ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCE SCHOOL OF NURSING AND MIDWIFERY DEPARTMENT OF NURSING

PERCEIVED BARRIERS TO IMPLEMENTING FAMILY – CENTRED CARE IN NEONATAL INTENSIVE CARE UNITE OF PUBLIC HOSPITALS IN ADDIS ABABA, ETHIPIA, 2025.

BY

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A THESIS HAS SUBMITTED TO THE GRADUTE PROGRAM, ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCE SCHOOL OF NURSING AND MIDWIFERY IN THE PARTIAL FULFILMENT OF THE REQUIREMENT OF DEGREE OF MASTER SCIENCE IN NEONATAL NURSING.

JUNE, 2025

ADDIS ABABA, ETHIPIA

ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCE SCHOOL OF NURSING AND MIDWIFERY DEPARTMENT OF NURSING

A thesis has on Perceived Barriers to Implementing Family-Centred Care in Neonatal Intensive Care Units of Public Hospitals in Addis Ababa, Ethiopia, 2025.

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A thesis has submitted To the Graduate Program, Addis Ababa University, College Of Health Science, School of Nursing and Midwifery in the Partial Fulfilment of the Requirement of Degree of Master Science in Neonatal Nursing.

June, 2025

Addis Ababa, Ethiopia

APPROVAL SHEET

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STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my own work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis. This thesis is submitted in partial fulfilment of the requirement for a graduate degree from Addis Ababa University at College of Health Science, School of Nursing and Midwifery. The thesis is deposited in the Addis Ababa University Digital Library and is made available to local, national and international scientific community. I solemnly declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma or certificate. Brief quotation from this thesis may be used without special permission provided that accurate and complete acknowledgement of the source is made. Requests for permission for extended quotation from, or reproduction of, this thesis in whole or in part may be granted by the Head of Department or all advisers of the theses when in his or her judgment the proposed use of the material is in the interest of the scholarship and publication. In all other instance, however, permission must be obtained from the author of the thesis.

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ACKNOWLEDGMENT

First, I would like to thank God for supporting me in all aspects of my life and helping me with this thesis.

I am also deeply grateful to my advisor, Tedesse Bedada (asst. professor) and Fikrtemariam Abebe (asst. professor), for their valuable guidance and unwavering support throughout my research process.

My heartfelt thanks go to Addis Ababa University College of Health Sciences, School of Nursing and Midwifery, for providing me with the opportunity to conduct this research.

Finally, my great praise goes to participants, health care professionals, and public hospitals administrators in Addis Ababa, who provided me with basic pieces of information.

Thank you all for your help and encouragement.

ACRONYMS AND ABBREVIATIONS

C/D…… Caesarean delivery

ECD……...…Early Child Development

FCC……...….Family- centred care

FOGSI….……..Federation of Obstetric and Gynaecological Societies of India National

IAP's …….India Academy Paediatrics

NICU……..... Neonatal intensive care unit

NNF……..Neonatology Forum

SPHMMC…….…St. Pauls Hospital Millennium Medical College

UNICEF .....United Nation Children Fund

WHO ……..…..World Health Organization

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Abstract

Background: Family-centered care (FCC) in neonatal intensive care units (NICUs) promotes parental involvement, decreased neonatal mortality, and increase neonatal outcomes. Despite worldwide evidence encouraging FCC, sub-Saharan Africa, including Ethiopia, affecting high neonatal mortality rates (32.6 /1,000 live births) due to inadequate FCC implementation. While studies in high-income countries suggested successful FCC, barriers in low-resource settings like Ethiopia remain unexplored.

Objectives: This study aimed to explore perceived barriers to FCC implementation in NICUs across public hospitals in Addis Ababa, Ethiopia.

Methodology: A descriptive design was used across three public hospitals (SPHMMC, Abebech Gobna, and St. Peters). Purposively recruited ten healthcare providers (nurses, doctors) and nine parents. An In-depth interviews were conducted using semi-structured guides question, translated, transcribed, and analyzed thematically via Open Code 4.03. Trustworthiness was confirmed through credibility, dependability, and confirmability measures.

Results: Nineteen interviews were conducted, with 10 health care provider participants and 9 care givers with mean age of 26 (± SD = 0.38). Two main themes were identified as facility-related barriers (lack of space, communication gaps, insufficient medicine supply, no FCC training, strict protocol) and family-related barriers (low health literacy, logistical barriers, and emotional distress). Congestion and bad NICU architecture limited family presence, and communication gaps and medicals were barriers to engagement.

Conclusion and recommendation: Applying FCC in NICUs requires multifaceted strategies like redesigning NICU room, flexible visitation rule, updating staff, and family support programs. Addressing gaps through government-NGO partnerships and prioritizing parental involvement can increase neonatal outcomes and reduce mortality. Future research might need explore FCC interventions in diverse Ethiopian healthcare settings to investigating equitable, family-center care.

Key words: Family-Centred Care (FCC), Neonatal Intensive Care Unit (NICU), Ethiopia.

CHAPTUR - ONE

1 Introduction

1.1 Background of the study

Family-centred care (FCC) in the NICU is an approach to health care that focuses on lessening mental and emotional trauma for relatives while empowering them to rescue their role as parents (1). FCC implementation can be classified into three levels: interventions supporting parents, parent-delivered interventions like skin-to-skin contact, and multidimensional care models such as Kangaroo mother care (2).

Worldwide, greater than 80% of births take place in public health facility with updated a skilled health care provider. 1 every 10 infants is delivered with preterm. around 2.4 million new-borns die every year, the more than half of them were in sub-Saharan Africa, mostly from preventable causes (3). In Ethiopia, the death rate around 32.6 deaths per 1000 live births, which is one of the highest rates in Africa (4).

Implementing family-centered care (FCC) in NICUs presents multiple barriers, despite it has a great benefits. The major factors that need for FCC and family support include an increasing NICU population, diverse family needs, family stress, and a lack of resources. FCC increase several attributes, such as family participation in care, collaboration among parents, and the maintenance of family respect and dignity (5). The key challenges were includes power imbalances, psychosocial issues, and structural limitations (6). The mindset of healthcare provider plays a crucial role in FCC practice; viewing parents as primary caregivers is essential for effective for FCC (7). The mind-set of healthcare professionals in seeing parents as primary caregivers is the most important factor influencing the implementation of Family-Centred Care (FCC). Other important factors influencing the success of FCC include staff behavioral changes, addressing family needs, the environment, and effective communication (8).

1.2 Statement of the problem

To prevent complications and subsequent negative outcomes, and to improve the quality of care for small and sick newborns, the WHO recommends integrating families in NCUs (9). Family centered care promotes a trustworthy and respectful partnership between family members and healthcare providers (HCPs), provider–client communication, shared decision-making, and

readiness to continue care after discharge (10,11). Family centered care could potentially reduce the work burden among HCPs, improve neonatal outcomes, and increase parental and HCPs' satisfaction, as well as reduce an infant's length of stay in the hospital(12).

However, globally, an estimated 2.4 million newborns die every year, the majority of them in sub-Saharan Africa, mostly from preventable causes (3). According to the World Health Organization (WHO), neonatal mortality remains a significant contributor to infant mortality rates in developing countries (9). In fact, about 99% of these deaths occur in low- and middle-income countries, with sub-Saharan Africa being particularly affected (13).

Studies in European countries like Sweden, Norway, and the Netherlands have shown the successful implementation of family-centred care (14). In contrast, countries in Africa, such as Ghana, have limited implementation of family-centered care (15). A study conducted in the Tigray region of Ethiopia showed that healthcare professionals had lower confidence regarding the practicality of integration and adaptability (16).

Studies have shown that factors affecting healthcare professionals include mindset, family needs, family caregiving, equal family participation, collaboration, maintaining families' respect and dignity, knowledge transformation, and the environment (5–7).

Consequently, inadequate family-centered care leads to developmental delays in cognitive, social, and emotional growth (15,17). Additionally, this results in parents experiencing heightened stress and anxiety, as well as reduced confidence in their ability to care for their child (17). Low family-centered care also has negative results due to increasing healthcare costs with longer hospital stays and additional medical expenses (15).

To avoid the problem, different study suggested that the importance of implementing family-centered care in the NICU. Therefore, this study aims to explore the perceived barriers to the implementation of family-centered care in the NICU in Addis Ababa, Ethiopia.

1.3 Objective of the Study

1.3.1 General objective

1. To explore perceived Barriers hindering the implementation of family-centred care in Neonatal Intensive Care Units (NICUs) in public hospitals in Addis Ababa, Ethiopia, 2025.

1.3.2 Specific objective

1. To explore the perceptions of healthcare providers regarding family-centred care in the NICUs of public hospitals in Addis Ababa, Ethiopia.

2. To explore the perceptions of parents regarding family-centred care in the NICUs of public hospitals in Addis Ababa, Ethiopia.

3. To identify the barriers that healthcare providers encounter in implementing family-centred care in the NICUs of public hospitals in Addis Ababa, Ethiopia.

4. To identify the barriers that parents face in participating in family-centred care in the NICUs of public hospitals in Addis Ababa, Ethiopia.

1.4 Significance of the study

Identify and addressing the barriers of family-centered care (FCC) in neonatal intensive care units (NICUs) can significantly increase neonatal care and family involvement for improve healthcare outcomes.

For individual clients: Parents well-informed and actively engaged in their infant's care can increasing bonding and promote emotional well-being. By undertaking barriers such as restricted access, communication gaps, and insufficient emotional support, helps to reduce family stress, anxiety, and feelings of helplessness.

For healthcare providers: recognizing perceived barriers enables them to develop more effective communication, ensuring families informed about the care and involved in their infant's care. Addressing these barriers results for trust, respect, and positive interactions between NICU staff and families.

For healthcare organization: Reduce the barrier of FCC can increase parental satisfaction, decrease neonatal death, and optimize overall healthcare delivery within the NICU unite.

For researcher: It also provides as basis for further research on FCC implementation with in the clinical area, exploring solutions to the challenges and evaluating effectiveness within different healthcare settings.

1.5 The strengths and limitation of the Study

1.5.1 The strengths of the Study

The inclusion of both healthcare workers (doctors, nurses) and parents ensured a balanced view of challenges from multiple stakeholders.

1.5.2 Limitations of the Study

The study was conducted in public hospitals in Addis Ababa, which may not reflect challenges in rural or private healthcare facilities.

Some participants (especially healthcare workers) may have provided socially acceptable responses rather than fully honest critiques of FCC barriers.

CHAPTUR-TWO

2. Literature review

2.1. Family centre care in NICU overview

Globally, at least 250 million children under the age of five are at risk of not achieving their full developmental potential, which can have lasting effects on their health, education, productivity, and overall well-being. This situation arises when children are not raised in an environment that is stable and attentive to their health and nutritional requirements, fails to protect them from threats, and lacks opportunities for early learning and responsive, emotionally supportive, and developmentally stimulating interactions starting from pregnancy. Family centre care is essential to establish the foundations early in life that enable individuals to survive and thrive (18).

Implementing family-centred care in the NICU helps shield children from the most severe impacts of adversity, yielding lifelong and intergenerational benefits for health, productivity, and social cohesion. Nurturing care occurs when we make the most of every interaction with neonates. Each moment-whether small or large, structured or unstructured-presents and opportunity to ensure that children are healthy, receive proper nutrition, feel safe, and begin to learn about themselves, others, and their environment. What we do is important, but how we do it holds even greater significance (19).

A study on the barriers to persistence in implementing quality neonatal care within Neonatal Intensive Care Units (NICUs) in sub-Saharan Africa highlights that limited resources and systemic challenges lead to poorer quality care, increased infant mortality, and dissatisfaction among both patients and healthcare workers (18).

Poor quality of care is a major contributor, accounting for roughly 60% of all neonatal deaths in low-resource settings. As a result investment in care during pregnancy, childbirth, and the first month of life is the smartest investment, with a quadruple return: saving mothers and new-borns, preventing stillbirths, reducing disabilities, and paving the way for optimal child development and lifelong health and well-being (20).

There are different factors affecting the implementation of family-centre care in NICUs mentioned in the previous study including the unavailability of equipment, low supplies, insufficient standard guidelines, protocols, and unavailability of trained and motivated healthcare workers, as well as supportive supervision and low client satisfaction (18).

2.2. Factors associated implementation of family centre care in NICU

2.2.1 Socio-demographic factors

A qualitative study exploring the barriers and facilitate neonatal care in rural communities in Australia show that seeking behaviour and engagement with healthcare providers increase the effects of rurality and isolation on neonatal outcomes and the overall experience of care. The study also identified main factors for accessing perinatal care in these areas, which were personal agency, health literacy, social capital, effective collaboration and communication among clinicians and services, technology-enabled care, and the availability of free perinatal care (21).

Worldwide qualitative study show that the persistent barriers for delivering qualified neonatal care in low-resource settings identified several critical barriers. These include a lack of physical resources, such as essential equipment and infrastructure like running water, alongside limited human resources, education, and access to essential neonatal training. Additionally, weak leadership at community level, local, and national levels was shown as a barrier to progress. Challenges such as poor communication among clinical teams, poor documentation, and the absence of standardized guidelines were also noted (22).

One study on sociodemographic factors influencing the outcomes of babies admitted to the neonatal care unit shows that several key determinants. Those included were the maternal age, family use of tobacco and alcohol, economical status, the location of delivery, as well as the father's job and education level. Low birth weight and the baby's male sex were also found to have a significant impact on neonatal outcomes. Due to the presence of specialized staff and sufficient logistics, the overall cure rate for NICU admissions was reported to be 69%. A 40-bed NICU in a tertiary care hospital is considered both necessary and adequate to meet the needs of this patient population in light of these findings (23).

As study conducted on explored the impact of socio-demographic factors show that : maternal age, education level, race, and marital status, distance from home to the hospital, and the number of children at home has parent engagement in the NICU. Increased family presence has been indicated among white mothers, those who are married, individuals with stronger family support, old family, higher education levels, and families with fewer children. However, findings regarding the relationship between the distances of the family home from the hospital and parental presence have shown mixed results (24).

2.2.2 Factors affecting integration of parent- infant care

A study done in Toronto, USA indicates that the importance of supporting parents as primary caregivers in the neonatal intensive care unit (NICU). The findings shows support is linked to enhanced neonatal feeding practices, great growth outcome, and improved family well-being which are crucial mediators for long-term positive outcome for nonatal neurodevelopmental and behavioural outcomes. For successful implementation of family-sick baby integrated care and cultural transformation within neonatal teams globally, it is important to adopt practical approaches tailored to their specific local contexts. Policies such as organizing meetings for parents and staff, along with encouragement relational communication, can help undo barriers to change by improving opportunities for collaborative knowledge creation, negotiation of parents, and the establishment of trust (25).

A qualitative study conducted in the Netherlands, Norway, and Sweden try to identify four major factors for implementing family-centred care in neonatal intensive care units thus are behavioural change among staff, family needs, the environment, and communication. Especially, nearly all healthcare professionals emphasized that the mentality of the professionals plays a crucial role in the successful implementation of family-centred care. Given that parents are the primary caregivers, and their involvement in the care of their infants has a great impacts on outcomes, underscoring the importance of integrating parents into the care process (26).

Another qualitative study conducted in a tertiary hospital NICU in the United States identified a complex set of mental, emotional, physical, and structural factors that influence a mother’s ability to visit the NICU and engage in kangaroo mother care (KMC). To alleviate the structural barriers that obstruct KMC, it is essential to provide social supports, including increasing maternity leave

policies and reliable hospital access through childcare, accommodation, and transportation services. These measures can help ease financial burdens and ultimately raised the health outcomes for both mothers and their preterm infants (27).

2.2.3 Lack of physical resources

A study conducted on the barrier on implementation of nurturing care show that the availability of basic equipment and infrastructure were the major finding. In line with this shortages of critical intensive care equipment, such as incubators, heaters, and non-invasive ventilators like continuous positive airway pressure (CPAP) machines, along with poorly maintained devices, affecting the provision of essential care. Most of the NICUs are not designed as adequate space for family involvement in the care of sick baby, has no delegated areas for discussions or comfortable spaces for families to spend time. Furthermore, rigid visitation rule can restrict the duration of family visits with their infants and limit caregiver participation in care activities (22).

2.2.4 Lack of skilled human resource

A study conducted in sub-Saharan Africa reviled that the major factors that affect implementation of FCC in NICU were inadequate training of staff and a shortage of resources. The NICU nurse often do not access enough training on the values of FCC, resulting in unreliable practices and a lack of clearness on how to effectively involve families. Additionally, inadequate access to educational materials and resources for both healthcare provider and families can impede the successful adoption of FCC (18).

Increasing in medicine and technology within neonatology have a great impact on establishment and improvement of supportive services for new-borns, integrating restoration experts into the multidisciplinary team of the neonatal intensive care unit (NICU). To ensure high-quality care for infants and their families, solid team dynamics are essential, including professional competence, communal respect, accountability and effective communication (28).

2.2.5 Communication Challenges

A communication gap between healthcare providers and caregivers result in misleading regarding care of the sick new-born, expectations, and roles. In addition to this, language barriers, such as those faced by non-English speaking families, can hinder their comprehension of medical information, ultimately limiting their ability to participating in care decision.

Communication barriers between healthcare providers and parents requires developing a coherent, comprehensive, and unified training program to prepare and create integrated coordination among the treatment team and the family, creating a positive attitude toward FCC and the presence of parents, improving relationships, and giving further attention and support by managers to personnel and the conditions of the ward (29).

CHAPTUR- THREE

3. METHOD AND MATERIAL

3.1. Study sitting and period

This study was conducted in Addis Ababa public hospitals. Addis Ababa is the capital city of Ethiopia which has an area of 530 km2. It is estimated 6.6 million people resided in the city in 2017 calculated based on the 2007 population enumeration with 3.8% yearly growth rate. Addis Ababa has 527 km² areas with an altitude of 2,355 m.a.s.l. It has 11 sub cities and has different government health facilities including 15 public hospitals in Addis Ababa; six hospitals under administration of Addis Ababa Regional Health Bureau (AARHB), nine of them are under federal ministry of health.

From those public hospitals St. Paul Hospital Millennium Medical College (SPHMMC), Abebech Gobna and St. Peters hospital in NICU, are selected with purposively from public hospitals in Addis Ababa. Those hospitals purposively selected for the current study as they are the public health hospital has NICU unite and serving the community with high patient flow. Those hospital had monthly admission of new-borns monthly on average Saint Paul's (100), Abebech Gobena (70), and St. Peters (74). The study was conducted from February to March 2025, Addis Ababa, Ethiopia.

3.2. Study design

This study utilized a descriptive design to achieve its objectives. The aim of this design was to gain a deeper understanding of the perceived barriers related to the implementation of family-centered care in the NICU, from both the healthcare providers' and families' perspectives. The study sought to explore experiences and insights from both sides to provide a comprehensive view of the challenges encountered.

3.3. Study participants and Eligibility criteria

3.3.1 Study participant

The study participants included all healthcare providers working in public hospitals in Addis Ababa, such as doctors, nurses, and other NICU staff members. Additionally, the study included parents and primary caregivers of NICU infants, specifically mothers or fathers of infants who were currently or recently admitted to the NICU.

3.3.2 Eligibility criteria

3.3.2.1 Inclusion criteria

Health care providers (Nurse) working 6 month and above with in the NICU of unit in selected public health facility during the time of data collection.

Parent or primary caregiver of an infant admitted to a NICU during the time of data collection in the selected public facility, Addis Ababa.

3.3.2.2 Exclusion criteria

Health care providers who are annual leave during data collection time and caregivers who do not consent to participate in the study and stay less than 48 hours in NICU unite.

3.4 Recruitment

Purposively eligible participants was selected such as NICU nurses and allied health professional and care givers who give their consent take part in the current study who provided rich information to the guiding questions. Those participants were purposively chosen from the NICU departments using current and previous work experience. The nurses in charge of the NICU units of the chosen hospital was get in touch with the care provider and infant parents who fit the eligibility requirements to discuss the goals of the study, the activities involved, and the request for participation. After each participant gives their consent, the researcher was approach them and follow them for conducting the interview. To bring maximum variation the care provider educational status and place of residence of parent were considered. The data was collected by using individual in-depth interviews guiding question from 10 parents and 9 healthcare providers by using open-ended questions. But data collection was continued until reaching data saturation and obtaining no new data from the participant.

3.5 Data collection tool and procedure

The principal investigator with the trained research assistant was conduct in-depth face-to-face interviews in a private room in the designated hospital. An interview guide was used to outline the open-ended topics in English and Amharic. The interview guide was included questions about demographics, prior and current barrier implementation family-centred care with in NICU and the important of family centre care, the role of parent in the NICU, and future intentions of the implementation of family centre care in NICU. The participants will be encouraged to share their

barrier of family-centred care with in NICU experiences and the significance of care for infants admitted with in NICU. The questions were depending on the interaction between the interviewer and the participant during the data collection time.

Data was collected until saturation is reached, when more data fails to reveal any new emergent codes or themes. The time and place of the interviews was determined based on the convenience of the participants. With the participants' permission, the assistant researcher was audio-record and take written notes during the interviews. A pilot-test interview was doing for three care provider and two infant parents who excluded from the main research interviews. The participant was appoint their free time and interviewed by trained qualitative researcher with face-to-face interviews in Amharic average of 20-25 minutes within an individual room by the primary investigator to avoid noises and interruptions. There was no any compensation to their time wastage and their contribution to this study. The interview was recorded by audio recorder. As soon as possible, it was translated and transcribed word by word and used as the primary research data. By setting probing questions, the principal investigator was probed the interview to achieve the objectives of the study.

Each day's interview session was end with a verbatim transcription of the answers that was recorded on audio and kept with field notes in Microsoft Word format.

3.6. Data analysis

Thematic analysis was conducted using Open-code 4.03 software to examine all of the data that were collected. The primary investigator was analyzing the data while collecting it. Inductive coding was used after data collection to generate emerging inductive codes. The supervisors were verifying that the principal investigator accurately transcribed the field notes and audio data. The thematic data analysis was involving three inter-related stages: data reduction, data displays, and data conclusion. The participants' socio-demographic data reported using descriptive statistics. Quotations from the participants' statements are used to illustrate the findings and highlight the key themes.

3.7. Trust Worthiness

To ensure the accuracy and reliability of the data, the study considered credibility, transferability, dependability, and confirmability.

To maintain credibility, it was triangulated in terms of study area and study participant. The principal investigator spent prolonged time with participants to gain a deep understanding of their experiences. Additionally, the preliminary findings were presented to the participants, who provided their feedback. Furthermore, supervisors verified that the principal investigator accurately transcribed the field notes and audio data and approved the preliminary results, themes, and sub-themes.

To maintain dependability, the process of selecting participants, collecting data, timing interviews, and analysing the data was described in detail. Each process was documented, and audio recordings were used. Finally, the raw data was submitted to the advisor to ensure reliability.

To maintain transferability, the study setting and procedure were addressed, and intertextual participant statements were quoted directly. The researchers preserved all audio recordings, transcripts, themes, and sub-themes.

To maintain confirmability, the raw data, transcription, and interpretation were cross-checked repeatedly with supervisors to minimize researcher bias.

3.8 Ethical consideration

Ethical clearance and an official letter was taken from Addis Ababa University (department of nursing and midwifery) to Saint Paul's Hospital Millennium Medical Collage, Abebech Gobna Hospital and St. Peters Hospital to get permission and support for conducting this study. A permission letter was obtained from each health facility IRB board. Before starting the interview, verbal and written consent was obtained from each participant. Participants was also informed about the purpose of the study, advantages and disadvantages of being a participant, confirm confidentiality, and be fully informed that the interviewed data are stored in a file without their name and with a code number assigned to it. It will not be revealed to anyone except the principal investigator, and it is not used for anything other than research purposes.

CHAPTUR- FOUR

4. RESULT AND DISCUSSION

4.1 RESULT

4.1.1 Sociodemographic

This study included 19 participants, comprising 10 healthcare provider and 9 parents or care givers in-depth interviews with a mean age of 26 years (± SD = 0.38).

Out of ten health care providers, 9 of them has BSC, 1 of them has MSC. From the 9 parents or caregivers six had completed secondary education, two had completed primary school, and only one was illiterate. Except one all the care participants are married.

Table 1. Sociodemographic characteristics of healthcare providers in public hospital, Addis Ababa, 2025.

Participant	Age	Sex	Occupation/ Responsibility	Work Experience (HCPs)	Education Level
HCP P-I	29	Female	nursing	6 years	BSC nurse
HCP P-2	29	Female	Nursing	6 years	BSc nurse
HCP P-3	27	Male	Nursing	7 months	MSc in Neonatology
HCP P-4	29	Female	Nursing	6 years	BSc nurse
HCP P-5	32	Male	Nurse	3 years	BSc nurse
HCP P-6	30	Female	Nursing	4 years	BSc nurse
HCP P-7	29	Female	Nursing	3 years	BSc nurse
HCP P-8	32	Female	Nursing	1 month	BSc nurse
HCP P-9	30	Male	Nursing	4 years	BSc nurse
HCP P-10	29	Female	Nursing	6 years	BSc nurse

*HCP- Indicates health care provider *P- Participant

Table 2. Sociodemographic characteristics of the parents or caregivers in public hospital, Addis Ababa, 2025.

Participant	Age	Sex	Responsibility	Education Level	Marital Status
Parent P-I	38	Female	House wife	Secondary	Married
Parent P-2	28	Female	House wife	Primary	Married
Parent P-3	28	Female	House wife	Illiterate	Married
Parent P-4	35	Female	Merchant	Primary	Married
parent P-5	22	Female	Housewife	Primary	Married
Parent P-6	21	Female	Housewife	Primary	Married
Parent P-7	20	Female	House servant	Can read and write	Unmarried
Parent P-8	25	Female	Private merchant	Diploma	Married
Parent P-9	48	Male	Merchant	Diploma	Married

4.1.2. Thematic presentation of the main themes and subthemes

Two main themes that arose from the eight subthemes were developed inductively following the analysis and coding of the data. The first theme was perceived facility barrier of family-centred care which included the subtheme of inadequate space for family involvement, communication gaps and limited resources, lack of training for healthcare providers, rigid rule and protocols. The second theme was perceived family barrier of FCC which included knowledge and health literacy, physical and logistical barriers, emotional burden and stress of family to their sick neonate, and perceived value of family involvement.

Table- 3 Thematic presentation of the main themes and subthemes

Main Themes	Subtheme	Sample Codes
Theme–I: Perceived facility barriers of family centre care	I. Inadequate Space for Family Involvement	✓ Lack of mother resting rooms ✓ Insufficient room ✓ High NICU admission ✓ Overcrowding

	II. Communication Gaps and Limited Resources	✓ Language barriers between providers and families ✓ Lack of detailed information sharing ✓ Staff aggressive ✓ Lack of time
	III. Lack of Training for Healthcare Providers	✓ No formal FCC training programs ✓ No formal counselling skill ✓ Unawareness of FCC guidelines ✓ Not well trained
	IV. Rigid Rule and Protocols	✓ Delivery with C/S ✓ Limited time to entrance ✓ Father has one hour to visit his sick baby ✓ No rules
Theme-II: Perceived family barriers of family centred care	I. Knowledge and Health Literacy	✓ I have no information about FCC ✓ Lack of awarness ✓ Do not know how to hold ✓ Not understand the NICU
	II. Physical and Logistical Barriers	✓ Distance from referral centers delaying mother's arrival ✓ Post-C/S pain limiting mobility ✓ Laboratory shortge ✓ Financial constraints ✓ Poverty
	III. Emotional Burden and Stress of family to their sick neonate	✓ Not comfortable environment ✓ Postpartum depression affecting bonding ✓ Trauma from unwanted pregnancies ✓ Fear of infection transmission

		✓ Do not understand the diseases
	IV Perceived Value of Family Involvement in the NICU	✓ Increase mothers to baby bonding ✓ Reduced workload for healthcare providers ✓ Crate safe environment ✓ Economic support ✓ Accessible cleaning materials

4.1.3 Perceived facility barriers of family- canter care

This them has emerged from the four sub themes those are inadequate space for family involvement, communication gaps and limited resources, lack of training for healthcare providers, and rigid rule and protocols. The subtheme is emerged from the code. This theme is tried to elaborate the internal and external barriers affecting implementation of family canter care with in the study area.

4.1.3.1 Insufficient space for family involvement

Almost in all areas of in this study found that, parents have expressed concerns regarding the lack of adequate space for their involvement in the care of their neonates. The design of the NICU is organized similar to that of other wards, which does not facilitate prearranged family participation in the care of critically ill new-borns. These limited conditions make it challenging to accommodate family visits.

"….The room by itself affects implementation of FCC. We lack mother resting rooms, and the NICU is overcrowded. eeee… the NICU room is not consider for the mother so it may need rearrangement of the infrastructure for the mother near to NICU. …When the NICU room is design the mother resting room should be under consideration because breast milk is very importance for the new-born" (Participant-6, HCP, BSc nurse).

"There is insufficient mother resting room... we cannot access them easily when needed." (Participant-1, HCP, BSc nurse)

The NICU room is often overcrowded, with numerous medical students, nursing staff, paediatrician, and 25 to 30 sick new-borns with in a single room. This may create consideration on cross-contamination among the sick neonates if the family added. Many healthcare providers are doubtful the entrance of family members into the NICU due to fears of cross contamination.

"The NICU is just seen as a warming room; except the staff no one don't understand … its needs FCC needed good environment to fully counseling and creates awareness unless it is difficult to apply FCC…….If the health care provider is trained and gained enough space it is not difficult to apply this Practice." (Participant-2, HCP, BSc nurse)

One participant told his frustration with caring for the new-born in such a overcrowded environment. They noted the high humidity levels and poor ventilation within the room, which contribute to rough atmosphere. This parent expressed frustration with the current situation, feeling restricted in his ability to engage in the care of his sick new born. This reflects a broader issue where inadequate space in the NICU not only affect family involvement but also impacts the overall well-being of both families and their new-borns during a critical time. Sample quotes

"…The structure is very complex-after delivery, no one cares about the mother's space Lack of room for the mother…The structure of the hospital itself is very complex. After delivery no one care about the mother. Even no one give you direction Delegate care provider while the mother give care her new born admitted in the NICU." (Participant-4, age 35, Parent)

" .....Shortage of breastfeeding mothering rooms near the NICU is a big problem her I had some experience newborn care when I was grow with my sitter so it is not new for me newborn care. hahah …alhamdelilahi I think I can give the care effectively." (Participiant-3, age 28, Parent)

4.1.3.2 Communication gaps and Limited resources

The information gap between the care provider and parents is a major issue identified in this study area, in the context of FCC. Many parents reported were unaware of their new-born admission to the NICU, shows that there is a critical breakdown in communication between healthcare providers and parents. Furthermore, it was noted that not all care providers have undergone training related

to family-centred care principles. This lack of training has resulted in an approach that fails to meet FCC.

"...I don't get daily updates about their baby's condition and ayyy…we have no sufficient information about disease condition of the sick new-born" (Participant -7, age 20, Parent)

Some of the parent indicated that due to the absence of clear and consistent information contributes to a stressful and anxious environment for families, which directly undermines the effectiveness of FCC. Some care providers express unwillingness to discuss the condition and progress of ill new-born with families, which may stem from their workload and shortage of time. This exacerbates the existing information gap, leading to increased stress for families, limited access to necessary resources, and affect bonding between mothers and their babies.

"...The care provider didn't explain well-I didn't understand my baby's treatment Eee… when the doctor told me about the baby health condition and medication he is taken I am not well understand due to language barrier." (Participiant-7, age 20, Parent)

Another critical issue highlighted across in this study area was the shortage of basic resources. Essential items, starting from cannulas and intravenous (IV) sets often prescribed outside the hospital, placing an additional financial burden on families. Many parents fined leave their neonate in the NICU while facing financial sufferings. Most of the staff reported that nearly all laboratory investigations and radiological screenings are done outside the hospital, which further make difficulties the situation for economically poor parents. Such type of condition disappoints frequent visits to their neonates, which affects the principles of family-cantered care.

"... For the first thing the room by itself affects implementation of FCC. We lack PPE like gowns cap, and sanitizers, making infection control difficult. In addition to this there are new-born admitted from referral catchment unable to gain their mother timely that means distance…?" (Participant -6, HCP, BSc nurse)

"...There's only one pulse oximeter for 30+ babies-how can we monitor effectively" (Participant-5, HCP, BSc nurse)

Moreover, there is also lack of accessible food for breastfeeding mothers whose infants are admitted to the NICU. This absence of support can affect mothers' ability to provide sufficient nutrition for their babies during critical period of care. To address this barrier, care providers have

suggested the launching a collaborative network encompassing social workers, hospitals itself, and non-governmental organizations (NGOs). This partnership might be provide the basic resources that require while the mother and her new-born with in the hospital such resource including food, diapers, wipes, formula milk, medications, and assistance with laboratory investigations for economically poor parents.

By resolving the communication gap and ensuring that parent have access to necessary resources, healthcare providers can adoptive a more supportive environment that not only improves stress but also strengthens the bond between mothers and sick new-born.

"…Language barriers exist-some providers can't communicate with families in their language Language barrier. Eee…Sometime language barrier between the health care provider and the family that means the care provider might cannot speak different language and unable communicate with the family create agape for practice of FCC." (Participant -3, HCP, MSc nurse)

4.1.3.3 Lack of Training for Healthcare Providers

As most participant of the care provider listed lack of staff training is a major problem affecting FCC in the NICU. Most of the care providers have not taken any formal training related to FCC, which is an important for implementing FCC. Some participants explore that they were unfamiliar with the concept of FCC. They simply adopted the practices through habitual actions from their day today activity. This informal learning results to lack of understanding on family-canter care.

"….We had learned from our seniors, neonatologist and friends otherwise we had not gained any training related to FCC throughout my experience. It is difficult to say the presence of family center care in our hospital." (Participant 2, HCP, BSc)

"….As far as I know there are no any type of training given related to family center care in our hospital. So with in the absence of any creation awareness within the hospital/ training it is very difficult to say some one knows or not. Eee…it is difficult to say is it practiced or not FCC within our hospital because unless someone know via reading, searching for journal and articles there is no such like practice with in the hospital so he/she did not know about FCC" (participant 3, HCP, MSC)

However, some care providers recognize its significance in improving patient care. Crowdedness in the NICU, fear of infection, and work overload can create an environment where the parent participation not given priority. Even experienced staff members may find it difficult to interact with families in these circumstances because of the physical limitations and the heavy workload.

As one care provider explore that FCC is vital for increasing mother-infant bonding, preventing neonatal distress, and facilitating a shorter period of improvement sick new-born. And also helps to parent involved in their infant's care, has a great value for emotional connections and greater value both the baby's development and the family's coping.

The absence of training not only affects individual caregivers but also undermines the overall quality of care provided in the NICU. Families may feel excluded or undervalued, leading to increased anxiety and stress during a challenging time. The lack of a good approach to FCC can create barriers to effective communication and collaboration between families and healthcare providers, which is essential for optimal neonatal outcomes.

Lack of staff training is a barrier that affects the delivery of care in the NICU. Addressing these gaps and raising an environment that prioritizes family involvement is essential for improving both family experiences and neonatal health outcomes. Sample quotes

"..... I have not taken any type of training related to family centred care. It is difficult to tell with confidence about the practice of FCC in our NICU but it is good. The care provider try to implement however different factor affect the care like that of the room, workload, and infrastructure of NICU setup. (Participant 1, HCP, and BSc nurse)

4.1.3.4 Rigid Rule and Protocols

The rigid rules and protocols of the Neonatal Intensive Care Unit (NICU) such as restrictions on family involvement during procedures, or lack of flexibility in care plans that do not consider family preferences, and invitation limitation have been identified as significant barriers to the effective implementation of family-centred care (FCC), with many participants expressing their concerns about these constraints.

One of the most complaints from participants is the restricted access for family involvement in the NICU. One parent participant at Abebech Gobena, say that only mothers are allowed to enter the

NICU, while fathers are permitted to visit their sick new-born only from 10:00 PM to 11:00 PM. This is not only limits the father's ability to engage with his child but also places an additional burden on the mother, who may already be facing physical challenges delivered with a caesarean section. Those who has surgical site pain, cause uncomfortable to sit for long periods of time while providing care for her new-born. This restriction can lead to feelings of isolation and helplessness the parents.

"The rule of the ward limits parent involvement—we can't stay with our baby. Within this hospital we have not participate in new-born care like skin-to-skin contact, feeding and we cannot know the condition of our baby at any time. So, the parent involvement for new-born care is very low do to restricted rule. Only care provider know the condition of our new-born health condition." (Participant -9, age 48, Parents).

In addition restrictions on family visits can increase the emotional distress through the parents. The inability for both parents to participate in their child's care might affect the development of emotional bonds, which are essential for both the baby's well-being and the family's coping mechanisms.

"….When the mother is in the side of her new-born she relived from her stress since she sew the condition of her baby. If the mother is on the side of the baby she start breast feeding, the baby also gain enough breast milk but It does not mean that frequent entrance of the mother to her sick neonates because this is the one of protocol of NICU (Participant- 4, HCP, BSc).

Moreover barriers includes shortage of gowns, shoes, and head capes can further complicate family access to their new-borns, due to inadequate resources. This also contributes to a sense of frustration and unhappiness among staff who may feel stunned by these logistical barriers.

The overall atmosphere created with NICU protocol lead to disappointment through care providers, that may feel inhibited in their ability to offer compassionate, family-cantered care.

Restrictions on family participation, logistical barrier related to protective tackle, and the emotional action on parents all contribute to an environmental that may affect mother new born bonding. Identifying and set goal on these barriers is essential for nurturing a more inclusive and supportive atmosphere that aligns with the concept of FCC and ultimately enhances both family experiences and neonatal health outcomes.

"...Frequent family entry is restricted due to infection fears." (Participant-5, HCP, BSc)

"...Mothers must wear gowns and sanitize, but sometimes supplies run out." (Participant-6, HCP BSc).

"...The hospital policies don't support family participation—it's seen as a burden. The father is not allowed entrance in NICU except 4-5pm for the case of infection prevention but the mother can visit her new-born any time she wants after they wear gown and sanitize their hand." (Participant-7, HCP, BSc)

4.1.4 Theme-II: Perceived family barriers of family centred care

4.1.4.1 Knowledge and Health Literacy

Most of the caregivers entering the Neonatal Intensive Care Unit (NICU) facing a difficult situation, due to absence of knowledge regarding the medical care provided to their new-borns. The healthcare providers often used very difficult medical terminology that cannot be understand by the caregivers. This unclear idea lead to raised anxiety and stress throughout the caregiver which might results disconnected from the care process and uncertain about their child's condition.

"...Parents from rural areas lack awareness-they don't accept FCC easily. All most of our patient come from Chanchio which is rural area and has no awareness about the FCC. Even if they are given health education about the condition they did not well acceptance. Where as those from Addis Ababa they easily understand the practice of family center care." (Participant-5, HCP, BSc nurse)

Knowing the ill new-born condition is crucial for relieving parent stress. However, many parents report feeling uninformed about the condition of their new born diagnosis, treatment, and family medical decision-making.

Some parents express confusion about why certain medications were prescribed or why specific investigations were conducted outside of the hospital setting. This confusion create feelings of helplessness and frustration, as they may perceive a lack of transparency in the care process. Furthermore, the absence of clear explanations regarding treatment options can affect their ability to make informed decisions about their sick new-born.

"…Many families believe once the baby is in NICU, their role is over. *They rely all things on the health care provider they believed that they has given all things, prevent them from death and like that….such like mother is challenging as "(Participant*-1, HCP, BSc nurse)

"…Some mothers have no ANC follow-up, so they don't understand NICU care." (*Participant*-1, HCP, BSc nurse)

A care giver come from rural areas has face additional challenges, as they often give the whole responsibility for their sick neonate entirely too healthcare providers upon admission to the NICU. Lack of awareness about essential sick baby care such as skin-to-skin attachment and the importance of breast milk for their new-born's health. Without this understanding, parents may not fully appreciate in the care of their ill new-born.

In addition well understanding the practice of new-born care has a great value in the concept of FCC. Lack of awareness about neonatal care causes a barrier with engage with healthcare providers. This breach understanding lead to missed family involvement in care decisions, which is vital for a supportive environment for both the neonate and the family.

Increasing parental awareness about FCC is very important for empower families involvement in the care of sick new-born. Solving these barriers in understanding, healthcare providers can increase more inclusive and supportive environment for the care of FCC, which is important both the parent and neonate.

"…Mothers are afraid to hold their preterm babies-they think they're too fragile." (*Participant*-2, HCP, BSc nurse)

"I didn't know about FCC-this is my first time in a NICU. I have no any experience about NICU so it is difficult to say about FCC. *"* (*Participant-2, age 28, Parent*)

4.1.4.2 Physical and Logistical Barriers

The physical and logistic are another barriers for implementation of family-cantered care (FCC) in the Neonatal Intensive Care Unit (NICU). These challenges create an impacting on the parents to engage fully in the care of their ill new-born's care and overall well-being.

Among the major issues is the transportation issues, particularly those who live far from the hospital and come from rural areas as a case of referral. This distance may also restrict the frequency and duration of the parents involvement in care activities, which is essential for develop a strong parent to new-born bond.

"…Distance from referral centers means mothers arrive late." (*Participant*-6, HCP, BSc nurse)

"…No transportation support-poor mothers struggle to visit. Shortage of economical support service like food and cloth is my challenge her." (*Participant*-7, age 20, Parent)

The physical design of the NICU is another challenge for family participation in the care of new-born. Like the mother's resting room is located far from the NICU, it can create additional barrier for her to be present with her new-born during she needed. The distance also disappoint the mothers from spending long period of time in the NICU, results reducing opportunities for mother to new-born bonding and affecting essential care practices of the sick baby like that of skin-to-skin contact.

Shortage of temperature control within the NICU can further dispirit family involvement. As the NICU has uncomfortable temperatures lead to a less welcoming for the parent, making it harder for families to spend extended time with their new-borns. This discomfort may lead some families to limit their visits or involving in the care activities.

"……The hospital lacks showers and clean toilets for mothers….Create safe and clean environment for the mother like toilet, hand washing soap, shower and such like things is needed. Since the mother has vaginal bleeding and feeling of discomfort so it needed to avoid as much as possible" (*Participant* -6, HCP, BSc nurse)

In addition to this low administrative apprehension regarding family-cantered practices results lack of support for FCC. Unless hospital administration does not prioritize FCC in the NICU it might lead to insufficient resources and staffing in the case of family engagement in the NICU.

Rigid visitation time is another logistical barrier that can limit parent involvement in the care of the new-born. When parent are restricted to visit at convenient times, it can disrupt their ability to bond with their new-born and stay informed about their child's condition. Flexible visitation policies are important for encouraging the family to their active involvement in care of their new-born.

The Financial issues are also another barriers in the care of FCC. The costs expense like for transportation, lodging, and meals, medication, laboratory investigation during extended hospital stays is another burden on parents. This financial issue prevent them from visiting as often as they would like to visit their sick new-born's care.

"Eeee…for the front line is insufficient mother resting room as a result when they came from outside of the hospital we cannot able accessed them when we want them. Because of they has no specific resting room it is very difficult to access the mother easily another thing is some women can't even afford diapers or baby clothes." (*Participant*-1, HCP, BSc nurse)

"….The challenge for me was price of medication. The price is not affordable with my capacity. My new-born is only given breastfeeding but it is not enough and didn't satisfy. When the doctor told me to buy powder milk I couldn't afford the price (Participant-7, age 20 parent)

Furthermore, limited access to educational materials has play another barriers in the practice of FCC. Parents who do not have access to real information about their child's condition and treatment options, they may feel ill-equipped to engage in decision-making. Providing accessible educational resources is important for empowering parent and increasing their involvement in FCC.

Transportation, inadequate temperature control, strict visitation policies, financial burden and lack of educational material contribute to as barrier in the care FCC. Solving these challenges is essential for promotes active parent participation in neonatal care, ultimately important both the neonate and their caregiver.

"...Mothers who deliver via C/S come late due to pain- delaying FCC. Because of the pain the mother is unable to visit the new-born timely. Those women who delivered with C/S afraid ambulation and unable to come and visit the new-born..." (Participant-3, HCP, MSc nurse)

4.1.4.3 Emotional Burden and Stress of family to their sick neonate

Most of the time admission of new-born to the Neonatal Intensive Care Unit (NICU) often creates emotional burden and stress within the parents. This insight might lead to feelings of helplessness and depression, as they uncertainty surrounding their new-born health.

Some caregiver explain fear of the NICU environment, expression concerns about the overall well-being of their new-born. They need supporter for care providers and hospital administrator to create as safe an environment as possible, emphasizing the need for clearness, and adequate resources to assure their new-born health.

"……The care provider should be tries to create safe environment as far as possible but I don't believe that thxe environment is safe for our baby." (Participants-9, age 48, Parents).

During admission of prolonged stay in the NICU of the neonate, parents often struggle with trust in the care provided by medical professionals. Lack of trust creates inadequate information sharing between care providers and parents. When parents is not well informed about their new-born condition, treatment plans, and the health progress day to day, it increase the anxiety which cause as a barrier of quality of care. It is important for give prioritize information sharing between the care provider and the parents throughout new-born discharge which facilitate the family centre care in the NICU.

"....Because the environment is crowded and the temperature within I don't believe that the environment is comfortable for our baby" (Participants-9, age 48, Parents).

4.1.4.4 Perceived Value of Family Involvement in NICU

Some of the parents understand that their active involvement in the care of the new-born is not only valuable but also important for the early improvement of their ill new-born. They often feel that their presence and engagement has a positive outcome, which enhancing creation of connection and safety for their new born at the period of treatment.

".....Parents who participate feel more satisfied with care. Those who has family around there gain good care in addition to this the mother also gain more satisfaction when she is with her baby as a result those baby having family around there and those haven't is not equal." (Participant-1, HCP, BSc nurse)

".....FCC increases mother-baby bonding and improves weight gain." (*Participant*-2, HCP, BSc nurse)

Parents believe that healthcare provider might need to recognize and value their input, as parents often has unique knowledge about their new-born behaviours and responses on the treatment decisions making. This communication and cooperation work might lead to more team care and better alignment between medical treatment and the new-born individual circumstances.

Also, when parents are participate in the care process, it decrease the burden of the care provider. Parents might assist a basic caregiving tasks like thus of bottle feeding, diaper changes, and give comfortable environment for their baby, which is not only supports the new born development but also allows nurses and doctors to focus on more complex medical treatment. This partnership can create a more effective workflow within the NICU, aims to benefiting all parties involved.

"…When mothers breastfeed, it's better than antibiotics for recovery…The presences of the mother is very important both the newborn and the health care provider because the baby should be gain enough breast milk since the best thing is breast milk over the formula feeding. So the presence of mother is important around her newborn because of the value of breast milk is more than antibiotics." (Participant -6, HCP BSc nurse)

"… It is very good there are so many things that they help us. For example they reduce work load of health care provider especially in our room like kangaroo mother care room family play very crucial role. In KMC room the mother passes very long time with their baby in compare to the health care provider so family centre care is a very important concept if apply every NICU." (Participant-1, age 38, Parent)

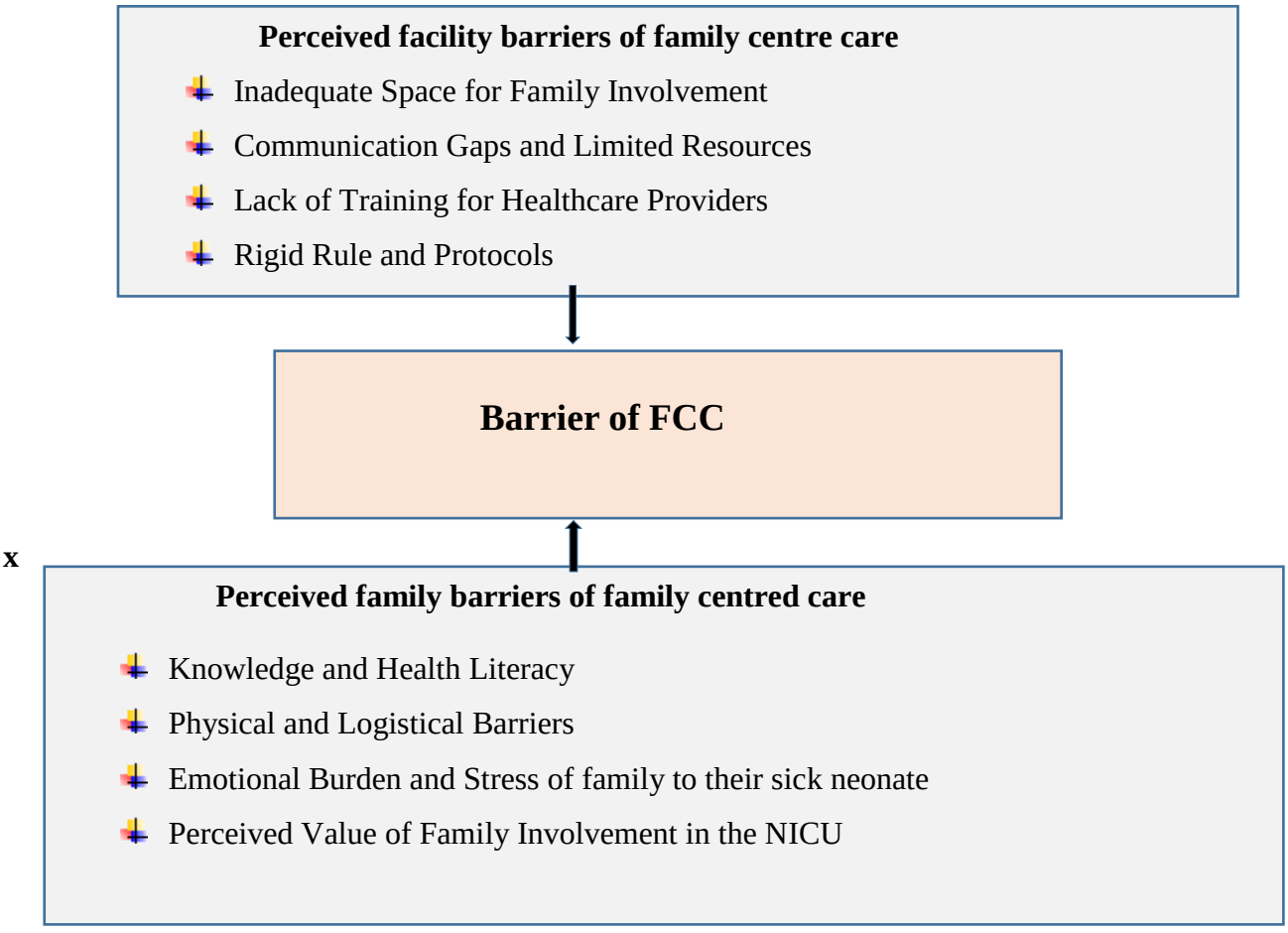

Figure -1 the diagrammatic summary of the thematic presentation of the study

4.2. DISCUSSION

This study try to explore the perceived barriers to implementing Family-Centred Care (FCC) in Neonatal Intensive Care Units (NICUs) of at three public hospitals in Addis Ababa, Ethiopia. The findings indicated that there is significant barriers from both healthcare providers and parents perspectives, which is in line with global study on FCC implementation in low income country.

The study identified inadequate space for parent involvement and poor NICU infrastructure as major barriers to FCC. From both of the parents and healthcare providers limited space and high patient-to-staff ratio were more explored as the barrier of family center care that unable to accommodate the parents in the NICU. This study finding is in line with a studies done in sub-Saharan Africa on the barriers of implementation of family center care, where NICUs often lack designated areas for family participation, leading to restricted visitation policies and fears of infection (18,22). The physical factors described in this study show that a critical need for structural designing to create good environments for implementing for family center care.

Communication gap between healthcare providers and parents were one of subtheme drawing from the theme of perceived facility barriers of family centre care. As many parents were unaware of their neonate's admission, current condition or treatment plans of the neonate, increase the parent stress. This finding is in line with a similar study done from Ghana and India, where poor communication and language barriers affects parental engagement in the neonatal care while in the NICU(15,29). Moreover, shortages of basic medical supplies like IV sets, lab services, and medication forced the parents to buy outside the hospital which, adding financial tension. Similar barriers have been documented in the previous study conducted in the low-resource settings, where resource scarcity undermines FCC (22).

Healthcare professionals admitted to having little formal training in FCC principles and instead depending on unofficial procedures they picked up from peers. The FCC was implemented inconsistently as a result of this lack of formal education. These results are consistent with research conducted in Ethiopia and sub-Saharan Africa. (16,18). n order to provide staff with FCC competencies, institutional support is necessary, as evidenced by the lack of standardized training programs.

Inflexible care plans and stringent visitation regulations (such as restricted hours and father exclusion) were noted as obstacles. These procedures, which were frequently created to prevent infections, unintentionally disadvantaged families. Similar problems have been documented in NICUs around the world, where strict regulations run counter to FCC principles (6,26). Addressing these policies through family-inclusive guidelines could mitigate their negative impact.

Many parents, especially those from rural areas, were ignorant of neonatal care procedures. This disparity decreased their confidence in taking part in decisions about their care, which has been seen in comparable situations (21,24). Educational interventions tailored to parents' literacy levels could empower them to engage more effectively in FCC.

Parental presence was restricted by financial limitations, distance from the hospital, and transportation issues. These obstacles are common in low-income environments, where families find it difficult to cover the indirect expenses of hospital stays (27).

Significant emotional distress was reported by the parents, who frequently felt helpless and mistrustful of the NICU setting. This is consistent with international research that links parental trauma and anxiety to NICU admissions(1,17). Family coping strategies may be improved by strengthening emotional support through peer networks and counselling.

Despite obstacles, parents understood how important their role was to their newborn's healing. The fundamental tenet of FCC—that family involvement enhances results—is supported by this finding (2,12). The necessity for comprehensive FCC models that address both structural and psychosocial barriers is highlighted by the fact that systemic barriers frequently overshadowed this potential.

Policymakers, hospital administrators, and healthcare providers must take a multifaceted approach in order to successfully implement FCC in NICUs while addressing the obstacles that have been identified. In order to balance infection control with parental access, policy should concentrate on infrastructure improvements by redesigning NICUs to include family-friendly areas. Healthcare professionals should receive FCC training that priorities teamwork and communication. To meet the needs of families while ensuring safety, visitation regulations should be reviewed. In order to

empower parents, family support programs like financial aid, transportation, and educational materials should also be made available.

CHAPTUR - FIVE

5. CONCLUSION AND RECOMMENDATION

5.1 Conclusion

This study highlights the various obstacles to FCC in NICUs at public hospitals, which stem from issues with resources, culture, and systems. Although the advantages of FCC are widely known, putting it into practice calls for specialized approaches that take local limitations into account. Healthcare systems can improve neonatal outcomes and parental satisfaction by emphasizing family involvement, which will ultimately advance equitable care in settings with limited resources. In order to overcome these obstacles, families and providers should co-design future interventions using a participatory approach.

5.2 Recommendations

For Policymakers

Secure government/NGO funding for essential resources (gowns, sanitizers, ventilators).

For Hospital Administrators

Allow flexible visiting hours for both parents, especially fathers.

Redesign NICUs with family-friendly spaces (e.g., parent lounges, KMC rooms) while maintaining infection control.

Conduct workshops on communication, empathy, and shared decision-making for NICU staff.

For Healthcare Providers

Use simple, non-medical language when explaining conditions and treatments.

Train parents in basic neonatal care (e.g., diaper changes, feeding) to empower them.

Assign designated staff to guide families through the NICU process.

For Future Research

Investigate FCC barriers in private NICUs for broader applicability.

Combine qualitative interviews with quantitative surveys for stronger evidence.

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7. ANNEXES

Annex I: English version of participants' information sheet

Title of the Research Project: Exploring perceived barriers to implementing family-centred care in the Neonatal Intensive Care Units at selected public hospitals in Addis Ababa, Ethiopia 2025.

Name of Principal Investigator: Workalem Tilahun

Name of the Organization: Addis Ababa University College of Health Sciences School of Nursing, and Midwifery Department of Neonatal Nursing.

Name of the Sponsor: Addis Ababa University College of Health Science.

Introduction

This information sheet and consent form are prepared with the aim of exploring perceived barriers to implementing family-centred care in the Neonatal Intensive Care Units at selected public hospitals in Addis Ababa, Ethiopia 2025.

Purpose of the Research Project: This study aims to explore perceived barriers to implementing family-centred care in the Neonatal Intensive Care Units.

Procedure: This study involves health care provider and parents who can fulfil the inclusion criteria. You are selected to be one of the study participants if you are willing to take part in this study and we kindly invite you to take part in our project. If you are willing to participate, we are so happy and we need you to clearly understand the aim of this study and show your agreement.

Finally, you are kindly requested to give your genuine response in the interview.

Benefits, Risks, and /or Discomfort

By participating in this research project, you may feel some discomfort in wasting your time. However, your participation is important to assess the barrier of nurturing care in the neonatal intensive care unit. There is no risk or direct benefit in participating in this research project.

Right to Refusal or Withdraw

You have the full right to refuse to participate in this research. You have also the full right to withdraw from this study at any time you wish.

Person to contact

This research project will be reviewed and approved by the Institutional Review Board (IRB) of Addis Ababa University College of Health Sciences. If you have any questions, you can contact any time, and you may ask at any time you want.

Name: Workalem Tilahun

Phone No: 0922709826

E-mail: tilahunworkalemgelatu1346@gimall.com

Annex II: English version of informed consent

Addis Ababa University College of Health Science School of Nursing and Midwifery Department of Neonatal Nursing.

A semi-structured questionnaire prepared to explore perceived barriers to implementing family centred care in the Neonatal Intensive Care Units at selected public hospitals in Addis Ababa, Ethiopia 2025.

Dear, my name is Workalem Tilahun .I am a master's neonatal nursing student at Addis Ababa University College of Health Sciences. I am interested in studying barrier of family centred care in the neonatal intensive care unit at selected public hospitals in Addis Ababa, Ethiopia. This semi structured questionnaire is designed for academic purposes and approved by Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery, in partial fulfilment of a master's degree in Neonatal Nursing. I hope you will help me by answering these questions. None of your answers will be available to anyone. All the information you give me will be kept private. Anyone who will not be willing to participate in the study will have the right to discontinue at any time in the process. Confidentiality and privacy are maintained by ensuring the respondents answer the questions in a separate place where no one can see them. Therefore, I need your honest and genuine response. The results of the study will hopefully serve as an important input for policy and intervention programs.

Would you be willing to participate in this study?

☐ Yes ☐ 2. No

If yes, proceed to the next page.

If not, please stop here.

Name of Researcher: Workalem Tilahun

Address: Addis Ababa University College of Health Science

Phone No: +251922709826

E-mail; - tilahunworkalemgelatu1346@gimall.com

Name of data collector_____ signature_____ Date of interviewing _____month_____/2017 E. C.

Time of interview began _____ hours_____ minutes Time of interview finished_____ hours_____ minutes
Checked on _____date_____ month/2017 E.C.

I am informed that this study is going to be conducted to explore perceived barriers to implementing family centred care in the Neonatal Intensive Care Units at selected public hospitals in Addis Ababa, Ethiopia 2025. I am informed that the information I give will be kept confidential, and only used for this study. I am also conscious that I have the right not to respond to any question without my interest. Hence, I agree to participate in the research voluntarily. Signature_____ Date_____

Annex III: Amharic version of the information sheet

በጥናቱለሚሳተፉ የስምምነትዉልእናአጠቃላይመረጃ

ጥናቱ ርዕሰ ጉዳይ ፡- በአዲስ አበባ ከተማ ዉስጥ በሚገኙ በተመረጡ የመንግሥት ሆስፒታሎች ስለሚሰጥ የጨቅላ ህጻናት ጽኑ ህሙማን አስተኝቶ ማከም ውስጥ የሚደረግ እንክብካቤ ለማድረግ እንቅፋት የሆኑ ጉዳዮችን ለመለየት የቀረበ ጥናት ነው። ጥናቱን የሚያካሂደዉ ስም ፡- ወርቃለም ጥላሁን የተቋሙ ስም ፡- አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የስፖንሰሩ ስም ፡- አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ መግቢያ ፡- ይህ የመረጃ ዝርዝር እና የስምምነት ቅፅ በአዲስ አበባ ከተማ ዉስጥ በሚገኙ በተመረጡ የመንግሥት ሆስፒታሎች ስለሚሰጥ የጨቅላ ህጻናት ጽኑ ህሙማን አስተኝቶ ማከም ውስጥ የሚደረግ እንክብካቤ እንክብካቤ ለማድረግ እንቅፋት የሆኑ ጉዳዮችን ለመለየት የቀረበ ጥናት ነው። የጥናቱ አላማ ፡- የዚህ ጥናት ዋና አላማ በአዲስ አበባ ከተማ ዉስጥ በሚገኙ በተመረጡ የመንግሥት ሆስፒታሎች ስለሚሰጥ የጨቅላ ህጻናት ጽኑ ህሙማን አስተኝቶ ማከም ውስጥ የሚደረግ እንክብካቤ እንክብካቤ ለማድረግ እንቅፋት የሆኑ ጉዳዮችን ለመለየት የቀረበ ጥናት ነው። የዚህ ጥናት ዉጤት በአዲስ አበባ ከተማ ጨቅላ ህጻናት ላይ የሚሰጠዉን ህክምና እንክብካቤ በማሻሻል የህጻናትን ሞት ለመቀነስ ያግዛል ። የጥናቱ ሂደት ፡- በጥናቱ ዉስጥ ለመሳተፍ የተካተቱትን መመዘኛዎች ያሟሉ ወላጆችን ያካትታል። በዚህ ጥናት ለመሳተፍ ፍቃደኛ ከሆኑ በታላቅ አክብሮት ተጋብዘዋል። ለመሳተፍ ፍቃደኛ ከሆኑ፤እኛ በጣም ደስተኞች ነን እናም የዚህን ጥናት አላማ በትክክል መረዳት እና ስምምነትዎን እዲያሳዩ እንፈልጋለን። በመጨረሻም በቃለ መጠይቁ ትክክለኛ ምላሽዎን እንዲሰጡ በአክብሮት እንጠይቃለን። ጥቅማጥቅም፤ጉዳት እና/ወይም የማይመች ነገር፡ በዚህ ጥናት በመሳተፍዎ የተወሰነ ደቂቃ ሊፈጅበዎት ይችላል። ሆኖም ግን የናንተ ተሳትፎ በጽኑ ህሙማን ጨቅላ ህጻናት እንክብካቤ ሁሪያ ለማጥናት እና አስፈላጊዉን መፍትሄ እዲወሰድ ያግዛል። በዚህ ጥናት በመሳተፈዎ ምንም አይነት ጉዳት ወይም ቀጥተኛ ጥቅም አይኖረውም። ማበረታቻ/ለማበረታታት ክፍያዎች ፡- በዚህ ጥናት ለመሳተፍ ማበረታቻ ወይም ክፍያ አይኖረዉም። ሚስጥራዊነት ፡- ከእርሰዎ የተሰበሰበዉ መረጃ በኮምፒተር ዉስጥ ስምዎ ሳይኖር በሚስጢር ይቀመጣል። የመቃወም ወይም የመተዉ መብት ፡- በዚህ ጥናት ዉስጥ ያለመሳተፍ ሙሉ መብት አለዎት በተጨማሪም ጥናቱን ሳያጠናቅቁ በፈለጉት ሰዓት የመተዉ መብትዎ የተጠበቀ ነዉ። ማግኘት የሚችሉት ሰዉ ፡- ይህ ጥናት አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ በተቋማት ግምገማ ቦርድ እዲፀድቅ ይደረጋል።ማናቸዉም ጥያቄ ሲኖረዎት በማንኛዉም ጊዜ ማነጋገር ይችላሉ በተጨማሪም ማንኛዉንም መረጃ በፈለጉት ጊዜ ማግኘት

ይችላሉ። ስም፡ ወርቃለም ጥላሁን ስልክ ቁጥር፡ +251922709826 ኢ-ሜል፡ tilahunworkalemgelatu1346@gimall.com

Annex IV: Amharic version of informed consent

አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ ነርሲንግ እና ሚድዋይፈሪ ትምህርት ቤት

ነርሲንግ ትምህርት ክፍል

በአዲስ አበባ ከተማ ዉስጥ በሚገኙ በተመረጡ የመንግሥት ሆስፒታሎች ስለሚሰጥ የጨቅላ ህጻናት ጽኑ ህሙማን ህክምና እንክብካቤ እንቅፋቶች ለመለየት የቀረበ ጥናት

ነው።

ዉድ የጥናቱ ተሳታፊዎች

ጤና ይስጥልኝ፣ ስሜ ወርቃለም ጥላሁን ይባላል። በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ በነርሲንግ እና ሚድዋይፍሪ ትምህርት ክፍል የሁለተኛ ዲግሪ ትምህርቴን እየተከታተልኩ እገኛለሁ።የሁለተኛ ዴግሪዬን ለመጨረስ ይረዳኝ ዘንድ በአዲስ አበባ ከተማ ዉስጥ በሚገኙ በተመረጡ የመንግሥት ሆስፒታሎች ስለሚሰጥ የጨቅላ ህጻናት ጽኑ ህሙማን አስተኝቶ ማከም ውስጥ የሚደረግ እንክብካቤ እንክብካቤ ለማድረግ እንቅፋት የሆኑ ጉዳዮችን ለመለየት ጥናት እያደረኩ እገኛለሁ።ጥናቱ አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ትምህርት ቤት በነርሲንግ እና ሚድዋይፍሪ ትምህርት ክፍል የጸደቀ ነዉ። ስለሆነም ከላይ የተዘረዘሩት የጥናቱ ዓላማዎች ይሳኩ ዘንድ በእናንተ በኩል በእውነታ ላይ የተመሠረተና ትክክለኛ የሆነ መረጃ እንድትሰጡኝ እየጠየኩ ለቃለ መጠይቁ የምትሰጡኝ መልስ ግላዊ እና ስማችሁን ያላካተተ በመሆኑ በከፍተኛ ሚስጥራዊነት የሚጠበቅ ይሆናል። ከዚህም በተጨማሪ በጥናቱ ላይ የምትሳተፉት በፍቃደኝነት ስለሆነ ካልተመቻችሁ ባስፈለጋችሁ ጊዜ ማቆም/ማቋረጥ መብታችሁ ነው። እርስዎ ጥያቄ በመመለስ ብትተባበሩኝ ለጥናቱ መሳካት የራስዎን ጉልህ ድርሻ ተወጡ ማለት ነው። መጠይቁን ለመመለስ ፍቃደኛ ነሽ/ነዎት?

1. አዎ ☐ አይደለሁም ☐

2. መልስዎ አዎ ከሆን ወደ ቀጣይ ገጽ ይሻገሩ። ጥናቱን የሚሰራዉ ፡- ወርቃለም ጥላሁን እባላለሁ ስልክ ቁጥር፡ (+251)922709826 ኢ-ሜል፡ tilahunworkalemgelatu1346@gimall.com ጥናቱን የሚሰበስበዉ ስም_____ ፊርማ_____ ጥናቱ መሰብሰብ የተጀመረበት ቀን_____ /2017 ዓ/ም ጥናቱ መሰብሰብ የተጀመረበት_____ ሰዓት

_____ ደቂቃ ጥናቱ ተሰብስቦ ያለቀበት_____ ሰዓት _____ ደቂቃ

የተጣራበት ቀን_____ወር_____ 2017ዓ/ም

የጥናቱ ተሳታፊዎች ፍቃደኝነት ቅፅ እኔ የጥናቱ ተሳታፊ የሆንኩኝ ወላጅ ይህ ጥናት በአዲስ አበባ ከተማ ዉስጥ በሚገኙ በተመረጡ የመንግሥት ሆስፒታሎች ስለሚሰጥ የጨቅላ ህጻናት ጽኑ ህሙማን አስተኝቶ ማከም ውስጥ የሚደረግ እንክብካቤ ለማድረግ እንቅፋት የሆኑ ጉዳዮችን ለመለየት መሆኑን አውቂያለሁ። የምሰጠውም ግላዊ መረጃዬ በሚስጥራዊነት እንደሚጠበቅ እና ለዚህ ጥናት አላማ ብቻ እንደሚውል ተነግሮኛል። ጥናቱ ውስጥ ያለፍላጎት ተሳታፊ ሆኜ መቀጠል እንደለለብኝ እና መቀጠል ባልፈለግሁ ጊዜ ማቆም እንደምችል ተረድቻለሁ። በአጠቃላይ ከላይ የተዘረዘሩትን መብቶቼን በማወቅና የእኔ በዚህ ጥናት ላይ መሳተፍ ጥቅም አለው ብዬ በማመን በሙሉ ፍቃደኝነት ለመሳተፍ ተስማምቻለሁ።

ፊርማ _____ ቀን_____

I. Data collection tool English version

Section I: Demographic Information of healthcare providers

1. Age: _____

2. Sex:

   a) Male

   b) Female

3. Position/Role:

   a) Nurse

   b) Doctor

   c) Medical doctor

   d) Resident

   e) Other: _____

4. Years of Experience in Neonatal Care:

   a) Less than 1 year

   b) 1-3 years

   c) 4-6 years

   d) More than 6 years

5. Education Level:

   a) Neonatologist

   b) Pediatrician

   c) Bachelor's Degree in neonatal

   d) Master's Degree in neonatal

e) Other: _____

Section II: Demographic Information of parents

1. Age.------
2. sex-----
   a. male
   b. female
3. Level of education.
   a. illiterate
   b. primary
   c. secondary
   d. diploma
   e. degree and above
4. What is your relationship to the neonate in the NICU?
   a. mother
   b. father
   c. grand parents
   d. others----------

5. How long has your infant been in the NICU? ----------

III. In-Depth Interview Guide for healthcare providers:-

Title: To explore perceived barriers to implementing family-centred care in the Neonatal Intensive Care Units at selected public hospitals in Addis Ababa, Ethiopia 2025.

Participant ID: _____

Interviewer Initials (Xxx): _____

Date: _____ Start Time: _____Am/Pm End Time_____

Introduction and Interview Purpose

Welcome and thank you again for agreeing to participate in this study. I'm _____, and I will be talking with you regarding your barriers on implementing of FCC in NICU.

Consent

- For the purpose of analysis, I would like to record our conversation. I will just take notes if you would prefer that our conversation not be recorded.

Do you have any questions before we begin?

S/N	Question	Probe
1	Understanding of Family-Centered Care (FCC) • Can you describe what Family-Centred Care means to you in the context of a NICU? • How do you perceive the role of families in the care of neonates within the NICU? • To what extent is FCC	• Can you elaborate on it more? • What is facilitators or hinders this

	currently practiced in your NICU	
2	Perceived barriers to FCC implementation: • What do you believe the main challenges in implementing FCC in the NICU? • Are there any other factors you believe hinder the implementation of FCC in the NICU? • In your opinion, what additional support or resources would be beneficial to improve FCC?	• Probe:-Staff, resource physical space, communication • Can you provide specific examples?
3	Recommendations: • What change you recommend to overcome barriers? • How can healthcare organizations support staff in implementing FCC practices more effectively?	

IV. In-Depth Interview Guide for Parents:-

Title: To explore perceived barriers to implementing family-centred care in the Neonatal Intensive Care Units at selected public hospitals in Addis Ababa, Ethiopia 2025.

Participant ID: _____

Interviewer Initials (Xxx): _____

Date: _____ Start Time: _____Am/Pm End Time_____

Introduction and Interview Purpose

Welcome and thank you again for agreeing to participate in this study. I'm _____, and I will be talking with you regarding your barriers on implementing of FCC in NICU.

Consent

- For the purpose of analysis, I would like to record our conversation. I will just take notes if you would prefer that our conversation not be recorded.

Do you have any questions before we begin?

1. Understanding of FCC:
    - How would you describe your understanding of Family-Centred Care in the context of your baby's stay in the NICU?
2. Personal Experiences::
    - Can you share your experiences in being involved in your baby's care while in the NICU?
    - What aspects of the NICU environment either facilitated or hindered your involvement in your baby's care?
3. Identifying Barriers:

- What challenges did you face in participating in the care of your baby in the NICU?

4. Suggestions for Improvement:

    - Based on your experience, what changes would you suggest to improve parental involvement in the NICU?

Closing

Thank you for your time and thoughtful responses. That is the entire question that I have for you. Is there anything else that you think we should know that I did not ask about?

Thanks again for your time.