AN EXPLORATION OF THE ROLE OF FAMILIES IN PROVIDING PRIMARY HEALTHCARE FOR CHILDREN

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ABSTRACT

Families remain a major social support system that plays a key role in the provision of primary healthcare (PHC) for children, and this role is especially important as PHC would normally take place before a child is taken to hospital for further treatment. The literature shows that although families have a direct influence on their children’s PHC, the former’s role is limited as a result of socio-economic factors such as poverty, unemployment and distance to healthcare centres. In South Africa, PHC is offered by the state but is of a lower standard than the more specialised, ‘hi-tech’ health services available in the private sector. Although the public health sector is over-stretched and under-resourced, the government has established PHC facilities in many locations throughout South Africa. This status quo requires families to play a role by knowing the locations of such facilities in order to maintain their children’s health. The provision of primary health in South Africa is a two-tiered system that requires the involvement of both families and healthcare providers. The results of the study indicated that there were various interpretations of PHC by both parents and health professionals, owing to different levels of knowledge about the concept. The lack of knowledge of the various forms of home remedies greatly affected the application of PHC in terms of a need to appreciate PHC practices in the family setting; and health professionals need to disseminate knowledge to parents on a routine basis as part of their work at hospitals. The findings furthermore suggested that parents and healthcare workers faced various challenges in the provision of PHC. The implications of the study pointed to the need for a more extensive study that engaged a high number of participants of both parents and healthcare professionals to place the results into perspective. Other implications required a concerted effort from government, parents, healthcare professionals and other stakeholders to arrive at a prudent and logical improvement of PHC in South Africa.
KEY WORDS

Challenges
Children
Experiences
Health belief model
Healthcare professionals
Parents
Primary healthcare
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>DSD</td>
<td>Department of Social Development</td>
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<tr>
<td>DR</td>
<td>Doctor</td>
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<td>HBM</td>
<td>Health belief model</td>
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<td>NSE</td>
<td>Nurse</td>
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<td>PHC</td>
<td>Primary healthcare</td>
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<td>PRT</td>
<td>Parent</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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DECLARATION

I declare that the study entitled An exploration of the role of families in providing primary healthcare for children is a result of my own research. All sources used in this study have been indicated and fully acknowledged by means of complete references.

Name: Zadma Bozad

Date: 31 October 2018

Signed: [Signature]

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CHAPTER 1
INTRODUCTION

1.1 Background and rationale

Families remain a major social support system and will continue to play a role in the provision of primary healthcare (PHC), particularly for children; but this role has been adversely affected by the closure of many local healthcare facilities. This has occurred due to numerous factors such as poverty, negligence, lack of education, distance to healthcare centres, and the reluctance of families themselves to play their part (Shi, 2012). The literature showed that although families have a direct influence on their children’s primary healthcare, their roles had been limited as a result of socio-economic issues such as poverty, unemployment and the distance to healthcare centres (Alkon, Mackie, Wolff & Bernzweig, 2010).

Mulaudzi, Kauchali and Patrick (2009), postulated that although the family’s role of providing PHC was dependent on knowing the existence of the nearest PHC facility, other difficulties emerged due to various conditions such as difficulties in taking children to hospital, inadequate services, problematic relationships with PHC service providers, safety measures in the facilities, and parental preferences in care and treatment (Alkon et al., 2010).

In South Africa, the state offers basic PHC, which is of a lower standard than the specialised, ‘hi-tech’ health services available in the private sector (Mulaudzi et al., 2009). Although the public health sector is over-stretched and under-resourced, the government has established PHC facilities in many locations throughout the country. This requires families to play a role in knowing the locations of these facilities in order to benefit the health of their children. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) point out that the provision of PHC
in South Africa is a two-tiered system, which requires the involvement of both families and healthcare providers. Institutions in the public sector, however, suffer from poor management, underfunding and deteriorating infrastructure, thus having an adverse effect on healthcare systems, especially in disseminating information to families about PHC for their children. While access to health facilities has improved, the quality of healthcare has fallen as a result of the poor provision of information and lack of involvement by families in healthcare practices (Vohra, Madhavan, Sambamoorthi & St Peter, 2014).

A study by Atun, Thyra, Secci, Ohiri and Adeyi (2010) shown that PHC provision was associated with more appropriate, more effective and less costly care, especially for children, as people were better informed. The role of families in PHC provision are aimed at improving health in deprived populations, and could, therefore, succeed in narrowing the health gap between socially deprived and more socially advantaged populations (Shi, 2007). It was important for families to provide PHC to themselves, as the point of first intervention, when there was no health practitioner (Leslie, Mehus, Hawkins, Boat, McCabe, Barkin & Brown, 2016).

The importance of families in the provision of healthcare for their children was that their presence, participation and provision of care to children enabled children to recover sooner and made visits to healthcare professionals less traumatising for children (Molina & Marcon, 2009). Parents were in a position to explain their children’s condition to health professionals because of prior PHC or first aid that were offered (Mehta, 2008). As a result, there was value in the communication between parents and healthcare professionals in the case of a sick child, who has the parent’s emotional and physical support (Maria De Maria Oliveira, Pinheiro, Ferreira,
de Lima & de Mello, 2014). Therefore, proximity to health centres was key to dealing with emergencies that families would not be able to handle. The authors stated that family involvement improved their communication with healthcare professionals (Maria De Oliveira et al., 2014). The family experienced less anxiety and was more inclined to become involved in PHC (Mehta, 2008), which encouraged the families’ autonomy, treatment adherence, and the coping process (Maria De Oliveira et al., 2014). Johnson, Abraham and Conway (2008) stated that the involvement of families in PHC for their children decreases anxiety for both children and parents.

1.2 Theoretical framework

The health belief model, which explains that the improvement of healthcare, especially for children, involves people’s behaviour and beliefs in understanding health matters, is the theory that underpinned the present study. The health belief model illustrated that healthcare improvement, especially for children, concerned people’s behaviour and beliefs in understanding health. The relevance of this model lay in its explanation of the importance of families regarding PHC provision (Maggie & Macdowall, 2006). The authors stated that at its core, the model suggested that the likelihood of a family taking action for a given health problem was based on the interaction between four types of belief. Individuals had to take action to protect or promote the health of their children if they perceived them to be susceptible to a condition or problem that they believed would have potentially serious consequences. Sakai, Fink, Kumamaru and Kawachi, (2016) suggested that there was a need for a course of action that reduced their susceptibility or minimised the consequences. They argued that there had to be a belief that the benefits of taking action outweighed the costs or barriers (Maggie & Macdowall, 2006; Sakai et al, 2016).
Nutbeam, Harris and Wise (2010) argued that families needed to believe that healthcare provision meant avoiding the risk of infection and the consequences it brought and, therefore, serious as the case was, required actions to reduce the risk. Maggie and Macdowall (2006) further pointed out that the health belief model had been found to be most useful when applied to behaviours that fitted the theoretical framework, such as prevention strategies, which included screening and immunisation. The advantage of this model was the relatively simple way that it illustrated the importance of family beliefs about health and the relative costs and benefits of actions to provide or improve health, and especially for children. This model was relevant to the present study precisely because its aim was to provide an understanding of why parents had to provide PHC to their children (Maggie & Macdowall, 2006).

1.3 Problem statement

The family is significant to children’s health, despite its limited role in the provision of PHC (Alkon, et al., 2010). If the family does not play its role in the provision of PHC, serious challenges to the health of children emerge, especially if the family is unable to obtain the services of a true medical facility (World Health Organization, 2012; Carroll & Vickers, 2014). The family’s role helps it to be able to provide physical support to children in instances where first aid may be required before a child is taken to a health centre. Cases that present complex symptoms still enable families to offer emotional support, as they take the children to health centres (Comer, Furr, Cooper-Vince, Kerns, Chan, Edson & Freeman, 2014).

The status of PHC provision is therefore instructive in gauging the current role and offering recommendations for support, and is premised on the difficulties that families face in gaining timely access to primary care (Shartzer, Long & Anderson, 2015). In this light, an exploration
into the role of families in providing PHC for their children is timely, to understand family experiences and perceptions of healthcare professionals in PHC settings (Alkon et al., 2010). The present study aims to fill a gap in the literature on how families can improve their role in PHC provision to children (Sakai et al., 2016) by offering new knowledge in this field.

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1.4 Research question
What role do families play in providing primary healthcare to their children?

1.5 Aims and objectives of the study
The research question led to the formulation of the aim and objectives of the study.

1.5.1 Aim of the study
The study aim is to explore the role of families in providing primary healthcare (PHC) to their children.

1.5.2 Objectives of the study
The objectives of this study were:

- to explore the roles of parents with regard to providing PHC to their children
- to explore the experiences of parents regarding their role in providing PHC to their children
- to explore health professionals’ roles towards families regarding the provision of PHC.
1.6 Research approach and design

The study employed a qualitative approach, which Creswell (2013) describes as a form of systematic empirical inquiry into meaning, grounded in the world of experience. This approach helped the researcher to understand how others make sense of their experiences (Denzin & Lincoln, 2011). The present study employed an explorative-descriptive research design. An exploratory research design exposes significant features of a topic, as well as its bearing to the exploration (Babbie & Mouton, 2001). The exploratory research design was use to explore the research topic with varying levels of depth (Creswell, 2013). Meanwhile, descriptive research design provided information about the naturally occurring health status, behaviour or other characteristics of participants. Creswell (2013) suggests that descriptive studies can answer questions such as ‘what is’ or ‘what was’.

Additionally, descriptive research design is a method that describes structures of the participant, on the basis of data obtained from a sample (Burns & Grove, 2010). Therefore, an exploratory research design was the most appropriate for the present study, as it permitted the researcher to increase understanding of the experiences and challenges of the family offering PHC to children. The use of a qualitative methodology sanctioned the researcher to have direct interaction with participants in their own natural settings; this facilitated the yield of rich descriptive data (Hennink, Hutter & Bailey, 2010).

1.7 Significance of the study

The findings of the study are intended to add new insights to the existing body of knowledge concerning the role of families in the provision of healthcare for their children. These insights could be use by academics and researchers as a basis for further research. The findings of the present study could inform intervention programmes from different stakeholders such as
departments of health, government, families and private health professionals. The study not only concerned the role of families in providing PHC for their children but also the information obtained from respondents was useful to both health practitioners and health ministries. The findings can be used by PHC centres as a basis for taking appropriate action regarding parental and/or family neglect.

1.8 Definitions of key terms

**Child**: A child (plural: children) is a human being between the stages of birth and puberty. The legal definition of a child generally refers to a human being below the age of 18 years (Children’s Act No. 38 of 2005).

**Child health**: A state of physical, mental, intellectual, social and emotional wellbeing that is not merely the absence of disease or infirmity. Healthy children live in families, environments and communities that provide them with the opportunity to reach their fullest developmental potential. Child health is the extent to which individual children or groups of children are able or enabled to (1) develop and realise their potential; (2) satisfy their needs; and (3) develop the capacities that allow them to interact successfully with their biological, physical and social environments (Ottawa Charter for Health Promotion, 2016).

**Family**: A social unit of two or more persons related by blood, marriage or adoption, and having a shared commitment to the mutual relationship (Daly, 2011).

**Health belief model**: A psychological model that tries to describe health behaviours; this is done by taking into account the attitudes and beliefs of individuals (Champion & Skinner, 2008).
**Primary healthcare:** Practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. It also forms an integral part of both the country's health system, of which it is the central function, the focus and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system’s aim of bringing healthcare as close as possible to where people live and work, and it constitutes the first element of a continuing healthcare process (Larajo, 2016).

**Socio-economic factors:** Factors such as income, education, physical environment and race that directly and indirectly contribute to children’s health in general (nutritional status, diseases and obesity, among others). These factors may increase a child’s risk for malnutrition, weight gain and obesity, which contributes to the development of other chronic diseases, including cardiovascular disease, high blood pressure, high cholesterol and diabetes (Kereliuk, Brawerman & Dolinsky, 2017).

### 1.10 Outline of chapters

**Chapter One** introduces the study, gives a background that informs the rationale to the study, and provides insight into the theoretical framework of the study. The problem statement is identified, along with research questions, aims and objectives of the study. The chapter further offers an insight into the research methodology used in the study, as well as the significance of the study. It also defines key terms, along with the study outline.

**Chapter Two** presents the detailed theoretical framework that guided the study. The health belief model was relevant because of its explanation of the importance of families in PHC provision.

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**Chapter Three** reviews the available literature on the topic. It conceptualises a family and a child for purposes of the study and then reviews the literature on the content of PHC, how it is understood by the family, and what forms this understanding. The chapter also evaluates the role of the family and the limitations that present in providing PHC to children.

**Chapter Four** sets out the research methodology applied in the study. Areas covered include study design and approach, study population, data collection methods, data analysis, data verification, limitations of the study and ethical considerations.

**Chapter Five** presents the results of the research, discusses the main findings, and incorporates the purpose of the literature review. It engages aspects of the concept of a family, a household and a child in the South African context; it engages the literature on the definition and importance of PHC to the findings; and also acts as a link between the function of a family and the role of healthcare professionals in providing PHC to children.

**Chapter Six** offers a general conclusion to the study, highlighting the study’s objective and whether it accomplished its aim, followed by recommendations that are addressed to parents, health professionals and other stakeholders in PHC generally.
CHAPTER 2
THEORETICAL FRAMEWORK

2.1 Introduction

The present chapter examines and explores the health belief model as the theoretical framework to the study, by providing a discussion of the health belief model, which explains that improvement of healthcare, and especially for children, is a core value that surrounds people’s behaviour and beliefs in understanding health. The health belief model holds that improvement in healthcare, especially for children, involves people’s behaviour and beliefs in understanding health. The relevance of this model lies in its explanation of the importance of families regarding PHC provision (Maggie & Macdowall, 2006).

The health belief model, which is the theory underpinning the present study, explains that improvements in healthcare, especially for children, involve people’s behaviour and beliefs in understanding health (Salari & Filus, 2017). The relevance of this model lies in its explanation of the importance of families regarding PHC provision (Maggie & Macdowall, 2006). The authors say that, at its core, the model suggests that the likelihood of a family taking action for a given health problem is based on the interaction between four types of beliefs (Maggie & Macdowall, 2006). The individuals take action to protect or promote the health of their children if they perceive themselves to be susceptible to a condition or problem that they believe will have potentially serious consequences. Sakai et al., (2016) state that there is a need for the availability of a course of action that reduces their susceptibility or minimises the consequences. They argue that there should be a belief that the benefits of taking action outweigh the costs or barriers (Maggie & Macdowall, 2006; Sakai et al., 2016).
The main strength of the health belief model is that it uses modest health-related tenets to gauge the ease of implementing, applying and testing the efficacy of a given benefit for a presenting disease or condition (Molisani, 2015). It offers a practical application of the theory to practice by using a theoretical framework to investigate the cognitive perceptions that inform decisions to choose from a wide range of behaviours. In addition, the present study uses the health belief model to engage its effectiveness on the provision of PHC for children, by parents and healthcare professionals.

2.2 History of the health belief model

The health belief model (HBM) was formulated in the early 1950s to comprehend the reasons why people did not observe efforts to prevent the contraction of disease, as well as to promote behavioural research and interventions (Viswanath, Orleans, Glanz & Rimer, 2008). The HBM was developed by a group of social psychologists who were working for the Public Health Service of the USA (Rosenstock, 1974; Hochbaum, 1958). The four researchers included Drs Godfrey Hochbaum, Stephen Keagles, Howard Leventhal and Irwin Rosenstock (Rosenstock, 1974). In this health setting, they attempted to find out why people across the USA were reluctant to use preventable methods for asymptomatic diseases. The Public Health Service of the USA was more inclined to the prevention of diseases rather than treatment because this was the current concept of medical care. The Service had produced a number of guidelines that were widely available free or at low cost, to aid the prevention of diseases such as tuberculosis, rheumatic fever, polio and influenza (Rosenstock, 1974). The point of departure was the public’s failure to respond to preventive methods, whilst it was assumed that they were aware of the attendant risks to their health.
Hochbaum, Keagles, Leventhal and Rosenstock, who were social psychologists, were considerably influenced by Kurt Lewin’s theories, which involved a phenomenological approach (Rosenstock, 1974). This approach states that it is the world or the part thereof surrounding the perceiver that determines what they will do – and not the physical environment. This is an indication that a person’s perceptions of various things are key to forming their decisions, rather than the physical environment with, for example, the presence of factors that may lead to disease. Secondly, as social psychologists, they looked at the need to apply practical solutions to solve problems as they arose. On the strength of Lewin’s work, these psychologists believed that an individual had three major dispositions to dealing with life, which included positive, negative and neutral values or valences (Rosenstock, 1974). These three dispositions influenced people’s behaviour in their day-to-day work (Bond, 2013). Bond (2013) added that disease was a negative value, which would require the individual to avoid that course of action unless they had to engage in areas of higher negative valence (Rosenstock, 1974). These foregoing factors were instrumental in the development of a theory that would explain people’s predispositions to preventing disease and their behaviour when they were not suffering from a disease (Green & Murphy, 2014). Other factors included probable barriers to accepting health services, and an explanation of the behaviour of people who had access to preventive measures freely or at very low cost (Skinner, Tiro & Champion, 2015).

These four factors guided the concepts that formed the original tenets of the theory, which have continuously evolved to form other deeply embedded practical aspects. The tenets that form the core of the model are that individuals had to believe that they were susceptible to it (Green & Murphy, 2014); it would have a moderate severity on a component of their life (O’connor,
Martin, Weeks & Ong, 2014). They had to believe that a given course of action would benefit them by reducing their susceptibility to a disease (Fisher-Owens, Gansky, Platt, Weintraub, Soobader, Bramlett & Newacheck, 2007); and that the benefits were not affected by barriers such as costs, convenience, pain and embarrassment (Skinner, Tiro & Champion, 2015).

2.3 Tenets of the health belief model

The underlying concept of the original Health Belief Model is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958). The four major theoretical constructs that inform the model are perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers, as depicted in Figure 1. Other constructs that have been added over time that form the basis of the present study include cues to action, motivating factors and self-efficacy (Armitage & Conner, 2009).
2.3.1 Perceived seriousness

The construct above refers to an individual’s subjective belief about the seriousness of a condition in terms of the harm that results from acquiring the disease or unhealthy state. An individual is inclined to take action to prevent a given occurrence if they believe that possible negative effects resulting from contracting the disease can lead to serious consequences (Orji, Vassileva & Mandryk, 2012). The consequences may have physiological, psychological or social effects. It follows that the greater the impact on a person’s life, the greater the seriousness that they will attach to it.
The individual’s degree of seriousness is based on two major factors: firstly, medical information that the individual has about a disease, and secondly the belief that contracting the disease will have severe effects on their life (Turner, Hunt, DiBrezzo & Jones, 2004). Some of the issues that would arise from medical factors include the effect of the disease on the individual’s physical or mental faculties and the probability that the disease might lead to death. In the event that the consequences are grave, the person will tend to regard the disease as potentially serious (McCormick-Brown, 1999). Such medical factors may move beyond simple perceptions about the seriousness of a disease to the consideration of other broader complex issues that arise therefrom (Stein, 1992). Effects of disease on an individual’s job, family, social relations and networks have a cumulative effect on a person’s perception of the seriousness of the disease. For instance, a person who believes that flu is a minor ailment will not regard it as serious. If they have asthma, flu may be perceived as a serious disease because it may necessitate hospitalisation, which in turn may lead to loss of wages and the attendant failure to look after their family. This scenario indicates that the perception that one has about the seriousness of a disease depends on the individual, and thus the degree of seriousness can vary from one person to another (Rosenstock, 1974). Therefore, a person’s traits, attitudes and health beliefs inform their help-seeking behaviour (Jones, Smith & Llewellyn, 2014).

In addition, perceived seriousness presents a strong cognitive component that depends on the knowledge that one has about the disease (Rosenstock, 1974). If a person has insufficient information about a disease and believes that they are in perfect health, it is highly probable that they will not seek any preventive measures. If they have information about the seriousness of a disease, they will adopt preventive measures based on the seriousness that they attach to the disease. If a person is knowledgeable about their health, public adverts and campaigns about
the ongoing provision of preventive measures, facilitate their decision to go to a health facility to seek treatment as a way of increasing the likelihood of adopting healthy behaviours (Stein, 1992). Perceived seriousness of health issues, such as mental problems, might lead to help-seeking behaviour in instances where individuals perceive benefits from this behaviour. Conversely related to the above, a recent study on preventive measures for adolescents showed that seriousness was a strong negative predictor of an individual’s intention to seek help if they perceived that preventive measures held low benefits, or if they had a low level of health motivation (O’connor, et al., 2014).

With regard to this O’connor’s (2014) study, the perceived seriousness of a condition informs a family unit’s individual subjective belief about the seriousness of a disease. The extent of the action that is taken by a family in a bid to support a sick child forms the core focus of this current study. The family’s inclination to take action to prevent harm to a child because of disease indicates the extent of the seriousness it attaches to the consequences of the disease and the child’s health.

### 2.3.2 Perceived susceptibility

Susceptibility refers to an individual’s ability to accept that they have acquired a particular disease or state. The ability to accept a given condition depends on the denial or acceptance of one’s health condition (Rosenstock, 1974). This concept deals more with one’s assessment of the risk of contracting a disease or a condition (de Wit, Vet, Schutten & van Steenbergen, 2005; Chen, Fox, Cantrell, Stockdale & Kagawa-Singer, 2007). The greater the risk of contracting a disease, the greater the likelihood of engaging in practices that decrease the occurrence of that risk (Jones, 2015). This concept is also viewed as a logical connotation that drives the action
of people. According to Sharma (2016), it is logical for a person who believes that they are at risk of contracting a particular disease that they will take steps to prevent it from happening (Sharma, 2016). This concept is also an indication that the greater the susceptibility or risk, the higher the chances that people will adopt healthier behaviours; and the lower the susceptibility to risk, the higher the chances that people will engage in high-risk behaviour (Jones, 2015).

The cumulative effect of susceptibility and seriousness leads to the perception of the threat (Stretcher & Rosenstock, 1997). In instances where the perceived threat is serious, the person will change their behaviour to stop the threat. Though it may seem that this action will lead to behavioural change, it has been noted that just as increased susceptibility may not lead to a change in behaviour, the increased threat may not necessarily lead to behavioural change (Leverack, 2016). Susceptibility presents to a family a way of dealing physically and psychologically with the condition of a child who is susceptible to disease. Susceptibility also points to the possibility of a family’s denial, or acceptance, of a child’s health condition (Rosenstock, 1974). It is argued that within family circles, with a possible extension to healthcare professionals, this aspect enables a family to evaluate its logical options towards risks involved in the contraction of a particular disease. It also addresses the steps that a family may take to adopt healthier behaviours.

2.3.2 Perceived benefit

A perceived benefit refers to an individual’s subjective view of the value of engaging in particularly healthy behaviour as a tool for offsetting a perceived threat (Orji et al., 2012). The concept also refers to one’s opinion of the usefulness of a new behaviour in reducing the risk of contracting a disease (Jones, 2015). An individual’s stimulus to use a particular mode of
action-changing behaviour necessitates that one believes that the precaution being taken is effective in preventing the perceived threat or condition (Sharma, 2016). The perceived behaviour should have positive benefits, for an individual to use it. If the behaviour has a more negative implication, an individual may not use it (O’conor et al., 2014). For instance, an individual who believes that quitting smoking reduces the chances of contracting lung cancer is more likely to adopt behaviours that reduce the chances of acquiring lung cancer. However, that while one’s acceptance of one’s susceptibility to a serious disease guides the forces that lead to action, it does not define the course of action that will actually be taken (Jones, 2015).

The course of action that is taken is influenced by the effectiveness of available alternatives in reducing the perceived threat (Rosenstock, 1974). It follows that the action taken is informed by the perceptions that surround the effectiveness of the known available alternatives in reducing the threat that an individual faces. In addition, an individual’s behaviour depends on the degree of the benefits, which they stand to derive from the available alternatives. If the benefits of the alternatives outweigh the benefits of the principle course of action, then the individual will choose from the alternatives (Sharma, 2016). This is a subjective decision that an individual takes in the belief that it is the best course of action that will reduce their susceptibility to, or seriousness of, an illness (Orji et al., 2012).

The concept of perceived benefit explains a family’s subjective view of engaging a sick child in a particular healthy behaviour as a way of dealing with a perceived threat (O’conor et al., 2014). In addition, this concept informs the value that the family attaches to the adoption of a behaviour that reduces the risk of contracting a disease (Sharma, 2016). The concept also questions a family’s decision to decline the application of a particular behaviour.
2.3.3 Perceived barriers

‘Perceived barrier’ refers to a person’s subjective evaluation of the obstacles associated with a given course of action as a solution to, or treatment of, a condition or targeted behaviour (Orji et al., 2012). It is understood also as the potentially negative aspects of a health action that acts as an obstacle to undertaking the recommended behaviour (Janz & Becker, 1984). This usually hinges on the fact that, while an individual might believe in the effectiveness of a benefit in reducing the threat of a disease or a condition, negative values attached to the process serve as barriers and validate the rationale for declining the course of action (Rosenstock, 1974). According to Orji et al., (2012), this tendency does not indicate that the course of action is ineffective; but it indicates that the obstacles associated with the course of action make a person decline the action. It may be said that the individual’s assessment of negative outcomes outweighs the positive outcomes.

The barrier usually relates to characteristics of the course of action or the measure itself. If the course of action is characterised by expenses, discomfort, pain and inconvenience, a person may be disposed to decline to use it and either opt for alternatives or fail to seek any help at all (Sharma, 2016). A case in point is a person who wishes to test for tuberculosis but, owing to fear of the dangers of X-rays, he opts for a tuberculosis test (Rosenstock, 1974). This explains the position of a person who has the will to act, but subsequently takes a course of action that has weak negative aspects, as opposed to one with the will to act but for whom the potential negative effects pose a risk. The latter will most likely decline the course of action (O’Connor et al., 2014).
The originator of the course of action may be articulate in disseminating information about the benefits of the course of action and/or whether the obstacles are actual or perceived (Orji et al., 2012). If the obstacles are not actual, lack of information on the benefits of the process, with little information on the perceived barriers, denies a person the ability to make an informed decision. There are instances where a person is overwhelmed by fear and anxiety, and their assessment is subjective, rather than objective (Rosenstock, 1974); i.e. lack of constructive assessment affects their ability to make an informed decision. Sharma (2016) states that it is important for such a person to perceive that the benefits of the new behaviour outweigh the consequences of continuing an old behaviour. This line of thought upholds the need for change by invoking its benefits, by requiring that one uses the consequence of continuing a given course of action as a springboard (Umeh & Rogan-Gibson, 2001). This latter position reflects on the need to do away with the threat other than the need to evaluate the barriers.

A family’s ability to use an objective, other than a subjective, evaluation of perceived barriers is a preferred choice (Taylor, Bury, Campling, Carter, Garfield, Newbould & Rennie, 2007). This choice, however, involves the awareness of, and the ability to offer support to, a child who needs PHC in the course of obtaining a solution to or treatment for a given condition (Bishop, Baker, Boyle & MacKinnon 2015). It is proposed that the family’s belief in the individual effectiveness of a benefit in reducing the threat of a disease or a condition adds value to the process of rationalising the course of action (WHO, 2012).

### 2.3.4 Cues to action

The above tenet is an extension of the health belief model (HBM), which initially comprised the four tenets of seriousness, susceptibility, benefits and barriers. These tenets involve the
people, things or events, which lead to individuals changing their behaviour (Graham, 2002; Ali, 2002). This tenet is an improvement of the HBM, which is refer to as a modifying variable that affects an individual’s choice of action and is thus an indication that the cues spur an individual to adopt positive actions. Rosenstock (1974)suggested this tenet as an important behavioural determinant. Recent research suggests that cues to action can include both external triggers such as medical advice or public awareness campaigns, and internal triggers such as previous experience with a disease (Dodel, & Mesch, 2017; Claar, 2011).

This tenet is seen as a trigger for health behaviour that is used when an individual attaches a value to particular beliefs (Rosenstock, 1966). It may be understood as a personal belief that one is able to institute as a given behaviour for purposes of change in a given community (Janz & Becker, 1984; Rosenstock, 1974). Cues to action act as a trigger in instances where susceptibility and severity are not strong enough to induce an individual to change. Contemporary research shows that there is a limited likelihood of an individual engaging in fruitful actions owing to a low perceived susceptibility and lack of cues to act (Heid, Knobloch, Schulz, & Safdar, 2016). Researchers are urge to conduct further inquiry into the improvement of susceptibility and cues to act. The cues will act as either external triggers that propel the individual to take a positive course of action or internal triggers that arise from interpersonal interactions and media communications.

In instances where a family engages positive actions to improve the health of a child, this may be based on internal triggers within the family, which may extend to external triggers such as government adverts, mass mobilisation and sensitisation.
2.3.5 Self-efficacy

Rosenstock, Stretcher and Becker (1988) added this tenet to the HBM as the description of a person’s disposition to their beliefs to perform a new act or undertake a new course of action (Orji et al., 2012; Rosenstock, Stretcher & Becker, 1988). This tenet was introduced against the backdrop of a general trend that people may not attempt to do something new unless they think that they can do it. This tendency is an indication that if an individual believes that new behaviour is beneficial, but they have low self-esteem about their ability to perform it, they then have a low self-efficacy towards performing it (Orji et al., 2012). It follows that the chances of performing the behaviour would be low.

Self-efficacy has proven to be a strong tool in determining the behaviour of an individual regarding their disposition towards behaviours that lead to good health (Schwarzer, 2014). This position is amplified by Montano and Kasprzyk, (2015) who maintains that cognitive attributes such as self-efficacy place normative pressure on individuals to develop a disposition to engage in a course of action that is good for their health.

2.4 Weaknesses of the HBM

As noted earlier, the HBM comprises six tenets that are independent predictors of health behaviour, which are used concurrently to lead to a particular result (Sharma, 2016). The concept of this model shows a grouping of perceived seriousness and susceptibility that leads to perceived threats on the one hand, and perceived benefits with perceived barriers, on the other hand, to facilitate the assessment of the course of action to be taken (Sharma, 2016). It is therefore, that an individual’s perception of a threat and barriers affect their disposition to taking a course of action to obtain the benefits. The individual’s benefits can be derived from
performing the behaviour, or there are few barriers to performing it or some combination of these. Therefore, without the inter-relatedness of the six components, the model is not effective.

Armitage and Conner (2009) indicate that while the HBM has six tenets which are key to its implementation, the model does not explain the relationships between the tenets regarding their formulation and combinations. For instance, although a threat may be a consequence of severity and susceptibility, it is listed as an independent tenet. While this could be true, elasticity with the rules of combination leads to a higher degree of adaptability and applicability of the model. No clear rules for combining the formulated variables exists (Armitage & Conner, 2009). However, this weakness can also be viewed as a strength, because the lack of strict rules of combination offers flexibility that makes the HBM adaptable and applicable to many health behaviours and population groups (Sharma, 2016).

The HBM is premised on an individual’s belief in the possible benefits that they attach to a behaviour, which is in line with the position of Orji et al. (2012) who place an inclination on one’s action in embracing a course of action to avert the negative effects of a condition. It is argued that, in a similar way, the individual may decline to perform a particular action because of a low level of belief. The degree of engagement that the model places on the individual’s discretion is a weakness as far as the individual exercises incorrect discretion that leads to negative results.

The model assumes that an individual has sufficient knowledge about a given condition. According to Rosenstock (1974), the perceived seriousness of a condition is dependent on the
knowledge that one has about the disease. While one may argue that a high level of information technology minimises the possibility of ignorance on the part of individuals, a qualitative study that evaluates the use of this technology is key to establishing whether this technology is used for obtaining valuable information or social media (Weatherall, Greenwood, Chee & Wasi, 2006). Conversely, if the use of technology does not lead to improvements in health, its impact might be missing the mark (Weatherall, et al., 2006).

In addition, continued lack of knowledge may affect one’s perception of the risk that a condition presents. Jones (2015) states that the greater a susceptibility or risk, the higher the chances that people will adopt healthier behaviours; and the lower the susceptibility to risk, the higher the chances that people will engage in high-risk behaviour. It is, however, probable that an individual who does not have adequate knowledge of a given condition, will engage in risky behaviour. It follows that the stimulus to a particular action may hinge on the ability to make an informed decision on a given course of action. The cumulative effect of the lack of adequate knowledge clouds one’s judgment of the risks and obstacles that may arise from the decision that is made.

2.5 Effectiveness of the HBM

The effectiveness of the HBM requires that certain aspects are to be considered. Consequently, if these factors are not considered, the HBM’s effectiveness may be placed into disrepute. These factors include future consequences that the individual should ponder; the self-identity to which an individual ascribes; concern for appearance; and the perceived importance of a course of action. The present section evaluates theses four concepts, as set out in the following paragraphs.
2.5.1 Consideration of future consequences

The main challenge for a person in adopting a healthy behaviour is the instant benefit and repercussions associated with the behaviour because most individuals wish to obtain future benefits in the shortest time (Orji et al., 2012). It becomes difficult to motivate oneself to adopt a new behaviour if one does not envisage any future benefits from it. If one cannot attach value to future health benefits in terms of time, cost or comfort, one might forgo the perceived long-term benefits (Adams, 2012). To consider future benefits as a springboard to adopting a new lifestyle, Strathman, Gleicher, Boninger and Edwards (1994) suggest consideration of future consequences (CFC) as a contributory step in the effectiveness of the HBM.

The CFC tenet is instructive in measuring the extent to which a person may regard the possible remote results of their present behaviour and the extent to which they are influenced by these remote results (Strathman et al., 1994). Regarding the HBM, as one balances threats versus perceived benefits and barriers, one should be able to consider the decision to adopt a future behaviour as hinging on future results or possible outcomes. Research indicates that CFC is a predictor of a variety of significant behaviours (Prescott & Logan, 2016). Examples of some successfully predicted behaviours are health conditions, environmental behaviour, and alcohol use (Strathman et al., 1994). Additional research has also shown that a person who exercises more willingly is more likely to go for an HIV test and less likely to engage in risky sexual practices (Ouellette, Robert, Frederick, Monica & Meg, 2005).

Although the efficacy of CFC predicts a variety of behaviours, there have been a few tests of its validity within known theoretical frameworks, which deals as a tool with behavioral change (Orbell, Perugini & Rakow 2004). The former researchers propose that an individual should
apply CFC aggressively within the bounds of the HBM as it is a crucial component that informs the decision to adopt a given course of action.

2.5.2 Self-identity

Another tenet that is key to adopting a given course of action is the concept of self-identity. Self-identity refers to the prominent and enduring part of one’s self-perception in relation to a particular behaviour (Sparks, Jessop, Chapman & Holmes, 2010). The perception that one has about oneself and health consciousness is important in regulating the adoption of human behaviours. Individuals who perceive themselves to be conscious of health behaviour will more often associate themselves with the application of health practices (Orji et al., 2012). For instance, a smoker who views himself as a non-smoker or a teen, sees binge-drinking as something they cannot do or be associated with and, as a result, their behaviour change is typically more enduring than that of a person who does not invoke their sense of identity (Orji et al., 2012). Its relationship to strengthening the model lies in the individual’s perception of stopping habits that lead to disease and adopting those that improve their health.

The self-identity concept has been tested in some theoretical frameworks, such as the theory of planned behaviour, and it has been established that persons who see themselves as ‘green’ consumers have a strong disposition to consume organic vegetables (Spark & Shepherd, 1992). As a result, self-identity has been noted to have an independent predictive effect on the intentions of an individual with regard to dietary changes associated with reducing fat in a diet (Szalavitz, 2012). However, if a person’s identity is conditioned to unhealthy practices, unhealthy behaviour will be the consequence of their actions. For example, a person whose
identity and sense of self are directly connected with unhealthy behaviour will probably continue the behaviour (Orji et al., 2012).

2.5.3 Concern for appearance

Another concept that needs consideration is concern for appearance, which suggests that individuals who are concerned about their health perceive that it is their responsibility to engage in protective health behaviour (Orji et al., 2012). This view is based on subjective perceptions of susceptibility to health risks and is an important component of an individual’s disposition to adopt a particular behaviour (Vollrath, Knoch & Cassano, 1999). The weight that a person attaches to their subjective appearance determines their disposition to pursue a specific course of action. To this end, research indicates that one’s personality affects one’s perceptions of susceptibility to health risks directly through engagement in risky health behaviours, and indirectly through the effects of personality on risky health behaviours (Vollrath et al., 1999; O’Connor et al., 2014; Sheeran, Harris & Epton, 2014).

Without detracting from the foregoing, it is probable that people may engage in health practices and preventive practices for reasons that are not related to their conditions or wellness (Orji et al., 2012). At times, an individual’s reasons for improving their appearance may be for reasons such as popularity or attractiveness rather than health implications. This kind of evaluation is inform by socio-cultural and social-psychological factors that affect individuals in society (Mildestvedt, Meland & Eide, 2007). For instance, in South African society, considerable importance is placed on an individual’s physical appearance, owing to media influence, which generally presents physically attractive characters (Orji et al., 2012). This policy proposes such
people as ideal images that society should seek to attain, regardless of any health implications involved in achieving such goals.

As long as the media project physical attractiveness as a depiction of happiness, success and social acceptance, while obesity is linked to laziness and untidiness, concern about appearance will remain when attempting to change people’s perceptions about behavioural change (Kai-Yan, 2002). Research indicates that concern about appearance influences an individual’s decision to adopt various behaviours (Funk, Salathé & Jansen, 2010). Although this indicates overwhelming evidence regarding the impact of an individual’s appearance, it has not been extensively adopted as a field to be studied in healthcare promotion (Orji et al., 2012). It is the researcher’s view that concern for appearance is taken seriously because an individual’s perception of their appearance has an effect on their behaviour, well-being and adherence to treatment. It, therefore, follows that this tenet is a crucial factor in preventing negative health behaviours. In families, the behaviour of parents and health professionals is pivotal in PHC for children. Such adults have a key role in improving their own perceptions towards PHC, which has the potential of helping parents to improve their role in PHC provision to children.

### 2.5.4 Perceived importance

Perceived importance relates to the amount of value that a person attaches to the outcomes of a particular behaviour (Green & Murphy, 2014). Perceived importance should not be confused with perceived benefit because the latter is inclined towards the benefits that will flow from performing appropriate behaviour to avert a threat. In perceived importance, the values that a person attaches to the outcome of a particular behaviour may be positive as a result of adopting the required behaviour, or they may be negative as a result of indulging in the unhealthy
behaviour (Orji et al., 2012). The benefits of a health process may be good insofar as they eradicate a threat, but the individual may not attach value or importance to them. While there is a fine line between benefit and importance, there is research that suggests that perceived importance is an important predictor of behaviour (Deshpande, Basil & Basil, 2009).

The evaluation of perceived importance is not based on its ability to prevent a given threat, but on the value that an individual attaches to it. One should approach this concept as an ethical issue that supports an individual’s moral judgment (Honjo and Siegel, 2003). If one approaches it as an attitude, one is in a position to establish that the mental or neutral state of readiness that exerts an influence on an individual’s response to situations has to be used to explain their behaviour (Montano & Kasprzyk, 2015). This view is in line with cognitive psychology, which forms the basis of the works of Hochbaum, Keagles, Leventhal and Rosenstock who developed the HBM.

In addition, this use of attitudes as a starting point is instructive in enabling a researcher to understand the process of ‘unpacking’ a perception as a key element that impels an individual’s decisions (Skinner, Tiro & Champion, 2015). Kok, Bartholomew, Parcel, Gottlieb and Fernández (2014) state that a perception is formed through a process that includes stimulation, registration, organisation and interpretation; modelling others; and one’s direct experiences with people and situations. An individual’s awareness and acceptance of a stimulus play a vital role in starting the perception process (Walker & Jackson, 2015). This is followed by registration, which involves a person’s receptiveness towards the stimulus. The receptiveness may be selective of their existing beliefs, attitudes and personality (Christon, McLeod, Wheat, Corona & Islam, 2016). Receptiveness, in turn, affects their disposition to adopting a given
course of action. The importance that a family attaches to the health of a child is related to the extent of the effect that PHC will have on the latter.

**Applicability of the HBM**

The perceived seriousness of a condition informs a family’s individual subjective belief about the seriousness of a disease when providing PHC. As indicated earlier, one’s engagement in given objectionable health behaviour is related to one’s perception about the seriousness of a disease. Thus, it has been suggested that people make decisions, which inform their behaviour (Polit & Beck, 2004; Tarkang & Zotor, 2015). The perceived benefits inform either the subjective or objective view of a condition that the child may have. The ability to evaluate perceived barriers indicates the awareness of a specific course of action in a bid to improve the child’s condition. These perceptions form the core of the HBM, which is instructive in the provision of PHC to children.

Regarding perceived benefits: where an individual perceives that a certain course of action is likely to be of benefit, the value attached to that benefit informs the decision to undergo treatment or take a certain cause of action. In this regard, Beresford and Sloper (2008) suggest that the urge to make a decision on one’s own behalf or on behalf of another requires making choices on the basis of benefits that one hopes to obtain. The applicability of the action to enjoy the benefits is also evident in the behaviour change by an individual (Carpenter, 2010).

Susceptibility is used to indicate a family’s mode of dealing with the conditions of a child through the provision of PHC. In this regard, the applicability of perceived susceptibility lies
in the perceptions that individuals have of a specific health problem and its effect on life (Joseph, Burke, Tuason, Barker & Pasick, 2009), which is an indication that individuals start taking action to prevent the occurrence of a disease. Conversely, those who perceive that they are immune, do not take precautionary measures to avoid the occurrence of an event (Joseph et al, 2009). Other components such as self-efficacy aid the determination of an individual to embrace behaviours that lead to good health (Schwarzer, 2014). Montano and Kasprzyk, (2015) who states that cognitive attributes such as self-efficacy place normative pressure on individuals to develop a disposition that directs them towards actions that are good for their health. The use of cues to action may enhance the family’s and the health professionals’ roles in providing PHC to children.

These six concepts, which form the HBM, help to evaluate and inform a family’s role in improving PHC for children. They have been widely used in behavioural and social science theories, which relates to the cognitive aspects of the HBM.

2.6 Conclusion

The HBM comprises six tenets, which explains an individual’s perception of the seriousness, susceptibility, benefits and barriers regarding a healthy action. There are, however, other tenets, which, subject to further research, could be instructive in the fundamentals of the HBM. These tenets include perceived importance, concern for appearance, self-identity and consideration of future consequences. The next chapter deals with the literature review of the present study.
CHAPTER 3
LITERATURE REVIEW

3.1 Introduction

The preceding chapter outlined the theoretical basis of the present study. Chapter 3 provided an overview and understanding of a review of the literature on PHC; of families in relation to the provision of PHC; and the role that healthcare professionals play in the provision of PHC.

3.2 Primary healthcare

The World Health Organization (2012: 1) defines PHC as:

... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford… It forms an integral part of both the country’s health system, of which it is the central function and main focus and the overall social economic development of the community. It is the first level of contact of individuals, the family and the community… and constitutes the first element of a continuing health care process.

This definition alludes to essential health as a key component in PHC and requires that such healthcare be based on practical, scientific and socially acceptable methods. In this regard, parents should be able to apply PHC to their children in ways that the community and health professionals embrace (Harrison, 2010). Dookie and Singh (2012) view PHC as a public health strategy derived from the social model of health and that is based on the philosophy that health
gains are obtained better when people’s basic needs are met first. De Maeseneer, Willems, De Sutter, Van de Geuchte and Billings (2007) view it as a strategy that may be used to achieve equitable care; they qualify the social determinants of ill health, including poor living conditions and unemployment, as important factors to consider in a PHC strategy. It is evident from Dookie and Singh’s (2012) research that the adequacy of a PHC system lies in its ability to respond to the needs of individuals and families.

The essence of PHC for children is to protect lives and deliver cost-effective care. PHC is associated with a more equitable distribution of health in populations (Alkon et al., 2010), which therefore means that families have a significant role to play in improving primary care, and therefore overall health across major population subgroups requires their involvement (Sweeney, Bazemore, Phillips, Etz & Stange, 2012). Sanders, Baum and Benos (2011) state that PHC embraces both clinical and societal or community or social perspectives which indicate that, while it may be used in a medical setting, it may also operate in a social setting such as a family. This point relates to the general view that PHC is a healthcare system that is useful in preventing illness, providing health, and achieving equitable universal care for children, and requires family participation (Lévesque, Gervais, Chevalier, Gauvin, Anassour-Laouan-Sidi, Gingras & Bird 2014). Visagie and Schneider (2014) suggest that community involvement in healthcare hinges on diagnosing specific ailments that require PHC.

From a health perspective, PHC involves a plethora of concepts that are not limited to remedial solutions. It is necessary from a health perspective that persons offering PHC know when and how to provide it (Shi, 2012). In addition, the essence of PHC is the ability to offer relief to
individuals before they go to a hospital. This position places PHC as a grassroots-level concept, with the necessity of various skills before the family can adequately perform it (Shivalli, Majra, Akshaya & Qadiri, 2015). Aigbiremolen, Alenoghena, Eboreime and Abejegah (2014) view PHC as a grassroots service which acts as a frontline in the healthcare system in providing families with an opportunity to maintain the health of its members. This view reinforces the qualification of PHC as a grassroots management approach that is expected to be innovative in engaging the community, family and patient to ensure the provision of PHC (Epping-Jordan, Pruitt, Bengoa & Wagner, 2004). One may argue that a strong and accessible PHC system helps the community to understand their own lives from a family perspective; thus minimising frequent visits to the hospital (Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana, & Cherish, 2011).

Levesque, Breton, Senn, Levesque, Bergeron & Roy (2013) indicate that PHC is a healthcare system that is useful in preventing illness, providing health and achieving equitable universal care for children, and requires family participation. While this definition does not qualify the key players in PHC, it indicates what the system offers other than who the key players should be. In South Africa, PHC is understood by parents as a way of helping sick children before they are taken to the hospital, thus enabling parents to play an active role in offering an enabling environment for children to grow and develop in (Berger & Font, 2015). It is also a way for parents to offer remedial solutions to sick individuals (Gruber & Haldeman, 2009).

The relevance of PHC is evident in the role it plays in society. It offers relief as a measure of first resort to a person needing medical help (Erny-Albrecht, Bywood & Oliver-Baxter, 2015). Bodenheimer (2006) avers that it may be used to offer routine preventive care as a way of
managing less complex health issues affecting an individual. It is generally true that the person first offering PHC is a family member, and then medical personnel (Thepwongsa, Kirby, Schattner, Shaw, & Piterman, 2014; Britt, Miller, Henderson, Bayram, Valenti, Harrison & O'Halloran, 2013), which shows that family and medical personnel play a key role in PHC. It is thus important to assess the importance of PHC by the family as the first point of contact, and medical personnel as a subsequent point of contact.

PHC is relevant as it promotes health, prevents disease, and provides counselling, patient education, diagnosis and treatment of acute and chronic illnesses in various healthcare settings. Regarding the promotion of child health, PHC strengthens the family’s dual role in promoting and preventing disease. This stance is backed up by research on specific ailments such as cancer and sickle cell disease which shows that appropriate PHC for the disease enables the family to provide social support to the sick child (Moorhead, Hazlett, Harrison, Carroll, Irwin & Hoving, 2013). PHC also improves child health at minimal cost.

3.3 Families and PHC

The relationship between the family and PHC is premise on the need to offer solutions to ailing children before they can receive comprehensive treatment at a hospital by medical personnel. Therefore, at the core of this relationship, is the parents’ provision of remedial solutions to children before forwarding them to hospital (Prezant, Weekes & Miller, 2008). The family is expected to offer home-based remedies to sick children before they can be taken to hospital for further treatment. Therefore, PHC depends on the family’s creativity and ability to have its own home remedies for treating individuals before formal medical attention can be sought (Blumenthal & DiClemente, 2013). This means that the community has a broad role in PHC.

http://etd.uwc.ac.za/
by ensuring that families, as the smallest units, are the points of first contact for offering PHC to children (Mash, Ogunbanjo, Naidoo & Hellenberg, 2015).

The family plays various roles in providing PHC. While these roles tend to be varied, the point of emphasis should be how the family plays its role in improving the provision of PHC. It is clear from an engagement of the relationship between families and PHC that any effort to promote child health must necessarily involve families (Gruber & Haldeman, 2009), but the degree of involvement when questions of PHC are involved (Pina, Moraes, Furtado & Mello, 2015; Myrhaug, Jahsen & Østensjo, 2016) remains limited. It follows that the degree or quality of PHC in family environments in which children are raised varies considerably, as not all families offer safe, stable and high-quality care (Waldfogel, Craigie & Brooks-Gunn, 2010).

The family needs to acquire adequate information on: how to look after sick children against the backdrop that a child may fall sick when the parent is not able to go to a health centre; or the adult does not have information or education on what to do before taking the child to hospital (Faruqi, Spooner, Joshi, Lloyd, Dennis, Stocks & Harris, 2015). Once a parent has the necessary information, they can use it to provide PHC to children. Furthermore, a family needs to offer social support to an ailing member of the family. Botha and Booyse (2013) and Roman, Schenck, Ryan, Brey, Neil, Novuyo, Minnaar-McDonald and Saville (2016) state that the family needs to continue functioning optimally as a way of supporting its members when they are sick. Therefore, a child’s functioning will remain at or above an optimum level where the family is able to offer support that contributes to the family’s general well-being; this calls
for a certain expected level of engagement between a family and its children to provide both physical and emotional healing (Roman et al., 2016).

Family involvement is key in ensuring that a patient has a steady recovery. They point to the need to educate the community about the nature of the disease and its prevention, diagnosis and treatment. (Vorster, Sacks, Amod, Seab & Kern, 2016) indicate that the point of departure is when families lack the necessary knowledge of PHC that may be used on children, coupled with an inadequate support system of friends, extended family or professionals to help with these vital tasks. Issues such as information and understanding may be difficult owing to lack of such knowledge.

Thus, when families or parents have basic knowledge about the symptoms of a child’s sickness, they may consult a health officer (Sweeney et al., 2012). (Mosadeghrad, 2014) says that the family’s role in PHC is a preventive measure, characterised by the likelihood that disadvantaged children may not have preventive measures at their homes, before visiting healthcare centres. (Mosadeghrad, 2014) argue that many preventive activities stress the early detection of specific diseases based on the involvement of the community or families in the provision of PHC.

There is a need to establish how the family role blends with the use of prevention as a measure in the South African context, which may be in the form of family tips and strategies concerning the health of their children, and social and recreational opportunities that promote affordable and good health (Levesque et al., 2013). Families have an expectation that government through
its agencies must provide educational and practical services. Firstly, with regard to education, the family expects government to teach them PHC in all its aspects such as remedial solutions, maternal health, child health, disease prevention, chronic disease management and referral to clinics (Khuzwayo & Mushabela, 2017). Secondly, this role extends to the provision of services to children such as vaccination and health check-ups in homes and for nutritional intake such as vitamins A, B and C (Khuzwayo & Mushabela, 2017). This role has to be documented to extend to actual treatment in the event that the homes that government nurses and medical practitioners visit, has sick children (Naidoo, 2012). Conversely related to the above, communities require government medical personnel who come to their homes to make referrals to the appropriate medical centres or hospitals (Naidoo, Van Wyk & Joubert; 2016). While being able to offer only limited services, these medical personnel are in a position to direct parents who need specific services and health advice to enquire in the right places.

The expectation by families that government should offer PHC to children should be downplayed, if the former seek to recognise and uphold their role in the provision of PHC as a concept that starts at home (Woolf, 2011). Other authors, however, disagree in that they state that health professionals in the public sectors such as hospitals form a crucial part of government in the dispensing of their services. It, therefore, follows that there is a need for an engagement where family on the one hand and government, on the other hand, do what is possible in the circumstance to create an environment for the provision of PHC at home (Carman, Dardess, Maurer, Sofaer, Adams, Bechtel & Sweeney, 2013; Smith, Saunders, Stuckhardt & McGinnis, 2013). Families have the ability to be creative and use home-made remedies, which should be emphasised to place the family in a position to provide remedial solutions without necessarily going to hospital (Li, 2014).
Various constraints and challenges inhibit parents’ ability to offer adequate PHC to children. According to some fathers, it the role of mothers to look after children – a role that some mothers abide by (Bhana, Nzimakwe & Nzimakwe, 2011). While this view concretises gender stereotypes, it fails to show that both parents can perform sound roles in the provision of PHC in a family. As such, a patriarchal society creates challenges to the use of PHC insofar as it exacerbates the effects of gender masculinities, and subsequently shapes the roles of both male and female and their role in shaping identities of partners in a relationship and displaying particular behaviours in parents (Jewkes, Nduna, Jama-Shai, Chirwa & Dunkle, 2016).

The lifestyle of some parents affects the possible engagement of PHC in their families. Research shows that a parent’s lifestyle may be the cause of the failure to engage PHC in families (Kühn & Slabbert, 2017). This includes the parent’s use of drugs and the labelling of children (Radebe, 2015). It may be argued that the lifestyle that some parents lead is the cause of their failure to provide PHC in a family. Poverty or the lack of funds to provide adequate PHC for children with chronic illnesses such as asthma is another challenge. Financial constraints leave many families unable to offer PHC (Stear, Potter & Labadarios, 2011). This is worsened where a parent has to obtain specialised items (e.g. thermometer) for offering PHC (Faruqi et al., 2015). This difficulty is intensified by the pressures of work, when both parents have to be at work at the same times, regardless of the existence of a sick child in the family. This is exacerbated when parent/s lack a social support system to assist in providing PHC when they have to be at work (Stear et al., 2011).

The lack of human resources by government in medical centres and hospitals to offer or to improve the provision of PHC education to parents obstructs the effective dissemination of
information about PHC in a community (Meintjes & Nolte, 2016). Subsequently, the shortage of health professionals who would otherwise offer education and practical advice greatly affects such a service (Meintjes & Nolte, 2016). Another challenge that affects the family’s supportive PHC role towards children is the lack, or inconsistent supply, of drugs for treating children (Meintjes & Nolte, 2016). Such problems are beyond the scope of parents who cannot afford to purchase such drugs themselves. According to Stear et al. (2011), financial constraints leave many families unable to provide PHC to children, especially when they require specialised treatment. The existence of an emotionally supportive role would not be enough to help patients in the wake of the lack of funds to pay for necessary medical treatment (Stear et al., 2011).

Parents are not informed about various kinds of PHC from the perspective of remedial solutions. Sweeney et al., (2012) are of the opinion that most parents are quick to take a child to hospital regardless of the fact that they might be in a position to offer remedial treatment to the child. The failure to offer preventive strategies limits the use of PHC in families (Mosadeghrad, 2014), which presents a challenge as the parents might not be able to distinguish if an ailment in a child requires them to go to hospital or use a home-remedial solution (Sweeney et al., 2012). Conversely, another challenge lies in the possibility that parents may think that a serious medical condition is a minor condition, owing to lack of adequate information about the ailment (Manea, Favero, Stellini, Romoli, Mazzucato & Facchin, 2007).

A further barrier to accessing PHC is revealed in a study by the US Rural Information Hub which shows that this barrier exists in both developing and developed economies (Langelier, Moore & Baker, 2015). Families in rural areas have generally to travel long distances to access
PHC services, which is a significant burden in terms of time and money (Langelier, et al., 2015). In addition, the lack of reliable transportation is a further barrier. According to McLaren, Ardington and Leibbrandt (2013), 90% of South Africans live within 7 km of the nearest public clinic, and two-thirds live less than 2 km away. McLaren et al. (2013) state, however, that 15% of black adults live more than 5 km from the nearest health facility, in contrast with only 7% of coloured and 4% of white people. This notable difference in proximity to public clinics indicates that poorer people reside further from the nearest medical centre, and struggle more to access good-quality healthcare facilities (McLaren et. al., 2013). These unfortunate circumstances have a negative effect on the kind of role such families play in the provision of PHC to their children.

3.4 Professionals and provision of primary healthcare

The provision of PHC includes many key players such as health professionals, parents, support staff at hospitals, and the community that provides further social support (Ndhambi, 2013). Rapakwana (2009) states that ensuring an effective role in the family provision of PHC for their children requires an effective mechanism to ensure parental education, social support, and linkage with public healthcare providers. This mechanism includes the need for basic knowledge and resources to provide a nurturing, safe environment and to provide for the emotional, physical, developmental and healthcare needs of their children (Biglan, Flay, Embry & Sandler, 2012). It is prudent to establish whether a family’s insufficient knowledge of PHC skills and an inadequate support system of friends, extended family and professionals to help with these vital tasks, affect its role in providing PHC (Khuzwayo & Mushabela, 2017).
In the context of PHC, professionals refer to support staff who are qualified doctors or nurses, registered with the Health Professionals Council of South Africa, and as such have the authority to diagnose and prescribe treatment for an ailing child (Health Professionals Act, 1974). In this regard, health professionals include doctors and nurses employed by the government in public hospitals. Furthermore, nurses have a role and responsibility to adopt strict precautions and control owing to their perceived understanding of a patient, their family and workplace roles (Smolowitz, Speakman, Wojnar, Whelan, Ulrich, Hayes & Wood, 2015). Health practitioners are required to teach families positive and effective coping strategies on how to overcome obstacles and handle a child’s illness in a way that holistically promotes health for the child and their family (Smolowitz et al., 2015).

Medical professionals need to offer education to the community on the role of PHC before a child is taken to a hospital (Kemppainen, Kerttu & Hannele, 2013). However, the practitioners need to understand the concept of PHC because it is at times conflated with first aid (Hasson, Keeney & McKenna, 2000). In addition, health professionals at times allude to lack of use of the healthcare knowledge they dispense to families. Sweeney et al. (2012) indicate that healthcare professionals feel irrelevant when families do not use information provided. In this regard, Woolf (2011) reiterates that medical professionals should improve their engagements with families to effectively inform them on how to apply PHC.

Medical professionals, and especially doctors, have to support the provision of clinical care at the primary health centre level, by utilising this occasion to the optimum and instil a culture of PHC application before parents bring children to health centres or hospitals. Nkosi, Howood, Vermark and Cosser (2009) state that this role is unfortunately underutilised because of the
lack of facilities, the continuing trend of using visiting doctors, and the subsequent failure to train nurses and other related personnel to provide healthcare. This is a crucial component in dealing with the care of children with chronic illnesses. While the lack of training is a challenge for health professionals, it also speaks to families as far as they are the key agents of PHC before children are taken to hospital. Coyne (2015) points out that health professionals are probably central to family involvement in the provision of PHC for their children, and this requires engagement with the management of health facilities to help doctors to develop this role.

3.5 Challenges to health professionals in the provision of PHC

There are various challenges that health professionals face in the course of their engagements with parents. According to health professionals, some parents do not have knowledge of how to use remedial or ‘home-made’ solutions for ailments (Vorster et al., 2016). The cumulative effect of the lack of knowledge leads to a consequential decline in the quality of health of a family. As a result, families are not able to deal with common symptoms of diseases, hygiene, nutrition and education, which require both parties to recognise each other’s role (Carroll & Vickers, 2014). In addition, lack of knowledge on how to use remedial or homemade solutions for ailments the authors exacerbate the amount of work upon medical personnel in providing health services, and their empathy (Carroll & Vickers, 2014).

The shortage of medical personnel affects the time taken to help patients (Nkosi et al., 2009), which affects the ability of health centres in providing quality PHC services. This shortage, coupled with lack of experience and adequate training of nurses in handling patients prevents the provision of PHC and subsequent dissemination of education to families. Consequently,
the desired level of care is not achieved. Nkosi et al. (2009) state that healthcare that is provided at district level has to resonate with the commitment and skills that health professionals bring to bear. Closely related is lack of parental truthfulness regarding the state of a child, which places medical personnel in a position, which requires them to rely on their own clinical judgment. One is torn between alluding to the lack of, or the existence of neglect (Baines 2016).

The existence of gender masculinities is another issue that shapes the engagements between medical professionals and parents at health centres (Bhana et al., 2011). This issue plays a role in shaping identities and leading to particular behaviours in parents, which affects the role of the family in providing PHC to children (Jewkes et al., 2016). Thus, the men assert that PHC is reserved for women, and the latter comply by ensuring that they single-handedly provide PHC to the children. Research indicates that health professionals decry the parents’ lack of adequate information on the benefits of PHC (Bhana et al. 2011). These benefits have to be applied within the social spaces regarding gender masculinities. The lack of information applies not only to PHC but also to the social bounds within which the gender stereotypes operate in. A study by Meintjes and Nolte (2016) in Gauteng Province on the PHC challenges by parents of children with atopic eczema shows that parents who took children to the health centres failed to receive adequate care because the health professionals did not know the disease that the presenting symptoms indicated.

To children, their parents appear at times to be depressed, thus leading to a plethora of emotional and psychological problems. Keeshin and Dubowitz (2013) state that depression in the mother is at times a cause of neglect of her child. Consequently, the child does not receive
the necessary healthcare or the mother's depression compromises her ability to provide adequate care for her infant. Furthermore, to be considered is that a health professional has to deal with the mother's depression yet the former is neither a counsellor nor a psychologist. Thus, a problem that a parent is not able to solve technically shifts to medical personnel, in the course of attempting to offer PHC. In this context, emotional issues experienced by parents are challenging insofar as medical personnel have to balance their professional and emotional lives without being overly sympathetic (Favin, Steinglass, Fields, Banerjee & Sawhney, 2012).

3.6 Conclusion

The current chapter has reviewed the available literature on the concepts of PHC, the roles of families and health officers in implementation, and the challenges in the South African context. It has unpacked the concept of PHC, with regard to its definition and scope. It has evaluated the role of families and healthcare professionals in providing PHC. It is therefore important to review the proposed theoretical framework of the study.
CHAPTER 4
RESEARCH METHODOLOGY

4.1 Introduction
The present chapter presented a detailed discussion based on the brief insights in Chapter One on the methodology adopted for the study. The current chapter described the research approach, research design, research population, and sampling as well as the research setting. In addition, it detailed the mode of data collection and analysis, including ethical considerations.

4.2 Research question
The research question followed an identified problem in the field of research (Marczyk, DeMatteo, & Festinger, 2005) and in addressing the research problem, the following research question was posed:

- What role do families play in providing primary healthcare to their children?

4.3 Aims and objectives of the study
The aim of the study was to explore the role of families in providing primary healthcare to their children.

The objectives of the study were:

- to explore the roles of families in providing primary healthcare to their children
- to explore the experiences of parents regarding their role in providing primary healthcare to their children
- to explore health professionals’ roles towards families regard the provision of primary healthcare.
4.4 Research approach and design

The study employed a qualitative research approach and methodology as this involved exploration with the aim of gaining an understanding of reasons, opinions and motivations for a given research theme (Creswell, 2013). The qualitative approach involved in-depth questions that attempted to explain the richness of the information collected (Henning, van Rensburg & Smit, 2004). The focus was on participants as the source of data, which made the researcher the primary instrument for data collection and analysis in qualitative research (Hancock & Algozzine, 2006).

An explorative and descriptive design was used for this research. An explorative research design was a mode of discovering new ideas about a particular issue that had not been widely researched (De Vos, Strydom, Fouché & Delport, 2011). Babbie & Mouton (2001) stated that explorative studies assist a researcher to produce novel comprehensions of a given topic an indication that exploratory research design is inductive in nature as a researcher begins by observing the issue and attempts to draw uncertain simplifications from it (Clark & Adler, 2011). It enabled the researcher to explain concepts from the participants’ points of view, without biases regarding the topic of study (Tinarwo, 2011).

4.5 Research methodology

4.5.1 Population and sampling

A population refers to the total number of people who participate in a study as selected respondents (Neuman, 2000). The present study was conducted in two community health centres (Heideveld and Gatesville) in Athlone, a suburb of Cape Town to the east of the city centre, on the Cape Flats. The main health centres in Athlone are in Gatesville Park and
Heideveld. Some of the services provided included immunisation and child health, treatment of sexually transmitted diseases and infections, contraception (family planning), health education, substance abuse counselling and testing, and nutrition services. The population included parents and healthcare workers, who included doctors and nurses working at these health centres.

Sampling, which was the process of selecting participants from the population or the total group of individuals (Neuman, 2011), was done purposively whereby the researcher selected information-rich cases for study (Denzin & Lincoln, 2011; Palys, 2008). Purposive sampling was used as the researcher did not know enough about the provision of PHC by families (Lewis-Beck, Bryman & Liao, 2004) and therefore deliberately sought participants who possessed particular characteristics (Lewis-Beck, 2004). With regard to the parents, the inclusion criteria for their selection were that the participant was a parent, or a guardian for children under their care; and secondly that the participant had had a sick child who was in need of treatment. Regarding health professionals, their inclusion was based on their permanent employment as workers at the respective health centres. There were instances where some nurses or doctors from other areas such as Mitchells Plain were posted to the health centres under review for a few days, as a relief measure. This category of health professional was excluded from the population sample. Data were collected until data saturation occurred (Creswell, 2013). As a tool of qualitative research, saturation was used to indicate that, on the basis of the collected or analysed data, any subsequent data collection and/or analysis was not necessary (Saunders, Sim, Kingstone, Baker, Waterfield, Bartlam & Jinks, 2018). As such, similarities in the answers that parents, doctors and nurses offered at each centre were used as a yardstick to indicate that there was no need to collect any more data.
4.5.2 Pilot study

A pilot study refers to an initial assessment of the interview schedule, as a mode of testing and confirming the veracity of the instrument (De Vos, et al., 2011). A pilot study was done by testing the instrument on a small group of participants from the target population. The interview schedules were pre-tested on two parents and a doctor and a nurse who did not form part of the main study (Saunders, Lewis & Thornbill, 2009). The pilot study was valuable as it assisted the researcher to identify vague items in the interview schedule and improve these so that questions offered clarity for participants in the main study. After the pilot study, questions were refine and corrected by removing some, and moving and merging some others.

4.5.3 Data collection

Data were collected using semi-structured interviews, which are semi-directive interviews that helped the interviewer to maintain the focus of the intended study (Neuman, 2011). The semi-structured interview guide was designed to use open-ended questions to allow participants to give in-depth information by elaborating more on the study topic (Creswell, 2013; Neuman, 2011). The researcher followed a particular format in developing interview guides (O'Reilly & Dogra, 2016). All the question were structured in a manner that required the participant’s opinion other than hearsay answers. All the question were open-ended to enable the researcher to allow the participants to offer rich data arising from their understanding of the questions put to them.

Data collection commenced after seeking permission from the Senate Research and Ethics Committee of the University of the Western Cape, as well as the management of the community.
health centres. Participants were informed about the nature of the study by the researcher before they participated. Participants signed a consent form (see Appendix B) to indicate their willingness and voluntary participation in the study. Participants were also informed about confidentiality (their personal details not to be made available and codes to be used to identify them), anonymity and that their participation was voluntary and, if they feel uncomfortable in continuing to participate, they were free to withdraw without any repercussions on them. Permission was also sought for audio-recording interviews to maintain data authenticity, without distractions and memory lapses that occur with taking notes (Markle, West & Rich, 2011). Interviews were conducted in English, and a translator was used where participants preferred a local language.

4.5.3.1 Individual interviews sessions

Interviews in explorative research allow the researcher to achieve valuable, personalised information (Hancock & Algozzine, 2016). A successful interview hinges on the researcher’s identification of key participants with knowledge and opinions that are vital to the study. The researcher was introduced to the social worker at each health centre. The social worker assisted the researcher to identify parents who had come to the centre as well as introducing the researcher to medical personnel for the purpose of conducting the present research, which helped the researcher to speak to these parents to establish if they fell within the inclusion criteria for the selection of participants for the study. Thereafter, if the parent or medical professional met the criteria set by the researcher, they would be informed about the research. This step was followed by obtaining their consent and subsequently conducting interviews (Saunders, et al., 2009).
The researcher was able to obtain a suitable room at each health centre, which was conducive and comfortable for the participants during the interviews. Privacy in the course of interviews was beneficial in ensuring that participants answered questions to the best of their ability, with minimum distractions (Hancock & Algozzine, 2016). The interview room was quiet, and it was established that this quiet environment enabled participants to answer questions easily.

The researcher used an interpreter in the course of obtaining data from the participants. This is because she needed someone who had a higher degree of fluency in English. According to Berman and Tyyskä (2011), the interpreter is key to dealing with issues of ambiguities in interpreted content that the main researcher may let pass like assumptions and similarities. As such, the use of an interpreter averted all these risks. To ensure that the interpreter was not a potential risk for the results, the researcher ensured that she also listened to the recorded transcripts to ensure that they correspond with the interpretations given.

Open-ended questions were asked one at a time, thereby giving time to respond. In addition, the researcher gave participants extra time to talk and tell their stories. The interview schedule was arranged so that sensitive questions were asked at the end, to allow openness and trust to develop. In addition, the interviewer requested extra information and clarity on points that seemed unclear. Most interviews were concluded within the agreed reasonable times (45–70 minutes) and participants were asked whether there was anything else important that should be included. The researcher maintained a level of communication that kept the interview active as it extended beyond the simplicity of recording answers and enhancing the quality of the data that were collected (O'Rourke, Crowley, Eigenbrode & Wulfhorst, 2013). During interviews, the researcher adhered to these communication techniques as a way of staying active. She
maintained active listening coupled with minimal verbal responses, which minimised interruptions in the participants’ story flow. Audio recording enhanced the efficiency of the data collection because it minimised breaks in the information flow to the researcher (Gale, Heath, Cameron, Rashid & Redwood, 2013). In addition, field notes were instructive in helping the researcher observe the physical expressions of participants in the course of providing offering data (Johnson, Douglas, Bigby & Iacono, 2011). The collection of data reached saturation when participants exhausted the information that they had to offer to the researcher and no new information emerged (Fusch & Ness, 2015).

At the end of each session, the researcher downloaded the audio-recorded interview onto a computer, which was password protected, for confidentiality purposes. After the interviews, the researcher transcribed them (Stuckey, 2014). It was important to transcribe data and write up field notes soon after data collection to enable the researcher not to miss nuanced aspects of the research (Anderson, 2010).

4.5.3.2 Field notes

Field notes, which are minutes taken while observing behaviour and activities at the research site (Creswell, 2009), enabled the researcher to describe participants through a record of non-verbal cues about them in the course of interviews, by the observation of their attitudes, perceptions and feelings (De Vos, et al., 2011). The researcher used the services of a research assistant who was attentive during the interviews, to take field notes. There were instructive in the detection of the reactions of participants, and documentation of these points after each session. These notes were also instructive in the course of analysis and interpretation of data.
4.6 Data analysis

Data analysis, which is the converting of collected data into findings (De Vos et al., 2011), was done through thematic analysis where data were analysed and assembled in a meaningful and comprehensive manner (Terre Blanche & Kerry, 2001).

The five steps of Terre Blanche and Kerry (2001) were used to analyse the data:

1. Firstly, the researcher familiarised herself with the data by immersing herself in it and reading it over and over again to help her to understand the content and get to know it better.

2. Secondly, the researcher took notes on the transcribed data to enable her to identify key features such as dominant themes, in relation to the research question; this helped the researcher to ensure that the answers she looked for in the transcriptions aligned with the research questions.

3. The third step involved the coding of data. This is synonymous with the concept of coding or breaking up data into manageable pieces that create a source for understanding and clustering the pieces by factors or reasons or codes that make them stand out. This step enables the researcher to understand data in a better and more logical manner.

4. Fourthly, the researcher elaborated on the themes by exploring them and noting how they related to the overall research. Thus, the researcher was able to explain key themes from the data that had been collected.

5. The fifth step was to interpret and check data to enhance the researcher’s understanding and inspection of the data. The interpretation was based on the ability of the data to answer the research question, and engage with the relevant literature and theory that guided the research.
4.7 Data verification and trustworthiness

The concept of trustworthiness in qualitative analysis revolved around issues of truth-value, applicability, consistency and neutrality in the course of carrying out the research (Neuman, 2011). Trustworthiness was important to ensure that the research undertaken be measured against the ability to generalise it to other settings, and make it reliable, valid and objective. In the present research, trustworthiness was assessed according to credibility, transferability, dependability and conformability (Given, 2008).

**Credibility**, which is the extent to which a research account is believable and appropriate, with particular reference to the level of agreement between participants and the researcher (Mills, Durepos, & Wiebe, 2010), was maintained by accurately reflecting the information as provided by the participants (Given, 2008). To achieve credibility, researchers have to inculcate confidence in the 'truth' of their findings. The first step to achieving credibility required the adopting of research methods that were well established in qualitative research. The researcher achieved this by using semi-structured interviews (Creswell, 2013; Neuman, 2011), audio-
recording (Sutton & Austin, 2015) and a data analysis method of Terre Blanche and Kerry (2001) that had clear, illustrated guidelines on data analysis. Accordingly, explanations that the researcher offered to participants was a basis or guide that informed the use of the semi-structured interviews, audio-recording and data analysis. Furthermore, the researcher prolonged her engagement with the two research settings by spending a long period at the centre to gain a better understanding for the reasons that parents gave for bringing their children to the health centres. By speaking to parents, the healthcare professionals helped to develop rapport between the researcher and the participants (Creswell, 2013) which facilitated the researcher’s understanding of PHC from the perspective of parents on the one hand, and medical professionals on the other.

Transferability refers to the likelihood that the same research findings could be applied to other participants in similar circumstances or be transferred to other contexts. To achieve transferability, the researcher focuses on how closely participants are linked to the context being studied, and the contextual boundaries of the findings (Given, 2008). To achieve transferability, the present researcher established that participant parents and medical professionals were linked to the context of offering children PHC. While the former offered it before the child was brought to a hospital, the latter performed it and gave advice on primary health at the hospital. Thus, in a similar setting where parents or medical professionals offer PHC, the findings of the present study could be transferred to geographical settings other than Athlone. This follows the reasoning that a context can refer to people of similar characteristics in another research setting (Davies & McKenzie, 2004). In addition, the researcher offered a thick description by giving a detailed account of her experiences in the research setting as well as how participants engaged with the topic (Wagner, Lukassen & Mahlendorf, 2010).
**Dependability** as a concept indicates that the findings of a research are consistent and could be repeated (Given, 2008). To achieve dependability, the researcher engaged the use of external audits, whereby a researcher or her supervisor who was not involved in the research process, scrutinised the process and the findings (Akkerman, Admiraal, Brekelmans & Oost, 2008). This scrutiny ensured that the findings were an accurate depiction of the study as far as they were supported by the data. The researcher’s supervisor offered objective and constructive criticism, which informed the researcher’s findings arising from analysis of the data.

**Conformability** refers to the extent to which the findings of a study are shaped by the respondents, and not by researcher bias, motivation or interest (De Vos et al, 2011). This concept was applied to ensure that the researcher maintained a neutral position by respecting participants’ opinions, other than labelling or influencing their views (De Vos et al, 2011). To achieve conformability, the researcher used an external audit where a researcher who was not involved in conducting the research examined the process and findings of the research study (Akkerman et al., 2008). The researcher used her supervisor to scrutinise the process and the findings of the research. In addition, the researcher reminded herself of her position as a third-party observer who took a deliberate decision not to be influenced or allow bias to inform the findings.

### 4.8 Ethical considerations

Regarding permission, the researcher obtained approval to carry out the study in the research settings in Athlone from the University of Western Cape’s Senate Research Committee (ethical clearance letter: Appendix A). The researcher also gained permission from the health centres to conduct research there. The participants participated after they were informed of the study (information sheet: Appendix B). All adult participants signed consent forms to show their
willingness to take part in the research (Consent form: Appendix C). In addition, the signatures on the informed consent forms is a mode of accountability by the researcher to the university that she had explained the need for informed consent to the participants. Permission to audio record was obtained to ensure that the answers given would be captured verbatim (De Vos et al., 2011). Research participants were informed that participation was voluntary and that they had the right to withdraw from the study at any point (De Vos, et al., 2011). The researcher assured participants that all information provided by them would be treated sensitively and confidentially, and she ensured that research participants remained anonymous to all who would encounter their information. Participants were assured that their identity would not be made known to any third parties by the researcher before, during and after the process of data collection and analysis (De Vos et al., 2011). To ensure further anonymity, each interview was transferred to the researcher’s personal computer where it was stored in a password-protected folder, with the password known only to the researcher. Significant codes were used to identify participants’ interviews. It was anticipated that respondents were likely to experience stress during the interviews (Creswell, 2013). Debriefing support was organised through the social workers who were also counsellors and who were willing to counsel participants affected by the study. No harmful or deceitful acts were directed to participants in the study.

4.9 Limitations of the study

The limitations of the study were issues that the researcher could not regulate; these included flaws and situations beyond the researcher’s control that placed constraints on the research methodology and conclusions (De Vos, et al., 2011). While the study was aimed at exploring families’ provision of PHC to children, its findings did not represent the general perceptions of families, health centres or the university. The study was not a reflection of the nationwide provision of PHC by families to children because it was limited to Athlone.
The use of the English language in asking questions and receiving answers was a limitation. The researcher resolved this by engaging an interpreter who also doubled as a research assistant, who was able to ask questions and write answers in English (Creswell, 2013).

4.10 Conclusion

The present chapter presents the methodology adopted for the study and explains the research processes employed throughout the study. The methodology of the research is important as it helped to place emphasis on systematic ways of providing answers to research questions and attending to the research problem. The chapter offers a detailed elucidation of the research approach, method and design. Sampling techniques, data collection methods, data analysis processes and a statement of ethics that guided the conduct of the research are discussed. The research results are presented and discussed in the next chapter.
CHAPTER 5
PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

5.1 Introduction
The current chapter presents and discusses the findings of this study, which explored the attitudes, and perceptions of the role of families in providing PHC to their children in selected community health centres. The research adopted a qualitative methodological approach to collect data. Terre Blanche and Kerry’s (2001) thematic analysis was used to analyse the data to establish the existence of trends that presented themes and sub-themes. The aim of the study was guided by the following objectives:

- to explore the roles of families in providing PHC to their children
- to explore the experiences of parents regarding their role in providing PHC to their children
- to explore health professionals’ role towards families in providing PHC.

5.2 Demographic data of participants
Demographic data were used to provide the background to understanding the types of participants and their points of reference relating to their perceptions and experiences. A narrative of the demographic information of parents and healthcare professionals, are depicted in Table 1.

The analysis of demographics is important in determining the generalisability of research findings, disaggregation on grounds of gender, and to ensure that number of participants is sufficient to offer adequate information as a methodological strength (Underwood, Ehrenreich, More, Solis & Brinkley; 2015).

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<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Language</th>
<th>Ethnicity</th>
<th>No. of children</th>
<th>Level of education</th>
<th>Employment</th>
<th>Years of experience</th>
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<td>Doctor</td>
<td>5</td>
</tr>
<tr>
<td>Dr 2</td>
<td>M</td>
<td>57</td>
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</table>
5.2.1 Age range
The participants who took part in the study were between the ages of 25 and 55 years.

5.2.2 Language
All 20 participants used English as the language of communication. This was helpful in ensuring that the researcher did not have to obtain an interpreter for other languages including English.

5.2.3 Gender
The participants comprised 14 women and six men. Parents comprised seven women and three men. The health professionals included three female doctors and one male. The nurses comprised an equal distribution of three male and three female nurses.

5.2.4 Ethnicity
The participants comprised one white, 10 African and nine coloured people respectively.

5.2.5 Work experience of participants
The participants included 10 health professionals and 10 parents. Within the cohort of health professionals, it was evident that nurses had more years of experience in providing PHC. This was in contrast with the doctors, who had fewer years of experience. While 1 doctor had 30 years of experience (DR2), the others varied from 8 years (DR3) and 6 years (DR4), to 5 years (DR1) respectively.

5.2.6 Education of participants
The participants attained various levels of education. All the doctors had both a degree and a master’s degree. All the nurses had a diploma in either nursing, midwifery and/or clinical nursing.
Parents had a grade 12 certificate up to a master’s degree. The other 6 parents had a grade sufficient for communicating and articulating issues.

5.2.7 Employment

Of the health professionals, four were employed as doctors and six as nurses. Of the parents, six were gainfully employed in various capacities. Three of the remaining parents were housewives and 1 was a postgraduate student.

5.2.8 Children

Of all the parents, only two parents had four children, with other parents having less than four children.

5.3 Presentation and discussion of findings

The findings as presented below emerged from the data that were analysed from the transcribed semi-structured interviews and field notes. Three themes evident from the discussions were: providing PHC, experiences and challenges in providing PHC, and health professionals’ roles towards families in providing PHC. The themes and subthemes are presented in Table 2. The results are presented by the use of participants’ direct quotes from the transcribed data. The literature review and theoretical framework were used to substantiate or negate the findings as per the data collected.

The themes and sub-themes that emerged from analysed, transcribed, collected data are tabulated below.

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Table 2: Themes and sub-themes

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5.3.1 **Theme 1: Providing PHC**

The study findings showed that parents had various understanding of the concept of providing PHC; this was clear in the manner in which they explained their appreciation of the concept in the way that it addressed PHC. Engagement with the two sub-themes indicated that parents and health professionals had different understandings of the concept. Therefore, the researcher used the sub-themes that dealt with the key theme. The two sub-themes were constantly evident in the study, across the parental and the health professional divide.

5.3.1.1 **Sub-theme 1.1: Parents’ role in providing PHC**

Lévesque et al., (2014) indicate that PHC is a healthcare system that is useful in preventing illness, providing health and achieving equitable universal care for children, but requires family participation. In addition, Aigbiremolen et al., (2014) view it as a grassroots service which acts as
a frontline of the healthcare system in providing the family with an opportunity to ensure the health of its members. This definition does not offer a subjective qualification of the term ‘grassroot’. However, a look at the two definitions reveals that the family acts as the first point of contact for the child before a hospital or health centre is engaged. This point matches the qualification of PHC as a grassroot management approach to providing healthcare services to communities, where the service starts at the family, as the most basic level (Aigbiremolen et al., 2014). Østergaard, Bjertrup and Samuelsen (2016) reiterated this position by stating that the family should offer solutions to sick children to avoid frequent hospital visits. It must be repeated that PHC refers to help offered to a child before they are taken to a hospital.

It is against this definition that the researcher sought to establish the meaning of this concept from parents and healthcare professionals. Regarding parents, PHC indicates that parents have to take steps to prevent the escalation of illnesses among children. Parents had various responses to their understanding of PHC. Some parents understood it as a response to a child’s illness before taking them to hospital. Regarding this position, one participant said:

‘Healthcare for children means the remedies that a parent can give to a child from home before coming to hospital.’ (PRT 1)

Another participant alluded to this by stating that it involves:

‘Giving them help at home before [one] brings them to hospital.’ (PRT 3)

Another participant corroborated this position when he referred to PHC as:
‘… the ability to look after the children before taking them to hospital.’ (PRT 5)

Another participant reiterated this position by stating that PHC:

‘... is the service that you get from the clinics that starts at home depending on the requirement to the child.’ (PRT 7)

According to another participant, PHC was:

‘... the first treatment that a parent gives to a child before going to hospital.’ (PRT 8)

These definitions point to the essentiality of PHC as defined by the World Health Organization (WHO) as what is socially accepted as basic treatment for children before taking them to hospital through family and community participation (WHO, 2017). While this definition alludes to essential health as a key component in PHC, it requires that it be based on practical, scientific and socially acceptable methods. Within the bounds of the HBM, these definitions and the responses from participants show that PHC is a health strategy that requires the family to pursue health gains through remedial solutions used by the parents (Dookie & Singh, 2012).

One participant conflated the role of providing first aid with PHC. According to participant 6, PHC was:

‘about offering emergency treatment to children at home and in hospital. It’s about when you need to help your baby in emergency treatment.’ (PRT 6)
This quote indicated that if the situation of a child was not life threatening, then one had to provide PHC. This position failed to consider Levesque et al.’s (2013) definition of PHC as a healthcare system that is useful in preventing illness, providing health and achieving equitable universal care for children, but requiring family participation. This definition shows that PHC is not limited to emergencies, but that it is an obligation of parents towards ill children. However, PHC alludes to remedial solutions that a parent provides to a child prior to taking them to hospital (Sen, Al-Faisal & AlSaleh, 2012). The position of the participant above towards first aid, however, alludes to the family’s role in providing a crucial emergency service where the life of a child is at risk (UNICEF, 2009).

Some participants did not understand the concept of PHC, as indicated by the following quote:

‘… is everything that makes a child OK, less aggressive. Not only when a child is sick.’ (PRT 2)

This quote showed a lack of understanding of the role of PHC. It indicated that anything that a parent did for the betterment of a child’s well-being was PHC. This view shows that anything that makes a child OK or fine according to the parent is PHC. It is also evident of a vague understanding of the context of PHC and parents did not have clear views on the scope of the concept. Furthermore, there was a lack of appreciation of PHC as a grassroot management approach to providing healthcare services to communities, where the service originates from the family as the most basic level (Aigbiremolen et al., 2014). A strong, accessible PHC system is instructive in
helping the community to understand their own lives, from a family perspective, thus preventing frequent hospital visits (Bronwyn et al., 2011).

The essence of PHC for children is to protect lives and deliver cost-effective care. The PHC influence has been growing ever since researchers were able to distinguish the family’s role in the involvement of primary care from other aspects of the health services delivery system. This evidence shows that PHC helps prevent illness and death, regardless of whether the care is characterised by that of PHC physicians, a relationship with a source of primary care, or receiving important features of primary care (Baicker & Chandra, 2004). These definitions also embrace Sanders, Baum and Benos’ (2011) view that PHC needs to be understood as a concerted effort by family and community to offer treatment to children before they are taken to hospital. Against this definition, parents illuminated an understanding of their roles. One participant gave the opinion that her role as a mother was to:

‘Look after a child when he or she is sick. I do whatever I can do and then I take them to hospital when I fail. Like my child bumped her head and did not tell me. She threw up and then I asked her. Took her to Red Cross and told them she bumped her head.’

(PRT 4)

In the same vein, another parent stated that:

‘I have a role to play and it starts with me before it goes to the clinic. For instance, if she has a temperature, I give Panado before we go to the clinic.’ (PRT 7)
The above points to a remedial solution that was given as a way of enhancing PHC; this was further illuminated by a parent who stated:

‘I have a role to play in giving the first line of treatment to my children.’ (PRT 8)

A parent state the following reason for the remedial solution:

‘Yes, I think so because when you are with kids, they may fall sick at night. So you need to do something before taking the child for that moment before you take them to the doctor.’ (PRT 10)

The recognition of the role of offering help before taking a child to hospital indicated that these parents understood their role in offering PHC, which covers the gap in the literature that indicates the need for the use of PHC as a tool that provides an enabling environment for children to grow and develop in (Berger & Font, 2015). In addition, this approach is in line with the literature that families should be directly involved in efforts to promote child health through remedial solutions (Gruber & Haldeman, 2009). The parent who offers relief, such as fever syrup, is in line with a family’s creativity and ability to provide remedies that improve an individual’s health before medical attention is sought (Blumenthal & DiClemente, 2013).

Other parents, however, did not recognise this role. They held the position that help had to be by taking children to hospital once they presented signs of illness.
‘A parent has a great role to play. You have to take the child to hospital. You must go to hospital because at times a flu is not a flu. You go to hospital and then you are helped from there. You help by taking to hospital.’ (PRT 5)

The point of departure in the above participant’s understanding of her role was in simply taking the child to hospital other than offering a remedial solution to the child. This stance was repeated by another participant who stated:

‘I have a role to take the very young to the hospital or to help older children to give some kind of medication.’ (PRT 6)

These findings run against the literature as they indicate a lack of, and a need by the family to acquire, adequate information on how to look after children who may be ill (Faruqi et al., 2015). In addition, the findings do not qualify the reasons for failure by the parent to offer PHC on account reasons such as travel distance, work demands or lack of knowledge of the required care (Faruqi et al., 2015).

Regarding the theory perspective, the parents’ provision of or failure to offer PHC to children before taking them to hospital shows a confused understanding of PHC. In contrast with the HBM’s requirement that perceived seriousness of the disease should impel one to get help, the findings indicate that help need not only come from hospitals but also from the home as well (Dookie & Singh, 2012). The point of departure lies largely in the lack of a uniform appreciation
and application of the role of PHC by parents. As such, the parents’ action of offering the first line of treatment points to their attempt to prevent a given occurrence if they believe that the possible negative effects resulting from having the disease can lead to serious consequences (Orji et al., 2012). In addition, parents need to be in a position that enables them to appreciate the benefits of using PHC. While this seems to be an unconventional way of applying the HBM, it indicates that PHC is a perceived benefit that accrues out of an appreciation that its use counters the seriousness of the disease (Orji et al., 2012).

As shown above, parents are expected to be involved in PHC but they do not always have a uniform understanding of the concept. It is, however, yet to be seen how health professionals’ views on PHC can improve this situation.

5.3.1.2 Sub-theme 1.2: Health professionals’ views on providing PHC

Health professionals had varying definitions for PHC. One participant stated:

‘This is the initial care done at the most basic level for a patient to stabilise the patient and then refer if you are not able to deal with a patient at another level. If you are the first contact, you can provide. If you are not able, then refer.’ (DR1)

He further distinguished PHC from first aid by qualifying the latter as:
‘... an emergency for life while PHC is general things that are not life-threatening.’
(DR1)

Another participant stated that PHC is:

‘Essential health that refers to care of children, adults, at the community level, which is affordable to the community. It is more comprehensive than first aid and requires a high level of training.’(DR2)

These two definitions show that PHC has to be given at a time when care is given as soon as an individual’s situation requires it, and indicates that PHC is qualified by its essential nature. This view, however, has to be balance against the ability of the person providing PHC to be able to establish if the help that is being given is of a general or specific nature (Shi, 2012).

Another participant contextualised PHC as primary, secondary and tertiary health care. She stated:

‘We have primary, secondary and tertiary health. PHC is where the parent goes to sees a nurse or a doctor and engages at a first level. It’s only when we fail to manage at the primary level that we refer to a secondary level, which may refer to the tertiary level. PHC deals with minor ailments and emergencies as they arise. It is the first door to the community before sending to the secondary or other levels.’ (NSE5)

Some participants, however, conflated it with first aid. One stated that:

‘PHC is first aid, starts at home. It is all about preventing and treating. At hospital, it is an extended version of PHC. We see patients coming from the local units.’ (NSE4)
The above view showed a failure to distinguish PHC from first aid; this lack of clarity extended to the concept of primary health in terms of the place and its proximity to the place where it is offered. Literature distinguishes first aid from PHC; according to Hasson et al., (2000), first aid refers to the help given to a person experiencing sudden illness or injury with the aim to save life, or prevent the condition from worsening, or to promote recovery. The connection with PHC is that first aid, too, is given before a patient is forwarded to a health professional (Hasson et al., 2000). The point of departure is the concept of emergency with regard to first aid, and the concept of essentiality with regard to PHC (Levesque et al., 2013). Where the two concepts meet, it indicates that first aid has been offered as a form of PHC.

A participant added that PHC is the initial intervention in a serious condition prior to professional medical help becoming available. In this regard, another participant stated that PHC:

‘... is the care closest to home for the whole family in all aspects. In Cape Town, it is supposed to be in every 5 km radius and addresses maternal health, child health etc.’ (DR3)

This was evident when another participant referred to PHC as:

‘... the care that is accessible to people usually where they are or close. It is where a person walks in and can get care immediately.’ (NSE6)

Further contextualisation was evident with the qualification of who was supposed to offer it. One participant referred to PHC as:
‘… the first contact by a health professional like a nurse. Most parents go to a clinic before coming to the hospital. She comes directly from school direct. So the person who has seen the child as the point of first contact with regard to PHC.’ (DR 4)

Some health professionals attributed their lack of information on what first aid as follows:

‘Where I see a child, I don’t clearly understand it. I can’t answer it because I don’t know.’

(NSE3)

These viewpoints by health professionals illustrate three positions. First, one group understands what PHC is in terms of time and place and distinguishes it from first aid. The second group conflates PHC with first aid, while the third group does not present any understanding of PHC. In relation to the literature, the perception by the first group matched the definitions by Levesque et al., (2013) and Aigbiremolen et al.’s (2014) perception of PHC as a grassroot approach from the family to hospitals and health centres. The second group connoted a high level of skill with PHC, which required only health professionals to provide it other than parents. The third group illustrate a lack of understanding of PHC and also points to a lack of understanding of primary care by some healthcare professionals. Dookie and Singh (2012) state that a poor understanding of PHC creates unrealistic expectations in service delivery and health outcomes, and thus places a barrier in the provision, implementation and sustainability of health services, which indicates that there should a consistent understanding of the concept of PHC by professionals.
To a great extent, the cumulative effect of the definitions points to the need for the family to get involved in an understanding, as well as use, of PHC (Shivalli et al., 2015). With regard to the theoretical underpinnings, this position also reiterated the tenets of the HBM which indicated that the underlying concept of the original HBM was that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Buldeo & Gilbert, 2015). According to one doctor:

‘Parents are not equipped with knowledge. They just run in and think everything is an emergency.’ (DR1)

Another doctor stated that the nature of care that parents offer a child:

‘...depends on the level of understanding and education of the parents to apply basic things and remedies. Some parents are knowledgeable, like adding salt and sugar to water.’ (DR2)

The views from these two participants indicate that an appreciation of the child’s condition informs the parents’ appreciation of the seriousness, susceptibility and benefits of a child’s condition, and determines the level of reaction from the parents based on the knowledge they have (Chen et al., 2007). Therefore the education or teaching disseminated by health professionals enables parents to appreciate that children are susceptible to other complications if PHC is not administered as soon as possible.

In conclusion, the provision of PHC is dependent on the parents’ role and the health professionals’ views in providing it. The parents’ role hinges on their understanding of PHC, first aid and the
various remedial actions to offer children before taking them to hospital. Health professionals’ views inform the parents’ subsequent actions in offering PHC as a result of initial visits to hospital. The major problem is the lack of a consistent understanding or explanation of PHC by medical professionals to families.

5.3.2 Theme 2: Experiences and challenges in providing PHC

The findings from the present study showed that the various modes of engagement between parents and health professionals indicated an understanding of the role of PHC. This role stemmed from their understanding of PHC as a concept. It follows, therefore, that the use of PHC by parents was based on their initial and subsequent understanding coupled with the knowledge that they received from health professionals at hospitals. The findings on this theme were categorised into two sub-themes, of the parents’ and the healthcare professionals’ experience and challenges with PHC.

5.3.2.1 Sub-theme 2.1: Parents’ experiences and challenges

The findings show that parents had various experiences with the provision of PHC. Some families, however, displayed a lack of adequate information on PHC skills for use on children, coupled with an inadequate support system of friends and extended family. One parent stated:

‘I use my common sense, I get it from the clinics. I think as a parent you must know your child.’ (PRT 9)

This answer pointed to the possibility of doing tasks without obtaining advice on how to do them, as long as the remedial action offered some kind of substantive relief.
Another participant stated:

‘I don't know how to use on babies and as a result, I fear to use them. So I prefer to go to hospital after doing what I can.’ (PRT 7)

This position showed a lack of knowledge and a decision to take the child to hospital as soon as they were noted to be unwell. This parent also mentioned that she and her kinfolk were from another country and thus could not obtain information easily. This behaviour is in line with the literature which states that when families or parents have basic knowledge about the symptoms of a child’s sickness, they may consult a health officer (Sweeney et al., 2012). This adds voice to the position that the family’s role is a preventive measure.

With regard to experiences, parents indicated that they had various sources for the mode of applying PHC to children. One participant said that he depended on the experiences of other individuals to guide his own approach to PHC. He stated:

‘Families may get more knowledge and information from the seeing of other people, clients. You listen to their problems, especially when at work. You listen to what they say, like about drugs and learn. There is some knowledge you can get from work experience. I learn from others.’ (PRT1)

Leslie, Mehus, Hawkins, Boat, McCabe, Barkin and Brown (2016) state that the parents’ potential of providing help to children lies in integrating them into the use of PHC in home settings, through receiving advice from other parents or other adults who are raising children. The above participant
learned to do more complex PHC such as using breathing equipment at home for the child because she had asthma. He stated:

‘I know that other parents always rush to take a child to hospital who are much eager to do so without giving assistance. I always believe I can do it. My child has asthma as the serious health issue. What I did was to get an oxygen machine at home which I try to use other than bringing the child to hospital all the time. It saves me time and relief instead of bringing her to hospital.’ (PRT1)

Furthermore, Leslie, Mehus, Hawkins, Boat, McCabe, Barkin & Brown, (2016) assert that parental intervention as a way of offering care in the family setting is key to solving serious health conditions in the future that arise out of failure to offer PHC at the family level.

For other parents, their experiences are shaped by the adoption and use of remedial solutions that they use for PHC. One participant stated:

‘They do not want to take the child to hospital soon. Others hit their children. Others swear at their children. Before taking them to hospital, some love them, give medicine, put them in a bath if they have a fever. If the child is not improving, take the child to hospital.’ (PRT 2)

Another participant said that she was able to establish when a child was not well, use cues as a mode of applying remedial solutions. She stated:
‘I can see from the nagging, crying, the eyes are dilated and I know that there is something wrong. I usually buy Panado and Allergex, then I give them. I buy Vicks and put it under their feet to help. Sometimes I have to force them to open the mouth and they must drink it.’ (P3)

In this regard, Aluka, Gyuse, Udonwa, Asibong, Meremikwu and Oyo-Ita (2013) are of the view that the use of remedial actions such as cold water sponging or taking Panado is safe, and parents should be encouraged to take children to the nearest health centre. Health professionals are required to educate parents on the need to measure the temperature of a child to ascertain that there is a fever, so that remedial action may be taken (Green, Jeena, Kotze, Lewis, Webb & Wells (2013). This position concretises the concept of susceptibility of a disease as a factor that shows parents the need to use PHC before the risk associated with a child’s condition is exacerbated (de Wit, Vet, Schutten & van Steenbergen, 2005).

The first challenge that was clear from the interviews was that parents do not have the requisite knowledge regarding remedial solutions. Thus, they are not in a position to engage the possible solutions to a presenting problem. One participant stated:

‘Parents are not equipped with knowledge. They just run in and think everything is an emergency.’(DR1)

Another participant who was creative, indicated that she would get an opinion from a friend who was a medical professional before she went to a medical facility. She stated:
‘We don’t have a sick fund. I use a professional approach with a doctor who is a friend for a second opinion before I bring the child to hospital.’ (PRT1)

Adeniyi, Yogeswaran, Wright and Longo-Mbenza (2015) say that lack of knowledge affects the control of diseases in families in rural communities – a situation that is exacerbated by the use of inaccurate information from friends and family members. This leads to irresponsibility of parents about offering PHC to children and is a major challenge, especially when they do not want to learn to use remedial solutions to help their children before taking them to hospital. This observation is premised on the fact that some of the presenting symptoms in children required only a home-made remedy for a cure, other than rushing to hospital under the pretext of an emergency. When asked about the failure by parents to offer first aid, one parent stated:

‘Some [parents] are just irresponsible.’ (PRT 2)

It is submitted that a lack of knowledge leads to irresponsibility on the part of parents. In addition, gender masculinities affect the provision of PHC in families where the man indicates that the provision of PHC in families is a preserve of the mother. This behaviour creates a challenge to the use of PHC, propagated by men and acquiesced to by women. Consequently, while male parents stated that the female counterparts were best placed to offer PHC, the women reiterated that as mothers, it was their duty to offer PHC to children. Some parents still believe that it is the position of the mother to ensure that the child receives adequate PHC. One father retorted:

‘[My wife] is better placed to help with the children. It is her role.’ (PTC 6)
He hastened to add:

‘It is a challenge. As a father, I do play a minimum role and most of this falls on the weight of my wife. I offer a supportive role.’ (PTC 6)

A female participant stated:

‘It is my role as a mother to look after a child when he or she is sick. I do whatever I can do and then I take them to hospital when I fail.’ (PTC4)

This position shows that while some male parents confirm that it is a female role, some female parents confirm that it is their role as mothers to offer PHC to their children. This confirms the continued existence of gender masculinities and their role in shaping identities of partners in a relationship and having particular behaviours in parents (Jewkes et al., 2016). Subsequently, most decisions in a family that oscillate around tasks, responsibilities and concerns about PHC are made by women (Adeniyi et al., 2015). The problem with this position is the negative effect it has on the provision of PHC in families (Ncube, 2007). It is worth noting that, of all the participants, it was only one male participant who insisted that it was a female role.

In addition, the study also indicated that the lifestyle of parents was partly to blame for their failure to ensure that PHC was practised at home, e.g. parents’ use of drugs, and the labeling of children. One participant stated:

‘Other parent do drugs and don’t care about their children. This affects the children at school, especially where the children are labelled or called names at
school. Some parents do not care for the child and when the child develops habits, they are scared for the child.’ (PRT 2)

Another participant said that, with regard to lifestyle and caring for children, there was a:

‘…failure to prioritise like having brand clothes but no child health development.’ (DR2)

This statement is in line with literature that suggests that good lifestyle habits and behaviour have a positive effect on individuals’ attitudes towards PHC, a position that extends from families to health centres (AlAteeq & AlArawi, 2014). Therefore, habits such as excessive smoking and drinking should be reduced to a minimum level where they do not affect the provision of PHC in families (Al Hosani, Al Ali, Al-Marashda, Al-Shamsi, Al-Ansari, Al-Behandy, & Elhassan, 2014).

Furthermore, the lack of education on sanitation and feeding was pointed out by one of the parents as the broad concept that related to the appreciation of PHC. A participant who argued for training stated:

‘Workshops should be used where people come and get this information. For example, the toilets in Manenburg, Khayelitsha. The government has to provide the right stuff for the people. It’s a lot of things, beyond the health stuff. The health stuff is the first priority. The problem is that people do not know what to give the children in terms of food.’ (PRT 5)

Some parents alluded to financial problems, which seemed to affect children who fell sick and needed to be admitted and receive specialised treatment. As a result, parents who lacked funds had a huge challenge. One parent stated:
'It has been tough because it was expensive for me because I was not on medical aid, especially with my second-born. I used to pay for ambulances, nebulisers and other things.' (PRT8)

Another participant viewed the matter as follows:

‘As a generalisation, they don’t neglect their children. A good number become hysterical before doing the basic things. Other reasons include poverty that makes it hard for them to access knowledge.’ (DR 2)

These views are in line with literature that shows there is a connection between poverty and PHC insofar as the family has limited access to PHC on account of poverty (Grut, Braathen, Mji & Ingstad, 2012). Thus, poverty and lack of basic knowledge of PHC can prevent the positive effects of PHC. These findings are in line with those of Stear et al., (2011) who stated that financial constraints leave many families unable to provide PHC.

Another challenge was the inability of parents to balance their work and looking after a sick child, which was exacerbated by a lack of social networks to help parents when a child was sick. One participant retorted that it was difficult to balance work and a sick child:

‘It is tough because it affects my focus at work. I can’t go to work when the child is not feeling well. It is tough especially when you have to get a day off and the boss may not understand.’ (PRT 7)

Another participant stated:

‘If the parent is going to work, she should give the child to someone.’ (PRT2)
It is evident that if a parent does not have a support system at work or from social connections, it would be hard to look after their family. This would in turn affect access to healthcare, where the parent is not able to do so because of the barriers (Loignon, Hudon, Goulet, Boyer, De Laat, Fournier & Bush, 2015).

It should be stated that where one is unable to get treatment, the HBM is defeated due to such challenges. Perceived benefits, such as an individual’s subjective view of engaging in a particular healthy behaviour, is a way of avoiding perceived threats (Orji et al., 2012). As families play a critical role in promoting child health and development, it is instructive to evaluate their experiences and challenges (Darling-Churchill & Lippman, 2016). In line with this position, parents believe that they have to give the first line of treatment. One participant stated:

‘I know that other parents always rush to take a child to hospital who are much eager to do so without giving assistance. I always believe I can do it. My child has asthma as the serious health issue. What I did was to get an oxygen machine at home which I try to use other than bringing the child to hospital all the time. It saves me time and relief instead of bringing her to hospital.’ (PRT 1)

Another participant responded that:

‘It is my role as a mother to look after a child when he or she is sick. I do whatever I can do and then I take them to hospital when I fail.’ (PRT 4)

These two positions exemplify Berger and Font’s (2015) illustration of the need to have parental love and care that stems from the physical, mental and social economic continuum. It has to be
noted, however, that the notion of a role or responsibility is best evaluated against the actual inputs that parents make as a way of helping a child before they go to hospital. Some participants engage the challenges of offering specialised PHC by getting medical equipment. Such a participant places her asthmatic child on:

‘… an oxygen machine at home which I try to use other than bringing the child to hospital all the time. It saves me time and relief instead of bringing her to hospital.’ (PRT 1)

This behaviour indicates that some families go ahead and acquire specialised information for children who have chronic illnesses such as asthma (Faruqi et al., 2015). Another parent referred to the specialised information as home remedies. She stated:

‘I give Panado in case of a headache or a temperature. I ensure that they eat fruits a lot to avoid sicknesses like flu.’ (PRT 8)

In relation to the above, another participant stated:

‘I give Panado, I use a thermometer to check the temperature. And I try treating. It is when I can no longer help the child that I take the child to the hospital. I apply a sponge. If it is hot, if it’s a flu I use balm on the back, the chest. If it fails, I go to hospital. If I cannot help the baby, then I take them to the hospital, like if he or she needs an injection.’ (PRT 9)

It is clear from the above that the role that a family plays in the provision of PHC depends on the correct skills that it harnesses to improve the health of an individual before forwarding them to hospital (Nickels, Arvaiza & Valle, 2016). This kind of social support that engages technical, physical and moral support for an ailing member of the family is instructive in showing that
families appreciate offering remedial solutions to their children (Botha & Booysen, 2013). The HBM embraces the family’s role in using PHC as far as this role includes an appreciation that a child is unwell, followed by using remedial solutions to offer relief before going to a health centre or hospital. The point of departure concerns the extent of a parent’s knowledge of remedial solutions for a given ailment (Rosenstock, 1974).

In conclusion, lack of knowledge of PHC, poverty and irresponsible lifestyles all point to challenges that affect the effectiveness of PHC in the home. On this basis, it is imperative to establish the challenges that health professionals and parents face in offering PHC to children.

5.3.2.2 Sub-theme 2.2: Health professionals’ experiences and challenges

Findings relate to health professionals’ experiences which are based on their professional and practical experiences with patients and parents, while the challenges are gaps that they perceive that need to be addressed if the provision of PHC is to improve.

Various challenges are experienced by health professionals in the course of their engagements with parents and patients. These include a lack of appreciation of how to use remedial or home-made solutions, to ailments (Langelier, et al., 2015), which affects families’ coping with the presenting symptoms in children (Carroll & Vickers, 2014). The shortage of medical personnel furthermore affects the time taken to assist patients, who usually have to wait for long periods (Nkosi et al.,
These issues are exacerbated where health professionals lack the requisite experience and training to deal with patients (Nkosi et al., 2009).

Health professionals’ challenges are varied where some posit the existence or the non-existence of neglect. Regarding the existence of neglect, some parents did not offer PHC to their children before taking them to hospital. Some health professionals noticed the failure to provide PHC due to:

‘Undernourished, running nose, sores on the eyes and the physical examination; I just look at the child.’ (NSE 1)

Other areas of neglect include:

‘Poor nutrition, lack of education about healthier choices, failure to prioritise like having brand clothes but no child health development.’ (NSE 2)

The participant feared that such a trend would lead to long-term consequences such as:

‘Instability in growth due to the fact that the child is stunted from a young age, like no food, being from door to door.’ (NSE 1)

These quotes are in line with Keeshin and Dubowitz’ (2013) assertion that neglect exists when a child does not receive necessary healthcare or a mother's depression compromises her ability to provide adequate care for her infant. A problem with this literature, however, is that it is limited to the provision of PHC by the mother only, and secondly, it is linked to her depression. While this
note speaks volumes to the study, it has to be noted that other caregivers (e.g. fathers, grandparents, step-parents or guardians) may also exhibit neglect (Henderson, Stevenson & Teaster, 2009), which indicates a failure by parents to appreciate the dangers that a given health complication presents to the child and the failure to take appropriate steps to prevent it (Green & Murphy, 2014).

Other participants did not envisage neglect but rather indicated a plethora of reasons that relate to circumstances that are not attributed to intentional wrongdoing by the parents. One participant stated:

‘As a generalisation, parents do not provide basic care and they become hysterical before doing the basic things. Other reasons include poverty that makes it hard for them to access knowledge.’ (DR1)

In addition, the other challenge is the lack of human resources to cater for the ever-increasing number of children. One participant stated:

‘Particular challenges especially during after hours, the service lack physical resources to offer support to the inundated numbers.’ (NSE 3)

When asked whether the parents depicted neglect, one participant hastened to state that lack of knowledge was the challenge:

‘Parents are not equipped with knowledge. They just run in and think everything is an emergency. Generally, they just come to the hospital. If the parents were to read, they could tell the child has diarrhoea or the child is dehydrated, they make use of ORS. (DR 1)
Lack of knowledge on how to offer PHC to children is a great challenge. One participant stated:

‘... long-term consequences include deficiencies due to lack of vitamins, malnourishing that lead to chest infections and other sickness.’ (DR 2)

Professionals decry the lack of physical resources in terms of human resources to deal with the large numbers of patients. However, some cope by having a positive attitude towards their work in terms of what they can accomplish each day. The statements below illustrate this matter:

‘Particular challenges especially during after hours, the service lack physical resources to offer support to the inundated numbers.’ (NSE 2) [NSE 3 said the same above.]

‘Although we are few staff, there can never be enough staff for community.’ (NSE 5)

Lack of knowledge was a key issue that prevented the provision of PHC and is in line with the literature that suggests that lack of knowledge affects the ability of parents to offer PHC (Dookie, & Singh, 2012). This concurs with the notion of failure by parents to appreciate the dangers that a given health complication presents to a child and the failure to take appropriate steps to prevent it (Green & Murphy, 2014).
The health professionals to a large extent stated that lack of knowledge leads to parents’ failure to use PHC at home. Most of them were quick to disqualify the claim of lack of knowledge as an inference of ignorance (Chatterjee, Datta & Sriganesh, 2012).

‘It is about the lack of knowledge. I don't think a parent can decide to ignore his or her child. It is basically lack of knowledge by the parents.’ (DR 2)

Another participant stated:

‘I don't think it is neglect of the children necessarily but rather a lack of education to them. For instance, when I tell them something, they say I am the first to say that, like giving Panado for a fever.’ (DR 3)

As a result, the issue of neglect was alluded to by some participants. While this showed that participants appreciated the need for PHC, others pointed to lack of knowledge. According to Mills (2016), it is parents’ lack of knowledge that leads to their failure to engage PHC at home (Mills, 2016). These views add credibility to the perception that lack of knowledge does not necessarily mean ignorance (Chatterjee, Datta & Sriganesh, 2012).

Another participant had the following to say:

‘In the long term, some parents do not neglect, like bringing them for immunisation shot. Something that is small should be dealt with to avoid bigger problems. They don't neglect, but oversimplify things. One instance is where a child had cancer and the parents was concerned with the child taking his medication. At times it is ignorance.’ (DR 4)
While the failure to take a child for immunisation shots arises out of lack of knowledge about the specifics of immunisation, this lack of knowledge extends to other factors such as lack of vaccines, lack of access to immunisation services, attitudes and practices of health professionals and parental beliefs based on the knowledge that they have (Favin et al., 2012). Another participant stated:

‘Sometime you see it as a neglect and at other moments, it is not. For instance, the baby collapses because of low sugar. The first question to ask the mother is whether she feeds the baby. There are mothers who wake up early and rush out then feed the baby for five minutes, which is neglect. At times there are reasons like financial, social problems, work-related problems, frustrations that do not show that there is neglect.’ (NSE 4)

Other participants alluded to emotional challenges, where they faced a challenge in balancing the professional and emotional aspects of their lives. This challenge is in line with the literature regarding health professionals which states that emotional imbalances among parents influence their attitudes and actual provision of PHC at home (Favin et al., 2012). One health professional stated that:

‘For me, I love babies, I deliver babies, so it is one thing. It becomes a challenge when I put more emotions in the way.’ (NSE 4)

Health professionals also identified poverty as a problem in offering PHC, from a medical perspective, as this makes it hard for them to access the benefits of treatment. One participant stated:
‘Some parents can’t afford to come to the hospital. So poverty is the issue. Drugs and alcohol keeps them complacent. At times, the child is in a foster home and as a result it’s out on simple things.’ (DR 4)

Health professionals have indicated that barriers to the responsiveness of parents towards PHC is a challenge that parents face (Bloch, Rozmovits & Giambrone 2011).

In conclusion, lack of education on PHC, lack of physical resources, instances of neglect and gender masculinities have been found to be the main experiences that health professionals have engaged with in their interaction with parents. It is imperative to ascertain the role of the health professionals play in a bid to engage PHC. There is a thin line between experiences and challenges and, as such, challenges involve a lack of appreciation of how to use remedial or home-made solutions for ailments, lack of a coping mechanism to offer parents who have children with chronic ailments, and the large numbers of parents they deal with as a result of insufficient human resources (Langelier, et al., 2015).

5.3.3 Theme 3: Health professional’s role towards families regarding provision of PHC

The role of healthcare professionals in families’ PHC provision is expected to go beyond simple or expected requirements to providing medical assistance when a carer brings a sick child to the health centre. Molepo (2014) alludes to the requirement that health practitioners have to teach families positive and effective coping strategies on how to overcome obstacles and handle the
child’s illness in a way that promotes health for the child and his or her family holistically. This includes the provision of moral and emotional support to a sick child. Various aspects call for the input of medical professionals.

The HBM places health professionals in a position of influence as government employees to disseminate information on PHC to families. This duty is in line with the need to educate parents on the four tenets of HBM which place an individual in a position to appreciate the perceived seriousness and susceptibility of a disease, and the benefits of, as well as the barriers to, receiving treatment (Jones, 2015). A parent’s motive to use a particular remedial solution requires that it is effective in reducing complications that would otherwise arise from the dangers that the child’s ailment presents (Sharma, 2016).

Health professionals are expected to support the provision of clinical care at PHC centres by using this place to optimum levels (Nkosi et al., 2009). PHC has to be limited to the provision of clinical care where PHC would not be adequate for allievating the child’s condition. In turn, this process develops the parent’s ability to develop and use homemade remedies for minor ailments.
Gauged from the research, the provision of coping strategies was, however, limited to physical educational support other than the provision of moral and emotional support. One participant stated:

'We always advise the parents about the use of ORS, a mixture of sugar and salt. Then the mother will be doing this as PHC at home. If it spills out of hand, like a rising temperature, then we advise the parents to bring the children forward.'
(NSE 5)

Another participant stated:

‘There are things that parents have to do first. Most mothers pick up these things, like putting the baby in cold water before the temperature drops, or giving Panado. They depend on the nature of the problem. If a seizure happens, the nurse has to ask for how long it happened, take note of the time, observe what happened, and report to the doctor. The mothers should use home remedies. For diarrhoea, the mother must use ORS to help the baby replace the nutrients lost.’ (NSE 4)

This advice related to the provision of actual skills to parents, to use when children were sick. It did not relate to advising parents on how they should cope emotionally with poor health of their children. Consequently, the results showed that the support of health professionals was limited as far as it did not help parents to cope emotionally. It therefore fell short of the requirement as stipulated by Molepo (2014). Molepo (2014) states that health professionals need to inform parents that if they are emotionally affected, their children are affected as well. This is an indication that parental coping is instructive in ensuring that children are not affected.
In addition, health professionals have a role in educating parents on how to use local remedies when a child is sick, before taking them to hospital (Coote, 2010). Kredo, Adeniyi, Bateganya, & Pienaar, (2014) reiterates the benefit of this education by stating that families that have ongoing contact with mental health professionals are more likely to recover from the crisis and cope with the situation, due to the education received. According to one participant:

‘Treat the child, advise the parent to use lukewarm water and do tepid sponging, give Panado, so I treat and advise.’ (DR 2)

‘You can get that booklet and look at the back, you will get some of the information.’ (DR 1)

This is an indication that the provision of education is part of the routine purpose of health centres, where specific times are dedicated to ways of caring for children. According to Cassel and Guest (2012) educational programmes by health professionals that reiterate health education are instructive in guiding families on how to care for the sick. Health professionals are in a position of influence to provide health education as part of their routine or work schedule (Jones, 2015).

In conclusion, while health professionals reiterated their role in the provision of physical and medical treatment and advice on how parents can do this at home, they did not expound on the role of helping parents to cope with the emotional and moral stresses that come with ill children.
5.4 Conclusion

The present chapter presented and discussed the study’s findings that explored attitudes and perceptions of the role of families in providing PHC to their children at two selected community health centres in Athlone. In doing so, the study illuminated three themes: (1) the provision of PHC; (2) experiences and challenges in providing PHC; and (3) the health professional’s role towards families regarding the provision of PHC. The next chapter presents a conclusion and recommendations regarding the study.
CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The present chapter summarises the study, giving a conclusion to the findings and recommendations. The aim of the study was to explore the role of families in providing PHC to their children at two healthcare centres. The use of a qualitative methodological approach, which according to Yilmaz (2013), is the best method of investigation that describes people’s feelings, opinions, views and beliefs from their own natural environments, guided the pursuit of this aim. The research question was dealt with in Chapter Five, by way of presentation and discussion of the study findings. The conclusions are drawn from the objectives that lead to achieving the aim of the study and the answers to the study’s research question.

The study had three objectives:

1. to explore the roles of families in providing PHC to their children
2. to explore the experiences of parents regarding their role in providing PHC to their children
3. to explore health professionals’ roles towards families regarding the provision of PHC.

The collected data obtained from participants was analysed and led to the development of three themes in Chapter Five. Subsequently, the literature review was used to examine the data, to elaborate, explore, compare and contrast the study findings study. A summary of the chapters in their numerical order follows in the section below.
6.2 Summary of the study

The study summary provides a brief synopsis of the chapters in numerical order.

6.2.1 Chapter 1: Introduction to the study

Chapter One introduced the study and explained the rationale to the study and gave insight into its theoretical framework. The problem statement was presented, along with the research questions, aims and the objectives of the study. The chapter defined the study’s research methodology, the significance of the study, and defined key terms along with the study outline.

6.2.2 Chapter 2: Theoretical framework

The second chapter presented the detailed theoretical framework which guided the study. The HBM was relevant because of its explanation of the importance of families regarding PHC provision.

6.2.3 Chapter 3: Literature review

In Chapter 3, literature on the topic was reviewed that focuses on PHC, the role of the family in providing PHC and the role of PHC professionals. This chapter reviewed available literature on the content of PHC, how it was understood by the family, and what formed this understanding. The chapter also evaluated the role of the family and the limitations that it presented within the context of providing PHC to children.
6.2.4 Chapter 4: Research methodology

Chapter 4 presented the research methodology applied in the study. The areas that were engaged included study design and approach, study population, data collection methods, data analysis, data verification, limitations of the study and ethical considerations.

6.2.5 Chapter 5: Presentation and discussion of findings

Chapter Five presents the themes that emerged regarding the objectives, namely the roles of families in providing PHC to their children; the experiences of parents regarding their role in providing PHC to their children; and health professionals’ roles towards families in the provision of PHC.

6.2.5.1 Theme 1: Providing PHC

The findings from this study showed that both the parents and medical professionals provide PHC. This understanding was evident in the two sub-themes of parents’ and health professionals’ roles in the provision of PHC: PHC by parents and understanding of PHC by health professionals. Thus, while the parents were expected to be involved in PHC, they did not have a uniform understanding of the concept. The parents’ role hinged on their understanding of PHC, first aid and knowledge of the various remedial actions to offer a child before taking them to hospital. Health professionals’ views informed parents’ subsequent actions in offering PHC as a result of their initial visits to hospital. The major problem was the lack of a consistent understanding or explanation of PHC by medical professionals to families.
6.2.5.2 Theme 2: Experiences and challenges in providing PHC

The study findings showed that lack of education about PHC, physical resources, instances of neglect and gender masculinities were key experiences that health professionals experienced in their interaction with parents. There was a fine line between experiences and challenges; the challenges related to lack of appreciation of how to use remedial or home-made solutions to ailments, lack of a coping mechanism to offer parents who have children with chronic ailments, and the large number of parents they dealt with because of insufficient human resources.

6.2.5.3 Theme 3: Health professionals’ roles towards families regarding PHC provision

Health professionals provided education and knowledge on how and when to use PHC. While health professionals reiterated their role in providing physical and medical treatment and advice on how parents can do this at home, they did not expound on the role of helping parents to cope with the emotional and moral stressors that came with ill children.

6.2.6 Chapter 6: Conclusion and recommendations

Lastly, this section of the study presents a conclusion and recommendations about the study. It also gives an overall summary by chapter the study and the limitations that require concurrent attention as a mode of evaluating the study.
6.3 Limitations of the study

The study was impeded by various methodological limitations, which directly and indirectly affected the study outcome. In relation to the study’s findings, the following limitations were observed:

- The biggest problem related to language. The researcher’s first language is Arabic and it thus affected the mode of questioning and the responses. The researcher’s write-ups were in Arabic and had to be translated into English in an academic style, without conflating what she was saying. The use of an interpreter was a sound way of solving the problem, but it did not remove all chances of the effects of conducting research in a foreign language.

- The sample size was small and as such inadequate to enable the researcher to generalise the findings to the entire population. The sample included 10 parents, 4 doctors and 6 nurses from the health centres of Heideveld and Abdulrahman in Athlone, which made it difficult to generalise the findings to the rest of the population. Since all parents classified themselves as either coloured or black, their findings could not be generalised across other racial groups such as whites and Indians. Among the healthcare professionals, there was only one white doctor, which was not sufficient to generalise her findings to the white race. Consequently, the applicability of the findings was limited to the study population.

- The full impact of PHC was not adequately realised as far as the research did not establish the provision of coping strategies for parents who had children with chronic illnesses. The
participants, such as healthcare professionals, did not have a uniform understanding of PHC, despite their training, which was exacerbated by various connotations that medical professionals had about the concept.

### 6.4 Recommendations

The recommendations are grouped into four areas: (1) government, (2) parents, (3) medical practitioners and (4) future research on improving the provision of PHC in South Africa.

#### 6.4.1 Recommendations to government

- The government should ensure that medical centres appreciate the role of PHC as a point of first contact for children who need help with illness or discomfort. This is because some participants did not appreciate the meaning of PHC, which is an indication that lack of knowledge could mean that engagement with the concept is limited.
- The provincial government should design refresher courses for health professionals to ensure that they understand the concepts of PHC. This recommendation is based on the perception that they deal with the public and, as a result, need to be conversant with the advice that they give.
6.4.2. Recommendations for parents

- Parents should not apply gender stereotyping when looking after children as it will lead problems such as gender masculinities which say that only a particular gender may look after sick children. This has to be avoided to ensure that PHC is enjoyed by children, regardless of which parent offers it.

6.4.3. Recommendations to health practitioners

- Action should be undertaken by Departments of Education and Health to ensure that medical personnel appreciate the differences between PHC and first aid; this can aid the quality of advice that they give to the public who seek treatment and advice.

6.4.4. Recommendations for further research

- Studies should be done on other components that affect PHC, such as sanitation and lifestyle. This should be done via empirical studies that address the needs of particular neighbourhoods that struggle with PHC.

- Research on a medical aid system that provides apparatus for PHC in respect of chronic illnesses should be undertaken to ensure that parents who have to provide PHC that requires expensive medical treatment are not prevented by lack of funds. This can be done by carrying out a due diligence study that identifies key issues in offering PHC for chronic illnesses.

- The role of PHC should be re-engaged by establishing how it can be enhanced by dealing with all parents in community mobilisation clinics, to teach mothers and
fathers about taking responsibility in supporting ill children; this will boost the self-esteem of children and parents in the course of giving and receiving PHC.

6.5 Conclusion

The study focused on the role of parents in offering PHC to children. It was noted that a clear understanding of PHC, and an engagement of homemade remedies, were instructive in ensuring that parents were able to offer the former to their children before taking them to hospital. The findings suggest that parents and healthcare workers face various challenges which affect their abilities to deal with providing PHC. Consequently, a more extensive study that engages with a high number of participants of both parents and healthcare professionals should be done to place the results into perspective. It follows that a concerted effort from government, parents, healthcare professionals and other stakeholders is needed to arrive at a prudent and logical improvement of PHC in South Africa.

The HBM theory offers a viable theoretical framework in which the concept of PHC and its effect on the family was explored. In addition, it was also used to add value to the concepts of PHC with regard to understanding roles and challenges.

The findings show that parents had an understanding of the concept, but their role needed an engagement that supported children with chronic illnesses, if the role of parents was to remain viable. It was also established that the challenges had to be tackled to enable parents see the continued relevance of PHC.
REFERENCES


http://etd.uwc.ac.za/


Honjo K, Siegel M. Perceived importance of being thin and smoking initiation among young girls. Tobacco control. 2003(12) 289–295.


http://etd.uwc.ac.za/


http://etd.uwc.ac.za/


http://etd.uwc.ac.za/


http://etd.uwc.ac.za/


APPENDIX 1: INFORMATION SHEET

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Project Title: An exploration of the role of families in providing primary healthcare for children

What is this study about?
This is a research project being conducted by Zadma Bozad at the University of the Western Cape. I am inviting you to participate in this research project because you have expertise and experience in the field. The purpose of this research project is to explore the role of families in providing primary health care to their children.

What will I be asked to do if I agree to participate?
You will be asked to fill in the agreement form for the interview guide and use of audiotape prior to conducting the interview. You will be asked to respond to the interview questions in the way you understand them. The interview will take about 60 minutes. The university day care centre will be used as study site. The questions for the interview are exploring the relationship of parents and teachers interactions with the children and how do their attachment get affected.

Would my participation in this study be kept confidential?
The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, thus your name will not be included for any purpose in this research project. A code will be use to differentiate different transcriptions of participants. Only the researcher will be able to link your identity and will have access to the identification key especially for the information verification. To ensure your confidentiality, the interviews will be copied to a computer immediately afterwards and deleted from the audiotape. The interviews will be kept in the password protected folder which will be known to the researcher only. The transcriptions will be identified with codes and stored in the lockable filing cabinet, personal to the researcher. If we write a report or article about this research project, your identity will be protected to the highest.

What are the risks of this research?
There may be some risks from participating in this research study. The risks may include psychological, social, emotional and legal risks. There might also be risks that are currently unforeseeable as all human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?
This research is not designed to help you personally, but the results may help the investigator learn more about primary health care for children. We hope that, in the future, other people might benefit from this study through improved understanding of child-parent-teacher interactions.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study? All possible precautions will be taken to protect you from experiencing any harm form the research process. If however, you are or feel that you are being negatively affected by this research suitable assistance will be sought for you at University of the Western Cape.

What if I have questions?
This research is being conducted by Zadma Bozad in the Social Work Department at the University of the Western Cape. If you have any questions about the research study itself, please contact me on my cellphone: 0740873984 or add your email address here. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:
Prof. C. Schenck
Dept of Social Work
cschenck@uwc.ac.za
021 9592277

Dean of the Faculty of Community and Health Sciences:
Prof José Frantz
University of the Western Cape

http://etd.uwc.ac.za/
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape’s Senate Research Committee and Ethics Committee.
Title of Research Project: An exploration of the role of families in providing primary healthcare for children

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

I give permission that the interview can be audio recorded.

Participant’s name................................

Participant’s signature................................

Date........................................
APPENDIX 3: INTERVIEW SCHEDULE FOR PROFESSIONALS

INTERVIEW GUIDE: PROFESSIONALS

NB: Ensure written consent form is signed and collected before the interview commences.

Research introduction: This study is conducted in fulfilment for the requirements to obtain a Master’s degree in Child and Family Studies at the University of the Western Cape. The study seeks to find out the role of families in providing primary health care to their children.

Your experiences and suggestions will go a long way to understanding the role of families in providing primary healthcare for children.

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<tr>
<th>Name of organisation</th>
<th>Respondent code #</th>
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<th>Sex:</th>
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<tr>
<th>Previous experience in health care work:</th>
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<th>Qualification:</th>
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<tr>
<th>Length of time working for health department:</th>
<th>Length of time working in this area:</th>
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What do parents do when the child is sick?

How do you know when the child is sick?

How do you respond to your child’s primary health care needs?

What is your experience regarding the provision of primary health care for your children

What is your experience regarding the role in providing primary health care for their families?

What is your understanding of primary health care neglect by parents?

How do parents fail to meet their children’s primary health care needs?

What effects/consequences of this type of neglect are children subjected/exposed to?

What reasons do parents give for neglecting to meet children’s health care needs?
APPENDIX 4: INTERVIEW SCHEDULE FOR PARENTS

INTERVIEW GUIDE: PARENTS

NB: Ensure written consent form is signed and collected before the interview commences.

Research introduction: This study is conducted in fulfilment for the requirements to obtain a Master’s degree in Child and Family Studies at the University of the Western Cape. The study seeks to find out the role of families in providing primary health care to their children.

Your experiences and suggestions will go a long way to understand the role of families in providing primary healthcare for children.

Respondent code ……………………..

Ethnicity…………………………

How many children in family…………………………

Parents educational qualification…………………………

Employment status of parents…………………………

Any history of family violence, substance abuse……………………

Married/cohabiting…………………………

1) Please tell me about your family?

2) What is your understanding of your role to provide health care for your children?
3) What is your role regarding the provision of primary health care?

4) Does lack of knowledge affect parents in providing primary health care for children?

5) How do families get information about primary health care for their children?

6) What do parents do when the child is sick?

7) How do you know when the child is sick?

8) How do you respond to your child’s primary health care needs?

9) What is your experience regarding the provision of primary health care for your children?

10) What is your experience regarding the role in providing primary health care for their families?

Thank you for participating in answering these questions.
APPENDIX 5: ETHICS CLEARANCE

26 April 2017

Mrs Z Bozad
Social Work
Faculty of Community and Health Sciences

Ethics Reference Number: BM17/3/1

Project Title: An exploration of role of families in providing healthcare for children.

Approval Period: 26 April 2017 – 26 April 2018

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms. Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050
APPENDIX 6: LETTER FROM EDITOR

Mrs Z Bozad  
Department of Social Work  
Faculty of Community and Health Sciences  
University of the Western Cape

Dear Mrs Bozad

Thesis entitled: An exploration of the role of families in providing primary healthcare for children

I declare that I have read and edited the above document from the standpoint of grammar, syntax, idiom and punctuation according to the norms of English in the style followed in South Africa, and the style and format generally used by academic and scientific publications.

I have worked for many years, and continue to work, as a copy editor and proofreader for the publishing division of the SA Medical Association on all their journals, which embrace general medicine, bioethics, psychiatry, surgery, radiology etc. I retired some years ago, but continue working for them on a regular freelance basis, and also undertake editing for under- and postgraduate students.

Yours sincerely

Robert Matzdorff  
mobile 084 582 0460