Practices of Primary Caretakers of Children aged 1 - 5 Years before attending Peri-Urban and Urban Clinics In Thaba Nchu

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Abstract

Background:
The basic philosophy of Primary Health Care (PHC) is self-reliance and community participation. In South Africa PHC is free, and there is a perception that the service is misused. Before embarking on health promotion and health education campaigns to foster self-reliance, it is necessary to determine the current self-care practices of community members.

Methods:
This descriptive study was conducted among caretakers of sick or injured children aged between 1 and 5 years, attending peri-urban and urban clinics in Thaba Nchu, Free State Province, South Africa. Clinics were grouped according to their service hours, and a random sample of clinics was chosen. For these clinics a random sample of days were selected. On these days one researcher (SINY) interviewed caretakers using a structured questionnaire. Nursing staff at the clinics served as translators where necessary.

Results:
Of the 151 respondents, the majority was female (90.1%) and the child's mother (74.2%). Approximately half (51%) had completed standard 8 or higher. The majority (79.5%) had sought advice from a relative or neighbour for the illness in question. In 80.8%, the respondents were advised to go to the clinic. The median duration of illness before taking the child to the clinic was 3 days. Cough was the major presenting complaint in 66.9% of the children. At the clinic the majority of the children (78.8%) received treatment with no follow-up.

Conclusion:
In most cases advice was sought before going to the clinic. There are ample opportunities for patient education, which should be extended to include other family members. Self-care needs to be encouraged and facilitated.

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Introduction

The vision of the World Health Organisation (WHO) was health for all by the year 2000. At the Alma-Ata conference, Primary Health Care (PHC) was declared the vehicle to improve the health of the community. The basic philosophy of Primary Health Care is self-reliance and community participation, which can be seen as the "heart" of PHC[1].

The cost of health care all over the word is escalating. In this country PHC is free, resulting in a growing perception that PHC services are being overused. Besides creating dependency on the clinic, the overuse of services increases the costs of running a clinic. The Browne Commission of inquiry into health services recommends the encouragement of responsible self-medication as an essential component of health care, specifically as a cost-saving measure[2].

Self-care refers to all the actions taken by the sufferer (or attendant in the case of a child) on his or her own behalf. This includes self-medication, consultation with family members, neighbours or friends, and consulting

alternative healers[3]. Research has shown that self-care activities can be substitutes rather than stimuli for health services utilization[4].

The vision of the Free State Provincial Department of Health is "A healthy and self-reliant Free State community". Self-reliance is defined as a state of mind that regards the mental and material resources of the members of a community as the primary stock to draw on in the pursuit of their own objectives[5]. It implies taking initiative for one's health care using basic knowledge available to you and understanding how you use it.

The health care worker should aim to build on the good health habits and knowledge already practised by the people, using resources already available to foster self-reliance. Before embarking on health promotion and health education campaigns, it is necessary to understand the current knowledge and practices of community members. If it is true that the free PHC services are being misused and overburdened by excessive, unnecessary attendance, we need to know how people take care of themselves when ill; what they do; what other resources are available to them and what they know about the illness. This knowledge can help planners to design campaigns to foster self-care and self-reliance, applicable and acceptable to the communities.

This research project aimed to

(i) Investigate the home care practices of primary caretakers of sick or injured children between 1 - 5 years, prior to a visit to the clinic

(ii) Examine the support available to these caretakers in the home and neighbourhood and the influence of this support.

METHODS

This descriptive study was conducted among caretakers of sick or injured children aged between 1 – 5 years, attending peri-urban and urban clinics in Thaba Nchu, Free State province, South Africa. The term primary caretaker refers to the most important adult person responsible for the care and well being of the child most of the time. A sick child is a child who is perceived as not being his/her normal healthy self, and is indicated by the caretaker as being ill (unwell or sick).

There are 13 clinics and 3 mobile clinics in Thaba Nchu district. Five of these are peri-urban and one is a polyclinic within the hospital. Of these six clinics, three operate 12 hours a day 07:00 - 19:00, two operate 8 hours a day 08:00 - 16:00 and one clinic operates 24 hours.

Of the three 07:00 - 19:00 (Mon. - Sun) clinics, one was chosen at random, as was one of the two 08:00-16:00 (Mon. - Fri) clinics. The 24-hour clinic was also included in the study. A random sample of 7 different weekdays for the 24 hours clinic and the 07:00 - 19:00 clinic was selected over a period of seven weeks during the winter of 1999. For the 08:00 - 16:00 clinic, five different weekdays over a period of 5 weeks were selected at random.

All caretakers of sick children between 1-5 years seen at the clinic on a selected day were included in the study. If the child was seen for a follow-up visit and was no longer ill, the caretaker was not interviewed. Written consent was obtained from the respondents.

An English questionnaire was administered by one researcher (SINY). Nursing staff at the clinics were used as interpreters. There was also a standard Tswana translation of the

Table 1: Demographic characteristics of respondent (n = 151)

		Percentage
Gender	Female	90.1
Relationship	Mother	74.2
	Grandmother	7.9
	Father	5.3
	Sister	2.0
	Others	10.6
Education:		
Highest standard completed	4	15.2
	5	11.3
	6	14.6
	7	7.9
	8	15.9
	9	11.9
	10	23.2
Age: In years	16 – 19	11.9
	20 – 24	21.9
	25 – 29	21.2
	30 – 34	20.0
	35 – 39	9.3
	40 – 49	8.6
	50+	6.6

questionnaire so that the questions (translation) were the same for all respondents irrespective of the interpreter.

A pilot study was done on 5 mothers, 3 of them professional nurses, to refine the questions.

Consent from the Department of Health, Free State Province as well as the District Health services were obtained. The Ethics committee of the Faculty of Health Sciences, UFS, approved the protocol.

RESULTS

One hundred and fifty three (153) interviews were conducted. Two were excluded because the respondents were younger than 16 years, thus n = 151. At the 08:00-16:00 clinic, 35 interviews were conducted, at the 24 hour clinic, 54 interviews and at the 07:00-19:00 clinic, 62 interviews.

Table I summarises the demographic characteristics of the respondents. Females comprised 90.1%, and mothers 74.2%. The majority of respondents (63.1%) were aged between 20 and 34 years, while 51% had completed standard 8 and above.

The majority of people (96.7%) said that they would seek advice if the child were sick, mainly from mother/mother-in-law (32.5%), followed by husband (23.2%) and neighbours (17.2%).

Most respondents walked to the clinic (80.1%), while 16.6% took a taxi. Approximately half (51%) took less than 30 minutes to get to the clinic and only 17.3% took an hour or longer.

While 16.6% of children were brought to the clinic with a day's history of sickness, and 19.9% within two days, the median duration of illness/sickness was 3 days. Five children (3.3%) were brought in after 2 weeks and two children (1.3%) after 28 days.

Table II: Presenting complaints (n=151)

Major Complaint	Percentage
Cough	66.9
Diarrhoea	5.3
Fever	3.3
Skin rash	3.3
Vomiting	2.6
Burns	2.6
Sores in the mouth	2.6
Painful ear	2.6
Poor appetite	2.0
Other	8.6

Other Complaints	Percentage
Cough	13,2
Loss of appetite	12.6
Fever	12.6
Vomiting	10.6
Diarrhoea	4.6
Painful ear	2.0
Itching/Discharging eye	2.0
Other	7.3

Cough was a major presenting complaint, accounting for 66.9% (Table II). Cough was also the most prevalent other complaint (13.2%) and the most frequent symptom (41.1%) noticed at the beginning of the illness (Table III).

For this particular illness, 79.5% of caretakers sought advice. Of those who sought advice, 35.8% consulted their mothers or mothers-in-law, 25% their husbands and 20% consulted people not related to them.

In 80.8% of the cases, caretakers were advised to take the child to the clinic. In four of the 23 cases who received other advice, the information about the advice was not complete enough to make a judgement about its appropriateness. Of the 19 cases where the information could be evaluated, the researchers judged that in 12 cases (63%) the advice was appropriate, and in 7 cases (37%) not appropriate. Of the caretakers who sought advice from someone, 96.7 % followed that advice.

Table III: Symptoms noticed at the beginning of the illness (n=151)

Symtoms	Percentage
Cough	41.1
Refusing food/loss of appetite	23.2
Fever	14.6
Weak/tired/not playing	13.9
Runny nose	13.2
Crying	13.2
Vomiting	8.6
Skin rash	3.3
Restless	2.6
Red/itchy eyes	2.6
Diarrhoea	1.3
Sleeping a lot	1.3
Pricked by a piece of bottle	1.3
Painful ear	1.3
Cries when passing urine	1.3
Scratching	1.3
Swollen	1.3
Other	4.6

Approximately half of the respondents (52.3%) administered some form of medication before visiting the clinic. Of these, 16.6% gave paracetamol, followed by 8.6% who administered an unnamed cough mixture. Only 4.0% stated that they had given the child traditional / herbal / home remedies. In 9 of the 79 cases where something was administered, the information about the medication was not complete enough to make a judgement about its appropriateness. Of the 70 cases where the information could be evaluated, the researchers judged that in 46 cases (66%) the medication was appropriate, and in 24 cases (34%) not appropriate.

Table IV: Where the remedy was obtained from (n=79)

	Percentage
Clinic	31.6
Shop	29.1
Chemist	17.7
Homemade	7.6
The yard (garden)	5.1
Neighbour	3.8
Private doctor	2.5

Of those who administered some form of medication, 31.6% received it from the clinic while 46.8% obtained their remedies from either a shop or chemist (Table IV).

Of the 151 respondents, 95.4% did not take the child anywhere else for treatment before coming to the clinic. Of the 7 who did, 4 took the child to a general practitioner, 2 to another clinic and 1 to the hospital.

Table V: Outcome of clinic visit (n=151)

Outcome	Percentage
Treatment, not followed up	78.8
Treatment, followed up	17.9
No treatment, follow-up appointment	2.0
No treatment, no follow-up	0.7
Appointment with a doctor	0.7

Approximately three-quarters (78.8%) of the children received treatment with no follow-up from the clinic while 17.9% received treatment and were to be followed up (Table V).

DISCUSSION

Children between 0-9 years comprise 20% of the population of the Free State and South Africa[6]. This makes investigation in this age group a priority for the future of the country. The age group 1-5 years was chosen for this study, as paediatric morbidity is particularly high in this age group.

Shortcomings of the study include the low numbers of respondents. Since the study was done in winter, it might have been difficult for respondents to walk to the clinic in bad weather, which may account for the low numbers. At the time, there was a general shortage of drugs in the clinics because the clinics were re-stocking according to a new code list. The new code did not provide for cough mixtures. In terms of the community's interpretation, this meant that there was "no medicine" available at the clinic and this perception could have kept more people away or forced them to seek help elsewhere.

The study was concerned only with patients attending government clinics. Valuable inputs from people attending private practitioners and other alternative health care providers, regarding home care practices, could not be assessed.

In this study, mothers comprised 74.2% of respondents and the majority of them were the decision-makers (alone or in consultation) in matters regarding the welfare of their children. These were young mothers, of whom 75% were younger than 35 years and many had a high school education. This suggests that they may be good candidates for group discussions and other interactive methods of health education, aimed at influencing behavioural changes.

The consumers of health services provided as a result of legislation such as the human rights bill, health bill and patients health charter (still in the pipeline), often highlighted in the media, the consumers of health services are becoming more aware of their rights and hopefully their role and responsibility in personal health maintenance and personal health care. If consumers are active and informed, it is easier for the providers to form a partnership with them in containing costs and improving services. In short, a partnership in cost-effective quality services.

In this study all respondents recognised illness in the child. Despite the fact that they were well educated, the majority sought advice from someone when the noticed that the child was ill. This implies that when a child is perceived or evaluated as being sick, there is someone who is told about it. This is a significant person who should be considered a resource person. Decisions are made in consultation with other people, mainly family members. This finding is similar to the findings of a study done in Kenya[7] where almost all mothers, regardless of age, marital status or educational level, sought advice before taking a child with malaria to a healthcare facility.

The presence of a resource person suggests that in order to facilitate self-care, patient education should target a wider group beyond mothers or primary caretakers. In our study the resource person mainly advised the primary caretaker (mother) to take the child to the clinic. This suggests that the resource person believes in the clinic and that clinic utilisation is seen as the first line of action.

More than half (52.3%) of the respondents administered some form of medication to the child. In other words, they practised self-medication, which implies self-care, before coming to the clinic. Two thirds of them gave the correct medication as far as symptom relief was concerned. In a study of children up to 8 years attending general paediatrics at a health care centre in Guadalajara, 36% of patients were treated before

the consultation, and 81% of these cases were treated correctly[8].

Since our study did not seek to establish whether the subjects had any knowledge regarding the correct use, side effects and other relevant pharmacokinetics of commonly used, over the counter medication, we could not come to any conclusion regarding the subjects' "scientific" knowledge of the medication they administered. A study done in Zimbabwe concerning diarrhoea diseases[9], found that although the majority of mothers had heard about and administered the sugar salt solution in cases of diarrhoea, half of them did not know how the solution worked; some thought that it cured diarrhoea.

Every patient seeking help has expectations based on his/her understanding of the illness. There must be a balance between satisfying the patient's and the health carer's agenda. When patients' expectations and medical management are in conflict, the conflict should to be reconciled by negotiation[3]. Finding a compromise between the patient's expectations and health worker's offer will help to cement the partnership between the community and the Department of Health.

Almost all patients in this study did receive some form of medication from the clinic. The majority was not given a return appointment, indicating that the health care worker expected complete resolution of the illness (symptoms). From this we can extrapolate that the health care worker considered the complaints to be minor illnesses. It has been our observation that some medication was always given, even when it was not necessary, because patients expected it. Since the patient's reason for visiting the clinic was not considered in depth and the majority of patients received some form of medication, it was not possible to determine the percentage of unnecessary clinic visits. However, the median duration of the illness before coming to the clinic was 3 days, which suggests that the children were observed at home. Three days observation and self-care seem a reasonable observation period for this age group; and most inserts for over the counter medication recommend a professional consultation if the patient's condition does not improve after 2-3 days of using the medication.

Those who administered medication obtained it from a shop or chemist, indicating that a source of medicine was available within the community.

Opportunities for health education and promotion before the onset of an illness must be exploited to the maximum. Healthy women and infants often have regular contact with health services over prolonged periods of time during antenatal and post-natal visits, family planning visits and baby clinics. This contact provides an ideal opportunity for patient education. If the primary caretaker (mother) can be taught to recognise and self-diagnose the most common childhood conditions, this could lead to correct self-medication. The role of the PHC worker in the facilities has to be revisited. The health care worker can support the individual and communities by providing information regarding the causes of poor health and disease, disease prevention, self-care and self-rehabilitation as well as instruction in basic first aid and the provision of curative and preventative services. Through such interaction, health care delivery becomes a partnership. Skills are transferred from health care personnel to the individual, thus promoting self-reliance.

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