CAREGIVERS' PERCEPTIONS OF COMPASSION ABILITY AMONG PAEDIATRIC HEALTHCARE PROVIDERS IN KENYATTA NATIONAL HOSPITAL, NAIROBI, KENYA.

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ABSTRACT

INTRODUCTION: Compassion fatigue has the potential to impair compassion ability among paediatric health care providers (PHCPs). Despite the increased number of paediatric patients in the public hospitals occasioned by improved health services, the impact on PHCPs compassion ability has not been established.
OBJECTIVES: The primary objective of this study was to describe paediatric caregivers' perceptions of compassion ability among PHCPs.
METHODS: The study adopted the phenomenological research design. Data collection methods included unstructured interviews, focused group discussions and narratives. Perceptions of compassion ability among PHCP were sought from family caregivers of paediatric patients admitted during the period of study.
RESULTS: 42 caregivers were included in the study. Majority were mothers aged between 21-30 years. The study found that caregivers perceived compassionate care as love and friendliness, timeliness in treatment, adequate consultation time and getting enough information from their PHCPs. Compassionate care varied from PHCP to PHCP depending on possession of these qualities. The PHCPs who had these qualities were viewed as compassionate while those who lacked them were viewed as uncompassionate.
CONCLUSIONS: Caregivers conceptualize compassionate care as love and friendliness, timeliness in treatment, adequate consultation time and receiving adequate information concerning their children. PHCP need to understand these are important components of their services and realize that caregivers are not just interested in their services but in how these services are delivered.

Key Words; Compassion**,** Compassion Fatigue, Compassion Ability, Empathy, Caregiver Perceptions, Burn Out, Treatment Compliance

1.0 Introduction

Compassion is an empathic feeling by an individual for the distress being experienced by another person. It compels the individual to try to alleviate the other person's distress and it's considered the basis of health care professions (Meadors&Lamson, 2008). Though working in the medical field can be rewarding and personally fulfilling, it can also be demanding and stressful for primary health care providers. This can lead to a form of burn out that affects one's professionalism through emotional exhaustion, cynicism and depersonalization. This has the potential to lead to lowered quality of care to patients, higher chances of making medical errors and eventual premature retirement from the profession (Shanafelt et al., 2012). The burn out unique to health care professions is described as compassion fatigue and interferes with a health care provider's ability to form a therapeutic relationship with their clients. A therapeutic relationship is a pre-requisite to provision of quality care (van Mol, Kompanje, Benoit, Bakker & Nijkamp, 2015).

Caregivers and children desire respect, appreciation, communication and being confident of the skill of their health care provider. Existing literature outlines five fundamentals to service satisfaction. The first fundamental is acknowledgement, where the health care provider is expected to call the patient by name, make eye contact and ask what they can do for the patient. The second fundamental is self-introduction by the health care provider by skill and experience. The third fundamental is an estimate of the duration that the medical exam, test or treatment may take. The fourth fundamental is explanation of what is to happen, step by step and being available to answer questions. This includes leaving a contact where the professional may be reached. The fifth fundamental is thanking the patient and the caregiver for choosing the hospital, cooperation and especially the family for supporting the patient (Lerwick, 2016). Compassion fatigue has the potential to impair these qualities in PHCPs due to repeated exposures of very sick children hence affecting their ability to show compassion.

In Kenya, the national hospital insurance fund has continued to offer universal health coverage thereby increasing the number of patients seeking help especially in the public health sector. In Kenya, children account for 43% of the population according to Society for International Development making them a significant focus in matters of health (Pyone, Smith & van den Broek, 2017). Most of the services in the 0-5 years age group are free in the public hospitals. Despite the increase in numbers of patients, the numbers of paediatric health care providers has not increased at the same rate. This means that the paediatric health care providers handle huge workloads with potential risk for compassion fatigue which may affect the quality of care that they give to their patients. However, the impact of rising numbers of patients on paediatric health care provider's ability to offer compassionate care has not been given much effort locally. Most of the studies on the area have focused on the self -reports of the health care professionals and hardly the recipients of their care such as their patients or paediatric caregivers. This study assessed the perceptions of paediatric caregivers on the compassion ability of their children's health care providers.

2.0 Literature Review

This study was anchored on phenomenology theory. This theory was advanced by Edmund Husserl in 1989. According to this theory, meaning is made through examining views of people who have been through an experience. It involves describing a lived experience with the aim of exploring meaning and trying to make sense of it. This is done through rich descriptions or narratives that bring out the lived experience (Klettlinger, Wirfel, &Bielak, 2015); (Davidsen, 2013). According to

Welman and Kruger (1999, p. 189) "phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved" (Groenewald, 2004). The aim of using phenomenological qualitative research is to capture as closely as possible how people experience phenomena and the context in which they experience it.

2.1 Empirical Literature Review

Compassion is an empathic feeling by an individual for the distress being experienced by another person. It compels the individual to try to alleviate the other person's distress and it's considered the basis of health care professions (Meadors & Lamson, 2008). It is characterized by empathy, respect, genuineness, effective communication and being readily available for consultation. Salmani et al. (2017) evaluated how caregivers perceive nursing behaviours in Iran among 18 nurses in both private and government hospitals. The outstanding theme was fluctuation in care. Caregivers expressed satisfaction with nursing behaviours which they said were respectful to their children. They felt valued when a nurse explained what they wanted to do with their child such as inserting an Intravenous (IV) line or administering medicine. The current study examined whether such fluctuation of care was experienced by caregivers in Kenya.

Sleath et al. (2011) assessed caregiver ratings of participatory decision making styles and child and caregiver satisfaction among 320 children with asthma. The study found that involving children and caregivers elicited satisfaction with treatment and healthcare providers were perceived positively. According to Salmani *et al.* (2017) behaviours such as politeness in asking questions and greeting caregivers was perceived as respectful. This shows that being humane and treating caregivers respectfully were perceived by caregivers as a sign of respect and acceptance. The current study did not centre on asthma patients but caregivers of different critical care units in a national hospital in Kenya.

In a study of 63 caregivers in Florida, Brooten *et al.* (2013) assessed the perceptions of caregivers towards the healthcare providers of children in intensive care unit at the time of death. Identifying the caregivers by their names was perceived as compassionate and as understanding when they answered questions from caregivers. This study informs on what caregivers of children at the end of life expect from their health care providers while the current study focused caregiver experiences with treatment procedures for their children.

Chinawa, Obu, Manyike, Obi and Chinawa (2016) conducted a study among 227 caregivers of children admitted in three major teaching and referral hospitals in Nigeria to assess their perceptions of the attitude and skills of paediatricians. Over half of the respondents felt that paediatricians were competent because they treated the children in a caring humane way, not technically. 34.4 % of the respondents were not aware of the cadre of doctors treating their children because they did not introduce themselves during the ward rounds. The study also found that interaction between a patient and the doctor is affected by length of contact and the workload of the doctor. Current study sought to find out if similar experiences are experienced by paediatric caregivers in Kenya.

Similar findings were identified by Keiza, Chege and Omuga (2017) who did a study in the oncology department of Kenyatta National Hospital among 107 caregivers to evaluate their perception to care of children being treated for cancer. The study found that 54.2 % of the caregivers were dissatisfied with information provided concerning the child's illness, the manner

the doctors and nurses handled their questions and issues about involvement in decision making. This study recommended further research to evaluate enhancement of care among children.

3.0 Research Methodology

The study adopted a phenomenological study design in examining the caregiver perceptions of compassion ability among their paediatric health care providers because it helps in capturing subjective experiences of respondents.

The targeted population comprised of family caregivers of children admitted in various paediatric units in Kenyatta National Hospital.

Table 1: Target Population

Paediatric Unit	Total Number of Patients	Sampled Participants
Orthopaedic	50	10
Surgical Ward	50	10
Medical	50	10
Oncology for FGD	50	6
PICU/NICU for FGD	10	6
NBU for FGD	120	6
Narratives	12 (FGD participants)	3

KNH was purposively selected due to its high paediatric capacity. The researcher then used multi stage sampling to select different paediatric units, simple random sampling to select participants for individual interviews and purposive sampling for FGD as well as narrative participants. The sample size of 51 was deemed to ensure saturation was attained while limiting repetitiveness.

Data was collected using sociodemographic questionnaires for participants in individual interviews as well as their children, unstructured interview and focused discussion group guides. Finally one narrative per focused group discussion was conducted to get an in-depth analysis of the situation.

Instrument validity was ensured by using unstructured interviews and focused group discussions were easy to understand and that they captured the study objectives so as to gather adequate and relevant information. The researcher by using triangulation in data collection was able to validate information obtained from different participants.

Reliability is the ability of an instrument to yield similar results in a repeat study. The researcher carried out a pilot study one month prior to the study to find out any challenges with the study instruments before the actual study. None were identified.

The data was collected after seeking necessary authorization from Kenyatta University, NACOSTI and KNH. The researcher approached the participants and sought their permission to participate. The purpose of the research was explained, the procedures to be followed and the risks and benefits outlined. The participants were informed of availability of psychological debriefing and referral for counseling if it was deemed necessary. A written informed consent was signed by the participants who chose to be included in the study. Participants in the individual interviews provided their sociodemographic information and the interview proceeded guided by unstructured schedules. Focused group discussions included caregivers of children with similar illnesses such as the oncology ward. Codes for participants were used to avoid identifying information.

The gathered data was checked for completeness, cleaned and coded. The sociodemographic data was analyzed using descriptive statistics and reported using frequency tables and percentages. The data collected from individual interviews, focused groups and narratives was analyzed thematically

since it was qualitative in nature. Finally the collected data was put under lock and key and is to be destroyed after five years.

4.0 Research Findings and Discussion

The target population was 51 respondents. Out of these 30 respondents participated in the individual interviews while 12 respondents participated in focused group discussions representing a response rate of 82.4%.

4.1 Demographic Characteristics of Respondents

The demographic characteristics of the caregivers in individual interviews together with those of the patients were collected. These included age, gender, marital status, residence, relationship to the child and period of caregiving for caregivers. On the other hand, the demographic characteristics of the children included the period of hospitalization, ward, and their diagnosis. Table 2 and 3 shows the demographic characteristics of the caregivers and the children respectively.

Table 4.1: Demographic Characteristics of Respondents

Age		
	Frequency	**Percent**
21-30	20	66.70%
31-40	7	23.30%
41-50	2	6.70%
51+	1	3.30%
Total	30	100%
Gender		
Gender	**Frequency**	**Percentage**
Female	30	100%
Total	30	100%
Marital Status		
	Frequency	**Percent**
Married	25	83%
Separated	2	6.7%
Single	3	10%
Total	30	100%
Residence		
	Frequency	**Percent**
Urban	14	46.7%
Semi urban	5	16.7%
Rural	11	36.7%
Total	30	100%
Relationship to the Child		
	Frequency	**Percent**
Mother	29	96.7%
Others (Grandmother)	1	3.3%
Total	30	100%
Period of Caregiving		
	Frequency	**Percent**

0-6 weeks	22	73.3%
>6-12 weeks	4	13.3%
>12 weeks	4	13.3%
Total	30	100%

Table 1 shows that two thirds of the respondents were aged between 21-30 years while those aged 51 and above formed only 3.3%. All the caregivers were females. More than three quarters (83%) were married and 6.7% separated. Nearly half (46.7%) lived in urban centres while 16.7%lived in semi-urban settings. Almost all the caregivers (96.7%) were mothers to the children while the rest (3.3%) were grandmothers. Nearly three quarters (73.3%) had been caregiving for a period of 0-6 weeks and 13.3% for 6-12 weeks and more than 12 weeks.

4.2 Demographic Characteristics of Children

Table 2: Demographic Characteristics of Children

Age		
	Frequency	**Percent**
< 0- 6 months	14	46.7%
>6 month -1 year	1	3.3%
>1 - 5 years	7	23.3%
>5- 10 years	6	20%
>10-15 years	2	6.7%
Total	30	100%
Period of Hospitalization		
	Frequency	**Percent**
0-4 weeks	19	63.4%
>4 – 8 weeks	4	13.3 %
>8 -12 weeks	3	10%
>12 weeks -1 year	3	10%
>1year	1	3.3%
Total	30	100%
Ward		
	Frequency	**Percent**
NBU	8	26.7%
Paed medical	22	73.3%
Total	30	100%
Diagnosis		
	Frequency	**Percent**
Preterm	5	16.7%
Respiratory	5	16.7%
Liver	2	6.7%
Renal	2	6.7%
Congenital illnesses	4	13.3%
Tropical	1	3.3%
Cancer	3	10%
Total	30	100%

Table 2 shows that about half of the children (46.7%) were aged between 0 – 6 weeks of age while those aged 6 months to 1 year were the least at 3.3%. Those aged between 1-5 years were 23%. This

indicates that most of the paediatric patients were 5 years and below. Those above 5 years were 26.7% with the highest age being 15. This is likely to be because of free health services for children 5 years and below. Out of these, the majority (63.4%) had been hospitalized for 0-4 weeks. Almost three quarters of children (73.3%) were in the Paediatric medical wards and over a quarter (26.7%) from the New Born Unit. Less than a quarter (16.7%) of the children were born preterm and a similar number had respiratory conditions while 3.3% had tropical diseases.

4.3 Caregivers' Perception of Compassion Ability of Paediatric Health Care Providers

The study sought to explore how caregivers perceived compassion ability of paediatric health care providers. Compassion ability was measured in terms of caregiver observations, time taken during consultation with PHCP and amount of information given by PHCP. Their observations were conceptualized in different themes which included the following, love and friendliness, communication, timeliness and listening.

Love and Friendliness

Participants perceived love and friendliness as an important aspect of compassion. Some perceived love and friendliness in terms of warm reception, polite communication and timely treatment while others saw it as the way in which PHCPs cared or assisted the children, and how they related with children and assisted with meals. Some excerpts on love and friendliness are listed below.

> Participant LF 1: "For me compassion means love, warm reception, polite communication and timely treatment."
>
> Participant LF 5: '' Compassionate care is based on how a PHCP treats a caregiver and her child. So far compassionate care here is low.''

This is consistent with findings by Salmani, Hasanvand, Bagheri and Mandegari (2017) that caregivers expect PHCPs especially nurses to have age appropriate baby talk which would help reduce emotional distress and promote relaxation in children. Similar views were elicited by a study conducted among nurses who deal with children in needle related medical procedures. It found that parents were an extension of the children and were required to help a child relax during a medical procedure. Nurses also needed to know how to interact with children at different age groups. Some conversation was necessary before a needle procedure and it depended on how anxious the child was, whether the child had been exposed to needles before and age of the child. If a child was anxious minimal information was given concerning injections while more was offered to a curious child (Karlsson, Rydstrom, Enskar & Englund, 2014). When the children are relaxed, their parents are more likely to relax and follow through with the treatment procedures. The findings also agree with a study by Palazzi *et al*. (2015) who found that communication that is patient-centred portrays empathy and uses language and nonverbal signals effectively leading to patient satisfaction. This reveals that caregivers are looking for signs that their PHCPs care even as they entrust their childrens' care to them. PHCPs should be aware that caregivers are reading their nonverbal behavior as they attend to their children and interpreting it as either compassionate or uncompassionate. This observation affects how their services are rated and accepted.

Communication

The theme of communication featured prominently in the responses of the participants. Good response from nurses and doctors, politeness in communication, service without delay and service with kindness were presented as the indicators of good communication which according to them manifested compassion. On the other hand, lack of compassion was indicated by use of harsh

language when communicating to caregivers and the patients. Below are some of the responses given by the participants.

> Participant C1: "Compassionate care means a good response from the nurses and doctors"
> Participant C2: "Compassionate care means service with kindness and mercy. Uncompassionate care is when the PHCP is harsh, uses harsh language, or is not humble."

The findings above on communication are in tandem with the study by Salmani *et al*. (2017) and Marginean *et al.* (2017) who found fluctuation of care in hospitals where nurses would fail in communicating with patients and caregivers when carrying out basic procedures. PHCPs who involved the caregivers in the treatment procedures through communication were found to be compassionate while those who did not caused them to be distressed. Showing interest means being ready to hear the viewpoint of the parents and finding out what the treatment being offered means to them. If anything needs to be clarified, this should be done politely keeping in mind that parents may not fully understand some medical procedures. Only when questions are fully addressed do parents/caregivers feel comfortable with the treatment being offered to their children. When caregivers are relaxed, the children are more likely to be relaxed making the work of the PHCPs easier.

Timeliness

Timeliness was also reported by the participants as an aspect of compassion ability. Responding on time and noticing changes in symptoms of the patients was considered an indicator of compassion. Giving the right treatment as required was seen as compassion just as receiving help when in need. Quick response and giving the right information were deemed to indicate compassion ability. Some of the responses are sampled below.

> Participant T1: "Compassionate care means responding on time and being able to notice when the baby's condition changes."
> Participant T2: "Compassionate care means being helped when you ask for help"
> Participant T3: "Compassionate care is shown by good communication, quick response giving the right information and remembering various patients' needs even when they are many."

Listening

A few respondents considered compassion ability as being listened to by the doctor. To them listening was a way of communicating empathy which gave a sense of relief and being understood. Some felt that the PHCPs were in a hurry even during the ward rounds and did not have time to listen to their concerns about their children. Listening therefore proves to be a beginning point for effective treatment as indicated by two respondents below.

> Participant L1: "Compassionate care means being listened to, attended to on time. It is having someone backing you up."
> Participant L2: "When the doctor listened to me, I felt relieved, and understood. Compassionate care to me is having someone take time to hear you out rather than rushing you in the process of consultation."

The findings on listening partly agree with Marginean et al. (2017) who observed that health care providers asked closed ended questions hindering their listening skill. However, the study did not focus directly on listening but the questioning procedure which involved closed ended questioning. Caregivers considered being listened to rather than being asked questions as compassion ability on the part of the PHCPs. Time is a precious commodity for all PHCPs hence they may be tempted to rush the patient in order to save it. However, this results in miscommunication and lack of satisfaction by the patient. According to Palazzi *et al.* (2015)**,** listening is an art**.** The PHCP needs to encourage the patient by inviting him/her to talk and showing that they are listening by leaning

forward, nodding or by simply saying ‘’I am listening.’’ The study proposes a model for enhancing the listening skill. It is Stop, Look and Listen. The PHCP needs to stop thinking about anything else and concentrate on the patient. The PHCP also needs to be aware of their own mood. The PHCP also needs to look whether the setting provides privacy and judge the emotional state of the patient.

Consultation Time

Generally, the respondents indicated that the time taken by the doctor for consultation depended on different factors. Some of the caregivers indicated that consultation time depended on the condition of the child's sickness whereby, a very sick child would get more time compared to one who was not. Another factor found to determine the consultation time was the type of ward. The participants noted that consultation time was longer in the private more than the public wards. Similarly, when a concern was raised or a question asked; doctors would spend more time to address that concern. Finally, consultation time was determined by the whether the doctor was accompanied by other hospital staff like nurses and students. The doctor was more hurried when accompanied by other personnel than when he/she was alone.

Majority of the caregivers considered consultation time as an important aspect of compassion ability. Most of them were of the opinion that consultation time lasted for 5-10 minutes and while some of the caregivers were satisfied with the time, others were not. Caregivers who received longer time during consultation (over 10 minutes) and their concerns addressed during the consultation expressed satisfaction with consultation time. However, some caregivers were not at ease to consult the doctor when accompanied by other staff members like medical students. Most of those who were discontented with such consultation felt excluded because doctors would discuss among themselves. Most caregivers took that negatively. The following are some of the excerpts on consultation time.

> Participant CT1: “Consultation lasts 5-8 minutes and depends on how sick the child is. It is longer when the child is very sick.”
>
> Participant CT2: “Consultation time depends on how sick the child is, if very sick, the doctor takes more time and less when not very sick. Most of the time I am satisfied with time spent. However, sometimes the doctor writes more than he listens.”
>
> Participant CT3: “Consultation time depends on the condition of the patient. I took 20 minutes during admission. The doctor took history, blood from the patient and fixed an IV line for fluids.”

The findings agree with Chinawa et al. (2016) who found that caregivers preferred PHCPs who spent time with a patient because it provided room for personal expression. In the current study most caregivers felt their concerns were addressed fully if the doctor spent more than 10 minutes. This could mean that spending more time with a patient is interpreted as compassion and goes a long way in reducing the distress of a caregiver.

Amount of Information given by PHCP.

The study found that scarcity of information was a recurring theme in most of the paediatric units. Respondents in individual interviews as well as those in FGDs had similar views even those caregivers who had some information still had gaps in most of the areas surrounding their children's treatment. For instance some would know the condition their child was being treated for but miss to know the modalities of treatment, duration, possible complications or the outcome. For others they had not been told anything about their child and only overheard it from different PHCPs while handing over to a different shift. For some caregivers blood would be drawn from their children without proper explanation and when the results got misplaced and more blood was needed, they would now be told what it was all about. Sometimes they would not know their children needed to

be transfused until it became urgent. This was especially identified in the NBU and Oncology wards where caregivers did not stay with their patients and visited only at specific times.

Because of the nature of NBU where mothers went to feed the babies every 3 hours, sometimes the doctors would be gone from the unit by the time they visited or they would be too busy to address their needs. At the time of the current study the population of the babies ranged between 120 and140 making it almost impossible to meet all the caregivers' information needs. In the Oncology ward, the caregivers could meet the professor for updates on their children every Thursday. The doctors in the oncology ward were not always easy to access for information. While the nurses were easily available in the oncology ward and NBU, the information they could give was limited. A study conducted among nurses taking care of children in palliative care found that nurses spent more time with caregivers than doctors and hence were more accessible for information. However they reported feeling like their role was merely supporting decisions made by doctors. The study also found that the nurses were not trained in communicating difficult news to recipients of palliative care. Their communication was informed by their own values, attitudes and past experiences.

> Participant AI 1: "I know my child is on chemotherapy but the doctors have not been able to find the site of primary cancer." (FGD Oncology)
>
> Participant AI2: "Occasionally there is a good doctor like the one working this week. He has explained what is to be done to my baby in theatre and I am contented." (FGD, NBU)
>
> Participant AI7: "Sometimes blood is taken from my baby without getting any feedback, and then when a situation becomes critical, they start rushing to me to get donors to give blood to the baby." (FGD NBU)

The findings by Keiza, Chege and Omuga (2017) concur with the current study findings where some caregivers indicated that they lacked adequate information on their children's illness, type of treatment and even the side effects. This study had been conducted in the same hospital among caregivers of children in the oncology ward. The findings also agree with a study by (Melo, Ferreira, Lima & Mello, 2014) which showed that when caregivers receive inadequate information concerning their children, they become anxious and distressed about the treatment given. Receiving adequate information about patients therefore communicates compassion and goes a long way in relieving unnecessary suspicion and distress to paediatric caregivers. Some of the possible reasons that impede PHCPs from sharing information could be past failures in treatment, feeling vulnerable or past patient losses which leave the PHCPs guilty of giving hope especially in the NBU and Oncology wards where the mortality rates are high (Granek, Bartels, Barrera & Scheinemann, 2015). Despite this, PHCPs need to understand how to communicate with caregivers taking into to account their emotional states. Communicating difficult news can be incorporated into the basic training for PHCPs. This would ease communication between PHCPs and caregivers making the latter more receptive of the information relayed by PHCPs.

Difference in the Levels of Compassion

The study sought to find out if compassion ability varied among the different PHCPs. The findings were conflicting. While a large number felt that the nurses were more compassionate, others stated that the doctors were compassionate and still others believed that both doctors and nurses were equally compassionate. Those who felt nurses were the most compassionate indicated that they talked to children, were understanding and were available to the caregivers. This indicates that availability was considered an important indicator of compassion. Elderly nurses were also found to be more compassionate. This could be because elderly nurses have greater experience on how to communicate compassion to both caregivers and patients. They were also found to be politer and responsive.

On the other hand, those who felt that doctors were compassionate stated that they answered questions from patients, took time with caregivers, responded immediately whenever called upon, they were available when needed, had friendly attitude, and communicated well with the caregivers. This supports the earlier findings on responsiveness of health care providers, availability, communication and friendliness as indicators of compassion. Finally, those who felt that both doctors and nurses are compassionate indicated that all of them took time to listen; they consistently attended to patients and administered medication to children at the right time. Some of the responses are provided below.

> Participant LC 1: "Compassion levels differ. Doctors are more compassionate because they respond fast"
>
> Participant LC 2: "Compassion levels differ. Professor is more compassionate because he/she takes time during the ward round to attend to the child."
>
> Participant LC 3: "I consider doctors more compassionate than nurses. They are friendlier to the parent and the child. The fact that they prescribe medications makes them look like they care the most."

These findings are in agreement with those found by Salmani *et al.* (2017) who found that nurses who took time to explain a medical procedure such as fixing an IV line were found to be more compassionate than their peers who simply took a child away from the caregiver without explaining what they intended to do with the child. It also concurs with a study done in Nigeria by Chinawa *et al.* (2016) which found that paediatricians were viewed as compassionate when they appeared unhurried, were willing to create rapport with patients as well as caregivers and had the ability to listen to caregivers' concerns. This could therefore imply that since nurses spend most time with patients, they make caregivers feel that someone is always available to answer their call.

5.0 Conclusions and Policy Implications

The study aimed to establish caregivers' perceptions of compassion ability among paediatric health care providers**.** The following conclusions were made from the study findings:

Majority of the caregivers felt that adequate consultation time, timeliness, polite communication and responsiveness were important aspects of compassion ability. Doctors were viewed as compassionate when they appeared unhurried during consultation time as well as during the ward rounds. They were rated as friendlier to the children and caregivers and mostly were rated as polite. However those doctors who were not available for consultation and information on the progress of a child were viewed as uncompassionate. Nurses were rated as compassionate mostly based on their close proximity and availability to the caregivers. Those who were willing to give information about a child in the absence of a doctor were viewed as compassionate especially in the paediatric medical wards. In the NBU, those who went out of their way to train first time mothers how to handle the premature babies were viewed as compassionate. On the other hand nurses who were harsh, unavailable or unwilling to relay information from the doctors were viewed as uncompassionate. In the NBU, nutritionists who helped caregivers to express milk for their premature babies were rated highly for compassion. Physiotherapists in the paediatric medical wards were rated as compassionate for explaining their procedures to the caregivers. Professors in the oncology ward were rated as compassionate for being available to share information about their patients. Caregivers in the Oncology ward reported that professors were accessible on phone.

Perception of compassion ability among the different PHCPs varied from caregiver to caregiver. Perceptions depended mainly on their roles. Since doctors are expected to consult, make a diagnosis and give feedback depending on findings, caregivers rated doctors mainly on friendliness during consultation and ability to answer questions concerning their children when caregivers sought the answers. Nurses on the other hand were mainly evaluated on availability and politeness since they

interacted more with caregivers because they were stationed in the wards as opposed to doctors who would come to the ward and leave at various times. As custodians of patients' files in the ward, caregivers expected them to share as much information as possible though it was established some of the information needed to come from the doctors. It would be good for the institutions to brief the caregivers on how to access patient information when it was needed.

Paediatric health care providers especially nurses and doctors may need to increase their consultation time with paediatric caregivers in order to give them room for expression of their expectations and also ensure proper understanding of the procedures.

There may be need for health institutions to formulate practice policies that promote education on compassion ability among PHCPs which may help in treatment compliance

5.1 Recommendations for Further Studies

This study focused on the views of caregivers rather than the health care providers and so another study may need to be conducted to assess the views of the health care providers on their capacity for compassion ability.

This study was qualitative and relied on the subjective experiences of the caregivers. A quantitative study may need to be conducted to find out the extent to which the identified indicators of compassion ability influence compliance.

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