silva-Rodrigues, F. M., Sparapani, V. C., Pfeifer, L. L., de Lima, R. A. G. and Nascimento,L. C. 2014. Coping Strategies Used by Hospitalized Children With Cancer Undergoing Chemotherapy. *Journal of Nursing Scholarship*, 47(2): 143-151

Srivastava, K. 2011. Positive mental health and its relationship with resilience. *Industrial Psychiatry Journal*, 20(2): 75-76.

Shrivastava, S., Shrivastava, P. and Ramasamy, J. 2020.Roping-in religious leaders and faith experts in the effective containment of the coronavirus disease-2019 pandemic.*International Journal of Health System and Disaster Management,* 3(3): 130-131.Available: http://www.shbonweb.com/article.asp?issn=2589-9767;year=2020;volume=3;issue=3;spage=130;epage=131;aulast=Shrivastava (Accessed 11 June 2020).

Stanley, R. M., Bonsu, B. K., Zhao, W., Ehrlich, P. F., Rogers, A. J. and Xiang, H. 2012. US Estimates of Hospitalized Children with Severe Traumatic Brain Injury: Implications for Clinical Trials. *Pediatrics*, 129(1): 24-30. Available: https://pediatrics.aappublications.org/content/129/1/e24.long (Accessed: 04 February 2020).

Stegemann, T., Geretsgger, M., Quoc, E. P., Riedl, H. and Smetana, M. 2019.Music Therapy and Other Music-Based Interventions in Pediatric Health Care: An Overview. *Medicines*, 6(1): 1-12.

Stone, L. L., Otten, R., Soenens, B., Engels, R. C. M. E., and Janssens, J .M. A. M. 2015. Relations Between Parental and Child Separation Anxiety: The Role of Dependency-Oriented Psychological Control. *Journal of Child and Family Studies,* 24:3192–3199.

Stremler, R., Haddad, S., Pullenayegum, E. and Parshuram, C. 2017.Psychological Outcomes in Parents of Critically Ill Hospitalized Children.*Journal of Pediatric Nursing*, 34:36-43.

Sukhodolsky, D. G., Bloch, M. G., Panza, K. E. and Reichow, B. 2013. Cognitive-Behavioral Therapy for Anxiety in Children With High-Functioning Autism: A Meta-analysis. *Pediatrics*, 132(5): 1341-1350.

Sutton, J. and Austin, Z. 2015. Qualitative Research: Data Collection, Analysis, and Management. *The Canadian Journal of Hospital Pharmacy*, 68(3): 226-231.

Svalastog, A. L., Donev, D., Kristoffersen, N. J. and Gajović, S. 2017. Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society.*Croatian Medical Journal*, 58(6): 431-435.

Swarbrick, M. and Yudof, J. 2015. *Wellness in the 8 dimensions*. Available: https://www.researchgate.net/publication/299127407 (Accessed: 12 June 2020).

Tabei, S. Z., Zarei, N. and Joulaei, H. 2016. The Impact of Spirituality on Health.*Shiraz E-Medical journal*, 17(6): 1-6.

Tehrani, T. H., Haghighi, M., Bazmamoun, H. 2012.Effects of Stress on Mothers of Hospitalized Children in a Hospital in Iran.*Iran Journal of Child Neurology*, 6(4): 39-45.

Temesgen, H. 2016. Social Work Practice: Roles and Challenges of Social Workers in Selected Public Hospitals in Addis Ababa.*Masters*, Addis Ababa University. Available: http://etd.aau.edu.et/bitstream/handle/123456789/1800/Hiwot%20Temesgen.pdf?sequence=1&isAllowed=y (Accessed: 27 May 2019).

ter Meulen, E. W., Poley, M. J., van Dijk, M., Rogers, A. D. andRode, H. 2016. The hospital costs associated with acute paediatric burn injuries. *South African Medical Journal*, 106(11):1120-1124.

Therivel, J. and Schub, T. 2019. Spiritual Care: Providing to Children and their Families: What Is Providing Spiritual Care to Children and Their Families?: 1-7. Available: https://www.ebscohost.com/assets-sample-content/SWRC-Spiritual-Care-Providing-to-Clildren-Families-Practice-Skill.pdf (Accessed: 2 February 2020).

Thesen, E. J. 2014. Challenges faced by child and youth care workers with regard to discipline of children with challenging behaviour in residential child and youth care centre. *Masters*.University of the Western Cape. Available: http://www.naccw.org.za/images/PDFs/Conference_Presentations/Eddie_Thesen_1.pdf (Accessed: 7 March 2020).

Thurman, T. R., Taylor, T. M., Nice, J., Luckett, B., Taylor, M. and Kvalsvig, J. D. 2018. Factors associated with retention intentions among Isibindi child and youth care workers in South Africa: results from a national survey*. Human Resources for Health*, 16(1): 1-7

Torio, C. M., Encinosa, W., Berdahl, T., McCormick, M. C. and Simpson, L. A. 2015 Annual Report on Health Care for Children and Youth in the United States: National Estimates of Cost, Utilization and Expenditures for Children With Mental Health Conditions. *Academic Pediatrics*, 15(1): 19-35.

Trivedi, M. and Denton, E. 2019. Asthma in Children and Adults: What Are the Differences and What Can They Tell us About Asthma?.*Frontiers in Pediatrics*, 7: 1-15

Troyer, J. A., Tost, J. R., Yoshimura, M., LaFontaine, S. D. and Mabie, A. R. 2012. Teaching Students How to Meditate Can Improve Level ofConsciousness and Problem Solving Ability. Procedia - Social and Behavioral Sciences, 69: 153 – 161. Available:

https://www.sciencedirect.com/science/article/pii/S1877042812053803 (Accessed: 4 February 2020).

Trudel-Fitzgerald, C., Millstein, R., von Hippel, R. A, Howe, C. J., Tomasso, L. P., Wagner, G. R. and VanderWeele, T. J. 2019. Psychological well-being as part of the public health debate? Insight into dimensions, interventions, and policy.*BMC Public Health*, 19(1): 1-11.

Tyler, M. C., Wehby, G. L., Robbins, J. M. and Damiano, P. C. 2013. Separation Anxiety in Children Ages 4 through 9 with Oral Clefts. *Cleft Palate Craniofac Journal*, 50(5): 520-527. Available: https://ppc.uiowa.edu/publications/separation-anxiety-children-ages-4-through-9-oral-clefts (Accessed: 15 May 2019).

Uggla, L., Bonde, L. O., Hammar, U., Wrangsjo, B. and Gustafsson, B. 2018. Music therapy supported the health-related quality of life for children undergoing haematopoietic stem cell transplants. *Acta Paediatrica*, 107(11): 1986-1994.

Ugwumadu, L., Chakrabarti, M., William-Brown, E., Rendle, J., Swift, I., John, B., Allen-Coward, H. and Ofuasia, E. 2017. The role of the multidisciplinary team in the management of deep infiltrating endometriosis. *Gynecological Surgery,* 14(15): 1-4.

Ullan, A. M., Belver, M. H., Fernandez, E., Lorente, F., Badia, M. and Fernandez, B. 2012.The effect of a program to promote play to reduce children's post-surgical pain: with plush toys, it hurts less. *Pediatric Management Nursing*, 15(1): 273-282.

Uprichard, E. 2011. Sampling: bridging probability and non-probability designs. *International Journal of Social Research Methodology*, November: 1-11.

Vakili, R., Abbasi, M. A., Hashemi, S. A. G., Khademi, G. and Saeidi, M. 2015. Preparation a Child for Surgery and Hospitalization*. International Journal of Pediatrics*, 3: 593-599

Van Breda, A. D. 2018. A critical review of resilience theory and its relevance for social work.*Social work/Maatskaplike werk,* 54(1): 1-18.

Van den Berg, V. L. 2016. Still lost in translation: language barriers in South African health care remain.*South African Family Practice*, 58(6): 229–231.

van Dijk, L. 2017. Interventions reducing anxiety in hospitalized children:
A systematic literature review from 2010 to 2017.*Masters,* Jönköping University.

Van Huyssteen, J. 2015. The utilisation of group work by social workers at NGOs in the implementation of family preservation services.*Masters*, Stellenbosch University. Available: https://www.semanticscholar.org/paper/The-utilisation-of-group-work-by-social-workers-at-Huyssteen/c0945ce118e6922d332e81b23d3a21be0019844e (Accessed: 23 March 2020)

van Leeuwen, R. and Schep-Akkerman, A. 2015. Nurses' Perceptions of Spirituality and Spiritual Care in Different Health Care Settings in the Netherlands.*Religions*, *6*(4): 1346–1357.

Vardar-Yagli, N., Saglam, M., Inal-Ince, D., Calik-Kutukcu, E., Arikan, H., Savci, S., Ozcelik, U., and Kiper, N. 2016.Hospitalization of Children with Cystic Fibrosis Adversely Affects Mothers' Physical Activity, Sleep Quality, and Psychological Status. *Journal of Child and Family Studies*, 26: 800–809.

Vejzovic, V., Bozic, J., Panova, G. Babajic, M. and Bramhagen A. C. 2020. Children still experience pain during hospital stay: a cross-sectional study from four countries in Europe. *BMC Pediatrics,* 20: 1-6. Available: https://bmcpediatr.biomedcentral.com/track/pdf/10.1186/s12887-020-1937-1 (Accessed: 30 June 2020).

Ventegodt S., Kandel I., Ervin D. A., Merrick J. 2016.Concepts of Holistic Care. In: Rubin I. L., Merrick J., Greydanus D. E., Patel D. R. eds. *Health Care for People with Intellectual and Developmental Disabilities across the Lifespan*. Springer.

Villani, D., Sorgente, A., Iannello, P. and Antonietti, A. 2019. The Role of Spirituality and Religiosity in Subjective Well-Being of Individuals with Different Religious Status. *Frontiers in*

Psychology, 10: 1-11. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6630357/ (Accessed: 12 January 2020).

Vitorino, L. M., Lucchetti, G., Leao, F. C., Vallada, H. and Peres, M. F. 2018.The association between spirituality and religiousness and mental health*. Scientific Reports*, 8(1): 1-9. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6250706/ (Accessed: 14 January 2020)

Von Holdt, K. and Murphy, M. 2007. Public Hospitals in South Africa: Stressed Institutions, Disempowered Management. In: Buhlungu, S., Daniel, J., Southall, R. and Lutchman, J. eds. *State of the Nation: South Africa 2007*. HSRC Press: Cape Town, 312-341.

Walker-Vischer, L. A. 2014. The Experience of Latino Parents of Hospitalized Children during Family Centered Rounds.*Doctoral Projects.*Paper 31. Available: https://scholarworks.sjsu.edu/etd_doctoral/31/ (Accessed 3 May 2018)

Walliman, Nicholas. 2011. Research Methods: The Basics. 1st ed. Routledge

Weil, S. 2012. Social Workers' Role in the Delivery of Play Therapy to Children.Masters, St. Catherine University and University of St. Thomas St. Paul, Minnesota. Available: https://pdfs.semanticscholar.org/96bc/ed85e0307792df21287c642116acbd4756bf.pdf?_ga=2.230454613.831301147.1598309658-2049887471.1592757142 (Accessed: 3 April 2019).

Williams, C. 2007.Research Methods.*Journal of Business & Economic Research,* 5(3): 65-72

Wong, C. L. Yim, W., Kwok, B. M. C., Choi, K. C., Wah, B. K. and Chan, C. W. H. 2018. Effects of therapeutic play on children undergoing cast-removal procedures: a randomised controlled trial. *BMJ Open*, 8(7): 1-10. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6042539/ (Accessed: 11 June 2018).

Wong, L. P. 2008. Data analysis in qualitative research: a brief guide to using Nvivo. *Malaysian Family Physician,* 3(1): 14-20. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4267019/ (Accessed: 30 September 2018).

Woo, J. and Lin, Y. 2016. Kids' Perceptions toward Children's Ward Healing Environments: A Case Study of Taiwan University Children's Hospital. *Journal of Healthcare Engineering*, October: 1-10.

Yates, G. J., Beckmann, N. B., Voss, M. E, Anderson, M. R. and Silverman, M. J. 2018. Caregiver Perceptions of Music Therapy for Children Hospitalized for a Blood and Marrow Transplant: An Interpretivist Investigation. *Global Advances in Health and Medicine*, 7: 1–8.

Yati, M., Wahyuni, S., Pratiwi, D.S. and Islaeli .2017.The effect of storytelling in a play therapy on anxiety level in pre-school children during hospitalization in the general hospital of buton.*Public Health of Indonesia,* 3(3): 96-101. Available: http://stikbar.org/ycabpublisher/index.php/PHI/article/view/134/pdf (Accessed: 14 January 2019).

Yount, G., Rachlin, K. and Siegel, J. 2013. Expressive arts therapy for hospitalized children: a pilot study measuring cortisol levels. Pediatric Reports, 5(7): 28-30. Available:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3718231/ (Accessed: 12 September 2018).

Zerden, L. S., Lombardi, B. M. and Jones, A. 2019. Social workers in integrated health care: Improving care throughout the life course. Social Work in Health Care, 58(1): 142-149.

Zimmerman, M. A. 2013. Resiliency Theory: A Strengths-Based Approach to Research and Practice for Adolescent Health. *Health Education and Behaviour*, 40(4): 1-5.

Zimmerman, J. and Dabelko, H. I. 2007. Collaborative Models of Patient Care: New Opportunities for Hospital Social Workers. *Social Work in Health Care*, 44(4): 33-47.

Appendix 1

LETTER OF PERMISSION

Dear Department of health

I am a prospective Masters of Health student at the Durban University of Technology. My Research is being done on the roles of child and youth care workers within a hospital context. The aim of this study is to explore the potential role of child and youth care work in a hospital context. My research touches on the fact that many children and their families face trauma, fear and anxiety when a child is hospitalized due to illnesses or injuries.Most healthcare settings work on the premise of attending to the physical dimensions of care whilst neglecting the psychological, social and spiritual aspects.This makes it important to inquire what child and youth can do to support a holistic plan of care and how they can work collaboratively with other disciplinary experts within a health care setting. Given the need for child and youth care workers due to the daily admission of children at hospitals, it is crucial to inquire what child care workers can do to alleviate the trauma faced by illness, injuries as well as the distress brought on by hospitalization for both children and their families.

To further continue with this research, I would like to utilize participants from R. K Khans hospital in Chatsworth, reason being is that these registered health care professionals will be able to give insight on how the child care workers can used their specialised skills to help children who are traumatised due to hospitalization.

In order for my proposal to be approved I will need to collect data from a mixed group of health care professionals, using semi-structured interviews. The participants of the mixed group includes occupational therapists, doctors and nurses with 3 or more years of experience, working at a hospital. In order to do this I would require the permission from the department of health. I have attached a letter of information which provides all details regarding my study and a letter of consent which will be given to participants before the

interview can take place. If permission is granted, interviews may be conducted preferably at R.K Khan. I am available for further questions regarding this. If agreed upon, a signed letter of permission will be needed to commence with my research.

Yours Sincerely
Celest Castelina Heeralal
0612234634

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

Ref: KZ_201905_003

Dear Ms CC Heeralal
(DUT)

Subject: Approval of a Research Proposal:

1. The research proposal titled **'An exploratory study of the potential role of child and youth care work in a hospital context'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at RK Khan hospital.

2. You are requested to take note of the following:

   a. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   b. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   c. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete.*

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 30/05/19.

Appendix 3

LETTER OF PERMISSION

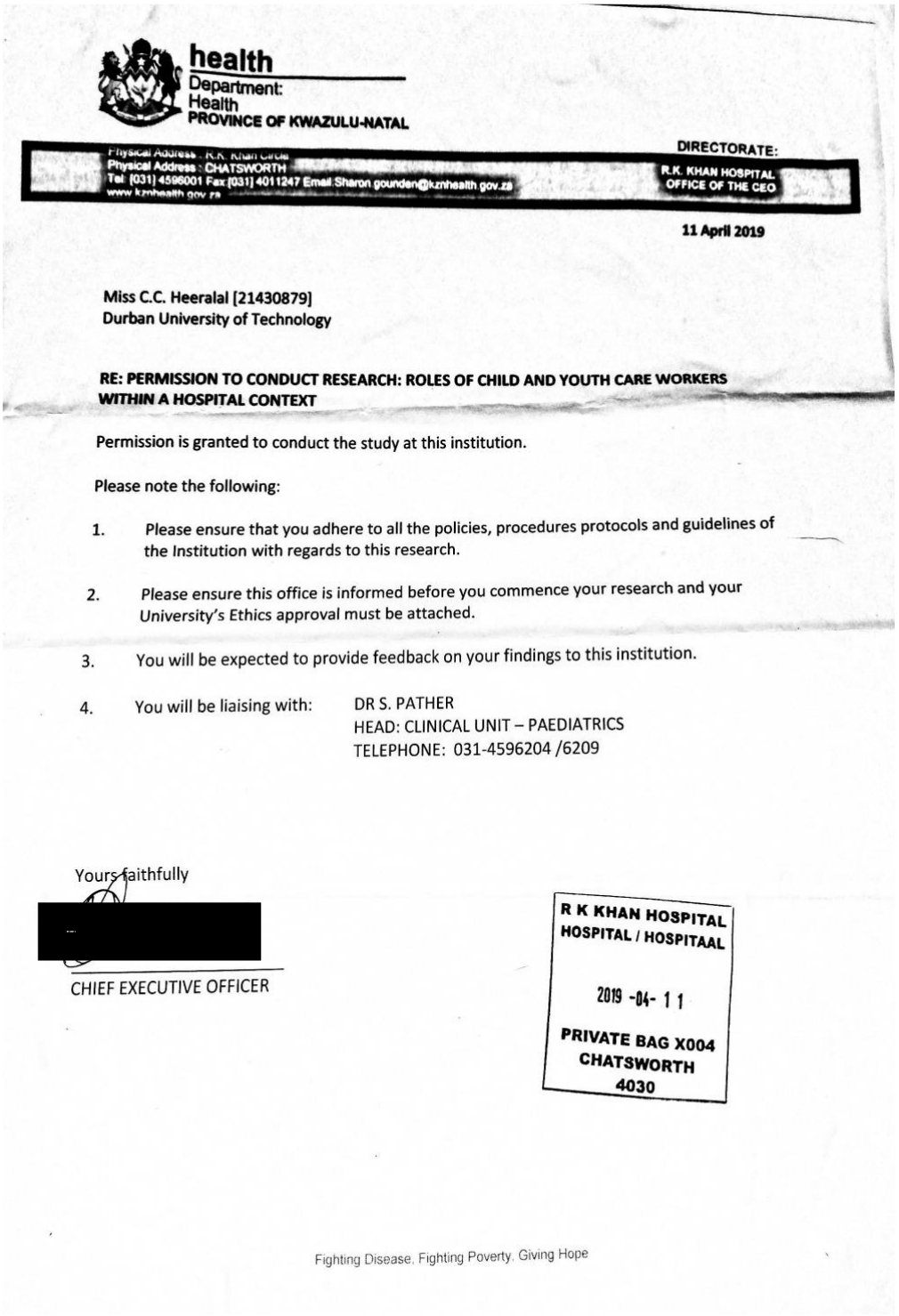
Warm Greetings Dr P. S. Subban

I am a prospective Masters of Health student at The Durban University of Technology. My Research is being done on the roles of child and youth care workers within a hospital context.

I would like to utilize participants from this hospital. In order for my proposal to be approved I will need to collect data from these participants. The participants include parents of children who have been hospitalised and a few hospital service providers who work with these admitted young people. In order to do this I would require your permission.

Yours Sincerely
Celest Castelina Heeralal
0612234634

Appendix 4



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

[redacted]
Physical Address : CHATSWORTH
Tel: [031] 4596001 Fax [031] 4011247 Email Sharon.gounden@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
R.K. KHAN HOSPITAL
OFFICE OF THE CEO

11 April 2019

Miss C.C. Heeralal [21430879]
Durban University of Technology

RE: PERMISSION TO CONDUCT RESEARCH: ROLES OF CHILD AND YOUTH CARE WORKERS WITHIN A HOSPITAL CONTEXT

Permission is granted to conduct the study at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures protocols and guidelines of the Institution with regards to this research.
2. Please ensure this office is informed before you commence your research and your University's Ethics approval must be attached.
3. You will be expected to provide feedback on your findings to this institution.
4. You will be liaising with: DR S. PATHER
   HEAD: CLINICAL UNIT – PAEDIATRICS
   TELEPHONE: 031-4596204 /6209

Yours faithfully

[redacted]

CHIEF EXECUTIVE OFFICER

R K KHAN HOSPITAL
HOSPITAL / HOSPITAAL
2019 -04- 11
PRIVATE BAG X004
CHATSWORTH
4030

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 5

LETTER OF PERMISSION

Warm Greetings Ms Zeni Thumbadoo

I am a prospective Masters of Health student at the Durban University of Technology. My Research is being done on the roles of child and youth care workers within a hospital context. The aim of this study is to explore the potential role of child and youth care work in a hospital context. My research touches on the fact that many children and their families face trauma, fear and anxiety when a child is hospitalized due to illnesses or injuries.Most healthcare settings work on the premise of attending to the physical dimensions of care whilst neglecting the psychological, social and spiritual aspects.This makes it important to inquire what child and youth can do to support a holistic plan of care and how they can work collaboratively with other disciplinary experts within a health care setting. Given the need for child and youth care workers due to the daily admission of children at hospitals, it is crucial to inquire what child care workers can do to alleviate the trauma faced by illness, injuries as well as the distress brought on by hospitalization for both children and their families.

To further continue with this research, I would like to utilize participants from NACCW (Durban), reason being is that these senior child care workers are able to comment on the potential roles of child care workers in hospitals due to their extensive knowledge about this field of work.

In order for my proposal to be approved I will need to collect data from these participants, using semi-structured interviews. The participants include senior child and youth care workers, with 3 or more years of experience at a senior level, working at NACCW. In order to do this I would require your permission. I have attached a letter of information which provides all details regarding my study and a letter of consent which will be given to participants before the interview can take place. If permission is granted, interviews may be conducted preferably

at their offices in NACCW. I am available for further questions regarding this. If agreed upon, a signed letter of permission will be needed to commence with my research.

Yours Sincerely
Celest Castelina Heeralal
0612234634

Appendix 6

NACCW
NATIONAL ASSOCIATION OF CHILD CARE WORKERS

HEAD OFFICE: PO Box 36407 Glosderry 7702 | Office No. 9, 220 Ottery Road, Ottery 7800
Tel: (021) 762-6076 | Fax: (021) 762-5352 | www.naccw.org.za

Dear Celest

The NACCW hereby agrees for Celest Castelina Heeralal to conduct her research for the study titled, "An exploratory study on the roles of child and youth care work in a hospital context".

Best wishes in taking the research forward.

Kind Regards

Nicia de Nobrega
Monitoring and Evaluation Manager

[redacted]

The National Association of Child Care Workers is an independent, non-profit organisation which provides the professional training and infrastructure to promote healthy child and youth development and to improve standards of care and treatment for troubled children and youth at risk in family, Community and residential group care settings

Non-Profit Organisation 022-979-NPO Publisher of the quarterly journal CHILD & YOUTH CARE www.naccw.org.za

LETTER OF INFORMATION

Title of the Research Study: An exploratory study on the roles of child and youth care work in a hospital context.

Principal Investigator/s/researcher: Celest Castelina Heeralal, Masters in health science.

Co-Investigator/s/supervisor/s: Professor Raisuyah Bhagwan, Phd

Brief Introduction and Purpose of the Study: My name is Celest Castelina Heeralal. I am a student at the Durban University of Technology, and I am currently pursuing my Masters in Health Science. My research is based on the roles that child and youth care workers can play in a hospital context. Many children, who are hospitalized, encounter great fears and struggles during their stay at the hospital, and so do their families. These children and their families may be affected psychosocially and may not get the correct form of support that may be needed. However, child and youth care workers are well trained to work with both children and their family to overcome fears and other struggle that they may face and therefore are able to help these children and families cope with, and overcome their fears of hospitalization. In this way, showing both hospital staff and patients how child and youth care workers may be beneficial to the hospital environment.

Outline of the Procedures: Interviews will be done with a mixed group of 10 - 15 hospital staff members who work closely with hospitalized children and their families and 10 - 15 senior child and youth care workers from NACCW. You are allowed to pull out of the interview whenever they feel any sense of discomfort.

Risks or Discomforts to the Participant: there will be no risks or discomfort posed to you.

Benefits: to be involved in the publication of the study

Reason/s why the Participant May Be Withdrawn from the Study: you may withdraw whenever they feel a sense of discomfort for personal reasons.

Remuneration: There will be no type of remuneration given. The participation is voluntary

Costs of the Study: You will not be asked to cover any cost of the study.

Confidentiality: all the information gained from you will be strictly confidential and upon my report the participants name will not be mentioned instead you will be labeled as a number.

Research-related Injury: there will be no injuries during this study.

Research-related Injury:

Please contact the researcher (0612234634), my supervisor(031-3732197) or the Institutional Research Ethics Administrator on 031 3732375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof S Moyo on 0313732577 or moyos@dut.ac.za

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Celest Castelina Heeralal,

About the nature, conduct, benefits and risks of this study- Research Ethics Clearance Number: _____,

- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerizedsystem by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own freewill) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may Relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature/ Thumbprint**

I, _____ (Celest Castelina Heeralal) here with confirm that the above participant has been fully informedabout the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**
_____	_____	_____
Full Name of Legal Guardian(If applicable)	**Date**	**Signature**

REFERENCES

Department of Health: 2004.*Ethics in Health Research: Principles, Structures and Processes*
http://www.doh.gov.za/docs/factsheets/guidelines/ethnics/

Department of Health.2006.*South African Good Clinical Practice Guidelines*. 2ndEd. Available at: http://www.nhrec.org.za/?page_id=14

Appendix 9

Interview schedule

Sample 1

1) What are some of the most common issues warranting hospitalization of a child?

2) What are some of the ways in which the hospital helps children to deal with the trauma of hospitalisation?

3) What are some of the ways in which the hospital environment context provides support for parents and families of the child who has been hospitalised?

4) What are some of the support structures that need to be put in place to help children and their families through the crises of illnesses and hospitalisation?

5) Can you indicate how child and youth care workers can assist children in coping with their illness and hospitalisation?

6) Can you indicate how child and youth care workers can assist families in coping with the child's illness and hospitalisation?

7) What are some of the ways in which child and youth care workers can function better within the hospital's multi-disciplinary team?

Appendix 10

Interview schedule

Sample 2

1) What are your views on the roles of child and youth care workers in a hospital context?

2) What are some of the ways in which child and youth care workers can provide support to children who have been hospitalised?

3) What are the ways in which child and youth care workers can support families when their child is hospitalised?

4) What are some of the creative therapeutic programs that can be introduced within the hospital environment?

5) How do you think that a child and youth care worker can function better within the hospital's multi-disciplinary team?

6) How do you think that the hospital environment can benefit from employing child and youth care workers?

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: irec@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

4 June 2019

Miss C C Heeralal
P.O. Box 562351
Chatsworth
Durban

Dear Miss Heeralal

An exploratory study of the potential role of child and youth care work in a hospital context.
Ethical Clearance number IREC 010/19

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

[redacted]

Professor J K Adam
Chairperson: IREC

DUT DURBAN UNIVERSITY OF TECHNOLOGY
2019 -06- 04
INSTITUTIONAL RESEARCH ETHICS COMMITTEE
P O BOX 1334 DURBAN 4000 SOUTH AFRICA