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Encountering Children in Crisis Settings – Experiences of Nurse Delegates and Their Suggested Core Competencies

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Degree Programme in Global Development and Management in Health Care
Master's Thesis
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Laurea University of Applied Sciences **Abstract**
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There are many different kinds of crises the world faces today: natural and manmade disasters and epidemics that disrupt daily life. One of the most vulnerable populations in crises is children and they often make up the majority of the victims. Humanitarian aid organisations and non-governmental organisations provide humanitarian aid in crisis settings and therefore nurse delegates, who work for these organisations, encounter lots of children on their missions around the world.

The goal of this study was to enhance nurse delegates' competencies for encountering children in crisis settings by exploring core competencies in this area. The objective was to enable nurses to be more prepared to care for this vulnerable group of people in crisis settings. The research method in this study was qualitative and thematic interviews with open-ended questions were used to collect data. Altogether five nurse delegates were interviewed during the years 2018 and 2019. This thesis was started in association with professionals in the Gaming for Peace project in which Laurea University of Applied Sciences formed part of an international consortium.

The results of the study were organised into three themes; core competencies for encountering children in crisis settings, challenges nurse delegates faced in crisis settings and children in crisis settings. In terms of core competencies for encountering children in crisis settings some of the key findings were practical nursing skills, occupational coping skills and psycho-social skills. Some of the main challenges the nurse delegates faced were communication and trust issues and infrastructural challenges. Children in crisis settings were often unaccompanied and overburdened and in poor physical and mental health.

Nurse delegates recognised the need for more training on how to encounter children in crisis settings, for example through training in paediatrics and child psychology. The findings of this study were corroborated by findings of other similar studies. Nevertheless, more research is recommended on the core competencies for encountering children in crisis settings and, additionally, children's needs and perspective should be included in disaster preparedness plans on both national and international level.

Keywords: children, crisis settings, core competencies, nurse delegates, qualitative study

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1 Introduction

As a global community there are many challenges that we face in the world today. Since 1992 the European Commission has been providing humanitarian aid in over 110 countries helping millions of people all over the world each year (European Commission 2020a). In crisis and conflict situations, children are particularly vulnerable (European Commission 2017). According to data from the World Bank (2019a, 2019b), the global population of 0-14-year-olds has increased by 107 million between 2008 and 2018 representing about 26% of the total global population. A 2009 report by the United Nations Children's Fund (UNICEF) reveals that there are more than 1 billion children under the age of 18 situated in a conflict area or an area emerging from war (Children and Conflict in a Changing World 2009). In a report published by Save the Children it is stated that more than 375 million children were living in a conflict zone in 2016 – this comes to 1 in every 6 of the world's children (The War on Children 2018). The exact number of children in conflict or other disaster areas varies depending on how the calculations are made but the underlying message is the same. Children are very highly affected by crises and disasters on a global scale.

Children who are growing up around armed conflict or political violence are arguably one of the most vulnerable and high-risk populations worldwide. In these settings, child casualties are on the rise and children's long-term well-being may be threatened by experiences of trauma and deprivation. (Cummings, Merrilees, Taylor & Mondi 2016.) The UNICEF report (2009) includes a recommendation to care for and protect children in armed conflict. The report also calls for a multi-sectoral approach involving national governments, members of civil society and international actors in order to scale up activities and increase benefits for children (UNICEF 2009). Additionally, there are human right's laws and legislation protecting the rights of children that should be adhered to, such as the United Nation's Convention on the Rights of the Child (1990) and the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (2002), which have both been widely ratified globally (United Nations Human Rights Office of the High Commissioner 1990 & 2002).

According to Beach and Bernardo (2012, 544) there are many different kinds of crises that the world potentially faces such as disasters, acts of terrorism and public health emergencies are all a reality and nurses and other health care professionals need to be able to care for infants, children and adolescents in situations like these. There is research indicating that health care staff responding to disasters or emergencies might not have adequate training

regarding paediatrics and that more training is needed despite some gains over the last few decades (Mace & Burn 2007; Zaveri & Agrawal 2006; Almonte 2009).

This thesis was started in association with the Gaming for Peace Project (GAP) in which the Laurea University of Applied Sciences formed part of a consortium that aimed to include soft skills - communication and cooperation - in the training curriculum of personnel being deployed on Conflict Prevention and Peace Building (CPPB) missions. The GAP project has received funding from the European Union's Horizon 2020 research and innovation programme. (Gaming for Peace 2018.)

The goal of this study was to enhance nurse delegates' competencies for encountering children in crisis settings. The objective of this study was to explore the core competencies for encountering children in crisis settings that would enable nurse delegates to care for this vulnerable group of people in crisis response. A literature review was conducted to clarify the key concepts, which are children in crisis settings, humanitarian aid work in crisis settings and nursing competencies. In order to gain additional insight on the topic of encountering children in crisis settings five thematic interviews using open-ended questions were conducted with nurse delegates, who had returned from deployment with international aid organizations in crisis settings.

2 Encountering Children in Crisis Settings

2.1 Children in Crisis Settings

Understanding the human development process is a necessary part of nursing care (Mandleco 2012, 158). In caring for children, the human development process is emphasized. For example, in the infancy period – which is considered to last from the age of one month old to one year old – the child begins as a person unable to perform independent actions and by the end of the year they can walk, feed and begin to speak. During the first six months of a child's life there is a lot of growth taking place. (De Sevo 2014, 12.)

Large-scale disasters have many repercussions. They are physically dangerous, very stressful and they can be economically devastating for communities and the people who live in them (National Center for Disease Preparedness 2017). There are physiological, developmental and emotional differences between adults and children, and this is crucial to understand. Children are more vulnerable than adults in disaster settings when it comes to communicable disease, injuries and environmental exposure and, in terms of health care, they may need specially trained health providers to manage their medical concerns (Beach & Bernardo 2012, 543;

Seaman & Maguire 2015; Emergency Care for Children: Growing Pains 2007, 223-224; National Center for Disease Preparedness 2017). A child is, therefore, not a small adult (Fergusson & Lawton 2009, 1). Children have special dietary needs and are completely dependent on their family for both material and emotional support and protection (Seaman & Maguire 2015). Due to their physiological differences compared to adults' children are more susceptible to injury and they exhibit higher mortality rates than adults in disaster settings. The treatment of children may be different that of adults. (Beach & Bernardo 2012, 543; Emergency Care for Children: Growing Pains 2007, 224.) Specialized staff are generally in short supply in economically challenged communities. (National Center for Disease Preparedness 2017.)

There is research available about the effects of armed conflict and violence on children and how it affects their mental health and other areas of life (Bhardwaj, Bourey, Rai, Adhikari, Worthman & Kohrt 2018; Siriwardhana, Pannala, Siribaddana, Sumathipala & Stewart 2013; Machel 1996). Not only do children suffer as victims of injuries and death in conflicts, but they can lose the structures that give meaning to their social and cultural lives, as the whole fabric of their society is torn to pieces. War violates every right of the child and many of today's conflicts can last the length of an entire childhood, from birth to early adulthood. (Machel 1996.) Conflicts disrupt the normal functioning of society by disintegrating basic services and social protection, which further lead to violation of children's rights. Conflict-affected countries also showed slower progress towards the Millennium Development Goals than their more fortunate counterparts. This means that children growing up in these countries are more likely to be poor, malnourished and not attending school. (Children and Conflict in a Changing World 2009.)

There is a requirement for specialized equipment and different approaches when caring for children in crisis settings. Just like adults, children also require mental health services after a disaster, but these services must be age appropriate. (Emergency Care for Children: Growing Pains 2007, 224.) Some of the most common signs of distress in children are changes in their behaviour, such as an outgoing child becoming shy and withdrawn or behaviour regression, such as reverting back to drinking from a bottle instead of a cup (Emergency Care for Children: Growing Pains 2007, 224; De Sevo 2014, 118). A child's age, cognitive level and the level of exposure to the disaster can affect their reaction to the event. Preschool-aged children will react differently from school-aged children and adolescents. Children may worry about abandonment and have other fears and anxieties. (Emergency Care for Children: Growing Pains 2007, 224.)

2.2 Humanitarian Aid Work in Crisis Settings

There are many different organizations involved in humanitarian aid work globally, such as the International Federation of the Red Cross and Red Crescent Societies (IFRC), the European Commission and Médecins San Frontièrs (IFRC 2020a; Médecins Sans Frontièrs 2020; European Commission 2020a). All of these organizations work in areas that can be considered crisis settings. The IFRC has various different kinds of emergency response units (ERUs) that can be deployed at short notice and are self-sufficient for up to one month. These standardized units are made up of trained personnel and modules of equipment. For example, there are water and sanitation ERUs, logistics ERUs and also basic health care, referral hospital and rapid deployment hospital ERUs. An ERU can be made up of many different professions such as doctors, nurses, logisticians and technicians, who work together with local professionals. (IFRC 2020b.)

The European Union (EU) is also a significant provider of humanitarian aid on a global scale. The European Commission's Humanitarian Aid and Civil Protection (ECHO) department works together with 200 partner organizations in order to provide humanitarian assistance globally. EU humanitarian aid funding has gone up in recent years and currently the EU has reached over 4 million children in emergencies, ensuring that they have access to education. (European Commission 2019.)

In humanitarian aid work ethical dilemmas arise frequently and they can complicate the decision-making process (Civaner, Vatansever, & Pala 2017; Clarinval & Biller-Andorno 2014). Some of these ethical dilemmas arise from the attitudes of stakeholders, mismanagement of relief efforts and the media, which in turn can lead to discrimination, unjust resource allocation and violations of personal rights (Civaner et al. 2017). Also, different values can end up being weighed against each other – it is not always possible to implement them all simultaneously (Clarinval & Biller-Adorno 2014).

There are an increasing number of international emergency medical teams deployed worldwide to assist populations affected by disaster. Since the 2010 earthquake in Haiti emergency medical teams have come under criticism due to lack of preparedness, ill-adapted care and insufficient coordination with local healthcare systems. (Camacho et al. 2016.) Even though the training of healthcare workers has long been seen as an integral part of disaster preparedness, traditional training practices have not been systematically developed, examined or tested. There is currently no accepted standard for healthcare worker training in disaster response, instead programmes have adopted different formats to achieve their training and educational goals. (Hsu, Thomas, Bass, Whyne, Kelen and Green 2006). The World Health Organization's Global Health Emergency Workforce programme aims to address these issues by ensuring quality and accountability through appropriate education and training of emergency medical teams (Camacho et al. 2016).

With regards to responding to children's needs in disaster settings, whether on a national or international level, deficiencies in resources and training of prehospital care providers have been documented (Mace & Burn 2007; Zaveri & Agrawal 2006). In the research by Mace and Burn (2007) disaster medical assistance teams (DMATs) responding to disasters were frequently short on supplies for treating paediatric patients and only approximately one third of DMATs had extensive paediatric protocols in place. In her study Almonte (2009) found that most US Navy deployed nurses felt that they were unprepared for providing paediatric care when responding to the 2004 tsunami in the Indian Ocean.

Nurses who have achieved a level of competence in disaster and emergency response are better equipped to recognize and respond to disasters that can diminish quality of life, endanger health or pose a risk to the population. Disaster nursing is one of the specialty areas for nursing practice and nurses can either make use of these competencies in disaster situations for limited periods of time or they may devote their careers to disaster nursing. (Speraw & Persell 2012, 670-671.)

2.3 Nursing Competencies

In professional life, including nursing, there is often discussion related to competencies. A competency can be defined as an expected level of performance that integrates knowledge, skills, abilities and judgement. Therefore, an individual who is demonstrating competence is performing successfully at an expected level. (American Nurses Association 2010.) Competence can be seen as a consistent, demonstrated level of performance where knowledge is proficiently applied to the clinical situation (Speraw & Persell 2012, 671). While it may be agreed that all health care professionals should demonstrate levels of competency in their work, there is still disparity when it comes to the definition, attainment, importance and context of these competencies in different health care environments. Acquiring a common understanding of these competencies is necessary for understanding and improving organizational, professional and patient outcomes. (Kelly, Vottero & Christie-McAuliffe 2014.)

As an example of nursing competencies, the Society of Pediatric Nurses (SPN) in the United States has outlined core competencies for paediatric nurses. The mission of SPN is to advance the specialty of paediatric nursing through excellence in education, research and practice. The idea behind creating these competencies came from SPN's board of directors, whose aim was to assist the transition of the graduating nursing student into the profession of paediatric nursing in an acute care setting. The core competencies for baccalaureate-prepared nurses in nursing residency programmes share the key concept of family-centered care (Figure 1). (Society of Pediatric Nurses 2017.)

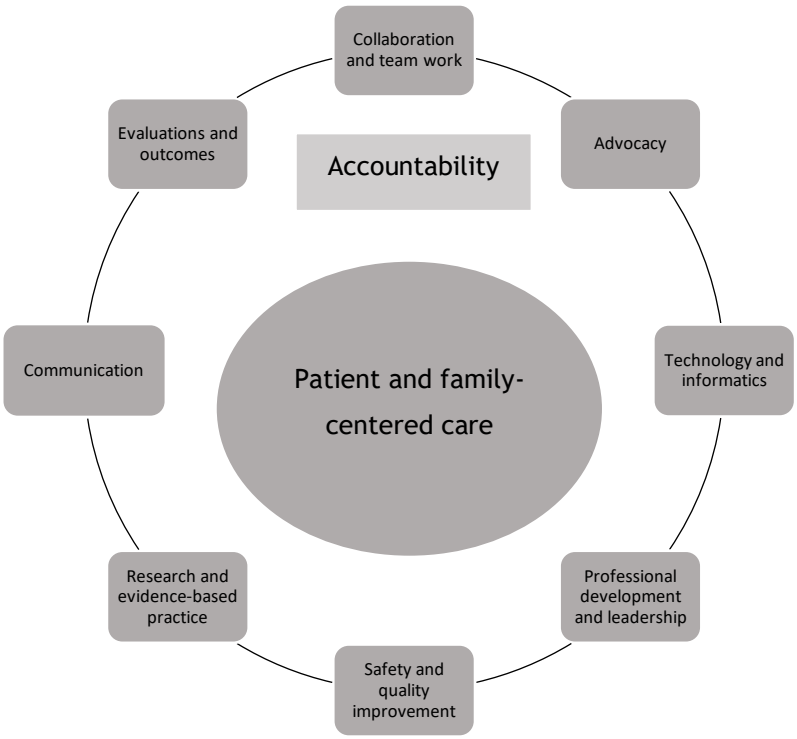

Figure 1: Pediatric Residency Core Competency Model (Society of Pediatric Nurses 2017)

The eight core competency domains are communication, collaboration and teamwork, advocacy, technology and informatics, professional development and leadership, safety and quality improvement, research and evidence-based practice and evaluations and outcomes. Accountability is an over-arching theme that should always be considered by paediatric nurses. All of these competencies are described in detail with definitions and requirements clearly outlined in the documentation. (Society of Pediatric Nurses 2017.)

In their research Hsu et al. (2006) defined seven cross-cutting competencies for healthcare worker's training and education in disaster preparedness (Table 1). Comprehensive terminal objectives for each competency were also described.

Cross-Cutting Competencies for Healthcare Workers in Disaster Preparedness
1. Recognize a potential critical event and implement initial actions
2. Apply the principles of critical event management
3. Demonstrate critical event safety principles
4. Understand the institutional emergency operations plan
5. Demonstrate effective critical event communications
6. Understand the incident command system and your role in it
7. Demonstrate the knowledge and skills needed to fulfil your role during a critical event

Table 1: Cross-cutting Competencies for Healthcare Workers in Disaster Preparedness (Hsu et al. 2006)

3 Goals, Objectives and Research Questions

The goal of this study was to enhance nurse delegates' competencies for encountering children in crisis settings. The objective of this study was to explore the core competencies for encountering children in crisis settings that would enable nurse delegates to care for this vulnerable group of people in crisis response.

This study aimed to answer to the following questions:

1. What kinds of experiences nurse delegates have of encountering children in crisis settings?
2. What were the core competencies for encountering children in crisis settings?

4 Methods

4.1 Qualitative Approach

This study used a qualitative research approach to find answers to the research questions. Qualitative research is valuable because it can help us understand different phenomena, especially in nursing there are many phenomena that cannot be measured using only the

quantitative research approach, instead the human experience needs to be investigated. (Kankkunen & Vehviläinen-Julkunen 2009, 57.) The topics of interest in this study were nurse delegates' experiences of encountering children in crisis settings and nursing competencies for encountering children in crisis settings so, in order to find out more, hearing about the experiences of nurse delegates who have returned from field work in crisis settings was invaluable. In qualitative research the narratives about meanings and experiences are of interest rather than just numbers and statistics (Toles & Barroso 2018, 94).

4.2 Building the theoretical framework of the study

In order to gain an understanding of nurses' competencies for encountering children in crisis settings a literature review was performed. A literature review can be seen as an integral part of any research. By reviewing previous literature on the topic of interest, the researcher is better able to understand the research topic in context. (Suhonen, Axelin & Stolt 2016, 7.) The purpose of a literature review is to find out what kind of research has previously been published on the topic and from what perspective (Hirsjärvi, Remes & Sajavaara 2005, 112). In this study, a literature review was done in order to enhance the researcher's knowledge on the topic. A literature review is also important from an ethical point of view seeing as ethical considerations should be deliberated throughout the course of the research process. In this way the researcher can be sure they are ethically sound. (Oliver 2010, 27.) The information gathered during the literature review also helps to increase the validity of the interview and analysis of data.

For this study information on the subject was sought from different databases. The databases used were OVID, PubMed, ProQuest, Ebook Central and Google Books. The information-wielding search terms used were nursing, nursing competencies, crisis response, emergency nursing, children, conflict, paediatric nursing, humanitarian aid and disaster nursing. Additionally, searches were made for books at the Laurea University of Applied Sciences library, both on location in Tikkurila and online. Some studies and literature were found as suggested reading, either by a database or a supervising lecturer. Studies were also found in the references of other studies. During the course of these literature searches, the key concepts pertaining to the thesis started to emerge and the theoretical framework for this thesis was formed.

In this study the terms crisis, crisis setting, disaster, disaster setting, emergency and conflict are all used, and they all refer to a similar type of situation for example a natural or man-made disaster or an epidemic that disrupts everyday life. This decision was made at the discretion of the researcher in order to remain true to the contents of the source material used. The unifying factor in the source material used in this thesis was the perspective of

children in different crisis settings, whether the setting was a natural or man-made disaster or another emergency situation.

4.3 Collecting qualitative data

A thematic interview using open-ended questions was selected as the data collection method in this study because it allowed the informants to give more varied answers to the questions (Sullivan-Bolyai & Bova 2018, 253). In thematic interviews it is typical that the thematic areas of the interview are known in advance, but the precise phrasing and order of the interview questions is not set in stone – this open-endedness is typical in the qualitative research approach (Hirsjärvi, Remes & Sajavaara 2009, 208; Tuomi & Sarajärvi 2009, 75).

In this study a non-probability sampling method was used (Haber 2018, 217). Informants for the study were rounded up via snowballing. In the snowballing technique the researcher makes use of social contacts and, after the initial intentional contact, the rest follow as recommended informants (Kankkunen & Vehviläinen-Julkunen 2009, 85; Haber 2018, 220). In rounding up informants for the interview the inclusion criteria for selection of the sample were that the informant must have a nursing background and experience of working for an aid organization or non-governmental organization (NGO) in an area that can be defined as a crisis setting – an area affected by a man-made or natural disaster or an epidemic that disrupts daily life (Kankkunen & Vehviläinen-Julkunen 2009, 83). The informants for this study were rounded via three primary contacts. Two of the primary contacts were lecturers at Laurea University of Applied Sciences and one informant was a colleague of the researcher. All three primary contacts recommended informants, who fit the inclusion criteria defined in this study. Using the snowballing technique ten informants were identified for this thesis and five of these informants agreed to be interviewed for this thesis.

Originally the plan was to conduct a focus group interview with the informants. Due to clashing schedules and the varied geographical locations of the informants, the data collection method had to be altered. The eventual chosen data collection method was one-on-one interviews using Skype phone calls online, which were recorded on the researcher's mobile phone. A pilot interview was conducted at first with an informant who fit the inclusion criteria defined in the research. The pilot interview was conducted in order to ensure that the technology worked as intended and to test the interview questions to see whether they guided the conversation towards the research questions. The pilot interview was essentially used to test the reliability of the data collection method (Sullivan-Bolyai & Bova 2018, 258; Kankkunen & Vehviläinen-Julkunen 2009, 152). In the pilot the researcher also asked for feedback and made a few minor alterations to the wording of the questions in order to make them more coherent.

After the thesis plan was accepted by the thesis supervisor at Laurea University of Applied Sciences, email invitations were initially sent to six of the informants to take part in the thesis interview (Appendix 1). After the first set of email invitations a second set of invitations were sent to a further four informants. Altogether five informants agreed to be interviewed. After an affirmative response from an informant to the invitation a time was scheduled for the interview. Prior to the interview the researcher sent the informant the informed consent document (Appendix 2) via email. It was agreed that the informant would print out the document, sign it, scan the signed document and send it back to the researcher via email. This method of attaining informed consent was chosen due to the varying geographical locations of the informants and it was accepted by the thesis supervisor. The informed consent documents were stored in the Laurea University of Applied Sciences online cloud service and on the researcher's private laptop, and they were permanently deleted once this thesis was evaluated and graded.

The two main themes guiding the discussion during the interview were 1) nurse delegates' experiences of encountering children in crisis settings and 2) core competencies for encountering children in crisis settings. At the beginning of the interview the researcher asked the informant to briefly describe their previous deployments. The initial plan for the interview questions to guide the discussion is presented in Table 2.

Theme	Theme
Nurse delegates' experiences of encountering children in crisis settings.	Core competencies for encountering children in crisis settings
Questions	Questions
How would you describe encounters you had with children when working as a nurse in a crisis setting?	How did you cope with these encounters as a professional? What "tools" did you use?
How were you prepared for these types of encounters?	How did your training before deployment influence encountering children in crisis settings?
How would you describe the challenges you faced when encountering children in crisis settings?	What kinds of things do you wish you would have known in advance?
What kinds of things did you find to be important when encountering children in crisis settings?	What competencies (attitudes, skills, knowledge) do you think are useful for encountering children in crisis settings?

Table 2: Interview themes and questions

As is typical in qualitative research and thematic interviews, not all of the questions were asked in every interview and the questions were not always phrased in the same way. Often the answers were covered naturally without separately having to ask the specific question. The interviews were successfully conducted as planned using Skype as a platform. The

interviews were recorded on the researcher's phone and stored on the researcher's laptop hard drive and in a private folder in the online cloud service provided by Laurea University of Applied Sciences. All interview recordings were successful and of good sound quality with only a few minor technical flaws, which did not affect the overall result. The aim of the interviews was to collect a sufficient amount of data in order to reach saturation of information (Kankkunen & Vehviläinen-Julkunen 2009, 84; Hirsjärvi et al. 2005, 171).

In this thesis the researcher was aware of the first and last names of the five informants as well as their email addresses and skype contact details. The researcher attained the first and last names of the informants, as well as their email addresses during the snowballing phase of the research through the first initial contacts that were made when rounding up informants. The skype contact details were shared later, once contact had been established via email with the informants. In the interviews, only the first name of the informant was mentioned at the beginning of the recording for recognition purposes in order aid the data analysis process for the researcher. The contact details were saved for the course of the research in order to later send the informants a link to the finalized thesis. The contact details were stored in a separate document on the researcher's private laptop and as a back-up copy in the online cloud service provided by Laurea University of Applied Sciences. This constituted the data management plan of this thesis.

As per the Regulation (EU) 2016/679 of the European Parliament and the Council, also known as the General Data Protection Regulation (GDPR), the personal information of the informants in this interview was respected and their right to privacy was acknowledged – it was made clear to them in the invitation letter that no identifiable information that could tie them to this thesis would be used in the final draft. In the transcripts the informants were labelled nurse 1, nurse 2 etc. and these labels were also used when quoting them in the analysis process. According to the GDPR personal data is any data information that relates to an identifiable or identified individual, and full names and email addresses fall under this category (European Commission 2020c). After the evaluation and grading of this thesis, the contact details were permanently deleted from the researcher's computer and the online cloud service.

The informants' ages ranged from 31 to 44 years old. There were four female informants and one male informant. The informants had worked in various crisis settings: Yemen, Haiti, Sierra Leone, Nepal, Iraq, Bangladesh, Greece, Pakistan and Zimbabwe. The informants had mainly been deployed as nurse delegates in international aid organizations and a couple of them had also held positions as team leaders or supervisors.

4.4 Data Analysis

The chosen method for data analysis in this study was inductive content analysis (Kankkunen & Vehviläinen-Julkunen 2009, 133; Tuomi & Sarajärvi 2009, 108). In inductive content analysis, the researcher lets the categories rise from the material itself in addition to the research questions (Kankkunen & Vehviläinen-Julkunen 2009, 135). In inductive content analysis the organization of the data is important – this process includes open coding, creating categories and abstraction. When analysing multifaceted and sensitive phenomena typical to nursing, content analysis is particularly well-suited. Inductive content analysis offers insight into phenomena that has previously not been studied or when knowledge on the topic is fragmented. (Elo & Kyngäs 2007, 109-113.)

The themes of this thesis were decided by the researcher in advance and they were based on the research questions (Table 2). In addition to guiding the interviews, these themes also guided the analysis process. The researcher aimed to find the answers to the research questions and the data that was wielded from the interviews could be applied to the chosen themes. The precise wording of the themes changed during the course of the research to better reflect the data (Table 3). In addition to the two themes that guided the analysis process a third theme emerged from the data and that was children in crisis settings. Nurse delegates spoke at length about the condition of children in crisis settings and remembered, quite specifically, many encounters that they had had.

Themes guiding the interviews	Themes Emerging from the Data
Nurse delegates' experiences of encountering children in crisis settings	Challenges nurse delegates faced when encountering children in crisis settings
	Children in crisis settings
Core competencies for encountering children in crisis settings	Core competencies for encountering children in crisis settings

Table 3: Theme synthesis during data analysis

The interview recordings in this thesis were transcribed verbatim. First, the recording was listened to and typed out on the computer. After this a second listen was conducted to check that the transcript was accurate. The transcripts were referred to various times during the analysis process. Altogether there were approximately 16 pages of transcript written in the Calibri font at size 10 with single spacing. In this thesis the method for inductive content analysis included three main steps. First the material was reduced to pertinent sentences or phrases. Then the phrases and sentences were clustered, and subcategories were defined. In the final phase of analysis, abstraction, the main categories were synthesized and grouped below the relevant themes (Tuomi & Sarajärvi 2009, 10).

In the reduction phase of inductive content analysis pertinent sentences or phrases were highlighted in the five transcripts and then grouped together to form the analysis units in this study – this was the open coding phase of analysis. A pertinent sentence or phrase was one in which the informant answered the questions asked by the interviewer in a way that wielded meaningful and interesting information in terms of this study. The rest of the transcript that didn't pertain to the themes of this thesis was largely disregarded. Pertinent answers from all five interviews were grouped together as quotes. The quotes were then grouped into reduced phrases that described the data (Table 4).

Pertinent sentences or phrases / Analysis units	Reduced phrases
When you don't have everything what you would have and being realistic that you can't save everyone – that is going to be mentally very challenging… -Nurse 5	Feeling helpless when it is not possible to support the survival of all patients
And then when you see really, really sick kids in a situation where you can't help them… So, it felt really awful. -Nurse 5	Facing the reality that it is not going to be possible to treat every patient
Trying to explain to a really sick child what you're doing via interpreter and being put up in this protective equipment and suit that it felt really awful. -Nurse 5	
And of course when you see the kind of cases where the future of the child will not be nice it's not easy to handle those situations later on and they always come later. –Nurse 4	

Table 4: Example of content analysis during the reduction phase

The second stage of analysis, clustering, was performed by combining reduced phrases that had similar meanings together to form descriptive subcategories – this was the creating categories phase of content analysis (Table 5).

Reduced Phrases	Subcategory
Feeling helpless when it is not possible to support the survival of all patients	Inability to provide proper care for all patients
Facing the reality that it is not going to be possible to treat every patient	

Table 5: Example of content analysis during the clustering phase

In the final stage of the analysis process, called abstraction, main categories were synthesized and then grouped under the appropriate themes (Table 6).

Reduced Phrases	Subcategory	Main category	Theme
Facing the reality that it is not going to be possible to treat every patient	Inability to provide proper care for all patients	Challenges related to providing and managing treatment	Challenges nurse delegates faced in crisis settings
Feeling helpless when it is not possible to support the survival of all patients			
Difficulties in decision-making related to patient care and treatment	Challenges in decision-making, prioritization and assessing treatment outcomes in patient care		
The need to prioritize in patient care			
Weighing the benefits of treatment against the possible bad effects			

Table 6: Example of content analysis during the abstraction phase

5 Results

The results of the thesis are presented in Figures 2, 3 and 4 according to theme. The three themes of the thesis results are core competencies for encountering children in crisis settings, challenges nurse delegates faced in crisis settings and children in crisis settings. The results will be described one theme at a time. The figures present the theme, main categories, subcategories and, in some cases, a further level of subcategories.

5.1 Core competencies for encountering children in crisis settings

One of the interview questions was “What competencies (attitudes, skills, knowledge) do you think are useful for encountering children in crisis settings?”. Discussion related to this question began to arise at other points during the interviews as well, for example when the nurse delegates spoke about the skills that they felt were important when working in crisis settings as a nurse delegate. The nurse delegates mentioned various different skills that are outlined in Figure 2.

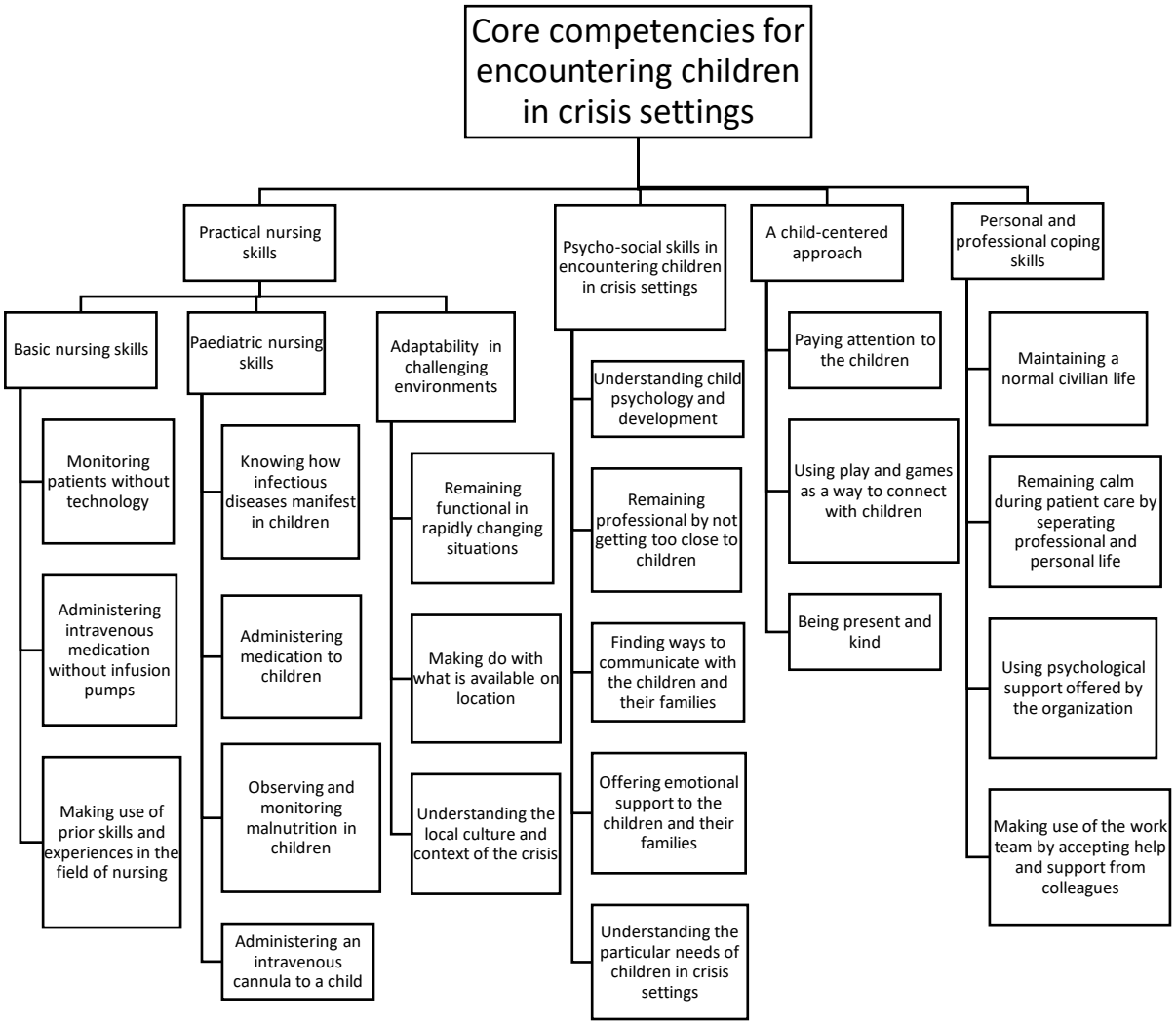

Figure 2: Core Competencies for Encountering Children in Crisis Settings

5.1.1 Practical nursing skills

Practical nursing skills were mentioned by many of the nurse delegates during the interviews. So-called basic nursing skills were emphasized, such as being able to monitor the patients without the aid of machines and laboratory results, which were not always immediately available on location in different crisis settings. Overall, making use of skills learned during one's nursing career, even just in Finland, was seen as very useful.

> That you can examine someone from nurse's perspective without having all the tools or all the machines that you would have…
>
> Well, I would say working in all kinds of crisis settings, it would be beneficial to have more skills without the monitors and without the technology. So, learning kind of like 'old-school' styles.

Paediatric nursing skills were also brought up as important when caring for children in crisis settings. The particulars of the administration of medication to children and the knowledge of how different infectious diseases manifest in children were noted as essential information before deployment, for example children's dosages of medication are usually a fraction of those of adults and the disease profile of malaria in a child can be very different when compared to an adult. Malnutrition was also mentioned many times by the nurse delegates, particularly when dealing with refugee camps and population movements. Otherwise healthy children were adversely affected by lack of clean water and food, and oral rehydration therapy was then administered. Measuring for malnutrition was also brought up – the purpose and significance of measuring the circumference of the upper arm was mentioned, meaning that nurse delegates should understand why it is done and how to do it properly. The ability to administer intravenous medication without an infusion pump was also mentioned, as was the skill to apply an intravenous cannula on a child.

> What comes to skills, I think it's really important that you have a very strong background and especially with children.
>
> So, I think the nutrition is quite essential. It might not be the case always but quite often it is.
>
> I would say nutrition and all kind of like water sanitation issues.

Another practical nursing skill that was brought up was adaptability in changing environments. This is perhaps not traditionally viewed as a nursing skill, but even in developed countries nurses are under quite a bit of pressure in hospitals and health centers due to large patient numbers and the fast-paced nature of the work in general. Adaptability is a useful skill when working in the field in crisis settings as well. In the interviews nurse delegates spoke of situations changing rapidly due to various reasons and how it was important to remain functional. Often the field hospital or mobile clinic was the only place available for the local population to receive help and care. Not being able to use all the technology and other resources that are readily available in Finnish hospitals, for example, was a challenge that had to be navigated by adapting and making do with what was available on location.

> Maybe the competency here would be that you … find a solution of doings things if you can't do them in the way that you have normally always done.
>
> Maybe adapting skills to different contexts, that's a very wide thing but that is the most important in my opinion.
>
> But maybe knowing that you need to adapt all the skills what you have, that you need to adapt them to local context…

Understanding something about the local culture and context was seen as a valuable asset when encountering children in crisis settings. For example, knowing about what the typical family unit is like or what the main religions are and how they affect daily life can be helpful. Some of the nurse delegates mentioned education as well – in some areas people were less educated than in others and the literacy rate was very low. This meant that written instructions were not necessarily understood. One nurse delegate told about an experience in a refugee camp in Bangladesh of giving a bar of soap to a family so they could wash themselves, but instead of using it in the intended way they had tried to eat it. This spoke volumes to the nurse delegate, both about the hunger of the family and of how the nurse delegates would have to work harder on communicating information to the local population.

> And I think it's really important that you get a good information package before you go that even though it's not always the reality when you go to the place but still you kind of have the basic understanding and information that what are you actually dealing with, what is the situation, what is the knowledge level of these people.
>
> So, you kind of, you need to understand where you're going and what is the knowledge level of these people. It doesn't make sense to talk about things that go way to high. You need to be in the basics.
>
> I think culture-wise, how will you actually approach people from these communities.

5.1.2 Psycho-social skills for encountering children in crisis settings

Psycho-social skills for encountering children in crisis settings were emphasized in the data. When encountering children in crisis settings the nurse delegates spoke of language barriers often being a challenge. In order to offset this challenge nurse delegates attempted to gain the trust of children and their families via alternate methods of communication. Translators were used when possible, but they were not always readily available or the dialect the translator spoke was not the same as what the child or their family spoke. Nurses mentioned drawing pictures for children and their families in order to explain medical procedures. Finding an alternate way to communicate with the children and their families was seen as important in order to gain their trust and relay important information.

Supporting the children and their families was also mentioned by many nurse delegates. This meant, for example, being positive and giving them hope for the future even if the current situation seemed quite bleak. Holding out hope for a brighter future was seen as an important resource for the families. Nurse delegates also spoke of being honest and explaining the situations without sugar-coating. Still, seeing the silver lining was seen as something that could aid the child and family in their recovery.

> I think like family support in a way, like I think people who are on a mission and who will encounter children who are in a conflict, I think first and foremost is to know the family dynamics, in a way. Like how does it work in that culture, in that context, for example.
>
> I think to know the family dynamics the line of support for the children, that is a good skill set.
>
> …I think it's really important that you're kind of in the same level as the children – you go down, you throw balls to them… you can kind of pat them when you go past them, you kind of look them in the eye, you're kind of present, you smile, you try to keep the spirit up…
>
> …I think it's extremely important you kind of keep up the good kind of atmosphere and you try to smile and be kind and notice everybody because it's extremely important for the children to be noticed.
>
> Because when you take good contact – especially the children – the situations go more smoothly and it's easier to get them somehow to live again when they have some kind of contact and somebody is giving them the feeling that somebody is caring, also that the children… that they are important to somebody so they start to live their life again.

Nurse delegates also mentioned unaccompanied children many times and pondered their need for psychological support and adult attention. One nurse delegate spoke of a small child who became sad whenever he saw her because she reminded him of his own mother, who was not present. Being professional in these situations was seen as important – it was wise not to get too close to the patients, because eventually the nurse delegate would also be leaving and if the child became too attached then they might have to deal with yet another loss. Nevertheless, when encountering children in crisis settings it was seen as important to be present and to offer support and kindness.

Understanding the basics about child psychology was also mentioned as something potentially useful for encountering children in crisis settings. The nurse delegates seemed very intent on being able to support and help the children in crisis settings as best they could, and they recognized the long-term psychological damage that a crisis setting can cause for a child. The particular needs of children in a crisis setting was also mentioned in the data. It was acknowledged that normal life is disrupted by a crisis and that this has a strong effect on the well-being of the children.

> Of course, they are all children, but they have different needs they have been in a different environment which is not peaceful or something like that.
>
> And I think more of, you know… more of a course or something, not really not necessarily a course but like – it might help if there is really a skill set on how to, for example on how particularly children in conflict should be approached.

5.1.3 A child-centred approach

A child-centred approach was brought up by the nurse delegates. This meant taking the child into account and paying attention to them and performing nursing and medical procedures in a way that made the child feel safe and cared for. A child generally needs a longer period of time to prepare for procedures than adults because they can be very fearful, and they have a smaller understanding of what is going on.

Nurse delegates spoke about how important play was to a child. Two of the nurse delegates mentioned carrying balloons in their pockets so that they could take them out and blow them up for children. Showing a sense of humour through jokes and play was seen as important and they would often work as trust-builders between nurse delegate and child, especially when there was no common language.

> I always carry some like balloons or something with me and try to play with them somehow because, especially when I am working in the operating theatre, it's nice to do the most that you can do to make the environment feel safe.
>
> Usually with kids it's easiest to take the contact by playing something with them and trying to ease the situation, somehow get it lighter.

Being present and kind was seen as important when encountering children in crisis settings. Spending time with the children by their side and comforting them was seen as valuable. Sometimes just smiling and giving them a pat on the back was enough to put a smile back on the child's face. Keeping up a positive atmosphere was mentioned. The adaptability of children was also mentioned – children will quickly adapt to new environments and begin to live their normal lives despite the trying circumstances.

> So, these children, they are so happy about you just being, just paying attention to them…
>
> Yeah, being present and really paying attention what you're doing with that child when you're doing it.
>
> …in a way you get their acceptance when you give them your time and I think that's quite an easy way to get it.

5.1.4 Personal and professional coping skills

When working as a nurse delegate in crisis settings certain personal and professional coping skills were very useful. In the interviews one of the questions was "How did you cope with these encounters as a professional? What 'tools' did you use?". The purpose of this question

was to try and find out what types of skills were required, both professional and personal, from the nurse delegate in order to be able to do such demanding work.

The most common answer was to try and maintain a normal civilian life – reading the local news back home, skype phone calls with friends and family, socializing with colleagues and going out when possible. Often, it was not possible to leave the vicinity of the field hospitals or refugee camps due to security reasons and other organizational regulations. One nurse delegate said that she eventually has a countdown for when she gets to go back home.

> Well, I think like personally, just the coping mechanisms that I have, like you know, being out somehow with friends.
>
> Yeah, just keeping in touch with significant others, with friends, with family, going out. For example, I made a couple of friends from these countries, or the local people.
>
> Yeah, I think keeping yourself busy in a way. And not thinking so much of the...difficulties that you are facing and the difficulties of the people you are serving.
>
> …you do kind of cope and you do those little things during the day that you talk with your colleagues, having dinner, you go early to bed, you do your yoga, you send WhatsApp messages to home…
>
> So, it's those small things. But you just keep kind of going on until you get home and then you are totally exhausted.

Using the psychological support offered by the organization was also seen to be very useful. Support was offered both on site and back home. Additionally, speaking with colleagues about experiences and feelings was helpful for the nurse delegates. This included asking for and accepting help when caring for children. Most of the nurse delegates whom were interviewed for this thesis did not have paediatric experience and were therefore reliant on help from more experienced colleagues.

> So, how did I cope with that (not having paediatric experience) was basically, I asked very specific orders from those two paediatric nurses I had in my team just to tell me what to do and being very honest about I'm not a paediatric nurse… so I got pretty good backup and support from them.

Another coping mechanism that was mentioned was separating professional and personal life and aiming to remain calm during patient care. It was seen as important to keep oneself calm during the patient contacts and to then deal with difficult emotions later, during personal time.

> …there are a lot of very difficult cases and I try to keep calm when I'm involved and after that I do let go.
>
> So that was kind of like you just have to be very cool about your emotions.

But when you're there in the field you just do what you can.

5.2 Children in crisis settings

In the interviews the nurse delegates mentioned the condition of children in crisis settings. The descriptions of children usually followed the interview question "How would you describe encounters you had with children in crisis settings?". This question seemed to help the nurse delegates open up and tell the researcher more about their experiences, thoughts and feelings. The results of this theme are shown in Figure 3.

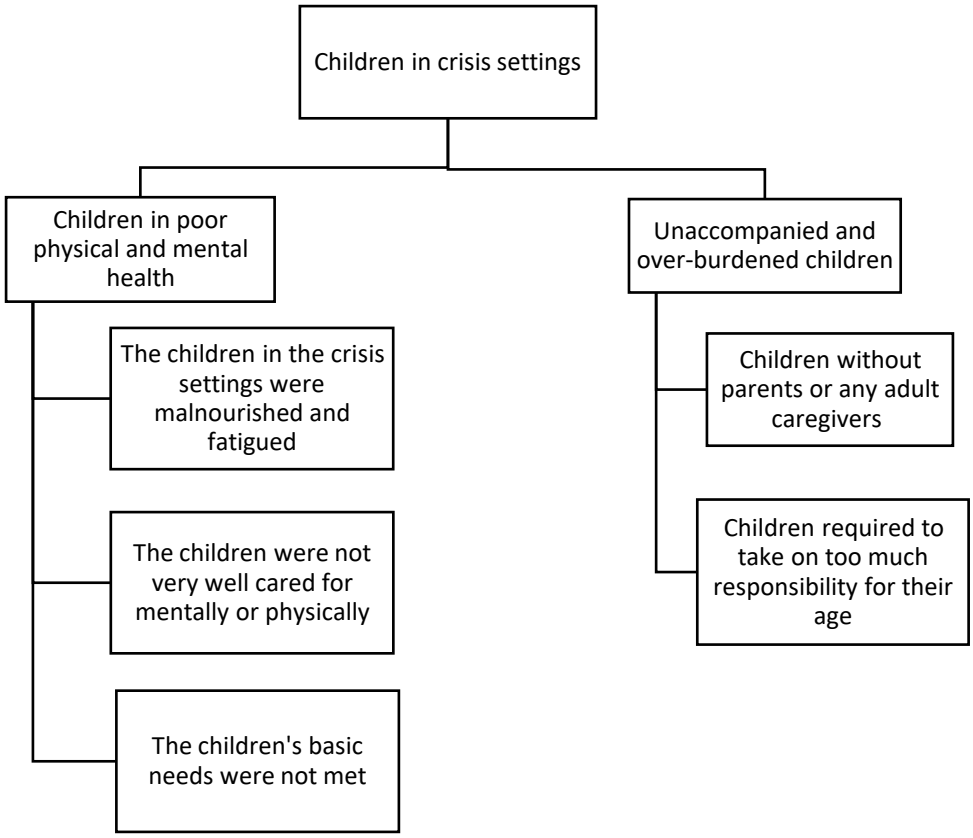

Figure 3: Children in Crisis Settings

5.2.1 Children in poor physical and mental health

The children were often malnourished and fatigued. Nutrition issues were mentioned by various nurse delegates – sometimes the children had sustained longer periods of malnutrition and this had a detrimental effect on their general health. Children respond to malnutrition faster and more dramatically than adults and this was noted by the nurse delegates as a big challenge in the field hospitals. It required expertise from the nurse delegate when it came to treating malnutrition in children.

> And then, also in the field hospital emergency, there were children who were malnourished and that had weakened their status…
>
> They are extremely malnourished. The half year-old children weigh about 4-5kg maximum so most of them are in a critical state in the normal stage…
>
> …people have been travelling days from Myanmar to Bangladesh and once they got into the camps the children were malnourished and starving and dehydrated. And yeah, so children they are not so resilient for that kind of…lack of nutrition and water…

In many cases the basic needs of children were not met. Often, they did not have a safety net of secure adults, they did not have access to clean water or food, they did not have proper shelter and their general health had been overlooked for some time. For example, one nurse delegate mentioned the lack of information regarding vaccinations, meaning that basic health care in their regular home environment was already lacking. Children also suffered from ailments that are common in young children, such as seasonal flus and other infections.

> So, the situation is really severe from the basic level even.
>
> And then in addition all these infectious diseases that are occurring because there are no vaccinations among the children…

5.2.2 Unaccompanied and over-burdened children

Nurse delegates met lots of children on their missions around the world and a couple of them even mentioned that children made up the majority of patient contacts in field hospitals and mobile clinics. Children were often unaccompanied – they had no parents with them and sometimes no adult caregivers at all. Sometimes children were accompanied by grandparents or even neighbours and some children were travelling with siblings.

Some of the nurse delegates noted that children were required to take on more responsibility than they should have to at such a young age. This was said to be due to the gruelling nature of crisis, for example in the population movement of Rohingyas from Myanmar to Bangladesh. Children had to care for their younger siblings, carry heavy loads, forgo attention and love from their parents and withstand harsh environments such as refugee camps.

> …all these settings where I have been working, so the children there are used to being treated quite harsh and they are being treated as adults in many cases…
>
> For example, in Greece we saw a lot of patients, a lot of children… They had been travelling a long distance already, so they don't really get that kind of attention or treatment from their parents what we are used to in Finland for example.

> And some of the contacts are when the child has been alone with no parents, maybe some neighbour with them, and it has been quite rough to build some trust with them because they don't have any safe person with them…
>
> There were also these kids who weren't sick themselves, but they had lost their family members and they would come to us just to get some comfort and support.

5.3 Challenges nurse delegates faced in crisis settings

One of the themes that rose from the data was related to the challenges nurse delegates faced when encountering children in crisis settings. One of the interview questions was "How would you describe the challenges you faced when encountering children in crisis settings?" so this topic did not arise completely organically, although most of the nurse delegates started to talk about the challenges they faced before the researcher even had time to ask this question. In two out of five interviews the question was not asked at all because the nurse delegates started to talk about the challenges naturally. The purpose of this question was to try and understand what the nurse delegates felt to be difficult and demanding when encountering children in crisis settings and to try to pinpoint whether any of these challenges might be related to potential competencies in this field of work. By outlining challenges, the nurse delegates might be inclined to consider competencies. The main challenges were identified as infrastructural challenges, communication and trust issues and challenges related to providing and managing treatment (Figure 4).

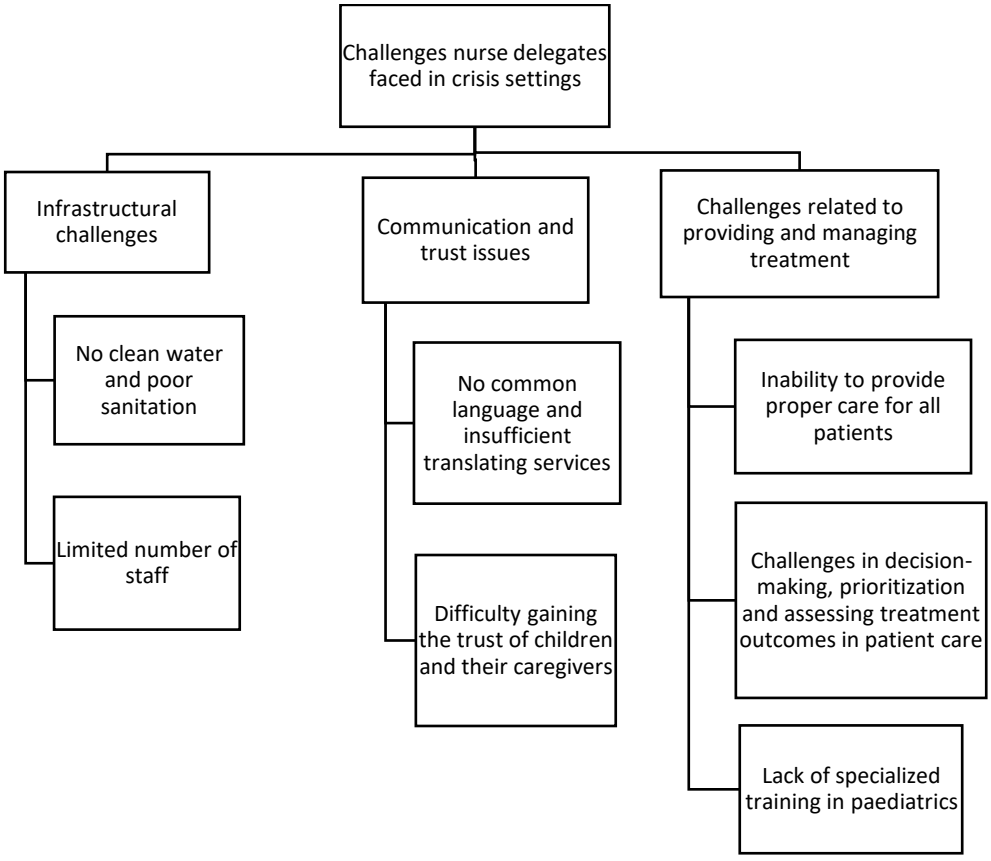

Figure 4: Challenges Nurse Delegates Faced in Crisis Settings

5.3.1 Infrastructural challenges

Nurse delegates spoke at length about the conditions in the field hospitals and mobile clinics in crisis settings – there was often not enough clean water for everybody not to mention sufficient sanitation, especially considering the sheer volume of people, for example in refugee camps. Basic needs were brought up in many of the interviews as well, mainly because they were not met in so many cases. People simply did not have what they needed to enable even the simplest humane existence.

Lack of staff and resources in the field were also mentioned routinely in the thesis interviews. There was not enough medicine, not enough health care technology, limited or no possibility for laboratory testing and not enough trained health care staff. One nurse said that it was quite a routine situation for her to treat over fifty patients per day in a field hospital. This limited access to treatment meant that the nurse delegates had to face the facts – they could not treat everyone, at least not in the exact way required and in the way they could back home in a well-equipped hospital.

> …we didn't have enough resources to help. Or machines, or medicines, or lab results or tests or whatever so it's very basic level.

> And the lack of resources is one of the things that I found the most demanding.
>
> Well, there were a lot of challenges…the setting was not providing clean water that would be like the first problem…
>
> I mean the basic needs, they didn't really have that like hygiene and water and sanitation, that was lacking.

5.3.2 Communication and trust issues

Communication issues were discussed in many of the interviews. A lack of common language was a challenge in many of the encounters with children in crisis settings and, additionally, the availability of sufficient translating services was also a problem. In some cases, translators were available but the dialect they spoke was not the one the children and their families spoke. Getting a proper anamnesis was very difficult and finding out what was really wrong with the patient was challenging. One nurse delegate even said that she had to "go with the flow" and use her own judgement as best she could to figure out what the problem was.

> Like most significant thing is I think the language barrier and not knowing probably like the particular need of children in their respective culture.
>
> We had translators, but the problem is that the Bangla translators don't speak exactly same language as the Rohingya people, so this is kind of a problem.

Trust issues were brought up in every interview. Gaining the trust of children and their families was seen as very difficult when encountering them in crisis settings. There were a few main reasons behind the trust issues according to the nurse delegates. The language barrier and communication issues hindered trust building between nurse delegate and patient. The education level of patients varied a lot. Some patients and their families were illiterate, which meant that it was especially difficult to try and convey any information to them. Children were frightened and did not understand what was going on.

The nurse delegates noted that if a child's parents or other caregivers were distrustful of the health care professionals it created an almost impossible situation – it was doubly difficult to establish trust because the children could see that their closest caregivers were not comfortable, and this made them very sceptical. Nurse delegates mentioned that sometimes it was easier to deal with the children than their parents – sometimes parents stood in the way of trust building whereas children were said to be more adaptable to new situations and ready to trust nurse delegates.

> So, the trust – I think like the building of trust in some way is quite challenging in a sense because they came from a community that is really like – a conflict community, for example – and then it's difficult to approach them.

> The literacy rate is 2% among the women so it's really, extremely difficult to give health education or health promotion… the basic knowledge level is extremely low, with the children and with the adults.
>
> Some of the challenges are related to situations when the children have been there without their parents, so that's the like… The trust issue is really, really sad in those cases.
>
> And also, if there are parents in the situation or somebody who the child is really trusting and if the parent is not trusting us then it's not easy to be there in the situation and try to build trust.

5.3.3 Challenges related to providing and managing treatment

The nurse delegates mentioned feelings of inadequacy and helplessness in the interviews. These feelings were often associated with not being able to provide proper care to all the children needing it. For example, sometimes a certain medication was not readily available, some laboratory tests were not possible to take or there was not enough staff to care for everyone. This made the nurse delegates feel distraught and quite awful.

> And then when you see really, really sick kids in a situation where you can't help them… So, it felt really awful.
>
> Access to the care was limited so… Losing children there, it was a challenge…
>
> When you don't have everything what you would have and being realistic that you can't save everyone – that is going to be mentally very challenging…

Nurse delegates spoke of the difficulty of being the one making decisions regarding treatment, such as prioritization in patient care. For example, one of the nurse delegates was caring for many children in a paediatric ward and one of the children was very ill and needed immediate medical attention. It was possible that the child would not survive. The other less ill children also needed medical attention and, in addition, emotional support, so the nurse delegate pondered how to split her time between all the children equally and how to prioritize caregiving. Would it be more valuable to try and support the children who were likely to survive and hopefully positively affect the outcome for them, or should she spend most of her energy trying to help the most ill child, who was unlikely to survive?

> Who do you prioritize? It's… I think it's extremely challenging.
>
> It's very demanding when you should be the one who is deciding.

The nurse delegates also mentioned cases where the treatment might do more harm than good. One of the nurse delegates mentioned administering oral rehydration therapy (ORT) to treat malnutrition in children but the only water that was readily available was contaminated and there was not enough clean water to go around. The field hospital was able to provide sachets of ORT but only half a litre of clean water per patient, which was nowhere near

enough to see them through the course of treatment. The nurse delegate pondered whether the treatment was actually putting the children and their families in more danger because they were likely to consume the ORT with contaminated water and then potentially contract life-threatening diseases.

> So, it was like, we could treat them, but it was not what they actually needed. So, in the beginning that was really causing frustration and difficulties for me at least to think about is this fair to give them this treatment causing them probably even more problems?

A lack of training in paediatric health care was also mentioned various times in the interviews. Paediatrics skills were seen as important but many of the nurse delegates felt that they were not adequately prepared in this area. Despite this lack of training the nurse delegates still felt that they were able to work with children successfully by consulting more experienced colleagues and by using their own pre-existing skills and adapting them to the current context. The nurse delegates also seemed to use their own interpersonal skills when caring for children in crisis settings – the nurse delegates spoke of using their own "personal skills" and "just being myself" when encountering children in crisis settings.

6 Discussion

6.1 Evaluation of the study methods

The sample size in this study was quite small – five informants were interviewed. In qualitative research it is more difficult to define an appropriate sample size. Sometimes minimum and maximum informant numbers are suggested but this is not always necessarily helpful because it depends on the topic of research, the nature of the research questions, the hetero- or homogeneity of the population and the richness of the data. It will usually suffice if the researcher ends up with detailed enough data to answer the research questions. (Gerrish & Lathlean 2015, 182-183.) The research questions posed in this study were answered in a thorough and varied manner. The interviewed nurse delegates spoke at length about their experiences in the field and they contemplated what the core competencies could be for encountering children in crisis settings. In this respect the research was successful. Themes arose organically from the interviews – there were two themes guiding the interviews but as the data accumulated these themes were revised and in the final results there are three themes (Table 3). Nevertheless, the limited sample size affects the generalizability or transferability of this research (Holloway & Wheeler 2009, 303).

In qualitative research, it is common that there is no uniform concept of validity in the same way as there is in quantitative research – validity has different implications and applications

in qualitative studies. It is advisable for qualitative researchers to be particularly systematic and organized in their research, as this also increases validity. (Holloway & Wheeler 2009, 297.) In this study the researcher aimed to be as systematic and organized as possible – all documents were properly stored and backed up during the course of the study.

The concept of trustworthiness can be used as an alternative for the concept of validity in qualitative research (Holloway & Wheeler 2009, 297-298; Gerrish & Lacey 2010, 138-139). Reflexivity is one of the tools for demonstrating trustworthiness in qualitative research and it entails that the researcher critically examines their own preconceptions and relationships with the informants in the study in addition to reflecting on their own feelings, actions and conflicts experienced during the research process (Holloway & Wheeler 2009, 304-305). Some of the data collection methods commonly used in qualitative research, such as interviews and focus groups, can be seen as more prone to the personal bias and influence of the researcher and sometimes the mere presence of the researcher can be disruptive (Gerrish & Lacey 2010, 83; Gerrish & Lathlean 2015, 437).

In this thesis the nursing background of the researcher was disclosed to the informants in the invitation letter that was sent via email. A shared professional background with the informants may have affected the course and content of the discussions in the interview. It may have had a positive impact on the discussion by allowing the informants to describe their experiences and thoughts in more vivid detail while occasionally also using some professional terminology. This may not have been the case if they had been explaining their experiences to someone who does not have any experience in the field of health care. The same argument could be made the other way around – perhaps the informants would have described their experiences and thoughts more clearly and using more synonyms or relatable examples if they had been speaking to someone without a background in health care. The interviews were conducted online using Skype as a platform and this posed limits on the conversation as well. It was not possible to take notes on body language or expressions because the videocall feature did not work seamlessly due to varying internet speeds, so most of the interviews were essentially just phone calls.

Another tool that can be used to test for trustworthiness in qualitative research is the audit or decision trail. This refers to making the thought process and decision-making process of the researcher as transparent as possible. It should be possible for the reader to follow along and understand why certain decisions were made during the course of the research. (Holloway & Wheeler 2009, 310.) In this study the transcripts and ensuing reduction, clustering and abstraction were all documented digitally, and examples of this documentation are also presented in the thesis (Tables 4-6).

6.2 Evaluation of the study results

The International Council of Nurses (ICN) published a revised set of core competencies in disaster nursing in 2019. The ICN identified three different levels of nursing with the third level nurse being the most experienced in disaster response. None of the competencies described in the list specifically mention encountering children in crisis settings. Adapting basic infection control practices to the available resources, isolating individuals and/or families at risk of spreading communicable diseases, prioritizing patient care, performing rapid triage, using available multi-lingual resources to provide clear communication with the affected population and regularly assessing oneself and colleagues during the disaster event to identify the possible need for physical or psychological support were among the many listed competencies. (Core Competencies in Disaster Nursing 2019.) These competencies are in line with some of the findings in this thesis, for example adapting practices to the available resources and making use of psychological support offered by the organization and the team of delegates while on a mission were mentioned as core competencies for encountering children in crisis settings. Communication and trust issues and managing and prioritizing patient care were mentioned in this thesis as challenges nurse delegates faced when encountering children in crisis settings.

In her dissertation Woolsey (2009) researched whether the inclusion of developmentally protective elements in emergency response planning would mitigate further psychological damage in the 6 to 10-year-old child. One major finding in her research was that, on a national level in the United States, children's needs are not addressed in emergency plans. Emphasis was put on researching children's responses to natural disaster and incorporating these findings into emergency response planning.

Similar findings to the ones in this thesis were reported in a study by Johnson, Gaskins & Seibert (2012). They did an integrative literature review on what the clinical skill and knowledge requirements for military health care providers caring for children in disaster, humanitarian and civic assistance operations should be. Even their research questions were very similar to those in this thesis. The most frequently mentioned clinical skills and knowledge requirements were infectious diseases, vaccines, malnutrition, sanitation and care of injuries and wounds. Less frequently mentioned were nutrition, paediatric medications and dosages and management of dehydration. In this thesis some of the findings include knowing how diseases manifest in children, administering medication to children and observing and monitoring malnutrition in children. In their research Johnson et al. (2012) concluded that in addition to aforementioned clinical skills and knowledge requirements the military health care providers also need to be more comfortable making diagnoses without relying on medical

technology. This was also mentioned in this thesis as a core competency falling under the subcategory of basic nursing skills.

Overall, the nurse delegates interviewed for this thesis expressed similar views about insufficient training in paediatrics and they wished for more training on the topic. This was in line with previous research from Mace & Burn (2007), Zaveri & Agrawal (2006) and Almonte (2009). Additionally, deficiencies in resources were reported both in this thesis and in the research by Mace & Burn (2007) and Zaveri & Agrawal (2006). According to Speraw & Persell (2012, 670) nurses who have achieved a level of competence in disaster and emergency response are better equipped to recognize and respond to disasters and this view was echoed by the nurse delegates interviewed for this thesis when discussing nursing competencies for encountering children in crisis settings. The nurse delegates interviewed for this thesis also brought up the fact that, despite all the training in the world, it is never possible to be fully prepared for what might be waiting for you on location when you arrive on your mission.

6.3 Ethical Considerations

The ethical principles put forth in the Helsinki Declaration (2013) were followed in the research process of this thesis. Precautions were taken to ensure the privacy and anonymity of the informants. After explaining the aims and methods of the research and making sure the informants understood and agreed with the information given, informed consent documents were presented for written signature. (World Medical Association 2013.) Informed consent is based on people's right to information on a topic – participants should be presented with sufficient information in order for them to make an informed decision about their participation (Oliver 2010, 28). In this research, the selected informants are not considered to be a vulnerable population and, therefore, a research permit from an ethical committee was not sought out (World Medical Association 2013). This study has received no outsider funding.

7 Conclusion

Overall, there does not seem to be very much research on the topic of encountering children in crisis settings and the related competencies. Based on the research done for this thesis children's needs in crisis settings seem to be grossly underrepresented in both the research and the planning involved in different emergency, disaster or crisis scenarios (Emergency Care for Children: Growing Pains 2007, 226). Perhaps this has led to nurse delegates reporting feelings of unpreparedness when it comes to encountering children in crisis settings, since there simply doesn't seem to be enough information on the subject. Steps have been taken by various stakeholders to rectify the situation, particularly after major disasters or crises such

as the September 11th, 2001 terrorist attacks in the United States (Emergency Care for Children: Growing Pains 2007, 227).

The nurse delegates who were interviewed for this thesis hoped for more training on the topic of encountering children in crisis settings. They saw it as valuable and important. Nevertheless, they did feel that by using their prior skills in nursing and by being themselves and using their personalities to navigate the situations they were able to cope fairly well with children. The training they wished for was more clinical – information of how infectious diseases manifest in children, training in child psychology and learning more about malnutrition and how to treat it in children.

The competencies presented in this thesis are only the beginning – more research needs to be done on the topic of encountering children in crisis settings and what the core competencies ought to be. Nevertheless, the findings in this thesis are corroborated by findings in other research. Even if the topic matter of the research was not exactly the same as in this thesis, similar themes arose, such as adaptability, infectious diseases, malnutrition, administering medication to children and recognizing the need for physical or psychological support during missions and utilizing the available services.

8 Recommendations

Further research is most definitely needed on the topic of this thesis. Nurse delegates who have been on missions around the world have an abundance of knowledge on the topic of encountering children in crisis settings, and their experiences are invaluable when considering the core competencies for this area of expertise. It is evident from the results of this thesis as well as from data published by reputable organizations such as Save the Children, UNICEF and the European Union that children are disproportionately affected in many conflicts globally and that children tend to suffer the most (UNICEF 2019; Save the Children 2018; European Commission 2017). Therefore, it stands to reason that on missions with NGOs and other humanitarian aid organizations nurse delegates will continue to encounter many children in crisis settings.

The results of this study and the previous evidence revealed the need for further training in paediatric nursing as well as encountering children in crisis settings in general. In view of these findings it would be worthwhile to further formulate of a set of core competencies for encountering children in crisis settings. Trying to be as prepared as possible when going out into the field in a crisis setting is likely the wisest course of action, seeing as it would probably make adapting to the local circumstances more manageable. Additionally, including

children's needs and perspective in disaster preparedness plans, both on a national and international level, would also be a step in the right direction when it comes to enhancing the wellbeing of children in crisis settings and helping to prepare nurse delegates to better care for children in crisis settings.

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Appendices

Appendix 1: Email Invitation to Interview

Hello,

You are receiving this message because a mutual acquaintance has recommended you to be a participant in an interview for my master's thesis study. I am a master's degree student at Laurea University of Applied Sciences in the degree programme Global Development and Management in Health Care. My background is in nursing. The topic of my thesis is "Core Competencies for Encountering Children in Crisis Settings". **I am interested in what kinds of competencies nurses have for encountering children in crisis settings and what these core competencies could potentially be**. I plan to conduct interviews with nurses, who have been deployed in crisis settings with international aid organizations or non-governmental organizations. A crisis setting in this context is defined as a natural or man-made disaster or an epidemic that disrupts daily life.

This thesis is realized in association with the international Gaming for Peace Project (GAP) in which the Laurea University of Applied Sciences forms part of a consortium that aims to include soft skills - communication and cooperation - in the training curriculum of personnel being deployed on Conflict Prevention and Peace Building (CPPB) missions. The GAP project has received funding from the European Union's Horizon 2020 research and innovation programme. The end result of the GAP project is to create a simulation game, which CPPB personnel can use for training purposes prior to deployment. https://gap-project.eu/

The plan is to conduct individual Skype interviews with the participants during the spring and early summer of 2018. The interview will be in English and recorded on the interviewer's phone. The duration of the interview is approximately 30 minutes based on the interview pilot. Participation in the interview is fully voluntary and anonymous. The interviewer will adhere to the ethical guidelines put forth in the Helsinki Declaration (2013). Informed consent documents will be sent via email for signature before the interviews.

I would be very grateful for your participation! If you are willing to participate, please kindly respond to this email so we can agree on a date and time.

Kind regards,
Greta Hagfors

Appendix 2: Informed Consent Document

My name is Greta Hagfors and I am a master's degree student at Laurea University of Applied Sciences. My degree programme is called Global Development and Management in Health Care and I am currently working on my master's thesis. The topic of my thesis is "Core Competencies for Encountering Children in Crisis Settings". **I am interested in what kinds of competencies nurses have for encountering children in crisis settings and what these core competencies could potentially be**. I plan to conduct interviews with nurses, who have been deployed in crisis settings with international aid organizations or non-governmental organizations. A crisis setting in this context is defined as a natural or man-made disaster or an epidemic that disrupts daily life.

This thesis is realized in association with the international Gaming for Peace Project (GAP) in which the Laurea University of Applied Sciences forms part of a consortium that aims to include soft skills - communication and cooperation - in the training curriculum of personnel being deployed on Conflict Prevention and Peace Building (CPPB) missions. The GAP project has received funding from the European Union's Horizon 2020 research and innovation programme. The end result of the GAP project is to create a simulation game, which CPPB personnel can use for training purposes prior to deployment.

The interview will be in English and it will be guided by some questions by the interviewer. The interview will be recorded on the interviewer's phone where the recording will be safely stored. A backup of the recording will be stored on the interviewer's home laptop for the duration of the study. Once the study is complete and has been evaluated, the recordings will be permanently deleted. Participation in the interview is fully voluntary and anonymous. Personal identification information of the participants will not be linked to the recording. The interviewer will follow the ethical guidelines put forth in the Helsinki Declaration (2013). The finished thesis will be published online in the Theseus database, which is readily accessible to everyone. The interviewer will gladly answer any further questions regarding the thesis and interview via email, phone and on the day of the interview.

Kind regards,
Greta Hagfors

By signing this informed consent document, I hereby agree to participate in the interview. I have received sufficient information regarding the purpose of this study. I give my permission to utilize the interview recording for the purposes of this study.

_____

Signature Place Date