CAUSES, PSYCHOSOCIAL PROBLEMS OF BURN AND SUPPORT SERVICES FOR HOSPITALIZED BURN INFLICTED PATIENTS AT YEKATIT 12 HOSPITA

By Hanna Solomon

A Thesis Submitted to the School of Social Work, Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Social Work (MSW)

Addis Ababa University

Addis Ababa Ethiopia

May, 2021

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College of Social Sciences

School of Social Work MSW Examining Committee

This is to certify that the Thesis prepared by Hanna Solomon, entitled: causes, psychosocial social problems of burn and psychosocial support services for hospitalized burn inflicted patients at yekatit 12 hospital in partial fulfillment of the requirement for the degree of Master of Social Work complies with the regulation of the University and meets the accepted standards with respect to originality and quality**.**

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DECLARATION

I, the undersigned, declare that this Master's thesis is my original work and all the sources or materials used have been duly acknowledged.

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Advisor's Approval

This Master's thesis has been submitted for examination with my approval as a university Advisor.

Name Comdr. Demelash Kassaye (PhD) Associate Professor

Signature ________________

Date ________________

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ABSTRACT

This research has conducted on causes, psychosocial social problems of burn and psychosocial support services for hospitalized burn inflicted patients. Many studies have been done on the burn injury and related issues but there was little/no research done in Ethiopia regarding on psychosocial social problems of burn and psychosocial support services for hospitalized burn inflicted patients. Thus, this study was conducted to describe and explore the causes, psychosocial social problems of burn and psychosocial support services for hospitalized burn inflicted patients'. The qualitative research design with a case study approach was employed. The study uses in-depth interview, and Key informant interview as a method for data collection. The study was conducted at Yekatit 12 Hospital Addis Ababa. The study area was selected purposively because the method is flexible to set criteria for getting the type of research participant that the study requires. Participants of the study were taken from both sexes and different background such as burn injured in patients, burn unit head nurse and the hospital administrator to get a variety of views about the issue .The data had collected through primary sources. The general findings of this study are burn injury damaged patient's physical as well as psychological and social health. It also indicated participants were hampered in their psychology and developed the feeling of hopelessness, depression, anxiety and sense of powerlessness caused from fear of loss on their physical appearance. To maintain the data quality and to assure the trustworthiness, the data's obtained from different sources were triangulated. Furthermore, data's was analyzed thematically including the direct quota as necessary. Besides, the researcher has implication from social work education, practice, and research and policy point of view.

Key words: *Burn injury, Emotion, psychosocial support, hospital, Pain.*

ABBREVIATIONS

AD:	Annon Domino, in the year of Lord
BC:	Before Christ
CDC:	Centers for Disease Control
NHPH:	National Public Health Partnership
OPD:	Out Patient Department
PTSD:	Post Traumatic Stress Disorder\
TBSA:	Total Body Surface Area
TETAF:	Texas EMS Trauma & Acute Care Foundation Trauma Division
WHO:	World Health organization

CHAPTER ONE: INTRODUCTION

1.1 Background

Burn is a thermal injury caused by biological, chemical, electrical and physical agents with local and systemic repercussions, these are the most severe form of trauma that has afflicted humanity since time immemorial and that over the years and the scientific revolution has improved the results in its treatment (Hettiararchys & Dziewulski, 2004).

Burns injury affects the structures, function and appearance of body parts, due to the presence of scars and contractures and considered a severe trauma that causes physical, emotional and social squeal. Esthetic problems after a burn were common among severely burned patients (Emily, Mclaughlin and Ava, 2012).

Burn is the leading cause of deaths of injury among unintentional injuries in low and middle income countries. As per the World Health Organization (2008), burns account for an estimated 300,000 deaths annually, majority (> 95%) of which occurs in developing countries. Each year in the United States, 1.1 million burn injuries require medical attention; approximately 50,000 of these require hospitalization, with 20,000 patients having major burns involving at least 25% of their total body surface. In addition, someone dies in a fire every 2 hours, and someone is injured due to burn every 23 minutes and up to 10,000 people in the United States die every year of burn-related infections (Karter, 2001). According to WHO (2002) estimated number of deaths and mortality rates due to fire related burns in low and middle income countries of South-East Asia and Africa 184,000 and 43,000 respectively at the year of 2002 .

Adult burn mortality has been neglected public health issue in South Africa and across the continent due to scarcity or inadequacy of empirical data and the greater emphasis on

maternal and child health threats. The overall Cape Town burn mortality rate of 7.9 per 100 000 person years is higher than the world average of 5.0 per 100,000 and even the African Region one of 6.1 per100,000 (Niekerk, Laubscher, and Laflamme, 2009).

Urban migration, poverty, and the development of slum areas relate significantly to overcrowding and the risk of burns. In low income households, kerosene constitutes 56% of the energy source and 21 million households in South Africa use kerosene as a daily energy source, constituting 25% of income spent on energy sources. It is estimated that there are approximately 45,000 paraffin-related fires annually and 3000 deaths (Rode, Berg & Rogers, 2011).

Burn injuries account for 4.8% of trauma deaths in Nigeria (Solagberu, Adekanye and Ofoegbu ,2003) and 6.7% of surgically related deaths (Adesunkanmi, Akinkuolie & Badru, 2002).In children, burns and scalds are the fourth commonest cause of trauma after road traffic accidents, accidental falls and bites (Chama & Na'aya, 2002).

The overall Cape Town burn mortality rate of 7.9 per 100 000 person years is higher than the world average of 5.0 per 100 000 and even the African Region one of 6.1 per 100 000 (Peck, Molnar, & Swart, 2009).

A combined hospital and community based survey of burn injuries in rural southern Ethiopia estimated the lifetime incidence of burns among women of reproductive age to be 11% (Courtright, Haile, & Kohls, 1993). However, in low-income countries like Ethiopia, health services may not be available to all sectors of the population and additionally vital registration and health reports are incomplete in northern Ethiopia the annual incidence of burn injuries was 1.2% (80/7309) of a community based study of the Mekele town (Nega & Lindtjørn, 2002).

Different studies conducted related with burn injury in Ethiopia did not describe and explore the psychosocial problems and psychosocial support services for burn injury patients. Therefore, this study focuses on to describe and explore the causes, psychosocial problems of burn and psychosocial support services for burn inflicted patients.

1.2 Statement of the Problem

Historically, burn care has focused on medical issues rather than on psychological problems and quality of life. The psychological impact of burn injuries has become a subject of interest only over the last few decades, as growing insight into the pathophysiology of burn injuries and advances in medical care have made it possible to decrease the mortality rate. Nowadays, the psychosocial impact of burn injury has become a topic of interest in both burn practice and research. It has become clear that there are many distressing factors that may cause psychological problems in burn patients (Van loey, Van Son, 2003).

A major burn injury can impair skin integrity, sensation and may lead to hypertrophic scarring. In addition to changes in appearance and function brought about by scaring, deeper burn may result in damage or complete loss of functionally cosmetically important body parts (Rose &Herndon, 1997). Furthermore, many forms of psychological disturbance have been noted including body image dissatisfaction, depression post traumatic distress that often may take years to recover (Kleve & Robinson, 1999). The physical and psychological consequence of a major burn injury can interfere significantly with social and occupational performance, which may be aggravated by environmental barriers or lack of social support (Druery, Brown &Muller, 2005).

Psychological concern commonly witnessed among burn patients is pain-related distress or procedural anxiety associated with painful treatments. Indeed, in addition to the trauma of suffering a burn, the ensuing medical procedures can also be traumatizing, sometimes resulting in fear and helplessness (Jennifer, Laura and Diana, 2018).

Psychosocial issues in the burn patient are profound. Psychological recovery parallels physical recovery. A psychological survey needs to be addressed and the patient's psychological status upheld (Castana, Makrodimou, Katsaraki, Apastolopoulou, Alexakis, 2004). Emotional devastation is the culmination of the injury, hospital stay, and consequences of the burn. (McNulty, 2002) .Estimates that one half of all burn patients become permanently disabled, with a large segment having psychological impairment. Psychological sequela that impairs function includes fear, anxiety, stress disorder, and behavior regression (Shepperd & McNulty, 2002).

Psychological burn care parallels physical care and can be broken down into stages: critical, acute (first 3 months), chronic or sub-acute (after the first trimester), and delayed (greater than 6 months). Psychological symptoms range from mild, such as fear, sadness, uneasiness, worry, and lack of self-confidence, to severe, like depression, anxiety, delirium, and posttraumatic stress disorder. Adjustment is not necessarily directly affected by burn severity but may be related to its visibility (Williams & Griffiths, 1991).

On the other hand many family issues happened for the patient, such as angry and reproachful spouse, being strange to family members due to facial changes, dependence on the spouse and children, a sense of being humiliated by the spouse, reduced satisfaction with marital relations, fear of divorce and disintegration of the family, being rejected by family members, causing harm to maternal and spouse identity (Abtan, Naderifar, Rahnama, Norisancholi, 2020).

Even though burn injury has psychosocial influences on the lives of the patients and their family, much of the work that has been done so far in Ethiopia concerns are medical detection and treatment. The researcher recognized that there was no study regarding on psychosocial problems and psychosocial support services in Ethiopia .So there is a research limitation, in addressing the multidimensional psychosocial support service of burn injury in the country in general and in the study area in particular. Hence, the researcher believes that investigating such issue in such particular group is timely and helpful so as to understand the service of psychosocial support for burn injury patients, and contributing to the psychosocial and medical intervention. This research is therefore, anticipated to fill such research gaps.

1.3 Research Question

1. What are the main causes of burn injuries?

2. What are psychological problems among burn injured patients?

3. What types of psycho-social support services are being provided for burn injured patients?

1.4 Objective

1.4.1 General Objective

The overall assessment of psychosocial support services in hospitalized burn inflicted patients.

1.4.2 Specific Objective

- To identify the main causes of burn injuries.
- To describe the psychological problems among burn injured patients.
- To assess the psychosocial support services are being provided for burn injured patients.

1.5 Significance of the Study

This study has explained about the cause, psychosocial problem and psychosocial support services for burn paients. Besides, it can be is used as a source of information for Yekatit 12 Hospital to evaluate its intervention mechanisms of the patients.

The study may provide some insight and serves as a supplementary source of information for those people who deal with the psychosocial support services for burn inflicted patients and who want to conduct detail study on the same topic and practitioners in the area as consideration of the holistic aspect burn.

On the other hand, since the study primarily conducted to assess the psychosocial support services for burn inflicted patients could be significant to enhance the awareness of the community about burn. It also helps to improve their attitude and knowledge toward psychosocial problems of burn.

In general, considering the shortage of researches that focuses on psychosocial support services for burn injury patients in Ethiopia. This study support for the burn care giving hospitals to improve their quality service has a vital importance for the country in providing basic considerate of patients affected by burn . And also contributes to the knowledge gap observed as a result of the scarce information on psychosocial problems of burn injury patients in Ethiopia. Besides to the academic circles, service providers including social workers may appropriate their services to be able to address the concern. Furthermore, researchers can use the findings as inputs for further studies.

1.6. Scope of the Study

Conceptually, the study is limited to indicating the psychosocial services in hospitalized burn inflicted patients. It summaries how the services provision look like and also the burn injury affects the patient's life in a multidimensional way. Geographically, the study is limited on Yekatit 12 hospital. Methodologically, the study relied on purposive sampling and the maximum number of respondents was decided at the point of data saturation.

1.7. Limitations of the Study

In conduct this study, the sample was drawn from the patients who were admitted in burn unit during data collection period. For this reason, making generalization is difficult about the burn injury patients. Furthermore, Socio cultural diversity of the patients was also the limitation of the study. Such as language barriers in understanding the patients with full context.

CHAPTER TWO: LITERATURE REVIEW

Burn is a thermal injury caused by biological, chemical, electrical and physical agents with local and systemic repercussions, these are the most severe form of trauma that has afflicted humanity since time immemorial and that over the years and the scientific revolution has improved the results in its treatment (Hettiararchys, Dziewulski, 2004).

The prevalence/epidemiology of burn injury varies from one part of the world to another and even in the same environment over a time period. It is a function of civilization, industrialization, culture and societal stability (Olaitan & Olaitan, 2005).

Burn injury is a major component of unintentional injuries worldwide. It is the leading cause of deaths from injury in some countries. In Egypt, 9% of deaths among married women were due to burns. In India, more than 10,000 burn-associated deaths and over one million moderate to severe burns occur each year. In a hospital in Zimbabwe, burns comprised8% of trauma admissions .A combined hospital and community based survey of burn injuries in rural southern Ethiopia estimated the lifetime incidence of burns among women of reproductive age to be 11%. Two retrospective analyses of pediatric inpatients showed that burns accounted for 0.8% and1.7% of all pediatric admissions. Burns were the third commonest unintentional injuries among children, next to firearms and falls and the second leading causes of death (Federal Ministry of Health, 2016).

Burns are also a leading cause of disability and disfigurement: fire-related burns alone are estimated to cause 10 million disability adjusted life years (DALYS) per annum. In Nepal, burns are the second most common form of child injury and cause 5% of all disability in the country. In India, over 1,000,000 people suffer moderate to severe burns each year. In Bangladesh, more

than 173,000 children are burnt every year. Many of these injuries and the disability they cause are entirely preventable. Estimates have indicated that ‘the provision of adequate burn care could reduce the time spent in hospital by 35% and the overall mortality rate by 30% (Federal Ministry of Health, 2016).

When we come to the setting in Ethiopia, as any other developing country, there is high susceptibility to burn injuries considering the presence of many risk factors. There are quite few studies done that help us to have some picture of burn injury in Ethiopia. One of these is the study is done in Mekele town, Tigray region the annual incidence of burn injuries was 1.2% (8/7309). Children less than five years old had the highest incidence 4.8% (36/710) among which 17 (48%) were boys and 19 (52%) were girls. All the burn injuries that occurred in the 10 to 14 year old children were seen among girls. There was no difference in the incidence of burn injuries between 15-59 old males (12/1655, 9.72%) and females (17/2373, 9.72%).However 14/16 domestic burn injuries (87.5%) and 9/11 (81.8%) work related burn injuries (Nega & Lindtjørn, 2002).

According to a retrospective study done in Attat Hospital over 7 years period (1983-1989) the cumulative incidence of burns in 16 communities (total population = 10,183) served by the hospital was found to be 5-11%. The study population possesses inadequate knowledge regarding burn prevention and burn first aid. Deleterious traditional compounds were used on 32% of burn patients in the villages (Courtright, Haile &Elaine Kohls, 1993).

Burns can result in significant long-term consequences which in the absence of a comprehensive and coordinated rehabilitation program can leave children scarred, physically and psychologically, for the rest of their lives. Most rehabilitation program seeks to prevent long term problems such as scarring, contractures and other physical problems that limit functioning.

However attention should also be paid to managing pain as well as psychological issues such as anxiety, post-traumatic stress, phobias and isolation (Esselman ,2007 and. Smith , Smith & Rainey,2006) The most common physical long-term consequences following a burn include hypertrophic scarring, extensive contractures, the formation of keloids and the need to amputate an extremity (Esselman, 2007*)*. Hypertrophic scarring in particular has been found to be one of the most significant long-term consequences of childhood burns, occurring in almost half of severe cases (Spurr, 1990). Keloid formation is relatively more common among children of African descent (Taylor*,* 2003).

2.1. History and Advancement of Burn Treatments

Burn treatments have been described since ancient times (Artz, 1970). Burn and their treatments are recognized in cave pictures which are more than 3500 years old. Documentation in the Egyptian papyrus Ebersof 1500 BC advocated a 5-day treatment regimen using a mixture of cattle dung, bees wax and barley porridge soaked in balm for the topical treatment of burn. In 600 BC, the Chinese treated burn wounds with extracts from tea leaves. Nearly 100 years later, Hippocrates described the use of porcine skin mixed with a resin of bitumen impregnate in bulky dressings which were alternated with warm vinegar soaks augmented with tanning solutions made from oak bark. A Greek philosopher celsusre commended a lotion with wine and myrrh for burns in the first century AD (Majno, 1975).

In the middle of the 16th century, Ambroise Paré a French surgeon treated burns with onions and probably was the first to describe early burn wound excision. In the early 17th century, Guilhelmus Fabricius Hildanus father of German surgery discussed the pathophysiology of burns and made unique contributions to the treatment of subsequent cicatricle contractures. In 1797, Edward Kentish described pressure dressings as a means to relieve burn pain and blisters.

He was also the first to recognize gastric and duodenal ulceration as a complication of severe burn (Curling, 1842).The recognition of the importance of burn surface area and skin grafting and clarified diagnostic and surgical understanding of burn during and after World War I, agreement was reached that the best management of deep burn wounds included excision, skin grafting and pain management. However, despite a centuries-long history of treatments for burns, many patients still died of shock and infection mainly because the fundamental understanding of the pathophysiological effects of burns was not clear (Ribeiro, Jacobsen and Mathers, 2008).

Major burn injury is one of the most severe traumas a person can experience, with devastating effects on the skin, the largest organ in the body. Normal skin protects us from invasive infection by microorganisms, prevents fluid losses, and helps regulate body temperature. These protective things are destroyed after burn injury, and without proper treatment the natural prognosis for extensive burns is reduced because of burn shock, multi-organ failure and sepsis. Viewed globally, burn injury is one of the leading causes of trauma death and one of thirty leading causes worldwide of loss of life years due to premature mortality and years lived with disability (Morten, 2003). The severity of a burn injury depends on burn-specific as well as general factors, such as body surface area affected, depth of injury, age of the victim, associated injuries or diseases, and to a certain extent also on location of injury.Burn-specific factors affecting morbidity and mortality are best described through the surface area of the burn measured as the percentage of the total body surface area (TBSA) burned and the depth of the burn with superficial burn being limited to the epidermal or superficial dermal parts of the skin. Deeper injuries penetrate further down to the deep dermal skin layers or through all skin

layers down into subcutaneous tissue as full thickness or sub-dermal injuries. Muscular or skeletal structures can also be damaged as a result of severe burn injury (Morten, 2003).

2.2. Causes of Burn Injury

Burn is a major public health problem worldwide associated with significant morbidity and mortality (WHO, 2008). It occurs in any age group with majority among children and old age might range in severity from very minor requiring no treatment to extremely severe requiring highest level of intensive treatment. There are several causes of burns, ranging from direct heat (including flames and hot liquids) to chemical or electrical injury .Presentations differ depending on the cause, and severity was dependent on both contact time and the temperature to which the skin has been exposed (Benson, Dickson, Boyce, 2006).

Cause of burn classified as the following:

Thermal burn: They are caused by flashed light, flame, blazing, or contact with a hot surface which are explosions of flammable liquids, natural gas, propane, gasoline results into flash burns. The Intense heating involved in flash burns that lasts for short period. In addition to this flame burns are usually caused by prolonged exposure to intense heat, frequently associated with clothing ignited by stoves and heaters, improper use of flammable liquids, automobile accidents and house fires. The other type under thermal burn is Scalds involve hot liquids like water, oil, grease or tar. A deep burn can be caused by water at 140 degrees centigrade in 3 seconds, but same injury will be resulted in just one second at 156 degrees centigrade. Next contact burns are caused by hot coals, plastics, metals or glass which was painful and deep. (Masood, et., al , 2016).

Chemical burn: They are caused by exposure to reactive chemical substances such as strong acids or alkalis (Gnaneswaran, Perera, Perera & Sawhney, 2015). Chemical burns are produced when the skin is exposed to a corrosive material, such as an acidic or alkaline substance. Exposure to a variety of common substances can lead to an injury. Corrosive substances that have capacity to cause burns can range from non-lethal capsaicin-based sprays used by law enforcement to commonly available chemicals found in households, industrial settings and construction work sites. One critical aspect to always consider when responding to a patient with a known or suspected chemical burn is the risk of exposure to the responder by the same causative agent (Kearns, et.al, 2014).

Electrical burn: Passage of electrical current from an electrical outlet or appliance through the body may results into the electrical burn (Buja, Arifi, & Hoxha 2010). Mortality is somehow higher among high voltage electrical injuries and lightening. Most of complications of them were morbid in kidney, heart, extremities (including amputations) and nervous systems. Long-term psychological problems were reported with greater incidence rates in high voltage injuries. Psychological and posttraumatic stress disorders were also reported (Latifi, & Karimi, 2017)

Radiological burns: Alpha, beta or gamma radiations are responsible for radiological burn. To stop the injury process there is a need of decontamination procedure for the people exposed to these types of radiation. (Masood, et., al , 2016). Accidental exposure to radiation leading to injury and illness occurs notwithstanding safety devices and protocols used for protection. The medical management of radiation casualties is a major concern. Radiation effects are principally thermal, similar to electrical burn injuries, but with some unique systemic expression. The pathological effects of radiation to the skin are known; it is often difficult to

assess the level of severity, quickly and with accuracy, because of the delay between exposure and the appearance of lesions and obscured lesions. The severity depends mainly on the nature of the radiation. High-energy penetrating radiation causes more irreversible damage than low-energy radiation, which penetrates tissues less than the former (Pandey and Rajan, 2004).

2.3. Classification of Burn

First-degree burns: The epidermis is involved in first degree burns which are like sun burn, erythematous and sore. The minor thermal injury or exposure to severe ultraviolet radiation may cause first degree burns. Their healing time is 5 to 10 days (Rizwan, Zafeer , Rehan , Muhammad and Irfan, 2016).

Second-degree burns: It is further divided into two categories

A superficial partial thickness burn: They usually invade into the superficial papillary dermis. They are characterized with reddish blisters. When pressure is applied, the blisters may shrink and their healing time is 2-3 weeks.

Deep partial thickness burns: They penetrate the reticular dermis and are yellow or white in color, rough in nature and are very painful. They require more than 3 weeks for complete healing (Rizwan, Zafeer, Rehan, Muhammad and Irfan, 2016).

Third-degree burns: They damage both inner and outer layers of the skin, that’s why this is the most severe type of burns. They are white in color and usually non-achy. Only a small number of such type of burns heal their own which is a long-time process Rizwan, Zafeer , Rehan , Muhammad and Irfan, 2016).

Fourth degree burn: They invade into muscles, ligaments, tendons, nerves, blood vessels, and bones, through the skin. Severe medical emergency treatment is required for this kind of burns. They are black and burned (Vadukul, 2012).

2.4. Psychosocial Problems of Burn Injured Patients

Today, although recent care advances lead to saving lives of burn patients, many of these patients still suffer from burn-related complications (Blakeney, Rosenberg, Rosenberg, & Faber, 2008). Considering numerous burn complications, including scarring, deformity, and dysfunction, the recovery process becomes challenging and prolonged (Coffey, Everett, Miller and Brown, 2011).

Evidence suggests that burns can have the most significant impact on patients' quality of life and impair their physical, mental, social and spiritual welfare (Mogharab , Sabzekar , Sharifzadeh & Azani , 2014), while burn victims must return to their former roles and responsibilities despite all the devastating injuries (Blakeney, Rosenberg, Rosenberg, & Faber, 2008) . Meanwhile, considering the sudden changes in life following the burn injury, victims and their family members do not have enough time to adapt to the new circumstances (Graneheim, Lundman, 2004). Overall, considering the high number of burn patients, the incidence of complications and subsequent mortality, and the high costs imposed to the healthcare system, on the one hand, few studies focusing on lived experiences of burn survivors (Blakeney, Rosenberg, Rosenberg, & Faber, 2008), on the other hand, as nurses care for a large number of patients simultaneously in the burn departments and nursing care is provided regardless of what patients are experiencing, however, the uncomfortable and different experiences of these patients require a personal care plan (Pishnamazi, Asiabar , Karimavi , Zaeri , Zadeh 2012).

The effect of applying organizational culture improvement model of patient education on anxiety and satisfaction of burned hospitalized patients' clinical trial psychiatric problems are very common in burn survivors. A range of psychological problems such as anxiety, depression, low self-esteem and trauma-related disorders can occur in these patients. Severity of burns, total body surface area involved, site of burns and burn depth all have a role in the development of psychiatric problems. Social and environmental factors may also play a part in the genesis of psychiatric sequel (Shulman, 2016).

When evaluating any burn survivors ,health care providers must be sensitive to the patients' possible experience with post-traumatic stress disorder (PTDS).PTDS is character used by three symptom clusters:(1) re-experiencing intrusive ,distressing thoughts ,dreams ,or images of the traumatic events(2)avoidance of trauma related thoughts, feelings and situations; and (3) hyper arousal, i.e. persistent sleep disturbance, easy startle ,increased tension and irritability (Dalgeish ,2004). Between 20-46% of burn survivors meet criteria for PTDS in the first post – burn year, and almost 50-63%of survivors meet criteria for at least one of the symptom clusters. On the other hand post traumatic distress has been positively related to more intense pain among hospitalized burn patients (Taal and Faber, 1997).

Psychological factors reported to affect quality of life are post-trauma distress, sleep problems, and body image. After 2 months discharge, post-traumatic distress was found to be related to significant impairments in physical and also psychosocial adjustment, even taking into account pre-burn physical functioning. Sleep disturbances were reported in 73% of burn patients at 1week after discharge, and to a smaller extent at 1 year post-burn in another study (Masoodi, et al., 2013).Pain and consumption of pain medication were positively associated with the total number of sleep problems (Brad, et al., 2002).

Burn patients had not been able to forget those hard times full of pain, panic, stress and sadness, feeling of being roasted while you are alive and being burnt down inch by inch although some time had passed since the incidence. Some of them blamed themselves for remembering the moment of neglect that led to the accident (Abtan, Naderifar, Rahnama & Noorisanchooli, 2020).

The psychosocial difficulties encountered by patients after a burn Injury may include:

- Problems managing pain, itching and discomfort and complications with post-traumatic stress including anxiety, nightmares, flashbacks, avoidance, emotional numbing.
- Mental health difficulties such as delirium, depression, anxiety.
- Grief and loss issues.
- Functional problems of mobility and handiness which inhibit/delay return to work or school.
- Problems about medical choices and decisions.
- Difficulties coping with social reintegration.
- Social support problems e.g. family, partner, peer isolation etc.

Moreover, patients presenting with burns injuries have higher rates of pre-morbid psychosocial difficulties related to the general population including substance abuse, self-harm, psychosis, relationship difficulties, thoughtless risk taking and despair (Patterson, et., al 2003).

2.5. Psychosocial Support Services

Burns injuries are commonly life-threatening traumas which contain sever pain, discomfort, hospitalization, operations, itching, pressure and physical limitations. Those issues have significant implications for the affected individual and their families. Furthermore, burn care treatment can be prolonged and painful requiring a variety of psychological and social resources for optimal recovery (Wood, 2009).

Noticeable challenges inherent in long-term psychosocial rehabilitation following a major trauma are those concomitants with adjusting social functioning and alteration. Social challenges may include struggle coping with the behavior of others or with one's own behavior in social conditions and may involve social inhibition and prime social skills. Among burn survivors, factors for instance social contribution and perceived social support account for a considerable amount of variance in psychosocial adjustment (Waqas. et al, 2018).

According to Texas EMS Trauma & Acute Care Foundation Trauma Division (TETAF) psychological distress occurs in most survivors of severe burn injuries. Although the hospital may be limited in providing professional support due to the short time the patient remains in the emergency center, the caregiver should remain aware of the patient's psychosocial status and provide support as indicated (TETAF, 2016).

Samples of burn patients treated in the burn unit at Uppsala University Hospital at follow-up, 71 of the 86 former patients injured at work (83 %) were again working of the remaining patients, nine individuals (10 %) were on sick leave or had a disability pension, and six (7 %) were unemployed of those at work, 21 patients (30%) reported having a better job than before the burn accident, 44 patients (62%) had the same job as before the burn injury, and six patients (8%) reported that because of burn-related factors they had changed to a less skilled job

than before the accident(Dyster J., 2006). Eight psychosocial specialists (seven women), currently working in UK burn care interviews, specialists described the psychosocial support they provided to patients and their families, in relation to many different psychosocial concerns for burn patients themselves (children, young people and adults), common problems related to anxieties about treatment (e.g. dressing changes, surgery) and concerns about social situations, availability of social support and coming to terms with any changes in their appearance (e.g. scarring, amputation) interviewees reported providing support for anxiety, depression, post-traumatic stress disorder or trauma symptoms relating to the event which led to their burn injury and, in some cases bereavement(Guest, Griffiths and Diana, 2018).

One of the fundamental experiences of the therapists was addressing the psychological and emotional challenges of the patient as therapists felt that patients were still coming to terms with the trauma of the burn incident. As a result, patients appeared to be inclined to mood changes, depression and an overwhelming sense of fear of survival or of death. Patients seemed to be so traumatized by the event that this affected their willingness to participate and engage in therapy (Dunpath, Chetty, & Reyden, 2016). Treatment plans and programs must be based on an assumption of life beyond the hospital; however death also occurs on the burn unit and psychosocial treatment planning includes plans for assisting patients in living to the cessation of life. As part of such a plan, the patient's family must be aided in preparing for and enduring bereavement. In this event, supporting and enhancing whatever coping strengths the family manifests is the primary task for psychotherapy. Most families initially deny the possibility of death, appearing not to hear an unwanted prognosis. Staff can allow the family to maintain hope while subtly preparing them with honest statements which pose death as an outcome which is possible to accept. Comforting the bereft and helping them to care for themselves, physically and

spiritually, are essential elements of a plan that facilitates the family's ability to participate in the process.

2.7. Theoretical Framework

Engel (1977) offered an entirely new way to conceptualize human health and illness the Bio-Psycho-Social model (Kaplan and Coogan, 2004).

The Bio-Psycho-Social model is a comprehensive, integrative, and elegant model that allows us to address all major areas of the presenting issue across three spheres: physical, psychological, and sociocultural. It allows (and actually encourages) us to holistically examine the interactive and reciprocal effects of environment, genetics, and behavior (Stevens & Smith, 2005).

Engel provides concrete reasons for which he is of opinion that new approach is needed in modern medicine, like for instance, that patients with the same diagnosis and laboratory tests can present with completely different course of disease for different psychosocial characteristics; that for proper diagnosis it is necessary to extensively interview the patient during which important, not only biomedical, information can be obtained for correct diagnosis and treatment method; that psychosocial factors often determine whether the patients considers her/himself sick or in need for medical assistance; that psychosocial factors are interrelated with the biological ones to the extent that they may influence the course and outcome of treatment; that emotional relations between patients and physicians can affect the speed of recovery (Havelka, M., Lucanin, J., & Lucanin, D., 2009).

The meaning of illness and all the cognates to do with abnormality becomes an issue in conditions of uncertainty and dispute as to whether such and such a condition is an illness or not, in circumstances when it seems that no further observation or laboratory test would settle the

matter clearly one way or the other. This uncertainty arises when criteria that normally go together, in the paradigm or prototypical kind of case, fall apart. Three key features of illness typically go together :the person complains of distress or pain; second, they are unable to do things they need to do, there is incapacity or activity limitation, loss of agency; and third, there is the assumption that these things are because something is not well with the person's body or mind. This last assumption implies that medical/psychological expertise is required, hopefully, to reduce the harm (the distress/pain and incapacity) and not create more. When these features and assumptions are all present and correct, there are conditions for certainty—but insofar as they cleave apart, some present, some absent, or dubious, the position becomes ambiguous; attribution of illness and the closely linked perceived need for healthcare professional attention, become uncertain. With uncertainty comes controversy .Examples of general kinds of case where attribution of illness and/or need for medical attention is commonly contested include: some mental health diagnoses, especially those associated with non-voluntary admissions; 'medically unexplained' conditions; alleged over treating of conditions that are regarded rather as 'normal', self-limiting, or less harmful compared with harms from treating; stigmatizing difference and diversity, and lifestyle choices even if they carry raised risk of illness (Bolton D, Gillett G. ,2019) .

Activity limitation is the core behavioral feature of illness or injury, pain and distress are their subjectively experienced aspects. But even these subjective experiences turn out to be thoroughly bio psychosocial, whichever way one approaches them: by philosophical analysis of 'subjective experience', or in terms of neuropsychological models of causal pathways, or behavioral models of interpersonal pain signaling functions (Bolton D, Gillett G. ,2019).

CHAPTER THREE: RESEARCH METHODS

3.1 Research Design

Burns and Grove (2003, P. 195) define a research design as a blue print for conducting a study with maximum control over factor that may interfere with the validity of the findings. This research is qualitative in its nature aimed to assess the psychosocial service of burn injury patients admitted at Yekatit 12 Hospital.

This research is qualitative research that relies on qualitative data. The data were collected through qualitative techniques such as in-depth interview, key informant interview and document analysis. Qualitative research methods provide a broad picture when used to collect data on health, risk, illness, and health-seeking behavior (Kielmann, Cataldo and Seeley, 2012).

The study relied on case study research because it is grounded in deep and varied sources of information. It employs quotes of key participants, stories, prose composed from interviews, and other literary techniques to create mental images that bring to life the complexity of the many variables inherent in the phenomenon being studied (Hancock and Algozzine,2006).Case study research involves the study of an issue explored through one or more cases within a bounded system (Creswell,2007).Among the different types of case studies for this research, single case with embedded units was conducted where a case refers to patients inflicted with burn injury.

From the type of case study for this research exploratory case study is used when there is no pre-determined outcome. It also appropriate for when you wish to gain an extensive and in-depth description of a social phenomenon. The exploratory case study is used to explore presumed causal links that are too complex for a survey or experiment (Yin, 2014).

3.2. Description of Study Area

The study was conducted at Yekatit 12 hospital. The Hospital is found in Addis Ababa Arada sub-city. The hospital provides service for population of approximately 4 million people. It has nine departments and six units and has 265 beds. And it is the first burn unit in Ethiopia inaugurated in 2002.It was the main referral hospital for treatment of severe burns for many years. The unit had equipped with a total number of 19 beds, including 7 beds for children and 12 beds for adults.

3.3. Study Participants

The study participants are burn injury patients who are admitted in Yekatit 12 Hospital burn unit and the health care professionals of the burn unit of the hospital. The professionals are selected based on their service in burn unit and the patients at the unit are selected based on inclusion criteria which include;

- Burn patients less than 18 years of old.
- Admitted burn injury patients.
- The willingness of the participant's to take part in the study

3.4. Sampling Method

Since this study is qualitative, it used non-probability sampling method. Among the types of non-probability sampling methods, the study utilized purposive sampling. The researcher chose the sample "because they have particular features or characteristics which will enable detailed exploration and understanding of the central themes and puzzles which the researcher wishes to study. These may be socio-demographic characteristics or may relate to specific

experiences, behaviors & roles" (Ritchie & Lewis, 2003, p.78). The reason why the researcher chose purposive sampling is because the method is flexible to set criteria for getting the type of research participant that the study requires. In addition to that, the method is also flexible in deciding the maximum number of participants. As soon as data saturates, the researcher can stop the data collection process. Data saturation is a point in the data collection process were collecting additional information is no longer worth to the study and unable to gather new data that differ from the existing ones (Fusch, Patricia & Ness, Lawrence, 2015).

The main objective of this study is to assess the psychosocial support services in hospitalized burn patients at Yekatit 12 Hospital. Therefore, the study participants are patients and professionals of the unit. In aggregate terms, 16 participants were part of the data collection process; 13 patients and 3 professionals.

3.5. Data collection Methods

The study used both primary sources of data collected using in-depth interview and key informant interview. It was guided through open-ended questions which were conducted with patients and the professionals, respectively. This helped the researcher to probe and the respondents to give sufficient explanation on the subject matter. The researcher first prepared the guiding questions in English. Then, the interview guiding questions were translated into Amharic and approved by three language experts regarding the quality of the translation. The researcher has conducted this to make sure that the original essences of the questions are not missed while translating the questions. Then, the interviews were conducted in Amharic.

3.5.1 In-depth Interview

The interview guides was composed of open ended questions as it is an in depth interview and it was provided for burn injury inpatients from both sexes .Probing questions were also asked during the interview process to clarify answers. They were asked about the cause of their burn injury, their psychological reaction for their injury and the psychosocial services which they got from the hospital.

3.5.2. Key informant interview

The researcher made the interview with key informants, and all of them were health care providers working at Yekatit 12 hospital. One of them was head nurse of burn unit and the other two participants were also nurses on administrator position of the nursing department and worked in burn unit in previous time. Unstructured questions were used as a method of data collection to assess the psychosocial service of burn injury patients and how the services were provided. This helped the researcher to triangulate data obtained through in-depth interview with burn injury patients.

3.6. Data Collection Procedures

The researcher obtained given an official letter from the School of Social Work and submitted to the hospital to get approval. After the ethical approval, the researcher identified potential respondents of the study with the help of the professionals of the unit and conducted the interview.

The time and place to conduct both the in-depth interview and key informant interview was selected by the respondents. The time was at the respondent’s preference and the place was convenient to make the interview. The researcher gained both oral and written consent from the

participants before the interview session and the maximum time of each interview was 37 minutes.

3.7. Data Analysis

Data analysis is a mechanism for reducing and organizing data to produce findings that require interpretation by the researcher (Burns & Grove, 2003). Data analysis consists of preparing and organizing the data for analysis, reducing the data into themes through a process of coding and condensing the codes, and finally representing the data in figures, tables, or a discussion (Creswell, 2007, P. 164). Accordingly, the steps in the data analysis process of this study are the following.

The first step in data analysis is pre-coding the raw data. I conducted the entire interview with Amharic language. After data collection I transcribed the data from field notes in to English language every day. In addition, tape recorded interview of participants are transcribed in to text format originally to Amharic and back translated to English. Then, I read and re-read the transcripts closely until understanding of the main points are achieved. According to Boyatzis (1998) pre-coding is done by circling, highlighting, bolding, underlining, or coloring rich or significant participant quotes or passages that strike the researcher. After the pre-coding process coding followed. Coding is reducing the data into meaningful segments and assigning names for the segments (Creswell, 2007). In this study the codes after the interview were transcribed both specific topics or words and recurrent issues in the text were coded and then codes also emerged.

The codes transformed in to categorical labels. Categorizing in qualitative research means, searching for patterns or grouping exactly alike, very much alike data or data which have something in common within coded data (Saldana, 2008).Categorizing transcribed data helps to

sort out texts into various segments, which make the data to be manageable. A category contains related codes explored from the analysis of the data. In this study the coded data were categorized depending on the similarity and relationship of codes under different headings and condensed into categories.

According to Saldana (2008, p.13), “A theme is an outcome of coding, categorization, and analytic reflection, not something that is in itself coded.” In this study, themes were created from the categories by extracting common and significant linkages. After refining themes, interpretation followed to look for meanings. Interpretation deals with less obvious and more abstract dimensions of the data, the act of “reading in to“and “extracting meaning from” (Padgett, 2008, p. 171). After all the processes the final report was prepared. I employed pseudonyms instead of code numbers while presenting participant‘s story to maintain their anonymity.

3.8 Quality Assurance

Qualitative researchers have agreed to ensure that data trustworthiness, whether the data has obtained from direct observations, focus groups, or interviews, is evidenced by transferability, dependability, conformability and credibility (Cypress and Brigitte, 2017). Transferability refers to evidence supporting findings to other contexts across different participants, groups, situations, and so forth and dependability is the claim that similar findings would be obtained if the study were repeated while conformability refers to objectivity /neutrality/ and the control of researcher bias. On the other hand credibility refers to the believability of the findings and is enhanced by evidence. In this study, the quality assurance criterion (transferability, dependability, conformability and credibility) ensured by the following strategies. The researcher spent longer time in the field to collect data, triangulating the data

(using the primary and secondary data sources), then using questions, maintaining data coherence during analysis and evaluating the research by individual that is a professional and familiar to the topic.

3.9 Ethical Considerations

The study was carried through the code of Ethics of Social Work. The researcher received a letter of support from Addis Ababa University, School of Social Work before started data collection process. In addition, the researcher developed a statement of an informed consent for the patients to develop trust and confidentiality and asked for their consent. The consent form was prepared in English and translated into Amharic before presented for participants. The researcher explained the purpose of the study for the participants clearly as the study output will be for educational purpose. The participants were informed as their names would not be attached to the information they provided. They were communicated with full right to stop the interviewer at any time if they do not understand what the interviewer is asking or if they do not feel comfortable, they can skip questions. In other words, the issue of willingness and right to privacy were secured. Besides, the researcher informed participants as their cooperation were very useful for the accomplishment of the study.

CHAPTER FOUR: FINDINGS OF THE STUDY

4.1 Demographic characteristics of participants

As indicated in the objectives of the study, the first characteristics of the research participants' examined in the study were sex, age, marital status, level of education ,Duration of hospital stay and residence based on predetermined inclusion criteria.

The below table explains the details of each of the participants who participate in interview

No	Pseudo Name	Age	Sex	Marital Status	Education Level	Duration of hospital stay	Residence
1	Kemale	40	M	Married	Grade 8	2 month	Gambela
2	Aschalew	22	M	Single	Grade 6	3 month	Ataye
3	Alemu	18	M	Single	Grade 9	$2^{1/2}$ month	Addis Ababa
4	Kassa	23	M	Married	Grade 11	3 month	Addis Ababa
5	Munira	22	F	Married	Grade 10	2 month	Bale
6	Girma	62	M	Married	Basic education	2 month	Addis Ababa
7	Jemile	37	M	Married	Grade 6	3 month	Asebe Teferi
8	Deriba	27	M	Married	Grade 8	$2^{1/2}$ month	Addis Ababa
9	Almaz	65	F	Married	Illiterate	2 month	Addis Ababa
10	Ayalneshe	40	F	Single	Illiterate	3 month	Fenote selam
11	Tadesse	50	M	Married	Basic education	3 month	Alamata
12	Alemitu	60	F	Widowed	Illitrate	3 month	Fiche wenoda
13	Zerihune	26	M	Married	Grade 7	3 month	Adama

Table 1: Characteristics of Participants

No	Name	Sex	Marital status	Position at the unit	Year of service
1	Kelemua	F	Married	Head nurse of burn unit	20
2	Azeb	F	Married	Matron	16
3	Mesfine	M	Married	Assistant Matron	9

Table 2: Characteristics of key informants

4.2. The causes of Burn Injury

The cause that result burn injury can be summarized in five categories based on the information obtained from the participant of the study .These are: Gasoline explosion, electric burn, machine explosion, house fire and scald burn.

Gasoline explosion

kemale, Munira and deriba were exposed for burn injury due to explosion of gasoline .But the circumstance were different on each participant .The incident happened for kemale said, " *me and my friend were pumping fuel for the generator. Then next to us my wife put a flamed charcoal to make our meal and she didn't notice what we were doing. However, the explosion occurred and I injured severely and it affected my both legs but my friend's accident was mild."*

Munira also said, *"I injured when I was preparing to cook my family dinner .In the middle of the preparation I want water to add on the food and there was a plastic bottle put inside the cabinet and I took out and pour in to the food but the liquid was not water, it was gasoline which was put by my husband for another purpose. The burn injury affected my face, both hands and chest."*

Deriba's accident happened when he was on construction area. He said, "*the time was rainy and all of our colleagues on construction site were being together in a security guard's*

room until the rain halts .Me and one of his friend napped on security guard's bed .Then others also tried the room to warm through burning a wood .But the wood didn't easily flammable. So they pour a gasoline which was put on a plastic bottle. They considered a gasoline as kerosene but it flamed quickly. Then everyone in that room escaped but me and my didn't wake up early .The fire also flamed every corner of the room then we woke up when our friends throwing a stone on the roof .But the situation was so worsen and we didn't able to get out of the room quickly. Both of us wounded but the injury was on my legs, hand and face severely affected."

Electric burn

Aschalew, Alemu, Jemile and Zerihune exposed for injury through electric burn . Aschalew's injury occurred when he and his relatives were going to a funeral ceremony. He said, *"I was caring mesobe filled with injera besides in the middle of our journey the mesobe trapped by electric wire and I injured. So I lost my left hand and both legs inflamed*."

Alemu was a carpenter and the injury occurred when he was changing roofing of someone's house. He said, *"I brought a wood for the roofing and during crossing the line an electric wire was broken. Then it affected my both hands and chest but my right hand was so affected than the left."* Jemile and Zerihune's job was similar to Alemu .But the injury on Jemile affected both his legs and his left leg become paralyzed. Zerihune's injury was on his right shoulder and left leg.

Machine explosion

Kassa was construction worker. He said," *I injured during working through vibrator machine but it explodes. It affected my both hands and the burn extends up to my bones."*

House fire

Girma and Tadesse were exposed for burn as a result of an omitted glowing candle ignition created house fire. Girma said," *the injury occurred when my son's bedroom suddenly burn .Then I tried to rescuing him from the room and a plastic celling melted and dropped on my body. The burn affected my hand and back.*" Tadess's injury occurred 30 years ago when he was young. He said,"*my house suddenly burned due to omitted glowing candle ignition and the local community around my house helped me tried to stop the fire. But the moment of their trial a fired wood from the top of the roof dumped and hit my shoulder. Then the injury affected my left side and stick to on left hand."*

Scald burn

Almaz, Ayalneshe and Alemitu injury were as a result of scald burn. Almaz was diabetes mellitus patient and her leg inflamed due to hot water and the wound didn't heal easily. Ayalneshe said, *my injury occurred when she was 6 month old baby .my mother was baking injera and making sauce side by side and sit me on one adjacent to the wall .Then she continued her work but I suddenly rolling and touched the sauce container and it spilled out and injured my right hand and my side . Besides the injury form a contracture and inhibit my hand movement. "*Alemitu also injured through boiled coffee overturned on her body. Then it affected her both legs and she didn't able to move.

4.3. Psychological Problems of Patients after Burn Injury

The participants of the study revealed that they are struggling mainly with stress, frustration, anger, unhappiness, felling of dependency, anxiety, fear and depression as a result of being injured through burn were the most common. Perhaps the most difficult behavior for

patient, family, and staff is the patient's expressions of anger. Patients, of course, have many reasons to be angry, and they need to express that anger in order to define and direct it adaptively; however, there are significant limitations upon the availability of situations in which they can express anger. Patients have almost no privacy, or can they relieve tension through physical activities such as running. Typically, family members and patient care staff, having devoted much time and energy to the patient, are prone to perceive the patient's angry behavior as a personal and unjust attack by an ungrateful patient.

The research participant Kemale described that:

I am a 40 year's old and married and have three children. I was a merchant and the only person that generate income for my family .Due to the burn injury the accident affected my both thigh and legs and it inhibits my movements plus the only position which I sleep is my back .I had a frustration on my body being disable because my legs didn't move.

Another participant also described:

I am a 62 year old and married and have three children .The injury affected my emotion badly and most of the time I cried and asked God why those things happened on me and my family .I am an old person and my injury couldn't heal easily because I had a hypertension and my Doctors told me if my blood pressure able not decrease, my injured hand and back couldn't to be operated. My son also injured due to the burn accident and the two of us admitted this hospital in one room and my wife also stayed here from the very beginning to help me and my son. And she didn't taking care of our daughters who are a 12 and 14 years old. I had a fear on if some strangers know stayed the night alone, they might attack them those overlapping problems stressed me a lot.

Deriba also explained his feeling:

I am a 27 year old married person. I had a depression due to the burn injury because every morning I took hydrotherapy .During the procedure started it's painful and the nurses also touching my leg to clean the would at that moment I felt horrific .The doctors also ordered me to walk and it's more challenging for me to do such things and I had distress . On the other hand my brother resigned from his work to taking care of me. And no one support us financially, so I felt been a problem for him.

Almaz also described:

I am a 65 year old and married and have seven children .The burn injury affected my leg and it didn't heal. Doctors told me the diabetes that I have prevented the wound from healing and it worried me a lot. They made a skin graft for my leg repeatedly but the wound didn't dry and created a lesion. I frustrated a lot because my injured leg condition becomes worsened. I lost my hope , I saw many individuals who had diabetes and wounded their legs become amputated .when I remember such kind of things I will prefer to die .So I don't want to be a burden on my kids if my legs don't heal.

Tadesse explained his emotions:

I am 50 years old married and have three children. I had a burn 30 years ago, and the injury was on my left side and stuck to my left arm. My injuries were not easily cured, and I had one hand stuck to my side. As a result, I divorced my wife. My life was marred by loneliness and disability. But my family was close, and I was able to recover a little from the grief I was experiencing. Then, a few years later, I married my current wife. I also hired Mother Theresa

charity Wolo branch. We are also raising children. However, I came here when people told me that I could come to the hospital with my disability and be cured.

4.4. Burn and Its Psychological Effect

The consequence that burn injury will result in the patient's life is a psychosocial problem. The respondents of this study disclosed that the injury affects their psychological and social life. The psychological reactions of the participants can be summarized as anger, unhappiness, sadness, self-blaming, depression and post-traumatic stress disorder.

There are patients who feel angry when they think that they become disabled due to burn injury. The respondent's experienced different emotions after the injury.

Alemu said;

> "After the accident, I felt isolated because I had no visitor but my brother. My friends used to work together but when I had an accident they never came to visit me. I also planned to do in my life many things including marriage but I am unable to do that because of this injury. I assumed when I finished my contract, it was a job I thought would be better paid, but I don't think my injuries will make me work anymore. I am afraid that the injury to my hands will make me dependent .I was active and visionary person however I become desperate" (IDI Alemu).

Kassa also explained the feeling as;

> "I was very worried about how I would be able to do my job after this injury. I'm worried about a lot of things right now because I'm the one who brought the money to our house and we live on rent. I blame myself for being a patient of such injury because the cause of

the injury was machine explosion. I regret that if I had been careful, I would not have been harmed "(IDI Kassa).

Munira a married woman who is rearing her two year old baby with her husband;

"I don't want to remember the accident and my husband was injured in the fire. May Allah help us and save our son. My husband was hurt to save me. Only my mother is here to take care of me. Our home was in Bale Ginir, and my whole family was there. My mother is helping to take care of me. I can't move or eat on my own. My hands are so hurt I can't even open my mouth because of the burn on my face. When I speak, I feel a tingling sensation in my lips. I'm very worried about whether my son will be scared when he sees me "(IDI Munira).

Girma explained his situation by saying;

"I don't have a hope and couldn't run the usual life that I used to have since I have been told that I am injured through burn. I couldn't concentrate for thinking about my future. I suddenly get depressed and become hopeless. I complain a lot about life. I feel worried when I think about my families future and my son's injury and my condition . I over consider about the burn injury and at the end got a headache and it increase my blood pressure" (IDI - Girma).

Jemile also explained his feeling. He said;

"All of a sudden, I become distressing, angry and depressed when I think about the injury happened on me. I lose hope in everything and because it affect me being dependent. I become impatient for anything. I complained everything. I don't have any option to cover my expenses. My family also living in rental house and they couldn't have to pay, I was

the one who cover for all costs. And now due to the injury I couldn’t move my body .All things become undesirably reversed” (IDI - Jemile).

Deriba also said;

“I complained by saying why I am being disable. I complained God what my sin is for being exposed for such injury. My siblings stayed with me and didn’t able to go to work. I disturbed their life because of my injury. I over thinking about my family’s future regarding on how to be able to cover our expense .My kids also sow my healthy physical appearance and how they accepting my situation after all things passed. So I become dependent on them both physically and financially “(IDI - Deriba).

Most of the patients experience several types of psychological disorders as a result of the burn injury. Their experience starts when they inflicted with burn. Some of them overcome the situation and plan to start again their normal life. But most of them will remain with their psychological problems.

The patients also experience difficulties in their social and personal life. One example; the patients are unable to communicate physically with their families and relatives because of the restriction of entrance in burn unit .They get permission for only one attendant due to protect them for infection but patients had curious to see their family as other units. Therefore the injury made them feel isolated and their pain was unique and unseen by anyone.

Almaz said;

“My children didn’t see me due to the restriction and I missed them a lot .In addition to that only one person is allowed to stay with me since I came here. It is very difficult for my son to get help from others because they restrict us don't let anyone in so it's hard.

It’s difficult to move my body through myself .Only my son is supporting me because of the repeated operation on my leg “(IDI Almaz).

Tadesse also said;

“I lost my marriage due to my injury. My wife left me saying I don't want to live with you anymore and I lived alone for 20 years with disability .But next to God my brothers were helping me to get out of those difficult situations. And now I came here for skin graft surgery and treatment hoping that the Doctors detach my hand from my side .Then if it’s successfully complete, I would become a full-fledged healthy person” (IDI - Tadesse).

Alemitu said that;

“I couldn’t move my legs and walk because of the burn injury. How can I being dependent on my children at this age? I wish God would relieve me and give me rest as my husband. I’m scarring on thinking about my future life “(IDI- Alemitu).

As it is clearly explained in the above sub-theme, burn injury affected the patients’ physical, psychological and social life. The participants explained several issues and concerns regarding the effects of the burn injury. These issues are also discussed with the KII sessions.

KII-2 presents the problems as follows;

“The burn injury highly affects the patient’s social, spiritual, financial and physical life. The most common psychological problems faced by burn injury we observed here is patient’s pain, anxiety, depression, post-traumatic stress disorder, concern about bodily disfigurement, social isolation and financial burden due to the prolonged duration of hospitalization and treatment required. Once they injured it affected them and their

family social life. There attendants stayed here until their discharge .And most of them come from out of Addis Ababa then their relatives couldn't come visit them easily. Their social life will be interrupted because they are admitted for long time until they recover from their wound .The medical procedure take long time because their wound heal depend on the size and depth of the burn injury . Most of them took substantially long time to accept their situation "(KII-2).

4.5. Psychosocial Support Services

Yekatit 12 Hospital is one of the hospitals under Addis Ababa City Administration Health Bureau that has been giving routine health services for Addis Ababa and other referral cases from different regional states of Ethiopia. It has been the main referral hospital for treatment of burn patients for many years.

There were some administrational concerns like shortage in supply of drugs, limited laboratory services and expensiveness of some medications; all participants consistently agree that the professionals of the burn unit are providing a professional health care service for their patients. The patients said they already developed a family like relationship with the professional, especially with the nurses who are giving care and support in every session.

According to KII-1 said, "*Visitors and attendants must wear gown, cap and shoes cover .Because every patients admitted in burn unit easily predispose for infection .So health professionals in burn unit also responsible to protect each patients from such kind of infections*."

Besides the health care service, key informants explained their service to solve patients' psycho-social problems stated that;

KII-2 explained this support by saying;

"We tried to advice the patients during dressing time on morning session. Most of the patients cannot accept their situation immediately. We will tell them how to improve their live through mentioning some lived experiences and success stories. We will show them how to cope up with the difficult situations that the injury will bring to their life" (KII - 2).

KII-3 also explained the service of the unit by saying;

"The psychosocial support regarding on admitted patients, we are providing counseling while giving medical care. We also counsel our patients about physical exercise. Because the injury might affect their movement and patients also feel pain when they tried to move their body from one direction to another. and we told them lying with their affected side for long hours caused bedsore .So we show them how to flex, extend their hands and legs, walk and sit with the help of their attendants. In addition to that their diet should also be containing high protein to help their wound healing fasten. Generally we tell many things what is good and bad for their health**."**

The burn unit head nurse KII-1 also explained her experience regarding psycho-social support as follows;

" I think psychosocial support is an emotional support and I tried to being close for patients to know their feeling and problems .I tried to assess If there family support them or not, if they have no attendant how can we help and link them for the concerned office to get free medical care and other services. I usually allocate some time for the emotionally sensitive patients. Especially when they came here from rural areas and new

for hospital environment, I will tell them what they have to know about the injury, what kind of things expected from them, the treatment and ask them to reflect on it "(KII - 1).

The KIIs also emphasize the importance of psychosocial support and recommends;

"Psychosocial support will help to improve the patients' health status. This is unquestionable. All the team, including the doctor and the nurses, shall have a formal skill regarding psychosocial support. Currently, the nurses are providing the support based on the nursing care. Burn injury requires a multidisciplinary health care team. But it may be costly to create this team in our country. For instance if the hospital hire a clinical psychologist, psychiatrist and nutritionist it will improve the progress of patients condition .On the other hand as long as patients stay in the hospital for long time, they will have to pay special expenses, including medical expenses which in turn affects the patients' pocket" **(*KII-1*).**

In the same approach, KII- 3 also underlines the importance of psycho-social support by saying;

"As an institution of health care, it will be better if we provide a holistic health care service especially for patients inflicted with burn. It will make our work easier and the relationships with patients better. It also helps us to understand the feelings of our patients. So to add a psychosocial training and services on our biomedical knowledge will be able to provide a comprehensive support in this case" **(*KII-3*)**.

KII-1 also shares the same idea with her colleagues, she said;

"It is undisputable that burn injury needs a psychosocial support. Most of the patients come here with 3rd and 4th degree burn and the injury predisposes those disabled. Beside

their injury, the disfigurement makes the patients to lose hope because they do not think that the scars caused by the wound will heal. This issue will forward the question of for how long that the patient will remain in this situation. It is known that the care that we provide in this unit do not address all the difficulties that the patients have. Therefore, it is true that, if there is a comprehensive psycho-social support, it will help the patients in different aspect. It will also ease the burden of dealing with psycho-social problems informally from the medical professionals**" (*KII-2*).**

CHAPTER FIVE: DISCUSSION

5.1 Causes of Burn

There are several causes of burns, ranging from direct heat(including flames and hot liquids) to chemical or electrical injury .Presentations differ depending on the cause, and severity is dependent on both contact time and the temperature to which the skin has been exposed (Benson, Dickson & Boyce, 2006) . Flame burns account for approximately 50% of adult cases, whereas in children scalding predominates, accounting for 70% of injuries. Flame burns can be associated with other injuries, including airway trauma. Electrical burns may present with an entry and exit point where the current has passed through the body. Internal damage, following the path of electricity, can occur along with the external burns (Hettiaratchy, Dziewulski, 2004). Cardiac involvement, particularly arrhythmias, may be present; damage is voltage-dependent. Chemical burns can be caused either by household products or, more usually, by an industrial accident; wet cement is a common cause. With the exception of hydrofluoric acid, alkaline substances generally cause more damage than acids, although pain is often minimal in the initial stages. Alkali damage is due to saponification of fat, creating further heat and damage. Other causes of burns or burn-like injuries include direct contact thermal burns (from radiators, motorbike exhausts, etc) friction burns and prolonged exposure to ultraviolet radiation (Rudall N,and Green A. , 2010).

The main causes of burn injury according to the participants are gasoline explosion, electric burn, machine explosion, house fire and thermal burn.

Three of the participants their injuries were caused through explosion of gasoline .Two of them were affected on their home but one participant was injured in his work place. A study

conducted on Epidemiology of burn injuries in Mekele town, northern Ethiopia revealed that the main risk factor associated with burn injuries are open fire, protected fire, kerosene stove, electric stove. from a total of 7309 individuals most burn occurred at home 81%,followed by accidents at work 12% and the rest 7% sustained burns at recreational place (Estfanos k. and Lindtjorn B.,2002).

Electrical burns are quite different from thermal and chemical burns. The severity of the electrical injury depends on many factors, such as the voltage, duration of contact, tissue resistance, skin moisture, and the presence of flash components and the ignition of clothing. Most of these injuries among adults are due to high voltage electric lines (Varghese G,1986).

The study conducted on electric burns and complication shows ,a total of 444 patients were admitted to their burn center between September 2017 and August 2018. Among these patients, 39 (8.8%) were electrical burns. Of the 139 patients hospitalized at their Burn Center ICU, 25 (17.9%) were electrical burns (Başaran, Gürbüz, Özlü, Daş .2020).

On this research four of the participants were injured through electric burn. Besides the three participants were injured while working, and the accident was caused by a broken power line that passed through the roof. But a fourth participant as injured while traveling .As the finding of the study revealed that participants injury differ on one another; their arms, chest, and shoulders were injured, and all of their legs were injured and one of them also paralyzed.

5.2. Psychological Problems of Patients after Burn Injury

Based on the findings, five of the respondents have reported that, most burn injury patients have developed some kind of psychological problems. As it was indicated in the finding, some of the major emotional problems which burn injury patients feels includes depression, fear,

anxiety, dependency, frustration, loneliness and disability. The study also found out that burn injury can affect the approach of patients by lowering their confidence .These findings are consistent with numerous studies.(Blumenfield, Schoeps, 1992) ,stated that depression may evoked by several causes. In some cases it's related to the loss of persons who were killed in the accident or the concomitant destruction of property. Additionally, the loss of bodily integrity might precipitate response of grief (Choiniere, Melzack, Rondeau, 1987). Pain social isolation during hospital stay and pre-morbid affective state may also have a relationship with post-burn depression. Pain and depression mood remain significant problem for burn injured patients .In a study (perry et al. 1987) examined more closely the relationship between acute psychiatric complication and pain. They compared hospitalized burn patients with and without a diagnosis of acute posttraumatic stress disorder (PTSD), and found that those patients with PTSD symptoms reported significantly more intense pain during both treatment (debridement) and at rest they also had larger burns than the other group. (Taal et., al. 1999) suggests greater degree of anxiety during procedure and before procedures in burn patients. According to (Loncar et al., 2006), examined the inter relationship between anxiety, depression and pain in burn injured patients and results showed that a significant number of patients had suffered from depressive and anxious symptomatology.

Another study also examine anxiety experienced by burn patients during this period is thought to be stemming from ineffective pain control, feeling of itching and deterioration of body integrity, loss of functions, hospitalization and fear regarding the surrounding. In addition, personality, lack of social support systems, applied interventions and the idea of losing independence are the factors increasing the feeling of anxiety (Pazar, İyigun & Sahin, 2016; Loncar, Bras & Mickovic, 2006).

5.3. Psychosocial Reactions of Burn Patients

Participant of the study disclosed that they are struggle mainly with isolation because their families didn't visit them as other ward admitted patients. In addition to that they feel insecure for their future life because of the trauma caused by the burn injury. And also they were the main source of generate income for their families, but due to the burn injury worried about how they will be able to support their families. On the other hand some participants likewise do not want to remember the accident because the incident was traumatic when they think about it.

A study showed that about two thirds of patients have some psychological disability that requires therapy at hospital discharge and of as long as 6 month afterwards (Blades, Mellis, Munsteer,1982).The sequel are mild to moderate in most patients and relate to issues of depression ,anxiety and alcoholism .There is evidence that some problems ,if not treated ,can persist for an extended period of time (Wallace, Lees 1988).

According to (Martha , Peter , Cate , Jeffrey, 2017)stated that low income, unemployment, remoteness of residence, poor housing tenure, limited material resources and restricted social support will be significant predictors of poorer psychosocial outcomes in adult survivors with burns.

Psychological Factors such as previous experiences (injury, pain), current condition (treatment process) and anxiety related to concerns for the future (life time, physical deterioration, loss of independence and so on), pain expectation, condition of the wound and the need to stay at the hospital significantly affects the pain (Cimen & Erdine, 2007; Kursun, 2007).

5.4. Psychosocial Support Services

The burn unit giving services for admitted patients and their attendant .According to KIIs stated that they provide medical care and psychosocial support for their patients which was giving advice for their patients during dressing time ,sharing lived experience of other patients who had sever burn injury and recovered ,how to cope up their current difficult situation regarding on their health ,making exercise for improving their range of motion, the type of diet to help for their wound healing fasten .

Guide line of North Bristol NHS Trust stated that emotional support having a burn injury often, and understandably, can affect people emotionally. As part of the team, there is a clinical psychologist who routinely makes contact with people whilst they are on the ward, and provides support where that is required (North Bristol NHS Trust, 2019). In addition to that social support when you first go home from hospital, you may have difficulty carrying out some of your everyday activities. In many cases, family and friends can support you until you regain your independence. However, for some individuals this may not be possible. If you think you might have difficulties returning home without help, please speak to your nurse about this at the earliest opportunity. A referral can be made at your request to a social worker who will assess whether you are able to have ongoing support from social services. These services can take some time to arrange and there are set criteria for what can be provided (North Bristol NHS Trust, 2019).

CHAPTER SIX: CONCLUSION AND IMPLICATIONS

6.1. Conclusion

Burn injury patients are struggling with several challenges that the injury brought to their life. Especially in a poor country like Ethiopia, were the health care service is very limited and the patients will be prone to recurring problems in their routines.

The central aim of this study is to assess the psychosocial services of burn injury patients who are getting service at Yekatit 12 hospital. The results of the study indicate that burn injury affects the patient's life in a multilateral ways. The crises are not limited to the physical injury. The injury will result in psychological and social disorder in the patient's life. Although the injury affects the quality of life of the patients in different ways, there is no comprehensive way of providing psycho-social support for those patients in the hospital where this entire study is conducted. Furthermore, from some of the interview sessions the researcher learnt that it is pretty much luxurious to talk about a psycho-social support because; the patients may not be sure about return to their pervious life because of financial crisis happened to their life .and the professionals are very tight giving care to their patients who came to the hospital being in a critical condition.

The findings of this study also show that, burn injury affects the patient's physical, emotional and psycho-social life and requires a holistic intervention supported by skilled professionals. It also affects not only the life of the patient but also the surrounding primary care givers and their families. Therefore, it requires multidisciplinary interventions in order to minimize the difficulties.

6.2. Social Work Implication

This study has implication for social work practice, education, and research and policy point of view.

6.2.1. Implications for Social Work Education

Social workers work to advocate the wellbeing, participation and healthy life of burn injury patients. Although creating awareness in health care setting is more vital to provide numerous services on a burn unit, from case management to discharge planning, as well as various counseling function. Moreover, social worker should include on the activities with assessment of the patient to gain an understanding of the patient's prior physical, psychological, social health and coping skills of assessment of the availability of the family and other social networks, and evaluation of the economic situation. The information obtained during the assessment also provide for other members of the multidisciplinary team. To meet this, there should be adequate, well qualified, and capable social workers working in this issue and further in general all have a working understanding of the patient's situation. In this regard take part of higher institution, particularly for the school of social work. Therefore, the social workers can be intervening at individual, community, institution, government, and policy level gaps to fill with appropriate measure.

At the individual level, educational programs have to be set which targeted at health care givers or health professionals, burn patients and their families so that their attitudes towards the injury might be eased if not get rid of at all. In addition to educational programs group counseling of people with burn injury could be time-efficient and productive. Besides, inducing

empathy for a burn inflicted individuals can help to change the approaches of others. It is also very important to rehabilitate burn inflicted patients psychologically, socially, and economically.

At community level, health education programs are essential on burn injury through messages that considerably deal with the local community's give attention to protect them from the injury .And if the injury happens they look immediately the nearby health institution to reduce the complication .Consequently the messages must be structured to make sense within the context of understanding for the community living condition.

6.2.2. Implication for Social Work Practice

The finding of the study has also many implications for social work practice. Social work practitioners could identify, assess, describe and evaluate the need for more health care and social work services in the hospitals. In order to accomplish this goal, this research suggests the detailed and broad understanding with accurate information about the psychosocial support services in hospitalized burn inflicted patients .Multi-disciplinary professional in health care setting also working with the injured patients and their family should provide special care and treatment, counseling and social support to maintain the case and to provide proper care and support for patients.

6.3. Implication for Research

As most literatures are revealed there is a gap in research work, conducted on the psycho social support services in hospitalized burn inflicted patients. Hence the researcher believes that research should be conducted on this issue. Besides it is also essential to conduct a research on how to improve the psychosocial support services of burn inflicted individuals. The existing knowledge, attitudes and practices of the target group affecting to the injury should be explored

and researched before appropriate awareness programs are designed and implemented. This is best done through a combination of qualitative methods such as in-depth interview and quantitative methods such as surveys. Studies should also be conducted among health care providers to assess their attitudes and understanding on the importance of psychosocial support services for patient's health. Therefore, this study has a vital input for the issues studied further and fill the gaps were not addressed.

6.4. Implication for Policy

Since the major problem for the psycho social support for burn inflicted patients is unable to get much attention and more focus give for the medical treatment. To that end, governments and non-governmental organizations involved in health care delivers, should give an emphasis to improve the service must be include in their programs. Efforts at policy level should include,

More support and rehabilitation services have also been provided to patients. Besides burn injury prevention and control programs should be combined into the general health care system. In addition to reduce the fears about the disfiguration and disability of the injury, community health education has to be arranged. Mass media also disseminate information regarding on burn injury to communities for take care of prevention measures.

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ANNEXE I

PART I - Consent Form

My name is Hanna Solomon. I am Masters Student of Addis Ababa University School of Social work. I am currently conducting a research on psychosocial support services in hospitalized burn inflicted patients at Yekatit 12 hospital. The aim of the intended research is to capture and explore the psychosocial support services towards patients diagnose and treatment with burn injury. It is also aimed at identifying the patients need so that appropriate interventions would be designed for the issues from the responsible organs. For the successful completion of the study, the cooperation of those who inflicted with burn and capable of providing necessary data is essential.

The participants of the study will be patients over the age of eighteen years, diagnosed and admitted in burn unit and have the ability to make conversations in Amharic language and have the ability to contribute to the understanding of the psychosocial support and their needs regarding the concern.

I will conduct one-on-one interview. During this process, I would like to assure you that your identity will not be disclosed to anyone. This is to protect your privacy and confidentiality of the information you will provide. I will use tape recorders to correctly record the conversations we will make, and the recordings will be locked in a safe place and will not be exposed to anyone. This will be done based on your willingness and permission. You have the right to drop from answering to some questions or quitting participation in general. However, your honest answer to the questions and inclusive participation will help me for better outcome for the research. Kindly requesting you by signing this form, you agree to participate in this research under the conditions described above. I am really thankful for your collaboration for the success of the study.

Participant's Signature ______________________

Date__________________________

Name of the interviewer: Hanna Solomon

Signature ______________________

Date __________________________

PART II. Interview guide for patients diagnosed with burn injury

1. Socio demographic characteristics of Respondents

Age___________________________

Sex__________________________

Marital status______________________

Educational level _____________________

Place of residence: - rural____________Urban____________

2. Would you tell me the reason why you are admitted in burn unit?

Probing questions

a) Did you get checked in any other health institutions before you join were admitted in burn unit?
b) How long did you stay in burn unit?

3 How were you exposed for burn injury?

Probing question

a. Who rescued you from the injury?
b. Did the injury affect your social life?

4. What are the services you are getting from the hospital?

Probing questions

a) Did you get a psychological support from the hospital?
b) Did the provided services improve your social life?

5. Do you have a family member or relative visiting you?

Probing questions

a) How often your family members visited you?
b) Does your family member collaborate with the burn unit staffs in order to improve your emotional wellbeing?
c) Are there any restrictions to enter in burn unit for your family or relatives?
d) How do you feel about those restrictions?

6. What were your emotional reaction and responses about your burn injury?

Probing questions

a) Did you have an experience of depression, stress or feeling of hopelessness as result of your injury?
b) Did you lose something because of the injury?

7. Did the burn injury affect your social interaction?

Probing question

- Were there any strains, pressure or stigma you felt you faced because of your injury?

8. What kind of improvement was observed on your health after you took a treatment?

Probing question

a) Do you get adequate medical treatment and food from the hospital?
b) Do you get a psychological and social support from the hospital?

9. Has the burn injury predispose you for disability? If your answer is yes, how do you think to manage your future life?

Probing question

- What kind of support you got from the hospital to facilitate your future life?

10. What do you expect from the hospital to fulfill your need regarding on your injury?

Thank you for your cooperation!

PART III. Interview guide for burn unit head nurse

1) Can you tell me how long you were serving in burn unit?

2) How do burn injured patients get psychosocial support from the hospital?

Probing question

- What are the criteria to give them psychosocial support?

3) Did the psychosocial support improve patient's health condition? How?

4) What type of response have you heard from the patients regarding on the service which they get from the hospital?

5) What psychosocial care the hospital provided for burn injured patients on a daily bases?

6) Did you notice the psychosocial care improve patient's emotional wellbeing?

7) How do you express patients' social interaction with burn unit staffs and their family or relative?

8) What are the challenges regarding on the provision of psychosocial support?

Thank you for your cooperation!

PART IV. Interview guide for the hospital administrators

1) Can you tell me your responsibility in the Hospital?

2) What kind of services the hospital provided for burn injury patients?

3) How long the psychosocial supports continue for a patient in burn unit?

4) What are the criteria to give psychosocial support for burn injury patients?

5) How do you identify their psychosocial needs?

6) Do you get an external body support for burn injury patients?

7) What are the challenges the hospital face during the provision of psychosocial services?

Thank you for your cooperation!

ANNEX II . Questionnaire Amharic Version

የስምምነት ውል

ስሜ ሀና ሰለሞን ይባላል። በአዲስ አበባ ዩኒቨርስቲ የሶሻል ወርክ ትምህርት ክፍል ውስጥ የድህረ ምረቃ ተማሪ ነኝ:: ጥናቴንም እየሰራው ያለሁት የካቲት ሆስፒታል ውስጥ በቃጠሎ ህመም የተጎዱ ታማሚዎች ላይ የስነልቦናዊና ማህበሪዊ ድጋፍ የሚያመጣው ለውጥ ላይ ነው። የጥናቱ ዋና አላማ በቃጠሎ ህመም የተጎዱ ታማሚዎች ከምርመራ እና ህክምና ጎን ለጎን የሚያገኙትን ስነልቦናዊና ማህበራዊ ድጋፍ ለውጡን ለይቶ ለማውጣት ነው። ይህም አላማ ደግሞ የታማሚዎቹን ፍላጎት ለይቶ ለማውጣትና ተገቢ አገልግሎት ለማግኘት የሚያስችል የአሰራር ስልት ለሚመለከተው አካል ለማቅረብ ነው። ጥናቱ የተሳካ እንዲሆን የተሳታፊዎች ጠቃሚ መረጃ መስጠት አስፈላጊ ነው።

የጥናቱ ተሳታፊ የሚሆኑት እድሜያቸው 18 ዓመት በላይ የሆኑ እና ምርመራ ተደርጎላቸው በየካቲት 12 ሆስፒታል በቃጠሎ የህክምና ክፍል ውስጥ ተኝተው የሚታከሙ፣በቃጠሎ የተመላላሽ ህክምና ክፍል ክትትል ያላቸው ታካሚዎች ሆነው በአማርኛ ቋንቋ መግባባት የሚችሉ እና ስለማህበራዊ እና ስነልቦናዊ ድጋፍ ግንዛቤ ያላቸውና በዚያ ላይ ተያይዞ ፍላጎቶቻቸውን በተመለከተ መረጃ መስጠት የሚችሉ ናቸዉ።

ቃለ-መጠይቁን የማደርገው በአንድ ጊዜ ለአንድ ሰው ብቻ ነው። በዚህ ላይ ላረጋግጥሎት የምፈልገው የእርሶ ማንነት ለማንም ሰው አይገለፅም። ይህም እርሶ የሚሰጡት መረጃ የእርሶ መሆኑ ሚስጥራዊነቱ የተጠበቀ ይሆናል። በቃለመጠይቃችን ወቅት የድምፅ መቅጃ መጠቀም መረጃዎቹን በትክክል ለመያዝ ለሚረዳኝ እጠቀምበታለሁ። ሆኖም የተቀዱ ካሴቶች ሁሉ ማንም ሰው እንዳያገኛቸው ተቆልፈው ይቀመጣሉ። ይህም የሚሆነው በእርሶ ፍላጎትና ፈቃደኝነት ነው። ጥያቄዎችን አለመመለስ ወይም ተሳታፊ አለመሆን ይችላሉ። ነገር ግን የእርሶ ለጥያቄዎች የሚሰጡት እውነተኛ ምላሽ እና ሙሉ ተሳታፊነት የጥናት ውጤቱ መልካም እንዲሆን ይረዳኛል።

ከላይ በተገለፁት ሀሳቦች ከተስማሙ ስምምነትዎን በፊርማ እንዲያረጋግጡልኝ በትህትና እጠይቃለሁ።ለጥናቱ መሳካት ስለሚያደርጉት ትብብርም ከልብ አመሰግናለሁ።

የተሳታፊ ፊርማ---------------------------ቀን------------------------------------

የመረጃ ሰብሳቢ ስም -------------------ፊርማ-------------ቀን---------------------

ለቃጠሎህ ህመምተኞች የተዘጋጀ መጠይቅ

1. የስነ ህዝብ ጥያቄ

- እድሜ
- ፆታ
- የጋብቻሁኔታ
- የትምህርትደረጃ
- የመኖሪያአድራሻ፡- ገጠር____________ ከተማ___________

2. የቃጠሎ ህክምና ክፍል በምን ምክንያት አልጋ ይዘው እንደሆነ ሊነግሩኝ ይችላሉ ?

የማረጋገጫ ጥያቄ

- ➢ እዚህ ሆስፒታል ከመተኛቶ በፊት ሌላ የህክምና መስጫ ቦታ የህክምና እርዳታ አግኝተው ነበር ?
- ➢ እዚህ የቃጠሎ ህክምና አስተኝቶ ማከም ክፍል ውስጥ አልጋ ይዘው ምን ያህል ጊዜ ቆዩ ?

3. ለቃጠሎ አደጋ የተጋለጡበት ምክንያት ምንድን ነበር?

የማረጋገጫ ጥያቄዎች

- ➢ በአደጋው ጊዜ ደርሶ ያዳኖት ማን ነበር ?
- ➢ አደጋው በማህበራዊ ህይወቶ ላይ ተፅኖ አሳድሯል?

4. ከሆስፒታሉ እያገኙያሉትአገልግሎቶችምንድንናቸው?

የማረጋገጫጥያቄዎች

- ➢ ከሆስፒታሉ ያገኙት የስነልቦና ድጋፍ አለ?
- ➢ የሚያገኙዋቸው አገልግሎቶች በማህበራዊ ህይወቶ ላይ መሻሻልን አምጥቷል?

5. እዚህ እየመጣ የሚጠይቆት ቤተሰብ ወይም ዘመድ አለ?

የማረጋገጫጥያቄዎች

- ቤተሰቦችዎ በምን ያህል ጊዜ ነው እየመጡ የሚጠይቆት?
- ቤተሰቦችዎ እዚህ የቃጠሎ ህክምና ክፍል ውስጥ ከሚሰሩ ባለሙያዎች ጋር በመተባበር እርሶ የተሻለ ምቾት እንዲሰማዎት ያግዛሉ ?
- እርሶንለመጠየቅእዚህበሚመጡዘመዶቾወይምቤተሰቦችዎላይየተጣለክልከላአለ?
- ስለ ክልከላው እርሶ ምን ይሰማዎታል?

6. የቃጠሎው ህመም በስሜትዎ ላይ ያመጣው ለውጥ ምንድን ነበር?

የማረጋገጫ ጥያቄ

- በጉዳትዎ ምክንያት ለውጥረት፣ለጭንቀት ወይም ተስፋ መቁረጥ ተጋልጠው ነበር?
- በቃጠሎ ጉዳት ምክንያት ያጡት ነገር አለ ?

7. የቃጠሎ አደጋው የማህበራዊ ግንኙነትዎ ላይ ያደረሰው ጉዳት አለ?

የማረጋገጫጥያቄ

- በጉዳትዎ ምክንያት ይደርስብኛል ብለው የሚሰማዎት ማንኛውም ተፅኖ ወይም መገለል ነበር?

8. ህክምና ከወሰዱ በኋላ በጤናዎት ላይ ያስተዋሉት መሻሻል ምንድን ነው?

የማረጋገጫጥያቄ

- በቂ ህክምና እና ምግብ ከሆስፒታሉ አግኝተዋል?
- የስነልቦና እና የማህበራዊ ድጋፍ አገልግሎት ከሆስፒታሉ አግኝተዋል?

9. የቃጠሎው አደጋ ለአካል ጉዳት አጋልጦታል? መልስዎ አዎን ከሆነ ቀጣይ ህይወቶን እንዴት ሊመሩ አስበዋል?

የማረጋገጫ ጥያቄ

- ቀጣይ ህይወቶ ምቹ ለማድረግ ከሆስፒታሉ ምን አይነት ድጋፍ አግኝተዋል?

10. የደረሰብዎትን ጉዳት በተመለከተ ሆስፒታሉ እንዲያሚላልዎት የሚፈልጉት ነገር አለ?

ስለ ትብብርዎ አመሰግናለሁ!

ለቃጠሎ ህክምና ክፍል የነርሶች ሀላፊ የተዘጋጀ መጠይቅ

1) የቃጠሎ ህክምና መስጫ ክፍል ውስጥ ለምን ያህል ጊዜ እንዳገለገሉ ሊነግሩኝ ይችላሉ?
2) በቃጠሎ ህመም የተጎዱ ታማሚዎች ከሆስፒታሉ የስነልቦናዊ እና ማህበራዊ ድጋፍ እንዴት ነው የሚያገኙት?

የማረጋገጫጥያቄ

- የስነልቦናዊ እና ማህበሪዊ ድጋፍ ለታማሚዎቹ ለመስጠት መስፈርቱ ምንድን ነው?

3) የስነልቦናዊ እና ማህበራዊ ድጋፉ የታማሚዎቹን ጤና እንዲሻሻል ረድቷል? እንዴት?
4) ታማሚዎች ከሆስፒታሉ በሚያገኙት አገልግሎት ላይ ምን አይነት ምላሽ ሲሰጡ አድምጠው ያውቃሉ?
5) ሆስፒታሉ በቃጠሎ ህመም ለተጎዱ ታማሚዎች በየጊዜው የሚሰጠው የስነልቦናዊ እና ማህበራዊ ድጋፍ ምንድንነው?
6) የስነልቦናዊ እና ማህበራዊ ድጋፉ በታማሚዎች ጤና ላይ መሻሻል እንዲኖር ማድረጉን አስተውለዋል?
7) ታማሚዎች ከቤተሰቦቻቸው እና ከቃጠሎ ክፍል ባለሙያዎች ጋር ያላቸውን ማህበራዊ ግንኙነት እንዴት ይገልፁታል?
8) ስነልቦናዊ እና ማህበራዊ ድጋፎችን በተመለከተ አገልግሎቱ ሲሰጥ ያጋጠሙ ችግሮች ምንድን ነበሩ?

ለትብብርዎአመሰግናለሁ!

ለየካቲት 12 ሆስፒታል አስተዳደሮች የተዘጋጀ መጠይቅ

1) በሆስፒታሉ ውስጥ ያለዎትን ሀላፊነት ሊነግሩኝ ይችላሉ?
2) ሆስፒታሉ በቃጠሎ ለተጎዱ ታማሚዎች ሲያቀርብ የነበረው ምን አገልግሎቶች ነበሩ?
3) በቃጠሎ ጉዳት ደርሶባቸው ተኝተው ለሚታከሙ ህሙማን የስነልቦናዊ እና ማህበራዊ ድጋፎች ለምን ያህል ጊዜ ነው እየተሰጡ የሚቀጥለው?
4) ለታማሚዎቹ የስነልቦናዊ እና ማህበራዊ ድጋፍ ለመስጠት መስፈርቱ ምንድን ነው?
5) የታማሚዎቹን የስነልቦናዊ እና ማህበራዊ ፍላጎት እንዴት ትለዩታላቹ?
6) በቃጠሎ ህመም ለተጎዱ ታማሚዎች ከሌላ ተቋም የምታገኙት ድጋፍ አለ?
7) ሆስፒታሉ የስነልቦናዊ እና ማህበራዊ ድጋፍ አገልግሎት አሰጣጥ ላይ ያጋጠሙት ችግሮች ምንድን ናቸው?

ስለትብብርዎ አመሰግናለሁ!