



Parents' perception of family centred care for children hospitalized through road traffic accident: A qualitative study at two tertiary settings in Ghana



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ABSTRACT

Background: Conceptually, Family Centred Care promotes better medical outcomes by ensuring that families play key supporting roles in children's adaptation to unfamiliar clinical environments. This care approach is crucial to minimising traumatic experiences resulting from Road Traffic Accidents and subsequent hospitalisations.

Objectives: This study sought to understand Family Centred Care from a sub-Saharan context by exploring perceptions among parents and families whose children were hospitalised as a result of Road Traffic Accidents.

Method: The study was conducted at two government-funded institutions located in Ghana's capital city - Accra. Pediatric surgical units which admit RTA injured children were purposively selected sites for data collection. Using Constructivist Grounded Theory approaches, 19 participants were interviewed. A semi-structured interview guide aided in-depth individual interviews with probing questions to elicit detailed information from participants. Data collection and analysis occurred iteratively. Here, we employed constant comparative methods. Broad categories and sub-categories emerged from the analysis.

Findings: Significantly, all 19 participants embraced family centred care in principle. However, our observations revealed that both institutions practiced family centred care informally to a lesser degree. Three major categories emerged, namely: managing emotions, parental care roles and negotiating the system.

Conclusion: Culturally, Ghanaians perceive parents' devotion to hospitalised children as synonymous with good parenting. Equally, emotional support and parents' negotiation powers are important prerequisites for greater participation in the care process. Hence, we recommend that a coherent national policy, robust clinical guidelines, and a culturally-sensitive Family Centred Care model are integral to parents' participation in hospitals in Ghana.

1. Background

Family Centred Care (FCC) is a care concept in paediatric health which recognises family members of sick children as care recipients. This revolutionary approach enables care to be planned around the whole family and not just the sick child (Uniacke, Browne, & Shields, 2018). According to the Institute for Patient and Family-Centered Care (2019), the core components of FCC include dignity and respect, information sharing, participation and collaboration. FCC promotes parents and professionals collaborating efforts in caring for the sick child. Such collaborative efforts often result in positive outcomes for both children and families (Arabiat, Whitehead, Foster, Shields, & Harris, 2018; Matziou et al., 2018). Thus, FCC has evolved as a concept to ensure effective management of family experiences in pediatric healthcare institutions (Harrison, 2010).

The FCC concept has witnessed significant international acceptance and endorsement of its core principles in the second half of the 21st century. However, its implementation varies across a range of social contexts. Experts recognise differences in cultural values as key factors that shape FCC practices and implementation around the globe (Smith

& Coleman, 2009). Existing literature further reveals that most studies on FCC practice originate from the Western world. Thus, many authors relate the concept to Western practice. Nevertheless, a substantial number of new studies have emerged from developing countries in Asia and Eastern Europe. Interestingly, some authors also argue that FCC principles may not be appropriate for children in every conceivable socio-cultural context, given wide variations in clinical conditions cultural norms and social practices across different local contexts (Shields, 2007). Effectively, cultural diversities and clinical presentations of disease conditions influence FCC adaption globally (Al-Motlaq & Shields, 2017).

Literature on FCC practice for children involved in road traffic accidents (RTAs) is rather scant, especially in developing countries. For example, traumatic injuries from RTA are common occurrences in Ghana, a Low- Middle-Income Country (LMIC) in Africa. In Ghana, RTA injuries in children who are four years and above are among the common causes of hospital admissions (Abantanga & Mock, 1998; Adam, Alhassan, & Yabasin, 2016; Ametefe et al., 2016). The unexpected nature of RTA and severe injuries sustained impose serious demands on affected families (Foster, Young, Mitchell, Van, & Curtis,

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2017). These unexpected family tragedies result in prolonged hospital admissions and emotional disturbances as a result of adjustments to the hospital environment (Roscigno, 2016). Additionally, parents and families are often overburdened with high medical costs, long distant travels to access care, frequent hospital visits and lack of knowledge in obtaining appropriate medical care. In most cases, families are forced to relocate due to the long distance between the hospital and their homes. Moreover, there is acute shortage of suitable family spaces in most hospitals in Ghana. These challenges necessitate further exploration of FCC principles among parents of children who suffer injuries from RTAs in such local contexts.

Parents play key roles in helping children adapt to unfamiliar clinical environments. In the process, they experience high stress levels related to unfulfilled information needs, interpersonal relationships with clinicians and issues regarding the child's illness and progress towards recovery (Agostini, Monti, Neri, & Dellabartola, 2014; Hatzmann, Heymans, Ferrer-I-Carbonell, & van Praag, 2008; Masa'Deh, Collier, & Hall, 2012). Existing scholarship suggests that parents' perceptions and expectations of hospital experience have shaped the advancement of FCC in some clinical contexts (Hill, Knafli, & Santacroce, 2018; Raiskila et al., 2016). For example, in an integrated review of 49 research articles, Hill et al. (2018) identified respect and dignity, information sharing and participation as the most desirable aspects of FCC for parents. Other studies have observed similar perceptions regarding parents' desires for participation in care, negotiation of care and effective communication with health professionals (Corlett & Twycross, 2006; Coyne, 2008). Concepts such as collaboration and partnership have similarly been identified as equally significant. However, parents are perceived to have limited understanding about its operationalization in real-life contexts (Hill et al., 2018; Mikkelsen & Frederiksen, 2011). Nonetheless, parents' contribution to the development of the FCC concept is widely recognised.

Several related concepts and ideas in pediatric care predate FCC and its evolution (Jolley & Shields, 2009; Smith & Coleman, 2009). The literature has demonstrated that parents' perceptions contribute to areas such as the conceptual development of FCC, its popularity in pediatric care discourse, and the diverse terminologies which have evolved within different strands of the concept (Hutchfield, 1999). Also, the family's influence across different paradigms by virtue of changing parental roles and expectations in childcare have been widely researched (Carlsson, Nygren, & Svedberg, 2018; Hill et al., 2018; Shields, 2007). However, critical analysis of trending studies shows a lack of focus on sub-Saharan African perspectives (Al-Motlaq & Shields, 2017; Shields & Nixon, 2004).

Less is known about FCC in the African context (Okunola et al., 2017). FCC is acknowledged as a complex concept, which potentially contributes to its limited operationalization in non-Western cultures (Al-Motlaq & Shields, 2017). FCC is one of several medical care concepts, which addresses socio-cultural issues, including context appropriate implementation and practice of child health services (Al-Motlaq & Shields, 2017). It is therefore imperative to address the limited FCC research in the African cultures. This study explores FCC perceptions of parents whose children have been hospitalised as a result of RTAs in Ghana.

2. Methods

2.1. Design

This manuscript forms part of a larger study which adopted qualitative grounded theory approach, underpinned by constructivist ideologies (Charmaz, 2014). A key premise of the study is the notion that parents' views and perceptions on children's hospital care differ. The scarcity of scholarship on FCC in the Ghanaian context provides further justification for an exploratory grounded theory approach.

2.2. Setting

Two government-funded tertiary hospitals in Ghana's capital, Accra, were purposefully selected based on their designations as trauma and specialised care institutions. The selected hospitals also serve as national referral facilities in Ghana. Often, victims of RTAs who sustain fatal injuries are transferred to these two hospitals in Accra. The first study site is the largest teaching hospital in Ghana and the third largest in Africa, with a 1500-bed capacity, several specialised units and specialist personnel. The second institution is a 500-bed capacity Military hospital, designated as a national emergency response health facility.

2.3. Ethics

This research forms part of a PhD study and has met the university and national ethical standards. The study gained ethical approval from De Montfort Faculty of Health and Life Sciences for Human Research Ethics Committee, Institutional Review Board of the Noguchi Memorial Institute for Medical Research, Ghana and the 37 Hospital Institutional Review Board. Gatekeepers and the designated hospital's Institutional Review Boards granted approval for the conduct of the study in their facilities.

2.4. Population, sampling, and recruitment of participants

The research participants were mostly parents and close family members who are eighteen years and above, and are primary carers of children hospitalised due to RTAs. Purposive sampling was employed during initial sampling of fifteen participants. As a critical method of grounded theory approach, theoretical sampling technique was applied to recruit key participants at the advanced stage of data analysis. Four key participants were theoretically sampled for additional individual interviews. Only participants who consented to participate in the study were selected.

2.5. Data collection

Data collection and concurrent analysis of this phase of the study occurred between the second quarter of 2014 to first quarter of 2015. Individual face-to-face in-depth interviews were conducted with 16 parents (mothers and fathers) and three (3) other close family members who were primary carers (See Table 1). A semi-structured interview guide aided the interview process with several probing questions to elicit detailed information from participants. Data collection and analysis occurred iteratively. This enabled comparison between data to data and data to emerging categories until theoretical saturation was reached (Corbin, Strauss, & Strauss, 2008). The interviews lasted between 45 and 90 min with an average of 60 min. Interviews were conducted in both English and two local languages (Ewe and Twi). Digitally recorded interviews were transcribed and translated. A professional translator with a nursing background assisted with translation and transcription. The first author, who speaks all three languages and conducted the interviews, verified and validated the translated transcripts to minimize methodological errors related to cross-language in research (Santos, Black, & Sandelowski, 2015; Squires, 2009; Temple & Young, 2004).

Table 1
Parent participants in the research.

Parent Category	Number	Identification (ID) Code
Mothers	12	A-L
Fathers	4	M-P
Grandmothers	2	Q-R
Aunt	1	S
Total	19	A-S

2.6. Analysis

All transcripts were compared with the voice recordings to ensure that the data was captured correctly. The transcripts were carefully read line-by-line and initial coding identified preliminary categories. Theoretical sensitivity gained from initial partial engagement with literature aided identification of substantial codes (Corbin et al., 2008). Codes construction occurred using constant comparative methods. Thus, the initial codes were compared with data, and codes compared to codes to identify emerging categories (Charmaz, 2014). The data analysis progressed actively to the phase of focused coding. Focused coding involved the identification of codes with similar elements groupings together to reflect substantial concepts. Substantial concepts were labelled with terms which reflect collective meaning of grouped codes. This study being a part of bigger research with data from other categories of participants, the use of NVivo 11 software aided the data analysis process during coding, grouping of codes and re-grouping until theoretical saturation was reached.

The data analysis phase applied reflexive opportunity that contemporary constructivist grounded theory offers researchers to declare their influence over research process and research product. Thus, considering the Ghanaian context where nursing research is still evolving, theoretical codes which fit the cultural and practice context was considered key for purposes of acceptability and ownership of the research outcomes. In view of this, ten key participants who participated in the individual interview were theoretically sampled and engaged in two focused group discussions as part of the data analysis phase. Engagement with theoretical samples ensured that multiple dimensions of emerging concepts were fully explored. It also enabled the researcher to check if constructed codes and emerging concepts resonate with the participants' views (Charmaz, 2014).

3. Findings

A total of nineteen participants, mostly parents, took part in the research (see Table 1).

All participants had two or more children. The highest educational level was high school certificate. Most participants were engaged in small-scale commerce, such as trading and other semi-skilled micro enterprises. None of the parents was in formal employment. Sixteen of the participants were Christians, two Muslims and one professed an African traditionalist faith. For the purposes of confidentiality, participants' names were anonymized where direct statements are used. All the participants perceived FCC to involve parental presence, a concept informally practised in both institutions. Three key categories emerged as parents' perceived components of FCC as shown in Fig. 1. These are discussed under the next sessions.

3.1. Managing emotions

Parents' desire to manage their emotions was the initial motivations for parental presence. The unexpected accidents, traumatising injuries and unclear hospital practices were the basis for parents' heightened emotions. Participants demonstrated and verbalised several feelings and emotions such as blame and guilt, worry and anxiety, fear and sadness. The need for hospital visits to monitor children's progress was reported as traumatic enough to induce emotional management. Expressions of sympathy and derogatory comments by strangers and bystanders after RTA incidents were common. These negative reactions influenced parents' emotional reactions.

3.1.1. Blame and guilt

Self-blame and guilt were common characteristics among parents. Most participants blamed themselves for not being careful enough with child supervision. They reported their lack of oversight of the child's whereabouts prior to the accidents. Parents' guilt and shame emanate

from beliefs that the child's involvement in accidents was preventable.

"I blame myself partly for his accident. I knew this accident was preventable. I was always aware of the dangers concerning these kids, and they play around, but could I have stopped them from playing...?" (Participant B).

Nearly all parents laid blame to others for child's involvement in the RTA. Careless drivers and significant others guardians were listed as equally culpable. It was reported that drivers, especially minibuses commercial drivers, crashed into children due to over speeding. School authorities were equally blamed for inadequate supervision of children during school sessions.

"People at the accident scene told me that the trotro (commercial minibus) driver was over speeding" (Participant A).

Cultural beliefs shape how parents interpreted accidents and misfortunes. It is common to attribute tragedies to spiritual forces. Some parents believed that spiritual forces caused their children's involvement in accidents. These beliefs were grounded in previous interactions with spiritual "fathers" such as pastors and other "men of God". Some revealed that premonitions before accidents provided intuition to ascertain the spiritual dimensions of their child's accident. A participant articulated prevailing spiritual views succinctly in these words:

"Spiritually, my pastor saw this coming... he warned me that I should be prayerful and that some misfortunes will happen...and now see where we are? Some of these accidents have spiritual causes" (Participant E).

3.1.2. Anxiety and worry

Participants recalled feeling anxious and worried following their child's involvement in the accident. Parents said they first heard of the accident from eyewitnesses or "Good Samaritans" who had little information about which hospital the child had been transported to. In most cases, there is a period of uncertainty and anxiety when parents searched several hospitals to locate their injured child.

"The news of the accident got to us suddenly by a neighbour who witnessed it, and he was not sure which hospital the child rushed to. I anxiously ran without knowing exactly where I was heading...I was just worried and anxious to see my child" (Participant G).

Parents heightened experiences of fear of the unknown was related to minimal interactions with nursing staff, lack of prognosis information and severity of injuries. Uncertainties in medical treatment outcomes and fear of the child dying also persisted. According to parents, detailed information was scant, not particularly reassuring and often vague. Similarly, treatment arrangements and medical care options lacked clarity. Most parents reported that they had no previous experience related to hospital care of a sick child. Moreover, nurses and onlookers comments caused further anxiety upon arriving at the hospital.

3.1.3. Sadness and fear

Participants reported feeling sad and fearful upon seeing their injured child. These feelings stemmed from the severity of the injuries. Speculations about future complications also increased. Others fears related to possible death from complications. Some parents reported that they cried often when children were helplessly in pain. The sense of sadness and hopelessness was evident in participants' statements:

"I was very sad when my child is in pain. I fear a lot about how this whole episode of our lives will end. Sometimes I cried when she cries because things do not look good" (Participant E).

Poor administrative structures and arrangements for dealing with traumatised parents added to their woes. Limited resources and provisions were available for managing parents' emotions. Participants rarely mentioned efforts by staff to help manage parents' emotions.

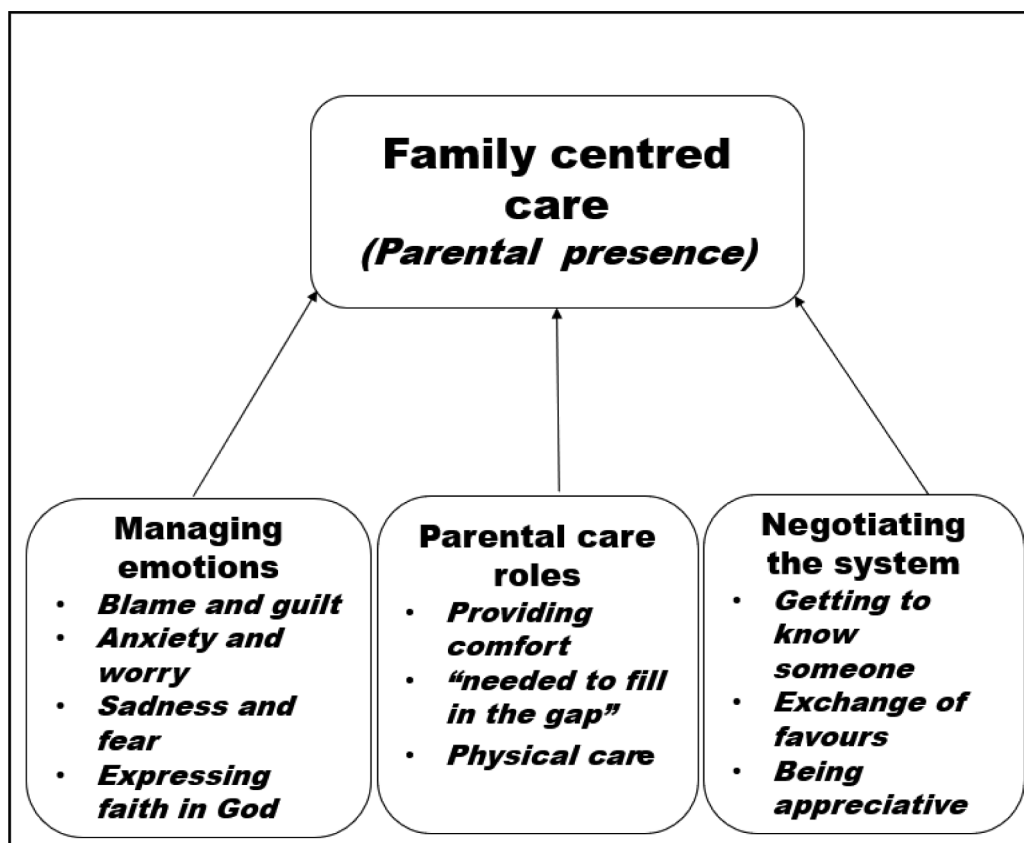


Fig. 1. Ghanaian parents' perceptions of family centred care (categories and sub-categories).

Often, parents had low expectations or felt that such requests constitute an imposition. Participants' emotional feelings and experiences influenced the decision to stay with the child in the hospital. Parents said they stayed around the children's ward to ensure that staff attend to their child, which gave them reassurance.

3.1.4. Expressing faith in God

Nearly all parents mentioned religious rituals they performed and perceived as important for the survival of the injured child while in hospital. These rituals enabled parents to cope with their emotions. They mostly prayed during critical phases of hospitalisation. The statement below exemplifies the embeddedness of spirituality in participants' consciousness and the prevalence of deity invocation practices during such crisis periods:

"I prayed when he was being sent to the theatre. Most of us mothers pray for our children. We even go to the extent of fasting and praying on empty stomach. Prayer is reassuring, and on daily basis, pastors come around to pray with us" (Participant B).

Parents revealed that even clinical staff sounded religious when reassuring them. According to them, staff will often say; *"God is in control"*. It is worth noting that although religiosity is integral to the Ghanaian way of life, religious practices are rarely incorporated into hospital care. Parents prayed often and recounted instances where clinical staff requested for supporting prayers, especially during surgical procedures. Despite these seemingly collaborative efforts between parents and staff, some parents intimated that such staff comments were hardly reassuring, as the spiritual element was perceived to be the prerogative of the family.

Parents heightened emotions were identified as the basis for wanting to stay with the child in hospital. Staying in hospital and getting regular updates on children's condition gave hope and reassurance. Additionally, participants perceived that sick children in

hospital needed their parents' attention the most. Therefore, parents consider their presence in hospital as non-negotiable.

3.2. Parental care roles

Participants emphasized the need to participate in child care in hospital. Nearly all of them said their presence enabled participation in important care task such as comforting, physical and supplementary care.

3.2.1. Providing comfort

Parents expressed passion in providing comfort care in hospital to ameliorate children's pain and suffering, especially when children expressed pain and discomfort. Therefore, it was the desire of parents to provide comforting care by offering soothing words, using diversion tactics, and maintaining physical contacts with child.

"I comforted him with soft-spoken words such as...it's okay, the pain will soon stop. I use the hand fan to fan him just to let him know that I care and I will make everything possible to take away his pain" (Participant G).

Invariably, parents were compelled to stay closely with their children in hospital as their absence made the children more distressed.

3.2.2. "Needed to fill in the gap"

Participants recounted the numerous instances that nurses requested for parents' assistance. This happens because parents were unofficially stationed on children's wards. Parents must request for and gain doctors and nurses approval to stay in the children's ward and this was done on case-by-case basis. Majority of parents stayed outside the wards and were only invited when professionals required their services. A parent labelled such invitations as *'needed to fill in the gap'*.

"I ensure that I am always available. Because they need us to fill in the gap. Most often, nurse called us unexpected to come in to help when they are short of staff" (Participant J).

3.2.3. Physical care

Participants perceived staff shortage as the basis for hospitals needing their assistance in providing care. Parents perform errands and routine physical care, including maintaining children's hygiene through bathing, grooming, changing nappies and serving bedpans. Feeding sick children was also parents' assigned role. Mothers especially spoon-fed children daily because of their sick state.

"I bathed my child, change the diapers. As you can see, his foot is hanged and he is not allowed to move around. So I even feed him in bed. In the evening, I only clean him with wet towel just before he sleeps" (Participant H).

According to participants, parents assist nurses to perform complex tasks. These include administering of medication, helping to keep child calm for intravenous line insertion and wound dressing.

3.3. Negotiating the system

Parents' acceptance into the children's ward following admission was not automatic. Different informal arrangements and negotiations strategy was employed to secure these privileges. Negotiating strategies included "Getting to know someone", "Exchange of favours" and "Being appreciative".

3.3.1. "Getting to know someone"

Social connections and networks with staff assisted parents to negotiate the care systems. Thus, participants said they identified familiar persons within the hospital environment whose influence assisted parents' acceptance and stay in hospital. We captured this concept as "getting to know someone". This phenomenon was rooted in procedural ambiguities. Particularly, parents perceived delays in children's diagnosis and treatment. They also shared concerns about lack of information and updates on their child's condition and progress. Consequently, most participants mentioned that they looked for an influential person to facilitate the child's care.

"I called my uncle who is a big man in the army to help me get my son admitted. Before then, we went to three hospital and none could attend to him because they said no bed. Even here, they initially turned us away. Since my uncle assisted, they gave us bed and the nurse began to treat us with respect" (Participant H).

Beyond the hospital, some participants considered external individuals who were related to hospital staff. Some participants intimated that knowing someone whose relations works at the hospital is an asset in desperate times. Occasionally, identifying with a public figure, people in high positions or a politician was also useful.

3.3.2. Exchange of favours

The exchange of favours was a key negotiation strategy to navigate complex hospital institutional arrangements. Parents negotiated to maintain cordial relationships with staff. Mostly, it was a practice of "give and take" or what we captured as "exchange of favours". For example, some participants acknowledged receiving assistance from staff such as financial incentives, arrangements with blood donors and provision of timely updates on children's progress. In return, parents performed additional care duties for support staff. Typically, parents readily carried out errands; thus, assisting with caring for one's own child, doing chores on the ward and caring for other children whose parents were unavailable.

"Here, you must be ready to help. When the nurses realise that you are helpful they will help you too. Sometimes the children make the ward

dirty and I help to clean...we help fetch water when the taps run out" (Participants F).

It was perceived that providing gifts in kind to professionals improved relationships between clinicians, especially, nurses and parents, which also increased parents' chances of being accepted on the wards.

3.3.3. Being appreciative

The practice of openly showing appreciation to staff was one strategy parents used to attract favours and acceptance. Participants emphasised that criticism of staff was counterproductive in securing favours.

"I always thank the staff for their care. They do well and we must acknowledge them. This makes them feel good and they like you. If this is what I have to say to feel welcomed, I will do it. All I want is to see my girl in good state" (Participant K).

The practice of mutual support is another strategy by which parent negotiated the system. Among parents, mothers help to care for each other's children. They showed appreciation to and spoke well about each other to staff. It was perceived that appreciating other mothers helps to elicit information and guidance, which is used to negotiate the system.

"At first, I did not have any friend and was not able to sleep. At night, I sit in the plastic chair until one of the mothers came to talk to me. She advised me, and also introduced me to one of the friendly night nurses...That was helpful" (Participant D).

4. Discussion

This is the first study to explore family centred care in the Ghanaian context. The key findings reflect largely, contextual socio-medico-cultural beliefs and practices. Emerging categories perceived resembles the antecedent for FCC practice (Darbyshire, 1993; Hutchfield, 1999). Parents' negative emotional experiences are substantially rooted in the importance society places on children and beliefs regarding the cause of RTAs. In Ghana, children are perceived as blessings and gifts from God (Nukunya, 2016; Salm & Falola, 2002). Therefore, any mishap that threatens the life of a child is perceived as a calamity upon the family.

Ghanaian cultural practices make parents liable for accidents and life-threatening misfortunes that threaten children's lives. As such, parents of a child involved in an RTA face public accusation of carelessness and irresponsibility. Nevertheless, parenting style in Ghana is predominantly a free-range approach, where children of all ages, play in open spaces and backyards with limited or no adult supervision (Petaluma, 2010). These practices predispose children to accidents and injuries. Also common in Ghana are spiritual connotations ascribed to sudden catastrophes that subject families to stressful situations as in the case of a child needing hospitalisation. For example, it is believed that a child's illness results from a bad omen from the parents' unrighteous lives (Nukunya, 2016; Nyinah, 1997). It is therefore not surprising that some parents attributed their child's accidents to spiritual causes, which largely explains parents' self-blame and guilt feelings.

Parenting in hospital constitutes opportunities for parents to prove their innocence and exhibit optimal care to appease society. By contrast, Darbyshire (1993) described parenting in hospitals as problematic since such practices may be subject to public scrutiny and judgement. These perspectives reflect diversities in social contexts, which shape childcare in hospital and FCC conceptually (de Beer & Brysiewicz, 2017). While our findings suggest that mothers are unwilling to give up parental roles, FCC seems to be silent on the contextual definitions of the family. Furthermore, childcare in Africa, and therefore Ghana is a communal process which involves extended families and sometimes, an entire community which is still a preserve for women (Akujobi, 2011; Imoh, 2012). Therefore, any model of childcare for the African context

must take into account the sensitivities of cultural norms and practices in line with the WHO (2019) action framework (Leave no one behind: strengthening health systems for UHC and the SDGs in Africa) for achieving the Sustainable Development Goals (SDGs).

The informal negotiating approach of medical system is in congruence with the findings of several authors (Andersen, 2004; Atinga, Bawole, & Nang-Beifubah, 2016). The “whom you know” approach in the Ghanaian culture stems from the social class system, where clients are labelled either low-status uneducated villagers or educated elite. Individuals of low social status forfeit their respect and importance from persons of higher-class status (Andersen, 2004). Here, the author suggests that parents labelled as uneducated and low class are likely to encounter health professionals who treat them with contempt and disrespect. In the face of these differential treatments, most parents seek social support from the educated elite in society to gain acceptance and respect in the public hospitals (Andersen, 2004). In Mozambique, Söderbäck and Christensson (2007) found that the educational background of parents has no influence on their desire to participate in childcare in hospitals. Abney-Roberts and Norman (2012) also assert that open visit is by no means the same as the practice of FCC. This study exposes the vulnerability of women and children, particularly of low socioeconomic status in the process of accessing healthcare in Ghana.

5. Implications

Findings from this research revealed limited institutional guidelines for family participation and involvement in care. The absence of a coherent national policy on FCC in Ghana can also be partially cited as a root cause. These findings offer greater impetus for new policies, practice and further research. In line with the WHO’s call for health system development and quality healthcare delivery, member countries are required to develop health policies, guidelines and tools for context specific health practice. Sustained community engagements in policy development is also seen as crucial for greater community ownership and participation in health systems development. A national policy of FCC in Ghana is urgent and long overdue.

Institutional policies on family participation in care are envisaged to manage parents and families expectations and also guide their active participation, taking into account differences in disease presentations and treatment requirements. This framework will also inform health professionals’ preparedness to educate and involve families in child care. Further research in the area of FCC in the Ghanaian context is necessary to inform policy and guideline development.

6. Limitation

The limited number of study sites and locations, as well as inclusion of mainly parents of RTA victims potentially limited the generalizability of the research findings. We share the assumption that parents may experience different approaches to childcare in other hospitals depending on the geographical location and facility type, which may influence perceptions of FCC.

7. Trustworthiness

The trustworthiness of any research purported to adopt constructivist grounded theory is judged based on its credibility, originality, resonance and usefulness of the research outcome (Charmaz, 2014). The credibility of this research is rooted in the researchers’ engagement with the participants during data collection and analysis. This ensured that the findings resonate with participants’ shared views. It is also acknowledged that findings from this study cannot claim originality within the westernized discourse of FCC. However, it is the first of its kind from the context of Ghana and useful as the basis for further studies in the sub-Saharan Africa and Ghana. It is worth noting

that, the perspective of families alone is not enough for the full understanding of institutional practice of FCC. A compliment of the professional perspectives in a different paper under review will give readers the full opportunity to judge the resonance of findings.

8. Conclusion

Although the principles underlying FCC have wider recognition, generalizing it as a common model for international practice is problematic. Contextual diversities require operationalizing its elements and dimensions for effective adoption. Parents’ empowerment is a prerequisites condition for community engagement and necessary for policy and guideline development. Efforts towards FCC in the Ghanaian sociocultural context should consider parental perspectives and participation. Based on the findings of this study and that from health professionals (presented in a different paper under review), we identified theoretically, the driving and retraining forces of FCC in the Ghanaian context. The theoretical model of forces of FCC within the Ghanaian context is also presented in another paper currently at a development stage. To enhance FCC practice in Ghana, we recommend the development of clinical guidelines for active parental participation in hospitals care in Ghana. Future FCC studies in Ghana are required.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijans.2019.100176>.

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