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Family involvement in nursing care
- a resource or burden?
From the perspective of Tanzanian nurses

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ABSTRACT

The health of the individual affects all family members, and families influence the process and outcome of health care. Nurses attitudes about the importance of involving the patients families in nursing care, greatly influences the quality of the meeting between the family and the nurse. Nurses working in Tanzania feel they cannot provide adequate healthcare due to heavy work load and limited resources. Tanzanian nurses and patients are highly dependent on the help of the patients' families. The aim of the study was to investigate Tanzanian nurses' attitudes towards involvement of patients' families in nursing care. In this quantitative, descriptive study, a questionnaire called "Families' importance in Nursing Care - Nurses' Attitudes" (FINC-NA) was handed out to registered nurses working at a regional hospital in Tanzania in 2009. The results were analysed and presented by descriptive statistics such as charts, tables and central values. The 47 nurses who answered the questionnaire had in general supportive attitudes towards the involvement of the patients' family in nursing care. One fifth of the nurses however viewed the patients' families as a burden. One third of the nurses feel that the presence of the patients' families holds them back in their work. Nurses above 40 years of age and nurses with no experience of a family member being seriously ill had less supportive attitudes towards patients family involvement compared to other subgroups in this study. The nurses with least years of nursing experience had the most supportive attitudes of all the subgroups. Besides nurses own experience of an ill family member, this study suggests that attitudes are affected by culture, working environment and education.

Keywords: Family nursing, Tanzania, attitudes, family involvement
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1 INTRODUCTION

With shorter hospital stays, more care is expected from family members (Saveman & Benzein, 2001). As a nursing student I have become interested in the ethical aspects of this situation, and also how the families’ involvement in nursing care is viewed upon by Swedish nurses compared to nurses working in other countries with other cultures and healthcare situations. In underdeveloped countries such as Tanzania it is more often the family members who are responsible for the care of the sick relatives (Juntunen & Nikkonen, 2008); I am therefore interested in exploring Tanzanian nurse’s view on the matter.

2 BACKGROUND

2.1 Family nursing

According to Harmon-Hanson (2005), it is important to acknowledge a family focus in nursing. The health of the individuals affects all family members, and families influence the process and outcome of health care (Harmon-Hanson, 2005; Wright, Watson & Bell, 2002). Harmon-Hanson (2005) also states that nurses should learn about family nursing to be able to provide client-centered holistic nursing care. Health care workers often disregard the fact that the families can be a powerful resource for the sick family member (Wright et al, 2002). To promote family health, it is important to build a trustful and caring relationship between the nurse and the family through communication (Benzein, Hagberg & Saveman, 2008a). Family-focused care is founded on the relationship between the nurse and the family which is built on mutual respect, collaboration and support for the family and patient (Coyer, Courtney & O’Sullivan, 2007). Friedman, Bowden and Jones (2003) consider family nursing as emphasizing a health orientation, a holistic and interactional perspective and keeping in mind the importance of family strengths. Saveman and Benzein (2001) chose the term family-focused nursing, to describe both the family as unit (with individual family members and the family unit in focus simultaneously) and family as context (with individual members in the foreground and the rest of the family as background).

Family nursing is a scientific discipline based in theory (Harmon-Hanson, 2005). Family nursing theories derive mainly from the following three groups of theories; Family social science theories, Family therapy theories, and Nursing models/theories (Friedman et al, 2003; Harmon-
Hanson & Rowe-Kaakinen, 2005). Improving nursing care of families by providing knowledge and understanding is the main purpose of theory in family nursing. In working with families it is important that the nurse uses an integrated approach from several theories to assess the family’s needs effectively.

2.2 Family involvement in nursing care

In Scandinavia during the 20th century, healthcare professionals at hospitals and institutions took over the responsibilities and roles of the family as primary caregivers to the sick family members (Kirkevold & Stromsnes, 2003). The previously active family was set as passive viewers to the suffering of their ill loved-ones. With decreased health care funding and resources in Sweden as many other developed countries, families are once again taking more responsibility for the care of ill family members with much care provided at home (Saveman & Benzein, 2001; Benzein, Hagberg & Saveman, 2008a).

2.3 Nurses attitudes towards the patients families and their involvement in nursing care

Nurses attitudes about the importance of involving the patients families in nursing care, greatly influences the quality of the meeting between the family and the nurse (Benzein, Johansson, Arestedt & Saveman, 2008c). Wright et al (2002) also state that the nurses’ professional attitudes strongly influence how they approach, get involved with and help the families in their health process. The results from a Swedish study on district nurses by Benzein, Johansson and Saveman (2004), showed that the nurses found the family as both a resource and a burden. The families were considered a resource when there was an open communication with the family surrounding the patient. They were then a resource for the patient, the district nurse and the other family members, both emotionally and practically. The family was perceived as a burden when the nurses found them demanding, or when they would take actions in the patient care without first consulting the district nurse. The nurses also found it hard to deal with the family when they openly showed their own suffering.

After a thorough literature review on nurses’ attitudes about the importance of involving families in nursing care, Benzein, Johansson, Årestedt, Berg and Saveman (2008b) realised that previous research on the matter was mostly context-specific nursing settings such as critical care or
surgical care. They also found that the results were at times ambiguous when nurses often claimed that families were important, but this belief was not always supported by evidence. The authors therefore constructed the instrument; Families’ importance in Nursing Care – Nurses’ Attitudes (FINC-NA), and sent it out to 1000 registered nurses in Sweden. The results showed that Swedish registered nurses have a supportive attitude about the importance of involving families in nursing care. Being a male registered nurse, a newly graduated registered nurse, and having no general approach to families in the working place however showed less supportive attitudes in this area (Benzein et al, 2008c).

A similar study was conducted in USA 2006 measuring attitudes of nursing staff working in hospital setting concerning family presence during routine nursing care (Fisher, Lindhorst, Matthews, Munroe, Paulin & Scott, 2008). The results showed that the nursing staff attitudes were mostly positive and those who believed that the presence of the family was important were more likely to include the families in the daily care.

2.4 Culture, family and the nurse

Culture determines our daily behavior, attitudes and values (Friedman et al, 2003). Culture links human groups to their environmental setting. A family’s ethnic belonging is determined by their cultural background, race and religion (Wright & Leahey, 1998). Together they determine both conscious and unconscious behaviors which are passed on from generation to generation. Ethnic belonging highly influences family interactions. The family, client, community and culture are factors determining health and well-being (Elliot, 2005). How we think and act when we are ill or caring for someone who is ill, is defined by our culture (Pilhammar Andersson, 1996). A family’s beliefs and values largely determine how they will cope with health and illness (Friedman et al, 2003).

Elliot (2005) mentions how the nursing education and practice in many nations are applying family nursing theories. She highlights the fact that no single theory is applicable to all cultures.

Although there are differences between cultures of how patients and family members express their needs, Fisher et al (2008) enlightens the cross cultural similarities in the nursing care needs of patients and families. In Transcultural nursing the goal is for nurses to provide safe, sensitive, beneficial and meaningful care to people of different cultures (Leininger, 2002a). Transcultural
nursing also focuses on similarities and differences between cultures with regards to humanistic care, health, illness, healing patterns, beliefs and values. Leininger also states that care is an essential human need and that caring is the heart and soul of nursing.

The ICN code of ethics for nurses states that “In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected” (ICN, 2006, p.4).

2.5 The health situation in Africa and the Republic of Tanzania

The major cause of death and disease in the African region are vaccine-preventable diseases (WHO, 2006). HIV/AIDS, Malaria and TBC are known as “the big three”, being the largest causes of death in the African region killing about three million people each year. The children are also greatly affected by measles, waterborne infections and parasitic diseases. According to statistics from the United Nations Development Programme (UNDP, 2008), the people living in The Republic of Tanzania in 2006 had a 36% probability of not surviving past the age of 40, and 22% of the children below the age of 5 years were underweight. There are 2 doctors for every 100,000 inhabitants, 62% of the citizens have access to clean water and 47% access to adequate sanitary facilities (SIDA, 2008). People living with HIV/AIDS are estimated to 6.5% of those between the age of 15 and 49 years.

2.6 The African family

In Africa the concept of family is much wider than in Europe, including children, parents, grandparents, uncles, aunts, brothers, sisters and other immediate relatives (Juntunen & Nikkonen, 2008; Juntunen, Nikkonen & Janhonen, 2002). A household in the traditional African society is what European societies call family. The children are responsible for the well-being of their parents when they become old and no longer can earn money; this well-being is obtained from respect of the elders and deceased ancestors, including physical, economic, social and emotional components (Juntunen et al, 2002). When a family member is sick and needs bed-side care it is in the first hand the spouse who attends to the patients basic needs; washing, feeding etc. After the spouse it is a family member of the same sex who is responsible. The family acts as mediators between healthcare personnel, the patient and other family members (Juntunen & Nikkonen, 2008). Patients without family care are dependent on the care of the nurses, which is
often more technical in nature. Acknowledging family as a care resource could be interpreted by the nurses as a lack of respect for their status and expertise.

Mothers in Tanzania are educated by healthcare workers on the etiology, symptoms and treatment of Malaria (Montgomery, Mwengee, Kong‘o, & Pool, 2006). Although all children under the age of five receive free treatment, healthcare workers think the mothers often wait too long before seeking treatment for their malaria-sick child. The mothers are therefore perceived as lazy, ignorant and neglectful. The main problem according to Montgomery et al (2006) is the fact that the male family members most often make decisions regarding when and what kind of treatment the child should receive, and therefore all health education should be directed to both men and women.

2.7 Nurses in Tanzania

According to Häggström, Mbusa and Wadensten (2008), Tanzanian nurses experience ethical dilemmas and workplace distress on a day to day basis. The nurses feel they cannot provide adequate healthcare to their patients due to heavy work load, insufficient equipment, lack of protective gear, and to many patients to each nurse. They are also troubled by the attitudes of the doctors who often look down on them and do not value their knowledge and also encourage the nurses to prioritize rich patients before those in greatest need. The nurses also feel they have no support from their supervisors and insufficient respect for their work. Ethical dilemmas also occur when caring for HIV patients in the same room as other patients due to the lack of privacy and secrecy, especially concerning the stigmatization surrounding HIV and AIDS. Despite all the distressful factors influencing the Tanzanian nurses working environment, the study showed that the nurses still try to be positive and keep struggling for better health care for their patients.

3 THE STUDY PROBLEM

The health of an individual family member affects the whole family, both emotionally and practically. Communication between the family and the nurse is needed to enhance family health. The quality of this communication is highly based on the nurses’ attitudes and beliefs regarding the involvement of the family in nursing care. Nurses working in Tanzania feel they cannot provide adequate healthcare due to heavy work load and limited resources. Tanzanian nurses and
patients are highly dependent on the help of the patients’ families. Knowledge of the Tanzanian nurses’ attitudes towards the involvement of the families in nursing care is needed.

4 AIM OF THE STUDY

The aim of the study is to investigate Tanzanian nurses’ attitudes towards families’ involvement in nursing care.

4.1 Research question

Do Tanzanian nurses view the patients’ families as a resource or a burden when caring for the patient?

5 DESIGN

5.1 Design and method

This study is empirical with a quantitative approach. It is a descriptive analysis of the study results obtained during the three weeks of my data collection, aimed at describing Tanzanian nurses’ attitudes of the involvement of families in nursing care. The instrument I used was a questionnaire called Families’ importance in Nursing Care – Nurses’ Attitudes (FINC-NA), designed by Benzein et al (2008b) (Appendix 1). The questionnaire consists of 26 items and the response alternatives are formed according to a 4-point Lickert scale where; 1 (strongly disagree), 2 (disagree), 3 (agree) and 4 (strongly agree)(Benzein et al 2008c). A Lickert scale is used to describe and measure attitudes (Olsson & Sörensen, 2007). The possible range of the scores is 26 to 104 for the whole instrument. The more supportive the attitude the nurses have, the higher score she or he will have. As the instrument has four response alternatives where two are unsupportive attitudes and two are supportive attitudes. A total score of 52 or below indicates a complete unsupportive attitude to the involvement of family in nursing care. The instrument has been tested in ways to increase validity and reliability (Benzein et al 2008c). The demographic section of the instrument contains data such as age, gender, and years of experience in nursing. The definition of family is broadened to include emotional relationships along with the individuals related by bloodlines or by law.
The questionnaire measures four aspects of nurses’ attitudes about the importance of families in nursing care (Benzein et al 2008c) (Appendix 2): family as a resource in nursing care (Fam-RNC) with 10 items and possible score range from 10-40; family as a conversational partner (Fam-CP) including eight items, score range 8-32; family as a burden (Fam-B) with four items inverted before analysis, score range 4-16; and family as its own resource (Fam-OR), four items with possible score range of 4-16.

5.2 Study setting and sample

The questionnaire was handed out to registered nurses working at the Kilimanjaro Christian Medical Centre (KCMC) in Tanzania, during three weeks in the fall of 2009. KCMC is a referral hospital for over six million people in the Northern Zone of Tanzania (Tumaini University, 2005). It has a total bed capacity of about 450 patients. Approximately 100 nurses work at KCMC and almost all are female (C. Mushi, personal communication 28 September 2009). The aim was to reach as many nurses as possible. All nurses I came in contact with when going through the wards were asked to participate.

5.3 Inclusion Criteria

The inclusion criteria for the registered nurses were that they had to be English speaking and currently employed at KCMC. Only fully completed questionnaires were considered for analysis in this study.

5.4 Data Collection

The questionnaire (Appendix 1) was handed out to registered nurses working at KCMC during the period of my data collection. Most nurses chose to take the questionnaire home and return it on their next shift. Only three nurses chose to fill out the form in my presence. It became clear after the first week that I alone would not be able to get enough nurses to fill in the questionnaire during the stipulated time for data collection. I was mainly stationed on the paediatric and the maternity wards during the weeks of my data collection. I was assisted by one of the nurses working at KCMC who made it possible for me to visit the other wards. The nurse helped to introduce me and my study to the nurses. She also handed out about 15 questionnaires by herself.
In total 65 questionnaires were handed out, 53 were returned to me. Six questionnaires were excluded due to the inclusion criteria for analysis. One as it was answered by a nursing student and therefore did not match the inclusion criteria. Five questionnaires were excluded due to internal dropouts, the respondents had either missed to answer one or more of the questions or chose more than one option.

5.5.1 Data analysis

As I only have chosen registered nurses in this study, the term nurse in the rest of this paper refers to registered nurses.

*Step 1.* The data of all results were entered into Windows Excel consecutively as they were collected. Before analysis the data was controlled again to make sure no mistakes had been made during data entry. Each respondent was given a column first entering the demographic characteristics, followed by their answers of the questionnaire (Appendix 3). As the score of the FINC-NA and its subscales are calculated from results on a Likert scale, the data was treated as ordinal data using non-parametric statistics (Olsson & Sørensen, 2007). The following values were given for the response alternatives: 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree. A high score indicates a more positive attitude.

*Step 2.* Following the analysis procedure of Benzein et al (2008c), the results from the 4 questions under the subscale Family as a burden (Fam-B) were inverted as the questions measure a negative attitude towards the involvement of families in nursing care.

*Step 3.* The total score of each respondent was calculated as well as the sum of the scores from each subscale. These were the values that where compared and analyzed.

*Step 4.* The data was then grouped and analyzed separately based on different subgroups after demographic characteristics. The subgroups “Years of nursing experience” was divided between the nurses having worked 5 years or less, and 6 years or more. It was the same division and limit used by Benzein et al (2008c) to compare between “newly graduated nurses” and “expert nurses”. The subgroups based on the age of the nurses were divided by respondents being under 40 years of age and 40 or above. The age limit was chosen as the mean age of the participants was 39 years and the fact that about 50% of the respondents were above and about 50% were below the
age of 40. Analysis was performed between the subgroups of nurses having their own experience of a seriously ill family member in need of hospital care and those stating no such experience. There was also a comparison made between nurses indicating there was no general approach to family care at their place of work, and those who had. Only one male responded, therefore no comparison was made based on gender.

Step 5. After the subgroups were made and the results compared and analyzed, comparison was made with the subscales of the instrument (Appendix 4). Due to the aim of the study, analysis of the results were only made on the total score of the instrument and the subscales “Family as a resource in nursing care” (Fam-RNC) and “Family as a burden” (Fam-B).

Step 6. I chose a few of the statements from the questionnaire to see the distribution of the attitudes from all the respondents. The distribution of the nurses responses were displayed in pie charts. The statements I chose to look closer at were “The presence of family members eases my workload”, “I gain a lot of worthwhile knowledge from families which I can use in my work”, “The presence of family members is important for the family members themselves”, and “The presence of family members holds me back in my work”.

Step 7. Tables and diagrams were constructed to obtain a better overview of the results. Charts were created to visualize the distribution of responses for the statements under the subscales “Family as a resource in nursing care” (Fam-RNC) and “Family as a burden” (Fam-B). Before this was done the responses “Agree” and “Strongly Agree” were grouped, as were the responses “Disagree” and “Strongly Disagree”.

All analysis was performed using Windows Excel 2007.

5.5.2 Statistical analysis

All of the data was analyzed using descriptive statistics. Descriptive statistics is used to visualize and summarize results, making it possible to draw conclusions of the population based on the sample (Norusis, 2000). Mean values and standard deviations were calculated of the respondents' ages and years since graduation. Median values (md) and first and third quartiles (Q1, Q3) were calculated as well as quartile deviations (Q=(Q3-Q1)/2) (Olsson & Sörensen, 2007). The quartile deviation Q, is a good alternative to the standard deviation which cannot be calculated on ordinal
data (Byström, 2000). Non-parametric statistics such as median and quartiles were used on the results due to the instrument using ordinal data. With ordinal data the values cannot be calculated by the four rules of arithmetic (Olsson & Sörensen, 2007). The median is the centre value of a data set that has been organized from lowest to highest score (Eljeertsen, 2003). The first quartile (Q1) is the value that limits 25% of the lowest scores in the data set and the third quartile (Q3) is the above limit with 75% of the scores below it.

6 ETHICAL ASPECTS

Before handing out any questionnaire, permission was given by the Matron, Mrs Mauscui and the Director of the Hospital, Professor Shaw to conduct this study at KCMC. They had a few months prior to my arrival received and introductory letter describing the purpose of my visit (Appendix 5). A tour of the hospital was provided by the matrons assistant were she shortly introduced me to the nurses on duty and asked them to assist me when the questionnaires would be handed out. When starting my data collection I introduced myself to the nurses before giving out my questionnaire as a nursing student from Sweden, at KCMC to do my bachelor thesis. Relevant information about the study was given together with the questionnaire to all participants, including information about the participation being voluntary and anonymous, and that the material would be handled confidentially. This information is also clearly stated on the questionnaire itself (Appendix 1). According to Olsson and Sörensen (2007) it is important to inform all participants about the purpose of the study and that it is voluntary to participate. The nurses who received the questionnaires from the nurse assisting me only got the verbal part of the information from her. The material has been handled confidentially as no one but I have had access to the raw data. No single person can be identified by the results which assure the participants anonymity.

7 RESULTS

At the end of my data collection I received 53 filled questionnaires out of the 65 that were handed out. This gave a response rate of 81.5%, and external disappearance of 18.5%. Finally 47 questionnaires could be used in the data analysis which is equivalent to 72% of the questionnaires handed out.
7.1 Personal and organizational characteristics of the respondents

The 47 nurses had ages ranging from 22 to 60 years with a mean value of 39 years. Only one of the respondents was male. On average they had a working experience of 13 years (SD= 11) as nurses, ranging from 0 to 37 years. Most of the nurses (n=38; 81 %) indicated that they had a general approach to family care at the workplace. The nurses who answered no to this question were working on the same wards as the nurses who responded yes. A large part of the nurses (n=37; 79 %) had experienced at least one of their own family member who had been seriously ill and in need of hospital care. Results of the demographic and organizational characteristics are found in Table 1.

Table 1. Personal and organizational background characteristics of the respondents, N=47

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, m (SD)</td>
<td>39 (11)</td>
</tr>
<tr>
<td>Below 40 years old</td>
<td>25</td>
</tr>
<tr>
<td>40 years old and above</td>
<td>22</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male, n</td>
<td>1</td>
</tr>
<tr>
<td>Female, n</td>
<td>46</td>
</tr>
<tr>
<td>Years since graduation as RN, m (SD)</td>
<td>13 (11)</td>
</tr>
<tr>
<td>5 years or less, n</td>
<td>16</td>
</tr>
<tr>
<td>6 years or more, n</td>
<td>31</td>
</tr>
<tr>
<td>Has a member of your family ever been seriously ill and in need of hospital care?</td>
<td></td>
</tr>
<tr>
<td>Yes, n</td>
<td>37</td>
</tr>
<tr>
<td>No, n</td>
<td>10</td>
</tr>
<tr>
<td>Is there a general approach to the care of families at your place of work?</td>
<td></td>
</tr>
<tr>
<td>Yes, n</td>
<td>38</td>
</tr>
<tr>
<td>No, n</td>
<td>9</td>
</tr>
<tr>
<td>Distribution of nurses between wards</td>
<td></td>
</tr>
<tr>
<td>Pediatric wards</td>
<td>14</td>
</tr>
<tr>
<td>Medical wards</td>
<td>8</td>
</tr>
<tr>
<td>Obstetrics and Gynecology wards</td>
<td>8</td>
</tr>
<tr>
<td>Surgical wards</td>
<td>7</td>
</tr>
<tr>
<td>ICU &amp; Casualty</td>
<td>6</td>
</tr>
<tr>
<td>Other wards</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: m, mean; SD, standard deviation; md, median

a. "Other wards" includes one nurse from Research; one from the Eye, Ear, Nose and Throat clinic, and two nurses from surgery.
7.2 Results of the FINC-NA instrument

The median (Md) value of the total sum of scores from all nurses in the study was 76 (Q=6), ranging from 57 to 95 points from the FINC-NA instrument. This indicates that the Tanzanian nurses participating in this study have a supportive attitude towards involvement of the patients' family in nursing care. The large spread of results shows a large range of attitudes between the nurses from almost completely unsupportive to very supportive. There was a normal distribution of the results from the nurses' total score of the instrument.

The nurses below 40 years of age, gave higher total points on the scale compared to nurses 40 years and above; Md= 77(Q=9) verses Md=74(Q=6). The nurses under 40 had a much larger spread of results indicating a larger variation in attitudes within this group. Fewer years of nursing experience (five years or less) also gave higher scores than from the nurses with longer working experience (six years or more): Md=78 (Q=9) and Md=76(Q=4) respectively. Also here the nurses with less working experience had a larger spread in results showing a large variety of attitudes towards family involvement within this subgroup. The nurses who had experience of a member of their own family being seriously ill and in need of hospital care showed a slightly more positive attitude towards the involvement of families compared to those nurses without personal experience of a sick family member (Md= 76 (Q=7) compared to Md=74 (Q=4)). There was very little difference of the median values between the subgroups of nurses indicating there was a general approach to the care of families at their place of work and those nurses claiming there was no general approach. The results of the total scores are found in Table 2 and Figure 1.
### Table 2. All results of the FINC-NA instrument, including subscales and subgroups

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Fam-RNC</th>
<th>Fam-B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All participants, md (q1-q3)</td>
<td>29 (26-34)</td>
<td>12 (10-13)</td>
<td>76 (71-83)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40 years old, md (q1-q3)</td>
<td>31 (27-36)</td>
<td>12 (11-14)</td>
<td>77 (71-88)</td>
</tr>
<tr>
<td>≥40 years old, md (q1-q3)</td>
<td>29 (25-31)</td>
<td>12 (10-12)</td>
<td>74 (67-78)</td>
</tr>
<tr>
<td>Years since graduation as RN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years or less, md (q1-q3)</td>
<td>31 (27-35)</td>
<td>12 (10-13)</td>
<td>78 (71-89)</td>
</tr>
<tr>
<td>6 years or more, md (q1-q3)</td>
<td>29 (26-32)</td>
<td>12 (11-13)</td>
<td>76 (71-78)</td>
</tr>
<tr>
<td>Have had a seriously ill family member (a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, md (q1-q3)</td>
<td>30 (26-35)</td>
<td>12 (11-13)</td>
<td>76 (71-85)</td>
</tr>
<tr>
<td>No, md (q1-q3)</td>
<td>29 (28-30)</td>
<td>11 (10-12)</td>
<td>74 (71-78)</td>
</tr>
<tr>
<td>General approach to families (b)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, md (q1-q3)</td>
<td>30 (26-34)</td>
<td>12 (10-13)</td>
<td>76 (71-85)</td>
</tr>
<tr>
<td>No, md (q1-q3)</td>
<td>29 (27-34)</td>
<td>11 (11-13)</td>
<td>77 (71-78)</td>
</tr>
</tbody>
</table>

Note: md, median; q1, first quartile; q3, third quartile.
Fam-RNC: family as a resource in nursing care, Fam-B: family as a burden family.
Possible score range: Fam-RNC 10-40, Fam-B 4-16, Total 26-104.

a. Results of Fam-B were inverted before analysis
b. Has a member of your family ever been seriously ill and in need of hospital care?
c. Is there a general approach to the care of families at your place of work?

![Median values of FINC-NA](image)

**Figure 1.** The figure shows the median scores for the respondents total results of the FINC-NA instrument within each subgroup. The subgroups divide the nurses based on them being: younger than 40 years of age or above 40; having up to 5 years of nursing experience or 6 years or more; nurses having experience of an own ill family member and nurses without such experience; and nurses claiming there is an approach of family care at the place of work or not. The last column shows the median result of all of the respondents.
7.3 Results of the subscale “family as a resource in nursing care”

The majority of the nurses view the families as being a resource in nursing care. The median value for all of the nurses was 29 (Q=4). The results show that they in general agree to the statements given under the subscale “family as a resource” (Appendix 2). Nurses below the age of 40 and nurses with less working experience showed more positive attitudes towards the importance of families, regarding them as resources in their nursing care. Nurses’ experience of an ill family member of their own was also a factor influencing a more positive attitude. Having a general approach at the work place did not influence the factor of viewing the patients’ family as a resource in nursing care so much. Results of the subscale family as a resource in nursing care (Fam-RNC) are found in Table 2, Figure 2.

![Bar chart](chart.png)

Figure 2. The chart represents the actual distribution of the nurses responses to the statements under the subscale Family as a Resource in Nursing Care (Fam-FNC). N=47.
The first statement of the questionnaire is "The presence of family members eases my workload". Three quarters (74%, n=35) of all respondents agrees or strongly agrees to this statement (Figure 3).

![Pie chart](image)

Figure 3. Distribution of responses from all respondents on the statement "The presence of family members eases my workload". N=47.

Three quarters (76%, n=36) of the nurses answered that they do gain a lot of worthwhile knowledge from families that they can use in their work (Figure 4).

![Pie chart](image)

Figure 4. Distribution of responses from all respondents on the statement: "I gain a lot of worthwhile knowledge from families which I can use in my work". N=47.
Two thirds (66%, n=31) of the nurses in this study agreed or strongly agreed to the statement "The presence of family members is important for the family members themselves" (Figure 5).

![Pie chart showing responses](image)

Figure 5. Distribution of responses from all respondents on the statement: "The presence of family members is important for the family members themselves". N=47.

### 7.4 Results of the subscale "Family as a burden"

Looking at the results from all the respondents there is a large spread in the total data set in this subscale. Considering the spread of results, more of the nurses below 40 years of age gave higher scores with more supportive attitudes under this subscale compared to nurses above 40. Having experience of an ill family member of their own was also an indication for not seeing the patients' family as a much of a burden compared to the group with no such experience. One fifth (n=9) of all the nurses had such low scores under this subscale, showing they believe the patients family to be a burden in nursing care. The results of the subscale "Family as a burden" are found in Table 2, Figure 6.
The statement "the presence of family members holds me back in my work" clearly shows if the family members are considered a burden or not by the nurse. A third (n=16) of the nurses in this study either agrees or strongly agrees with this statement (Figure 7).

Figure 6. The chart represents the actual distribution of the nurses responses to the statements under the subscale Family as a Burden (Fam-B). N=47.

Figure 7. Distribution of responses from all respondents on the statement "The presence of family members holds me back in my work". N=47.
8 DISCUSSION

8.1 Method discussion

8.1.1 Choice of method and instrument

The instrument used in this study was constructed by Benzein et al (2008b) as they had found that no such instrument existed that measured the attitudes of registered nurses about the importance of involving families in nursing care. I chose it as the aim of my study was to measure Tanzanian nurses attitudes in this matter, and this instrument had already been tested on Swedish nurses and tested for reliability and validity. The validity indicates the research instruments ability to measure what is intended to measure (Olsson & Sörensen, 2007). Reliability indicates the accuracy of the instrument measures what is intended to be measured.

I also found the instrument appropriate for my study due to the fact that it requires no written answers and therefore is not time consuming for the respondents. The inclusion criterion of the nurses having to be English speaking was due to the questionnaire being written in English. All registered nurses at KCMC are however English speaking so it was never an issue.

Madelein Leininger's qualitative research approach Ethonursing could have been used to describe the nursing culture with regard to family nursing (Leininger, 2002a). This would however have required a qualitative research method such as interviews which I thought may be a problem in finding willing respondents and conducting enough interviews during the three week data collection period.

8.1.2 Data collection

My first intention was to try to reach the whole population of nurses working at KCMC. I was told on the first day that there were over 100 nurses employed by the hospital. I then decided to ask every nurse I came in contact with during the time of my data collection. The head nurses were asked by the matrons' assistant to assist me in getting the nurses on the ward to fill in the forms. Several nurses agreed to fill in the form but it generally took a lot of reminding. From the experience of the troubles I encountered during my data collection I realize how important it is to have someone local to introduce me to the field. Pilhammar-Andersson (1996) calls this person
the “Gate-keeper”. A gate-keeper introduces the researcher to the field and to the people you want to observe or study, they also have knowledge about when and where it is best to conduct the study.

Being that the questionnaire only takes 5-10 minutes to fill in, I thought it would be the ideal method to answer my study questions, for nurses working under heavy workload. It took however a lot longer time for me alone to get the nurses willing to listen and assist me, even after having worked with them on the wards. As a quantitative method such as this one requires answers from many nurses it would have taken many more weeks to obtain enough results without the assistance of the nurse who followed me to the different wards. As all nurses I came in contact with were asked to participate, a nonprobability sampling method was used known as convenience sampling (Polit & Beck, 2008). Convenience sampling is the weakest form of sampling and least likely to produce accurate and representative samples.

8.1.3 Sample size and response rate

The external dropout measures how many people who did not want to take part in the study (Olsson & Sörensen, 2007). Their attitudes are often different from the average population and can make the results distorted when trying to describe the population. The external dropout of this study was 19%. It could have changed the outcome of the results as these non-respondents attitudes may have distorted the results more negatively, as these nurses may have a general negative attitude to the question of families’ importance in nursing care. Polit and Beck (2008) call this “nonresponse bias”. Other reasons for not being willing to fill out the form could be lack of time and interest. Internal dropouts are the ones where some questions have not been answered (Olsson & Sörensen, 2007). Six questionnaires were excluded due to this problem. One reason could be lack of time when filling out the form, although most nurses filled them out during their breaks or at home. Another reason could be that they did not fully understand the question and therefore left it blank, or they found the question irrelevant. Finally 47 questionnaires could be used in the data analysis which is equivalent to 72% of the questionnaires handed out. According to Ejvegård (2009) a response rate of 80% is desirable for the results to be considered reliable. The sample size of 47 is the reason why relative frequency was used with caution in the data analysis. According to Eljertsson (2003) relative numbers should be avoided when the sample size is below 50.
8.2 Result discussion

The major findings in this study were that a majority of the nurses feel that the patients’ families are important and valuable in nursing care, providing them with worthwhile knowledge and easing their workload. Factors that influenced slightly more supportive attitudes in this group of nurses were: more recent education (fewer years of working experience as nurses), being young, and having experience of an own family member in need of hospital care. Besides these factors I also discuss the influence of culture and working environment affecting nurses’ attitudes towards family involvement in nursing care. Although most of the nurses had supportive attitudes, surprisingly as many as one third feel that the presence of family members holds them back in their work and a fifth of all the respondents perceived the patients’ families as being a burden in nursing care.

8.2.1 Age and years of working experience affecting attitudes

Younger and less experienced nurses saw patients’ families more as a resource and less as a burden compared to their older and more experienced colleagues. They had the most supportive attitudes towards family involvement in nursing care. These results are in contrast to the results from the Swedish study conducted by Benzein et al (2008c), where newly graduated registered nurses had less supportive attitudes about the importance of the family involvement in nursing care compared to more experienced nurses. A literature review by Verhaeghe Defloor, Van Zaueren, Duijnste and Grypdonck (2005) showed similar findings to this study, that nurses with less experience are better than their more experienced colleagues at acknowledging family needs. They suggested that the less experienced nurses have been given better and more recent education in this area providing them with abilities to attend to the family members appropriately. Unfortunately no distinction was made in this study between nurses who had a bachelor degree and those who did not. This could have further enlightened the importance of education.

8.2.2 General approach to care of the patients’ family

Nurses working on the same wards answered differently concerning the question whether or not there was a general approach towards the care of families at their place of work. One fifth of the nurses answered negatively to this question. Either the question was unclear or not all nurses have been given comprehensible guidelines about such an approach. There was a larger spread in
the data from the group claiming there was a general approach indicating a large variety in attitudes. The nurses working environment strongly influences the behavior of the nurses and the amount of family-centeredness (Friedman et al, 2003). It is the encouragement of the leadership such as support and education in these matters that play a large role (Fisher et al, 2008; Friedman et al, 2003). The practice of family nursing is also dependent on how the nurse views the family and works with it. A large part of the nurses felt that the presence of patients’ families eased their workload and they also felt they gained a lot of worthwhile knowledge from them. This implies that a majority of the nurses view the patients’ families as a resource in nursing care and acknowledge the benefits of involving them in the care of the patient. Another benefit of family involvement of nursing care is suggested by Coyer et al (2007) to minimize the relatives’ feelings of helplessness and isolation. As many as a third of the nurses in this study do not believe that it is important for the family members themselves to be present in nursing care.

8.2.3 Culture and working conditions affecting attitudes

The nursing profession is in itself an own culture with its own learned values, symbols and patterns (Leininger, 2002b). Transcultural nursing research has however shown evidence for more diversities than similarities between nurses and nursing culture worldwide.

The study conducted by Benzein et al (2008c) using the FINC-NA instrument on Swedish nurses showed much more supportive attitudes towards the involvement of families in nursing care than the results found in this study. The median value for all respondents working in a hospital care setting in Sweden was 87(Q=7), corresponding to 11 % higher median value (more supportive attitude) compared to the median value obtained in this study. The subgroups with the lowest scores in the Swedish study still had much higher scores than any of the subgroups of the Tanzanian nurses in this study. To explain the large differences in the results it is important to have an idea about the role of the nurse in a developing country compared to developed countries such as Sweden. It is also important to have an understanding of the culture and under what conditions in which the nurses are working. According to Torsvik and Hedlund (2008) there is an emphasis in nursing education in the Western world on the caring role of nursing. Tanzania nursing education on the other hand focuses more on the curing role with the more medical and practical aspect of nursing. The authors suggest that different cure and care traditions between countries and culture are a result of different value systems in the nursing education. In the same
study they demonstrated an example of how culture affects attitudes, behavior and values. Nursing students in Tanzania expressed that it was more polite to speak less directly and show little emotional involvement in the care of patients. The students felt that a nurse should be more professional than emotional whereas Norwegian nursing students in the same study interpreted lack of empathy as neglect of good nursing standards.

Nurses working on a pediatric ward in Tanzania claimed there were several problems with their working environment which they prioritized over a need for a good relationship with their clients (Manongi, Nasuwa, Mwangi, Reyburn, Poulsen & Chandler (2009). The factors contributing to poor attitudes towards patients and carers were: lack of respect from senior colleagues and administrative staff; low salary; inadequate equipment; and shortage of staff. Häggström et al (2008) also described how the same factors resulted in the Tanzanian nurses in their study lost the motivation in their work which affected their moral negatively. All these environmental factors could play a large role in why the Tanzanian nurses in this study have much less supportive attitudes than Swedish nurses, to the importance of the patients’ families in nursing care. This could also explain why several nurses in this study feel that the presence of patients’ family members holds them back in their work. Åstedt-Kurki et al (2001) also claim that interaction between healthcare providers and family members is complicated by lack of time, heavy work schedules and negative attitudes. Coyer et al (2007) suggest that there should be a balance between considerations of the individual nurse’s clinical practice, the patient’s needs and the family’s needs.

8.2.4 Nurses experience of an ill family member of their own

In this study, a large part of the nurses had their own experience of a seriously ill family member and these nurses were generally more supportive. The nurses with no experience of an own family member being seriously ill and in need of hospital care saw family members as slightly more of a burden compared to the other groups. A qualitative study by (Saveman, Måhlen, & Benzein, 2005) showed that nursing students beliefs about families in nursing care were strongly influenced by their personal experiences. As Benzein et al (2008c) discuss more research on how nurses personal experience influence their attitudes in nursing care is needed.
8.3 Generalization of the results

The sample size of 47 respondents is too small to make generalizations or any grand conclusions of the results. The results and discussion only represents the respondents' attitudes towards the importance of family involvement in nursing care. As the nurses were chosen by convenience sampling, this also weakens the generalization of the results. The results cannot either be generalized to the attitudes of all nurses working in Tanzania, as KCMC is a large referral and university hospital and also not all wards were represented here.

8.4 Conclusions

The Tanzanian nurses in this study had in general supportive attitudes towards the involvement of families in nursing care and a majority of the nurses perceive the patients' family as a resource in nursing care. Yet there were several nurses that considered the families as a burden. Factors contributing to more supportive attitudes were having more recent education and experience of a seriously ill family member of one's own in need of hospital care. Education in these matters affect nurses attitudes in a positive way. Culture and working conditions are other probable factors that influence these attitudes.

8.5 Clinical implications

As education in the importance of family involvement affects nurses' attitudes in a positive way, nursing education should include elements of family nursing. Åstedt-Kurki et al (2001) also suggest that education for nurses and other hospital staff should focus on attitudes and specific skills for successful relationships between the family and the healthcare provider.

With increasing amounts of new cultural encounters in Swedish health care, it is important to have an idea of how the role of the family and the role of the nurse can look in different cultures, creating a greater understanding between the nurse, the patient and the family.

8.6 Future research

More studies are needed on how much the nurses own personal experiences influence their attitudes in nursing care. Before comparing attitudes of nurses in various areas it is important to understand the role of the nurse in their working environment. Further research is therefore
suggested on describing the role of the nurse in different cultures and countries.

A qualitative study using Leininger’s (2002a) Ethnonursing approach could be made to give an in depth description over the nursing culture in Tanzania and the attitudes of the importance of family involvement in nursing care.

9 ACKNOWLEDGMENTS

First I would like to thank Dr Eva Benzein at Kalmar University for letting me use her research instrument in this study and for encouraging me to bring it to Tanzania. I am also very grateful to the Matron at KCMC Mrs Mauseui and the Director of the Hospital, Professor Shaw for giving me the permission to conduct my study at KCMC. I am very grateful to the head of the Faculty of Nursing at KCMC, Mrs Msuya for making me feel welcome at KCMC and for a lot of practical help. Mrs Cecilia Mushi I wish to thank for practical help and introducing me to the wards at KCMC. I also wish to thank Mrs Vivianne Saria, my “gatekeeper”, who was an essential help in distributing the questionnaires to the other nurses. This study was made possible thanks to the funding received from SIDA in the form of a Minor Field Study scholarship. I am also grateful for the travel scholarship received from the Red Cross University College. And last but certainly not least I wish to thank my supervisor Gabriella Ahlenius and examiner Dr Ann-Charlotte Egmar for all their encouragement, support and helpful discussions surrounding this thesis.
10 REFERENCES


Thank you for taking your time to fill out this questionnaire!

By doing this you are helping me with my bachelor thesis in nursing, and for this I am very grateful. My thesis is about nurses’ attitudes towards the importance of families in nursing care. The questionnaire was constructed by E. Benzein and B-I. Saveman at Kalmar University in Sweden 2006, and has been tested on Swedish nurses.

It is of course voluntary to fill out the form and absolutely anonymous.

I will handle the material confidentially and the results will be presented so no single person’s answers can be identified.

Please don’t hesitate to ask me about anything regarding the questionnaire or my study.

When finished with the form, please put it back in the same envelope and seal it to secure your anonymity, and then give it back to me.

Best regards

Kristina Zarins

Nursing student at the Red Cross University College in Sweden

### Families’ importance in Nursing Care

<table>
<thead>
<tr>
<th>Demographic section – Personal and organizational characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of birth ..........</td>
</tr>
<tr>
<td>Are you □ Male? □ Female?</td>
</tr>
<tr>
<td>Which year did you graduate as a Registered Nurse? ..........</td>
</tr>
<tr>
<td>In what type of care organisation have you mostly worked?</td>
</tr>
<tr>
<td>Hospital care □ Primary health care □ Community care □ Other ..........</td>
</tr>
<tr>
<td>In what type of care unit/department are you currently working? ..........</td>
</tr>
<tr>
<td>Is there a general approach to the care of families at your place of work? Yes □ No □</td>
</tr>
<tr>
<td>Has a member of your family ever been seriously ill and in need of professional care? Yes □ No □</td>
</tr>
</tbody>
</table>
Instructions for the questionnaire

The questionnaire consists of a few statements regarding the importance of families in nursing care. The statements are not put in any specific order and some may seem similar to others, however they are not identical. Please answer the questionnaire with what you first think of when you read them. Please put an X in the box (□) that best represents your thought for each statement.

The concept of Family includes family members, friends, neighbours, or other close relationships.

Please put an X in the box that best represents your thought for each statement

<table>
<thead>
<tr>
<th></th>
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<th>disagree</th>
<th>agree</th>
<th>strongly agree</th>
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<td>The presence of family members eases my workload</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2</td>
<td>The presence of family members gives me a feeling of security</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3</td>
<td>The presence of family members is important to me as a nurse</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4</td>
<td>Family members should be invited to actively take part in the patient’s nursing care</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5</td>
<td>Family members should be invited to actively take part in planning patient care</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6</td>
<td>A good relationship with family members gives me job satisfaction</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7</td>
<td>Getting involved with families gives me a feeling of being useful</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8</td>
<td>I gain a lot of worthwhile knowledge from families which I can use in my work</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9</td>
<td>The presence of family members is important for the family members themselves</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10</td>
<td>It is important to spend time with families</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11</td>
<td>I invite family members to have a conversation at the end of the care period</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12</td>
<td>I ask family members to take part in discussions from the very first contact, when a patient comes into my care</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>13</td>
<td>I always find out what family members a patient has</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>14</td>
<td>I invite family members to speak about changes in the patient’s condition</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>15</td>
<td>I invite family members to speak when planning care</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<td></td>
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<tr>
<td>16</td>
<td>It is important to find out what family members a patient has</td>
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</tr>
<tr>
<td>17</td>
<td>I invite family members to actively take part in the patient's care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Discussion with family members during first care contact saves time in my future work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>The presence of family members makes me feel that they are checking up on me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>The presence of family members makes me feel stressed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>The presence of family members holds me back in my work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I don't have time to take care of families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>I see myself as a resource for families so that they can cope as well as possible with their situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I consider family members as co-operating partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>I ask families how I can support them</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you again for your time and help!

Kristina Zarins

Nursing student at the Red Cross University College, Sweden
APPENDIX 2: Subscales to the FINC-NA Instrument

Family as a resource in nursing care (Fam-RNC)
1. The presence of family members eases my workload
2. The presence of family members gives me a feeling of security
3. The presence of family members is important to me as a nurse
4. Family members should be invited to actively take part in the patient’s nursing care
5. Family members should be invited to actively take part in planning patient care
6. A good relationship with family members gives me job satisfaction
7. Getting involved with families gives me a feeling of being useful
8. I gain a lot of worthwhile knowledge from families which I can use in my work
9. The presence of family members is important for the family members themselves
10. It is important to spend time with families

Family as a conversational partner (Fam-CP)
11. I invite family members to have a conversation at the end of the care period
12. I ask family members to take part in discussions from the very first contact, when a patient comes into my care
13. I always find out what family members a patient has
14. I invite family members to speak about changes in the patient’s condition
15. I invite family members to speak when planning care
16. It is important to find out what family members a patient has
17. I invite family members to actively take part in the patient’s care
18. Discussion with family members during first care contact saves time in my future work

Family as a burden (Fam-B)
19. The presence of family members makes me feel that they are checking up on me
20. The presence of family members makes me feel stressed
21. The presence of family members holds me back in my work
22. I don’t have time to take care of families

Family as own resource (Fam-OR)
23. I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves
24. I see myself as a resource for families so that they can cope as well as possible with their situation
25. I consider family members as co-operating partners
26. I ask families how I can support them
APPENDIX 3: Example of Data entry

Example of data entry from one respondent (X) in excel. Statements 19-22 are the items under the subscale Fam-B which were inverted before analysis.

<table>
<thead>
<tr>
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<th>Respondent X</th>
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<tbody>
<tr>
<td>Age</td>
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</tr>
<tr>
<td>Sex (F/M)</td>
<td>F</td>
</tr>
<tr>
<td>Years since graduation</td>
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</tr>
<tr>
<td>Type of Care Organisation (HIP/C/O)*</td>
<td>H</td>
</tr>
<tr>
<td>Type of unit/department currently working</td>
<td>Pediatric</td>
</tr>
<tr>
<td>General Approach (Y/N)</td>
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</tr>
<tr>
<td>Family member been seriously ill (Y/N)</td>
<td>Y</td>
</tr>
</tbody>
</table>

* H (Hospital care) P(Primary Health Care) C(Community Care) O(Other)

1. (Strongly Disagree) 2(Disagree) 3(Agree) 4(strongly Agree)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. The presence of family members eases my workload</td>
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</tr>
<tr>
<td>2. The presence of family members gives me a feeling of security</td>
<td>3</td>
</tr>
<tr>
<td>3. The presence of family members is important to me as a nurse</td>
<td>4</td>
</tr>
<tr>
<td>4. Family members should be invited to actively take part in the patient’s nursing care</td>
<td>4</td>
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<tr>
<td>5. Family members should be invited to actively take part in planning patient care</td>
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</tr>
<tr>
<td>6. A good relationship with family members gives me job satisfaction</td>
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<td>8. I gain a lot of worthwhile knowledge from families which I can use in my work</td>
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<td>9. The presence of family members is important for the family members themselves</td>
<td>4</td>
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<td>10. It is important to spend time with families</td>
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<tr>
<td>11. I invite family members to have a conversation at the end of the care period</td>
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<td>12. I ask family members to take part in discussions from the very first contact, when a patient comes into my care</td>
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<td>13. I always find out what family members a patient has</td>
<td>4</td>
</tr>
<tr>
<td>14. I invite family members to speak about changes in the patient’s condition</td>
<td>4</td>
</tr>
<tr>
<td>15. I invite family members to speak when planning care</td>
<td>4</td>
</tr>
<tr>
<td>16. It is important to find out what family members a patient has</td>
<td>4</td>
</tr>
<tr>
<td>17. I invite family members to actively take part in the patient’s care</td>
<td>4</td>
</tr>
<tr>
<td>18. Discussion with family members during first care contact saves time in my future work</td>
<td>4</td>
</tr>
<tr>
<td>19. The presence of family members makes me feel that they are checking up on me</td>
<td>1</td>
</tr>
<tr>
<td>20. The presence of family members makes me feel stressed</td>
<td>1</td>
</tr>
<tr>
<td>21. The presence of family members holds me back in my work</td>
<td>3</td>
</tr>
<tr>
<td>22. I don’t have time to take care of families</td>
<td>1</td>
</tr>
<tr>
<td>23. I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves</td>
<td>4</td>
</tr>
<tr>
<td>24. I see myself as a resource for families so that they can cope as well as possible with their situation</td>
<td>4</td>
</tr>
<tr>
<td>25. I consider family members as co-operating partners</td>
<td>4</td>
</tr>
<tr>
<td>26. I ask families how I can support them</td>
<td>4</td>
</tr>
</tbody>
</table>

| Total score | 93 |
APPENDIX 4: Example of results after subscales

Example from the results from one respondent (X) divided after subscales. Results under the subscale Fam-B were inverted before analysis.

<table>
<thead>
<tr>
<th>Demographic Section</th>
<th>Respondent X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>56</td>
</tr>
<tr>
<td>Sex (F/M)</td>
<td>F</td>
</tr>
<tr>
<td>Years since graduation</td>
<td>32</td>
</tr>
<tr>
<td>Type of Care Organisation (H/P/C/O)*</td>
<td>H</td>
</tr>
<tr>
<td>Type of unit/department currently working</td>
<td>Pediatric</td>
</tr>
<tr>
<td>General Approach (Y/N)</td>
<td>Y</td>
</tr>
<tr>
<td>Family member been seriously ill (Y/N)</td>
<td>Y</td>
</tr>
</tbody>
</table>

* H (Hospital care) P (Primary Health Care) C (Community Care) O (Other)

**Family as a resource in nursing care (Fam-RNC)**

1. The presence of family members eases my workload 4
2. The presence of family members gives me a feeling of security 3
3. The presence of family members is important to me as a nurse 4
4. Family members should be invited to actively take part in the patient’s nursing care 4
5. Family members should be invited to actively take part in planning patient care 4
6. A good relationship with family members gives me job satisfaction 4
7. Getting involved with families gives me a feeling of being useful 4
8. I gain a lot of worthwhile knowledge from families which I can use in my work 4
9. The presence of family members is important for the family members themselves 4
10. It is important to spend time with families 4
**sum** 39

**Family as a conversational partner (Fam-CP)**

11. I invite family members to have a conversation at the end of the care period 4
12. I ask family members to take part in discussions from the very first contact, when a patient comes into my care 4
13. I always find out what family members a patient has 4
14. I invite family members to speak about changes in the patient’s condition 4
15. I invite family members to speak when planning care 4
16. It is important to find out what family members a patient has 4
17. I invite family members to actively take part in the patient’s care 4
18. Discussion with family members during first care contact saves time in my future work 4
**sum** 32

**Family as a burden (Fam-B)**

19. The presence of family members makes me feel that they are checking up on me 1
20. The presence of family members makes me feel stressed 1
21. The presence of family members holds me back in my work 3
22. I don’t have time to take care of families 1
**sum** 6

**Family as own Resource (Fam-OR)**

23. I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves 4
24. I see myself as a resource for families so that they can cope as well as possible with their situation 4
25. I consider family members as co-operating partners 4
26. I ask families how I can support them 4
**sum** 16

36
APPENDIX 5: Introductory letter

The Red Cross University College
- education and research in the healthcare sector

To whom it may concern

My name is Kristina Zarins and I am one of the fortunate nursing students from the Red Cross University College in Sweden, who has been given the opportunity to go to Tanzania this autumn to gather information for my bachelor-degree thesis. I will then have started my third and final year of my education towards a Bachelor of Science in Nursing. My research project is to study nurses’ attitudes towards family involvement in patient care, using a questionnaire developed by Dr. Eva Benzein (Associate Professor at the School of Human Sciences, Kalmar University) and her colleagues in Sweden. She has kindly given me her permission to use her research instrument for my thesis. I am now hoping for your permission to let as many of your nurses as possible fill out this questionnaire with my assistance when I come to your hospital this fall. The nurses will of course have the choice of not filling out the form, and it is absolutely anonymous. Dr. Benzein has tested this instrument on Swedish nurses and estimates that it roughly takes 10 minutes to fill out the form.

I am very much looking forward to visiting your hospital and beautiful country. Please do not hesitate to contact me if you need more information before I arrive.

Best regards

Kristina Zarins

Stockholm, April 2009

Email: Krazhk07@rkh.se