

THE EXPERIENCES AND PERCEPTIONS OF MOTHERS UTILIZING CHILD HEALTH SERVICES

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof, that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in parts submitted it for obtaining any qualification.

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ABSTRACT

Member states of the United Nations accepted eight Millennium Development Goals in 2000. Millennium Development Goal number four addresses the improvement of child health. The purpose of goal number four is to decrease the child mortality rate by 60% for the period 1990 to 2015. South Africa is one of twelve countries where the incidence of child mortality increased during this period.

Guided by the research question “What are the experiences and perceptions of mothers utilizing child health services”, a study was done. A qualitative, descriptive phenomenological methodology was applied to explore the experiences and perceptions of mothers utilizing child health services for children younger than two years.

The goal of this study was to determine the experiences and perceptions of mothers utilizing child health services.

The objectives were to explore their experiences and perceptions, with specific reference to the service they receive regarding:

- immunization
- nutrition assessment
- the growth of the child
- the growth chart
- other underlying illnesses

Ethical approval was obtained from Stellenbosch University and various health authorities. Validity was assured by adhering to the principles of trustworthiness, namely credibility, transferability, dependability, and conformability.

The population for this study was mothers who utilized ten clinics in a demarcated area of Cape Town for child health services. Purposive sampling was utilized to consciously select three clinics (N =10), and at each of the clinics four mothers were purposively selected to participate. A total of seventeen mothers participated in the study.

An interview guide was used to conduct interviews with participants. The researcher conducted and recorded the interviews after obtaining written informed consent from each participant. A field diary was kept for notation of observations.

Data analysis involved the transcribing of digitally recorded interviews, the coding of the data, the generating of themes and sub-themes, interpretation and organization of data and the drawing of conclusions.

The Modeling Role-Modeling Nursing theory of Erickson, Tomlin and Swain were utilized as conceptual theoretical framework to facilitate application to the broad population.

Findings of the study indicated varied experiences. All mothers did not receive information about the RtHB or RTHC. Not all mothers developed a relationship of trust with caregivers or were afforded the respect of becoming part of the child's health care team. According to the mothers integrated child health care services were not practised.

The consequences were missed opportunities in immunization, provision of Vitamin A, absence of growth monitoring, feeding assessment and provision of nutritional advice. Hospitals and private practitioners equally did not provide immunization services or offered holistic care.

Simple interventions such as oral rehydration, early recognition and treatment of diseases, immunization, growth monitoring and appropriate nutrition are not diligently offered; that could reduce the incidence of child morbidity and mortality.

The following recommendations are made: determine why hospitals do not immunize children. The root causes must be addressed to change practice. Rendering of child services must happen in an integrated approach. Staff must be empowered with skills regarding procurement, in particular regarding vaccines.

OPSOMMING

In 2000 het die lidlande van die Verenigde Volke Organisasie die Millenium Ontwikkelingsdoelwitte aanvaar. Die Millenium Ontwikkelingsdoelwit nommer vier roer die kwessie van kindergesondheid aan. Die strategie om die voorkoms van kindersterftes met 60% te verminder vanaf 1990 tot 2015 is die vierde millenium doelwit. Suid Afrika is een van twaalf lande in die wêreld waar die kindersterftes vir hierdie tydperk toegeneem het.

'n Studie is gedoen om te bepaal "Wat die ervaring en persepsies van moeders is wat van kindergesondheidsdienste gebruik maak. 'n Kwalitatiewe, beskrywende, fenomenologiese studie is gedoen, om die ervaring en persepsies van moeders wat kinders jonger as twee jaar na klinieke geneem het, te bepaal.

Die doel van die studie was om die ervaring en persepsies van moeders ten opsigte van kindergesondheidsdienste vas te stel.

Spesifieke doelwitte was die bepaling van die ervaring en persepsies rondom:

- immunisasiedienste
- groeimonitering
- voedingsvoorligting
- die groeikaart
- behandeling van siektes

Etiese goedkeuring was verkry vanaf die Universiteit van Stellenbosch en die verskeie gesondheidsowerhede. Geldigheid van die studie is verseker deur die beginsels van geloofwaardigheid na te kom naamlik, aaneemlikheid, betroubaarheid, oordraagbaarheid en insiklikheid.

Die bevolking betreffende die studie was moeders wat kliniekdienste gebruik het vir hulle kinders in 'n spesieke area van Kaapstad, bestaande uit tien klinieke. Drie klinieke (N=10) is doelgerig geselekteer vir deelname. Vier moeders is doelgerig by elk van die drie klinieke geselekteer vir deelname.

Onderhoude is met sewentien deelnemers gevoer. 'n Onderhoudsgids is gebruik en die navorser het rekord gehou van waarnemings. Die navorser het onderhoude gevoer en opgeneem na skriftelike toestemming daarvoor van elke deelnemer verkry is. 'n Veldwerkdagboek is gehou van alle waarnemings.

Data-analise het behels: digitale opnames wat woordeliks beskryf, tematies ontleed en geïnterpreteer is en volgens temas georganiseer is.

Toepassing na die breër populasie is bevorder deur die gebruik van die verpleegteorie van Erickson, Tomlin en Swain.

Bevindinge van die studie het getoon dat moeders verskillende ervarings gehad het. Nie alle moeders het inligting ontvang omtrent die RthB of RTHC nie. Nie alle moeders het vertroue in die kliniek nie en moeders word nie erken as bepalende faktore in die sorgspan nie. Volgens die moeders is geïntegreerde gesondheidsorg nie beoefen nie.

Die gevolge is dat geleentheid nie benut word om te immuniseer nie, vitamien A te verskaf, groei te kontroleer, voeding te bepaal en voedingsadvies te verskaf. Die voorraadvlakke van entstof word nie oral doeltreffend beheer nie. Hospitale en dokters beoefen nie altyd immunisering en holistiese kindergesondheidsdienste nie.

Eenvoudige intervensies, wat die voorkoms van kindermorbiditeit en kindermortaliteit kan bestry, word nie verskaf nie. Voorbeelde van sulke intervensies is mondelinge rehidrasie, vroeë diagnose en behandeling van siektes, immunisering, groei-monitoring en geskikte voedingsinligting.

Daar word aanbeveel dat daar indringend bepaal word hoekom hospitale nie kinders immuniseer nie en dat die oorsake aangespreek word. Integrasie van dienste by klinieke moet as prioriteit gesien en geïmplementeer word. Personeel se vaardighede betreffende beheer van voorraad moet verbeter word, veral t.o.v. entstof voorraad

DEDICATION

This thesis is dedicated to my daughter Dédé, the pride and joy of my life. Raising her is the actual accomplishment of my life.

Casper and Dédé enriched my life with three adorable bundles of joy, Adriaan, Ruan and Chrisli.

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ABBREVIATIONS AND ACRONYMS

EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
HIV	Human Immune Virus
IMCI	Integrated Management of Childhood Illnesses
MDG	Millennium Development Goals
MMHS	Metro Municipal Health Services
NDOH	National Department of Health
NEA	Nursing Education Associations
NHIS	National Health Information Systems
Palsa PLUS	Practical Approach to Lung Health and HIV/AIDS in South Africa
PGWC	Provincial Government of the Western Cape
PHC	Primary Health Care
RTHC	Road to Health Card
RtHB	Road to Health Book
SA	South Africa
SAHR	South African Health Review
TB	Tuberculosis
WHO	World Health Organization

CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY

1.1. INTRODUCTION

The researcher, during her accompaniment of students in clinical training at hospitals and clinics, observed various factors that led to concerns about the adherence to policies and standards in programmes directly linked to child health. This motivated the researcher to determine the experiences and perceptions of mothers about the health care services they were receiving at the Child Health Services.

It was observed that some professional nurses in hospitals tend to see immunization and growth monitoring as a service performed in clinics. At a particular hospital mothers are motivated to stay at the bedside when the child is in hospital as this is in the best interest of the child (Coetzee, 2010:1). The provision of health promotion information and the support of the best possible nutrition are required standards for internationally defined child friendly services (Coetzee, 2010:1). If the child does not go home fully immunized, the weight and appropriate growth parameters as plotted in the Road to Health Book and the required nutritional advice given, the mother has to take the child to a clinic to receive this service. This often means taking more leave or time away from home after spending time at the bedside of the sick child.

In some of the clinics the researcher observed that children are weighed with each visit, but no growth evaluation is recorded. Immunization is not monitored at each visit. Mothers visiting clinics on a Friday experience problems to access “preventative services”. Fridays appear to be reserved for attending to sick children. The golden rules of the Integrated Management of Childhood Illnesses programme are not observed – to monitor immunization and growth at each health contact/visit to a clinic. It appears as if integration of services is not practised.

The researcher found mothers to be a valuable source of information. When asking mothers about the anomalies such as why the child was not immunized, the mothers appear to know the reasons for deviation from policies such as “my child’s weight is too low to be immunized, the sister said the clinic will weigh my baby, the clinics must immunize children.”

1.2. RATIONALE

South Africa is one of 12 countries where the “under-five child mortality rate” has increased from 56/1000 live births in 1990 to approximately 67 to 73 /1000 live births in 2008 (Chopra, Davioud, Pattison, Fann & Lawn, 2008:30).

Despite improvements in health care delivery, implementation of quality programmes, adoption of health policies and legislation based upon best practice since 1994, South Africa has failed to reduce the maternal and under-five child mortality rate (Barron & Roma-Reardon, 2008: ix).

In 2000 the United Nations adopted the Millennium Development Goals (MDG) (Bhutta, Chopra, Axelson, Berman, Boerma, 2010: 2032). Member states agreed to achieve these developmental goals by 2015. Goal number four describes the actions and interventions required to reduce the under five child mortality rate by two thirds, based on the 1990 health indicators of each country. The expected “under five child mortality rate” should be 20/1,000 live births by 2015 (Bamford, 2007:5).

The burdens of disease contributing to the high mortality rate among children include pneumonia, diarrhoea, malaria and HIV. Simple strategies and improvements in the health care system may prevent these conditions. Interventions include oral rehydration, early recognition and treatment, providing mosquito nets, immunization and appropriate nutrition (Jensen, 2010:27

South Africa has a history of regarding the health programmes of children and mothers as priority programmes (Mhlanga, 2008:116). The National department of Health (NDOH) attempted to follow the approaches of the World Health Organization (WHO) approaches since 1978 until 2000 (Mhlanga, 2008:116). The Millennium Development Goals became the focus of development approaches after 2000. The attempt to reach goals number four and five is therefore not a new approach, but a continued focus with renewed and special actions.

South Africa declared Primary Health Care (PHC) the centrepiece of all its health policies since 1994 (Hogan, 2008:12). The Health Minister at the time of this research, Dr A Motsoaledi, alluded to the same aspect when he stated in an interview with eNews in March 2010 that priority funding will be amongst others in areas such as PHC services and immunization campaigns (Tom, 10 March 2010).

The indicators “maternal mortality rate” and “under-five child mortality rate” are indicators reflecting the health status of a country. (Dennill, King and Swanepoel, 2002: 18-23).

During the apartheid system the plight of women and children was due to a variety of social problems which included poverty, lack of nutrition and sanitation, unemployment, lack of immunization programmes and unsafe water. Improvements after 1994 can (amongst others), be ascribed to the implementation of free services, the Expanded Programme on Immunization and Integrated Management of Childhood Illnesses programme (Mhlanga, 2008:132-138). The Expanded Programme on Immunization (EPI) was introduced as policy in South Africa in 1994 (NDOH, 1995:1). The aim, according to the National Department of Health Strategic Plan 2009-2012, is to ensure 90% coverage in 90% of districts in South Africa.

There must be a high coverage in the Expanded Programme on Immunization programme to ensure protection from disease outbreaks and or imported diseases from neighbouring countries (Mhlanga, 2008:132-138).

Another programme introduced since 1996 is the Integrated Management of Childhood Illnesses (IMCI) strategy. The guidelines of the EPI and IMCI programmes are identical in respect of immunization and, if implemented correctly, should enhance the provision of immunization services and of nutrition of children under five (Bamford, 2007:10).

Sartorius, Kahn, Vounatsou, Collinson and Tollman found that there is a need for high quality health care that will minimize the inequalities in society (wealth and social privileges) that impact on child health (Sartorius, et al. 2010:4). The geographical access to services does not influence mortality but quality of care play a significant role in the child mortality rates. This is very significant as there is a tendency to regard services in metropolitan areas as good, due to accessibility to primary health care services. Primary Health Care Services consists of the elements of care required (Sartorius, et al., 2010:14).

The health care of children is a parental responsibility, but society and the government have a moral responsibility or obligation to ensure that the rights of children according to the constitution are protected. The core programmes rendered to children form the backbone of preventative child services in South Africa. Key health promotion activities include: immunization, the Integrated Management of Childhood Illness (IMCI) strategy, childhood infection prevention, neonatal health and developmental screening, growth monitoring and nutrition (Saloojee and Bamford, 2006:1-3).

Children make up 39% of the population and 54% of these children live in rural areas. Children have free access to primary health care services and only pay for services at secondary and tertiary level services based on a sliding scale linked to parental income (2006:120). Factors impacting on child health remain high levels of poverty, inequitable access to health care services and high maternal mortality. The allocation of free services does not change these factors (Sartorius, et al., 2010:14).

McKerrowi and Mulaudziii (2010:66) and Coetzee (2010:2), are of the opinion that the mother is a determining factor in the health outcome of children. The high maternal mortality rate therefore, will play a determining factor in the health outcome of children. Children who lost a mother have a fourfold increase in the risk of mortality (2010:66).

1.3 SIGNIFICANCE OF THE STUDY

De Vos, Strydom, Fouche and Delport (2005:384-5), express the opinion that an important way of evaluating the implementation of a programme is by obtaining detailed information on the clients' experiences, the work of the staff, and how the services are provided and organized. The statistical data routinely collected do not explain the experiences of the people utilizing the programme. The data only provide numerical information regarding coverage.

The problems experienced by service providers and users of the services are not clear. Data may indicate a successful programme, but data can be overstated. Data does not indicate the quality of programmes. According to De Vos, et al. (2005:384-5), gaining information on the experiences of the persons affected by the programme gives a more meaningful evaluation of what takes place during implementation.

The researcher as educator and clinician recognized the need to investigate the experiences of mothers. The researcher developed recommendations for further investigations and improvement of practice and training. Based on the findings of the study recommendations are made to the Western Cape Government Department of Health and the Cape Town Metro Municipal Health services.

This information can be used by nurse managers and nurse leaders to guide improvement of service delivery. The experiences of mothers may contribute to inspire a caring ethos in our students who are the future of the profession. The study can also assist in establishing the commitment to integrate health care provided to children. Integrated services require that all components of child healthcare are monitored at each contact session with a health care provider.

The data for the Western Cape Province reflects good coverage in programmes such as immunization. The challenge is to improve the quality of care once good coverage has been reached (Barron and Roma-Reardon, 2008:117).

1.4 THE PROBLEM STATEMENT

Various policies and interventions, based on best practices, were introduced to improve child health care services. The effect of non-adherence to policies and procedures by service providers in rendering child health services seems to be a contributing factor to the quality of care rendered.

1.5 RESEARCH QUESTION

What are the experiences and perceptions of mothers with children younger than 2 years about the child health services they are utilizing?

1.6 GOAL

To explore the experiences and perceptions of mothers utilizing child health services rendered to children younger than two years.

1.7 OBJECTIVES

The objectives set for this study were to explore the experiences and perceptions with specific reference to the service they receive regarding:

- immunization
- nutrition
- the growth of the child
- the growth chart
- other underlying illnesses

1.8 RESEARCH METHODOLOGY

In this chapter a brief description is given of the methodology applied in the study, a more in-depth description will be given in chapter 3.

1.8.1 Research design and approach

A qualitative, descriptive phenomenological approach was applied in this study to explore the experiences and perceptions of mothers utilizing child health services for children younger than two years.

1.8.2 Population and sampling

The target population was mothers of children younger than 24 months old who used the services at the clinics in a section of the eastern side of the metropolitan area.

Mothers were selected who utilized child health services at a cluster of ten clinics in a demarcated area in the Metropole. A purposive sample of n=3 (30%) of the clinics was selected from the total population.

A convenience purposive non-probability sampling method was applied to interview at least four voluntary mothers from each clinic who met the criteria and gave written informed consent. According to De Vos, et al. (2005:195), a sample of n=10 is adequate in qualitative research or until data saturation.

1.8.3 Specific criteria

Mothers with a child or children younger than twenty four months participated in the study.

Children in the age group 0-24 months are monitored monthly for growth and weight. Children receive the bulk of immunizations from birth to 18 months, thereafter immunization is scheduled at the ages of six and twelve years.

1.8.4 Definitions

For the purposes of this study to improve understanding and ensure rigour in the study the meaning of the following terms will be explained:

Mother: the biological mother, adoptive mother, grandmother, foster mother, sibling or father who bring the child to the clinic (this terminology was adopted to incorporate the different caregivers who bring children for child services).

Child Services: Comprehensive integrated services rendered to children which includes immunization, weighing, growth monitoring, developmental screening and the Integrated Management of Childhood Illnesses approach (NDOH: 2008).

Professional Nurse: Persons registered as professional nurses in terms of the Nursing Act 2005 (Act No 33 of 2005).

1.8.5 Data collection

An interview schedule based on the objectives was utilized to guide the interview and ensure all areas were explored.

The interviews were conducted in a private area. The researcher acted as a guide in the interview with each participant using the interview schedule. The researcher is not fluent in African ethnic languages therefore a research assistant fluent in Xhosa was available to assist should language found to be a barrier in an interview (paragraph 1.6.5). Interviews were digitally recorded and transcripts were made of each interview.

The researcher kept a reflective diary where notes of observation and reflections were recorded during data collection.

1.8.6 Pretesting

Pretesting was conducted using two mothers who complied with the sample criteria. The purpose was to determine the feasibility of the methodology of the study. It enabled the researcher to detect problems that may be encountered such as practical problems which needed adjustments.

1.8.7 Data analysis and interpretation

Data was recorded and taped during the interview. The researcher listened to the taped interviews and transcribed the interviews verbatim. Data management starts with data collection as described by Burns & Grove (2007:79). The gathering, management and interpretation of data were a concurrent process.

Three stages were used to analyse the data as described in Burns & Grove (2007:79), i.e. describing, analysing and interpreting.

In describing the researcher reflected on the interview, transcribed the interview, coded, kept memos of thoughts and insights; wrote observations on transcribed interviews and proceeded to display data in an organized manner using the model provided by Tesch (1990:144).

1.8.8 Ensuring validity

Validity in qualitative research refers to trustworthiness or soundness. De Vos et al. (2005:235-7), describes the work of Guba and Lincoln (1985), and Marshall and Rossman (1995), regarding the principles of trustworthiness.

Credibility in this study was maintained by ensuring that the interpretation of the researcher accurately reflects what the mother was saying and the meaning thereof. The researcher took care to ensure that findings were a true reflection of the subjects' views and were not influenced by the researcher.

Transferability was maintained by keeping detailed records of the coding and analysis process.

Dependability was maintained by an expert in research and nursing who reviewed the data analysis and the data coding process. This expert evaluated the validity of the data analyses.

Conformability was maintained by keeping a reflective diary during the interviews and data analyses process. The researcher conducted the interviews to ensure rigor in the process. A pretest was done to ensure that the methodology was sound.

The researcher used a conceptual theoretical framework, the Modeling Role-Modeling Nursing theory of Erickson, Tomlin and Swain (George, 2010:520). Some critics dispute the use of true phenomenology in nursing but see these phenomenological theories more as philosophical theories based upon the unconditional acceptance of the clients' version of reality (George, 2010:61). The use of a nursing theory will contribute to the validity of the study.

1.8.9 Ethical considerations

The following ethical principles were applied:

All participants were approached individually and, informed of the objectives of the study. It was made clear: that participation is voluntary; that they may withdraw at any stage during the interview if they no longer wished to participate. They were informed that the researcher is not working at the facility and that non-participation will not influence future treatment and access to the clinic.

Participants were informed that confidentiality will be maintained; the data will be stored in hard copy and electronic format for five years at the home of the researcher in a vault at the home of the researcher.

The human rights of the participants were considered at all times during the study, i.e. self-determination, privacy, anonymity, confidentiality, fair treatment, protection against discomfort and harm as described in Burns and Grove (2007:205).

Participants received the information sheet/consent sheet to read. A copy of the pamphlet was handed over to all participants to enable them to refer back to. Informed consent necessitates the researcher to convey knowledge but also to ensure that the subjects grasp the information conveyed (Burns & Grove.2007:217).

Participants were given a choice to receive feedback on the study. Participants could choose to contact the researcher or allow the researcher to provide written feedback to an address of choice about the findings of the study.

The researcher submitted the proposal to the Health Research Ethics Committees Human Research at University of Stellenbosch to obtain ethical clearance for the study.

Once ethical clearance and permission for the study were obtained submissions were made to the Ethics committees of the Provincial Government of The Western Cape (PGWC) and the Metro Municipal Health (MMHS) Services to obtain clearance to conduct the study in the clinics in the selected study area of Cape Town.

1.9. STUDY LAYOUT

Chapter 1:

The background, rationale, goal and objectives, a brief overview of the methodology and definitions applicable are described in this chapter.

Chapter 2:

The literature review on child health services, national and international tendencies and the realization of the Millennium Development Goals are discussed in Chapter 2.

Chapter 3:

The research design and methodology used in this study are presented in chapter 3.

Chapter 4:

In chapter 4 the interpretation of findings, literature review and conceptual frame work will be discussed.

Chapter 5:

The recommendations made based on the findings of the study and the conclusions reached are discussed in this chapter.

1.10 SUMMARY

In chapter one the researcher introduced the background, impetus and rationale for embarking on a study to interview mothers about their experiences when utilizing child services in a predetermined area of Cape Town. This was followed with a brief discussion of the aims, objectives, methodology and ethical considerations applied in this study. Lastly a brief outlay of the chapters of the study was provided.

1.11 CONCLUSIONS

The concerns of the researcher regarding observations made in the clinical field led to the study regarding the perceptions and experiences of mothers about the child health care services they are using. The rendering of child health services is an important element in health care delivery and the researcher found evidence in literature that supported this concern. The researcher aspires to contribute to the improvement in service delivery and education of nursing students through the completion of this research

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The researcher reviewed literature on the subject of health care provision for children younger than five years of age. This review was undertaken to understand how service provision to children changed with the introduction of various new health programmes and strategies since 1994 and how these programmes or strategies relate to the realization of the Millennium Development Goals (MDG's).

Phenomenologists tend not to embark on extended literature searches prior to conducting a study to prevent influencing the categorization process. The literature search in phenomenology serves as a guide to improve understanding of the subject and may even lead the researcher to explore different aspects (Munhall, 2001: 164). The researcher consulted literature prior to 1994 to understand the perceptions and changes that lead to the current health care provision. This included reviews on health care delivery prior to 1994 until 2010. Research articles about health care delivery to children younger than five years were read to obtain information around the different components of health service delivery aspects. Articles in newspapers were included in the study as the quality of health services and the attainment of the MDG's receive prominent media coverage.

2.2 SIGNIFICANCE OF THE INDICATOR “UNDER FIVE CHILD MORTALITY RATE”

The provision of health care services to mothers and children are an important element for health care provision in the Primary Health Care (PHC) approach and are listed as an element in the Alma Ata declaration in 1978 (Schaay and Saunders, 2008:5).

South Africa declared Primary Health Care (PHC) the centerpiece of all its health policies since 1994. Ms Hogan, Minister of Health in 2008, stated that mothers, babies and children are the “very heart of PHC” (Hogan, 2008:12).

In the South African Demographic and Health Survey (SADHS), of 2003 the authors are of the view that the child mortality indicator is an indication of the socio-economic position and the quality of life of the country's population (Schaay and Saunders, 2008: 7). This vision is not shared by other authors such as McKerrowi and Mulaudziii (2010:70), who see child mortality as a basic reflection of the health status of children and an alternative marker of the quality of health care.

De Haan (2005:148) describes mothers and children as vulnerable groups who represent a large component of the community utilizing health services. The health status and needs of these groups will influence the health policies and service delivery of a country.

In 2000 the United Nations adopted the Millennium Development Goals (MDG's) (Bhutta, Chopra, Axelson, Berman, Boerma, 2010: 2032). Member states agreed to achieve these developmental goals by 2015. Goal number four describes the actions and interventions required to reduce the "under five child mortality rate" by two thirds, based on the 1990 health and development indicators of each country. Based upon the MDG indicators "under five child mortality rate" in South Africa were expected to be 20/1,000 live births in 2015 (Bhutta et al., 2010: 2032).

In the report of the Secretary General of the United Nations on 31/7/2002 on the implementation of the strategy of the Millennium Development Goals (MDG's) the view was expressed that children dying from preventable diseases are unacceptable. Children born in developing countries are more likely to die than children in developed countries (The MDG report, 2008). Ninety three percent of the deaths occurring in the under five age group occurred in Africa and Asia – two of the world's developing continents (You, Wardlaw, Salama and Jones, 2009:2).

The burden of disease contributing to the high mortality rate among children includes pneumonia, diarrhoea, malaria and HIV. Simple strategies and improvements in the health care system may prevent these conditions. Interventions include oral rehydration, early recognition and treatment, providing mosquito nets, immunization and appropriate nutrition (Jensen, 2010:27).

2.3 IMPROVEMENTS INTRODUCED IN SERVICES RENDERED TO MOTHERS AND CHILDREN IN SOUTH AFRICA SINCE 1992

2.3.1 Political prioritizing of maternal and child health services

South Africa has a history of regarding the health programmes of children and mothers as priority programmes (Mhlanga, 2008:116). The National Department of Health (NDOH) attempted to follow the World Health Organization (WHO) approaches since 1978 until 2000 (Mhlanga, 2008:116). The attempt to reach the MDG number four and five is therefore not a new approach, but a continued focus with renewed and special actions.

During the apartheid system the plight of women and children were due to a variety of social problems which included poverty, lack of nutrition and sanitation, unemployment, lack of immunization programmes and unsafe water (Mhlanga, 2008:116).

As stated in paragraph 2.3 Primary Health Care has been the centrepiece of all health policies since 1994. Ms. Hogan, Minister of Health in 2008, emphasized that mothers, babies and children are the “very heart of PHC” (Hogan, 2008:12).

The Minister of Health in 2008, Ms. B Hogan, stated in the 2009/10 – 2011/12 National Department of Health (NDOH) Strategic Plan that the South African health care priorities remain to reach the MDG’s four and five. Cognizance is given to the interrelated influence of the actions to reach MDG one (Eradicate extreme poverty and hunger) and six (Combat HIV and AIDS) that will determine the ability to reach MDG’s four and five (NDOH (a), 2008:2-3).

The Minister of Health at the time of this study, Dr A Motsoaledi, alluded to the same aspect when he stated in a televised interview that priority funding areas will be, amongst others, Primary Health Care services and immunization campaigns (Tom, 10 March 2010). The statements of Ministers Hogan and Motsoaledi are indications of the importance of child health and in particular the strategies needed to reduce under-five child mortality rates.

2.3.2 Introduction of the expanded programme on immunization

The Expanded Programme on Immunization (EPI) was introduced as policy in South Africa in 1994 (NDOH, 2005:1). The first vaccinator’s manual was issued in January 1995, signed by Dr NCD Zuma, National Minister of Health at the time. One of the stated aims was to let immunization take place within the broader context of Primary Health Care (NDOH, 1995:1).

The aim, according to the National Department of Health Strategic Plan 2009-2012, is to ensure 90% coverage in 90% of districts in South Africa. The successes of the EPI programme is seen in the obtainment of polio free status; reduction in incidence of measles morbidity and mortality, and the decrease in neonatal tetanus incidence (Day & Gray, 2008:337).

The literature indicates that the provision of immunization is a vital component in the provision of Primary Health Care, specifically in the provision of child health care services. The provision of immunization to children is one of the eight (8) elements in the Alma Ata declaration. It is also one of the key strategies in the attempt to reduce the incidence of mortality in children younger than five in the Millennium Development Goal declaration.

Children younger than five years are more prone to develop infectious diseases that could lead to death or disability. It is an important function of the health care system to prevent these infections or control the spread of these infections to ensure a lower morbidity and mortality in the under five population. This could assist in achieving the Millennium Development Goal number four. The Expanded Programme on Immunization (2010),

intends to protect children early in life against infectious diseases before they are exposed to these diseases (Barron and Monticelli, 2010:1).

A high coverage in the Expanded Programme on Immunization is needed to ensure protection from disease outbreaks and/or imported diseases from neighbouring countries which is still a priority (Mhlanga, 2008:132-138). The data released by the National Health Information System (NHIS) indicate improvement in immunization coverage since 1994 (Day and Gray, 2008:338; Barron and Monticelli, 2008:46).

Lesley Bamford (2007) in a presentation during an Integrated Management of Childhood Illnesses workshop described the Expanded Programme on Immunization as follows: "One of the key child survival strategies is the Expanded Programme on Immunization" (Free usage, unpublished PowerPoint presentation).

Schaay and Saunders (2008:18) found that the Expanded Programme on Immunization coverage in Sub-Saharan Africa improved from 20% to 79% for the period 1980 - 2006. The writers are positive that Primary Health Care has a positive impact specifically when it addresses underlying social problems leading to health problems. The Director General of the National Department of Health in 2011, TD Mseleku, stated that the percentage of children fully immunized increased from 78% in 2002 to 84.6% in 2008 (NDOH (a), 2008:11).

2.3.3 Integrated management of childhood illnesses (IMCI) strategy

The Integrated Management of Childhood Illnesses programme was introduced in 1996 as a further strategy in managing childhood illnesses. This strategy promotes the implementation of the integrated Primary Health Care approach and requires that the immunization and nutrition of a child are monitored at each visit (NDOH (b), 2009: 82). It is envisaged that 80% of staff per facility will be trained in the Integrated Management of Childhood Illnesses approach by 2012 (NDOH (a), 2008: 31). The 2010 South African Health Review (SAHR) found that two of the most important predisposing factors in child deaths are malnutrition and HIV (McKerrowi and Mulaudziii, 2010:66). Both these aspects are monitored in the Integrated Management of Childhood Illnesses programme.

2.3.4 Addressing the burden of disease in child health services

The burden of disease contributing to the high mortality rate among children includes pneumonia, diarrhoea, malaria and HIV. As stated in paragraph 2.2 the strategies needed to address these conditions include interventions such as oral rehydration, early recognition and treatment of the conditions, providing mosquito nets, immunization and appropriate nutrition (Jensen, 2010:27). According to McKerrowi and Mulaudziii (2010:70), the selection

of programmes in the South African health services is not the concern, rather the continuation of quality.

The child services referred to by McKerrowi and Mulaudziii (2010:70) in the 2010 South African Health Review are the implementation of the Integrated Management of Childhood Illnesses, Expanded Programme on Immunization, nutrition programme, Prevention of Mother to Child Transition of HIV and Highly Active Anti-Retroviral Treatment programmes.

2.4 CONCERNS FOUND IN THE LITERATURE REGARDING ASPECTS LINKED TO THE RENDERING OF CHILD SERVICES

Dr Aaron Motsoaledi in an interview with Anso Tom summed up what was wrong in the South African context. He stated that other countries use the high technological facilities available in South Africa. These countries have a lack of technology, but they have a lower child mortality rate. "...South Africa has technology but our children are dying because we fail to monitor basic services such as immunizations, school health and nutrition" (Tom, 10 March 2010). He also stated at a congress of Nurse Educators in Gauteng that South Africa must strengthen response to maternal and child health priority programmes (Motsoaledi: 2009).

2.4.1 Concerns regarding the quality of data collected

McKerrowi and Mulaudziii (2009:60), discuss the need for good quality and accurate data. The indicator namely child or infant mortality rate not only allows for monitoring the quality of services, but must allow for suitable interventions. If data is not of good quality it limits the benefit derived from using such indicators (McKerrowi and Mulaudziii, 2009:60).

The data released by the National Health Information System (NHIS) indicates improvement in immunization coverage since 1994 (Day and Gray, 2008: 338; Barron & Monticelli, 2008:46). The South African District Health Survey (2003) warned that the data of the District Health Information System (DHIS) may be overstated. The authors warned that the quality of the data may be influenced by factors such as the use of incorrect denominators, the use of incorrect census data and clinic data that are not verified.

Corrigall, Coetzee and Cameron (2008:41) and Durrheim and Ogunbanjo (2000:130) cautioned in the findings of their studies that the data indicated low immunization coverage that predicts the danger of outbreak of vaccine preventable diseases. The observations in surveys did not correspond with the information of the DHIS that indicated high measles coverage at nine months and a low drop-out rate of 21%. This coverage is contradicted in a survey by Barron and Monticelli (2008: 46).

The measles outbreak of 2009-2010 in South Africa is a direct consequence of low herd cover. Herd immunity is the term used to refer to the incidence of protected individuals in a population. Fully immunized individuals in a community can indirectly protect those who are not immune against infection. The higher the immunization coverage the better the herd immunity appears to be (Trotter and Maiden, 2009: 851-861).

2.4.2 Problems in implementation of services

2.4.2.1 Implementation of programmes affecting quality of services

Day and Gray (2008:337), and Chopra et al. (2008:1294-304), reported that despite high coverage for most of the major packages within the child healthcare services the quality of care appears to be low.

According to Day and Gray (2008:350), many of the deaths in the under- five population were avoidable and could be attributed to programmes such as the Management of Childhood Illnesses programme which were not correctly implemented.

Brugha (1995:698), published an article after completing a survey in Ghana. This study has relevance to the current situation in Republic of South Africa (RSA), despite the date of the article. One of the findings was: "Logistical problems at the hospital, shortage of community health nurses, and assumption of false contraindications by some hospital workers were responsible for missed opportunities. Out Patient Department nurses often referred children with incomplete immunization to the primary health care department, 20 meters away."

Dr Aaron Motsoaledi in an interview stated that South Africa spends health care funds on quaternary (highly specialized tertiary) and curative health care which should preferably be spent at Primary Health Care where more people can be helped (Mannak, 2011: Business Live).

Mafubela, a former nurse and assistant director at the World Health Organization (WHO), stated that despite the fact that South Africa spends 8,7% of the Gross Domestic Product (GDP) on health, the health care outcomes are not as good as countries that are poorer and spend much less on health. Contributing factors are amongst others poor training of nurses and midwives; a curative rather than preventative approach; a lack of services providing education to schools and communities on nutrition and lack of infrastructure, equipment and consumables (Mafubela, 2011: Mail and Guardian).

2.4.2.2 Lack of integration of services

Bachmann and Barron (1996:947), in a survey on missed opportunities found that separating the provision of curative and preventive paediatric care resulted in many missed

opportunities for immunization. Fewer opportunities are missed if immunization and nutrition services are available all day and every day, rather than for limited periods of the week. The studies of Day and Gray (2008:337) and Chopra et al. (2008:1294-304), are concerned about the quality of services and how services are implemented

Shefer, Luman, Lyons, Coronado, Smith, Stevenson and Rodewald (2001:47-54), published findings of an immunization survey done on integrating women, infants and child services as part of a nutrition supplementation programme. The coverage increased when programmes were integrated. The writers perceived sustainable funding for integrated programmes as a problem. Funders tend to fund programmes that lead to the vertical implementation of said focus programmes and related health care aspects are not attended to.

2.4.2.3 Challenges in elimination of communicable diseases

In 2003 measles was still listed as one of the leading causes of death in children; however the concentrated efforts to immunize children led to a 78% reduction in measles globally. The 2010 MDG report warns that the measles strategy is not effective, due to dwindling funds. Poorer countries are unable to afford two doses of vaccine per child (Jensen, 2010:27). South Africa provides for two dosages of measles vaccine in the Expanded Programme on Immunization schedule.

The developing countries also report problems with the elimination of measles.

Muscat, Bang, Wohlfahrt, Glismann and Mølbak (2009: 383-389), found that measles outbreaks still persist in Europe despite 20 years of immunization. According to the study high incidences in some European countries indicated suboptimum coverage and surveillance that is required to ensure eradication.

Sugerman, Barskey, Delea, Ortega-Sanchez, Ralston, Rota, Waters-Montijo and Lebaron (2010:747-75), described the influence of measles outbreaks in “intentionally unimmunized children” in a population with high immunization coverage. The authors warn that it comes with great costs to public health. As these clusters of “intentionally unimmunized children” increase, the target of measles elimination will be threatened. In this context “intentionally unimmunized” refers to groups who choose not to immunize children based on various religious or moral justifications. These pockets of unimmunized groups’ threaten herd immunity. Immunization is compulsory in The United States of America, but parents may apply for exemption on religious grounds.

2.5 EVIDENCE OF PRACTICES THAT IMPROVES CHILD HEALTH OUTCOMES

2.5.1 The value of immunization programmes

China reported on the success of mass immunization campaigns. After the 2004 measles mass campaign the incidence of measles reduced by 95% (Sun, Li and Xu, 2010: 307-310).

In the United States of America Shore and Shore (2009:2) reported that the treatment and prevention of infectious diseases in children, aged between one and four years, decreased the death rate by fifty percent for the period 1980 to 2000. The authors are of the opinion that new paediatric immunizations contributed to the decline in mortality. The ability of parents to afford the available vaccines impacted on the immunization coverage. The number of vaccines in the programme increased from 8 dosages in 1987 to 25 in 2007 (Shore and Shore, 2009:3).

The successes of the Expanded Programme on Immunization are seen as obtaining polio free status; reduction in incidence of measles morbidity and mortality, and the decrease in neonatal tetanus incidence (Day and Gray, 2008:337).

2.5.2 Health worker influence on the success of services or programmes within service components

In a meta-analysis of studies Binkin, Chopra, Simen-Kapeu and Westhof (2011:4), found that the interventions by health workers to reduce the under-five mortality rate can be grouped in three broad groups. These groups are interventions in treatment for diseases; preventative interventions such as immunization and promotive interventions, such as improvement in nutrition and promotion of breastfeeding.

2.6 CONCEPTUAL THEORETICAL FRAMEWORK

Some of the earlier objections toward the use of qualitative research were based upon the absence of the qualities of validity and reliability as defined for quantitative research (Burns and Grove, 2007:546). Criteria to judge qualitative research were developed by researchers in various disciplines, which included nursing. These concepts are the establishment of rigor, trustworthiness and the auditable evidence of decision making (Burns and Grove, 2007:546). One of the criteria to establish trustworthiness is transferability. The use of a sound theoretical framework can add to the opinion regarding trustworthiness and application to the broad population.

For the purpose of this study the conceptual theoretical framework of Erickson, Tomlin and Swain: Modeling and Role-Modeling theory will be utilized. This theory is referred to as the “Modeling Role-Modeling” theory. The theory was first developed in 1983. This theory postulates that the nurse views the patient as an individual with needs and abilities and a unique perspective on the world. The nursing interventions are based upon the use of nursing knowledge and expertise to assist the client in reaching his health care needs. Modeling is the process where the nurse seeks understanding of the client and his needs. Role-modeling is the process used to reach the goals of the nursing intervention (George: 2010: 518-537).

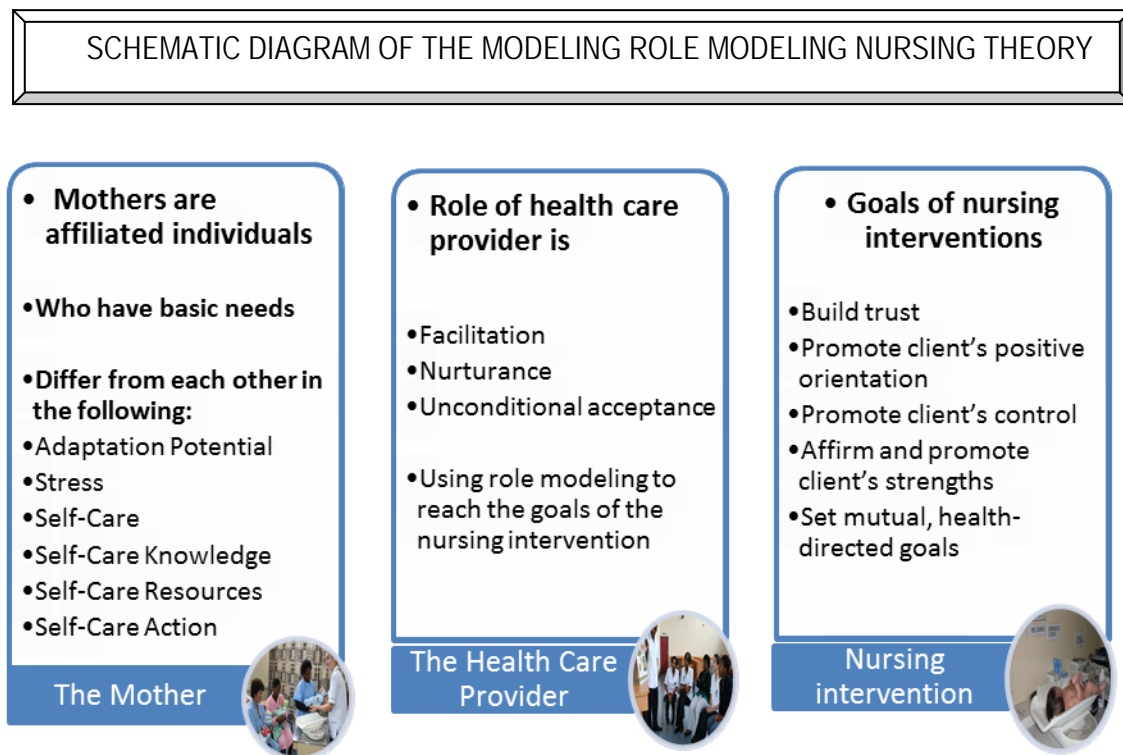


Figure 2.1: Schematic diagram of the Modeling Role-Modeling Nursing theory

Source (George: 2010: 518-537)

2.6.1 The “modeling role-modeling” theory

The theory postulates that people are holistic human beings who have basic needs and the desire or motivation to fulfill their potential. People differ from each other in the ability to fulfill these needs based on their cognitive level; their ability to adapt; access to resources and knowledge to care for health care needs.

The term environment refers to both external and internal stressors and resources that need to be adjusted to obtain health.

The nursing role is that of “modeling”, the process of accepting the uniqueness of the individual actively engaging to understand the client, his/her world and how this will influence the health behaviour. This process involves both a needs analysis in terms of the physical or health needs and the interaction between health care provider and client. The interaction role is that of accepting the client, and providing support and comfort.

The nursing plan is referred to as “Role-Modeling”. It is the process of facilitation to assist the client in obtaining health and allows for planning individual interventions for each client. The client remains the central component to determine how needs should be met. The nurse facilitates, nurtures, and unconditionally accepts the client. The interaction is directed by the client’s perception of the priority needs. The following must be obtained from the client and be recorded: the client’s knowledge requirements, the stressors, the available resources and ability to adapt. The client’s ability to mobilize resources to solve health care needs form part of the diagnoses. The goals of the nursing care are mutually determined by client and health care provider.

The nursing interventions consist of the following: building a trust relationship; building the client’s confidence or positive orientation; promote his/her ability to care for own his/her own health care needs; ensure that the client has access to resources and the knowledge to solve health care needs; and determine mutually agreed upon goals for improving the health status.

2.6.2 Application of the theory in the study

The researcher applied the theoretical framework by exploring the participating mothers’ individual needs and adaptation potential. The ability of the health care providers in realizing the goals of the nursing interventions were explored. The rendering of components of child services in the study represented the nursing interventions of the Modeling Role-Modeling theory. The mothers’ perceptions of the ability of the health care providers to facilitate nurturing and unconditional acceptance, will provide the evidence of the successful Modeling-Role of the service providers.

Figure 2.2: The Model Role-Modeling Nursing Theory: Framework of child health service provision (George: 2010: 518-537) portrays the interaction in the health care provision

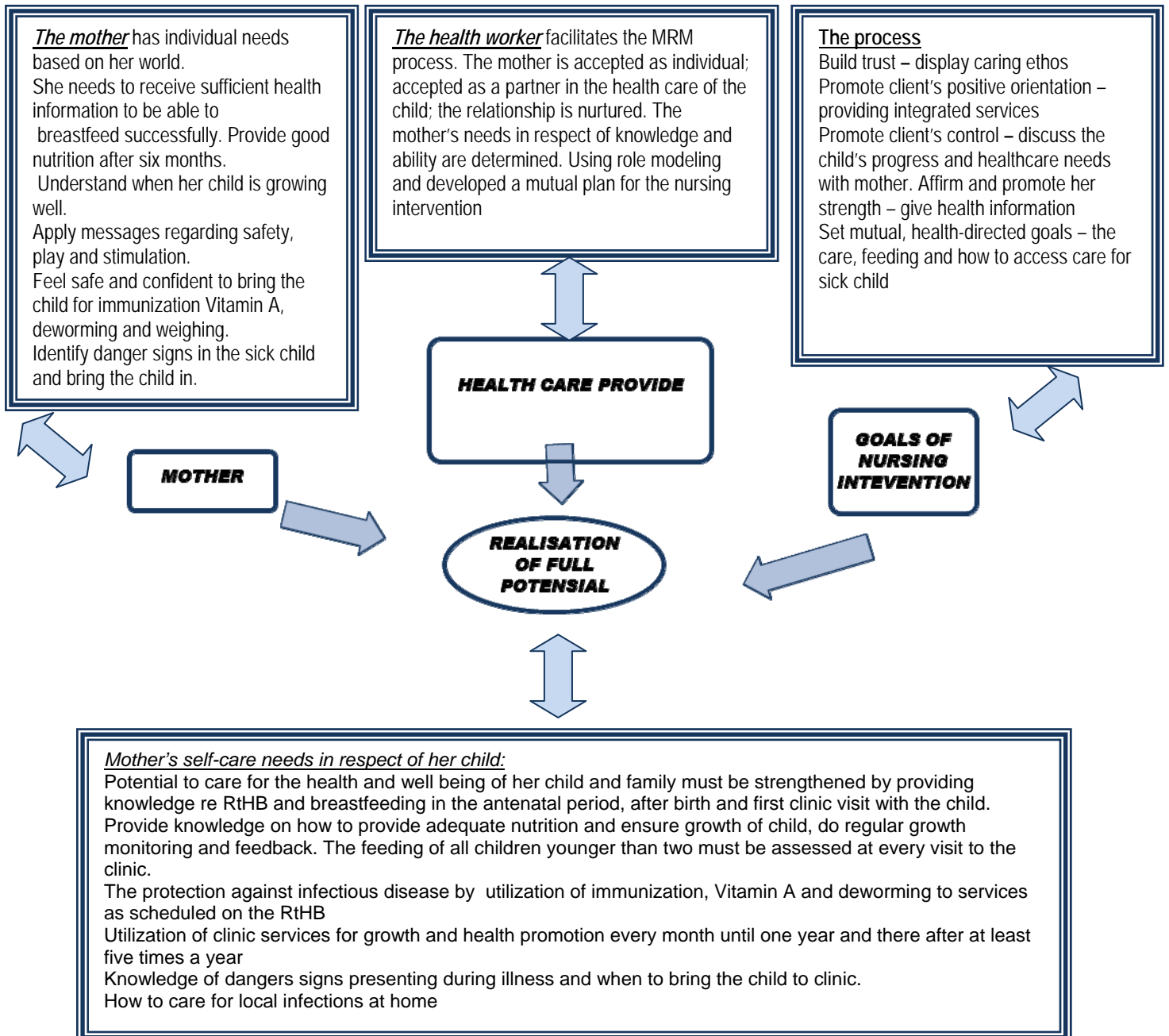


Figure 2.2: The Model Role – Modeling Nursing Theory: Framework of child health services provision

Source (George: 2010: 518-537)

2.7 SUMMARY

South Africa adopted Primary Health Care in 1992 as the vehicle for health service delivery. The programmes adopted since 1992 for child health services, comprise of well-structured programmes, developed by the World Health Organization, and adapted for South African conditions. The literature provides evidence that the health care of children, as a vulnerable group, remains a key factor in health care service delivery.

The concerns regarding rendering of child services are related to the quality of the data collected that influences health care planning. Problems with the implementation of programmes within the health care package for children, influences the quality of services rendered. Despite the fact that integrated Primary Health Care was adopted as a vehicle for service delivery, a lack of integration of services still exists.

Challenges remain to eliminate communicable diseases despite the improvement of immunization strategies and programmes. Positive evidence exists that immunization programmes, promotion of nutrition and breast-feeding and the treatment of diseases contribute to the success of child health services.

2.8 CONCLUSION

The researcher used the information obtained from the literature review, to guide the study.

The literature review supported the concerns of the researcher regarding the adherence of health care workers to policies and procedures. The literature review provided information that quantitative studies in South Africa highlighted the consequences of non-adherence to policies such as the measles outbreak in 2009 -2010. The quality of data collected for the National Health Information System may be a contributing factor to problems in confirming levels of immunization coverage. Various authors indicated the consequences on non-integration of services and the lack of quality in the services delivered. The political and medical concerns regarding the inability to improve the under five child mortality rate is well documented in the literature. Documented evidence is available in the literature of simple strategies that can be implemented to improve the health status of children and the quality of care rendered to this vulnerable group.

The researcher, utilizing the evidence derived from the literature study and observations from her own clinical experience, decided to obtain information from mothers regarding their experiences when they utilize health services rendered to children. In the next chapter the methodology is applied to obtain the experiences and reflections of mothers utilizing child health services.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the research design, research instruments, sampling criteria and techniques, data collection and data analysis are explained. The theoretical perspective of the phenomenological approach and aspects related to this study are included.

3.2 THE MOTIVATION FOR USING A PHENOMENOLOGICAL APPROACH

According to Munhill (2001:68) qualitative research can be described as using broadly defined questions about human experience and realities that are examined through direct contact in the natural environment to obtain rich and meaningful data. Experiences are explained in meaning (language) rather than numbers (ascribing data values).

De Vos, et al. (2005:269), are of the opinion that the qualitative researcher designs the strategy or approach that will work best given the circumstances under which the research is done. The qualitative approach focuses on people in an everyday living context and how these people attribute meaning to experiences.

Burns and Grove (2009:51), suggest that within a comprehensive model qualitative research allows us to explore significance, depth, density and complexity of phenomena. The perceptions gained through studies can direct nursing practice and assist with the development of theories.

Knowledge has meaning within a particular situation or context (Burns and Grove, 2009:51). Various meanings are possible – these meanings are linked or collected ideas or concepts. The meanings or thoughts are referred to as “gestalt” that can be a form of a theory. The challenge is to be able to look at any phenomenon in more than one way; to be able to move from “sedimented” view to a more open context to enable the development of new perspectives and theories in professional practice (Burns and Grove, 2009:52).

The literature review provided sufficient information to support the concerns of the researcher regarding the quality of care in child services. The researcher became increasingly fascinated to know how prevalent were the observations made.

The work experience of the researcher as clinician, educator and manager provided exposure to interviewing mothers. The researcher found mothers to be a valuable source of

information. The researcher required information about the actual experience of the mothers of the services.

One of the five strategies or designs of qualitative research is phenomenology.

Phenomenologists see the person as an integral part of the environment or world he lives in (Burns and Grove, 2009:52). Munhall (2001:14), explains phenomenological concepts such as subjectivity and subjective meanings – terms used to provide information on how people make sense of their experience and life. Phenomenologists conduct research in natural settings and consider it the best place to observe, ask questions and do interviews. The observations and field notes of the observer become part of the data that is collected. Pictures were created from the subjective data, the researchers own notes and observations. These pictures are presented and used in an inductive process to build knowledge and or theories (Munhall, 2001:71).

3.3 RESEARCH APPROACH

A qualitative, descriptive phenomenological methodology was applied in this study to explore the experiences and perceptions of mothers utilizing child health services for children younger than two years.

Babbie (2010:308), states that theory can be generated by comparing unfolding observations if the researcher compares incidents, steps back to review periodically, maintains a skeptical attitude and follows the research process. The qualitative approach can be used to describe what is taking place in a given situation and this discovery of patterns can lead to interventions to improve practice (Burns and Grove, 2007:66). Phenomenology refers to the lived experiences of persons (Burns and Grove, 2009:54).

3.4 GOAL OF THE STUDY

The lived experiences of mothers with children younger than two years who utilized health care offered at clinics, private general practitioners and hospitals were explored.

3.5 OBJECTIVES OF THE STUDY

The objectives set for this study were to explore the experiences and perceptions with specific reference to the service they receive regarding:

- immunization
- nutrition
- the growth of the child

- the growth chart
- other underlying illnesses

3.6 POPULATION AND SAMPLING

3.6.1 Population and sampling of clinics

There are ten clinics in this section of the eastern side of Cape Town. A purposive sample of n=3 (30%) of the clinics from the total population (ten) were used (provided that permission was granted) to conduct the research. The sample included clinics jointly managed by both the Provincial Government of the Western Cape and the Metro Municipal Health Services (to ensure that no prejudice and bias exist in the sampling process). Furthermore the researcher selected this area as it provided the opportunity to obtain information about the child health services at these clinics.

3.6.2 Population and sampling of clients

For the purpose of this study the intended population was:

- Mothers of children younger than 24 months old who used the clinic services in a section of the eastern side of the metropolitan area.
- Mothers who utilized child health services at a cluster of clinics in a demarcated area in the Metropole were selected (as described in 3.7.1).

A purposive sampling method was applied to interview at least four voluntary mothers, who met the criteria and gave informed written consent, from each of the clinics selected for the purpose of this study. According to De Vos, et al. (2005:195), a sample of n=10 is adequate in qualitative research or until data saturation. Munhall (2001:109), supports this and also states that participants are selected to achieve redundancy or saturation of data and that usually happens between 2 – 10 participants.

Each client received a number on arrival to ensure that fairness was applied in the order of waiting. The researcher approached the mothers while they were waiting to be called into the consultation area to establish if the client would be willing and had time to participate. If the client showed interest to participate in the study, the full process as described in paragraph 3.10 was followed. A total of seventeen mothers were interviewed. Table 3.1 provides the distribution of clients interviewed per clinic. At clinic A, six participants were interviewed; at clinic B, four participants were interviewed; and at clinic C, seven participants were interviewed. A total of seventeen participants were interviewed.

Table 3.1: Respondents interviewed per clinic

Facility	Respondent interviewed
Clinic A	6
Clinic B	4
Clinic C	7
Total	17

3.7 SPECIFIC CRITERIA

Mothers with a child or children younger than twenty four months were interviewed.

Children in the age group 0-24 months are monitored monthly for growth and weight. Children receive the bulk of immunizations from birth to 18 months, thereafter immunization is scheduled at the age of six and twelve years. Therefore, this age group of children was the target group in the research.

All interviews were recorded. Mothers who refused to have the interview recorded were excluded from the study.

3.8 UTILIZING THE INTERVIEW GUIDE TO COLLECT DATA

An interview guide was used to conduct the interviews (Annexure A). The interview guide consisted of the following: demographic data and seven questions that were asked during each interview. The researcher completed the demographic information for each participant and conducted the interview with each participant. The interviews were conducted in a private area. Interviews were recorded and transcribed. All reflections and observations were captured in field notes after the interview was concluded. These notes were documented when the interviews were transcribed.

The use of the interview schedule assisted in guiding, but not restricting the interviewing process. It ensured that the same information was asked from each participant. Digital recordings of the interviews improve the reliability of the data obtained as the data can be stored, controlled for accuracy and a much fuller set of data can be obtained (De Vos, et al. 2005:298).

The questions of the interview guide were as follows (Annexure A):

- Tell me about your child. Tell me about your child's clinic card.
- For which services do you bring your child to the clinic? How does it work?
- If you take your child to a private doctor what happens?

- If you take your child to a hospital what does the hospital do?
- What does the sister/doctor tell you about your child's growth /health/ how to take care of your child?
- Is there any experience at the clinic that you want to share with me?
- What makes it difficult for you to bring your child to the clinic?
- How can using the clinic be made easier for mothers?

Some participants were forthcoming with information. Other participants required more probing, reflecting, and paraphrasing to reveal information especially the more timid and shy women.

3.9 PRE-TEST (THE PILOT STUDY)

Consent was granted for four clinics. The researcher decided to conduct the pilot study at clinic A, the clinic that is jointly managed by the two authorities, namely the Provincial Government of the Western Cape and the Metro Municipal Health Services.

The pilot study was conducted using two mothers who complied with the sample criteria. The purpose of the pilot study was to determine the feasibility of the methodology of the study.

The researcher approached the three clients in the waiting queue who complied with the criteria of which two mothers agreed to participate. Informed written consent was obtained. By the time the first client's consultation was completed, the mother indicated that she had to go home. The researcher realized that waiting times are too long; clients will not be willing to do the interview after the consultation. The researcher adapted the process and asked the next client if she would be willing to do the interview whilst waiting for the consultation. She agreed to this process as she was assured that she will not lose her place in the queue. The interview was conducted. The second client was selected who was willing to participate in the interview whilst waiting for the consultation. Informed written consent was obtained and the interview was completed before it was her opportunity to be seen by the registered nurse.

The pilot study gave valuable information on how to approach the clients; i.e. that it is better to do the interview before the consultation.

3.10 DATA COLLECTION

The interviews were conducted under the guidance of the managers of the clinics. Managers were provided with a copy of the consent letter issued by their own managing authority and the Health Research Ethics Committee.

In clinic A the interviews were conducted on a Friday. Guided by the lessons learnt in the pilot study the researcher approached mothers and obtained informed written consent for interviews prior to the health consultations.

Both Clinics B and C offer services at a central and satellite clinic. Appointments were made with the managers of the clinics. The researcher explained the intended research, provided the proof of permission granted and a way forward was planned. At clinic B services to children were provided for four (4) days a week of which two days were provided at the satellite clinic and one day was reserved for TB services. It was agreed that data could be collected on any day that child services were rendered until the number of respondents for the research study were interviewed.

At clinic C the facility manager was very helpful but restricted the data collection to the main facility due to limited space at the satellite facility. She indicated that the best days to do interviews would be a Wednesday and a Thursday.

A total of seventeen participants were interviewed. Data redundancy or saturation appeared to have been reached after the seventeenth interview. No new themes or responses emerged during the last two interviews conducted.

3.11 ANALYSES AND INTERPRETATION OF DATA

The data analysis were done using Tesch's eight step model (1990:144), supported by the guidelines supplied by Burns and Grove (2009: 520-523).

Step 1:

Interviews were transcribed the day after the interview was conducted. The researcher transcribed the interviews word for word following the guidelines of Tesch. This involved listening to the data, transcribing words, silences and utterances recorded during the interview. Observations and field notes were added. Where mothers spoke Afrikaans the responses were translated. The researcher could note trends emerging from the data obtained from the mothers and the observations made in the clinic. The researcher read and reread the interviews to identify emerging topics.

Step 2:

When the interviews were completed and transcribed the researcher reviewed all transcriptions by listening to the digital data again and verifying the transcriptions. This was done to emerge in the data, ensuring accuracy and to reflect on the context and field notes

that contributed to the understanding of the bigger picture. Codes were identified in the transcribed data.

Step 3:

This phase consisted of digitally listing or tabulating all topics. The tabulation was done electronically and similar responses were identified.

Step 4:

The tabulating of topics assisted the researcher to identify trends and interpret the responses. Concepts were clustered from emerging trends and emerging subthemes and themes were identified. The researcher's notes were added to improve comprehension. This assisted in reducing data to themes and subthemes.

Step 5:

The data was refined by digitally extracting themes and subthemes that described the experiences and reflections of the mothers. The themes were arranged in logical order with reference to the conceptual framework and research.

Step 6:

The demographic information was tabulated and field notes were added. The data was analysed and interpreted using tables.

Step 7:

The content of the categories found in the transcribed interviews were analysed. The researcher noted that the demographic data aided the emerging trends found forthcoming from the analyses of the interviews.

Step 8:

A final set of themes and subthemes were assembled. The researcher then proceeded to compare the trends with the research goal and questions. Themes and subthemes were contextualized and conceptualized using the Modeling Role-Modeling Nursing Theory (George 2010: 520). Evidence in literature was used to reflect on the services rendered. The conceptual model was used to compare outcomes to standards of care.

3.12 ETHICS CONSIDERATIONS

3.12.1 Obtaining permission to do the study

The researcher submitted the proposal to the Health Research Ethics Committee for Human Research at University of Stellenbosch to obtain ethics clearance for the study.

Following ethics clearance and permission for the study, submissions were made to the Ethics committees of the Provincial Government of the Western Cape (PGWC) and the Metro Municipal Health (MMHS) Services to obtain ethics clearance to conduct the study in the clinics in the selected study area of Cape Town. Requesting permission to do the research is done to ensure that the human rights of the participants are considered at all times during the study i.e. self-determination, privacy, anonymity, confidentiality, fair treatment, protection against discomfort and harm as described in Burns and Grove (2007:205). Authorities who are responsible for rendering health services need to know when research is conducted, as they have a dual obligation to ensure that client rights are protected.

Standardized application forms were submitted to both authorities. It is important to understand that management of the services was not yet fully integrated. The sample consisted of ten clinics. Provincial Government of the Western Cape has full jurisdiction over one of the facilities; Metro Municipal Health Services have full jurisdiction over six clinics and jurisdiction was shared by both authorities for three clinics. Permission was therefore obtained from both authorities to ensure that all ten clinics were included in the sample.

3.12.2 Maintaining ethical standards during data collection

The researcher applied the envisaged standards as set out in the proposal.

All participants were approached individually. They were informed of the objectives of the study; that participation is voluntary; that they may withdraw at any stage during the interview if they do no longer wish to participate. They were informed that the researcher is not working at the facility and that non-participation will not influence future treatment and access to the clinic.

The researcher showed them the digital recorder, explained that the interview will be recorded and transcribed and that their name will only appear on the consent form. They were informed that the study will be published and that they may ask for feedback on the results. Documents will be kept for five years and will be safeguarded locked in a vault at the home address of the researcher. It is required of the researcher to protect the identity of the respondent and keep the information where accidental access is prohibited (Burns and Grove, 2009:205).

Mothers were handed the information and consent sheet to read. All participants were literate. Informed written consent was obtained for the actual interview and for the recording of the interview. A copy of the pamphlet was handed over to all participants to enable them

to refer back. Informed consent necessitates the researcher to convey knowledge but also to ensure that the subjects grasp the information conveyed (Burns and Grove, 2007:217).

The participants were informed that they can receive feedback on the outcome of the study. The participant could choose to contact the researcher or allow the researcher to provide written feedback to an address of choice about the findings of the study. The pamphlet contained the phone number of the researcher.

Consent forms were available in English and Xhosa. Only one participant took the Xhosa version to read, but preferred to sign the English consent form. All participants could speak English; therefore there was no need to use a translator. The Afrikaans speaking clients indicated that they are well versed in English. They used both languages during the interview but asked to sign the English version of the consent form.

3.13 VALIDITY

Validity in qualitative research refers to trustworthiness or soundness. De Vos et al. (2005:346-8), describes the norms of Guba and Lincoln (1985) and Marshall and Rossman (1995), who developed the standards that describe the principles of trustworthiness in qualitative designs:

3.13.1 Credibility

Credibility can be constructed when the description of the research conducted describes and categorizes the area under discussion accurately.

Credibility in this study was maintained by ensuring that the interpretation of the researcher accurately reflects what the mother was saying and meaning. The researcher could clarify any information immediately where needed and did so throughout the interview till the end. This was done to maintain internal validity and credibility. The researcher took care to ensure that findings were a true reflection of the subjects' views and were not influenced by the researcher.

3.13.2 Transferability

Transferability refers to the ability to apply the findings to another area in other words; it is the ability to generalize the findings.

Transferability was maintained by keeping detailed records of the coding and analysis process. The researcher created codes and themes and in the analysis process reflected the process of developing understanding through reflective memos, marginal remarks and the

displaying of the data analysis processes. This will assist if the processes should be replicated.

3.13.3 Dependability

Dependability refers to the ability to account for changes in the phenomena and design. Dependability was maintained by an expert in qualitative research and nursing who reviewed the data analysis and the data coding processes. The expert evaluated the reliability of data analyses. The researcher maintained dependability by carefully describing each step of the data collection and analysis processes.

3.13.4 Conformability

Conformability is the ability to verify that the data can be confirmed.

Conformability was maintained by keeping field notes during the interviews and data analyses processes; any preconceived ideas and observations were noted and bracketed to prevent influence from the researcher's thought processes into the process or the data analysis.

3.13.5 Applying rigor

The researcher conducted the interviews to ensure rigor in the process. A pilot study was done to ensure that the methodology was sound. The researcher described the analysis and interpretation processes to provide an evidence trail for all the steps in the process.

3.13.6 Conceptual theoretical framework

A conceptual theoretical framework, the Modeling Role-Modeling theory of Erickson, Tomlin and Swain (George 2010: 520), was applied to describe the expected health care in the child services continuum. This will enable other researchers to apply the process in other clinical settings or repeat the study to compare results. This assisted the researcher to apply structure into explaining the expected roles in the clinical setting (Burns and Grove, 2009: 155).

The theoretical framework is seldom used in qualitative studies, however the researcher decided to follow developing trends by using a theoretical framework as described by Burns and Grove (2009: 547).

Some critics dispute the use of true phenomenology in nursing but see these phenomenological theories more as philosophical theories based upon the unconditional acceptance of the clients' version of reality (George, 2010:61). The use of the nursing theory will contribute to the validity of the study.

3.14 SUMMARY

In this chapter the qualitative research process, the phenomenological approach and the scope it provided to obtain the information from mothers were discussed.

The discussion on the applied research methodology included the approach, goal and objectives, sampling methods applied, pilot study, data collection and the interview process. A description of the data analyses and interpretation processes using Tesch's eighth steps for analysing qualitative data were provided. The ethical considerations as applied in this study were explained, the steps followed to ensure validity and the process followed to obtain consent to conduct the research.

3.15 CONCLUSIONS

The use of the qualitative methodology allowed the researcher to probe the respondents for additional information. The methodology was conducive to obtaining in-depth information from the mothers. Utilizing the phenomenological approach allowed the researcher to "see" the healthcare environment through the eyes of the participants. This assisted in analyzing the information. Listening to the recorded interviews afterwards brought to mind the pictures and emotions of the mothers waiting in the queues to access health care services for their children. The challenge was to ensure that the ethical principles were upheld throughout the data collection process to protect the rights and identities of the participants and their children. The discussion of the data analysis process can be found in chapter four.

CHAPTER 4: DATA ANALYSES AND INTERPRETATION

4.1 INTRODUCTION

The analysis and interpretation of data collected during the interviews are discussed in this chapter. In particular the focus is on the experience of mothers with children younger than two years.

The data collection and interpretation process occurred simultaneously, as described by Burns and Grove (2007:507). The emergence of patterns during the interviews prompted the researcher to probe and explore aspects in subsequent interviews.

The data was transcribed listening to the digital recording; field notes were added and the researcher dwelled on and became immersed in the data by listening, reading and rereading the transcribed interviews, a process described by Burns and Grove (2009:520-521).

The data analyses of the interviews was done using Tesch's eight step model (Tesch, 1990:144).

The demographic data was analyzed and interpreted by assigning codes to give meaning to the data. These meanings were tabulated. This enabled the researcher to form a visual picture of the participants who participated in the interviews, and their pathway of interaction with health services.

The data from the interviews was then coded. After coding, formation of subthemes and themes followed. The model of Tesch (1990:144) was used, supported by the guidelines of Burns and Grove (2009: 521) in doing the coding.

4.2 ANALYSING AND CONTEXTUALIZING THE DEMOGRAPHIC INFORMATION OBTAINED

The following data emerged from the interpretation of the demographic information and the field notes of the observer.

4.2.1 Characteristics of the respondents

Seventeen participants were interviewed. All the children were accompanied by the biological mother except for one child who was accompanied by the grandmother. Eight mothers had only one child; seven mothers had two children; one mother had four pregnancies but two living children, and one mother had five children, including one set of

twins. The age of the children ranged between 3 weeks to 18 months. The group appeared to consist of mothers who had normally visited clinics and could provide information on their experiences, whilst utilizing services for their children. The data is displayed in table 4.1 in chapter 4.

Table 4.1: The characteristics of the respondents’ interviewed

CLINIC	RESPONDENT NO	RELATIONSHIP TO CHILD	NO. OF CHILDREN IN FAMILY	AGE OF CHILD
A	A1	Mother	G 2 P 2	6 months
A	A2	Mother	G2 P2	6 weeks
A	A3	Mother	G2 P2	2 months
A	A4	Mother	G5 P6 (twins)	13 months (twins)
A	A5	Mother	G1 P1	4months
A	A6	Mother	G1 P1	5 months
B	B1	Mother	G2 P2	10 months
B	B2	Mother	G1 P1	18 months
B	B3	Grandmother	G2 P2	18 months
B	B4	Mother	G1 P1	6 months
C	C1	Mother	G2 P2	6 weeks
C	MC	Mother	G1 P1	6 weeks
C	C3	Mother	G2 P2	6 weeks
C	C4	Mother	G1 P1	6 weeks
C	C5	Mother	G1 P1	4 weeks
C	C6	Mother	G1 P1	3 weeks
C	C7	Mother	G4 P2 M1 D1	4 weeks
Legend	G = Gravida	P = Para	M = Miscarriage	D = Died

(“Gravida” refers to the number of pregnancies a woman had; “Para” refers to the number of children a woman gave birth to.)

4.2.2 Service providers the mothers utilized for child health

The researcher proposed to explore the experiences and perceptions of mothers utilizing child health services rendered to children younger than two years. Table 4.2 summarizes the range of service providers’ utilized by these mothers. The study was done at the primary health clinics. All mothers indicated the clinic as a service provider of choice. The information obtained from the parents revealed that the mothers also used private medical practitioners and hospitals for the health care of their children. The hospital was used by choice but also used after hours if no clinic was open or if the mother made a deliberate choice to use the

direct route and not the required route via the primary health care referral system. Ten of the seventeen mothers indicated that they utilised the services of private practitioners for their children. Eight of the mothers indicated that their children were hospitalized. Only two mothers indicated that they took their children to a hospital on their own accord, while one mother indicated that it was after hours and the clinic was closed. One mother preferred the services of the hospital.

The mothers were interviewed about services received at these facilities as it forms part of the continuum of care. Health care guidelines and policies such as the Expanded Programme on Immunization (South Africa) require immunization services to be available at all service delivery points such as clinics, community health centers and hospitals. The Department of Health (NDOH, 2005:7) supports the participation of the private sector. Information available on 10 November 2011 on the website of the Department of Health actually motivates parents to visit their clinic or medical practitioner to obtain immunizations (<http://www.doh.gov.za/show.php>).

Table 4.2: The service providers utilized in the care of the child

Participants	Clinic	Private Doctor	Hospital
A1	<i>Used</i>	<i>Used</i>	<i>Used</i>
A2	<i>Used</i>	not used	<i>Used</i>
A3	<i>Used</i>	<i>Used</i>	<i>Used</i>
A4	<i>Used</i>	<i>Used</i>	<i>Used</i>
A5	<i>Used</i>	not used	not used
A6	<i>Used</i>	<i>Used</i>	not used
B1	<i>Used</i>	<i>Used</i>	<i>Used</i>
B2	<i>Used</i>	<i>Used</i>	<i>Used</i>
B3	<i>Used</i>	<i>Used</i>	<i>Used</i>
B4	<i>Used</i>	not used	not used
M1	<i>Used</i>	<i>Used</i>	not used
M2	<i>Used</i>	not used	not used
M3	<i>Used</i>	not used	<i>Used</i>
M4	<i>Used</i>	<i>Used</i>	not used
M5	<i>Used</i>	not used	not used
M6	<i>Used</i>	not used	not used
M7	<i>Used</i>	<i>Used</i>	not used

4.2.3 Facilities where children were born – the beginning of the mother’s interaction with health care services for her child

The mothers provided the following information during interviews which enabled the researcher to construct an image of the variety of circumstances that represents their journey to ensure optimal health for these children. Six mothers delivered at the MOU (Maternal Obstetrical Unit); seven mothers delivered in a referral hospital and two mothers in a private maternity unit. The two mothers who delivered at home went to the MOU directly after delivery. The data regarding the birth facilities is displayed in table 4.3

Table 4.3: Table reflecting place of birth

Participants	Delivery at home	Delivery at MOU	DELIVERY at Referral site	Delivery at Private Institution
A1			Yes	
A2	Yes			
A3	Yes			
A4		Yes		
A5			Yes	
A6			Yes	
B1		Yes		
B2			Yes	
B3		Yes		
B4				Yes
C1				Yes
C2		Yes		
C3			Yes	
C4			Yes	
C5			Yes	
C6		Yes		
C7		Yes		

4.3 ANALYSING AND CONTEXTUALIZING THE INTERVIEWS

The next step was to emerge in and analyse the interviews to obtain the stories of the experiences of these mothers. The researcher embarked on coding the interviews.

4.3.1 Codes that emerged from the interviews

Perceptions that emerged from the interviews were coded and interpreted.

Table 4.4: Building a relationship of trust

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Happy	<i>"No I am happy with the clinic"</i>	A2	Trust the staff
Improved relations	<i>"Staff are so nice. Will only be nasty if you are nasty to them. Get what I need from them. Way back with my first child nurses was stuck-up and treated us bad"</i>	A4	Ethos of caring improved
Frustration	<i>"They take too long with the people. Even if there is little people they take too long. They all go onto tea break and it is not right..." (sic)</i>	A1	Trust relationship not established
Acceptance of conditions	<i>"I don't know if they have a stock shortage but the sister are trying their best."</i>	A5	Problems in the system may influence service delivery

Table 4.5: Accepting the client as an individual

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Long waiting times	<i>"One often sit for eight hours One only waits very long, especially if you come for immunization and there is cases of emergency..."</i>	C1	Clients have responsibilities
No understanding	<i>"Staff can be more understanding. One asks because you do not know. They do not understand..."</i>	B2	Client is an individual with own needs
Expectations	<i>"Is not as if they will assist you. Urgently...not going to happen here."</i>	A6	No individual approach
Confidence	<i>"One waits long sometimes. I do not see any problem. I brought my own children here and now my grandchildren."</i>	B3	Services fulfill expectations

Table 4.6: Utilizing clinic services for health care

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Vertical services	<i>"For anything ... when your child is sick and for immunizations"</i>	A5	Knowledge of services offered
Weight monitoring	<i>"I bring my child for injections, if he is sick, something wrong... Yes, also sometimes just to weigh."</i>	B1	Prompting reminds her of other services observed
Help with mother's needs	<i>"When you don't know what's wrong with the child, she doesn't want to drink or she sleeps the whole time"</i>	C4	Services more than vertical programmes
Specific diseases	<i>"If the child has diarrhoea, vomits or for injections."</i>	C5	Sick children
Package of services	<i>"Basically they have weighing, immunizations, and if the child is sick or has accidents... if the child swallow something. If it is not an emergency, you bring the card. If it is an emergency then I cause a big fuzz." (sic)</i>	A4	Accidents and injuries

Table 4.7: Utilizing private doctor services for health care

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Look at child	<i>"He does not weigh them but look into the ears and mouth."</i>	C7	Limited range of service offered
Doctor is quicker	<i>"Sometimes we do... especially if you can't get to the clinic after 5 or in the mornings if you have a lot to do... There are many parents who feel the clinic is taking a lot of time... the doctor is quicker"</i>	H4	Waiting time curbs clinic services
Family decisions	<i>"It was my husband.... does not know what he told my husband."</i>		Child is cared for by family

Table 4.8: Utilizing hospital services for health care

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Accessing hospital after hours	<i>"I do not know if they looked, my child was not up to date. They said to go to clinic. At clinic they said it was given. So I do not know if they give immunization"</i>	A1	Do not know what hospital will provide
Access to doctor	<i>"O I hate that hospital... see you see immediately. That is better Basic all the same as at the clinic. Take weight, temperature; test her urine. Then you wait. You wait for hours."</i>	B2	Hope to see medical doctor
Comply or else.....	<i>"Then the mothers are "scolded." Then they give the injection or tell the mother to go to the clinic the next day."</i>	A4	Hospital will assess for adherence

Table 4.9: Integrated service delivery

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Integrated approach applied	<i>"They did explain that every time I come to the clinic the nurse will weigh the baby and the baby must pick up weight and if it goes down it is bad."</i>	A5	Mother aware of integration
No integration	<i>"Nobody discussed it with me. Only when I was at the MOU the counselor was there..."</i>	A3	The service is not integrated
Cannot recall	<i>"No, I remember they do it but I cannot remember when they will do it."</i>	A2	Mother not aware of integrated approach

Table 4.10: Access with a very sick child

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Prepared	<i>"They say if it is an emergency you must go in immediately."</i>	C1	Know not to sit in queue
	<i>"No.... I am going to tell them that she is very ill"</i>	C2	Know to inform staff
	<i>"I read about the sugar salt solution but if it is severe you have to go to the sister immediately."</i>	C7	Information available
Unprepared	<i>"I sat as normal, I went to the place indicated, place was locked. Said someone will see to you. I left after 90 minutes..."</i>	A6	No oral rehydration offered

Table 4.11: Growth monitoring

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Weighing ,no advice on nutrition	<i>"If the child is underweight or overweight if the child is underweight it is very dangerous to them"</i>	C1	Growth monitoring services limited to weight
Mother not involved	<i>"No I was actually planning to ask them if she had picked up"</i>	B3	No growth monitoring advice
	<i>"She said nothing, she only wrote in the card."</i>	C5	
Families provide knowledge on nutrition	<i>"Yes, they did but it was mostly my mother."</i>	B1	Family is the provider of feeding advice

Table 4.12: Health information provided to enable her to care for the child

Code	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Empowered	<i>"Everything about her is in it; also messages if she is sick that I can read; her birth weight and stuff. Everything is in it..."</i>	A3	
Knowledge	<i>"...this is dates when I must come. When sick must report... weight... when to come again..."</i>	A1	Information supplied on Road to Health Book
Spectator	<i>"...nothing, only said it is the clinic card. It must be used when I take the child to the clinic..."</i>	A2	
Dependent	<i>No, I asked, but they said it is my child's card."</i>	C3	

Table 4.13: Subthemes that emerges

Subthemes	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
Caring Ethos	<i>"The clinic give good services and I don't know if they have a stock shortage but the sisters are trying their best After hours will work and some people will take advantage of that privilege,"</i>	A5	Strategy conducive to build relationship of trust
Long waiting times	<i>"They take too long with the people. Even If there is little people they take too long"</i>	A1	Individual needs of clients not met
Multiple service providers involved in child health	<i>"Take child to doctor if in hurry. Clinic takes too long. Mostly doctors do not weigh or check immunization. Examine and finish. Do not look at RTHC."</i>	A4	All service providers does not provide holistic care
Enabling mother to care for the child	<i>"No the clinic is a big support for us." "... If you want information you have to ask questions all the time Staff can be more understanding. One asks because you do not know. They are not understanding (sic)..."</i>	C2 B2	Varying experiences regarding support provided to care for child
Mother acknowledged as part of the team	<i>"Staff can be more understanding. One asks because you do not know. They are not understanding Show more interest, human factor, ask more questions..."</i>	A6	Concept not well entrenched at service level
Health promotion activities	<i>" Your child is growing well mommy" "You must take your child for immunizations and Vitamin A... " "Yes, also sometimes just to weigh." "No they only told me how much she weighs and that she picked up....."</i>	A1 A5 C1 C6	Awareness of health promotion activities
Unavailability of services	<i>"I don't know if it was a financial problem because she was supposed to come for her injections last week but they did not have any in stock."</i>	A5	Vaccines out of stock
	<i>"The sister who does immunizations was not there and they told me to come here today. ...and the sister is not here today..."</i>	A2	Nursing staff on training
Integration of services	<i>"Look at everything..... Do not discuss weight and feeds. Will ask if child is still on the breast" "Yes, they look at everything, the eyes, muscles, movements; they undress her and look at everything..."</i>	A1 A3	Various concepts of integration exists

Nutritional needs	<i>"Yes, and if there is a problem I will give boiled water."</i>	C3	Feeding not assessed
	<i>"My "mother and they" told me....Give water because my mother said I should..."</i>	A3	
	<i>"Do not discuss weight and feeds. Will ask if child is still on the breast..."</i>	A6	

Table 4.14: Themes that emerged

Themes	Evidence: Example of quotation (source/number of interview in brackets)	Reference	Interpretation
1 Emotional response to service delivery	<i>"Good services. I do not find any problem with the services."</i>	C5	Establishing the trust relationship
2 Needs more understanding	<i>"I know they have to follow a procedure"</i>	A5	Accept the mother as part of the care team
3 Services not available	<i>"Hospital weighs, look at RTHC and immunizations. No immunizations or growth monitoring..."</i>	A4	Standard quality integrated services
4 Individual needs of clients not met	<i>"...supposed to come for her injections last week but they did not have any in stock."</i>	C5	Promote the client's control
	<i>"I have to take leave to come to the clinic and then I have to wait here for a very long time. Takes very long, if not here at 0800...waits whole morning."</i>	B4	
5 Information on Road to Health Book	<i>"Everything about her is in it; also messages if she is sick that I can read; her birth weight and stuff. Everything is in it..."</i>	A3	Provide information to care for the child
6 Provide health education	<i>"Ja...they will tell you if child is underweight. Like if the child becomes overweight. They ask about the food and they are satisfied. The twins are on breast and bottle feeding"</i>	A4	Affirm and promote the clients strengths
7 Facilitating entry of children with life threatening conditions	<i>"You tell them and after 10 minutes they say you must come this side -5 minutes. So if very sick they help you quickly..."(sic)</i>	B1	Set mutual self-directed goals

4.4 CONTEXTUALISING THE REFLECTIONS AND EXPERIENCES OF THE MOTHER WITH EXPECTED STANDARDS OF SERVICE PROVISION

A standard of provision can be declared as a desired or acceptable level of health care. Two aspects must be taken into account when this is interpreted - the national norms and standards define what should be offered. The local norms and standards define what is offered and this revolves around staff competency (NDOH, 2000:6).

The following themes evolved from the interviews with the mothers to reflect their experiences and perceptions on the health care provided for their children.

4.4.1 Establishing a relationship of trust

The norms and standards published by the National department of Health require that patients be treated with “courtesy kindness, empathy, tolerance and dignity” (NDOH, 2000:10) reflecting the intention that an ethos of caring is envisaged in health care delivery.

The same principle is entrenched in the Bill of Rights, chapter 2, section 27 of the Constitution of South Africa that determines that everybody has the right to health care. Section 28 (c) determines the right of children to basic nutrition, shelter, basic health care services and social services (Constitution of South Africa).

This relationship of trust was experienced by respondents who reported the relationship with staff as follows:

*“...Staff are so nice. Will only nasty if you are nasty to them.
Get what I need from them. Way back with my first child nurses
was stuck-up and treated us bad.....”* (Respondent A4)

*“The clinic give good services, I don’t know.....
but the sisters are trying their best”* (Respondent A5)

“Good services. I do not find any problem with the services...” (Respondent C5)

Staff should be positive in their approach to patients “....correcting misinterpretations and giving each patient a feeling of being welcome” according to policy (NDOH, 2000:13).

Not all participants described a positive experience. The following mothers had not yet established a trust relationship with the staff.

*“Staff can be more understanding. One asks because you do not
know.....They are not understanding (sic).....”* (Respondent B2)

*(Hospital)... “O I **hate** that place...! (Clinic) How will you know the sisters have raining to do some of the work? They are so busy and they do all they work like mmunization and family planning (Shakes head)” (Respondent B2)*

The Batho Pele principles, the eight principles that guide service providers to put people first, determine that the principle of courtesy should be maintained. People should be treated with courtesy and consideration (NDOH, 2000).

This establishment of the relationship of trust is also supported in the Modeling Role Modeling Nursing Theory of Erickson, Tomlin and Swain who describe this as the first step in the nursing process (George 2010: 520).

4.4.2 Accept the mother as part of the care team

The mother is the determining factor in the well-being of the child. McKerrowi and Mulaudziii (2010:66), established an increase in morbidity and mortality for maternal orphans or children whose mother is not healthy.

According to Coetzee the best predictor of a child's health outcome is the mother - child interaction (2008: unpublished notes).

In the Modeling Role- Modeling Nursing Theory of Erickson, Tomlin and Swain (George 2010: 520), the mother must be accepted as an individual with specific needs that may differ from other mothers. Each mother must also be accepted as a partner in the health care of the child and the relationship must be nurtured.

“Did askscold me out for mixed feeding.

Did not tell me what she weighed today; or maybe I forgot...” (Respondent C4)

“Do not discuss weight and feeds. Will ask if child is still on the breast...”

(Respondent C4)

“Never discuss. Asked to see dietician as she is eating too much.

Tell you dietician only available on certain days... Always in a hurry; not talking to child, calm her. Cold, just get job done” (Respondent B2)

“No I was actually planning to ask them if she had picked up...” (Respondent B4)

The experiences of the mothers do not portray awareness that the mother must be included in developing care plans for their child. It appears as if mothers do not always receive information about their children.

4.4.3 Standard quality integrated services

The following services are perceived to be child health services rendered at PHC level and are described as such in the policy document:

“Promotive, preventative (monitoring and promoting growth, immunizations, home care counselling, de-worming and promoting breast feeding), curative (assessing, classifying and treating) and rehabilitative services are given in accordance with provincial IMCI protocols at all times that the clinic is open” (NDOH, 2000:19).

All clinics must provide immunizations for at least five days a week and if the community desires additional periods specifically for child health promotion and prevention (NDOH, 2000:23). Provision of Vitamin A, deworming medication and EPI disease surveillance are included in the services rendered (NDOH (b), 2008:47).

In context of the Model Role-Modeling Nursing theory, the provision of health integrated services will strengthen the ability of the modeling and the role-modeling of the nurse/healthcare provided to establish needs, enable the client/mother to have control over the health care needs of the child and promote self-care (George, 2010: 521).

The success of the integrated approach was established by the following researchers: “Countries that had made the most progress as measured by average annual reduction of mortality were those which had higher coverage of comprehensive primary health care (Binkin, Chopra, Simen-Kapeu and Westhof, 2011:13).

“Look at everything..... Do not discuss weight and feeds. Will ask if child is still on the breast.” (Participant A1)

“Yes, they look at everything, the eyes, muscles, movements, they undress her and look at everything...” (Participant A3)

“Hospital weighs, look at RTHC and immunizations. No immunizations or growth monitoring...” (Participant C4)

“...supposed to come for her injections last week but they did not have any in stock”

(Participant A5)

The experience of the mothers indicates a shortfall in integrated services. This will influence the ability to establish the child’s health care needs and the mothers’ care deficit as defined in the Modeling Role-Modeling Nursing theory.

4.4.4 Promote the client's control

The mothers who did not receive nutritional education indicated that their mothers filled the gap. This is a concern as mothers provided mixed feeding; early introduction of porridge in the bottle, and water bottles to breastfed babies. These practices continue because the grandmothers provide the information and not the health workers.

In context of the MRM Nursing theory, the provision of health information will form part of the role-modeling of the nurse/healthcare provided, to enable the client/mother to have control over the health care needs of the child and promote self-care (George 2009: 521).

*"It seems as if he is never satisfied so I decided to also give a bottle...
I give him one bottle, then water and breast..."* (Participant C3)

"My mother told me to give him water..." (Participant C7)

*"If the child is underweight or overweight is the child is underweight
it is very dangerous to them....."* (Participant C1)

"Last time they said she is low weight for her age and then they discussed it..."
(Participant B3)

"Your child is growing well mommy." (mimicking the staff) (Participant C1)

The quoted evidence provided above suggests that health education is not provided on a regular basis. This is a concern as malnourishment is one of the leading causes of morbidity and mortality according to McKerrowi and Mulaudziii (2010:66).

To be able to achieve the target of Millennium Development Goal number four to decrease the child mortality by 60% by the year 2015, health workers need to concentrate on aspects such as providing information on nutrition to parents (2010:66).

4.4.5 Provide information in order to care for the child

"The World Health Organization international growth standards for assessing the growth and nutritional status of children provide the tool for early detection of growth faltering and for appropriate intervention" (Lartey, 2008:1).

In South Africa these standards are included in the Road to Health Book (RtHB). This book contains the growth charts (anthropometric measurements); health education messages; safety message; information on nutrition and danger signs that will alert the mother when the child should be taken to a health care practitioner (NDOH,(b) 2010: Unpublished training material).

The Modeling Role-Modeling (MRM) Nursing Theory of Erickson, Tomlin and Swain refers to the role modeling of the health care provider, where the client's positive orientation towards his/her health care needs are established, processes are put in place that will promote the client's control and affirm and promote his/her ability or strengths to deal with his/her health care needs (George 2010: 521).

The following quotation reflects the mothers experiences regarding the information provided about the Road to Health Card. The information provided is not comprehensive or standardized. This client-held record contains important messages about child care. Mothers who are well orientated will be able to interpret the growth curve of their child. The apparent failures to provide the basic information to mothers impede their self-care ability.

"They did explain that every time I come to the clinic the nurse will weigh the baby and the baby must pick up weight and if it goes down it is bad." (Participant A5)

"Everything about her is in it; also messages if she is sick that I can read; her birth weight and stuff. Everything is in it..." (Participant A3)

"...this is dates when must come. When sick must report; weight; when to come again..." (Participant A2)

"No, I asked, but they said it is my child's card..." (Participant C3)

"...nothing, only said it is the clinic card. It must be used when I take the child to the clinic..." (Participant C5)

4.4.6 Affirm and promote the clients' strengths

The mothers' reflections on services received, indicate that the adherence to this service standard can be clustered in three subcategories namely: - they either received no information, were just informed that it is the new chart or received sufficient information to enable them to use the card constructively. This is a concern as the mother is the most important determinant in predicting the child's health care outcome according to McKerrowi and Mulaudziii (2010:66) and Coetzee (2010:2).

In context of the MRM nursing theory the provision of health services will form part of the modeling role of the nurse/healthcare provided to establish the trust relationship; develop an understanding of the mother's world and her potential to realize the "self-care"(George 2010: 520).

“...this is dates when must come. When sick must report; weight; when to come again...” (Participant A1)

“Nothing, only said it is the clinic card. It must be used when I take the child to the clinic ...” (Participant B3)

“..No, I asked, but they said it is my child’s card...” (Participant C3)

4.4.7 Set mutual self-directed goals

The reflections of the mothers indicated that they are aware that they should inform the staff if their child is sick and display danger signs as depicted in the Road to Health Book. A concern was the absence of oral rehydration corners or areas as the interviews was conducted during the diarrhea season.

This is a good example of the ability of clients and health care providers to set mutual self-directed health goals. Both parties have one outcome in mind – to prevent children dying from dehydration. Posters in the clinic advise mothers to inform staff about the child having diarrhoea; pictures of children with severe dehydration or lethargy on the wall inform parents to report children looking as depicted, and oral rehydration corners provide an opportunity to start with rehydration as soon as the child enters the waiting area. The Modeling Role-Modeling Theory sees mutual goal setting as the last step in the nursing process (George 2010: 521).

“I read about the sugar salt solution but if it is severe have to go to the sister immediately...” (Participant C7)

“You tell them and after 10 minutes they say you must come this side -5 minutes. So if very sick they help you quickly...” (sic) (Participant B1)

“I sat as normal I went to the place indicated, place was locked. Said someone will see to you. I left after 90 minutes” (Participant A6)

4.8 DISCUSSION ON THE EXPERIENCES AND PERCEPTIONS OF MOTHERS

The objectives for this study were to explore the experiences and perceptions of mothers with reference to the service they receive regarding to:

- immunization
- nutrition
- the growth of the child

- the growth chart
- other underlying illnesses

The information gained from the analyses of the interviews indicates that the experiences of the mothers regarding the services received for the various programmes of the child services were diverse.

The findings show that services are not standardized and do not always comply with the norms and standards determined by the National Department of Health.

The detailed breakdown of the findings and recommendation for each of the elements of the objectives will be provided in chapter five.

In chapter five the outcomes of the study will be compared to the Modeling Role-Model theoretical framework of Theory of Erickson, Tomlin and Swain.

4.9 SUMMARY

In this chapter the data analysis and interpretation process were discussed. The data was transcribed and analysis of the interviews was done using Tesch's eight step model (1990:144) supported by the guidelines of Burns and Grove (2009: 521).

Codes emerged, subthemes developed and the data was reduced into seven themes through inductive reasoning. The themes explain the experiences and perceptions of mothers and provide information on which services mothers utilise and which services are offered to mothers.

4.10 CONCLUSION

The content and standards of health care programmes are determined by the National Department of Health. How the service is implemented and what happens at implementation level is determined by the staff of provincial or local health authorities. The researcher embarked on the study to determine what mothers' experiences and perceptions are about the health services they use. The interviews provided the information regarding the research objectives. It appears that there are diverse service deliveries. The detailed findings, recommendations and limitations are discussed in chapter five.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter the research findings for each of the objectives are discussed and recommendations are presented. The outcomes are linked to the theoretical framework to enable other researchers to compare research findings with other settings.

The limitations and specific challenges found during the research are emphasized.

5.2 THE RESEARCH PROBLEM

The research problem as stated in paragraph 1.4 is discussed in paragraph 5.2.

Various policies and interventions, based on best practices, were introduced to improve child health care services. The influence of non-adherence to policies and procedures by service providers in rendering child health services seems to be a contributing factor to the quality of care rendered.

5.2.1 Research question

The research question which gave guidance to the study was “What are the experiences and perceptions of mothers with children younger than 2 years about the child health services they are utilizing?”

5.2.2 Goal

To explore the experiences and perceptions of mothers utilizing child health services rendered to children younger than two years.

5.2.3 Objectives

The objectives set for this study were to explore the experiences and perceptions with specific reference to the service they receive regarding:

- immunization
- nutrition
- the growth of the child
- the growth chart
- other underlying illnesses.

5.3 RESEARCH FINDINGS

As stated in paragraph 4.4 the standard of provision of health services can be declared as a desired or acceptable level of health care. This acceptable level of service provision is determined by policies and procedures issued by the National Department of Health (NDOH, 2000:6).

Two aspects must be taken into account when service delivery is interpreted. The national norms and standards define what should be offered. The local norms and standards define what is offered and this revolves around staff competency (NDOH, 2000:6).

The burden of disease contributing to the high mortality rate among children includes pneumonia, diarrhoea, malaria and HIV. Simple strategies and improvements in the health care system may prevent these conditions. Interventions include oral rehydration, early recognition and treatment, providing mosquito nets, immunization and appropriate nutrition (Jensen, 2010:27).

5.3.1 Experiences and perceptions about immunization services

The Expanded Programme on Immunization (2010) intends to protect children early in life against infectious diseases before they are exposed to them (Barron and Monticelli, 2010).

As stated in paragraph 4.4 all clinics must provide immunizations for at least five days a week and if the community desires additional periods specifically for child health promotion and prevention (NDOH, 2000:23). Provision of Vitamin A, deworming medication and the Expanded Programme on Immunization and Disease Surveillance are included in the services rendered (NDOH (b), 2008:47).

Furthermore, as described in paragraph 4.2.2 health care guidelines and policies such as the Expanded Programme on Immunization (NDOH (b):2010), requires immunization services to be available at all service delivery points such as clinics, community health centers and hospitals.

The Department of Health (2005:7) supports the participation of the private sector. Information available on 10 November 2011 on the website of the Department of Health actually motivates parents to visit their clinic or medical practitioner to obtain immunizations (<http://www.doh.gov.za/show.php>).

5.3.1.1 Findings at clinical level

Two broad categories of challenges were found: vaccines that were out of stock and the professional nurse not on duty but on a course. In clinic A and B five children had missed opportunities because vaccines were out of stock. Furthermore, in clinic C the Professional

Nurse was attending training and the seven participants received no immunization. Twelve out of seventeen children were not immunized according to policy (NDOH (b): 2010).

“I don’t know if it was a financial problem because she was supposed to come for her injections last week but they did not have any in stock.” (Participant A5)

One of the mothers at clinic C was at the satellite clinic the previous week and was referred to the main clinic due to the absence of staff. The same predicament existed on the day she arrived at the main clinic. Nobody was available to immunize the child.

“Yes, the satellite clinic. The sister who does immunizations was not there and they told me to come here today.” (Participant C2)

The successes of the Expanded Programme on Immunization are seen as obtaining polio free status; reduction in incidence of measles morbidity and mortality, and the decrease in neonatal tetanus incidence (Day and Gray, 2008:337).

The measles outbreak of 2009-2010 in South Africa is a direct consequence of low herd cover. Herd immunity is the term used to refer to the incidence of protected individuals in a population. Fully immunized individuals in a community can indirectly protect those who are not immune against infection. The higher the immunization coverage the better the herd immunity appears to be (Trotter and Maiden, 2009.)

Corrigall, Coetzee and Cameron (2008:41) and Durrheim and Ogunbanjo (2000:130), cautioned in the findings of their studies that the data indicated low immunization coverage that predicts the danger of outbreak of vaccine preventable diseases. The observations in surveys did not correspond with the information of the DHIS that indicated high measles coverage at nine months and a low drop-out rate of 21%

The findings in this study appear to confirm the concerns that the data of the District Health Information System may be overstated. The measles outbreak in 2009 and 2010 confirms that the herd cover was not sufficient in counteracting this.

5.3.1.2 Findings about other health care service providers

At the hospitals the immunization service is not offered. Mothers explained that the card may be checked, but they were referred back to clinics. Other mothers recalled that the card was not even looked at.

“Ja do not look at card; ask about injections but do not offer to immunize...weighed the child, took the card along but staff did not look at it..”

(sic) (Participant A4)

The concept of “seamless health services” does not exist as far as immunization is concerned. This relates to the concerns of researchers stated in paragraph 2.4.2.2. Metcalf, Yach and de Beer conducted a survey in 1992 in the Western Cape to evaluate the outcome of proposals made after a previous study in 1990 to improve immunization services in Western Cape Provincial Hospitals. The study showed that only 13% of the children who needed immunization received the required dosages. It was also found that only 37% of the respondents were asked to provide their Road to Health Cards (RTHC) (Metcalf et al., 1992:149-52). Despite these findings and the time that elapsed since the two studies were done, the situation has not changed at service delivery level.

Mothers also utilize the services of private medical practitioners. The holistic approach to manage child health care appears not to be observed here.

“.. They do not check the card. They only examine en finish. There is a lot of thing on the card that the private doctor can look at, is that not true? They basically do not look at those aspects. They only make a diagnosis on the child’s “body” and “off they go...” (sic) (Participant A4)

Although the National Department of Health supports the participation of the private sector in child health services (NDOH, 2005:7), the experiences of mothers indicate that this does not happen at service level.

In conclusion, immunization status was not constantly monitored or provided when needed.

5.3.2 Experiences and perceptions about growth monitoring of the child

On 10 November 2011 The National Department of Health website contained the following information for the public regarding immunization services “Visit your local clinic or medical practitioner. The nursing sister will take your child’s weight, length and the head circumference to determine if your child is growing at the expected rate” (<http://www.doh.gov.za/show.php>). Growth monitoring is an integral part of the immunization visit.

Growth monitoring should be done at least once a month for children younger than twelve months. It is a preventive and promotional activity. Anthropometric measurements are

interpreted. The findings are used to facilitate communication and interaction with caregivers. The healthcare provider must communicate the information to increase caregiver's awareness about child growth, how to provide improved caring practices such as nutrition, provision of Vitamin A and deworming. The caregivers are also informed about related services such as immunization (NDOH (b), 2010).

Growth monitoring requires the following actions: weigh the child and plot the weight on the graph in the Road to Health Book. Evaluate whether the child gained weight since the previous visit. Interpret the direction of the curve to determine if there is good weight gain, whether the curve is flattening or whether there is a drop in the curve. Determine the child's weight for age classification i.e. normal weight; low weight or very low weight using the graph in the Road to Health Book (NDOH (b), 2009: 60).

5.3.2.1 Findings about growth monitoring

The findings about the mothers' experiences can be clustered in three groups. Mothers who knew that the growth curve indicates how the child is growing and mothers who received no information about the growth curve. The third group consisted of mothers who were exposed to health care providers who did not interpret the growth measurements correctly.

The mothers related the following about their experiences:

"They did explain that every time I come to the clinic the nurse will weigh the baby and the baby must pick up weight and if it goes down it is bad" (Participant A5)

"No I was actually planning to ask them if she had picked up" (Participant B4)

The Road to Health Book is a client-held record. The researcher observed the growth graph and history of each child. There were babies where the growth curve clearly showed evidence of flattening over a period of time. This flattening of the curve requires early intervention as it indicated unsatisfactory weight gain. The problem was addressed only when the child's weight became "low weight for age" (IMCI, 2009:60). The growth curve flattened out over a period of time and it appears as if this was not addressed. When prompted, the mother indicated that no feeding assessment was done.

"No, the last time they did say that she is underweight and then they did discuss it...." (Participant B3)

The importance of growth monitoring for child health service is evident in literature. In the South African Health Review of 2010 McKerrowi and Mulaudziii it is stated that at least a third of children who died were malnourished and a further 30% were underweight for their age (McKerrowi and Mulaudziii, 2010:66).

Krebs, Hambidge, Mazariegos, Westcott, Goco, Wright, Koso-Thomas, Tshetu, Carl Bose, Pasha, Goldenberg, Chomba, Carlo, Kindem, Das, Hartwell and McClure found that infants and young children have the highest risk of morbidity and mortality because of chronic malnutrition. They found that the incidence of malnutrition increases in the age group 6 to 18 months. The evidence shows that the consequences of the malnutrition due to pathological changes influence the quality of life should the child survive the episode of malnutrition (Krebs, et al., 2011).

The mothers' experiences are important; however what they are silent about also related their experiences. No mother verbalized that the child's length or the head circumference was measured. Growth monitoring, feeding assessment and the provision of advice on nutrition are closely linked. The experiences of mothers with regard to advice on nutrition received are discussed in paragraph 5.3.3.

In conclusion growth monitoring was not always done correctly.

5.3.3 Experiences and perceptions about information on nutrition

Chopra and McCoy (2000:19), describe the following requirements for a quality nutritional assessment. Staff should be adequately trained, use functioning scales and provide growth monitoring services in a timely and courteous manner. Weight should be plotted correctly. Appropriate counseling should be provided to improve the mother's knowledge about the growth and feeding of her child. This will increase client satisfaction and prevent morbidity and mortality due to malnutrition. Nutrition assessment is not a singular activity, but should be an integrated activity. This will increase access to other services such as immunization services.

Information on nutrition is defined in the Integrated Manual of Childhood Illnesses protocol as assessing the feeding of every child irrespective of nutritional status, **at every visit until the child is two years old**. After the assessment, the health care provider provides information about the correct feeding for the child's age. Once the child is two years old feeding must be assessed if the child is not growing well or if the child presents with anemia (NDOH (b), 2009:76).

Practitioners must give appropriate and relevant advice to mothers about giving the best nutrition to the child and by doing so giving the child the best start in life. Feeding advice

should be relevant both to the age of the child and to the family's social and economic situation (NDOH (b), 2009:76).

5.3.3.1 *Findings about the nutrition service provided*

The findings can be grouped in four categories, namely: information was supplied about the weight gain; feeding assessment and nutritional advice did not form part of the regular services provided; health care providers do not adhere to basic nutrition assessment guidelines. Family members appear to provide the nutrition information.

The mothers revealed varying experiences. Mothers remembered that they were told that the child is growing well after the child was weighed. A mother's comment about what she was told about her child's nutrition was:

"Your child is growing well mommy" (Participant A1)

The mother should receive information that empowers her to provide sufficient nutrition for the child according to the child's age and this should be linked to the weight gain on the growth curve of the Road to Health Book (NDOH (b), 2009:76). The mother must be able to see that the child is growing well.

One participant remembered the following about advice on nutrition for her child who had low weight for age.

"They ask about the food and they are satisfied. The twins are on breast and bottle feeding..." (Participant A4)

The researcher observed that the growth curve in the Road to Health Book of the child showed a flattening of the curve over a period of time. The nutrition could not have been sufficient. The mother did not recall any counselling that was provided.

Another mother recalled the following about provision of nutritional assessment and feeding advice:

"No, I remember they do it but I cannot remember when they will do it."
(Participant A2)

The mother remembered that staff provided counselling nutrition with her first child. However, with the next child nobody assessed the breastfeeding or discussed exclusive breastfeeding or when to introduce solids.

A mother who has a six months old child received no counselling or information. She indicated that she intended to ask the staff about the child's weight gain that day.

"They have not asked me yet..." (Participant B4)

The quoted evidence above suggests that health education is not provided regularly. This is a concern as malnourishment is one of the leading causes of morbidity and mortality according to McKerrowi and Mulaudziii (2010:66).

The mothers revealed incorrect feeding practices. Mothers did not indicate that they received advice to correct the practices.

"It seems as if he is never satisfied so I decided to also give a bottle.... I give him one bottle, then water and breast..." (Participant C3)

"Yes, and if there is a problem with the stomach I will give boiled water." (Participant C2)

(Comment of researcher - Mother believed that child should get boiled (clean) water is as it is good for the child. Give it on advice from her mother.)

Grandmothers and family members seem to be a frequent source or provider of nutrition information. The information included practices that should be discussed and corrected. The following statements reflect these incorrect practices that were not addressed.

"My mother told me to give him water..." (Participant C7)

"Yes, they did but it was more my mother..." (Participant A3)

"My 'mother and them' told me..." (Participant C1)

South Africa is one of 12 countries where the mortality rate in children younger than five has increased from 56/1000 live births in 1990 to approximately 67 to 73 /1000 live births in 2008 (Chopra, Davioud, Pattison, Fann & Lawn, 2008:30).

According to McKerrowi and Mulaudziii (2010:70) "...the ongoing reduction in childhood mortality cannot be achieved solely within the health system. It requires early access to and more regular utilization of existing services...."

In the study it was found that although mothers had access to the services, the nutrition services were not rendered and therefore the nutrition status will not improve. According to the Integrated Management of Childhood Illnesses training module, 60% of children under 5 years who die have malnutrition as part of the cause of death (NDOH (b), 2009:66).

The mothers who did not receive nutritional education indicated that their mothers filled the gap. This is a concern as mothers provided mixed feeding; early introduction of porridge in the bottle; giving water bottles to breastfed babies. These practices continue because the grandmothers provide the information and not the health workers.

Krebs, et al. (2010:2) found in a study that inadequate knowledge about appropriate foods and feeding practices are often a greater determinant of malnutrition than actual lack of food. Sound and culture-specific nutrition counselling should be given to mothers of young children in the widest possible use of indigenous foodstuffs that will help to ensure the optimal safe use of local affordable foods. They found that the child suffers most damage due to malnutrition during the first one to two years of his/her life. Prevention is likely to be the most beneficial at this age. The transition from exclusive breast feeding to a diversified diet is a particularly vulnerable time.

Binkin, Chopra, Simen-Kapeu and Westhof (2011:14) found that exclusive breastfeeding for six months have the greatest potential impact of any single intervention on the under-five child mortality rate. Malnourished children are known to be at an increased risk of death and it has been estimated that malnutrition contributes to about one-third of the child deaths that occur each year. Their study demonstrated that an improvement in childhood nutritional status is associated with a decline in under-5 mortality rates.

In conclusion, advice on nutrition was not continuously supplied.

The Road to Health Book is the client-held record that contains recommendations for feeding and caring for the child at different ages. The book contains the child's growth record and the record of provision of promotive services such as immunization, Vitamin A and deworming. It is an important communication and recording tool and should be used by the parents and those who care for the child.

The experiences and perceptions of mothers regarding the Road to Health Book are discussed in paragraph 5.3.4.

5.3.4 Experiences and perceptions about the road to health book

The Road to Health Book is seen as the “main record of the child’s health, growth and development. It must be kept in a safe place and be brought along whenever the child visits a health centre (whether it is for a well-baby visit or because he is sick) a doctor or other health care provider, a hospital outpatient department or emergency department or any other health appointment” (NDOH (b), 2010).

It is an important tool in recording and interpreting the development and growth of the child and all mothers should be informed about this book. It must be issued at the place of birth. If the child was born at home, it must be issued at the first contact visit to a health facility.

5.3.4.1 Findings about the road to health book

The following information was obtained during the interviews and from the demographic data. Eight mothers delivered at the MOU and only one received any health education about the Road to Health Book. Seven mothers delivered at a referral hospital and two mothers received information about the Road to Health Book. Two mothers delivered at a private facility and one mother received information about the Road to Health Book.

The information indicated a problem on all levels of health care to mothers. Service providers at primary, secondary and tertiary level, as well as the private health care services, do not provide information about the Road to Health Book.

The policy document on PHC states the following: “Information is given to mothers on booking for delivery, child preventive care, education about child feeding and the introduction of solid food” (NDOH, 2000:17). This is also confirmed in the policy document on quality of health care: “Enabling users to assess their health, practise preventive health care, and self-care (that) will improve their health and reduce unnecessary health care services and costs” (NDOH, 2007:5).

In the South African Health review of 2008 the concern was raised regarding the poor utilization of RtHB. Swart, Sanders and McLachlan found that numerous gaps exist in the implementation of growth monitoring and promotion within the South African context. These gaps included inaccurate assessment of weight of children, a failure to plot weights, the inability of nursing staff to identify the nutritionally at risk, poor utilization of the Road-to-Health card and poor communication with caretakers (Barron and Roma-Reardon 2008:135).

The implications are that mothers do not know the value of the book. The health information messages in the book provide valuable information about feeding, oral rehydration, play and

stimulation and safety of the child. There are drawings of children with danger signs that prompt the mother when to take the child to a health care service provider.

To conclude, most mothers did not receive the required information about the Road to Health Book.

In paragraph 5.3.5 the experiences and perceptions of mothers about the care received for sick children are discussed

5.3.5 Experiences and perception about underlying illnesses

The Integrated Management of Childhood Illnesses is the official approach to be utilized to manage sick children. It is envisaged that 80% of staff per facility will be trained in this approach by 2012 (NDOH (a), 2008: 31). Any other approach may be utilized provided that a holistic approach is applied in the examination and the information as required is provided. Professional nurses with the qualification of a diploma in Clinical Nursing Science, Health Assessment, Treatment and Care (referred to as Clinical Nurse Practitioners (CNP) use a different approach that should deliver identical results when assessing and managing ill children.

In the Integrated Management of Childhood Illnesses approach, the child is monitored for all diseases contributing to the main causes of deaths in the under five age group as children do not only present with one disease (e.g. respiratory infection and underlying malnutrition). All sick children should be assessed for growth, nutrition and immunization status (NDOH (b), 2009: 3).

As stated in 4.4.6 McKerrowi and Mulaudziii found that predisposing factors in child deaths are malnutrition and HIV (2010:66). Both these aspects are monitored in the Integrated Management of Childhood Illnesses programme. If the Integrated Management of Childhood Illnesses programmes are not followed children are not monitored for two of the most important predisposing factors.

5.3.5.1 Findings about underlying illnesses

The findings reflected the following aspects about the mothers' experiences:

- Could not recall that integrated or holistic management was rendered when the child was ill.
- Missed opportunities of Vitamin A dispensing indicated that an integrated service is not practised.
- Knew not to sit in the queue when their child is very ill, e.g. presenting with diarrhea.
- Mothers did not reflect adherence to the Integrated Management of Illnesses approach or a holistic approach.

One mother recalled a developmental assessment that was done

“They look at everything, the eyes, muscles, the movements; they take off all the clothes and look at everything.” (Participant A3)

Mothers did indicate that they bring the children to the clinic when they are sick, but when prompted to obtain more information about the visits when the child was sick the responses was “No, they do not....” One mother was more verbal and provided the following information:

“Cannot access a doctor...Do not think sister will give right services or medication... If you come here they will give the same medication, antibiotic...”
(Participant B2)

The participant did not reflect that a comprehensive assessment, nutrition assessment and immunization assessment was done when her child was sick. During the interview she revealed that she visited the clinic when her child was sick and that the child’s measles immunization was delayed. (It was observed the child was “low weight for age”). She reflected anger that she could not have access to a doctor; she did not realize the significance that the immunization and feeding assessment were not performed. In that clinic, services are rendered according to queues.

“...they have to do all the queues.....” Participant B2)

This participant recommended that more staff be appointed, because the staff often has to attend to more than one queue.

5.3.5.2 Findings about integration of services

Vitamin A should be provided to children from the age of 6 months and thereafter every 6 months until the age of 5 years. The reason for supplementation of vitamin A is to reduce deaths from malnutrition, measles and other infections. Blindness from severe vitamin A deficiency is also prevented.

Many children in South Africa have mild Vitamin A deficiency. Supplements are particularly important for children with malnutrition, or measles. Children attending the clinic must be assessed for Vitamin A supplementation. All opportunities such as illness and immunization visits should be utilized to give Vitamin A (NDOH (c), 2009: 28).

Only one mother referred to the fact that vitamin A is important for the child.

“...You must take your child for immunizations and Vitamin A...” (Participant A4)

The researcher observed missed opportunities for vitamin A on the Road to Health Cards of the children. Of the four children who were due to receive vitamin A, only one child received all the required dosages.

The three children who did not receive all the doses attended the same clinic. The researcher observed the practice utilized to provide vitamin A at 6 months. This dosage does not coincide with an immunization episode. Mothers come in to weigh the child which is done in the waiting area. If the child only needs Vitamin A the dosage is given and the mother leaves the clinic. This is user friendly as this ensures a fast queue. However, the concern remains whether the vitamin A was omitted or not recorded. Another concern is that the waiting area is not conducive for a discussion of the child's growth.

Bachmann and Barron (1998: 947) did a survey on missed opportunities in a Cape Town clinic. They found that separating the provision of curative and preventive paediatric care resulted in many missed opportunities for immunization. This finding is applicable to the provision of Vitamin A. The recommendations of this study appear to not have been implemented.

Integration of service was not practised as required by National and Provincial norms.

5.3.5.3 Facilitating entry of children with life threatening conditions

One of the requirements of managing ill children in health facilities is to prevent sick children from waiting in long queues. This aspect was assessed during the interviews.

The policy document of PHC provision requires that "Staff are able to organize and implement an effective triage system for clients attending the clinic based on the Integrated Management of Childhood Illnesses protocol" (NDOH, 2000:19).

According to Page, Hustache, Luquero, Djibo, Laouali, Manzo and Grais (2011:1) "diarrhea remains the second leading cause of death in children under 5 years of age in the world, representing nearly one in five child deaths – about 1.5 million each year in sub-Saharan Africa."

The Western Cape Provincial task team issued the following guidelines regarding fast-tracking sick children with possible life threatening diseases: "Where feasible a separate queue/ area or a fast track system will be in place for the assessment of sick & injured children. Children with "danger signs" IMCI, or "emergency signs" ETAT, or "red" classification (SATS) are to be seen IMMEDIATELY by the most senior healthcare provider available" (Hodkinson, Cheema, Lesch, Lee, Davis, Van As, Wallis, Gillespie, Parker,

Schlemmer, Finger, De Vries, Westwood, Argent, A Jonker, Malek, Cooke, Heyns, Werely, Stander, Cohen and Kuiler, 2011:2).

The reflections of the mothers indicated that they are aware that they should inform the staff if their child is sick and display danger signs as depicted in the Road to Health Book. A concern was the absence of the oral rehydration corner in one of the facilities. Oral rehydration corners provide an opportunity to start with rehydration as soon as the child enters the waiting area. Posters in the clinic advise mothers to inform staff about the child having diarrhoea. Pictures of children with severe dehydration or lethargy on the wall inform parents to report children looking as depicted. This represents a good example of good communication and participation of community in an initiative to prevent child deaths. It also proves the ability of clients and health care providers to set mutual health- directed goals. Both parties have one outcome in mind – to prevent children dying from dehydration.

In conclusion, mothers reported to the staff if the child had diarrhea. In some facilities the provision of oral rehydration was not available or visible.

5.4 THE CONCEPTUAL THEORETICAL FRAMEWORK

As stated in paragraph 2.6 the use of a sound theoretical framework can add to the opinion regarding trustworthiness and application to the broad population. For the purpose of this study the conceptual theoretical framework of Erickson, Tomlin and Swain the Modeling Role-Modeling theory was utilized (George, 2010: 518 -537). This theory is referred to as the “Modeling Role-Modeling” Nursing theory.

In the context of the Model Role-Modeling Nursing theory the provision of health services form part of the modeling role of the healthcare provided to establish the relationship of trust, develop an understanding of the mothers world and her potential to realize her “self-care” needs (George 2010: 520).

Figure 2.2 represents the expected outcomes of the nursing care relationship between the mother and the health care provider.

5.4.1 Findings about the nursing care relationship

The following themes emerged from the analysis, coding and deductive reasoning process. The themes provide information on the interaction of the mothers and health care providers with reference to the Model Role-Modeling Nursing theory.

5.4.1.1 Emerging themes related to the conceptual theoretical framework

Establishing the trust relationship

emotional response to service delivery indicated that some mothers established this relationship and others did not establish a trust relationship.

Accept the mother as part of the care team

mothers indicated that they need more understanding. The concept appears not to be well entrenched at service delivery level. Mothers are not always fully accepted as part of the team caring for the child.

Standard quality integrated services

services were not rendered at all levels of care according to determined national and or provincial norms and standards.

Promote the client's control

mothers related the support provided by clinics to care for the child. Individual needs of clients were not always met or taken into consideration.

Provide information to care for the child

information on Road to Health Book was not always provided at birth as required. This limits the mother's ability to mobilize resources to solve health care needs.

Affirm and promote the clients strengths

provision of health education to assist the mother to mobilize resources to solve health care needs were not evident in all cases.

Set mutual self-directed goals

facilitating entry of children with life threatening conditions (used diarrhea in this interview as example) were evident in clinics.

5.5 THE LIMITATIONS OF THE STUDY

The limitations of the study may be attributed to the research methodology followed, namely qualitative research that limits the relevance of the findings to the area of study.

5.6 RECOMMENDATIONS

The researcher trusts that the recommendations made in this report will assist in improving service delivery.

5.6.1 Summary of recommendations for services

South Africa is one of twelve countries where the incidence of child mortality increased in the period since 1990 (Chopra, et al., 2008:30). The realization of Millennium Development Goal number four will not be possible without all role players contributing towards reaching that goal. The contribution is to provide the service they are required to do, according to National policies and guidelines:

- Hospitals must provide immunization services
- Clinics and Community Health Centers must provide integrated comprehensive Primary Health Care in child health services
- Maternal Health Services must provide the required education when the Road to Health Book is issued to mothers
- Influence of incorrect practices observed by students in the clinical areas perpetuates the incorrect practices. Professional nurses must be reminded of their role in training student nurses
- Private Medical practitioners must render holistic child health care; they have a role to play to reduce child mortality.

5.7 RECOMMENDATIONS REGARDING IMMUNIZATION SERVICES RENDERED AT HOSPITALS

Improvement of immunization services should be intensified. Reasons for not immunizing children must be established and addressed.

The non-provision of immunization in the central hospitals was reported in two previous studies of Metcalf, Yach and de Beer 1990 and 1992. The 1992 study was conducted to evaluate the effectiveness of a February 1991 resolution of the Health Matters Committee (HMC) on immunization in hospitals (Metcalf, et al., 1994:149-52)

The findings of this study will be provided to the Western Cape Provincial Health Department: Directorate Nursing for dissemination to the appropriate Heads of Departments to rectify practices.

Provision of immunization appears not to be perceived as an important integral part of child health care services. Children are not immunized when they are admitted or treated in some

of the hospitals in the Western Cape that has such a proud history of providing child services.

5.8 RECOMMENDATIONS REGARDING SERVICES RENDERED AT CLINICS

South Africa has a major challenge to meet Millennium Development Goal number four. Simple strategies and improvements in the health care system may prevent these deaths. Interventions include oral rehydration, early recognition and treatment of diseases, providing mosquito nets, immunization and appropriate nutrition (Jensen, 2010:27). The problem at service level is that the simple strategies needed in the Western Cape are supplied but the quality of provision is a matter of concern

5.8.1 Provision of integrated child health services

The integration of services must be prioritized and intensified to prevent missed opportunities in the provision of vitamin A, immunization, growth monitoring and nutritional counseling, when children are attended to at clinic visits.

Ensure the understanding of the concept of integrated service delivery, namely : Integrated child services requires that a healthy child is monitored at each contact visit for immunizations, growth monitoring, developmental assessment, feeding assessment, provision of vitamin A and deworming. A sick child should be holistically assessed for all the main diseases leading to death, the presenting problem, immunization, growth monitoring and feeding assessment and the provision of nutritional counseling (NDOH, 2000:19).

The following are recommended in respect of child services:

- That the functional integration of child services be prioritized and implemented in a staggered approach
- Clinic managers and area managers must be empowered to manage change effectively
- A participatory action research may be useful to start an impetus of “best practice” in one area or clinic that can be used as example to be replicated
- Clinic managers must be retrained in the concept of delivery of integrated services. Each clinic must be monitored and supported during implementation
- Regular support visits should be provided until the concept is grasped, fully implemented and fully functional

Binkin, Chopra, Simen-Kapeu and Westhof (2011:13), found that countries that had made the most progress as measured by the average annual reduction of mortality were those which had higher coverage of integrated primary health care. They also found that the

strongest predictor of changes in the under-five mortality rates were improvements in access to and providing all the clinical services (Binkin, et al., 2011:12).

The rendering of integrated child services should be regarded as non-negotiable. The simple strategies to reduce child mortality and morbidity must be provided each time a child attends a clinic.

5.8.2 Maintaining quality standards in service delivery

Quality standards should be addressed.

The non-adherence to policies and procedures provides a threat to quality of care. The Clinic Supervisors Manual (NDOH: 2006) is available for use by the clinic managers, area and programme managers. This manual provides all the requirements to be monitored for adherence and quality of care at clinic level.

Adherence to standards between clinic supervision visits remains a challenge.

Initiating change within the group may lead to change in practice. The utilization of peer groups to review and audit documents are innovative approaches that should be considered.

Patient satisfaction should be monitored as part of quality control. Patient exit interviews to establish patient satisfaction and adherence to standards can be used. Another approach is the annual client satisfaction surveys.

The Provincial coordinating and supervision task teams provide regular feedback on supervision. Area and programme supervision are conducted. Despite these monitoring systems the findings indicate non-adherence.

Ensuring that quality is maintained will improve client satisfaction. Satisfied clients will improve the morale of health care providers.

5.8.3 Management of stock levels (with specific reference to vaccines)

Correct stock levels, especially of vaccines, should be maintained.

The findings of the study were that children were not immunized due to the insufficient supply of vaccines at clinic level.

The stock level of consumables, specifically vaccines, needs to be addressed urgently.

The calculation of minimum and maximum stock levels; reordering levels and the lead time from ordering to delivery must be calculated for each stock item.

The monitoring of the ability of staff to perform these calculations is an important supervisory function.

Staff who are unable to perform the function must receive additional training.

No child should leave any facility unimmunized.

5.8.4 Ensuring continuation of services and release of staff for training

Staff must be able to access opportunities for continuous professional development.

The continuation of services and simultaneous release of staff for training are challenges that requires more planning and a change to current practices. Staff needs to be updated on various aspects of service delivery and need to go for training. The challenge is to provide uninterrupted services. There are various options in providing uninterrupted services such as dividing the workload amongst the service providers remaining on site; or providing a relief worker when planned training is scheduled from a central office. There are concerns regarding the ability to release staff for formal and informal training due to shortage of staff. A good model is currently used to ensure relief of staff for the post-graduate diploma for the Nursing the Sick Child qualification. Relief of staff is assured by replacing the man hours of the staff attending the post-graduate course with staff provided from a central office. (Information obtained in an Interview with Prof Coetzee, M., 2011). Best practices should be shared and replicated.

Access to continuous professional development should be ensured without unduly compromising the continuation of services.

5.8.5 Provision of information about the Road to Health Book

Mothers in the public and private sector must receive information about the Road to Health Card when the card is issued.

Midwives should be knowledgeable in all aspects regarding the Road to Health Book as they should be able to inform mothers adequately about the use, purpose and interpretation of the information provided in the Road to Health Book. Continuous in-service training should include discussions and case studies which include the use of this book and appropriate information which the new mother should receive before being discharged. Supervision should be addressed to ensure that midwives provide information to mothers when issuing the book. The book contains valuable information that all mothers must be aware of. Mothers are extremely busy, anxious and some develop post natal depression during the neonatal period having difficulty to adjust to the new infant and care for her family (Abrahams,

2011:1). She may not read the book, not unless she was informed about the content and know that it contains important information.

5.8.6 Recommendations regarding structure and equipment

Aspects that impact on service delivery should be addressed

The clinics have limitations due to shortages of equipment, staff and old facilities.

5.8.6.1 Equipment

Currently, only one baby scale is provided per clinic. Additional scales will improve growth monitoring services. While weighing children in the triage area assists in streamlining services it deters further management of the child as the child must be undressed again to be observed for wasting, to be examined, or for developmental assessment. Providing more scales may assist in the integration of services. Where there is no staff to triage clients, the concern is that children will be sitting in the queues and nobody will notice that they are very sick if there is no triage staff. The posters assist in the child area to warn mothers not to sit in the queue with very sick children. This study indicated that this concept is working as there was no staff to triage in two of the facilities.

5.8.6.2 Manpower

Staff shortages impact on service delivery. Most participants requested additional staff to reduce waiting times. Integration of service may assist staff to work smarter. Clients do not need to wait in different queues to obtain services that could be rendered by one service provider. A Professional Registered Nurse, trained in Integrated Management of Childhood Illnesses and PALSA Plus will ensure a one stop shop approach that can only improve service delivery.

5.8.6.3 Facilities

Clinics are housed in very old buildings where structural outlay may be a challenge to functionally integrate the services. Minor changes can facilitate integration.

Addressing minor aspects can assist to improve client satisfaction.

5.9 RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher explored the experiences and perceptions of the mothers. The researcher acknowledges that the other role-players also have experiences and perceptions that contribute to the dynamics. The researcher identified the following that may contribute to provide answers to some of the challenges found in this study:

- Factors contributing to the perception that hospitals do not immunize children
- Participatory action research – integrating child health services in the clinic setting
- Factors prohibiting or promoting the rendering of integrated child health services at Primary Care Level
- Midwives' knowledge and understanding about the Road to Health Book.

5.10 SUMMARY

In this chapter the detailed findings with regard to research outcomes were discussed, including the limitations of the study. The findings were presented in the conceptual theoretical framework. Furthermore, recommendations were made with regard to service provision and possible research that could be valuable to solve some of the aspects highlighted in the findings.

5.11 CONCLUSIONS

Child health services are an important indicator of the quality of health care according to McKerrowi and Mulaudziii (2010:70). The researcher stated in paragraph 1.1 her concern about the apparent lack of adherence to policies in the child health services.

Various references were found in the literature that confirmed this concern. The experiences and reflections of the mothers who participated in this study confirmed the concerns of the researcher, as well as the findings of other researchers.

There is a national concern around the inability to reach the Millennium Development Goals, especially goal number four. The researcher is of the opinion that unless each role-player adheres to the service norms and standards at each contact with the child, the realization of Millennium Development Goal number four will not be possible. The reasons for not adhering to standards must be established. No amount of training and other interventions will change the situation unless the underlying causes are determined and addressed. The maintenance of child health care practice standards is not negotiable. Provision of the simple strategies that could decrease child mortality and morbidity cannot be negated. All health care providers should provide holistic care and diligently provide strategies such as oral rehydration, early recognition and treatment of diseases, immunization, growth monitoring and appropriate advice on nutrition.

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ADDENDA

ADDENDUM A: INTERVIEW SCHEDULE

Interview schedule:
The experience of mothers utilizing child services #

Date:	<input type="text"/>	Time	<input type="text"/>	Participant No	<input type="text"/>
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Ask parent for permission to look at the child's RTHC/ B to obtain data

Demographic data

Age	<input type="text"/>	Gender	<input type="text"/>	Nationality	<input type="text"/>	Race group	<input type="text"/>	DOB	<input type="text"/>
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Immunization

Scheduled immunizations	Date due according to DOB	Date administered	Single Missed vaccines at episode	Reason for missed immunizations	Comments
At birth					
6 weeks					
10 weeks					
14 weeks					
9 months					
18 months					

Child services used:

Evidence of Integrated services in RTHB- Y/N

IMCI	VIT A	DVS	Growth Monitoring	Injuries	Other- specify
	6 months	6weeks			
	12 months	9 months			
	18 months	18 months			
	24 months				

Comments and observations/Field notes

The interview (RTHC must be available during the discussion so she can refer to it)

- Tell me about your / the child. Tell me about your child's clinic card.
- For what services do you bring your child to the clinic? How does it work
- If you take your child to a private doctor what happens
- If you take your child to a hospital what happens at the hospital
- What does the sister/doctor tell you about your child's growth /health/ how to take care of your child
- Is there any experience at the clinic that you want to share with us
- What makes it difficult for you to bring your child to the clinic
- What can be done to make it easier for mothers to use the clinics

Time interview started:

Time interview ended:

Name of interviewer:

Name of research assistant:

Signature interviewer:

Signature research assistant:

ADDENDUM B: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: The experiences and perceptions of mothers utilizing child services

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Linda Jonker

ADDRESS: 86 Summerwood way, Summerwood at Pinehurst, Durbanville, 7600

CONTACT NUMBER: 0829255050

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

This study will be done at 3 clinics in this area.

We want to investigate child health service delivery to the community. To be able to do that we need to know what is happening to the community when they use the services. If we know what is good and what problems are experienced we can tell the people in charge of the services what happens at service delivery level..

For this specific study I want to look at how services are rendered for children younger than 2 years. I will ask you questions about your experiences when you bring your child and use the child services.

Why have you been invited to participate?

You had been selected because you brought your child to the clinic today

The study will be done at clinics. Other mothers will be participating in this study. This way we can find out what happens in the clinics and other places where children receive health care.

With your permission I will tape record what you tell me to ensure that I capture all you have said. The tape recorded tapes will be transcribed and be locked away in a cupboard with only access to me. After a period of five years I will destroy the taped conversation. Your name will not appear in the typed information. The information cannot be traced back to you. Your name will not be mentioned. The findings of the study will be made public and if you so wish you can read the report. You will find my contact number on this form if you wish to contact me. Should you feel uncomfortable with me recording the session you may refuse to have it recorded. Persons, who refuse to have the interview recorded, will not participate in the study. There are no consequences in not participating.

What will your responsibilities be?

Firstly you must indicate if you are willing to participate.

If you agree, I will need 45 – 60 minutes of your time to ask you some questions and give you an opportunity to share your experiences with me. I must emphasize again, there are no risks or rewards attached to participating in the study, except that it will help us to get a better understanding of the services.

Will you benefit from taking part in this research?

This study will look at aspects where services can be improved. If you agree to participate you may benefit from possible improvement in services

Are there in risks involved in your taking part in this research?

There are no risks involved in taking part in this study, no experiments will take place.

If you do not agree to take part, what alternatives do you have?

If you do not agree to participate there will no consequences – you may continue to use the services as before

Who will have access to your medical records?

The researcher is the only person who will look at your child's clinic card. You will be present while she is looking at the card.

What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

We are only going to have a discussion. There is no danger of any injuries.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled (*insert title of study*).

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 2011.

Signature of participant

Signature of witness

Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) on (*date*) 2011.

.....
Signature of investigator

.....
Signature of witness

Declaration by interpreter

I (*name*) declare that:

- I assisted the investigator (*name*) to explain the information in this document to (*name of participant*) using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) on (*date*)

.....
Signature of interpreter

.....
Signature of witness

**ADDENDUM C: ISIHLOMELO SOKU-1:
IPHEPHA ELINEENKCUKACHA LALOWO UTHATHA INXAXHEBA NEFOMU
YESIVUMELWANO**

ISIHLOKO SEPROJEKTHI YOPHANDO:

Amava nezimvo zoomama abasebenzi iinkonzo zabantwana

INOMBOLO YESALATHISI:

UMPHANDI OYINTLOKO: Linda Jonker

IDILESI: 86 Summerwood way, Summerwood at Pinehurst, Durbanville, 7600

IINOMBOLO ZOQHAGAMSHELWANO: 0829255050

Uyamenywa ukuba uthathe inxaxheba kwiprojekthi yophando. Nceda uthathe ixesha lakho ukufunda iinkcukacha ezibekwe apha, eziza kucacisa ngeenkcukacha zale projekthi. Nceda ubuze kwabo basebenza ngesi sifundo okanye kugqirha nayiphi na imibuzo nangayo nayiphi na into ngale projekthi ongayiqondiyo ngokupheleleyo. Kubaluleke kakhulu ukuba waneliseke ngokupheleleyo ukuba uyakuqonda ngokucacileyo okuqulathwe kolu phando nokuba ungabandakanyeka njani. Kwakhona, ukuthatha kwakho inxaxheba **akunyanzelekanga uyazikhethela** kwaye ungala ukuthatha inxaxheba. Ukuba uthi hayi, oku akuzi kukuchaphazela ngendlela embi. Ungarhoxa kwesi sifundo nanini na, nokuba uyavuma ukuthatha inxaxheba.

Esi sifundo sivunywe yiKomiti ngendlela yokuziphatha kuPhando lwezeMpilo kwiYunivesithi yaseStellenbosch kwaye luza kwenziwa ngokwemigaqo yokuziphatha ngokusesikweni nemithetho-siseko evunyiweyo kwamanye amazwe yeSibhengezo saseHelsinki, kunye neMigaqo yaseMzantsi Afrika yokusebenza kakuhle kwezeMpilo neMigaqo yokuziphatha ngokusesikweni kweBhunga loPhando kwezeMpilo (MRC) kuPhando.

Singantoni esi sifundo?

Esi sifundo siza kwenziwa kwiikliniki ezi-3 ezikulo mmandla.

Sifuna ukuphanda ngokunikezelwa kweenkonzo zabantwana zezempilo eluntwini. Ukuze sikwazi ukukwenza oko sidinga ukwazi ukuba kwenzeka ntoni na eluntwini xa lusebenzisa ezi nkonzo.

Ukuba siyakwazi okulungileyo nokuba zeziphi iingxaki ezifunyanwayo, singabaxelela abasemagunyeni ngeenkonzo ngokomgangatho wokunikezelwa kweenkonzo.

Kwesi sifundo sijolise koku, ndifuna ukujonga ukuba zinikezelwa njani iinkonzo zabantwana abaneminyaka engaphantsi kwemi-2. Ndiza kukubuza imibuzo ngamava akho xa uthe wazisa umntwana wakho waze wasebenzisa iinkonzo zabantwana.

Kutheni le nto umenyiwe ukuba uthathe inxaxheba?

Uye wakhethwa kuba uye wazisa umntwana wakho ekliniki namhlanje

Isifundo siza kwenziwa kwiikliniki. Abanye oomama baza kuthatha inxaxheba kwesi sifundo. Ngale ndlela siza kufumanisa ukuba kwenzeka ntoni kwiikliniki nakwezinye iindawo apho abantwana bafumana khona uncedo lwezempilo.

Ngemvume yakho ndiza kukushicilela oko undixelela kona ukuqinisekisa ukuba ndikubambe konke okutshoyo. Iiteyipu ezishicilelweyo ziza kuguqulwa zibe yintetho ebhaliweyo zitshixelwe ekhlabathini apho iza kuba ndim kuphela oza kufikelela kuzo. Emva kweminyaka emihlanu ndiza kuzitshabalalisa iincoko ezishicilelweyo. Igama lakho alizi kuvela kwiinkcukacha ezibhaliweyo. Iinkcukacha azinokuphandwa zibuyele kuwe. Igama lakho alizi kuchazwa. Okufunyanisiweyo kwesi sifundo kuza kwaziswa uluntu kwaye ukuba unomdla ungayifunda ingxelo. Uza kuzifumana iinombolo zam zoqhagamshelwano kule fomu ukuba unqwenela ukuqhagamshelana nam. Ukuba awuzivi

ukhululekile ukuba ndikushicilele kule seshoni ungala ukuba ndikushicilele. Abantu abangafuniyo ukushicilelwa kudliwano-ndlebe abazi kuthabatha nxaxheba kwesi sifundo. Akukho zingxaki ziza kubakho ngokungathathi nxaxheba kwakho.

Iza kuba yintoni uxanduva lwakho?

Okokuqala kufuneka uchaze ukuba uyafuna na ukuthatha inxaxheba.

Ukuba uyavuma, ndiza kudinga imizuzu engama-45 – 60 kwixesha lakho ndikubuza eminye imibuzo ndikunike nethuba lokwabelana ngamava nam. Kufuneka ndigxininise kwakhona, akukho bungozi okanye izinto oza kuzizuka ngokuthatha kwakho inxaxheba kwesi sifundo, ngaphandle kokuba oko kuza kusinceda siziqonde ngcono iinkonzo.

Uza kuzuzana na ngokuthatha kwakho inxaxheba kolu phando?

Esi sifundo siza kujonga imiba apho iinkonzo zinokuphuculwa khona. Ukuba uyavuma ukuthatha inxaxheba ungazuzana ekuphuculweni kweenkonzo okunokwenzeka

Ingaba bukhona na ubungozi ngokuthatha inxaxheba kwesi sifundo?

Akukho bungozi buza kubakho ngokuthatha kwakho inxaxheba kwesi sifundo, akukho nto iza kulingwa.

Ukuba awuvumi kuthatha nxaxheba, zeziphi ezinye izinto onokuzenza?

Ukuba zwuvumi kuthatha inxaxheba akukho nto imbi eza kwenzeka – ungaqhubeka usebenzisa iinkonzo njengakuqala

Ngubani na oza kuzifumana iingxelo zakho zonyango?

Umphandi nguye kuphela oza kulijonga ikhadi lasekliniki lomntwana wakho. Uza kube ukho xa ejonga ikhadi lakhe.

Kuza kwenzeka ntoni na ukuba kubekho isehlo somenzakalo esenzeka ngenxa yokuthatha kwakho inxaxheba kwesi sifundo sophando?

Siza kuba neengxoxo nje kuphela. Akukho bungozi bawo nawuphi na umenzakalo.

Ingaba uza kuhlawulwa na ngokuthatha kwakho inxaxheba kwesi sifundo kwaye ingaba zikhona na ezinye iindleko?

Awuzi kuhlawulwa ngokuthatha kwakho inxaxheba kwesi sifundo. Akuzi kubakho zindleko ekufuneka uzihlawule kuba uthatha inxaxheba kwesi sifundo.

Ingaba ikhona na enye into ekufuneka uyenzile okanye uyazile?

Ungaqhagamshelana ne**Komiti ngendlela yokuziphatha kuPhando lwezeMpilo** kwa-021-938 9207 xa unezinto ezikuxhalabisayo okanye izikhalazo ezingaqwalaselwanga ngokwanelisayo ngugqirha wakho okwesi sifundo.

Uza kufumana ikopi yezi nkcukacha nefomu yesivumelwano ukuba uzigcinele.

Isivumelwano nalowo uthatha inxaxheba

Ngokutyikitya ngezantsi, mna ndiyavuma ukuthatha inxaxheba kwisifundo sophando (*faka isihloko sesifundo*).

Ndiyavuma ukuba:

- Ndizifundile okanye ndizifundelwe ezi nkcukacha nale fomu yesivumelwano kwaye zibhalwe ngolwimi endilwaziyo nendiziva ndikhululekile ukulusebenzisa.
- Ndibenalo ithuba lokubuza imibuzo kwaye yonke imibuzo yam iphendulwe ngendlela eyanelisayo.
- Ndiyaqonda ukuba ukuthatha inxaxheba kwesi sifundo **akunyanzelekanga uyazikhethela** kwaye khange ndifakwe xinezelelo ukuba ndithathe inxaxheba.
- Ndingakhetha ukusishiya isifundo nanini na kwaye andizi kohlwaywa ngokwenza oko.
- Ndingacelwa ukuba ndisishiye esi sifundo phambi kokuba sigqitywe, ukuba ugqirha okwesi sifundo okanye umphandi ukubona oko kuza kuba luncedo, okanye ukuba andisilandeli isicwangciso sesi sifundo, njengoko bekuvunyelwene.

Sityikitywe e..... (*indawo*) nge-(*umhla*) ngo-2011

Ukutyikitya kwalowo uthatha inxaxheba

Ukutyikitya kwengqina

Isivumelwano nomphandi

Mna (*igama*) ndiyavuma ukuba:

- Ndizicacisile iinkcukacha ezikolu xwebhu ku
- Ndimkhuthazile ukuba abuze imibuzo kwaye athathe ixesha elaneleyo ukuba ayiphendule.
- Ndanelisekile ukuba uyiqonda ngokupheleleyo yonke imiba ekolu phando, njengoko ichaziwe ngentla
- Ndiyisebenzisile/andiyisebenzisanga itoliki. (*Ukuba kusetyenziswe itoliki kufuneka itoliki ityikitye isivumelwano ngezantsi.*)

Sityikitywe e..... (*indawo*) nge-(*umhla*) ngo-2011.

.....
Ukutyikitya komphandi

.....
Ukutyikitya kwengqina

Isivumelwano netoliki

Mna (*igama*) ndiyavuma ukuba:

- Ndimncedisile umphandi (*igama*) ukucacisa iinkcukacha ezikolu xwebhu (*igama lalowo uthatha inxaxheba*) ku- ndisebenzisa ulwimi lwesiBhulu/lwesiXhosa.
- Simkhuthazile ukuba abuse imibuzo kwaye athathe ixesha ukuyiphendula.
- Ndidlulise inkcazelo echanekileyo neyileyo ndiyichazelweyo.
- Ndanelisekile ukuba lowo uthatha inxaxheba ukuqonda ngokupheleleyo oko kuqulathwe kolu xwebhu lwesivumelwano kwaye yonke imibuzo yakhe iphenduleke ngokwanelisayo

Sityikitywe e..... (*indawo*) nge-(*umhla*)

.....
Ukutyikitya kwetoliki

.....
Ukutyikitya kwengqina

ADDENDUM D: ETHICAL APPROVAL



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

03 March 2011

MAILED

Mrs L. Jonker
Department of Nursing
2nd Floor
Teaching Block

Dear Mrs Jonker

Experiences and perceptions of mothers utilising child health services.

ETHICS REFERENCE NO: N10/11/392

RE : APPROVAL

A panel of the Health Research Ethics Committee reviewed this project on 19 January 2011; the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 2 March 2011 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit. Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 2 March 2011

Expiry Date: 2 March 2012

03 March 2011 12:51

Page 1 of 2



Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences



Verbind tot Optimale Gesondheid · Committed to Optimal Health

Afdeling Navorsingsontwikkeling en -steun · Division of Research Development and Support

Posbus/PO Box 19063 · Tygerberg 7505 · Suid-Afrika/South Africa
Tel.: +27 21 938 9075 · Faks/Fax: +27 21 931 3352

ADDENDUM E: PERMISSION TO CONDUCT RESEARCH



Civic Centre
12 Hertzog Boulevard
Cape Town 8001
P O Box 2815, Cape Town 8000
Ask for: Dr G H Visser
Tel: 021 400-3981
Cell: 083 298 8718
Fax: 021 421-4894

Iziko loLuntu
12 Hertzog Boulevard
Cape Town 8001
P O Box 2815, Cape Town 8000
Cela: Qrh G H Visser
Umrxeber: 021 400-3981
Cell: 083 298 8718
Ifekasi: 021 421-4894

Burgersentrum
Hertzog Boulevard 12
Kaapstad 8001
Posbus 2815, Kaapstad 8000
Vra vir: Dr G H Visser
Tel: 021 400-3981
Sel: 083 298 8718
Faks: 021 421-4894

E-mail: helene.visser@capetown.gov.za
Website: <http://www.capetown.gov.za>
Ref:
Filename: G:\Research\Jonker 10231.docx

CITY HEALTH — Specialised Health

2011-03-24

Dear Mrs Jonker

re: Research Proposal: The experiences and perceptions of mothers utilising child health services (ID No: 10231)

Permission has been granted for you to recruit patients do the research as per your protocol at Heideveld, Masincedane, Silvertown, Hanover Park and Manenberg Clinics in the Klipfontein Sub District. Due to big research projects already in progress, Gugulethu, Nyanga and Vuyani Clinics were excluded.

Contact People
Mr K Nkoko (Sub District Manager)
Tel: (021) 630-1667/ 082 433 1332
Mrs T Nojaholo (Head: PHC & Programmes)
Tel: (021) 630-1626/ 084 220 0133

Please note the following:

1. All individual patient information obtained must be kept confidential.
2. Access to clinics must be arranged with the relevant Managers such that normal activities are not disrupted.
3. A copy of the final report must be sent to City Health Head Office (P. O. Box 2815, Cape Town 8001) within 3 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID number (10231). Please use this in any future correspondence with us.

Thank you for your cooperation and please contact me if you require further information or assistance.

Yours sincerely

DR G H VISSER
MANAGER: SPECIALISED HEALTH

cc. Dr K Jennings
Mr K Nkoko & Mrs T Nojaholo



**DEPARTMENT
of HEALTH**
Provincial Government of the Western Cape

COMPONENT

healthres@pgwc.gov.za
tel: +27 21 483 9976: fax: +27 21 483 9895
1st Floor, Deneys Reitz House, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 29/2011
ENQUIRIES: Dr N Peer

PO BOX 247
Cape Gate
7652

For attention: Mrs Linda Jonker

Re: The experiences and perceptions of mothers utilizing child health services

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries.

Gugulethu CHC	Mrs Mabusela	Tel: (021) 637 1280/ 633 0020
Heideveld CHC	Sr A Eksteen	Tel: (021) 637 8054/6686
Nyanga CHC	Sr Manona	Tel: (021) 380 8000

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely


DR K VALLABHJEE
CHIEF DIRECTOR: STRATEGY & HEALTH SUPPORT
DATE: 16/3/11

CC

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ADDENDUM G: DECLARATION BY LANGUAGE PRACTITIONER



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TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proof-read and edited the document contained herein for language correctness.

(Ms IA Meyer)

SIGNED