

UNIVERSITY OF GHANA, LEGON
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES



**EXPLORING THE EXPERIENCES OF FAMILY CAREGIVERS OF CHILDREN
HOSPITALIZED DUE TO ROAD TRAFFIC ACCIDENT AT HO TEACHING
HOSPITAL IN GHANA**

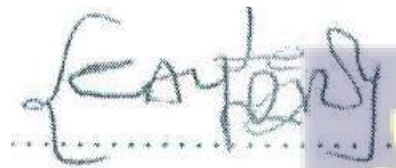
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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
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MASTER OF PHILOSOPHY DEGREE IN NURSING**

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DECLARATION

I, Cross Yaw Asamoah, hereby declare that apart from the specific references made which have been duly acknowledged, this research project is my own independent work undertaken under the supervision and guidance of Dr. Josephine Mpomaa Kyei and Prof. Lilian Akorfa Ohene, both at School of Nursing and Midwifery, University of Ghana, Legon. I also declare that no part of this proposal has been submitted for the award of any degree in this University or elsewhere.



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DEDICATION

This work is dedicated to my dear father, Mr. Kwame Tweneboah Koduah, who was my caregiver when I was involved in a road traffic accident and hospitalized at the Komfo Anokye Teaching Hospital (KATH) 19 years ago.



ACKNOWLEDGEMENT

I acknowledge the contributions of my supervisors, Dr. Josephine Mpomaa Kyei and Prof. Lillian Akorfa Ohene, for their enormous contributions, constructive criticisms, and pieces of advice throughout my studies. Undeterred by their busy schedules, they always made time to read and give comments that helped improve my research from one stage to another until its completion.

I must thank the participants who contributed data voluntarily because without their participation, this thesis could never have been completed. My heartfelt gratitude goes to the staff of Ho Teaching Hospital Paediatric and Child Health, Review Ethics Committee, for their support and encouragement throughout the research work.

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My appreciation also goes to my parents for their immense financial, prayers, and motivational support throughout my studies. My appreciation goes to Bethran Osei-Yeboah for the endless amount of support, love, and encouragement, and for spending time making the necessary corrections to complete my academic journey. I deeply appreciate their efforts. Finally, I thank God for seeing me through all the difficulties.

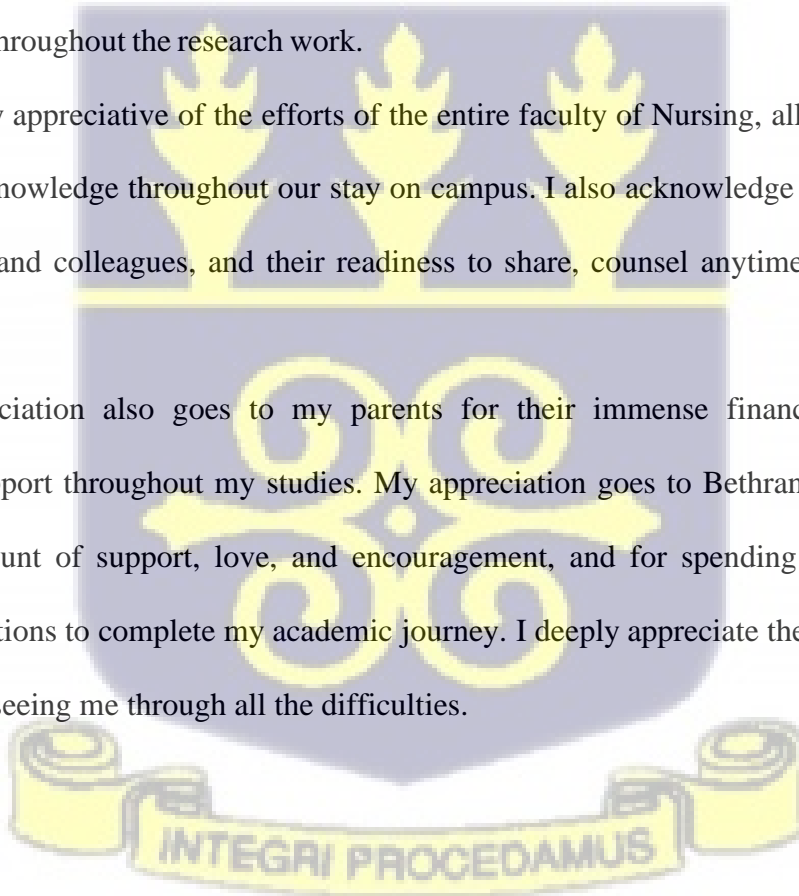
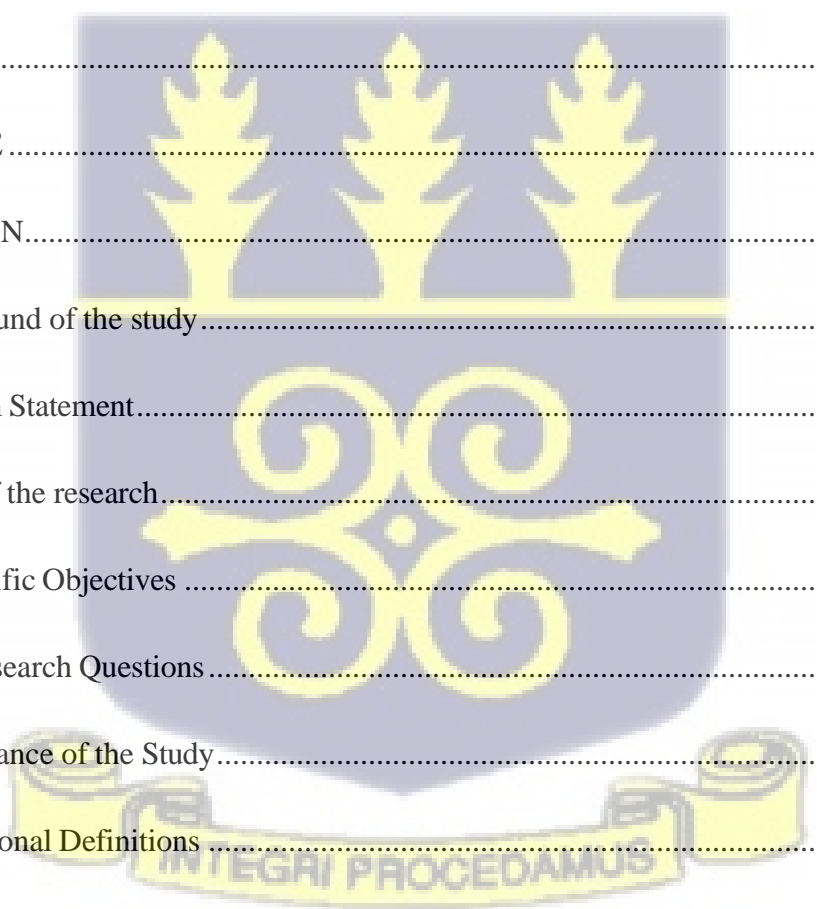
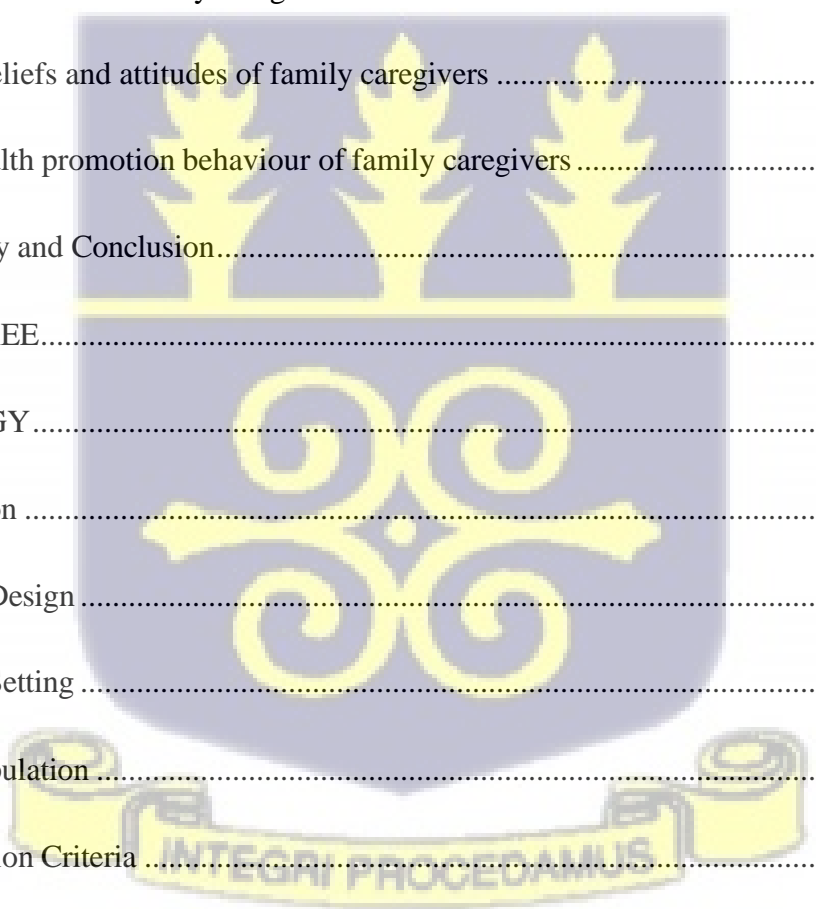


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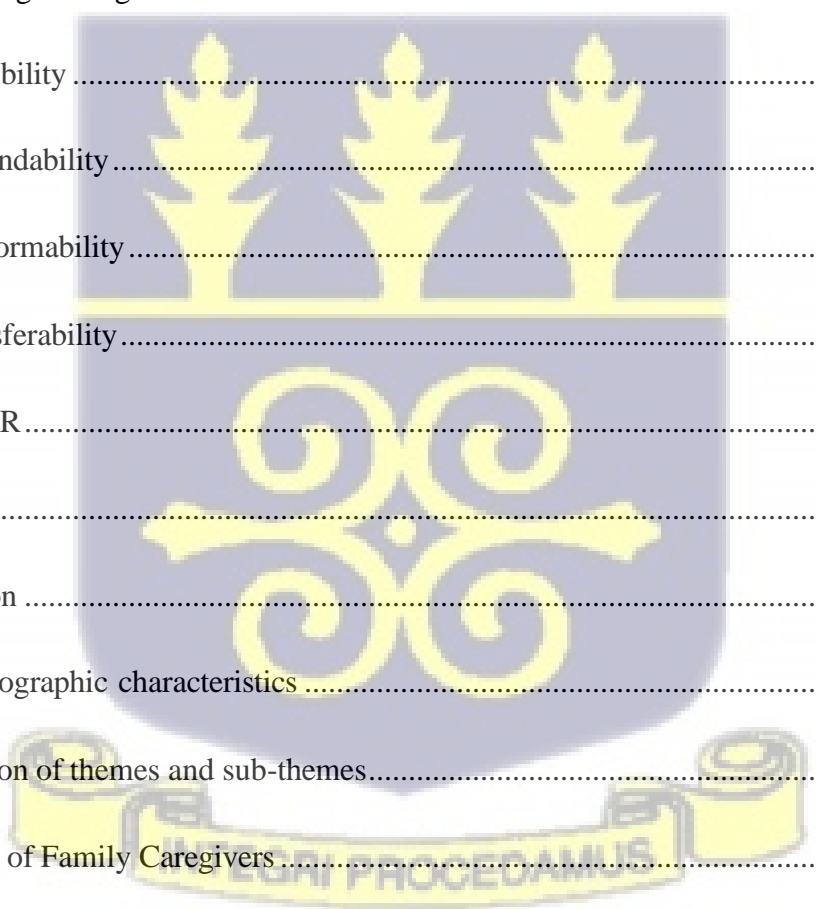
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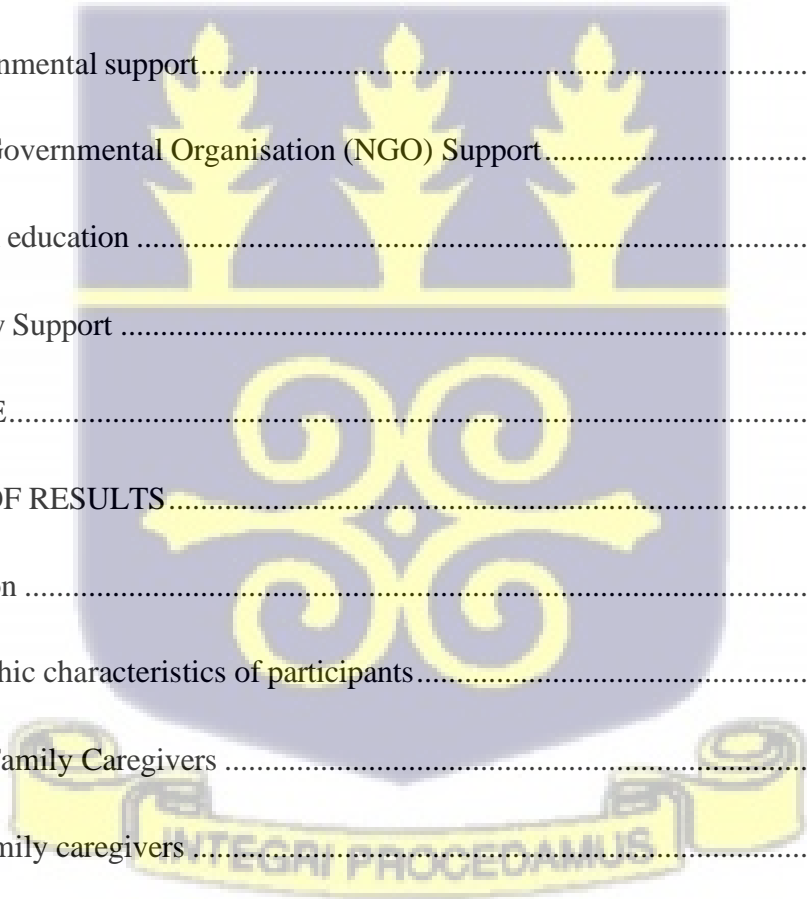
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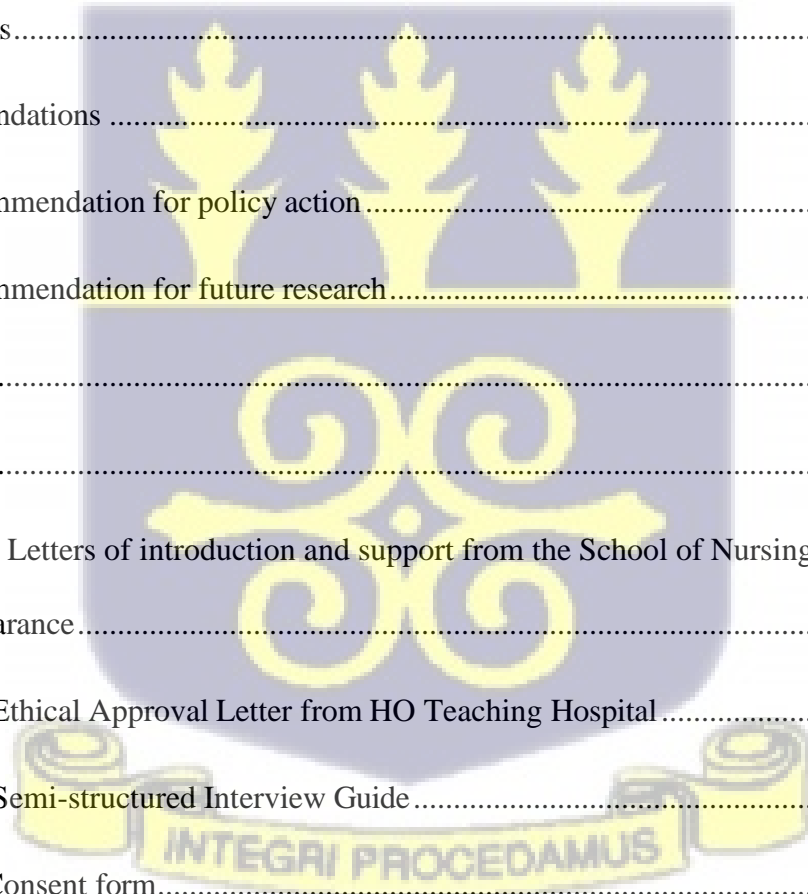
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ABBREVIATIONS AND ACRONYMS

AARP	American Association of Retired Persons
AIDS	Acquired Immuno-Deficiency Syndrome
CDC	Center for Disease Control
CGHM	Caregiver Health Model
ED	Emergency Department
HMH	Ho Municipal Hospital
HIV	Human Immunodeficiency Virus
HTH	Ho Teaching Hospital
NRSC	National Road Safety Commission
RH	Royal Hospital
UHAS	University of Health and Allied Sciences
UNICEF	United Nation's Global Fund
WHO	World Health Organization
HIV	Human Immunodeficiency Virus
NRSC	National Road Safety Commission



ABSTRACT

Family caregivers whose children are involved in road traffic accidents experience many challenges while taking care when they have been hospitalized. Some of which are emotional and psychological. This study seeks to explore and describe experiences of family caregivers caring for children hospitalized through road traffic accident at Ho Teaching Hospital, Ghana. Exploratory qualitative design was selected for the study using in- depth face to-face interviews. Purposive sampling was used to select respondents. Audio recordings were transcribed verbatim, cleaned and sorted into word document after which data was exported to Atlas.ti version 9 where themes and sub-themes were generated and analyzed. Overall, 4 main themes and 12 sub-themes emerged from the study. The major themes included, needs of family caregivers, tasks of family caregivers, beliefs and attitudes and health promotion behaviors. The study revealed that the respondents had different challenges for which support was warranted. Additionally, the caregivers indicated that they were solely responsible for performing their respective roles in protecting their children in a safe environment where they would grow. The respondents also disclosed that their belief in supernatural forces was a way of coping with their situations and helping them through their adversaries rather than it affecting them negatively. Further, they revealed that they receive different kinds support from different people which helps empower them and promote their well-being. Almost all the respondents indicated that they experienced some challenges while caring for their children involved in RTA with the majority being financial challenges however psychological challenges were the least. Nonetheless amidst all these challenges, they were all optimistic about full recovery. All stakeholders involved in child health care should build the capacity of caregivers to render safe and quality healthcare for these children.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The World Health Organization (WHO, 2024) revealed that approximately 1.19 million people die globally through road traffic accidents, while about 20 to 50 million people are left with non-fatal injuries. The most vulnerable population includes endangered road users who were pedestrians, cyclists, and motorcyclists (WHO, 2024). Among the fatalities, 93% are from low and middle-income countries (Sundet et al., 2021; WHO, 2022). A significant portion of these injuries is due to advancements in the automotive industry and affects individuals of all ages. The African Health Organization (AHO, 2020) have indicated that leading cause of death among adolescents and young adults between the ages of 15 and 35 years is road traffic injuries, and this has also been projected to rise to become the seventh cause of death by 2023 if no sustainable action plans are developed and implemented to curtail this.

According to the United Nations' Global Fund (UNICEF, 2022), children under 18 years of age make up a significant portion of the population, estimating their number at 2,375,649,484 in 2022. In light of this, there have been global and national laws put in place to protect children from harm and promote a safe environment for them to thrive. It is the responsibility of legal guardians (biological or primary and secondary) to ensure the safety of children. According to the World Health Organization (2015) the estimated deaths from road traffic injuries among people aged below eighteen (18) years is 186,300 annually. These deaths are three times higher in low- and middle-income countries than in high-income countries, however, majority of them are preventable.

Part of the responsibilities of legal guardians mandated by legislation includes nurturing and providing all forms of care for children when they are well or unwell (Riffin et al., 2019). A caregiver is responsible for helping to meet the daily needs of another person (Carter, 2023; Dixe et al., 2019). This can include tasks such as bathing, dressing, helping with mobility, preparing meals, administering medication, and communicating with medical staff. The care provided by family members can have significant impacts on the caregiver themselves. Caregivers are also responsible for performing or assisting with activities of daily living, as well as providing nursing care such as administering medication, providing tube feedings, managing wounds, monitoring vital signs, and operating medical equipment (Riffin et al., 2019). Furthermore, caregivers often provide significant financial assistance on the expenses related to the care they provide. (Nadarajah et al., 2024).

Across many countries, the development of a child can be affected by injuries in any form among children less than three years. The curiosity nature of children at their infant stage makes them run and play in their abode with no skills to identify and deal with potential health hazards (Stallard, 2019). According to CDC (2019) child unintentional injury death rates were highest among male children and babies under 1 year old and teenagers who are between the ages of 15 and 19 years. With these deaths motor vehicles cause the most deaths among these age groups (Dellinger & Gilchrist, 2019). The number of mortalities recorded annually is about 186,300 among children under 18 years globally. For deaths among 15-17years road traffic accident has been the main killer worldwide.

According to WHO (2019), it is expected that the number of vehicles on the road will double by 2030. This will also cause an increase in motor vehicular injuries and deaths predominantly in low- and middle-income countries. Additionally, the global population is

expected to reach 8 billion by 2025. Therefore, in respect of the 58 percent of the global population that will live in urban areas, urgent action is imperative to shield our children from the hazards of road traffic. Moreover by 2030, road traffic injuries among both children and adults are projected to surpass HIV/AIDS, malaria, and tuberculosis as a cause of death worldwide. Globally only 17 percent of the world's population are covered by an adequate child restraint law. However, a greater percentage of countries worldwide do not have these restraint laws. They also do not have any laws that require children to wear protective helmets while riding on motorcycles or bicycles. In many situations too, maintaining pedestrian safety is problematic. In addition, school buses and school zones are not given the needed attention pertaining to road safety and protection and as a result, thousands of children die each year on their way to and from school.

In Ghana, the National Road Safety Commission (NRSC, 2019) indicated that children pedestrians were more likely to be involved in road traffic accidents compared to adults. This is primarily because they have inadequate knowledge about road safety and hence they are unable to identify road and traffic dangers and signs (Adanu et al., 2023). A child-pedestrian is about 20 times likely to die in a crash when compared to a child car-occupant. The majority (57%) of these crashes occur on high-speed roads which course through village settlements (NRSC, 2019). Child-pedestrian deaths accounted for 34% of all pedestrian deaths (NRSC, 2019). Families and households in Ghana spend an average of US\$ 1687.65 in both direct and indirect cost the injuries sustained through road traffic accidents apart from the morbidities and mortalities associated road traffic accidents (Blankson et al., 2020; Blankson et al., 2019).

In attending to the health of children relating to road traffic accident, the role that caregivers play cannot be overlooked. The experience and perception of caregivers during

accident are very critical in identifying risk and social support (Hasan Reza & Henly,2018). There is the development of psychological adjustment difficulties on the part of caregivers when there is a traumatic event on the lives of children including road traffic accidents or other medical emergencies. Moreover, according to Williamson et al. (2019) caregivers experiences significant anxiety for the safety of their children and feel helpless to prevent future trauma. The situation of road traffic accident leads caregivers to get in touch with medical, police or social services.

The caregivers' knowledge and awareness of child injuries are crucial because they can help identify risks and hence prevent fatal injuries (Olsen et al., 2018).Also, caregivers' pre-existing knowledge and experiences assists in instituting measures that make the immediate environment safe there by avoiding injuries. To develop appropriate child injury prevention interventions, it is essential to explore caregivers' perceptions and experiences, as these insights provide helpful information. Moreover, when caregivers improve their supervision roles it helps to prevent many of the described injuries (Ning et al., 2019). This is because adults tend to influence children to change their risk-taking behaviour which could be effective in minimizing the potential to involved in injuries. (Ning et al., 2019; Prieto-González et al., 2021). Caregivers believe that proper supervision and injury prevention education in schools can effectively prevent injuries in children. This study therefore seeks to explore the experiences of family caregivers for children hospitalized due to road traffic accident.

1.2. Problem Statement

The Children's Act of Ghana, 1998 outlines the responsibilities of primary and secondary guardians to protect children under the age of 18 (Adonteng-Kissi, 2021; Cudjoe et al., 2020). The Ho Teaching Hospital is the largest tertiary hospital in the Volta region, and its paediatrics

department has seen a high number of paediatrics trauma cases, mostly males, between 2019 and 2022 (Ho District health Directorate, 2022).

Caregivers have reported experiencing anxiety and helplessness during inpatient care, and some have developed long-term mental health problems. Previous research has focused on the causes and effects of accidents on children, but there is a need to also focus on the caregivers, especially in developing countries where there are limited health systems and infrastructure to support them. In a survey conducted in the paediatrics department of Ho Teaching Hospital, caregivers of children involved in road traffic accident experienced varying challenges while for their children who have been hospitalized particularly during the first 72 hours of admission. The early traumatic symptoms in parents become a problem when it persists and evolve into serious, long-term mental health problems, with potentially chronic adverse effects on the family and the ill child. The caregivers were also doubtful of their children's returning to normal life and normal physiologic functioning prior to the accident. It is therefore vital to concentrate on family caregivers of children involved in road traffic accidents and explore their experiences to better understand them from their perspectives, provide and tailor healthcare services to help meet their specific needs and improve physical and mental wellbeing as well as their overall quality of life while performing their roles during these periods.

1.3 Purpose of the research

The research sought to explore the experiences of family caregivers of children hospitalized as a result of road traffic accident at Ho Teaching Hospital, Ghana.

1.3.1 Specific Objectives

The objectives of the study are to:

1. Assess the needs of family caregivers of children hospitalized due to road traffic accidents.
2. Describe the care task of family caregivers of children hospitalized due to road traffic accidents.
3. Explore the perceptions of family caregivers of children hospitalized due to road traffic accidents.
4. Explore the health promotion practices of family caregivers of children hospitalized due to road traffic accidents.

1.3.2 Research Questions

1. What are the needs of family caregivers during the hospitalisation of their children due to road traffic accident?
2. What are the care tasks of family caregivers during the hospitalisation of their children due to road traffic accident?
3. What are the perceptions of family caregivers during the hospitalisation of their children due to road traffic accident?
4. What are the health promotion behaviours of family caregivers during the hospitalisation of their children due to road traffic accident?

1.4 Significance of the Study

The purpose of this study was to explore the experiences of identify the unique characteristics of stress, anxiety, and psychological well-being experienced by caregivers during road traffic accident situations, and to provide insights that can aid institutions and other

facilities in addressing these issues. Additionally, the findings of this will contribute to existing academic literature and inform future studies on this topic.

1.5 Operational Definitions.

Children: A child between the ages of 1 to 12 years old, admitted as a result of RTAs.

Experiences: the attitude, beliefs, the task performed and the health promotional activities of family caregivers in their caring relationship.

Family Caregivers: a family person who provides direct care to the child without any wage.

1.6 Organization of the Study

Overall, the study was organised into six main chapters, which included, the background of the study, the problem statement, purpose of the study, objectives of the study, main and specific objectives of the study, significance of the study, theoretical framework and literature review, methodology, results discussion and finally summary.

The first chapter presented the background of the study. It also explained the problem statement of the study, the purpose of the study and the study objectives, which were both general and specific. This chapter also contained the study questions. The next chapter then examined the theoretical framework the theoretical basis underpinning this study. It highlights the literature review which was based on the major constructs of the theoretical framework which also formed the basis of the study determining the study's specific objectives.

Chapter three described the methodology of the study. It details how the study participants were recruited to obtain data. It also examined the study design, settings, study population, sampling method, method of data collection, how data was managed, ethical consideration, and rigor. The findings of the study were detailed in the next chapter, chapter four

and the penultimate chapter focused on the discussion of the study findings. In the final chapter, the summary of the study, implications, recommendations, and conclusions were presented.



CHAPTER TWO

THEORITICAL REVIEW AND LITERATURE REVIEW

2.1 Introduction

This chapter reviewed studies done in relation to the caregiver health of children in a hospital setting. The literature focuses on the caregiver health model and the objectives of the study. The literature was obtained from electronic databases such as “PUDMED”, “GOOGLE SCHOLAR”, “SEMANTIC SCHOLAR” and “RESEARCHGATE” using search terms such as “caregiver of children”, “child health”, “health of children”, “child-pedestrian”, “road traffic accidents” “family caregivers” and “caregiver health” either as single words or in combination. After numerous articles were reviewed, only those that were very relevant to the topic under study and ranged from 2018 to 2023 were used. However, some older articles that were classical and relevant to the study topic with empirical quality were also included in the interview. The literature review was then organized based on the study's objectives and the caregiver model's constructs.

2.2 Theoretical Framework

Three theories were found to be suitable for this study through rigorous literature. These were the World Health Organization Well-Being Index (WHO-5), The theory of family care during critical illness care and giver health model.

2.2.1 World Health Organization Well-Being Index (WHO-5)

The World Health Organization – Fie Well-being Index (WHO-5) is a self-reported measure of a recent mental wellbeing. It was introduced in 1998 in WHO regional office in Denmark as a part of DEPCARE project in primary care. It has total scoring system of 25 under five main

constructs to ascertain how an individual felt in the last two weeks. Constructs are identified WHO 1 - WHO 5, with WHO 1 eliciting 5 responses on how cheerful and in good spirits an individual has been in the past weeks. WHO 2, elicits responses on how calm and relaxed an individual rated on 5-point system, with 5 being the highest and 1 being the least. WHO - 3, elicits responses from how active and vigorous an individual has been also on the same 5-point system WHO - 4 and WHO - 5 elicits responses from waking up feeling fresh and rest and then one's daily life being filled with things that interest him or her respectively. Both of these are also on the 5-point scoring system. A total point of 25 is obtained when all 5 have maximum points, however in order to obtain a 100 score, the points are multiplied by 4. A percentage score of 0 represents worst possible whereas a percentage score of 100 represents best possible quality of life. This model is not ideal for the study because it address only the mental or psychological state of the individual with a two-week period which does entail all the factors contributing to health and wellbeing.

2.2.2 The theory of family care during critical illness care

The theory of family care during critical illness was developed in South Africa by de Beer and Brysiewicz in 2019 in critical care units to address challenges confronting family members and caregivers, their functioning and integrity with the involvement of healthcare professionals in a way that empowers them to take control of the determinants of their health as they go through the process of caring for their loved ones. The theory is based on empowerment as the man concept and four sub-concepts namely information sharing, proximity, garnering resources, and religious cooperation (de Beer and Brysiewicz, 2019).

According to the theory, empowerment reflects the phase of transition from feeling powerless to improved personal capacity to take control of factors that affect health negatively. Empowerment serves a positive influencer to manage physical, emotional, cognitive and environmental barriers to quality health with the help from healthcare professionals who integrate them into the care of their loved ones.

Proximity describes family members' ease of accessibility to their sick relative making it very easy for them to be closer to their loved one physically and emotionally. . Such closeness allows family caregivers to monitor the situation, track the care given to the patient, and develop trust among themselves and healthcare professionals.

Garnering resources pertains to how family caregivers acquire resources for themselves, concerning both material and non-material resources. It is significant for family caregivers to take care of themselves while performing informal caregiving roles for their sick relatives.

Cultural and religious cooperation describes how healthcare professionals demonstrate a sense of awareness, respect, understanding, and acceptance of the attitudes, values, beliefs, and practices of family caregivers during the critical illness of a loved one. In order to prevent discrimination and stigmatization based on cultural and religious grounds, HCPs should be mindful of their own cultural biases and prejudices. They should also respect and appreciate the background of others. This ensures that they discriminate against patients and families of diverse cultural and religious backgrounds. This further eliminates unhealthy situations of cultural, religious, or professional conflicts. This theory although could be utilized was not selected because to some extent it measures the cooperation of family caregivers with family as a sub construct.

2.2.3 Caregiver health model

This model was adopted for this study. Studies over the years have described the numerous health challenges experienced by family caregivers who provide care to their loved ones and experience changes in their own health (Continisio et al., 2023; Currie & Szabo, 2022). According to Weierbach and Cao, (2016) this model holistically identifies health and four determinant(s) that contribute to the health status of the family caregiver. These include the caregiver needs, caregiver beliefs and attitudes, and health promotion behaviors. The model was developed after a review of caregiver health literature focusing on the care provided by caregivers in the United States of America, which has a healthcare system primarily focusing on secondary prevention and individual healthcare needs of the family caregiver.

This model therefore places the family caregiver within the context of the geographical location of where the care is provided. This model has five constructs, a dependent construct, and four independent constructs. These include a dependent construct is health of the caregiver, and four independent constructs referred to as determinants. Health, which represents the caregiver's health, the dependent construct is operationalized holistically following the World Health Organization's definition (WHO, 2019). The remaining four independent constructs are caregiver health promotion activities, caregiver beliefs and attitudes, caregiver needs, and caregiver tasks.



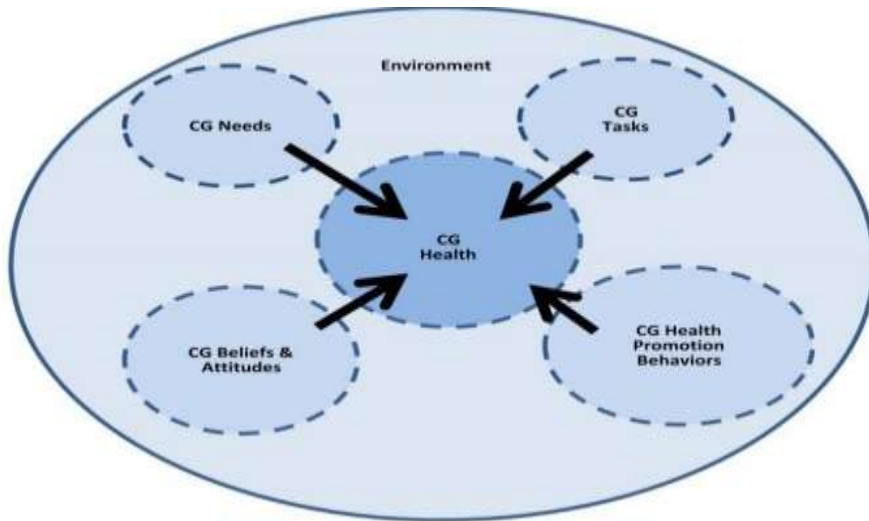


Figure 1: Caregiver Health Model

2.3 Model Justification

The model explains that caregivers often develop health problems among themselves while providing the necessary support for their sick relatives which they may ignore in many situation but capable of impacting them negatively physically, emotionally, mentally socially or financially (Zhang et al., 2021). Caregivers often view health promotion encompass nutrition and exercise alone while paying less attention to tobacco, drug, or alcohol as behaviors that need attention. How family members view caregiving impact their health. Additionally, the beliefs, attitudes and bad interpersonal relationship among family caregivers have negative consequences on their health outcomes. On the contrary, a good relationship between caregiver and care recipient improved health outcomes positively. (Hoffman & Rodriguez; Qiu et al., 2018).

Again, family caregiver roles and how they are performed have been found to negatively affect their health. Although they often do not complain while actively performing their roles on

many occasions, it is not unusual for them to experience some form of stress. Caregivers' needs are based on the care recipient's disease and disease management skills, home modifications, and the provision of supplies in the home. Although family caregiver needs often taken a back seat when caring for their sick relatives, it needs not be overlooked themselves and healthcare professionals.

2.4 Literature Review

The literature review was organized based on the objectives of the study and the quality-of-life concept hence the areas explored included: The needs of family caregivers during the hospitalisation of children due to road traffic accident, the task of family caregivers during the hospitalisation of children due to road traffic accident, the beliefs and attitude of family caregivers during the hospitalisation of children due to road traffic accident, the health promotion behaviour of family caregivers during the hospitalisation of children due to road traffic accident.

2.4.1 Research Gaps Identified from the Literature Review

The literature reviewed demonstrates a growing body of evidence on family caregiving in various healthcare contexts; however, several gaps remain in understanding caregivers' experiences during the hospitalization of children due to road traffic accidents. First, existing studies largely focus on caregiver burden in chronic illnesses, with limited exploration of the physical, emotional, and psychological well-being of caregivers in road traffic accident scenarios. Additionally, while literature discusses healthcare provider-patient interactions, there is an absence of studies examining caregiver-healthcare staff dynamics during hospitalization, including communication barriers and support structures. Furthermore, despite the increasing recognition of family caregivers' roles, there is a lack of evaluation of healthcare support systems and their effectiveness in assisting caregivers within hospital settings. Lastly, existing studies

seldom investigate the influence of cultural beliefs and social factors on caregiving experiences, particularly within the Ghanaian context, where societal expectations may shape caregiving approaches.

These identified gaps underscore the need for further research to address the overlooked aspects of caregiver experiences, healthcare interactions, and culturally informed caregiving practices.

2.4.2 The needs of family caregivers

In as much as many studies have revealed that caregivers all over the world contribute significantly towards the recovery of their family members and experience many challenges doing so it has also been established that there are many factors that need to be addressed to recognize and promote the wellbeing of caregivers regardless of the severity of illness of their loved ones (Reynolds et al., 2023). According to Ferrell et al., (2018) caregivers do not particularly prioritize their own personal, physical, spiritual, and psychological needs, however, it often take a back seat to in responding to their sick relatives. Other factors such as where the caregiver lives may also impact the needs of the caregiver and their ability to have help with the task they provide for the children.

A study on “Perceptions of Family Centered Care for Children in Ghana Hospitalized through Road Traffic Accident”, it was revealed that parents presence at the hospital environment was necessary for both patient and family in managing emotions, negotiating the system, as well as performing parental care roles although several challenges were encountered (Ohene, 2017; Ohene et al., 2019). The study revealed that communication with family and setting some boundaries as well as providing support for family in performing their roles was of significance in the care for the injured child in the hospital. As a result, it was suggested in the

study that institutional policies and protocols should reflect the family in the care of children on admission. Although the study revealed valid responses, the sample was drawn from two hospitals for the study as well as the used a small sample size and as a result, the findings cannot be generalized to the larger population.

In a study by Jeyathevan et al. (2019) on “Re-building relationships after a spinal cord injury: experiences of family caregivers and care recipients”, it was revealed that relationship between parents, families and their patients could lead to some of form of emotional, psychological and relationship challenges a result it the study disclosed that health professionals and other support groups should provide education and training such as communication skills training and coping strategies to help caregivers prior to discharge. The study also revealed that there was an over representation in the 10 years post discharge group because it was more likely they had better adjusted and readjusted to the condition and hence consented to the participate in the study. This was likely to cause selection bias as there was no representation of people who might not have adjusted from the condition and whose responses might be enlightening and significant to the study.

Another study by Lernevall et al., (2020) in their study “Support needs of parents of hospitalized children with a burn injury: An integrative review”, revealed that family care givers need support when taking of sick children. It was revealed that family caregivers needed adequate information at every stage of treatment as well as support to overcome emotional distress, guilty feelings and blame relating to the injuries sustained by their children. Further, it was revealed in the study that family care givers and parents should have other people to lean on either family or non-family for this kind of support to navigate through the entire disease process. Inadequate knowledge about resources availability and utilization, negative coping

relationships, role strain, fragmented continuity of care, caregiver injuries and illnesses amongst others were some of the negative consequences or burdens on family care givers taking care of patients with spinal cord injuries according to (Jeyathevan et al., 2020). However, from the same study, it was disclosed that access to support services from communities, positive coping strategies in relationships, and mastery of caregiving roles by family caregivers were significant in improving both the health of caregivers as well as patients in general.

Another study by Rosa et al. (2020) revealed that caregivers indicated having challenges with information and knowledge which was marked by the difficulty in recognizing the risk factors, signs and symptoms of a health condition, and the possible recurrence of the problem. However, for the caregivers who obtained knowledge concerning a condition on their initiative in research or from the experience of the incidence of accident episodes, the main doubts were related to the recovery of the compromised functions, especially to physical disability. Santa Rosa and colleagues further revealed that caregivers complained that there is a delay in scheduling exams and consultations, lack of priority in care, failure in the referral and counter referral system, and inadequate home visits by healthcare staff.

Following earlier research conducted in 2020, a study by Bayuo & Wong, (2021), family caregivers and other family members are often not prepared to assume roles in emergency caregiving situations however they are forced into suddenly when unforeseen circumstances do occur. As a result, some form of distress may occur among the family with varying determinants, severity, and pattern. As a result, the specific needs of family caregivers should be directed towards mitigating these forms of distress by healthcare givers and other support structures through family-centered care.

2.4.3 The care task of family caregivers

The study by Reynolds et al. (2023) showed that it was not unusual for family members for family caregivers who provide care by completing tasks to experience numerous stressors although there may be resources to help. The presence of these challenges was often perceived as harming health, which is manifested as caregiver stress. Additionally, what caregivers think and feel about the kind of help they need is important to consider because it is affected negatively by stress, patient problem behaviors and caregiver workload (Ferrell et al., 2018). Reynolds and colleagues sample sized used for the study is small and as a result the findings cannot be generalised for a larger population despite the valid results.

Amidst all the challenges caregivers of patients with various degrees of complications following traumatic event, it was revealed by Cheng et al., (2018) that caregiving competence, problem solving , coping abilities and social support satisfaction were noticed in their intervention group. It was also revealed from the study that the group also showed significantly greater improvements in terms of family functioning ($p < 0.05$) at one-month post-intervention, an increased number of social support ($p < 0.001$) and a lower level of burden at three-month post-intervention hence they were better equipped to taking care of the needs of their loved ones. Within the same year, another study conducted by Shepherd-Banigan et al., (2018) on “Interventions That Support or Involve Caregivers or Families of Patients with Traumatic Injury: a Systematic Review” revealed that interventions sought by TBI caregivers for psychological symptoms did not improve (SMD -0.26 , CI -0.57 to 0.05). On the other hand, however, it was revealed that in a qualitative analysis in the same study, there were mixed effects on caregiver burden and quality of life. At the same time, it was revealed that positive intervention effects on

post-traumatic caregivers' psychological symptoms were identified with certain interventions sought by caregivers for themselves.

Another study by Foster et al., (2019) revealed that parents were most at times not prepared for the negative changes in the behavior and psychological wellbeing of their children after injury. The study also revealed inadequate information provided for them during hospitalization, post discharge and follow up visits and as a result parents mental wellbeing were also significantly affected hence majority of mothers compared to fathers sought emotional support for themselves. Although significant results were revealed the study recruited only 30parents of critically injured children, therefore with a small sample size, generalisation of study results is problematic. Within the same year another study by January et al., (2019) on “Patterns of coping among caregivers of children with spinal cord injury: Associations with parent and child well-being” revealed that in order family caregivers to manage their emotions and their mental health to better take care of their children with injuries, they utilized many copings mechanisms majority of whom experienced symptoms of depression of depression and anxiety. As a result, it was suggested that fostering positive constructive and positive coping skills in the event of chronic illness was necessary to improve both the health and wellbeing of patients and their caregivers.

It was also revealed by Lever et al., (2019) that good hospital experiences(68.6%) by family caregivers, sufficient resources(35.8%), provision of counselling and support(27.6%), well controlled appointments (31.1%), and need as well significance of follow visits were positive enforcers for family care givers to attend follow up appointments. Despite the multitude of available resources, family caregivers continually underutilize support services. Reynolds et al., (2023) reported in their study that majority of family caregivers are closer to sick members

of the family and as a result they perform numerous duties, however while doing that, they are unable to access the support they needed despite the resources that have been made available by the state.

It was appreciated by Ribe et al (2018) that family caregivers' level of knowledge about their sick family members illness was a significant resource for them and their relatives in improving and promoting the physical emotional wellbeing. This was revealed in their study where parents who had higher level of education had improved wellbeing and physical wellbeing of their children who were being admitted at the hospital because they were informed to a higher extend when compared to others lower-level education. Many programs and interventions have been developed to support informal caregivers to cope with the demands of caregiving. Some of these support services include the provision of emotional or educational support by health professionals and community service providers. Therefore with the availability of these services and by requesting them from healthcare providers, family caregivers are empowered to perform their respective roles and therefore become more confident and skillful (Caro et al., 2018; Reynolds et al., 2023; Ying et al., 2018). Some examples of such support services available to them are education, support groups, counseling, and meal programs. Others also included personal care services such as home health or adult day centers, adequate health information, and referral systems. The availability of these services helps reduce and or relieve some or all of the stresses and burdens by empowering them to perform their roles as informal caregivers better (Ying et al., 2018). Additionally, the provision of respite also helps to alleviate caregiver. Many support services provided primarily acknowledges the roles and challenges of the family caregiver and further help them deal with difficult emotions such as grief, fear, resentment, anger, guilt, and helplessness that may result (Weierbach & Cao, 2020).

A year later, Bayuo & Wong, (2021) revealed that some other concerns of family members to be accepting new physical roles, and psychosocial and financial issues. In some other circumstances, roles can be friends, neighbors, in-laws and other members of the extended families may also assume major or supportive caregiving roles during the hospitalization of children.

2.4.4 The beliefs and attitude of family caregivers

Family caregivers' belief system has been known to be very adaptive and hence has contributed both positively and negatively on the performance of their roles as it was evident from a study by Akbar et al., (2018). Akbar and colleagues revealed that a safe relationship with God, possessing a good spiritual relationship with others helped improved their level of resilience to deal with all adversities and hence was attributed to positive and improved health outcomes.

In a qualitative study by Juguera Rodriguez et al., (2018) revealed that family care givers play a larger role while caring for patients with various degrees of spinal cord injuries from numerous aetiologies including those sustained from road traffic accidents. Among the roles included provision of emotional and psychological support for themselves and their relatives from which it was revealed that majority of the family care givers believed and relied on God on a supernatural level affected and improved the wellbeing of family care givers and their loved ones who were sick and unwell. Despite the valid and reliable results from this study, the findings of this study cannot be generalized.

A year later, a study among female caregivers, who provided care due to obligation and without emotional involvement revealed that the caregivers had mixed feelings and experienced poorer psychological health. In contrast, when the relationship between a caregiver and care

recipient was positive, caregiving roles were identified as cultural traditions and expectations. Among some other individuals and cultural groups, expecting to provide care, and provision of care may be viewed as a source of happiness and customarily fulfilling (Yang et al., 2019).

A study by Ohene et al., (2019) indicated that self-blame and guilt were common characteristics among parents especially when their children get sick for prolonged periods. They also revealed that most of their study participants blamed themselves for not being careful enough with child supervision leading to accidents and childhood illnesses. This was because they disclosed that they occasionally do not perform proper supervisory which in most situations preceded their injuries to their children. Although the guardians blamed themselves for the emotions they were going through, it was also revealed that they were preventable because the accidents that caused these emotions were preventable. They further showed that cultural beliefs shape how caregivers perceive accidents and misfortunes. Some caregivers believed that supernatural forces often the causes of their children's involvement in accidents. Further, Ohene and colleagues reported in their study that family caregivers experienced severe forms of fear of the unknown after their children accident was commonly because of inadequate interactions among nursing staff and medical staff, lack of prognosis information, severity of injuries and generally lack of full disclosure of medical information about their children's injuries, and hence treatment arrangements also lacked clarity. These created uncertainties in medical treatment outcomes and fear of the child dying (Ohene et al, 2019). Most caregivers reported that they had no previous experience related to hospital care of a sick child and when all these uncertainties they caused emotional and psychological stressors to the family caregivers. Moreover, the nurses' and onlookers' comments caused further anxiety upon arriving at the hospital. Several studies reported that family caregivers perceived religious rituals and practices as significant to

the recovery and the survival of the injured child while in hospital as well as helped cope with stressful life situations and encounters. They mostly prayed during critical phases of hospitalization (Friedemann et al, 2019). Another study by Coelho et al., (2019) on “Family Caregivers’ Anticipatory Grief: A Conceptual Framework for Understanding Its Multiple Challenges” revealed that exposure to life threatening conditions by patients and family caregivers often causes traumatic distress for which challenges family caregivers long term emotional regulation efforts. In the event of the seriousness of the patient’s condition, complications and potential loss of life, it was revealed that some family care perceive and anticipates grief which often affect their belief systems and way of living within a particular time frame when adjusting potential loss of life or loss while caring for their loved ones with severe life-threatening conditions. In as much there were valid responses, this qualitative recruited 26 family caregivers as a result the findings cannot be used for generalisation. Within the same year in Ghana, a study to investigate family members' beliefs and attitudes towards the visiting policies of intensive care units (ICUs) by Yakubu et al., (2019), it was revealed that family members generally believed and accept the benefits of conforming to the visiting policies in intensive care units. However, it was revealed that their attitudes were skeptical and restrictive in that most of them rather preferred one member to visit at a time as opposed to the community type of visitation which they believed could hinder the recovery process of their loved ones. The study therefore stated that there was meaningful relationship between the family’s beliefs and religion ($p = 0.002$).

In Asia, it was revealed in a qualitative study by Sudarsan et al., (2022) that the family caregivers cultural beliefs, religious, spiritual and complementary and alternative practices influenced their caregiving practices and as result caused clashes with healthcare providers as

they attempted to incorporate their beliefs and practices in to orthodox practices while caring for their loved ones on admission. Therefore, as result, it was suggested from the same study involving family caregivers in the care of patients, healthcare professionals should develop and implement approaches that is culturally safe to educate, and family care givers involved in the long-term management of sick children to yield effective results.

2.5 The health promotion behaviour of family caregivers

Family care givers often develop some form of healthcare challenges of their own while caring for their sick relatives which they may ignore because they tend to prioritise the recovery of their relative to their wellbeing in most situations (Hileman et al, 2018; Holmes et al., 2018).

Another study by Reina et al. (2019) revealed the opportunity costs (OC) that are involved in being a caregiver and to compare them with the direct costs assumed by the State and the families revealed that more than 55% of costs are assumed by families. This had the propensity to affect the general health and well-being of family caregivers according to the severity of the illness. Hence, providing care affects the overall health of caregivers negatively, which can compromise their ability to continue providing care support. Therefore if informal caregivers are to continue providing care, it is significant to help provide relief from distress and demands of maintaining the required care. Lawton et al., (2019) disclosed that there were both negative and positive consequences associated with providing care for loved ones who are sick which needs to be taken into perspective.

In an attempt to balance other activities such as work, family, and leisure with major caregiving responsibilities, primary caregivers often found it difficult to focus more on the positive aspects and hence experienced more negative reactions which further increased their

burden (Amanullah et al., 2020). Again, caregivers may become severely distressed if they are unable to participate in activities that are of value to them regardless of the degree to which they perform their caregiving roles. The feeling of being lonely, isolated, and easily bothered by caregivers maybe as a result of the demands and burden of caring for people with chronic disease conditions. (Amanullah et al., 2020).

Caregiver depression may also have a somatic component, such as anorexia, fatigue, exhaustion, and insomnia (Amanullah et al., 2020). They could suffer profound alterations in sleep patterns over time, which may cause depression. It could also exacerbate symptoms of chronic illnesses. Caring for people with chronic illness often cause pain to caregivers for which pain management is warranted. (Pritchard et al., 2022; Zeleke et al., 2021).

The results of the thirteen family care givers interviewed by van Sleeuwen et al., (2020) although cannot be generalized, it was appreciated existing challenges experienced by family care givers caring for family members admitted into the intensive care units with varying severity diseases. Key amongst them were challenges with mental health such as anxiety, more stress and difficulty expressing emotions. Also, quality of life impairment which was noticed as losing freedom of life and lack of understanding. These experiences normally affected their general wellbeing and health in general and as such the study revealed that it was necessary for healthcare providers to focus on both caregivers and ICU patients to help identify family care givers health problems earlier in order to give them the appropriate care and support, they need in order to promote and improve their wellbeing and quality of health.

As it has been revealed from many studies concerning the numerous challenges family caregivers go through while taking care of their children unexpectedly hospitalized in intensive

care units Chang et al., (2021). Within the same study, it was revealed that although the majority of the family caregivers had enough social support structures to help them manage the stress, they were experiencing either daily life stress or intensive care event stress, and most of them required extra support from healthcare providers such as medical illnesses, information about disease treatment as well as psychological support to improve their health and wellbeing.

2.5.1 Summary and Conclusion

The literature was reviewed with the caregiver health model. We then explore the empirical review using the objectives of the study. That is the needs of family caregivers, the task of family caregivers, the beliefs and attitude of family caregivers and the health promotion behaviour of family caregivers during the hospitalization of their children through road traffic accident.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section presents an overview of the methods and procedures that was used to carry out the study. It describes the research design, population, sample and sampling procedure used as well as how data was collected. In addition, the methods for data analysis, methodological rigor, and ethical consideration are also described.

3.2 Research Design

A qualitative approach specifically exploratory design was used in this study. This design was to describe and explain the phenomenon being studied. Moen and Middleton (2015) disclosed that the flexibility of an exploratory design made it possible to learn about participants perspectives on a phenomenon. This design was to describe and explain the phenomenon being studied. Moen and Middleton (2015) disclosed that the flexibility of an exploratory design made it possible to learn about participants perspectives on a phenomenon. It allowed the researcher to generalize to a theoretical understanding of the phenomenon being examined and enabled the researcher to comprehend a social event that was happening in its natural setting. The application of this design in the study helped the researcher to gain a deeper understanding of the underlying beliefs and attitudes of family caregivers, various tasks, and various roles they played, as well as allowing the researcher to explore topics with limited literature while allowing the participants contribute to knowledge development (Leppink, 2017; Rosenthal,2016). As a result, the experiences of family caregivers during the hospitalization of their children through road traffic accident was explored through interview approach which provided a rich description of social processes or experiences, participant meanings, behaviors, and perspectives.

3.3 Research Setting

The study was conducted at the Ho Teaching Hospital. The Ho municipality is one of the seventeen districts in the Volta Region and its administrative centre is Ho. It doubles as the regional capital for the Volta region. It occupies a land mass of 573.2 km². With reference to the 2021 census, the population of the municipality was 420: 84,843 males and 95,577 females (Ghana Statistical Services, 2022).

In the municipality, healthcare services are provided predominantly by three government facilities, including the Ho Teaching Hospital (HTH), Ho Municipal Hospital (HMH) and the Ho Polyclinic (HP). There are also numerous private hospitals and clinics, including, Royal Hospital (RH). However, the hospital of interest to my study is HTH.

Ho Teaching Hospital is the fifth public Teaching Hospital in Ghana. It was recommissioned in 2019 after going through a vigorous accreditation process by all the Health Professional Regulatory Bodies and the Health Facilities Regulatory Authority. As a teaching hospital, it provides specialized health care services to the people of the Volta Region and beyond. HTH is a 306-bed capacity facility, well equipped to provide health care services ranging from, emergency, out-and-in patient care including but not limited to Surgery; Medicine; Obstetrics and Gynaecology; Diagnostics and Rehabilitation; Paediatrics; Mental Health; and Public Health. It is the highest care level facility in the municipality and region providing tertiary health care services and partners with the University of Health and Allied Sciences (UHAS) for the training of Medical, Nursing, Midwifery and Allied health professional. Services are provided by Specialists in various medical and allied fields, General practitioners, Nurses, and Midwives (Ho Teaching Hospital, 2021).

The Hospital is deemed as a Medical Tourist Centre through provision of Innovative Health Care. The hospital serves Ghanaian's and other nationals from the Republic of Togo, Benin, and the Federal Republic of Nigeria.

3.4 Target Population

The target population included all family caregivers who cared for children who had been admitted to the children's ward as a result of road traffic accidents.

3.4.2 Inclusion Criteria

The inclusion criteria included.

1. Family caregivers who cared for children who have been admitted to the children's ward on account of road traffic accidents.
2. Family caregivers aged 18 years and above.

3.4.3 Exclusion Criteria

1. Family caregivers whose children have been admitted to the children's ward on account of other conditions.
2. Family caregivers who have rendered care to children involved in road traffic accidents in less than a week

3.5 Sampling Technique

Purposive sampling method was employed for the study. This approach was appropriate for the study since the researcher consciously selected certain subjects, elements, or incidents to include in the study. Purposive sampling was the best way to gain insights into a new area of study, discover new meaning, or obtain in-depth understanding of a complex experience, situation, or event.

3.5.1 Sample Size

The sample size is significant in qualitative study to determine the total number of participants willing to participate in the study who can help to advance understanding of the phenomenon being studied which is determined after achieving data saturation (Qureshi & Unlu, 2023; Subedi, 2021)(Subedi, 2021). Guest et al. (2020), explained data saturation as when data gathered is analyzed to the extent that no more new information or very little information is collected in relation to the study being conducted. Data saturation was achieved with 16 study participants after which no new insights and information was obtained and hence the same size was determined for this study.

3.6 Data Collection

3.6.1 Data Collection tool.

Exploratory qualitative research employs techniques that enable data collection about people's experiences (Polit & Beck, 2010). A semi-structured interview guide was used to collect the required data through face-to-face interviews. The guide consisted of two main parts: one documenting the core questions and another incorporating probing techniques to aid in eliciting detailed responses. This structure was adapted from Guion et al. (2011) to ensure the researcher could obtain comprehensive insights from participants.

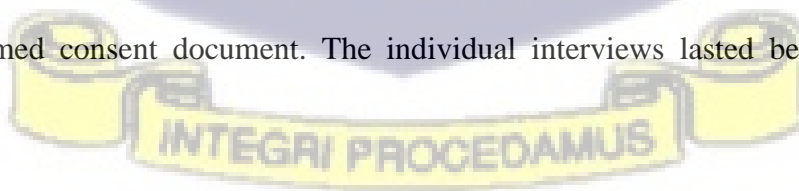
Additionally, the interview guide was structured into five major sections. The first section covered sociodemographic characteristics. The second section focused on the needs of the family caregivers, aligning with the study's second objectives. The third and fourth sections explored beliefs and attitudes of family caregivers and their health promotion behaviors, addressing the corresponding study objectives. To enhance data accuracy, the researcher also maintained a small notebook to document observations from the interviews. After each session, these

handwritten notes were compared with recorded voice notes to ensure data completeness and quality,

3.6.2 Data collection Technique

After the semi-structured interview guide had been developed, a face-to-face interview was conducted. Voice recorders and cameras were the devices used to capture the various meeting sessions that lasted between 30 and 60 minutes, approximately 45 minutes. A stop watch was used to monitor time during the face-to-face interviews. Transitions were used to successfully move from one question to the other to avoid skipping some questions and at the same time, taking notes. Probing was used to elicit for more information. Follow up questions were also used to help address questions and other sensitive issues that were missed and or skipped to gather more information of the topic of interest. The interviews were conducted at the sole decision and comfort of the respondents. The principal investigator was the sole investigator for this study; for conducting interviews, comparing interview notes with voice recordings in order to ensure data was complete, valid, reliable and accurate. Data was cleaned before and after transcription.

The interview guide was pretested on two study participants in Hohoe government hospital in relation to (Subedi, 2021) sample size calculation for qualitative study to ensure that the questions are clear and precise. Those who finally agreed to voluntarily participate in the study signed an informed consent document. The individual interviews lasted between 20 and 60 minutes.



3.7 Data Analysis

According to Hanson et al. (2011), qualitative data analysis involves immersing oneself in data to derive meaning and interpret findings. In this study, the researcher employed Braun and Clarke's (2006) thematic analysis framework, using Atlas.ti version 9 to facilitate coding, theme identification, and interpretation. The researcher began by manually transcribing the audio recordings verbatim and cross-checking the transcriptions for accuracy. Responses recorded in Twi were precisely translated into English to maintain consistency. Familiarization with data was achieved through repeated reading and listening to the recordings, ensuring a deep understanding of the narratives. During coding, preliminary labels were assigned to relevant segments of the data, reflecting key themes emerging from caregivers' responses. These codes were refined and clustered into broader themes and sub-themes based on patterns observed across the datasets.

The researcher carefully examined the relationship between different themes, ensuring that they accurately represented the participant's perspectives. As part of the refinement process, themes were continuously reviewed for coherence, with adjustments made where necessary. The final themes captured caregivers' needs, beliefs, attitudes, and health promotion behaviors, providing a structured understanding of their lived experiences. The data was organized within Atlas.Ti as hermeneutic units to support systematic analysis. Throughout the process, the researcher ensured methodological rigor by validating the themes against the raw transcripts and refining coding structures to enhance interpretive accuracy. Direct quotations were included to preserve authenticity and provided a rich representation of participants' voices. To ensure credibility, findings were discussed in relation to existing literature and theoretical perspectives, reinforcing the depth of the analysis. The study approach ensured a well-grounded thematic interpretation that captured the complexity caregivers' experiences in meaningful way.

3.8 Data management

Data was collected from the participants using a recorder, field notes through interviews. After each interview, the recording was re-listened to the recorded contents while comparing with the field notes to ensure data completeness and clarify all misconceptions to gather all data from respondents. All data was complete hence the researcher did not have to call respondents for clarification of some information. After the final interview, all the information gathered was uploaded onto otter.ai for transcription verbatim. This was followed by data quality checks for precision and accurate information before uploading onto ATAS.TI software for analysis.

All data collected and transcribed into a soft copy that will be kept safe on the researcher's laptop with a safe code protecting it for at least one to five (5) years after completion of the study before being destroyed or deleted permanently. The hard copies were kept safe in the researcher's custody, and accessible to the supervisors.

3.9 Ethical Considerations

Institutional approvals for the study were obtained from the University of Ghana – School of Nursing and Midwifery (SONM) and HTH, while ethical clearance was obtained from the Ethical Review Committee of the Ho Teaching Hospital with the number HTH- REC (04) FC_2023. Participants signed a written informed consent form voluntarily to participate in the study after the objectives and purpose of the study have been explained to them in the language they understand. Also, participants were informed that participation is voluntary so only those who met the criteria and were willing to participate were involved. Additionally, participants were assured of privacy, anonymity, and confidentiality of information as well as their right to withdraw from the study at any point they wish to without any repercussions to their person. They were treated equally.

3.10 Methodological Rigor

Rigor is simply defined as the quality or state of being very exact, careful, or with strict precision or the quality of being thorough and accurate. The development and refinement of the interview guide as part of a pilot study ensured trustworthiness via credibility, conformability, dependability, transferability, and reflexivity.

3.10.1 Credibility

Credibility permits the recognition of participant experiences as interpreted and contained within the study. To establish credibility, the researcher chose family caregivers whose children were hospitalized through road traffic accident and met the inclusion criteria, established rapport with them and had prolonged engagement with them to ensure thorough understanding of findings. The first interview was transcribed verbatim and coded to allow the researcher to relate the data's content. Respondents were contacted during the data processing phase to enhance data completion and reliability. The researcher appraised the individual transcripts and looked for similarities within and across all participants.

3.10.2 Dependability

In order to evaluate the degree to which the study's results could be repeated if conducted on a sample of participants with comparable qualities in a comparable setting. The researcher made sure that the interview guide, data analysis techniques, and data analysis results are all applied consistently. Participant backgrounds, as well as inclusion and exclusion criteria, were clearly defined. The researcher worked closely with the supervisor and the feedback from discussions were applied to improve subsequent interviews. There were clear guidelines about

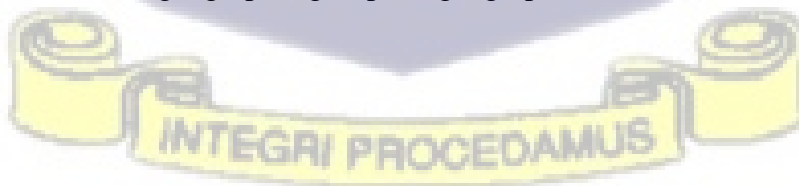
interview lengths and questions order. At the same time, adequate details regarding the participants' ages, genders, research context were provided.

3.10.3 Conformability

To guarantee that the results were accurate reflections of participant's experiences rather than the researcher's, audiotapes were transcribed verbatim. To support emergent themes, participants' direct quotes were used. Participants were questioned to elicit clarity. To get accounts from the appropriate participants, only family caregivers who met the inclusion criteria participated. Contextual data was provided using an audit trail that includes member check notes, summaries, and field notes to improve analysis. For avoiding bias, the researcher's beliefs and values was considered during the analysis.

3.10.4 Transferability

To provide readers with sufficient information to subtleties in the relationship between the study's environment and their personal experiences, the participants' backgrounds, including their age, the participant's gender, marital status, educational level, hospital, and unit were disclosed. The grounds for inclusion and exclusion were made explicit. To establish transferability the researcher gave a detail description of the population under study by describing the demographics and geographic boundaries of the study. The researcher also pretested the data collection tool with different geographic groups or geographic location.



CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the results for the study after analyzing the responses from the respondents. It presents the organization of themes and codes for the study, the sociodemographic characteristics and the themes generated with respect to the objectives of the study. The purpose of this study was to explore the experiences of family caregivers caring for children hospitalized due to road traffic accident at Ho Teaching Hospital, Ghana. Overall, 4 major themes and 12 subthemes emerged from the study.

4.1 Socio demographic characteristics

Overall, sixteen respondents in total were recruited for the study after reaching data saturation. Of the respondents fifteen were females and one male. Fifteen of the respondents were biological parents while only one was an aunt. Most of the respondents were traders, a few farmers and only one was an unemployed mother. Over two thirds of the respondents were Ewes, while the remaining one third were Gas and Akan's. Over half of the respondents had their highest level of education at SHS level, and a few at tertiary level. Most of the caregivers' ages ranged above 35 years and a small proportion of them were aged between 20 and 34 years. All the sixteen respondents were Christians who stayed at Ho and only two of them staying at Adaklu. About 12 of the respondents were married; three were single parents and only one was a widow. 11 of the respondents stayed in the hospital for a maximum of two – three weeks and the others stayed for less than 2 weeks. Fourteen respondents indicated that their children were knocked down by motorbikes while only two revealed that they were knocked down by vehicle. All participants spoke English Language. The result is presented in Table 4.1 below.

Table 4.1 Sociodemographic characteristics

Codes	Sex	Age Range	Religion	Marital Status	Level of Education	Relationship in with Child
P1	Male	20-30	Christian	Married	Senior Highcol	Parent
P2	Female	Above 30	Christian	Unemployed	Senior Highcol	Parent
P3	Female	Above30	Christian	Single	Senior Highcol	Parent
P4	Female	20-30	Christian	Married	Trading	Parent
P9	Female	20-30	Christian	Married	Senior Highcol	Parent
P9	Female	20-30	Christian	Married	Farming	Parent
P10	Female	20-30	Christian	Married	Farming	Parent
P11	Female	20-30	Christian	Married	Farming	Parent
P12	Female	20-30	Christian	Married	Farming	Parent
P13	Female	20-30	Christian	Married	Farming	Parent
P14	Female	20-30	Christian	Married	Farming	Parent
P15	Female	20-30	Christian	Tertiary	Trading	Parent
P16	Female	20-30	Christian	Married	Trading	Parent
P17	Female	20-30	Married	Tertiary	Trading	Parent
P18	Female	20-30	Married	Tertiary	Trading	Parent

Source: Researcher's field data, 2024

4.2 Organization of themes and sub-themes

Four main themes were developed according to the theoretical framework and study objectives and 11 sub-themes emerged from the data collection. The main theme includes needs of family, The task of family caregivers, The beliefs and attitude of family caregivers and health promotion behaviours. Table 4.2 below shows the details of the various themes and sub-themes.

Table 4.2 Themes and sub-themes

Themes	Sub-themes
1. Needs of family caregivers	Physical needs Financial needs Emotional needs Psychological needs.
2. The task of family caregivers	Physical responsibilities Child Protection
3. The beliefs and attitude of family caregivers	Spiritual belief system Pain and suffering
4. Health promotion behaviors	Government support NGO Support Health education Family support

Source: Researcher's field data 2024

4.3 The Needs of Family Caregivers

As family caregiver's most importantly caring for children less than eighteen years, it is paramount to be in optimum health to provide the necessary assistance for their dependents. As a result, all factors that determine good health is of essence for the family care giver whether these care givers have a sick child or not. The family care givers described their needs in the form of physical needs, emotional needs, psychological needs, and financial needs which are presented below.

4.3.1 Physical needs

Participants disclose their needs and challenges they are confronted with while caring for the sick children who have been hospitalized as evidenced by codes such as better sleeping areas, adequate nutrition o hospital premises, prevention of mosquitoes and food supplementation.

Most of the respondents demonstrated numerous physical challenges confronting them while caring for their loved ones hospitalized on account of road traffic accidents. About eight of the respondents indicated that they were unable to find good sleeping areas and hence they were bitten by mosquitoes as well as they suffered numerous body pains as a result and hence if they were able to find better sleeping areas to take of mosquitoes, would be beneficial to them throughout their length of stay. These make them feel uncomfortable especially during the night throughout the period.

This was evidenced by.

“Things like, the challenges are related to how to sit where to sleep, you will be bitten by mosquitoes. You could sleep in plastic chair till morning which is not comfortable at all. You wake up with numerous mosquito bites and body pains allover” – P1.

“You know, we are bitten by mosquitoes from where we sleep, so I use mosquito repellent ointment So, I bought that ointment so that when I am about to sleep then I will apply it and sleep” –P2

Twelve other respondents also indicated that they had difficulty acquiring a nutritious diet as there was no canteens and food vendors around especially during the weekend. The respondents agreed that adequate nutrition was necessary to promote good health for themselves and that of their children, however, there were occasions where finding food on the hospital’s

premises was very difficult especially over the weekends for which they had to struggle on many occasions. It was revealed by.

“It is very difficult to get food when you are in the hospital. You will have to roam quite a lot to find a food vendor. I went to the road side which is a very far place before I could get food to come and give it to the patient which was also quite expensive [...]” – P 5

“Like if they have somebody within the hospital premises selling food, not to be serving people free, it would have been good for us that way to prevent us from going hungry and roaming for long periods before getting food” – P7

Four other participants also indicated that they received some form of help from the healthcare workers. They indicated that timely health information was needed for them to equip them in rendering some specific duties for their sick children. They also indicated that healthcare workers provided some form of physical assistance to them. This was evidenced by:

“That one, there was some medicine they needed to be given to the child, but then I was not there, they did not tell me in time. If they had informed on time even when I do not have money I can search for money and buy it if is important for me to get that articular medication”- P 1

“The nurses and doctors call me by my child’s name, we smile, and when they send me, I go. They even do some of the things to help me even including money.” – P3

Overall, these statements reflect family caregivers’ physical needs while caring for the sick children. They all appreciate taking care of themselves to better care for their children regardless of the severity of their children’s illnesses.

4.3.2 Financial needs

Ability to afford to take care of oneself, pay for hospital services and for upkeep has been shown to promote a good sense of wellbeing and healthy living. They recognized the role adequate finances play in the recovery process of their children and eliminate psychological and emotional pressures among themselves. It was revealed that family care givers experienced financial challenges, some were unable to work to make ends meet because of the hospitalization and as a result they relied on donations from friends and other family members.

All but one of the respondents indicated that they had financial challenges. The respondents revealed that the cost of treatment was expensive particularly for those whose children had been booked for surgery as a result. As a result, they indicated that it was stressful for them during these states, and some had to resort to other means such as receiving donations from family members, schoolteachers, and others. This was evidenced by:

“Another thing is the expenses of the drugs, and more to the point some parts of her body are having a problem as we are sitting down, especially the jaw, so they said 6000 Ghana cedis is needed to fix it. I must provide it before the jaw is refixed of which I don't have as I'm sitting down. My problem is all about money. All I need is money. I don't have enough but I am supposed to provide for my child's needs.” – P6.

“Hmm, to be frank with you, it was all about money. I am finding difficulties in affording the services. ... Yes, I have support from fellow market, um, women. We have a group or association. So, they were able to organize and donate a little bit of something and my pastor also um, donated a token.” – P8

Only one respondent indicated she had no financial challenge because she was having support for the financial support from family members including her niece's parents who were living in another state when the child got involved in an accident. This was revealed by.

"I'm a bit fortunate or let's say we're a bit fortunate because the finances are coming, we are getting the immediate help to, ummm, take care of the hospital bills, the medicines, we have to buy the medications. They are that expensive but by the grace of God, help is coming." - P4

Overall, it was demonstrated by all the family caregivers that they were actually involved in the care of their children regardless of the challenges they went through and were willing to go every extent to obtain the financial assistance at their own expense in order to take care of their children.

4.3.3 Emotional needs

Many family caregivers are often not ready to assume some unexpected roles, therefore they tend to juggle many things at a time and hence they often adjust and adapt in case of emergencies most especially putting their emotional needs aside. Regardless of all the challenges they are confronted with, they were optimistic, hopeful of positive health outcomes and as such encouraged and motivated themselves. This is evidenced by the respondents indicating various forms of emotional challenges when their children were hospitalized during the entire period. It was however inferred that they needed emotional assistance to help them through their situation.

It was revealed by eight of the respondents that although they were going through their challenges, they had hope that both (their children's and themselves) would be fine. This was evidenced by;

“I know taking care of a child with this type of injuries is not easy. It drains you emotionally and financially. I have left my other children at home together with the other children. However, I know my child will recover. My prayers are that I was having the hope that the child, will still recover.” – P5

“It was every day, I cried but now I'm okay like I'm able to stand there, regardless of the pressure I'm okay. Currently I'm okay, I'm able to hold myself, I don't cry anymore. I have hope that my child will be fine.” – P12

Some of the respondents also indicated that they were not happy in the states their children were in. However, they needed to stay strong and motivated themselves to get through the challenges they were going through. This was evidenced by:

“That one, no, the child as she is here. I'm not happy about the mood she is, always my concern is of how to get the child healthy back again, so I'm making myself that no matter what it is, I should sacrifice myself for her survival.” P-1

“Um, the thing, I put in place is I must motivate myself that it's going to be okay. My child is going to be fine because seeing my son alive alone is something to encourage me to keep taking care of him to the last”- P2.

All the participants were directly involved their children's care. They indicated it was stressful at times however they were optimistic of total recovery for their children even it meant they had to go through emotional challenges, it was a price they were willing to pay.

3.4.4 Psychological Needs

A good and positive mental state enables an individual to have clarity and focus on ever activity one has to perform in order to achieve a certain objective. The pain, the anger and

obstacle family care givers experience while performing their responsibilities could often impair the sense of judgement and functioning however, paying attention to healthcare, making themselves available for health education, seeking clarification from healthcare providers as well as requesting for psychological assistance from healthcare providers were beneficial to care providers while caring for their children during hospitalization regardless of the length of stay.

It was revealed by a third of the respondents that a lot of things go through their minds and sometimes cause them to be depressed, nonetheless they have to encourage themselves and pay attention to the healthcare staff. This was evidenced by.

“We need to be paying attention to how doctors are treating our patients or listen to their advice even though we are having challenges. I think, um, in such cases, when your ward is at the hospital, I think the nurses, um, or the doctors have the right to educate you on how and when to take care of your ward when you are discharged. I think it will go a long way to help with we those who are going through some things, or, um, giving care to our children’s or family [..]” - P2.

“Since the child was admitted here, I did not know anything at all. What I don't know about, unless I consult them, I ask them, this thing is this, how do I do to it? Or they've asked me to do this, and I feel okay sometimes”- P12.

“I mean, psychologically, a lot of things go through my mind because um, the bills, and um, how the bills are like piling up and emotionally I become depressed and very anxious trying to know what has happened to my child, would he be, ok? Would he be like the way he was? Um, but I have to motivate myself that it's going to be okay. My child is going to

be fine, seeing my son alive alone is something to encourage me to keep taking care of him to the last” - P8.

4.4 Caregiver tasks

The responsibilities and roles of all family caregivers either biological guardians or secondary guardians have been enshrined numerous legislations and customary laws hence these knowledges are passed on even among people with no formal education and among different tribes. Knowledge of these responsibilities ensures adequate care is given to children regardless of circumstances such as socioeconomic challenges among others from care givers. A group of family care givers discussing their experiences of performing their roles for their children revealed that they provided physical responsibilities such as providing food shelter, paying for medication, as well as paying for cost of services. Also a few revealed that that they also protect their children from harsh conditions such as illnesses and trauma.

4.4.1 Physical responsibilities

Study participants expressed their conviction to providing the necessary care for the optimal health of their hospitalized children. Some of the physical responsibilities included assisting the performance of the usual activities of daily living such as buying and providing for children, paying for medications, assisting in serving medication and as well as engaging in passive range of motion exercises. This was evidenced by:

“The mother is there; at times I clean her. If the mother is not there, I will fetch water and when I soak the towel then I'll clean her maybe before the mother come, I have finished or I maybe on the process before the mother will come and meet us”. -P1
...From the time we came, I have been doing everything right for my child to get

better. I do the bathing, I clean her, not actually the normal bath but in bed as the nurses have taught me to do on numerous occasions. They have also taught me my role in caring in caring for her wound as well. Although it gets tiring at tiring at times, but then I'm fine
-P3

“Okay, um, the child cannot do the things she used to do for herself and it's when she wakes up she could bath by herself, dress up and everything but now that she is hospitalized she does not have the strength to do all those things. So basically, I do those things for her, at least I brush for her, brush her teeth, bath, and feed and help serve her with her prescribed medication. Also, if the nurses instruct me to perform any physical role, I do that such as changing her clothes. Although sometimes I am prevented from going to do my normal business because I must make sure I stay up, administer medications, and take care of the eerm, wound to prevent it from getting infected. Yeah, I am not bothered at all because I see it is role primarily” - P8

Only one of the respondents indicated that they helped their children perform some range of motion exercises passively. This was evidenced by:

“Like I'm even helping, in the morning they told me to be helping her to walk small, small, so every morning I help her walk, I engage her, I make her happy so that she can get better as the nurses told me to do when we were at the hospital” – P 3

4.4.2 Child protection

As part of the roles and responsibilities of family caregivers and guardians of children, protection from harm, illnesses and other harsh conditions are necessary for the child survival, growth and development. Most of the respondents indicated that in order to protect children

while on admission seeking counsel from healthcare givers was paramount, as well as being vigilant one very thing that goes pertaining to the child's care while on admission. This is evidenced by.

“Me when I came here, what I only think of is, I think is the doctors and nurses know best with respect to healthcare delivery services, and they know the medicine or the treatment given to the child to survive. So, I only look up to them. I also consult them if I need anything because I must protect my child from complication and death and who else can do that if not me” – P7.

Another respondent also indicated although it was not easy to be hospitalised for several weeks, it was part of his responsibility to be vigilant and mindful of everything going on and as result he must take active part if he wants to protect his child towards positive health outcomes with no complications. This is evidenced by;

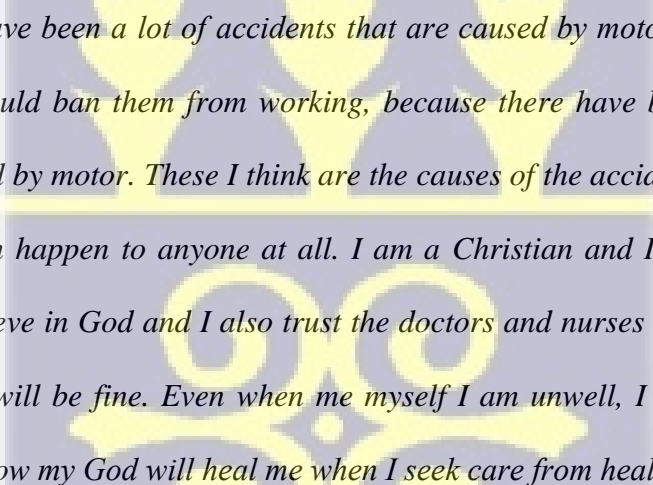
“Respectfully, as we are here it is because of something. I would be happier if my child and I were both healthy. We have been here for three weeks and the amount of money we have sent so far is not easy. The only thing I can do now is to be very vigilant in her care. I provide everything that she will need. I ask a lot questions when I do not understand, I am available when they are dressing her wound, I do everything I am asked because as a father you must be vigilant and protect your child and besides, he is the only male child out of six children. I do not really care about what other people do but I do care about mine” – P12

4.5.1 Spiritual belief systems

Unforeseen Incident

Participants believed that accidents do happen and as a result they did not attribute their children's ailment to any external supernatural forces as the sources. However, they of the belief that with the help of their maker, they together with their children will get better over time.

More than half of the respondents indicated that they had no superstitious beliefs concerning their children's involvement on road traffic accident. It was indicated that accidents occur naturally and if it were meant to occur, it occurs but not necessarily due to superstitious beliefs. This was evidenced by:



“Yes, there have been a lot of accidents that are caused by motorcycles. And I wish the government could ban them from working, because there have been a lot of casualties that are caused by motor. These I think are the causes of the accidents and not any spirits or gods. It can happen to anyone at all. I am a Christian and I do not believe in that, however I believe in God and I also trust the doctors and nurses who are providing care that my child will be fine. Even when me myself I am unwell, I do not attribute to any spirits but I know my God will heal me when I seek care from health experts” - P10

“It was meant to happen, and it had happened, so I don't really have any superstitions that this person in my family was the one who caused it. That is why it is called accidents, but I have to be strong for my niece since her parents are not here with us. I always seek medical advice when I am sick and I get better so I know hospital and medicines work so I am not worried at all” – P16

4.5.2 Pain and suffering

Exposure to traumatic events has an impact on individuals however how people's responses are generally different depending on individualities and severity of the impact. Often people are often not prepared to take some responsibilities and as a result they suffer great consequences. About a third of the respondents believed that the accident from which their children got injured had caused them a lot of pain and suffering and suffering, some believed that accidents caused and hence they believed that a ban on motorbikes would be more appropriate to prevent motorbike related accidents. This was evidenced by:

“Knowing that every accident the person dies and seeing my child in that situation, thought she's already dead. So, all I could do for myself was to cry. The kind of pains and situation my child went through it pains me a lot that she is going through it alone. If I could help, I would substitute mine for hers because I am an adult and my pain is nothing compared to hers.” –P3

“This accident has caused me to lose a lot, on the verge of even losing my child. So, I think we want to do something about them. I am currently unemployed and I am suffering a lot while taking care of her alone and having to care for her other younger siblings. At times I get so tired but must be strong and swallow everything, prioritize my child health's above everything and I believe her recovery is much better than my pain and suffering” – P2

4.6 Health Promotion Behaviours

In eliciting responses from the family care givers, all sixteen of them disclosed that in as much as they were ready to perform their respective roles, external assistance from other family members, government, other non-governmental organizations particularly for children involved

in road traffic accidents would be beneficial towards improving both patients and parent's health and wellbeing. Similarly, others also indicated availability of healthcare workers to provide adequate and timely health information for them could also be beneficial to keeping themselves healthy.

4.6.1 Governmental support

In as much as all respondents indicated both they and their children had registered for the Government of Ghana's National Health Insurance, the cost of managing children involved additional expenses often leading them to challenges in paying for the extra costs given unexpected events. As a result, it was revealed by many of them that there was some sort of assistance for children involved in road traffic accidents which parents can access that will eventually improve parents mental and emotional health as well as improve children's health.

Three of the respondents indicated that to help parents who have children admitted on account of road traffic accidents, there ought to be some sort of funds or subsidies from the government for specific medications during emergency situations like for children. This was evidenced by;

"I think the government needs to put up a supportive system for children who have been involved in road traffic accidents together with their families. This is because accidents occur suddenly and you must mobilize some financial resources although you have NHIS. But you might not have it some point. Hence, I think that if the government can assist in some forms, it will help us a lot because the stress for us is too much" –P-2

"There should be some form of assistance in the hospital and some of the drugs are expensive. Also, some form of donation or something that can be on there which can be kept in case of emergency, for some people, it's hard for them to get support" – P3.

“It is not easy at all; I have been moving in and out of the hospital for the past six weeks because of this road accident. My child was knocked down by a motorbike, the rider was only 18 years, unemployed and his family is not here as well. What can you do about it if he cannot genuinely support the mother? There is nothing you can do (sobs). I must care for my child but it expensive. I am a single mother with 2 children so all I am saying is if there is a governmental programme to help children in this state it might decrease our pressure small even it is subsidizing some drugs and labs.” – P12

4.6.2 Non-Governmental Organisation (NGO) Support

With respect to Nongovernmental subtheme, about six of the respondents also indicated that some non-governmental organisations could support people by investing in the hospital and other patients and their families in such situations for instance by providing appropriate accommodation and canteen facilities for relatives of sick people and patients themselves. This they claimed would be beneficial in improving their wellbeing indirectly.

This was evidenced by:

“Getting food every day is not easy, especially in the evening and on weekends in the facility. You know healthy food is healthy living. A sick child and his family should also eat very well while on admission. Here, they do well, they give us food usually in the morning, and afternoon, so investment into the. hospital by some big people can help” - P5.

“Yes, I think that non-governmental agencies or any other person can help in his own way in any form possible by providing something very small for children like these. Let me say investment because when they donate, the money at the moment, when the need is

not needed, that money can go into something else to provide a safe place for people who brings their patients to the hospital to have a good rest or get a good food to eat” –P8.

“So, I think the hospital should provide us with accommodation that we can sleep but be accessible to them when they need us, and food when we are in the hospital. If it is finding some challenges, management and leaders of the organization can ask for some assistance from other important stakeholders from the community which I think in the long run can influence us positively, because some of the finances can be channeled to providing some quality lodging facilities as well as eating facilities within the hospital environment to help ease some of our problem.” - P9

4.6.3 Health education

Access to health services including adequate and accurate information about specific disorders, its prevention and management to individuals serve as a fundamental principle of health promotion. As a result, it helps empower everyone to take some control of individual and societal factors that influence ill health. It was revealed by the respondents that each time they make themselves available to the healthcare providers, they were provided with adequate health information for which improved upon their level of functioning especially if the health information was provided on time. This is revealed by.

“With the healthcare professionals, they communicate everything that is needed to me concerning my niece.

They communicate everything they want to do for me, so if there is anything I don't understand too, I do well to ask and then I get the explanations I want, so, um, personally, I'm okay” – P4

“What I only think of is, I think is the doctors who know best. So, I only look up to them. I have no intention of seeking for medical services elsewhere. I have taken opportunity while here to ask every question even including myself as in how I can remain healthy to take care of myself.” – P5.

“I make her happy so that she can get better as the nurses told me to do when we were at the hospital. The health care workers have been phenomenal since admission. They are not quick to judge, neither do they get angry. I worry them myself even with the kind of food I should to get healthy myself. I remember when we care here first, there were no beds for us the mothers. We used to sleep in the plastic chairs so by the time you wake up, you will be experiencing bodily pains all over, so I reported and they guided me through everything. For that I was very happy and no I feel very okay going to them anytime for information.” – P 12

4.6.4 Family Support

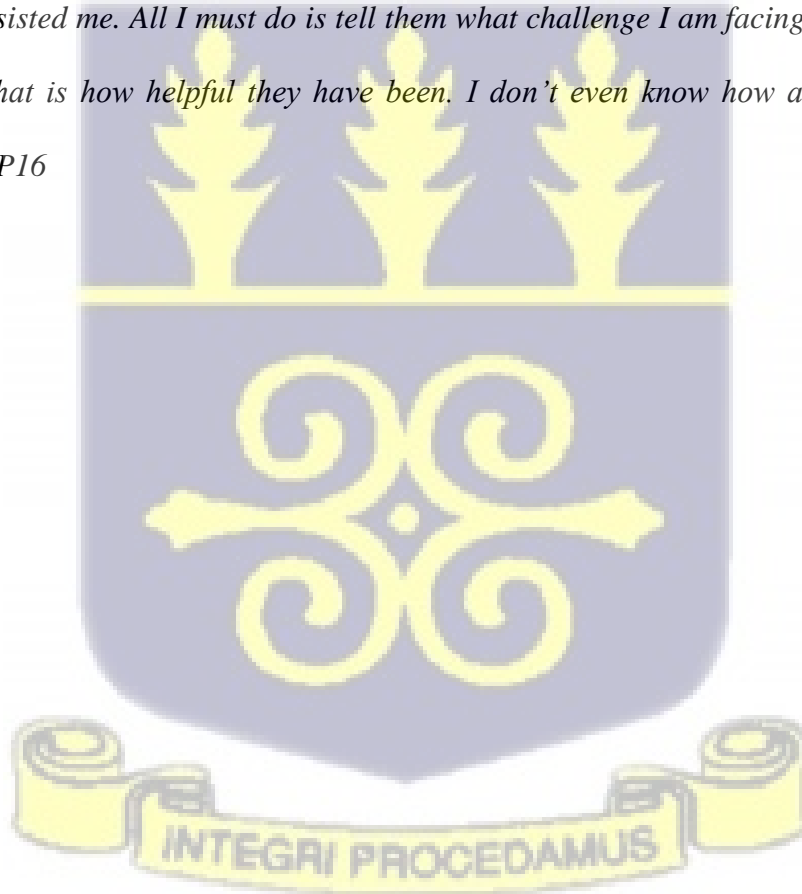
Social support system has been proven over the years to be effective promoting healthy living among ailing individuals as a result children primary support systems re their family and siblings. At the same time parents social support system also may include their parents, siblings, children or other external people such as friends and other external family members. It was revealed from the study that they go through many challenges while performing their roles under these circumstances and as a result they tend to other people from the families to ease their burden.

All but one of the respondents indicated they had some financial challenges which resulted them in seeking help from many areas. Also, many of them indicated that their families and

friends provided a lot of assistance for them not only financial which helped them to get through some of their challenges. This was evidenced by,

“My family have been very instrumental towards the care of this child since the accident occurred. If not for the help my friends, my family members and even her school. Had it not been this kind gesture, I would have suffered a lot. I have not been able to work so it is they who support me gradually”. - P13

“Family support is everything. They have assisted me financially, ermm spiritually by praying, um, physically by visiting, per what I went through, I think that is ok. They have really assisted me. All I must do is tell them what challenge I am facing and they will just assist. That is how helpful they have been. I don't even know how am going to repay them” – P16



CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

This chapter discusses the results that were gathered from the research and it illustrates the strengths and limitations of the study results with reference to relevant literature and theoretical framework used for this. It also contains an explanation of the significance and implications of the findings. The study findings generally revealed that family care givers either parents or secondary guardians are involved the care of the care of injured through the entire disease process till recovery.

5.1 Demographic characteristics of participants.

A total of sixteen respondents were selected for the study. The demographic characteristics of the respondents enhances the varied perspectives and experiences of each one of them which is relevant to the research inquiry (Foster et al., 2019; Gutowska, 2022).

With respect to occupation, most of respondents identified themselves as traders, with a minority engaged in farming, and one respondent classified as an unemployed mother. Respondents' occupation was relevant to the study because taking care of children hospitalized as result of road traffic accidents tend to be capital intensive requiring a lot of out-of-pocket expenditure by parents as was disclosed by majority of the study participants. Hence respondents' source of income was relevant in taking care of their hospitalized children. Despite majority of them indicated they were facing some financial challenges, they received appreciated and received some assistance from family members, church members and other benevolent embers of the community. As the care caregivers were concerned about the cost of treatment, sometimes often led to them seeking help from family members, church members among others.

This findings were found to be similar to studies from similar to studies from Jeyathevan et al. (2019) and Lernevall et al. (2020) who highlighted that caregivers financial resources were necessary for health recovery in hospitalized children, this study was found to be consistent with their findings as majority of the caregivers had a means of employment and were each making ends meet capable of taking care of the primary needs of the hospitalized children.

5.2 Needs of family Caregivers

The study sought out to identify the needs of family care givers for which it was revealed that some from the study that majority care givers had challenges meeting their physical needs such as adequate nutrition, good sleeping areas and sleeping patterns. Some were also worried to the extent that they would exchange the physical pains their children were going through to experience the pain if they had their way. This study results was found to be with a systematic review in Italy by Longo et al., (2020) who highlighted family caregiver strain and challenges when caring for orthopedic patients that the family caregivers roles during these circumstances could also lead to negative effects on their physical, emotional and mental states, hence the physical and emotional needs of the family caregivers is critical for the recovery of their sick children. Additionally, parents and caregivers experiencing difficulties with feeding and adequate sleeping in sleeping areas while caring for their children admitted as a result of road traffic accident from this study also agrees with the results of the study by Bekui et al., (2023) in Ghana where it was highlighted that family caregivers often physical experienced health challenges such as aches and pains, fatigue and sleep disruption while caring for their sick children hence the need to concentrate on by the caregivers which relates to physical challenges being experienced while on admission. Again, the results from the respondents from this study indicated that they paid much attention to the caring for their children and as result,

they made sure that their children were safe and doing better before they even considered themselves. Majority of them experienced bodily pains, mobility challenges, mosquito and other insect bites because there had to either sleep on the bare floor or on chairs if they wanted to closer with their children on the hospital premises because there were not accommodation facilities for them and hence preferred these methods over going home to sleep while their children remained on the hospital wards. Paying much attention and prioritizing the needs of their children conforms to Ferrell et al's (2018) which highlighted caregivers duties towards their children at times were burdensome because they often prioritized the care of the sick relatives over themselves and eventually impacting on their personal physical and general wellbeing in the process.

The findings from this study further revealed that family caregivers sometimes experienced emotional disturbances once their wards are unwell regardless of the severity of their disease condition, the availability or non-availability of funds and regardless of the whether it was accidental or not. Accordingly, they also tend to worry excessively, think a lot and often asked themselves questions about whether they were good or bad parents for this to have happened to their children regardless of how careful they supervised their children which affected their emotional wellbeing. The impairment in caregivers' emotional wellbeing suggests parents and other family caregivers caring for a child who is unhealthy and totally dependent on the caregivers can be burdensome hence there is the need for them to appreciate the challenges and seek assistance and manage the challenges very effectively. This was clearly demonstrated by studies from Ohene, (2017) and Ohene et al. (2019) who suggesting that family caregivers were able to managing their emotions and perform their parental care roles although despite the several challenges they go through in order to promote early recovery of their wards. Ohene et

al. (2019) further highlighted that self-blame and guilt were often experienced by caregivers when their children were sick for prolonged periods and as revealed by this study, there were varying lengths of hospitalization which impacted the emotional and mental states of the family caregivers. Again, the parents who went through mental and emotional stress while caring for their wards and as a result needed much information to be shared among especially concerning specific healthcare roles, they were responsible to play and if delayed or absent was proven to have caused emotional and mental stress. Owing to this, Rosa et al. (2020) who had earlier highlighted in their study that knowledge about health conditions which otherwise would be beneficial to parents and caregivers would have helped them in recognizing some challenges and other symptoms which their children when provided would be beneficial to prevent some potential complications and disabilities however if absent could be challenging for caregivers hence this finding significantly relates to that of Rosa and colleagues.

According to this when family caregivers paid significant attention to healthcare professionals making themselves available to be taught and clarification all doubts and misconceptions made them stay focused, cleared doubts and improved their psychological wellbeing. This supports Lernevall et al.'s (2020) study on support needs of hospitalised children with burn injury where it was highlighted that family caregivers needed adequate information at every stage of the treatment to equip them to overcome the challenges they were confronted with psychologically.

5.3 Task of family care givers

Most of the respondents from the study revealed they were biological guardians primarily responsible for performing all physical roles such as, purchasing medications as well as helping to perform activities of daily living in a way and manner that was appreciable by healthcare staff

while on admission. This was because they had received some knowledge and guidance from their primary healthcare providers. Accordingly, the various forms of support given by healthcare professionals them helped to equip them better care for their children. This suggests that this findings supports Cheng et al.'s (2018) study which highlighted that support services and guidance when provided for family caregivers helps improve their level of confidence, problem solving capabilities and social support satisfaction at every stage of their illness. The educational support and knowledge received from healthcare providers which improved their level of confidence to perform these roles is also consistent with earlier studies from Jeyathevan et al.'s (2019). This is because because it also helped and guided parents on the knowledge and acceptance of their respective caregiving roles at the hospital and at home as well as the differences in these different environments. This helped to appreciate their boundaries at hospitals and specific responsibilities they are expected to play while on admission as dictated and supervised by healthcare professionals.

Despite the challenges family caregivers were confronted with, they are willing to trust the healthcare workers and seek assistance towards promoting and maintaining their own health because it was part of their responsibilities. The various forms of assistance they sought to receive from the healthcare givers served as positive resources for their wellbeing and ultimately that of their children supporting a study by Lever et al. (2019) which highlighted that sufficient resources, provision of good counselling and support by healthcare professional were positive enforcers for family caregivers in performing specific responsibilities. In as much as much healthcare providers are willing to offer all the needed assistance directly to their primary patients and their caregivers, parents and family caregivers should be ready themselves to be impacted to help improve their level of performance. This results from the study was also found

to be consistent with Cheng et al.'s (2018) study which highlighted that if healthcare workers intervened and provided some assistance to family care givers in terms of difficulties regardless of the aetiologies there was significant improvement in their problem solving and coping abilities hence they are able to perform their respective roles and deal with tough emotional and physical challenges thereby improving their level of confidence and resilience and similar to this study most of the family caregivers were ready and willing to trust the healthcare professionals and seek assistance and guidance in the performance of their roles. Additionally the findings are also inconsistent with Bayuo and Wong's study (2021) who also highlighted that that parents and caregivers were often not prepared to perform some parental roles but were forced to learn and take up because of the unexpected events. Although true for both studies, this findings from this study indicated the caregivers were more than willing to learn to perform additional roles as instructed and supervised by healthcare professionals which opposes the caregivers from Bayuo and Wong's study where they were unwilling but forced to take up additional responsibilities.

5.4 The beliefs and attitude of family caregivers

From the study it was revealed that all the family caregivers had particular belief system in a supernatural being with many of them believing and appreciating in the existence of God regardless of their individual religious affiliations. This revelation was found to be consistent with Juguera Rodriguez et al., (2018) who highlighted in their study that family caregivers believed and relied God on a supernatural level which eventually affected and improve the wellbeing of family care givers and their loved ones who were sick and unwell. Additionally belief in God, supernatural being religious practices as revealed from this study is also consistent with Ferrell et al.'s (2018) study which also highlighted that religious rituals performed by family care givers was significant for the survival of their injured children although this study

findings did not specifically reveal any of caregivers performing specific revealed religious rituals. Further, caregivers believing in a supernatural and performing some religious practices also aligns with Sudarsan et al. (2022) whose study in Asia also revealed that family caregivers cultural beliefs, religious and spiritual beliefs and practices also influenced care giving practices.

The study results further revealed that the family caregivers also believed that the outcome of all accidents were instantaneous deaths and other losses at the time of its occurrence regardless of the medium through which it happened. This was found to be inconsistent with the study from Ohene et al. (2019) who also highlighted that family caregivers feared the unknown outcome of their ward's injuries, presumed to be death of their children child dying including other medical treatment outcome uncertainties however family caregiver in this study were optimistic about total recovery of their wards. This suggests that the participants of this study were sure of the outcomes compared to Ohene and colleagues whose study participants only had negative perceptions.

Additionally, this study also revealed that some of the family care believers experienced losses from the injuries sustained from motorbike and vehicular accidents and as a result it caused them a lot of pain and suffering, physically emotionally and psychologically which was found to be consistent with Juguera Rodriguez et al., (2018). Juguera Rodriguez and colleagues revealed that family caregivers played a significant role while caring for their patients with spinal cord injuries of varying aetiologies and severities, however they also experienced challenges with their emotional, mental and physical. Overall, these suggest that in order to help them perform their respective roles, there was the need for them to be in optimal health emotionally, mentally and physically and also to believe and rely on God a supernatural level for improved health outcomes.

5.5 Health Promotion Behaviors

The non-financial cost arising from having to care for one's own child or loved hospitalised caused numerous challenges for the caregivers of this study and as result requested for assistance from both governmental and nongovernmental organisations help mitigate the challenges and help promote their overall wellbeing. This was found to be consistent with the study from Ruiz-Adame et al. (2019) who highlighted that the opportunity cost that are involved in being a caregiver had the propensity to affect the general wellbeing which can also compromise the ability of the family caregivers to perform their caregiving roles and responsibilities.

Most of the care givers also experienced financial challenges in areas of settling hospital bills, for their own upkeep and that of their sick child which often affected their emotional wellbeing but not affecting their total performance. Although the study participants were not diagnosed with depression to affect their nutrition and sleeping patterns as described by Stones et al, (2020), it can therefore be concluded this result is distinct from that of Stones and colleagues.

Although family care givers revealed that they had several challenges regarding their length of hospitalization, the study revealed that most of the accidents occurred instantaneously, however after the injuries they were quite ready to perform their respective roles, however this findings differs from the study by Bayuo and Wong (2021). From their study, it was who indicated that parents and family caregivers performing their normal responsibilities are often not ready for some roles however in the event of accidents, they are forced to assume certain additional parental roles in order to help cater for children to obtain adequate health and recovery. Again, it was revealed that they sought for financial assistance from friends, family members and sometimes church members because they belonged to social and religious groups

under these unfavorable conditions especially if they cannot meet the financial needs of their children. This was found to be consistent with study from Chang et al., (2021) who revealed that family caregivers tend to have adequate social support structures that helped them to manage the stressors they were going through daily while caring for their children who had been hospitalised in the intensive care units.

From the study, majority of the respondents also revealed that they were willing to do everything possible to save the lives of their loved ones who had been involved in the accidents regardless of what happens to own health although. In as much as the family care givers were emotionally troubled, they also revealed that in order to help save their children's lives, they were willing to accept assistance, education and training on some other responsibilities which would be beneficial to the total recovery of their family members and healthcare professionals. This was also found to be consistent with study from van Sleuwen et al., (2020). According to van Sleuwen et al., (2020), family caregivers tend to experience mental health challenges such as anxiety, stress and difficulty expressing emotions. Hence, it was concluded that there was a need for healthcare providers to also focus on family caregivers to ensure adequate wellbeing and improved quality of life directly and indirectly for the sick children.

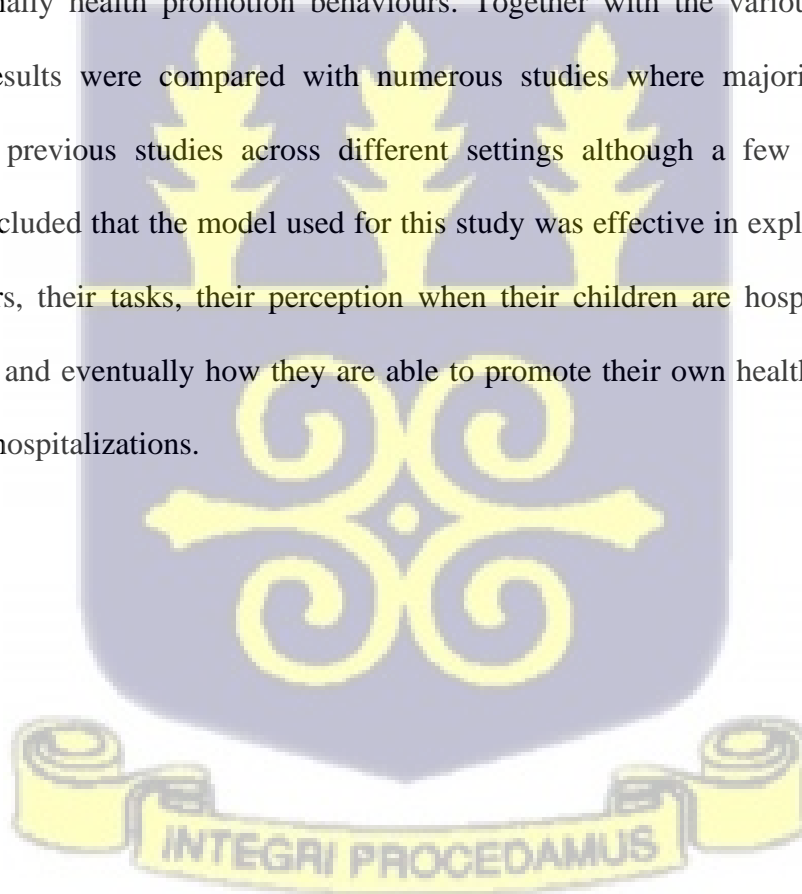
5.6 Effectiveness of the Model Used for This Study

As discussed earlier in the study that the model explains that caregivers often develop health problems among themselves while providing the necessary support for their sick relatives which they may ignore in many situations but capable of impacting them negatively physically, emotionally, mentally socially or financially (Zhang et al., 2021). Overall, the model fulfilled its intended cause explicitly identifying the various needs tasks and challenges family caregivers

experienced as well as the various support systems from relevant stakeholders to help improve their health and general wellbeing regardless of their various challenges they experienced. As a result, it can be concluded that the model was very effective in organizing the study through from literature review, semi structured interviews, study results presentation and finally in the discussion session.

5.7 Summary and conclusion

The discussion was carried out in relation to the four constructs of the caregiver model which included the needs of family caregivers, the task of family care givers, the beliefs and attitudes and finally health promotion behaviours. Together with the various subthemes that emerged, the results were compared with numerous studies where majority of them were consistent with previous studies across different settings although a few were not. It can therefore be concluded that the model used for this study was effective in exploring the needs of family caregivers, their tasks, their perception when their children are hospitalised post road traffic accidents and eventually how they are able to promote their own health and that of their children during hospitalizations.



CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter contains the conclusion and recommendations of the findings derived from the study. It contains a summary, conclusion, and recommendations.

6.2 Summary

Majority of the respondents were biologic parents who were predominantly traders. With respect to tribe, majority of them were Ewes while a few of them were Akans and Gas. Many of the respondents completed SHS level education and few had had tertiary level education and their ages ranged between 20 and 34 years.

From the study four major themes and twelve subthemes emerged. The major subthemes were in tandem with the constructs of the theoretical framework that was used for this study. The major themes were needs of family care givers out of which four subthemes emerged which were physical, emotional, financial and psychological needs of the family caregivers. Additionally, task of family caregivers also emerged as a major and two other subthemes being physical responsibilities and child protection. The third subtheme that emerged was beliefs and attitude of family caregivers where the subthemes religious belief system and child protection were the subthemes that emerged. The last major subtheme that emerged was health promotion behaviors. Four subthemes also emerged from the last major theme which were governmental support, non-governmental support, health education and family support.

Again, it was revealed that most of the respondents disclosed that they experienced some form of challenges with respect to caring for their children. More so, all the respondents indicated that

they were solely and fundamentally responsible for performing their basic physical roles such as feeding, bathing, purchasing medication amongst others regardless of what uncomfortable situation physically emotional and psychologically they went through.

Furthermore, majority of them also disclosed that they experienced financial challenges pertaining to payment of medication and healthcare cost associated with the hospitalization. Others also disclosed that they had challenges with sleeping and resting and having adequate nutrition as a result of the state of the wards. This in many situations created emotional and psychological challenges for them, however they were optimistic of good healthcare outcomes for their wards despite these challenges they went through.

In as much as some of the respondents indicated that they were unsure of the outcome of accidents with a few indicating spontaneous death being the outcome as well as pain and suffering, others had no superstitious or beliefs about the cause of accidents as well as regarding the outcome of their ward's ill health. Regardless of these beliefs, all were optimistic about positive healthcare outcomes because they believed they were the primary health advocates for their children's.

All the respondents revealed that some assistance from family, government and non-governmental organizations was necessary to promote the healthcare of any family caregiver caring for children involved in road traffic accidents, and thus, involvement and participation would be beneficial to the overall health of children and their family caregivers.

6.2.2 Conclusion

This study explored the experiences of family caregivers of children hospitalized due to road traffic accidents at the Ho Teaching Hospital, Ghana. Findings indicate that caregivers face

significant emotional, physical, and psychological challenges, often navigating unforeseen caregiving roles with minimal preparation. Despite the burden, caregiver gradually adapt to their responsibilities, driven by legal, societal, familial expectations to ensure the well-being of their hospitalized children.

The research further revealed that caregivers' coping mechanisms are shaped by healthcare support, personal resilience, and access to information. While professional guidance plays a crucial role in equipping caregivers fir duties, gaps in institutional support systems contribute to heightened stress and compromised health. Family caregivers also engage in health promotion behaviours, yet their own well-being is frequently neglected due to the overwhelming demands of caregiving. Based on these findings, it can be concluded that caregivers, whether biological parents or legal guardians, undertake both expected and additional caregiving roles, often at the expense of their own health.

To mitigate these challenges, structured interventions, including enhanced psychosocial support, caregiver education, and improved healthcare engagement, are essential in fostering a sustainable caregiving model. Strengthening these support mechanisms will not only improve caregiver outcomes but also contribute to more effective child rehabilitation and recovery.

6.3 Implications of the study

Overall, the result of this study is suitable for application in education, practice, and policy. The challenges the family caregivers experienced while caring for children hospitalized as a result of road traffic accidents revealed a gap in integrating family caregivers into the care and therefore in order to mitigate these challenges it is necessary for all managers of healthcare institutions to develop sound local policies specifically targeted at the specific challenges

implemented accordingly. Additionally, continuous professional development studies in medical sciences, nursing and allied health serves another boost for quality knowledge acquisition and practical application of concepts to improve well-being of parents and their family carers. More so, in-service training's in various health institutions, targeting nurses, midwives, pharmacists, laboratory personnel, doctors and physician assistants maybe beneficial to acquiring, intensifying practical evidence-based knowledge and skills necessary for improving quality health outcomes for family care givers.

The challenges the family caregivers experienced while caring for children hospitalized as a result of road traffic accidents revealed a gap in integrating family caregivers into the care and therefore in order to mitigate these challenges it is necessary for all managers of healthcare institutions to develop sound local policies specifically targeted at the specific challenges implemented accordingly. Also, to ensure these policies are implemented by relevant stakeholders to properly integrate the ethnos cultural perspectives of family care givers in caring for their sick relatives for better practice in future.

It was evident from the study that much efforts were directed towards improving the health status of the children who have been hospitalized and as result family caregivers were often neglected in many instances. It is therefore significant for healthcare workers to consciously integrate family caregivers in the care of their children and their well-being monitored while on admission and post admission. Again, healthcare professionals should also prioritize the care of these sick children by way of integrating family care approach through which parental and familial strengths and challenges would be identified and specific support and interventions tailored to suit these needs and improve their general health and wellbeing.

With respect to policy, it is significant for policy makers in health care system plan, implement and monitor the appropriate integration of family centered care approach across all level of health care institutions. This is to facilitate optimal positive health outcomes for patients, families and their significant others.

Again, the development of standard operating procedures specifically for families of children with hospitalized on account of road traffic accidents where mental healthcare access and coverage is significant in promoting psychological and emotional wellbeing of all caregivers

6.4 Limitations

The study was limited to family care givers in only one tertiary hospital which limited the generalization of the study. Majority of the respondents were females with only one male therefore the study did not provide enough information from the perspectives of fathers with these experiences therefore responses cannot be generalized for both mothers and fathers.

6.5 Recommendations

From the study, two main recommendations can be made: recommendations for policy action and for future research.

6.6.1 Recommendation for policy action

The researcher recommends implementing a comprehensive support program at Ho Teaching Hospital to address the unique challenges faced by family caregivers of children hospitalized due to road traffic accidents.

Also, the researcher recommends relevant stakeholders (health workforce monitoring and supervision directorate) in the Ho teaching Hospital to help conduct education sessions to educate caregivers about the medical and emotional aspects of caring for a child recovering from

a road traffic accident. Provide information on rehabilitation processes, potential complications, and strategies for coping.

Additionally, provision of Psychosocial Support Service and establishing counseling services to address the emotional toll on caregivers. This can include individual or group counseling sessions, aimed at helping caregivers navigate the stress and trauma associated with the accident. More so, ensuring and enhancing financial support to ease the burden on families, considering the potential economic strain caused by medical expenses and potential loss of income during the caregiving period. Further, introducing respite care options to provide caregivers with temporary relief. This could involve arranging for trained volunteers or professional caregivers to step in, allowing family members to take short breaks and recharge.

Creation / Establishment of Community Engagement Programs. Fostering community support through awareness campaigns and engagement programs. This could involve local organizations, schools, and religious institutions to create a network of assistance for the affected families. At the same time, advocating for policies that recognize and address the specific needs of family caregivers in such situations. This may involve working with governmental bodies to ensure legislative support for caregiver rights and assistance programs.

6.3.2 Recommendation for future research

The grey areas identified from this study can ensure further studies among family care givers involved in caring for children with road traffic injuries. Some of the studies may include but not limited to:

1. Wellbeing of family caregivers of children hospitalized on account of road traffic accident.

2. Family caregivers experiences with healthcare staff while caring for children hospitalized on account of road traffic accident.
3. Evaluate the existing healthcare support systems and their effectiveness in assisting family caregivers.
4. Examine the cultural factors that influence caregiving experiences.



REFERENCE

- Adanu, E. K., Dzinyela, R., & Agyemang, W. (2023). A comprehensive study of child pedestrian crash outcomes in Ghana. *Accident Analysis & Prevention*, *189*, 107146.
<https://doi.org/https://doi.org/10.1016/j.aap.2023.107146>
- Adonteng-Kissi, O. (2021). Child Labour Versus Realising Children's Right to Provision, Protection, and Participation in Ghana. *Australian Social Work*, *74*(4), 464–479.
<https://doi.org/10.1080/0312407X.2020.1742363>
- Amanullah, S., Vithianathan, A., Snelgrove, N., Ghuloum, S., & Shivakumar, K. S. (2020). *Women as Caregivers in the Elderly BT - Mental Health and Illness of Women* (P. S. Chandra, H. Herrman, J. Fisher, & A. Riecher-Rössler (eds.); pp. 3–18). Springer Singapore. https://doi.org/10.1007/978-981-10-2369-9_1
- Bayuo, J., & Wong, F. K. Y. (2021). Issues and concerns of family members of burn patients: A scoping review. *Burns*, *47*(3), 503–524.
<https://doi.org/https://doi.org/10.1016/j.burns.2020.04.023>
- Blankson, P.-K., Nonvignon, J., Aryeetey, G., & Aikins, M. (2020). Injuries and their related household costs in a tertiary hospital in Ghana. *African Journal of Emergency Medicine*, *10*, S44–S49. <https://doi.org/https://doi.org/10.1016/j.afjem.2020.04.004>
- Blankson, P., Amoako, J. K. A., Asah-opoku, K., Odei-ansong, F., & Lartey, M. Y. (2019). *Epidemiology of injuries presenting to the accident centre of Korle-Bu Teaching Hospital, Ghana*. *3*, 1–6.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.

Brennan-Ing, M., Seidel, L., & Karpiak, S. E. (2017). Social Support Systems and Social Network Characteristics of Older Adults with HIV. *Interdisciplinary Topics in Gerontology and Geriatrics*, 42, 159–172. <https://doi.org/10.1159/000448561>

Carter, R. (2023). *Helping yourself help others: A book for caregivers*. University of Arkansas Press.

Chang, P.-Y., Chang, T.-H., & Yu, J.-M. (2021). Perceived stress and social support needs among primary family caregivers of ICU Patients in Taiwan. *Heart & Lung*, 50(4), 491–498. <https://doi.org/10.1016/j.hrtlng.2021.03.001>

Cheng, H. Y., Chair, S. Y., & Chau, J. P. C. (2018). Effectiveness of a strength-oriented psychoeducation on caregiving competence, problem-solving abilities, psychosocial outcomes and physical health among family caregiver of stroke survivors: A randomised controlled trial. *International Journal of Nursing Studies*, 87, 84–93. <https://doi.org/10.1016/j.ijnurstu.2018.07.005>

Coelho, A., de Brito, M., Teixeira, P., Frade, P., Barros, L., & Barbosa, A. (2019). Family Caregivers' Anticipatory Grief: A Conceptual Framework for Understanding Its Multiple Challenges. *Qualitative Health Research*, 30(5), 693–703. <https://doi.org/10.1177/1049732319873330>

Cudjoe, E., Abdullah, A., & Chua, A. A. (2020). Children's Participation in Child Protection Practice in Ghana: Practitioners' Recommendations for Practice. *Journal of Social Service*

Research, 46(4), 462–474. <https://doi.org/10.1080/01488376.2019.1596196>

de Beer, J., & Brysiewicz, P. (2019). Developing a theory of family care during critical illness.

Southern African Journal of Critical Care, 35(1), 19–24.

<https://doi.org/10.7196/SAJCC.2019.v35i1.388>

Dellinger, A., & Gilchrist, J. (2019). Leading Causes of Fatal and Nonfatal Unintentional Injury

for Children and Teens and the Role of Lifestyle Clinicians. *American Journal of Lifestyle*

Medicine, 13(1), 7–21. <https://doi.org/10.1177/1559827617696297>

Dixe, M. D. A. C. R., Da Conceição Teixeira, L. F., Areosa, T. J. T. C. C., Frontini, R. C., De

Jesus Almeida Peralta, T., & Querido, A. I. F. (2019). Needs and skills of informal

caregivers to care for a dependent person: A cross-sectional study. *BMC Geriatrics*, 19(1),

1–9. <https://doi.org/10.1186/s12877-019-1274-0>

Ferrell, B., Kravitz, K., Borneman, T., & Friedmann, E. (2018). Family Caregivers: A

Qualitative Study to Better Understand the Quality-of-Life Concerns and Needs of This

Population. *Clinical Journal of Oncology Nursing*, 22, 286–294.

<https://doi.org/10.1188/18.CJON.286-294>

Foster, K., Mitchell, R., Young, A., Van, C., & Curtis, K. (2019). Parent experiences and

psychosocial support needs 6 months following paediatric critical injury: A qualitative

study. *Injury*, 50(5), 1082–1088. <https://doi.org/https://doi.org/10.1016/j.injury.2019.01.004>

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic

saturation in qualitative research. *PLoS ONE*, 15(5), 1–17.

<https://doi.org/10.1371/journal.pone.0232076>

- Guion, L. A., Diehl, D. C., & McDonald, D. (2011). *Conducting an In-depth Interview 1 Conducting an In-depth Interview*. 2–4.
- Gutowska, A. (2022). The Care of Adults with Intellectual Disabilities: Informal (Family) Caregivers' Perspectives. *International Journal of Environmental Research and Public Health*, 19(23). <https://doi.org/10.3390/ijerph192315622>
- Holmes, C. J., Barton, A. W., MacKillop, J., Galván, A., Owens, M. M., McCormick, M. J., Yu, T., Beach, S. R. H., Brody, G. H., & Sweet, L. H. (2018). Parenting and Salience Network Connectivity Among African Americans: A Protective Pathway for Health-Risk Behaviors. *Biological Psychiatry*, 84(5), 365–371. <https://doi.org/https://doi.org/10.1016/j.biopsych.2018.03.003>
- January, A. M., Kelly, E. H., Russell, H. F., Zebracki, K., & Vogel, L. C. (2019). Patterns of coping among caregivers of children with spinal cord injury: Associations with parent and child well-being. *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, 37(2), 150–161. <https://doi.org/10.1037/fsh0000415>
- Jeyathevan, G., Cameron, J. I., Craven, B. C., Munce, S. E. P., & Jaglal, S. B. (2019). Rebuilding relationships after a spinal cord injury: Experiences of family caregivers and care recipients. *BMC Neurology*, 19(1), 1–13. <https://doi.org/10.1186/s12883-019-1347-x>
- Jeyathevan, G., Catharine Craven, B., Cameron, J. I., & Jaglal, S. B. (2020). Facilitators and barriers to supporting individuals with spinal cord injury in the community: experiences of family caregivers and care recipients. *Disability and Rehabilitation*, 42(13), 1844–1854. <https://doi.org/10.1080/09638288.2018.1541102>

Juguera Rodriguez, L., Pardo Rios, M., Leal Costa, C., Castillo Hermoso, M., Perez Alonso, N., & Díaz Agea, J. L. (2018). Relatives of people with spinal cord injury: A qualitative study of caregivers' metamorphosis. *Spinal Cord*, 56(6), 548–549. <https://doi.org/10.1038/s41393-018-0092-0>

Lawton, A. J., Lee, K. A., Cheville, A. L., Ferrone, M. L., Rades, D., Balboni, T. A., & Abraham, J. L. (2019). Assessment and Management of Patients with Metastatic Spinal Cord Compression: A Multidisciplinary Review. *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology*, 37(1), 61–71. <https://doi.org/10.1200/JCO.2018.78.1211>

Lernevall, L. S. T., Moi, A. L., Cleary, M., Kornhaber, R., & Dreyer, P. (2020). Support needs of parents of hospitalised children with a burn injury: An integrative review. *Burns*, 46(4), 771–781. <https://doi.org/10.1016/j.burns.2019.04.021>

Lever, K., Peng, J., Lundine, J. P., Caupp, S., Wheeler, K. K., Sribnick, E. A., & Xiang, H. (2019). Attending Follow-up Appointments After Pediatric Traumatic Brain Injury: Caregiver-Perceived Barriers and Facilitators. *The Journal of Head Trauma Rehabilitation*, 34(2). https://journals.lww.com/headtraumarehab/fulltext/2019/03000/attending_follow_up_appointments_after_pediatric.12.aspx

Lilian, A. O. (2017). *Perceptions of Family Centred Care for Children in Ghana Hospitalised through Road Traffic Accident Lillian Akorfa Ohene A Thesis Submitted in Partial*

Fulfilment of the Requirements for the Award of Doctor of Philosophy Health and Life Sciences.

Longo, U. G., Matarese, M., Arcangeli, V., Alciati, V., Candela, V., Facchinetti, G., Marchetti, A., De Marinis, M. G., & Denaro, V. (2020). Family caregiver strain and challenges when caring for orthopedic patients: A systematic review. *Journal of Clinical Medicine*, 9(5). <https://doi.org/10.3390/jcm9051497>

Macneil, G., Kosberg, J., Durkin, D., Dooley, W., DeCoster, J., & Williamson, G. (2009). Caregiver Mental Health and Potentially Harmful Caregiving Behavior: The Central Role of Caregiver Anger. *The Gerontologist*, 50, 76–86. <https://doi.org/10.1093/geront/gnp099>

Macneil, G., Kosberg, J. I., Durkin, D. W., Dooley, W. K., Decoster, J., & Williamson, G. M. (2010). Caregiver mental health and potentially harmful caregiving behavior: the central role of caregiver anger. *The Gerontologist*, 50(1), 76–86. <https://doi.org/10.1093/geront/gnp099>

Nadarajah, A., Lazor, T., Meserve, A., Buchanan, F., Birken, C., & van den Heuvel, M. (2024). Experiences of Financial Stress and Supports in Caregivers During Pediatric Hospital Admission. *Hospital Pediatrics*, 14(4), 233–241. <https://doi.org/10.1542/hpeds.2023-007453>

Ning, P., Cheng, P., Schwebel, D. C., Yang, Y., Yu, R., Deng, J., Li, S., & Hu, G. (2019). An app-based intervention for caregivers to prevent unintentional injury among preschoolers: Cluster randomized controlled trial. *JMIR MHealth and UHealth*, 7(8). <https://doi.org/10.2196/13519>

- Ohene, L. A., Power, K. J., & Raghu, R. (2019). Parents' perception of family centred care for children hospitalized through road traffic accident: A qualitative study at two tertiary settings in Ghana. *International Journal of Africa Nursing Sciences*, *11*, 100176. <https://doi.org/https://doi.org/10.1016/j.ijans.2019.100176>
- Olsen, L. L., Ishikawa, T., Mâsse, L. C., Chan, G., & Brussoni, M. (2018). Risk Engagement and Protection Survey (REPS): developing and validating a survey tool on fathers' attitudes towards child injury protection and risk engagement. *Injury Prevention*, *24*(2), 106 LP – 112. <https://doi.org/10.1136/injuryprev-2017-042413>
- Prieto-González, P., Martínez-Castillo, J. L., Fernández-Galván, L. M., Casado, A., Soporki, S., & Sánchez-Infante, J. (2021). Epidemiology of sports-related injuries and associated risk factors in adolescent athletes: An injury surveillance. *International Journal of Environmental Research and Public Health*, *18*(9). <https://doi.org/10.3390/ijerph18094857>
- Pritchard, K. T., Baillargeon, J., Lee, W. C., Raji, M. A., & Kuo, Y. F. (2022). Trends in the Use of Opioids vs Nonpharmacologic Treatments in Adults with Pain, 2011-2019. *JAMA Network Open*, *5*(11), e2240612. <https://doi.org/10.1001/jamanetworkopen.2022.40612>
- Qiu, X., Sit, J. W. H., & Koo, F. K. (2018). The influence of Chinese culture on family caregivers of stroke survivors: a qualitative study. *Journal of Clinical Nursing*, *27*(1–2), e309–e319.
- Qureshi, H., & Unlu, Z. (2023). *Theoretical Saturation in Grounded Theory Studies: An Evaluative Tool*. *23*. <https://doi.org/10.18037/ausbd.1272631>
- Reynolds, L., Buchanan, B., Crabtree, S., & Bordanave, E. (2023). A Program to Improve the

Quality of Life of Caregivers of Older Adults with Chronic Conditions: A Pilot Study. *The Open Journal of Occupational Therapy*, 11(2), 1–11. <https://doi.org/10.15453/2168-6408.2073>

Riffin, C., Van Ness, P. H., Wolff, J. L., & Fried, T. (2019). Multifactorial Examination of Caregiver Burden in a National Sample of Family and Unpaid Caregivers. *Journal of the American Geriatrics Society*, 67(2), 277–283. <https://doi.org/10.1111/jgs.15664>

Rosa, R. D. L. da, Simões-Neto, J. P., Santos, R. L., Torres, B., Baptista, M. A. T., Kimura, N. R. S., & Dourado, M. C. N. (2020). Caregivers' resilience in mild and moderate Alzheimer's disease. *Aging & Mental Health*, 24(2), 250–258. <https://doi.org/10.1080/13607863.2018.1533520>

Ruiz-Adame Reina, M., Correa, M., & Burton, K. (2019). The opportunity costs of caring for people with dementia in Southern Spain. *Gaceta Sanitaria*, 33(1), 17–23. <https://doi.org/10.1016/j.gaceta.2017.06.004>

Scharlach, A. E., Gustavson, K., & Dal Santo, T. S. (2007). Assistance Received by Employed Caregivers and Their Care Recipients: Who Helps Care Recipients When Caregivers Work Full Time? *The Gerontologist*, 47(6), 752–762. <https://doi.org/10.1093/geront/47.6.752>

Schulz, R., & Sherwood, P. (2008). Physical and Mental Health Effects of Family Caregiving. *The American Journal of Nursing*, 108, 23–27; quiz 27. <https://doi.org/10.1097/01.NAJ.00003336406.45248.4c>

Shepherd-Banigan, M. E., Shapiro, A., McDuffie, J. R., Brancu, M., Sperber, N. R., Van Houtven, C. H., Kosinski, A. S., Mehta, N. N., Nagi, A., & Williams, J. W. (2018).

Interventions That Support or Involve Caregivers or Families of Patients with Traumatic Injury: a Systematic Review. *Journal of General Internal Medicine*, 33(7), 1177–1186. <https://doi.org/10.1007/s11606-018-4417-7>

Stallard, P. (2019). *Think good, feel good: A cognitive behavioural therapy workbook for children and young people*. John Wiley & Sons.

Subedi, K. R. (2021). Determining the Sample in Qualitative Research. *Scholars' Journal*, 4(December), 1–13. <https://doi.org/10.3126/scholars.v4i1.42457>

Sudarsan, I., Hoare, K., Sheridan, N., & Roberts, J. (2022). South Asian immigrants' and their family carers' beliefs, practices and experiences of childhood long-term conditions: An integrative review. *Journal of Advanced Nursing*, 78(7), 1897–1908. <https://doi.org/10.1111/jan.15217>

van Sleeuwen, D., van de Laar, F., Geense, W., van den Boogaard, M., & Zegers, M. (2020). Health problems among family caregivers of former intensive care unit (ICU) patients: an interview study. *BJGP Open*, 4(4), 1–13. <https://doi.org/10.3399/bjgpopen20X101061>

Weierbach, F. M., & Cao, Y. (2016, December). A model of health for family caregivers of elders. In *Healthcare* (Vol. 5, No. 1, p. 1). MDPI.

Williamson, V., Creswell, C., Butler, I., Christie, H., & Halligan, S. L. (2019). Parental Experiences of Supporting Children with Clinically Significant Post-Traumatic Distress: a Qualitative Study of Families Accessing Psychological Services. *Journal of Child and Adolescent Trauma*, 12(1), 61–72. <https://doi.org/10.1007/s40653-017-0158-8>

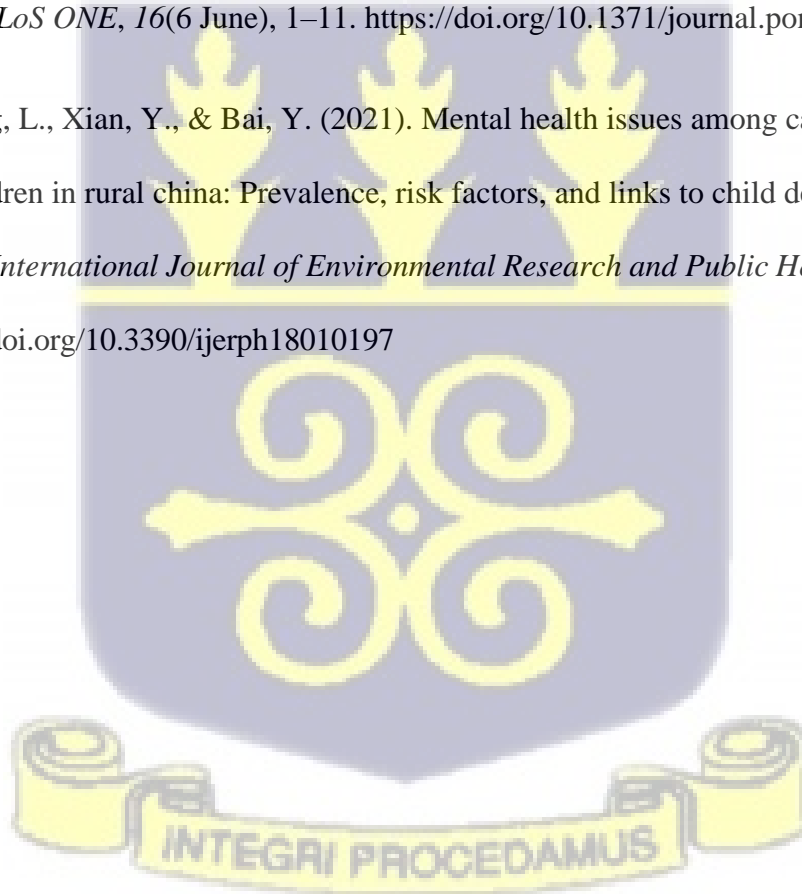
Yakubu, Y. H., Esmaili, M., & Navab, E. (2019). Family members' beliefs and attitudes

towards visiting policy in the intensive care units of Ghana. *Nursing Open*, 6(2), 526–534.
<https://doi.org/10.1002/nop2.234>

Yang, J. D., Hainaut, P., Gores, G. J., Amadou, A., Plymoth, A., & Roberts, L. R. (2019). A global view of hepatocellular carcinoma: trends, risk, prevention and management. *Nature Reviews. Gastroenterology & Hepatology*, 16(10), 589–604.
<https://doi.org/10.1038/s41575-019-0186-y>

Zelege, S., Kassaw, A., & Eshetie, Y. (2021). Non-pharmacological pain management practice and barriers among nurses working in Debre Tabor Comprehensive Specialized Hospital, Ethiopia. *PLoS ONE*, 16(6 June), 1–11. <https://doi.org/10.1371/journal.pone.0253086>

Zhang, S., Wang, L., Xian, Y., & Bai, Y. (2021). Mental health issues among caregivers of young children in rural china: Prevalence, risk factors, and links to child developmental outcomes. *International Journal of Environmental Research and Public Health*, 18(1), 1–19. <https://doi.org/10.3390/ijerph18010197>



APPENDICES

Appendix A – Letters of introduction and support from the school of Nursing and Midwifery for ethical clearance



SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref. No: 10929252

22nd February, 2023

The Chairman
Research Ethics Committee
Ho Teaching Hospital
Ho

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce to you **Mr. Cross Yaw Asamoah**, an MPhil Nursing student of the School of Nursing and Midwifery, University of Ghana, Legon.

The Scientific Review Committee of the School has approved the thesis topic: **"Exploring the Experiences of Family Caregivers Caring for their Children Hospitalized due to Road Traffic Accident at Ho Teaching Hospital."**

As part of the school's requirement, the student is required to obtain ethical clearance before embarking on data collection.

I hope that the Research Ethics Committee will consider the proposal and grant him ethical clearance to enable him to undertake the study.

Thank you.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Charles A. Klase'.

Charles A. Klase
School Administrator

School Administrator
School of Nursing & Midwifery
College of Health Sciences
University of Ghana

INTEGRI PROCEDAMUS



SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

DEPARTMENT OF PUBLIC HEALTH

Ref. No: 10929252

22nd February, 2022

The Chairperson
Research Ethics Committee
Ho Teaching Hospital
Ho

Dear Sir/Madam,

SUPPORT LETTER - ETHICAL CLEARANCE


This letter is to support the application for ethical clearance of **Mr. Cross Yaw Asamoah**, an MPhil Nursing student in the Department of Public Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the programme, he is to undertake a research on the topic: "Exploring the Experiences of Family Caregivers Caring for their Children Hospitalized due to Road Traffic Accident at Ho Teaching Hospital."

I hope that the Research Ethics Committee will consider the proposal to enable him collect data.

Thank you.

Yours faithfully,


Dr. Josephine Kyei
Research supervisor

INTEGRI PROCEDAMUS

22nd February, 2022

The Chairperson
Research Ethics Committee
Ho Teaching Hospital
Ho

Dear Sir/Madam,

SUPPORT LETTER - ETHICAL CLEARANCE

This letter is to support the application for ethical clearance of **Mr. Cross Yaw Asamoah**, an MPhil Nursing student in the Department of Public Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the programme, he is to undertake a research on the topic: **"Exploring the Experiences of Family Caregivers Caring for their Children Hospitalized due to Road Traffic Accident at Ho Teaching Hospital."**

I hope that the Research Ethics Committee will consider the proposal to enable him collect data.

Thank you.

Yours faithfully,



Dr. Lilian Ohene Akorfa
Co-research supervisor

P. O. Box LG 43, Legon, Accra, Ghana | Tel: +233 (0) 303 970 801
Email: nursing@ug.edu.gh | Website: www.nursing.ug.edu.gh



INTEGRI PROCEDAMUS

Appendix B: Ethical Approval Letter from HO Teaching Hospital

In case of reply the number _____

And the date of this Letter should be quoted _____

My Ref. No. *HTH/RPPME/* _____

Your Ref. No. _____

Our Core Values:

- ☒ Commitment
- ☒ Accountability
- ☒ Dedication
- ☒ Integrity
- ☒ Professionalism
- ☒ Innovation
- ☒ Teamwork
- ☒ Safe Care



HO TEACHING HOSPITAL
P O BOX MA-374
HO
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Fax:+233-(036) 2027323
Website: www.hth.gov.gh
Email: info@hth.gov.gh/
hvolta@yahoo.com

25th July 2023

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION

I hereby introduce to you the bearer of this letter, **Cross Yaw Asamoah**, a staff of the hospital and a student at the University of Ghana. He is carrying out a study titled: **“Exploring the Experience of Family Caregivers Caring for Their Children Hospitalized Due To Road Traffic Accident at Ho Teaching Hospital.”** This study has been approved by the Management of the Hospital after ethical approval was received from the Ho Teaching Hospital Research Ethics Committee with Protocol Identification number **HTH-REC (04) FC_2023**. The ethical approval is valid till **20th July 2024**.

Please accord him all the necessary assistance as this study will help improve the quality of care in Ho Teaching Hospital and contribute to the knowledge and practice of healthcare in general. In addition, inspect his identification card for validation and proof of payment (Data collection and Facility user fee). Furthermore, ensure patients’ names and identification numbers are anonymized. This is to protect the confidentiality and privacy of the patients.

If in doubt, kindly contact the Research Department: Room N32 on the administration block, or Telephone 0244853947. Also, kindly report any misconduct of the Principal Investigator to the Research Department for necessary actions, please.

Thank You.


[Simon Dzokoto]
Director, RPPME



Appendix C- Semi structured Interview Guide

Question	Probe
<u>SOCIO-DEMOGRAPHICS</u>	
1. Can you tell us about yourself (No Name - Participant)	Your age
	Place/District of residence
	Ethnic background
	Religion
	Marital status
	Level of education and profession
	Age of child
2. How did the accident occur?	Relationship with care recipient
THE NEEDS OF FAMILY CAREGIVERS	
3. Can you please tell me about the things needed in care the care of your child?	Financial Burden
	Social Life
4. May I know how you acquire those things?	Experience with child's accident
THE TASK OF FAMILY CAREGIVERS	
5. Can you please explain to me how what you do affect	How relevant it is
	Any identified benefit

your life? 6. Can you please tell me the care you render on daily basis for your child?	How it affects negatively Any identified negative effects
THE BELIEFS AND ATTITUDE OF FAMILY CAREGIVERS	
7. Please tell me about your beliefs on RTA?	Any positives/challenges
8. How does these beliefs interfere with the care you render to your child?	
9. Tell me how you felt and dealt with your child's accident?	
THE HEALTH PROMOTION BEHAVIOUR OF FAMILY CAREGIVERS	
10. May I know how taking care of your child affects your health physically, psychologically? 11. Can you share with me any other challenges/difficulties you encountered when taking care of your child? 12. What other strategies do you think can be beneficial to caregivers who are caring their child hospitalized through road accident?	



Appendix D

Participant Information Leaflet and Consent Form

This leaflet must be given to all prospective participants to enable them to know enough about the research before deciding to or not to participate.

Title of Research:

“Exploring The Experiences of Family Caregivers Caring for Children Hospitalized Due to Road Traffic Accident at a Teaching Hospital”.

This Informed Consent Form has two parts:

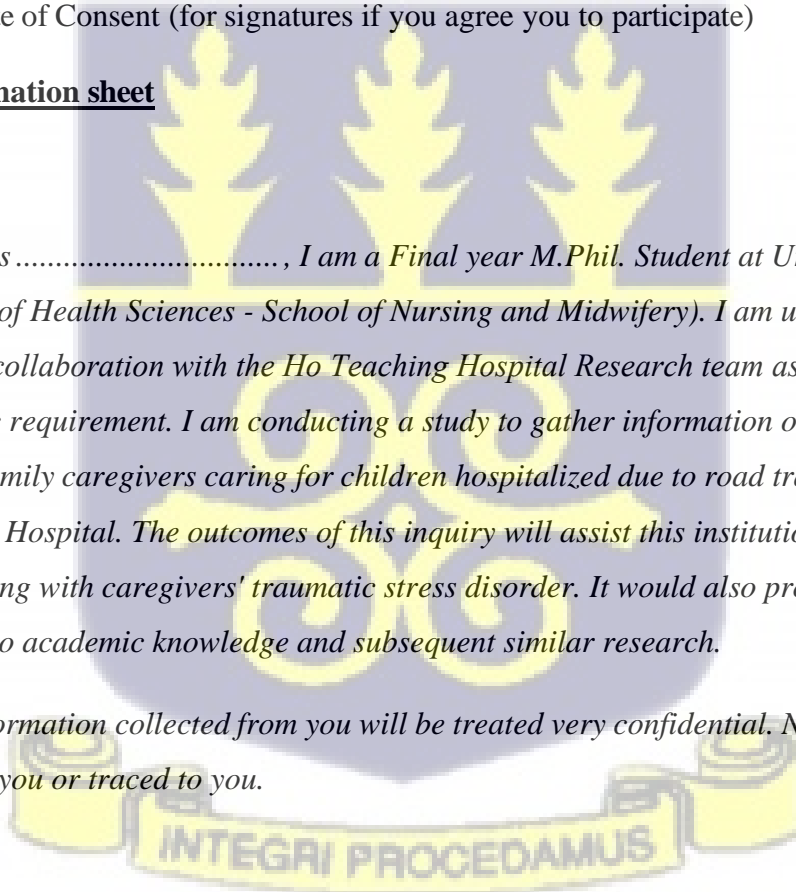
- Information Sheet (to share information about the survey with you)
- Certificate of Consent (for signatures if you agree you to participate)

PART 1: Information sheet

Introduction

My name is, I am a Final year M.Phil. Student at University of Ghana (College of Health Sciences - School of Nursing and Midwifery). I am undertaking this investigation in collaboration with the Ho Teaching Hospital Research team as a master’s degree academic requirement. I am conducting a study to gather information on exploring the experiences of family caregivers caring for children hospitalized due to road traffic accident at the Ho Teaching Hospital. The outcomes of this inquiry will assist this institution and other facilities in dealing with caregivers' traumatic stress disorder. It would also provide a useful material to add to academic knowledge and subsequent similar research.

All the information collected from you will be treated very confidential. Nothing you say will be linked to you or traced to you.



Name(s) and affiliation(s) of researcher(s)

Cross Yaw Asamoah, Student, School of Nursing and Midwifery – College of Health Sciences – University of Ghana.

The World Health Organization (WHO, 2024) revealed that approximately 1.19 million people die globally through road traffic accidents, while about 20 to 50 million people are left with non-fatal injuries. The most vulnerable population includes endangered road users who were pedestrians, cyclists, and motorcyclists (WHO, 2024). Among the fatalities, 93% are from low and middle-income countries (Sundet et al., 2021; WHO, 2022). A significant portion of these injuries is due to advancements in the automotive industry and affects individuals of all ages. The African Health Organization (AHO, 2020) have indicated that leading cause of death among adolescents and young adults between the ages of 15 and 35 years is road traffic injuries, and this has also been projected to rise to become the seventh cause of death by 2023 if no sustainable action plans are developed and implemented to curtail this.

According to the United Nations' Global Fund (UNICEF, 2022), children under 18 years of age make up a significant portion of the population, estimating their number at 2,375,649,484 in 2022. In light of this, there have been global and national laws put in place to protect children from harm and promote a safe environment for them to thrive. It is the responsibility of legal guardians (biological or primary and secondary) to ensure the safety of children. According to the World Health Organization (2015) the estimated deaths from road traffic injuries among people aged below eighteen (18) years is 186,300 annually. These deaths are three times higher in low- and middle-income countries than in high-income countries, however, majority of them are preventable.

Part of the responsibilities of legal guardians mandated by legislation includes nurturing and providing all forms of care for children when they are well or unwell (Riffin et al., 2019). A caregiver is responsible for helping to meet the daily needs of another person (Carter, 2023; Dixe et al., 2019). This can include tasks such as bathing, dressing, helping with mobility, preparing meals, administering medication, and communicating with medical staff. The care provided by family members can have significant impacts on the caregiver themselves. Caregivers are also responsible for performing or assisting with activities of daily living, as well as providing nursing care such as administering medication, providing tube feedings, managing wounds, monitoring vital signs, and operating medical equipment (Riffin et al., 2019). Furthermore, caregivers often provide significant financial assistance on the expenses related to the care they provide. (Nadarajah et al., 2024).

Across many countries, the development of a child can be affected by injuries in any form among children less than three years. The curiosity nature of children at their infant stage makes them run and play in their abode with no skills to identify and deal with potential health hazards (Stallard, 2019). According to CDC (2019) child unintentional injury death rates were highest among male children and babies under 1 year old and teenagers who are between the ages of 15 and 19 years. With these deaths motor vehicles cause the most deaths among these age groups (Dellinger & Gilchrist, 2019). The number of mortalities recorded annually is about 186,300 among children under 18 years globally. For deaths among 15-17years road traffic accident has been the main killer worldwide.

According to WHO (2019), it is expected that the number of vehicles on the road will double by 2030. This will also cause an increase in motor vehicular injuries and deaths predominantly in low- and middle-income countries. Additionally, the global population is

expected to reach 8 billion by 2025. Therefore, in respect of the 58 percent of the global population that will live in urban areas, urgent action is imperative to shield our children from the hazards of road traffic. Moreover by 2030, road traffic injuries among both children and adults are projected to surpass HIV/AIDS, malaria, and tuberculosis as a cause of death worldwide. Globally only 17 percent of the world's population are covered by an adequate child restraint law. However, a greater percentage of countries worldwide do not have these restraint laws. They also do not have any laws that require children to wear protective helmets while riding on motorcycles or bicycles. In many situations too, maintaining pedestrian safety is problematic. In addition, school buses and school zones are not given the needed attention pertaining to road safety and protection and as a result, thousands of children die each year on their way to and from school.

In Ghana, the National Road Safety Commission (NRSC, 2019) indicated that children pedestrians were more likely to be involved in road traffic accidents compared to adults. This is primarily because they have inadequate knowledge about road safety and hence they are unable to identify road and traffic dangers and signs (Adanu et al., 2023). A child-pedestrian is about 20 times likely to die in a crash when compared to a child car-occupant. The majority (57%) of these crashes occur on high-speed roads which course through village settlements (NRSC, 2019). Child-pedestrian deaths accounted for 34% of all pedestrian deaths (NRSC, 2019). Families and households in Ghana spend an average of US\$ 1687.65 in both direct and indirect cost the injuries sustained through road traffic accidents apart from the morbidities and mortalities associated road traffic accidents (Blankson et al., 2020; Blankson et al., 2019).

In attending to the health of children relating to road traffic accident, the role that caregivers play cannot be overlooked. The experience and perception of caregivers during

accident are very critical in identifying risk and social support (Hasan Reza & Henly,2018). There is the development of psychological adjustment difficulties on the part of caregivers when there is a traumatic event on the lives of children including road traffic accidents or other medical emergencies. Moreover, according to Williamson et al. (2019) caregivers experiences significant anxiety for the safety of their children and feel helpless to prevent future trauma. The situation of road traffic accident leads caregivers to get in touch with medical, police or social services.

The caregivers' knowledge and awareness of child injuries are crucial because they can help identify risks and hence prevent fatal injuries (Olsen et al., 2018).Also, caregivers' pre-existing knowledge and experiences assists in instituting measures that make the immediate environment safe there by avoiding injuries. To develop appropriate child injury prevention interventions, it is essential to explore caregivers' perceptions and experiences, as these insights provide helpful information. Moreover, when caregivers improve their supervision roles it helps to prevent many of the described injuries (Ning et al., 2019). This is because adults tend to influence children to change their risk-taking behaviour which could be effective in minimizing the potential to involved in injuries. (Ning et al., 2019; Prieto-González et al., 2021). Caregivers believe that proper supervision and injury prevention education in schools can effectively prevent injuries in children. This study therefore seeks to explore the experiences of family caregivers for children hospitalized due to road traffic accident.

Purpose(s) of research

The research seeks to explore and the experiences of family caregivers caring for their children hospitalized due to road traffic accident at Ho Teaching Hospital, Ghana.

1. Assess the needs of family caregivers of children hospitalized due to road traffic accidents.
2. Describe the responsibilities and duties of family caregivers of children hospitalized due to road traffic accidents.
3. Identify the attitudes and perceptions of family caregivers of children hospitalized due to road traffic accidents.
4. Explore the health promotion practices of family caregivers of children hospitalized due to road traffic accidents.

Procedure of the research, what shall be required of each participant and the approximate total number of participants that would be involved in the research.

If you volunteer to serve as a study participant, you will be asked to participate in an interview. The interview will gather information, as it would provide better understanding of caregivers' experiences after a child's accident through road traffic accident. The interview answers and information will be captured with both audio recorder and electronic questionnaire. The audio recording will allow us to revisit our discussion to ensure the accuracy of your answers and make the research comprehensive. This is a confidential discussion in that I will not report your names or who said what. Your privacy is important to us, and all recorded data will be stored on a secure device. Your names will NOT be included in the final report about this meeting. If you do not wish to have your interview session audio recorded, you will not be allowed to participate in the study.

Risk(s)

Participants may potentially experience psychological discomfort or emotional distress from asking their views on their experiences after a child's accident through traffic accident they

cared for. Anyone expressing or reporting discomfort will be reminded their participation is completely voluntary and that they are not obliged to complete the interview. They will be reminded they can stop at any time during the study, and they can choose not to answer certain questions during the interview. Participants who may express profound psychological and emotional distress will be referred to mental health department upon consent to receive care spearheaded by the principal investigator.

Benefit(s)

Your participation in this study would help in providing better understanding about the experiences and challenges of family caregivers caring for their children hospitalized due to road. It would also reveal special characteristics surrounding the stress, anxiety and psychological situation experienced by caregiver. The outcomes of this inquiry will assist this institution and other facilities in dealing with caregivers' during road traffic situations. It would also provide a useful material to add to academic knowledge and subsequent similar research.

Confidentiality

Personal information obtained from you will be treated as confidential. No names will be recorded, instead, a study ID will be used, which will be a unique number assigned to each participant. The research assistant will only ensure that you have signed, or thumb printed appropriately before the interview commences. Answers from the interview and other information will be captured using both audio recorder and electronic questionnaire. All materials, including the audio recordings and the electronic documents, will be stored on a secure storage device not connected to the internet, and will only be accessible to the investigators. After the study, the data will be kept for a minimum of 1-5 year upon completion of the project. After 1 year, the information (without names) could be used in future research and will remain in

a secure location. Findings may be published and/or presented at University of Ghana and scientific conferences in Ghana and internationally.

Duration

The discussion should take about **20 - 60 minutes**.

Voluntariness

Your participation is voluntary, and you can decide to stop the interview at any time. If you are receiving any hospital services, your participation or non-participation will not alter your required medical care, and participation is not required for you to receive hospital care and services. If you decide not to participate in the study, your decision will in no way influence the quality of the care that you will receive from the hospital.

Withdrawal from the research

Participants can choose to withdraw from the research at any time without having to explain you. You may also choose not to answer any question you find uncomfortable or private.

The consequence of withdrawal

There will be no consequence, loss of benefit or care if you choose to withdraw from the study. Please note, however, that some of the information that may have been obtained from you without identifiers (name etc), before you chose to withdraw, may have been modified or used in analysis reports and publications. These cannot be removed anymore. We do promise to make good faith effort to comply with your wishes as much as practicable.

Costs/Compensation

You will not be provided any incentive to take part in this research. However, findings from this research would help provide better understanding of caregivers' experiences after a child's accident. It would also reveal special characteristics surrounding the stress, anxiety and psychological situation experienced by caregiver. The outcomes of this inquiry will assist this institution and other facilities in dealing with caregivers' during road traffic accident situations. It would also provide a useful material to add to academic knowledge and subsequent similar research.

Funding Information

The whole research shall be solely by the Principal Investigator alone. There shall be no external sources of funding throughout the research.

Who to Contact?

If you have any questions, you may ask them now or later, even after the interview has started. If you wish to ask questions later, you may contact.

1. Mr. Cross Yaw Asamoah, Ho Teaching Hospital, Paediatric and Child Health Sub BMC,
P. O. Box MA 374, Ho –Volta Region. Telephone: +233248881841 /+233208881841
Email: crossadumasamoahyaw@gmail.com / cyasamoah@st.ug.edu.gh ,
2. Dr. Josephine Mpomaa Kyei. School of Nursing and Midwifery, College of Health
Sciences, Department of Public Health Nursing, University of Ghana
Telephone: +233208154212.
Email: maamejossy@yahoo.com / maamejossy274@gmail.com / jmkyei@ug.edu.gh

3. Prof. Lilian Akorfa Ohene. School of Nursing and Midwifery, College of Health Sciences, Department of Public Health Nursing, University of Ghana.

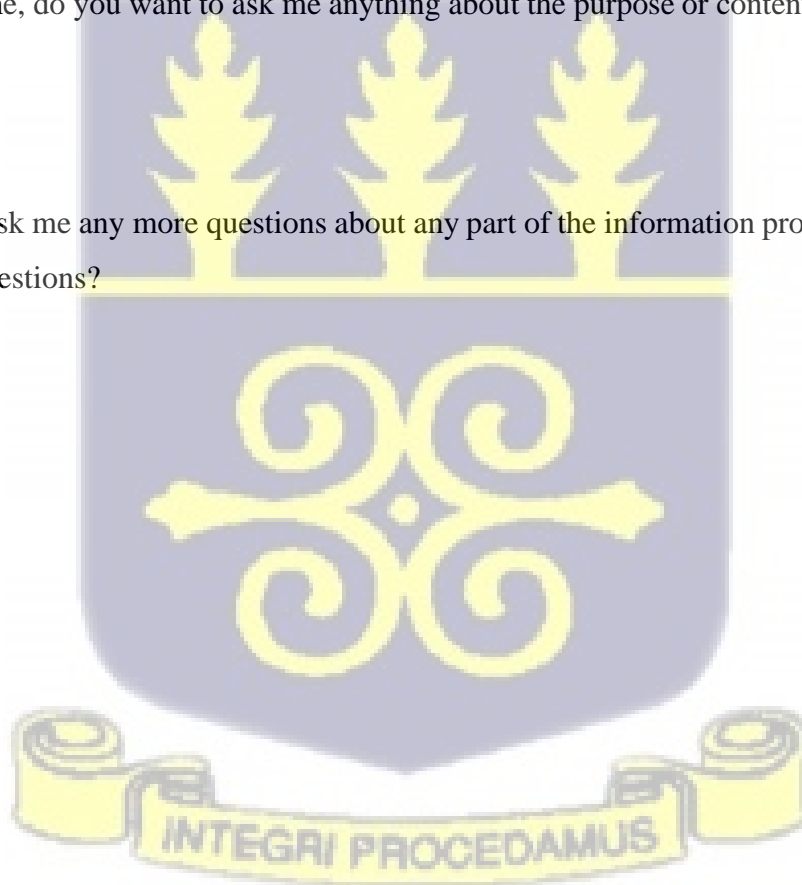
Telephone: +233246-395696 Email: lohene@ug.edu.gh

This protocol has been reviewed and approved by the Research Ethics Committee (REC) - Ho Teaching Hospital (HTH), which is a committee whose task is to make sure that research participants are protected from harm. If you have any ethical concerns during and after your participation in the study, you can contact HTH REC. Telephone: +233 - (036) 202731820/2028207. Email: info@hth.gov.gh

At this time, do you want to ask me anything about the purpose or content of this interview?

Questions

You can ask me any more questions about any part of the information provided above? Do you have any questions?



CONSENT FORM

TITLE OF STUDY: “EXPLORING THE EXPERIENCES OF FAMILY CAREGIVERS CARING FOR THEIR CHILDREN HOSPITALIZED DUE TO ROAD TRAFFIC ACCIDENT AT HO TEACHING HOSPITAL IN GHANA”

PARTICIPANTS’ STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants’ Information Sheet read and all questions satisfactorily explained to me in a language I understand (English). I fully understand the contents and any potential implications as well as my right to change my mind (i.e., withdraw from the research) even after I have signed this form. I voluntarily agree to be part of this research.

Name of Participant:

Participants’ Signature: OR Thumb Print:

Date:

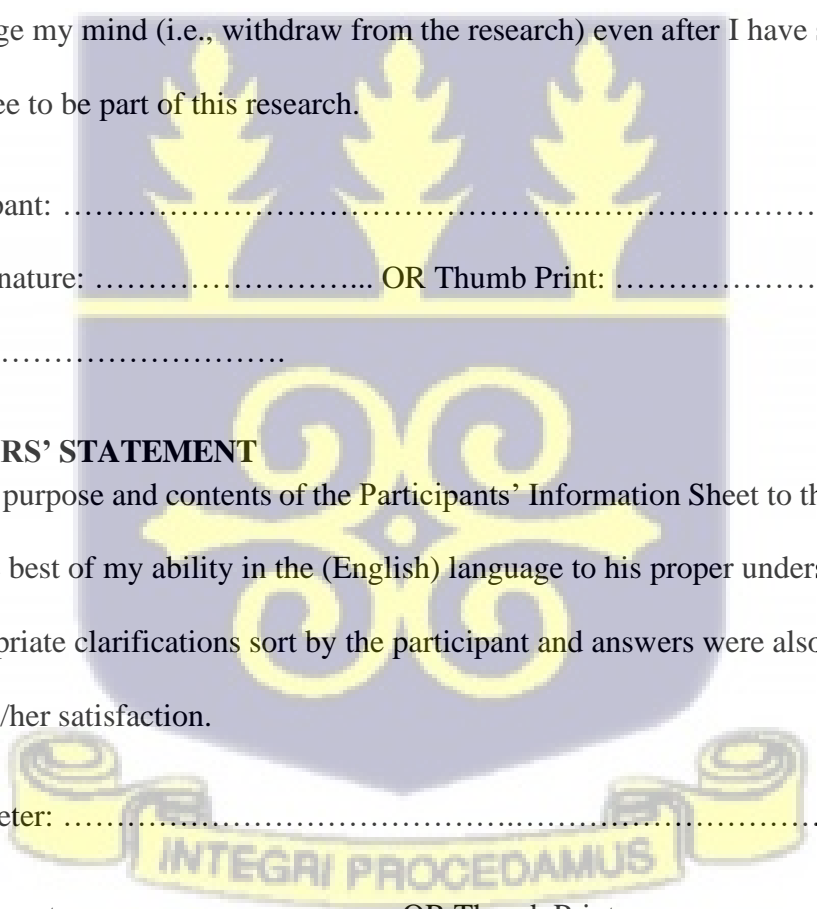
INTERPRETERS’ STATEMENT

I interpreted the purpose and contents of the Participants’ Information Sheet to the afore named participant to the best of my ability in the (English) language to his proper understanding. All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter:

Signature of Interpreter: OR Thumb Print:

Date: Contact Details:



STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language, he/she understood (English) I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:

Signature..... OR Thumb Print

Date:

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name:

Signature

Date.....

