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Posted Date: 11 June 2024

doi: 10.20944/preprints202406.0582.v1

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Article

It Is Not Always Bad, Positive Experiences of Guardians Utilizing Vhembe Primary Health Care Facilities for Under-Five Child Health Services: An Interpretative Phenomenology Study

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Abstract: Introduction: Guardians play a pivotal role in the management of childhood illness. Their responsibilities include home managing childhood illnesses and supporting continuity of care following healthcare facility treatment. Evidence has shown that guardians' negative experience in health care facilities when accessing under-five childcare services impacts their utilization of such facilities. Exploration of guardians' experiences is important in providing the evidence base necessary for quality childcare and reducing under-five morbidity and mortality. The study aimed to explore the experiences of guardians of children under five regarding the care received in Vhembe healthcare facilities. **Methods:** A qualitative approach using an interpretative phenomenology analysis (IPA) was used for this study. The study was conducted in eight primary healthcare facilities in the Vhembe district, with the highest headcount for children under five. Sixteen guardians were purposefully sampled for the study. Data analysis was done following the IPA steps of data analysis. Trustworthiness criteria were followed: credibility, confirmability, dependability, authenticity, and transferability. Ethical approval was obtained from the university and the province, followed by permission from the district and the operational managers before data collection. **Results:** The three emerging themes are associated with participants' positive experiences as they interfaced within the healthcare system: quality care, healthcare environment, support, and empowerment. The ten sub-themes were: timely service provision, availability of medicines, perceived nursing competence and professionalism, person-centred care, welcoming environment, effective communication, positive attitude of healthcare providers, guardians' satisfaction with care received, guardians' involvement in childcare and community support. **Conclusion:** It is indeed not always bad. The participants in this study had positive care experiences, which is crucial in the optimal utilization of health care services, resulting in improved health outcomes.

Keywords: child health services; guardians; positive experiences; primary healthcare; under-five child

1. Introduction and Background

Integrated Management of Childhood Illness (IMCI) is a strategy formulated by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1995 as a global strategy to end preventable childhood illnesses and promote child health and development [1]. It provides guidance on the treatment and care of significant causes of childhood morbidity and mortality, such as pneumonia, diarrhoea, and conditions with fever. The strategy focuses on

improving clinical care provided by health facilities to children under five. In addition, the strategy focuses on integrating childcare at home and hence the inclusion of community workers and guardians in managing childhood illness in the community [2]. The IMCI comprises preventive and curative components executed by mutual interactions between families/communities and health facilities [3].

Access to healthcare for children under five is dependent on the guardians. Therefore, the type of care and where the child can receive care depends on the guardian's choice, which influences previous experiences. Guardians' satisfaction with care contributes positively to the health service utilization for their children. The utilization is further influenced by the attitudes of healthcare workers in healthcare facilities, which can either attract or chase the guardians away and look for healthcare support elsewhere [4,5]. It is, therefore, imperative for healthcare facilities to be guardians-friendly to attract them to utilize such facilities.

Evidence has shown diverse experiences of guardians, however, with negative experiences common everywhere wherein guardians were accessing care for children under five years. Most evidence from elsewhere showed that there was unavailability of medications in most facilities, and guardians were made to go and buy from pharmacists, which made guardians reluctant to use healthcare facilities [6,7]. Some studies showed that guardians were dissatisfied with the attitudes of nurses and healthcare workers in some facilities whilst receiving under five childcare services [8,9]. Poor communication between the healthcare providers and guardians was also a common occurrence accompanying guardians' visits for child healthcare services [10].

Health system-related factors included mistreatment and disrespectful care, such as verbal and physical abuse by skilled healthcare providers. Mothers of children with abnormalities experienced devastation, denial, guilt, and lack of acceptance of the child's condition [11]. A study conducted in Ghana reported low participation and high drop-out rates by caregivers because of unsuitable schedules, uncomfortable venues and long waiting times [12,13].

Whilst all the negative evidence was common everywhere, there were also reports of satisfaction of some guardians following childcare services, including patient-centred care [14,15]. Such person-centred care is critical for child health services to promote access, utilization, and continuity of care. Person-centred care could thus ensure the provision of quality care. Communication between the healthcare professionals and parents of children is found to be helpful and cheerful as parents are being informed about their children's conditions, being introduced to the treatment and procedures, having their questions answered and being introduced to the paediatric intensive care unit (PICU) team [14]. Additionally, a study conducted in India among women utilizing the Integrated Childhood Diseases Services reported that women were satisfied with the services received [16]. The above diverse reports from literature prompted the researcher to explore and gain an understanding of the lived experiences of guardians of children under five years utilizing the primary health care services in the Vhembe district.

Aims and Objectives

The study aimed to explore and understand the lived experiences of guardians of children under five years utilizing the PHC services in the Vhembe district.

2. Methods

A qualitative, interpretative phenomenological analysis design was followed in this study. The interpretative phenomenology design provides the best opportunity to understand the 'lived experiences' of the participants [17]. The design assisted in gaining an insight into the lived experiences of guardians of children under five using primary health care services in the Vhembe district, South Africa. The study was conducted in eight primary healthcare facilities in the Vhembe district selected based on high headcount. Vhembe district is one of the most densely populated districts in Limpopo Province and has 124 primary health care facilities that all cater to children under five [18].

2.1. Population and Sampling

The targeted population for the study were all guardians who utilize the Vhembe primary healthcare facilities for under-five childcare services. The inclusion criteria were all guardians who had used the Vhembe primary healthcare facilities more than ones seeking care for children under five. The researcher purposefully selected guardians who met the inclusion criteria and whom the researchers believed had experience related to the phenomenon under study. Though many guardians were willing to participate in the study, only 16 guardians, determined by data saturation, were deemed sufficient for the study. Saturation was reached with participant number 13, and an additional three participants were interviewed to confirm the findings. The sample size of 16 is justifiable for a phenomenology study, as indicated in literature that two to twenty-five participants are suitable for an interpretative phenomenology study [17,19].

2.2. Data Collection Processes

Before data collection, the fourth author (SM) conducted a pilot study with three guardians who met the study's inclusion criteria. This was to ascertain the study's feasibility and determine whether participants clearly understood the research questions. Minor adjustments to the semi-structured interview guide were done. Operational managers were contacted to secure days for data collection in the facilities. The researcher recruited the participants in the queue whilst awaiting entry into the consultation rooms. An information leaflet was issued to all waiting for the child health service, and only those who were interested and met the inclusion criteria were recruited to participate. A private room ranging from a postnatal cubicle to a nurse's tearoom was secured for the interviews when the rooms were unused. Participants had to sign the consent form to be audio recorded during the interview and for the study results to be published. The researchers conducting the interviews were not involved in giving nursing care and had to establish rapport before the actual interviews started. Interviews used open-ended questions in line with interpretative phenomenology analysis (IPA) and the main research questions were: "What have been your experiences as you accessed under-five child primary healthcare services?" and "How did you experience the under-five primary healthcare services in Vhembe district facilities?". Participants were encouraged to be open enough to share and reflect on their experiences and their meaning, as this aligns with the phenomenological origins and principles of IPA [17]. Participants had pseudonyms for anonymity, so we addressed them as such. The researchers were able to jot down some of the notes that related to the reactions and responses the participants were giving as the researchers were probing to understand and interpret the interview findings. The interviews lasted for an hour and more with each participant. Interviews were conducted until saturation was reached. Data for this study was collected from 01 March 2022 to 30 June 2022.

2.3. Data Analysis

The audio-recorded interviews were transcribed verbatim into transcripts. Two of the researchers (first and second author) experienced in qualitative research analyzed the transcripts independently following the IPA framework [17,20]. Transcripts were read more than three times, and audio was listened to several times by the two researchers to immerse themselves in the data. Data analysis followed the steps highlighted in Smith and Osborn [20]: Step 1) Immersing the researcher in the data by reading the transcripts more than twice; Step 2) Writing notes in the margin of the transcript for initial noting; Step 3) Developing emergent themes by focusing on chunks of transcripts and analysis of notes made into themes; Step 4) Searching for connections across the emergent themes; Step 5) Moving to the next case trying to bracket previous themes and keeping an open mind; Step 6) Looking for patterns across cases and finding patterns of shared higher-order qualities across cases; and Step 7) Taking interpretations to deeper level using metaphors and temporal referents. The process was followed by a meeting of the researchers to discuss and agree on the table of themes and subthemes supported by participants' quotes [19].

2.4. Ethical Consideration

The study was guided by the ethical principles outlined in the Declaration of Helsinki and the South African National Department of Health policy about conducting research with humans as participants [21]. The study was conducted after approval from the Sefako Makgatho University Research Ethics Committee (SMUREC:/H/334/2021:IR). Permission was obtained from the Limpopo Provincial Health Ethics Committee, the Vhembe district PHC manager and the Operational managers of the facilities under study. Each of the participants signed a voluntary consent prior to data collection. Participants were interviewed in a private room to ensure privacy and confidentiality. Participants’ real names were not used to ensure anonymity and confidentiality, even during the publication of the study results.

2.5. Measures for Trustworthiness

The researchers adhered to credibility, confirmability, dependability, transferability, and authenticity as measures to ensure trustworthiness [22,23]. Credibility was ensured through peer review of the project as the study involved a well-experienced co-principal investigator and a team member for the main project who is also experienced in qualitative research. After 48 hours following the interviews, the researchers telephonically engaged with the few participants who had cell phones by giving them a summary of the findings (member checking) to verify if the report was a true reflection of their responses. The two experienced researchers who independently coded the data and reached consensus also strengthened the study’s credibility. The semi-structured interview guide was pretested on three participants who met the inclusion criteria for the study before the commencement of data collection. For the authenticity of the data, verbatim quotes were kept and put as evidence of actual participants’ voices during the study interviews. The study’s data, including audio recordings, transcripts and field notes, is kept safe as an audit trail by the principal investigator.

3. Findings

Participants for this study were guardians of children under five years who were receiving under-five child healthcare services from the eight selected primary healthcare centres in the Vhembe district. Sixteen guardians aged 22 to 67 years were the sample for the study. When recruited for the study, they were either a mother, a granny, or a sister to the under-five-year-old who was accessing the facility for service. The children in each guardian’s household ranged from one to five.

Three themes emerged from the study: the quality of care, the healthcare environmental and the support and empowerment strategies as the positive experiences that guardians reported. Table 1 below presents the themes and sub-themes of the study.

Table 1. Themes and sub-themes.

Themes	Sub-themes
1. Quality of care	1.1 Timely service provision
	1.2 Availability of medication
	1.3 Perceived nursing competency and professionalism
	1.4 Person-centred care
2. Health care environment	2.1 Welcoming environment
	2.2 Effective communication
	2.3 Positive attitudes of health care providers
	2.4 Client Satisfaction
3. Support and empowerment strategies	3.1 Involvement of guardian in childcare
	3.2 Community strategies

Theme 1: Quality Care

Participants reported experiencing quality care through timely service provision, availability of medication, perceived nursing competency and professionalism and person-centred care.

Subtheme 1.1: Timely Service Provision

Participants indicated that irrespective of the negative experiences that most guardians attest to when visiting health care facilities for care, their experiences were different and, in this instance, had timely service provision as the following excerpts demonstrate:

"For children, the services are good. They are treated early. The child health services do not go beyond 1 pm. With childcare, they are always done between 10 am and 11 am. I know from my personal experience." [Mashudu]

"They welcomed me well, they treated my children for their illnesses, and they even helped me quickly, and I got to leave early." [Memory]

Subtheme 1.2: Availability of Medication

Participants also indicated that they always accessed the prescribed medications for their sick children from the healthcare facilities, as shown below:

"I have never experienced any challenges. The only thing I look at when I am here is getting the treatment I am here for and the medication, which I always get, then I leave for home." [Muofhe]

"The clinic is giving us help; they really help in terms of giving medicine since I do not have to go and pay for them. I get medicine, and I go home and administer the medicine, and I see that the child gets well." [Khuliso]

Subtheme 1.3: Perceived Nursing Competency and Professionalism

Guardians noted that nurses were competent and professional in providing care, as in the following excerpts:

"I went to the clinic when my child had sores. In front of me, in the same queue, was a neighbour who had brought a child with sores. My neighbour's child was given an injection plus an ointment; I was not happy because my child was given medicine for drinking only. The nurse who served me explained that the sores were different and assured me that the sores would get better and that I should come back after three days. My child responded to the medication, and the sores healed. This taught me that nurses know what they are doing professionally and that, as clients, we should trust their judgement." [Provide]

"Before they do anything to my child, they involve me. They explained to me about the child's weight, how to give medicine to the child when I get home, and when to come back to the clinic." [Buhle]

Subtheme 1.4: Person-Centred Care

The care received from the healthcare facilities was seen as person-centred, for it was perceived by the guardian as quick, considerate, and provided to meet each child's specific needs. The following quotes confirm that:

"My child had a rash. I came to the clinic and explained the problem. I could see that the nurse was listening, and I was given treatment. I felt good after getting the service." [Jane]

"Some nurses are very quick to help patients, which is good. The nurses check if there are sick children, and these are served first." [Everjoy]

Theme 2: Healthcare Environment

This theme is about how study participants perceived the healthcare environment. The participants viewed the environment as welcoming; personnel working there communicated effectively, had positive attitudes towards clients, and brought client satisfaction with how they worked.

Subtheme 2.1: Welcoming Environment

Participants for the study further perceived the healthcare environment as welcoming, and the following extracts illustrate:

"I was excited by the welcoming attitude of healthcare providers I received that day. I was called granny and called to come in a friendly tone. Even from the security, when they asked for ID, and I said I left it at home, they did not trouble me." [MuIalo]

"Personally, I have medical aid and can access private healthcare services. However, I am no longer interested in using it, as I am getting good service here at the clinic. I prefer the public clinic because the services are friendly, convenient and closer to my home." [Elisa]

Subtheme 2.2: Effective Communication

Guardians applauded some of the nurses for communicating effectively with clients to their satisfaction, as evidenced by the following excerpts:

"Some nurses tell you what is going on with the child and give you instructions and medication for the illness. Some nurses explain very well when you have questions. In general, I got an adequate explanation of my child's illness and treatment that I was given." [Mpho]

"When I took my child to a healthcare facility, the nurses explained everything to me in an understanding way. I was given information on how I should position my child when and danger signs showing that the child is too sick." [Alilali].

Subtheme 2.3: Positive Attitudes of Health Care Providers

The findings also revealed the positive attitudes that nurses who were helping the guardians of the under-five displayed, evidenced by the following quotes:

"What made me happy and excited was that there were two nurses; one was weighing the children, and the other was writing, and they were both friendly with us. These nurses were very friendly and kind." [Mashudu]

"Yes, the service was excellent the last time I came to the facility; the nurses working that day were good and fast. I was treated well." [Unarine]

Subtheme 2.4: Client Satisfaction

The study participants expressed the fact that they were satisfied with the services received at healthcare facilities. They experienced the satisfaction from seeing nurses working fast and providing necessary help needed and they had these to say:

"The nurses check the number of people present and try their best to work as fast as possible, and they do not all go to lunch at the same time; some stay behind to help the patients, and you only spend part of the day here. I have not met any challenges since I do not usually come here. I was satisfied with the treatment I received" [Phophi]

"I liked the fact that they separate those with children and those without, others who are there for their treatment. So, we can get helped separately, and I think it is quicker that way, and you also do not get confused about where you are supposed to go to get help." [Ritshidze]

Theme 3: Support and Empowerment Strategies

This theme is about the support provided to guardians as a mechanism of mentoring and empowering them to provide child healthcare services for under-fives in the community. Two sub-themes emerged: guardian involvement in childcare and community strategies.

Subtheme 3.1: Involvement of Guardian in Childcare

Guardians reported the support and their involvement in childcare through health education given in clinics when bringing ill children and had this to say:

"As a parent, I was given health education on how to look after the child and only bring her to the clinic when I am supposed to get the help I need. When the child has diarrhoea at home, I follow the instructions on the card, make a salt sugar solution for the child, and give it to the child. I also follow the instructions concerning immunization dates. When it is cold, I ensure the child is in warm clothing to prevent them from catching the flu." [Everjoy].

"I had an experience when my child was sick and was given some medicines to drink at home. Before leaving for home, they taught me how to measure and give the medicine to the child. In addition, there was an emphasis on intervals of giving the medicine." [Flora]

Subtheme 3.2 Community Strategies

Guardians as community members shared ways or strategies, they apply in managing children under five at home when presenting with some symptoms. They highlighted that seeking medical attention, immunization, and weight were determinants of seeking clinical care. The following excerpts demonstrate that:

"I usually bring the child to the clinic for them to get medical treatment quickly. If the child gets a fever at night, I give them water to drink, and I use a wet towel on their face. If I have Panado in the house, then I administer the Panado. I ensure the child always washes their hands; I do not allow them to pick up food that fell on the floor. When it is cold, I make sure they are wearing warm clothes. I also do not allow the child to play with water to avoid flu; if the child gets hurt and bleeding, I treat the wound by cleaning it up and stopping the bleeding." [Ritshidze]

"I ensure I bring the child to the clinic for her weekly immunization and weighing. At home, I make sure she is being breastfed a lot." [Maria]

4. Discussion

Participants in this study had positive experiences of health services. They were received the service timeously, unlike the findings from other studies where the service was delayed [24,25]. Similarly, waiting time challenges were also reported in other studies conducted in South Africa [26,27]. In contrast, long waiting times was not a problem in the current study as participants indicated receiving quick child healthcare services, leaving the clinic before midday (13h00). It is encouraging to see participants happy with the quick services they receive. Treating participants fast might encourage mothers to report any childhood illness as it comes, for they know they will not be unnecessarily delayed.

Some participants in the current study received medications used in healthcare facilities for treating children under five. Their children were treated and discharged home with treatment. These findings are contrary to the study conducted in South Africa and Botswana, as medication was a significant challenge affecting managing childhood illnesses in clinics [25,28]. This might imply that the shortage of medications in most of the Vhembe clinics, as was noted in a study by Tshivhase [29] might have been addressed.

Participants perceived nurses as competent and professional. They indicated that they were even taught how to give medication to children at home. The experience of treating children and giving medication that heals was perceived as a comforting experience for the participants. This fully supports the IMCI strategy that asserts that health worker skills are usually improved when using the IMCI guidelines.

Participants also perceived the care they received as person-centred because the nurses were able to listen to them with interest and understanding. Furthermore, healthcare environment was perceived as welcoming, starting with the security personnel who received participants with a smile. Healthcare providers consulting guardians were reported to communicate effectively with positive attitudes towards the clients. A study conducted in the United States established that Communication is a crucial component of care and highlighted that communication with nurses determines recipient care satisfaction [28]. While poor communication displayed by nurses to patients affected patients' use of healthcare facilities [10].

Participants in this study were satisfied with the care they received from the healthcare facilities. Evidence has demonstrated that smaller healthcare facilities have reported higher patient satisfaction levels than bigger ones. This the authors attribute to the fact that the patient's perceptions of the healthcare environment in more bigger facilities could be different because these would be busier and even more difficult to navigate [31,32].

Some studies established that positive experiences of service quality in a healthcare setting affect patient satisfaction and customer loyalty and emphasize the importance of continuous quality improvement programs in healthcare delivery systems [33,34]. This is contrary to the previous study findings in Limpopo and elsewhere, wherein nurses were reported to be displaying negative attitudes towards patients [8,9,35].

Furthermore, participants in the current study acknowledged the support and empowerment they received from the healthcare facilities following the implementation of the IMCI strategy. In support, a study in Madagascar found that community workers involved in IMCI conducted their duties well, as they felt their activities influenced the health outcomes of the children in their communities. In contrast, a related study in Ethiopia established that many caregivers had poor knowledge regarding IMCI and had an unfavourable attitude towards childhood illnesses [36]. This points to the need to train caregivers to improve child health services for children under five.

Participants in the study recognised that community workers were knowledgeable and confident about IMCI implementation in the community, whilst a study conducted in Nigeria found that community workers were not knowledgeable about IMCI implementation [35]. They reported their involvement when a child is given treatment and the health education, they receive on how to treat the child in the home environment. This aligns with the Integrated Management of Childhood Illness Strategy [1].

Guardians indicated how they could treat children under five with fever and diarrhoea at home before getting to the health care facility. Knowledge shared by guardians in this study affirms the effect of health education and the importance of it in improving the quality of child healthcare services. The same guardians also cited the importance of bringing the child for immunization, which remains a core part of child health care services. Similarly, studies in other countries revealed that health education given to guardians is effective in the reduction of under-five child morbidity and mortality as they gain knowledge to manage childhood illnesses at home Nouman [34,36].

5. Conclusions

The study explored the experiences of guardians receiving under-five child health care services in the Vhembe district. This study brings unique insights into where care recipients had positive experiences as they interfaced with the healthcare systems. Such experiences are noted in other studies that point to the importance of positive experiential quality as perceived by the recipients of care and are pivotal in optimal utilization of health care services and improved health outcomes.

6. Recommendations

Lessons learned from this study would be necessary for enhancing and improving the quality of care. These findings could be shared with other care providers in primary healthcare settings. They could be utilized in developing continuous quality improvement initiatives for improving client satisfaction and, ultimately, the quality of care.

Author Contributions: LT and SM collected data for the study. IM analysed the data independently. All authors contributed equally to writing and editing of the manuscript.

Funding: The research reported in this article was supported by the South African Medical Research Council (SAMRC) through its Division of Research Capacity Development under the Research Capacity Development Initiative (RCDI) from funding received from the South African National Treasury [M054]. The content and findings reported are the sole deduction, view and responsibility of the researcher and do not reflect the official position and sentiments of the SAMRC.

Institutional Review Board Statement: The study was conducted according to the principles of the Helsinki Declaration. Accordingly, approval was granted by the Ethics Committee of the Sefako Makgatho Health Care Sciences University with the ethical reference: (SMUREC:/H/334/2021:IR). Permission was obtained from the Limpopo Provincial Health Ethics Committee, Vhembe district PHC manager and Operational managers of the facilities under study. Each of the participant signed a voluntary consent prior to data collection. No videos or photographs were taken while conducting the interviews but only audio recordings.

Informed Consent Statement: All participants signed the consent to publication of the study results.

Data Availability Statement: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Acknowledgments: The authors thank all the study participants, the Provincial Department of Health Limpopo, the Vhembe district PHC manager and the Operational managers of different PHC facilities, which were used as access points for participants.

Conflicts of Interest: All authors declare no conflict of interest.

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