

Perspectives of Nurses Managing Pediatric Oncology Patients at Kenyatta National Hospital, Nairobi City County, Kenya

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Abstract

Pediatric oncology nurses at Kenyatta National Hospital (KNH) must provide both intense emotional support and medical care to critically ill children and their families, given limited resources. The purpose of this study is to investigate the well-being, experiences, and coping strategies of pediatric oncology nurses at KNH, to develop institutionally-based programs for staff well-being. A qualitative phenomenological research design was utilized. Fifteen (15) Pediatric Oncology nurses were interviewed using semi-structured, in-depth interviews until data saturation was reached. The data were analyzed using inductive thematic analysis. The nurses expressed four (4) major themes related to their experiences: (1) experienced emotional/psychological burden of witnessing patients suffer; (2) communicated challenges associated with sharing complex and negative medical information; (3) chronic understaffing/shortage experienced in an organization, which impacts resources; and (4) utilized teamwork, spirituality, and encouragement from peers as coping strategies. The nurses at KNH experience high levels of stress, leading to burnout, yet they continue to practice diligently and with resilience. Programs to improve emotional health, increase nurse-to-patient ratios, and provide more structured/specialty training are needed as a result of this study.

Keywords: *Pediatric Oncology, Nursing Perspectives, Kenya, Qualitative Research, Resource-Limited Settings, Resilience*

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1. Introduction

Cancers arising in children are a serious public health issue in Kenya, with >3000 new cases of childhood cancer reported annually, and Kenyatta National Hospital is the sole National Referral Hospital in the country, managing an additional 1200 cases on an annual basis (Kenyatta National Hospital [KNH] n.d.). While there have been advancements, the survival rates of children with cancer in Kenya continue to lag at approximately 20%, while children in wealthier nations report survival rates of >80% (Ministry of Health [MoH], 2023). In the context of pediatric oncology mortality rates, pediatric oncology nurses from Kenyatta National Hospital serve the most vulnerable patients facing the greatest risk in the most critical

settings of complicated/advanced malignancies and have the additional burden of extremely poor patient-to-nurse ratios and limited access to medically essential medications (Njuguna et al., 2022), creating an environment in which the challenges faced by nurses are distinctly elevated and unique. Therefore, this study will examine the lived experiences of Kenyan pediatric oncology nurses, addressing a gap in the current local literature on the human aspect of oncology nursing in low-resource/resource-limited settings.

2. Literature Review

Pediatric oncology nursing worldwide is characterized by a two-tiered system, with one group in HICs (high-income countries) and another in LICs (low-income countries). Nurses in HICs have moral distress about end-of-life issues (Zendeh et al., 2022); those in sub-Saharan Africa's resource-poor settings experience moral distress when they see children die due to not being able to afford available treatments. The research of Njuguna et al. (2022) describes how poverty and socioeconomic status magnify the survival gap in Kenya due to untreated disease. Most prominently, "compassion fatigue" is seen in RLS settings where RNs provide surrogate parenting. The Ministry of Health (2023) identified that families often have little or no access to the necessary social safety net support and therefore may forego providing emotional care for their dying child at home; thus increasing the chance for secondary trauma to those families. Further complicating the nurse's experience is the moral injury caused by the nurse's knowledge of how a child should be cared for versus the circumstances that prevent quality care due to loss of access to medical communication technologies and cultural worldviews. Research indicates many families believe their child's cancer is a result of a spiritual curse or witchcraft (MoH, 2023). Since RNs are often treated as custodial rather than clinical caregivers in a culturally competent way that incorporates the desert farmer as a spiritual and cultural way of interpreting the provision of clinical care (WHO, 2021), there is an egregious imbalance between the number of RNs and the number of RNs caring for children receiving oncology care. In fact, studies suggest an oncology RN-to-child ratio of 1:5, whereas in RLS settings it is more than 1:15, thereby requiring all RNs to practice in a triage-like environment (Zendeh et al., 2022). In long-term retention of many now without formal substantiation for their RN role (MOH, 2023), most are not held accountable for the required daily documentation of their needed competency updates.

3. Methodology

3.1 Research Design

The current study utilized phenomenology as the research design. The purpose of using phenomenology was to gain an in-depth understanding of participants' experiences; therefore, the present study explored the essence of being a pediatric oncology nurse in a resource-limited environment.

3.2 Study Site and Population

The Pediatric Oncology unit located at Kenyatta National Hospital (KNH) was the study site for this research. KNH provided justification for the study site as they are a central site for oncology in Kenya and can manage the majority of the country's highest acuity oncology patients, creating an environment that requires high levels of stress for staff; therefore, the

target population for this study was registered nurses directly involved in providing direct care for children receiving oncology treatment.

3.3 Sample Size and Saturation

A sample size of 15 registered nurses was obtained for the study using purposive sampling. The sample size was determined to be large enough that, as additional interviews were completed, no new codes were identified or created in the content, consistently with previously established codes; therefore, thematic saturation occurred after the 12th interview. However, the final 3 interviews were used to confirm there was no information redundancy (Guest et al., 2006).

3.4 Data Collection

Data were collected through face-to-face, semi-structured interviews conducted in private within the hospital setting by me, the primary investigator, using a digital voice recorder, after obtaining explicit written consent from the participants. I also collected field notes to document my observations of nonverbal body language by the study participants during the interview process, as well as the hospital setting and other environmental factors, which were an important component of the research audit trail.

3.5 Data Analysis

Inductive thematic analysis by Braun and Clarke (2006) was used to analyze the data collected through transcription of verbatim recordings of each interview, transcribed verbatim without any prior theoretical assumptions (open coding), and then the open codes were brought together into several higher-order themes or overarching themes. NVivo software was used to facilitate data management and improve the rigour of the analysis.

4. Results and Discussion

Table 1: Demographic and Professional Characteristics of Participants (N = 15)

Category	N	%
Gender		
Female	13	86.7
Male	2	13.3
Age (years)		
20–29	3	20.0
30–39	2	13.3
40–49	2	13.3
50–59	8	53.3

Years of Experience in Pediatric Oncology

≤5 years	7	46.67
6–10 years	1	6.7
10-15	4	26.67
>15years	3	20

Highest Level of Education

Diploma	9	60
BScN	4	26.7
MSN (Oncology)	2	13.33

Professional Certifications in Oncology

None	9	60.0
Palliative Care	2	13.3
Basic Oncology Nursing	1	6.7
MSc Oncology	2	13.3
Essentials in Pediatric Oncology & Chemotherapy	1	6.7

Current Role at KNH

Pediatric Oncology Nurse	9	60.0
Palliative Care Nurse (Oncology Unit)	2	13.3
Pediatric Nurse (Oncology Ward Rotation)	2	13.3
Oncology Ward Nurse Manager / In-Charge	2	13.3

Total	15	100
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Table 2: Summary of subthemes and themes

Objective	Theme	Sub-theme	Illustrative Quote
To explore the emotional and psychological burden experienced by pediatric oncology nurses in caring for children with cancer.	1. Unmitigated Psycho-Emotional Trauma	1.1 Emotional Attachment and Trauma	<i>“You are with them every single day; you watch them grow. They become like your own children.” (Participant 3)</i>
		1.2 Lack of Formal Emotional Support	<i>“When a child passes, we just rely on each other at the bedside. There is no formal system to help us process the trauma.” (Participant 7)</i>
To identify and examine the communication challenges faced by pediatric oncology nurses when engaging with patients and their families.	2. Barriers to Therapeutic Dialogue	2.1 Family Denial, Cultural Resistance and Language Barriers	<i>“The denial is the biggest hurdle. They refuse to accept the diagnosis and lose valuable time for treatment.” (Participant 12)</i> <i>“Sometimes we have a child from Somalia who cannot speak any other language, and others, because of their faith, they will not accept the blood transfusion.” (Participant 13)</i>
		2.2 Inadequate Tools for Health Literacy	<i>“If we had pictures and simple charts to explain the procedure, the compliance would be so much better.” (Participant 5)</i>
To examine how organisational and resource challenges influence care delivery and nurses’ ability to provide quality pediatric oncology care.	3. Crippling Systemic Deficiencies	3.1 Unsafe Workload and Staffing Ratios	<i>“We are three on duty, patients are 70, so you can take even care of 20 to 25 patients. The constant pressure means we have to run.” (Participant 15)</i>
		3.2 Resource Scarcity	<i>“It is heartbreaking when parents have to buy the medication we should be providing. We feel so helpless.” (Participant 9)</i>
To explore the coping mechanisms and professional development needs of pediatric oncology nurses in managing work-related stress and improving clinical competence.	4. Informal Resilience and Skill Gaps	4.1 Peer Support as Survival Strategy	<i>“Teamwork is the only thing that keeps us sane and keeps the unit running. Without it, the unit would collapse.” (Participant 14)</i>
		4.2 Need for Specialised Pediatric Oncology Education	<i>“Oncology is a double speciality; we need much more than just general nursing knowledge to handle these complex cases.” (Participant 4)</i>

4.1 Theme 1: Unmitigated Psycho-Emotional Trauma

The most prominent theme was the deep emotional impact of caring for terminally ill children, described as a persistent weight that follows the nurse home.

Sub-theme 1.1: Emotional Attachment and Trauma

Participant 13: *"It's not easy... a child you've been playing with, associating nicely, then at the end of it, now the children are down, and there is nothing much in my hands that I'm supposed to offer. So it makes us feel a bit down. It's emotionally draining."*

Participant 2: *"The anxiety when a child suddenly drops... it makes you realise how much more training you really need to be truly ready for this."*

Sub-theme 1.2: Survival Through Isolation: The Absence of Formal Support

Participant 14: *"I learned one thing. Detach... Just handle that as a patient. Just like that. Otherwise, you simply cannot survive this job."*

Participant 1: *"We share everything. When a child dies, we don't need an office meeting... we just talk among ourselves, and that's our debriefing."*

Participant 4: *"I've been here two years. I've never seen us getting a debriefing... You carry it all and have to find your own ways."*

4.2 Theme 2: Barriers to Therapeutic Dialogue

Nurses identified communication as a double-edged sword: essential for care but fraught with cultural and emotional barriers.

Sub-theme 2.1: Family Denial, Cultural Resistance, and Language Barriers

Participant 11: *"Some parents just refuse to believe the diagnosis. They will tell you the child has been bewitched."*

Participant 12: *"Some parents believe it is a curse. They come here when they have already tried traditional healers, and by then, the cancer is too far gone."*

Sub-theme 2.2: Inadequate Tools for Health Literacy

Participant 8: *"It's easier for them to communicate when we explain using pictures. The children themselves need to be talked to."* (Participant 8)

Participant 5: *"When you show them pictures, this is how it is, and this is what comes next, the compliance is so much better."*

4.3 Theme 3: Crippling Systemic Deficiencies

The structural environment at KNH significantly impedes the nurses' ability to provide optimal care.

Sub-theme 3.1: Unsafe Workload and Staffing Ratios

Participant 7: *"We have a patient population of 70 patients to just 2 nurses. It's a very big challenge. You are just running... You don't even have time to give the emotional support the family needs."*

Participant 15: *"The workload is overwhelming. You are doing chemo, dressings, and admissions. By the end of the shift, you are physically broken."*

Sub-theme 3.2: Resource Scarcity

Participant 9: *"Sometimes we have a shortage of chemotherapy, so the patients have to buy their own."* (Participant 9)

Participant 8: *"If it wasn't for well-wishers and NGOs, we wouldn't have enough essential items to treat the children."*

Participant 3: *"The moment you realise the family can't afford even a simple antibiotic, you feel helpless."*

4.4 Theme 4: Informal Resilience and Skill Gaps

Despite the challenges, nurses have developed robust strategies to maintain their mental health.

Sub-theme 4.1: Peer Support as Survival Strategy

Participant 14: *"Teamwork is the only thing that keeps us sane and keeps the unit running."*

Participant 10: *"When you have supportive colleagues, you can share your burden. It makes it easier to cope."*

Sub-theme 4.2: 2 Need for Specialised Pediatric Oncology Education

Participant 4: *"Oncology is a double speciality; we need much more than just general nursing knowledge to handle these complex cases."*

Participant 6: *"There's too much workload, and it affects how we give care. You can't manage everything as expected."*

Participant 13: *"We rely on webinars from external NGOs because the hospital does not offer ongoing training."*

5. Discussion

Participants in this study found themselves facing intense emotional issues, systemic issues, and challenges within their profession that affect them when working in pediatric oncology care.

Theme 1, *Unmitigated Emotional Trauma*, demonstrated through Participant 13 and Participant 2's experiences that caring for critically ill children leads to significant anxiety, emotional exhaustion, and vicarious trauma. Professional detachment (Participant 14) and peer support (Participants 1 and 4) were two coping strategies used by nurses to manage these emotional issues, suggesting that they are implementing emotion-focused methods of coping based on the Transactional Model of Stress and Coping by Rieger and Yarbrow (2023) and Lankin et al. (2023). The absence of formal debriefing or counseling services increases nurses' susceptibility to burnout and decreases their ability to maintain psychological safety over time (Sawin et al., 2019).

Theme 2 examined impediments to effective therapeutic communication, including parents denying their child's ailment, cultural and language barriers experienced by all participants, and the influence of culture and language on therapeutic communication. Participants 5 and 8 noted the use of visual aids as a means for child psychologists to foster understanding and adherence among children and their parents, which is consistent with evidence from sub-Saharan African oncology (Buckle et al., 2013a; 2013b).

Theme 3 demonstrated systemic deficiencies and unsafe staffing ratios (7), insufficient resources (8 and 9), and potential for moral distress/impact to patient care (15). All of which are sources of pressure on caregivers. Theme 4 demonstrates that nurses depend on team support (10 and 14) and external training (13) to maintain their level of care, but the ability to provide the level of care expected is hampered by lack of institutionally provided support and education regarding pediatric oncology as a specialized area of clinical practice (Majamanda et al., 2023; Maree et al., 2024; Mojarad et al., 2019). Taken together, these themes illustrate the necessity for structured access to psychological support and sufficient, appropriate staffing, resources, and formal training in specialised pediatric oncology for nurses to maintain their level of resilience and continue to deliver quality care to children with cancer at KNH.

6. Conclusion

This study provides a comprehensive understanding of the lived experiences of pediatric oncology nurses at KNH. The experiences of pediatric oncology nurses working at KNH are not only challenging but are also shaped by multiple variables, such as emotional trauma from patient care and significant communication barriers, coupled with limited resources and excessive patient loads. Notwithstanding these challenges, the pediatric oncology nurses utilise informal forms of resilience via peer support; however, these informal methods alone cannot mitigate all of the mental, emotional, and ethical pressures that the nurses encounter. The findings from this study suggest an essential need for formal, structured institutional support systems to assist the nurses in maintaining their well-being and for providing safe, high-quality care; for example, debriefings, counselling services, and formalised training in pediatric oncology. If timely, coordinated interventions are not initiated to address the systemic and educational gaps within KNH, there is a significant risk to the ongoing sustainability of pediatric oncology services at KNH, and the future health and success of the dedicated nurses will likely be adversely affected.

7. Recommendations

7.1 Recommendations to Kenyatta National Hospital (KNH) Management: Develop a critical incident/trauma-focused psychosocial support program.

- Create mandatory debriefing sessions for clinical staff under the CISM model and hold them under qualified mental health practitioners as a method of helping with the long-term effects of trauma and grief. Create a Pediatric Psychosocial Support Team (PPST)
- Lead nurse managers to hire child psychologists and clinical/social workers dedicated to providing long-term psychosocial support to children with cancer, thus lessening the emotional impact on nurses who provide care for children with cancer. Establish specialised and mandatory cultural/conflict resolution training

- Provide nurses with training in how to manage cultural/spiritual/ethical barriers in providing care for patients. Address inadequate staffing levels and work distribution/scheduling
- Hire additional nurses to meet the recommended nurse-to-patient ratios provided by WHO and establish formal prioritisation of tasks to provide adequate, safe, and efficient delivery of care. Establish institutional provisions for essential supplies
- Ensure that medications and equipment deemed essential are provided to the institution so that neither nurses nor families have to provide them.

7.2 Recommendations for Future Research: Conduct quantitative studies to measure nurse burnout and job satisfaction. Evaluate the impact of structured support programs on nurse well-being and patient care. Conduct a comparative analysis of pediatric oncology nursing practice between units in different geographic areas (regionally and internationally). Evaluate if coping resources are sustainable long-term

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