

**“THE DETERMINANTS OF THE HELP SEEKING BEHAVIOUR OF PARENTS
HAVING CHILDREN WITH MINOR ILLNESS IN FRANCISTOWN,
BOTSWANA: “Case Study of Fungal Skin Infection”**

BY

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**A RESEARCH STUDY SUBMITTED IN PARTIAL FULFILMENT OF THE
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DECLARATION

I DECIDERIUS CHIKA IFEBUZOR, hereby declare that the dissertation for the Master in Medicine (Family Medicine) degree at the University of Limpopo (MEDUNSA Campus) submitted by me has not been previously submitted for degree at this or any other University. It is my original work in design and execution and all material and references contained herein have been duly acknowledged.

SIGNATURE

DATE

DEDICATION

I dedicate this work to my wife Adaku for her encouragement, support and understanding. You are really a blessing. Thank you for your support

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ABSTRACT

Aim: To understand the help seeking behaviour of parents having children with minor illnesses such as fungal skin infection and to respond appropriately to such behaviours.

Design: A descriptive qualitative study using the free attitude interview technique

Method: The study was conducted in Francistown City Council Clinics. Eight participants were interviewed. Using purposeful sampling chose the participants. Each respondent was asked the same exploratory question *“How much do you know about this skin infection?”* Exploratory question (Setswana) is *“O itse go le kae ka bolwetsi jone jo jwa letlalo?”* The probe follow up questions were used to encourage elaboration on the topic. The discussions were held in Setswana language. The interviews were audio – taped. The recordings were transcribed, and the ideas that emerged were developed into themes.

Results: Most of the respondents believed that Skin fungal infection was common in the community and it was generally called skin rash. It was believed to be infectious that it may be associated with HIV infection. Some however believe that its cause was known and it was treatable

The help seeking behaviour of parents having children with minor illness like skin fungal infection falls within these reasons: Availability of alternative treatment, Concern of the child especially if the child complains about the problem,

Concern of the parents when the parents consider such minor health concern as a health problem for the child, issues around difficult in management of the problem, If problem is tolerable.

Conclusion: Residents of Francistown city council, which was where the study was carried out perceived skin fungal infection as a common infectious skin problem, that is treatable.

There is adequate knowledge of the symptoms of skin fungal infection among the participants.

Some of the participants believed that skin fungal infection is common in children because they see the skin lesion as a normal change in colour for children before adult life. It was believe that as they get older the change in colour will then disappear.

Many of them believe that they do not know the cause and even the few that felt that they knew the cause could not give a good account of the exact cause of the skin fungal infection, only one said that it is caused by a germ.

Most of the participants were aware that it is treatable but yet they were not keen seeking for help when they come to the clinics because of one or two of the following reasons:

Availability of alternative treatment; Concern of the child especially if the child complains about the problem; Concern of the parents when the parents consider such minor health concern as a health on the child; Issues around difficult in management of the problem; Health problem being tolerable

TABLE OF CONTENTS

Declaration	ii
Dedication	iii
Acknowledgement	iv
Abstract	v
Chapter 1 INTRODUCTION TO RESEARCH PROJECT	1
1.0 Introduction	1
1.1 Background to Research Problem	1
1.2 Geographic Location	2
1.3 Demographic data	2
1.4 Health care facilities	3
Chapter 2 LITERATURE REVIEW	5
2.0 Introduction	5
2.1 Method of Literature search	5
2.2 Fungal Skin Infection & Children	5
2.3 Mode of transmission	8
2.4 Immunity to Fungus	8
2.5 Diagnosis of Fungus	9
2.6 Healthcare Seeking behaviour for childhood illnesses	9
2.7 Health, Illness & Cultural Beliefs	13
2.8 Neglect of a Child's Health	15

4.2.5	Respondent 5	45
4.2.6	Respondent 6	47
4.2.7	Respondent 7	49
4.2.8	Respondent 8	51
4.3.1	Main Themes from interview No. 1	53
4.3.2	Main Themes from interview No.2	54
4.3.3	Main Themes from interview No.3	56
4.3.4	Main Themes from interview No.4	57
4.3.5	Main Themes from interview No.5	59
4.3.6	Main Themes from interview No.6	60
4.3.7	Main Themes from interview No.7	62
4.3.8	Main Themes from interview No.8	63
4.4	Combined list of Themes	65
4.5	Divergent Views	69
4.6	Integrated Themes	70
4.6.1	Model of the Integrated Themes	70
4.6.2	Explanation of the Model	72
4.6.3	Integration of the Model	72
Chapter 5 DISCUSSIONS		74
5.0	Introduction	74
5.1	Methods	75
5.2	Results	77
5.3	Themes & Associations/Comparison with other Studies	80
5.3.1	Availability of alternative remedies (Home Remedies)	81
5.3.2	Recurrence/Experience & Management of health problems	81
5.3.3	Skin conditions not viewed as serious health problem	82
5.3.4	Cost & Accessibility to medical treatment	82
5.3.5	Child not complaining about health problem	83
5.4	Generalizability Versus Transferability	84

5.5	Conclusion	85
5.6	Recommendations	86
5.6.1	Take home message from Researcher	87
5.6.2	Complications if Neglected	88
REFERENCES		89
APPENDICES		
Appendix A	Sample of consent form	94
Appendix B	Statement by the researcher	95
Appendix C	Approved Research Protocol	96
Appendix D	Clearance Certificate MEDUNSA Research Committee	112
Table 1	Combined Themes	65
Figure 1	Model of the combined list of themes	71

CHAPTER 1

INTRODUCTION

1.0 Introduction

In Botswana fungal skin infection is a major health problem among children. From the researcher's experience more than 50% of children attend the government clinic with either of the parents or guardian. The prevalence of skin fungal infection is still very high in rural areas due to poverty and low socio-economic conditions. The infection rate is even higher these days due to the HIV/AIDS. Skin fungal infection has been recognized as one of the commonest skin infection in immuno-compromised states associated with HIV/AIDS that is becoming endemic in our society. Skin fungal infection poses an increase health hazard among children.

1.1 Background to Research Problem

The researcher worked for over three years in Francistown council clinics comprising of 16 health facilities, three of which were health posts while 13 of them were clinics. During this period of close working with the community, the researcher observed that majority of the parents bring their children to the clinic with fungal skin infection and other minor health problems without including the fungal skin infections as one of the presenting complaints. Parents concerns seem to be more on what their children

complained to them, than what they consider to be a health problem for their children. This particular behaviour or attitude of the parents/guardians was progressively increasing leading to a situation whereby the fungal skin infection gets worse and treatment becomes a source of economic waste.

The researcher chose fungal skin infection as one of the commonly neglected health problems among children brought by parents/guardians in Francistown council clinics. This study sought to understand the help seeking behavior of parents having children with minor illnesses such as fungal skin infection.

1.2 Geographic Location

Francistown Council Clinics are in Francistown city that is in Francistown district located in the eastern region of Botswana. It is the second largest city in Botswana. The city is located in the confluence of the Tati and Ntse rivers, and lies about 80km from Zimbabwean border on the main North-South trunk road. It covers an area of 19657 hectares. It accounts for 23% of the urban population in the country (Central statistics office 2000)

1.3 Demographic Data

The population of Francistown is 106,533, 51.5% of the population of Francistown being females and 48.5% being males. (Monekosso, GL 1994). Population density of

Francistown like other major urban settlements is over 1,000 persons per square kilometer (CSO, Preliminary Census 2001). The under five population in the district is 9105 which is approximately 10.3%. This is the target population for the study.

1.4 Health Care Facilities

Francistown City Council runs 16 health facilities, three of which were health posts while 13 of them were clinics. Out of the 13 clinics 2 operate 24hours with one having a maternity wing. The same two health facilities which operate 24hours runs ARV services with two other facilities bringing in the whole a total of four ARV clinics in Francistown City Council.

The 16 health facilities cater for a population of about 83,623 as per Botswana population and housing census 2001, in an area of 125675sq/kilometer. There are 45 localities in its constituency and these health facilities are evenly located in wards/localities for easy access by the community. The population is diverse in region and ethnicity. The health facilities render both preventive and curative services as well as rehabilitation and counseling. However, the core services for these facilities were meant to be preventive and primary health care scope. The increasing call for health services, led to curative services. At the centre of the city is the referral hospital where patients were being referred for in patient management.

City Council clinics render comprehensive primary care services, they even do home visits. The Central government allocates the budget, but they are managed by the Ministry of Local Government.

Services rendered are the following:

- Public health unit: which runs the family planning; ante natal, immunization, Pap smear, Isoniazide preventive therapy, child welfare, Tuberculosis programs and counseling services.
- Out patient: Patients with; medical, surgical, paediatrics, gynaecology and obstetrics.
- Special clinics: HIV clinics

The clinic's population is racially mixed – including the indigenous BaTswana, Coloured, and other black African nationals.

CHAPTER 2

LITERATURE REVIEW

2.0 INTRODUCTION

No documented or published study was found on the help seeking behaviour of parents having children with minor illness. However, few studies were identified on the parents help seeking behaviour, health and cultural beliefs and child neglect. As a result only few available related studies were specifically review in this study; however efforts were strictly made to gather relevant information on the study.

2.1 Method of Literature Search

The Medunsa Family Medicine Resource Centre assisted in the literature search for this study. The key words for this search were: Determinants, Parents/Guardians, Children, fungal infection and help seeking behavior.

The researcher also personally conducted searches on the Internet using Medline and PubMed queries and no study was found to be relevant to the study.

2.2 Fungal Skin Infection & Children

Fungal skin disorders are common and represent a significant component of any primary care practice that involves children. They grow in irregular masses and can be broadly divided into two basic forms: mould and yeast. Superficial fungal infection in children are usually caused by yeast (for example, *Candida malassezia*) or dermatophytes (eg, *Trichophyton*, *microsporum*, *epidermophyton*)

Dermatophytes can be acquired from people (anthropophilic), animals (zoophilic) or soil (geophilic). In the United States the most common source of exposure is other people.

The skin responds to this superficial infection by increased proliferation, which leads to scaling and epidermal thickening. ‘The most common dermatophyte in the United States and the world, *Trichophyton rubrum* causes the majority of skin infections that do not involve the scalp. It is estimated that 10% to 20% of the world’s population is infected by a dermatophyte (Hay RJ *et al* 1998)

Dermatophyte infections are commonly referred to as ringworm, or tinea. Tinea is further classified according to its locations on the body, the next part of the name describing the area of the body where it is found for example, *Tinea corporis* and *Tinea capitis* meaning fungal infection of the body and scalp respectively, Children primarily get it on the scalp this is uncommon for adults who experience it more on the trunk, neck, extremities and

skin folds. It is very much contagious and the incubation period is unknown but however it's usually seen 10-14 days after contact depending on the site. (Hay RJ, *et al* 1998).

Their appearance on the body depends largely on their location on the body. Tinea refers to dermatophyte infections which are generally classified by anatomic location; tinea capitis on the scalp, tinea cruris on the groin and tinea unguium on the nails. Tinea is also called ringworm especially when located on the body and is caused by group fungi that infect only the outer keratinous layer of skin, hair, and nails. These fungi can not survive on mucosal surfaces, such as the mouth or vaginal area. Superficial tinea infections are some of the most common dermatologic conditions in children. (Smith SD, *et al* 2001)

Irritation or itching on the skin does not always mean fungal skin infection. The best plan when the above signs appear to be present is to have the child seen by a physician right away. "Recognizing the common manifestations of paediatric fungal infections is a key part of any primary care practice. Of paramount importance is the clinical acumen of the physician. (Drs Berg & Erickson 2001) discuss several types of fungal infections in children; identify tools for diagnosis. Newer "off-label" therapies are also examined"

Dermatophyte infection of the general body surface that is not otherwise named more specifically is termed tinea corporis. The most common organisms responsible are *T. rubrum*, *Microsporum canis*, and *Trichophyton mentagrophytes* (Martin A & Kobayashi G, 1999). *T. rubrum* actually causes the majority of non scalp skin infections in the United States and the world.

“Tinea vesicolor is an infection of the stratum corneum epidermidis where sebaceous glands are present” (Drake LA, Dinehart SM, Farmer ER, *et al* 1996), caused by the lipophilic yeast *M.furfur* (previously called *pityrosporum orbiculare*), it is not contagious and in most cases represents a shift in the relationship between a human and his or her resident yeast flora.

2.3 Mode of transmission:

From the researcher’s knowledge, fungal skin infection in children cannot be completely avoided, though it is also not extremely common. Fungal infections are common skin diseases affecting millions of people world wide (Pierard G E *et al* 1996). The estimated lifetime risk of acquiring a dermatophyte infection is between 10 – 20% (Drake LA *et al* 1996). Dermatophytes are a group of closely related keratinophilic fungi that can invade keratinised humans and animals tissues such as skin, hair and nails causing dermatophytosis (Dobrowolska A *et al* 2006). Tinea infection can also be transmitted directly from contact with infected humans (anthropophilic organisms) or animals (zoophilic organisms) or indirectly from exposure to contaminated soils or fomites (geophilic organisms). The clinical manifestations of dermatophyte infections varies by the infection site and the patients immunologic response; genetic susceptibility may play a role in vulnerability to infection. (Hostetter MK, 2004)

2.4 Immunity to Fungus:

Older people are much less likely to contract fungal skin infection than children. For after having had the problem before they may have developed some level of immunity, which is protective, however immunity to fungus occurs far less efficiently than to bacteria and viral skin infections, so recurrent attacks do occur. To complicate things a bit further – because there are a number of different fungi, which causes these infections, immunity to one may not convey immunity to another. The infection occurs in both healthy and immuno-compromised patients and etiologic agents consists of dermatophytes, yeast and non dermatophyte molds. Dermatophytes are responsible for most superficial fungal infections (Aly R, 1994)

2.5 Diagnosis of Fungus:

Potassium hydroxide (KOH) microscopy is essential for the office – based diagnosis of tinea infections. This technique directly shows hyphae and confirms infection. The specimen is examined under the microscope after a drop of 10 to 20 percent KOH solution is added to the scraping from the active border of the lesion. KOH microscopy has good sensitivity and is more sensitive than a fungal culture. A positive test result justifies initiation of treatment. KOH microscopy has 76.5 percent sensitivity and an 81.6 percent negative predictive value for the diagnosis of tinea unguium compared with a

53.2 percent sensitivity and 69.0 percent negative predictive value with culture
(Karimzadegan-Nia M, *et al* 2007)

2.6 Health care seeking behaviour for childhood illnesses

Families offer the primary socialization for children are the first informal educators of children. The health parent relationships enhance children's good health. For example, positive parent child communication helps children express their health needs to their parents openly and help parents give health knowledge to their children effectively. In contrast negative communication hinders children to tell their illness experiences and block parents to deliver health to the children as well.

In particular so called psychosomatic problems of children are related to certain familial characteristics such as enmeshment, rigidity, over protection and conflict avoidance. There fore to prevent symptom oriented of children's illness and to understand the illness in their family level is the first step before help for child health is sought (Minuchin, *et al* 1978).

Studies have shown that early health seeking prevents complications and equally reduces the rate of death. Various studies from developing countries have reported that delay in seeking appropriate care and not seeking any care, contributes to the large number of child's deaths (Reyes H, *et al* 1997). Improving families' health care seeking behaviour could contribute significantly to reducing child mortality in developing countries. The

World Health Organization estimates that seeking prompt and appropriate care could reduce child's deaths due to acute respiratory infections by 20%. Early health seeking behaviour for child's minor and acute health problem could reduce morbidity, short and long term complications of the child health problem, this is seen in the integrated management of childhood illness (IMCI) strategy, besides improving providers skills in managing childhood illness also aims to improve families health care seeking behaviour. The health workers are trained to teach the mothers about danger signs and counsel them about need to seek care promptly if these signs occur. (WHO, 1997)

Culture and beliefs have extensively determined how parents/guardians seek help for their children's health. In recent years, epidemiologists and social scientist have devoted increasing attention to studying health-seeking behaviour associated with the two leading causes of child mortality, namely ADD and ARI. Health interview surveys appear to offer the best vehicle for analysing care seeking behaviour on a representative sample of children. These surveys typically involves a single cross-sectional interviews, based on a random sample of a defined population, in which mothers are asked to report about the illnesses experienced and health services or treatment used within a specified time period prior to interview. Such health interview surveys conducted in different countries report varying results about the determinants of care seeking behaviour during childhood illnesses. D'Souza reports that some illnesses are categorized as not for hospital. (D'Souza RM, 2003). In addition, past experience with similar illness can motivate mothers to play a 'waiting game' to see if the illness subsides on its own, particularly in situations where the cost of care is an inhibitory factor (D'Souza RM, 1999).

Various factors have been implicated as determinants of health seeking behaviour of parents. Some studies have reported that care seeking behaviour is predicted by household size, age and education of parents. Lack of access to health care due to high cost is perhaps the most common deterrent to optimal health care seeking in both rural and urban communities (Thind A, Cruz AM, 2003). Some studies have also shown that perceived illness severity, maternal recognition of certain signs and symptoms of childhood illness were critical factors determining health care seeking behaviour (Goldman N, Heuveline P, 2000).

Guardians and caretakers may also not seek for help or abstain from seeking care for their child health if they fail to recognize symptoms or do not consider them dangerous.

Moreover, one disease may be misinterpreted for another; especially where health information has focused on some illness while giving less attention to others. In Uganda, 'Omusudha' (hot body) is used for any childhood fever (Nsungwa-Sabiiti J et al 2004) and is frequently treated with anti-malarial drugs (Kallander K *et al* 2005), this may delay treatment for other febrile illness, in particular pneumonia since symptoms often overlap with those of malaria.

Once a caretaker or parents has recognized illness and decide to seek care, household responsibilities and long distances to health units may still delay care seeking (Peterson S, *et al* 2004)

When health care are sought, the quality of treatment or care received might not be adequate and may cause delay in subsequent seeking for the same health care. Further health care system deficiencies include limited human resources, drug supplies and services management capacity (Travis P, *et al* 2004). Despite these documentations of health care provision and system deficiencies, little attention has been paid to understanding how users view the quality of care provided and received. Early recognition, seek and treat has greatly reduced complications of common child health problems. To reduce pneumonia mortality, three crucial steps in management have been suggested by UNICEF: ‘recognize’, ‘seek’ and ‘treat’. These steps are equally important for malaria and diarrhoea. Many child deaths could be averted if timely recognition of symptoms was followed by prompt care seeking at a place where accurate diagnosis would lead to administration of right drugs in correct doses. We know that delay in healthcare seeking contributes to child deaths in eastern Uganda and not how caretakers’ experience the care seeking process or their perceptions of how different barriers have contributed to the fatal outcome.

In paediatrics patients, the responsibility of parents for illness behaviour of their children and the caregivers impact on the development of the children’s own subjective health concepts have to be considered. Parents monitor their children’s health state, decide whether medical care is to be sought and comply with medical recommendations or not. The children and adolescents illness related perceptions may be influenced by parental models and suggestions (Walker LS 1992). So far there are few studies on the relationship between parents and children’s illness concepts. Perrin and Shapiro reported

absent correlations between parental and children's health locus of control perceptions. Such different views points of parents and their children might complicate intervention planning.

2.7 Health, Illness and Cultural Beliefs

Several sociological models have been put forward to explain illness, cultural and medical belief and how cultural beliefs affects parents help seeking behaviour of their child's health problems, however little research has explained general practitioners understanding of parents perceptions of their children health and illness.

Recent literature has highlighted the differing perceptions of health between professionals and lay people and about the relationship between symptoms and illness. This was noted in Blaxter's report that mothers in deprived families may have cultural values and definitions of health and illness which may differ from those of medical professionals and this cultural behaviour may determine whether they should seek for help or not. (Blaxter, M 1981). Similarly Helman outlined the concepts of illness held by middle class Londoners, which were at variance with conventional medical beliefs (Helman CG, 1978)

Over years several sociological models have been advanced to account for illness and people's behaviour towards illness. However, some authors have assumed that there is an established process through which every individual passes in becoming ill

(Suchman E A, 1965). In the case of parents of young children, writers have sought to measure knowledge of illness and reaction to professionally defined symptoms categories (Fields S, Draper J, Kerr M, Hare MJ, 1983). Most studies were focused on life threatening disease as against minor health problems which were a core idea in this study. However, many studies were aimed at tendency to study deprived populations. Among parents, the recognition of illness and symptoms in their children appears to be embedded in a commonsense knowledge about what was normal and acceptable, particularly in relation to child's behaviour. Normality was not a static concept; it changes over time as the child develops from baby to infant to school child. Much of the process of recognizing illness was grounded in behavioural changes in the child, instead of or in addition to physical symptoms such as a runny nose or headache. The noting of behavioural changes and the extent to which these were concerns for parents were built on the concept of normality and beliefs. The Royal college of General practitioners report on Health and prevention in primary care stressed that careful attention should be paid to patient's belief about health and disease. However it has argued that beliefs are important barriers to care seeking in addition to the maternal ability to recognize symptoms (Hill Z, Kendall C, Arthur P, Kirkwood B, Adjei E, 2003). Care seeking is a complex process influenced by caretaker's individual circumstances and community health beliefs. Some illness episode may be interpreted as best suited for traditional care. Observation from eastern Uganda found the emic illness concept "enhonhi" (literally translated "bird disease") to involve symptoms of all three major childhood killers yet the stated treatment preference was herbs (Hildenwall *et al* 2007)

2.8 Neglect of Child's Health:

Neglect occurs when a child's basic needs food, clothing, a home, education, love, protection and health care not met adequately. (Dubowitz H, Black M, Starr RH, Zuravin S. 1993)

Health care providers and others have focused on child physical and sexual abuse, paying less attention to child neglect. (Wolock.L, & Horowitz H, 1984) There are several reasons why neglect has not received the attention it deserves (Dobowitz, H 1994). First the typically vague definitions of neglect have made it an amorphous phenomenon. Many are understandably unclear about what constitutes neglect, how to identify neglect or what course of action is appropriate and effective. Second, health care providers under demands to screen for multiple conditions and also to be aware of cost containment, thus limiting the time they spend with individual families to detect problems such as neglect. Thirdly; the strong association between child neglect and poverty. Often evokes a sense of hopelessness and helplessness among professionals, deterring them from becoming involved in the complex issues common among very low-income families. Finally, neglect does not evoke the horror and outrage that abuse does (Giovannoni JM, Becerra RM, 1979).

In defining neglect in health, our interest is to adequately protect children and to help ensure their health, safety and well being. Neglected health care can thus be conceptualized as occurring when children's basic health care needs are not met.

This relatively broad definition is based on the basic needs of children that are not met rather than on parental omissions in care. A basic health care need is one in which there is adequate evidence that health is harmed or jeopardized by the specific need not being addressed (for example, death of a child with diabetes due to lack of attention to recommendations. (Geffken G; Johnson SB; Silberstein J & Rosenbloom A, 1992)

Many situations may not arise to this standard of actual or potential harm (for example, a missed follow up appointment for an ear infection in a healthy child) Implicit in this definition is the likelihood that the care or treatment will significantly benefit the child. If the benefit is equivocal, for example, an experimental treatment for cancer, not receiving the treatment should not be construed as neglect. This definition of neglect is based on a child's un-met needs and does not include the issues of cause(s), or contributory factors) from the child's perspective, not receiving necessary care is neglect regardless of the reasons why such care is not provided. The causes however are important when considering how best to intervene.

This broad definition of neglect of children's health differs from the narrow framework embodied in Federal and the States laws that limit neglect to omissions in care by a parent or primary caregiver. (U.S. Congress: Child abuse prevention and treatment Act 1996). Child Protective Services (CPS) accordingly confines its involvement to narrow view. A broad child focused definition has many advantages over a narrow one by examining the role of all the contributory factors; the broad definition should lead to more varied and appropriate interventions. Potentially this broad approach should be more effective in preventing or ameliorating neglectful situations. The broad definition

more accurately reflects the array of possible cause not just parental behaviour. However, clarification of the parental role remains important: Parents are primarily responsible for their children's care. But professionals, community agencies and social policies also influence the health of children and therefore share responsibility. There are however several other important issues in conceptualising neglect: actual versus potential harm. Short versus long-term harm. Concern with physical and psychological outcomes and continuum of care.

The ecological theory that helps explain physical abuse and neglect is also useful with regard to medical neglect (Belsky J, 1980)

The ecological theory posits that there are multiple and interacting contributors to child maltreatment rather than any single cause, and these factors are at the levels of the individual child and parent, the family, the community and the society. For example, a parent who has lost his or her job and health insurance and is feeling depressed is at high risk for not ensuring that his or her child with fungal skin infection receives necessary care and medications.

Many of the characteristics of mothers of neglected children may also contribute to children's health care needs not being met. Maternal problems concerning emotional health, intellectual abilities and substance abuse have been associated with neglect. Emotional disturbances, especially depressions have frequently been found among mothers of neglected children. Intellectual impairment, including severe mental

retardation and lack of education has also been associated with neglect. (Martin, M. & Walters S, 1982)

Most illicit drugs pose definite risks to the fetus and child and the compromised care giving abilities of drug-abusing parents are a major concern. High rates of alcoholism and drug addiction have been found among families of neglected children.

Most decisions regarding children's health are made by parents including when to seek professional care. Crittenden's (1993) model helps refine our understanding of parental difficulties by considering four steps:

- (a) Perception of the child's problem
- (b) Interpretation of the problem
- (c) Response to the problem
- (d) Implementation

Difficulties with any of these steps may lead to health needs not being met. The parent first needs to perceive the problem. Parents may perceive the problem but interpret it incorrectly. Lack of knowledge is again an obstacle. A parent may feel moodiness is common in children, unaware that children can be depressed and for this condition parent may be unaware that treatment exists: Popular or folk interpretation of a symptom such as an infant crying frequently because "he's spoils" may lead to a problem being missed. Again parents with limited cognitive abilities or emotional problems may have difficult interpreting their child's cues, determining the care needed and understanding and implementing the treatment plan. Occasionally parents may not appreciate the

seriousness of the problem or the importance of the treatment due to inadequate communication with health care providers.

Inadequate knowledge about children and health and inappropriate expectation contribute to neglect for example, parents may not know that a baby with diarrhoea risks becoming dehydrated. Parents may not appreciate such needs, particularly if they are cognitively limited. Medical neglect may occur when parents refuse medical treatment for their child based on their religious beliefs, for example Jehovah's Witnesses refuse surgery when the need for blood transfusion is anticipated. ' A child is not to be deemed abused or neglected merely because she is receiving treatment by spiritual means, through prayer according to the tenets of a recognized religion (American Academy of Pediatrics, Committee on Bioethics, Religious exemptions from child abuse statutes. Pediatrics, 1988)

In some situation parents may be in denial an unconscious defence mechanism about a child's condition. Parents of neglected children are less knowledgeable about developmental milestones and have limited knowledge about parenting, poor skills, and low motivation to be a good parent (Herrenkohl. R. Herrenkohl E. & Egolf. B, 1983).

CHAPTER 3

METHODS

3.0 Introduction

A qualitative method using free attitude interview technique was chosen as a technique for data collection in this study. As part of preparation for this research, the researcher attended a course on research methodology organized by University of Limpopo in March 2006 and also attended a workshop in practical training in conducting a qualitative research organized by the Department of Family Medicine of the same University.

The research assistant, a nurse at Francistown city council clinic was trained by the researcher in qualitative research techniques. She is a registered midwife nurse.

3.1 Aim

To understand the help seeking behavior of parents having children with minor illnesses such as fungal skin infection

3.2 Objectives

- To assess parents knowledge and belief about skin fungal infection on their children
- To determine why parents do not complain about skin fungal infection among other minor health problems of their children

3.3 Research question

What are the determinants of the help seeking behaviour of parents having children with minor illnesses like fungal skin infections?

3.4 Study design

This study was a descriptive qualitative study. According to Pope and Colleagues (2000), a qualitative design is geared towards getting a sense of participant's views and perceptions. The free attitude (one to one) in depth interview technique was used.

3.4.1 The free Attitude interview in qualitative Research

The choice of qualitative or quantitative methods is a technical matter, which should be dictated by the nature of the research question, rather than the result of epistemological debate (Murphy & Mattson 1992).

Using qualitative methods in collaboration with anthropology techniques, will not only lead to increased patient satisfaction and improved clinical efficacy but it will also enhance the academic foundation of our evolving specialty as well (Nelson, 1998).

Individual and group interviews are used in data collection in qualitative studies (Creswell 1994)

The free attitude interview developed its characteristic form during an industrial psychological research, the so - called Hawthorne Research in 1929 in the United States. The researchers discovered that when they gave the interviewees the freedom to speak, the information obtained became more relevant than when they used a structured questionnaire (Meulenberg-Buskens 1998).

The free attitude interview technique, also described as a non-directive controlled depth interview, serves as a means of reflecting the respondent's feelings in a therapeutic context (Vrolijk, Djikema and Timmerman 1980).

The free attitude interview technique can be characterized as a person-to-person method to obtain information concerning opinion, while the interviewer is non-directive. The main interviewer's qualities, necessary to conduct a free attitude interview successfully, are the feeling of respect for the respondent and the interest one should have in hearing his/her opinion (Muelenberg-Buskens, 1998). This interviewer's attitude was described by Meulenberg-Buskens (1998) as 'unconditional positive regard', allowing the

interviewee to be and do as he feels like. When the interviewee feels respected, she will feel encouraged to talk and keep talking.

A free attitude interview is a “guided conversation” using an open-ended question, which defines the area explored, from which the idea can be pursued in more detail (Lofland 1971).

Qualitative interview techniques such as reflecting, clarifying and summarizing were used in this study to explore the question fully under a free atmosphere (Coulson, Goldstein & Ntuli 1995).

The researcher decided to use the free attitude interview technique in this study because it gives the interviewees more freedom to speak than the focus group interview, although it has the limitation in that it provides “indirect” information filtered through the views of the interviewees (Creswell 1994).

3.4.2 Study Population:

The sample population included parents/guardians attending Francistown city council clinics who brings his/her child between the ages of 5 years to 15 years irrespective of gender with a the skin condition among other health problems without including this as one of the child’s medical problems. The study was explained to such parents and only

those that consent were selected for the study. A free attitude interview and interview schedule/guide was used and the interview continued until information is saturated.

3.4.3 Sample:

The researcher used purposeful sampling. This is a sampling method whereby “subjects known to be articulate and able to provide vital information” are chosen (Reid 1996). Participants were selected among parents/guardians of children with fungal skin infections. Eight respondents had been selected by the time the researcher was of the opinion that the data was saturated.

3.4.4. Inclusion & Exclusion Criteria

Inclusion Criteria:

Adults accompanying children with minor ill health and a skin condition to the clinic, who did not include the skin condition as one of the child’s presenting complaints, that

agreed to participate in the study and were also resident in Francistown and could communicate freely in the local language (SeTswana) and / or English were selected.

Exclusion Criteria:

Adults who accompanied very ill children with skin fungal infection, and those who declined participation in this study.

Adults accompanying children who included the skin condition as one of the child's presenting complaints

3.5 Data Collection:

3.5.1 Free Attitude Interview:

The interview was conducted by the researcher and the research assistant while the researcher facilitates and clarifies issues. All the interviews were conducted in SeTswana since all the participants had a good understanding of the language.

Written informed consent was obtained before the interviews, after the aims and objectives of the study were explained to the participant. Following the protocol that was

approved by the Medunsa Research and Ethics Committee (MREC) Clearance Certificate No. MP 36/2006.

The interview comprised of an initial introductory phase about the study, conditions that apply for participation and getting the participants to acknowledge comprehension of this information. This was then followed by the initial exploratory question.

The exploratory question was asked pointing at the skin condition. This was facilitated using the interview schedule/guide to widen the discussion to obtain all the information needed without introducing any new question.

3.5.2 Interview schedule/guide:

1. English - Why did you not include it as one of the child's health problems?
Setswana – Ke eng o sa ka wa botsenya mo malwetsing, a botsogo jwa ngwana?
2. English – Do you think it treatable and how? Setswana – A o akanya gore bo ka alafiwa le gone jang?
3. English – What do you think is the cause of the skin problem? Setswana – O akanya gore malwetsi a letlalo a bakiwa ke eng?
4. English - Is it infectious to other children? Setswana - A go ka tsnena kana ga tshela bana ba bangwe.

For the purpose of this study, a signed informed consent (Modified Medunsa Consent Form) Appendix 1 was obtained from the parent and the interview was either conducted on that day or the person was invited for the interview on another day in the clinic if every factor was not favourable on that particular day. They filled in a short questionnaire, which was anonymous but had complete information on age, sex, occupation, educational background, marital status and family monthly income.

The interview was conducted in either English or the local language (Setswana) with the help of research assistant a nurse that was trained by the researcher; she understood English and Setswana very well. The assistance of the nurse was needed when she was not on duty and the researcher was present during the interview and occasionally clarifies issues. The researcher facilitated the discussion that ensued through clarification, reflective summaries and silences as necessary, as well as non-judgemental, non-interrogative and supportive approach as recommended. (Wood 1992; Babbie 1995). The interviews were recorded on audiotapes with the help of a battery operated micro-cassette recorder. The recorder was played several times and found to be functioning properly and adequate for use before it was used for the recording. The research assistant translated them to English.

3.5.3 Transcription of data:

The interviews that were recorded in the local language (SeTswana) were replayed and agreed on the same translation as a verbatim transcription and translation. After which they were given to an independent assistant that understands the local language (SeTswana) and English very well to verify correctness of the translation of each of the interview.

At the end of the process, the researcher was convinced that the relevant information has been obtained from the interview and the information was analysed and grouped thematically by the cut and paste technique. The relevant information along with the participant's personal data formed the basis for the write up of the dissertation. No special software package was used for the handling of the data.

3.6 Data Analysis:

Application of the grounded theory was made by concurrently collecting and analysing data with emphasis on respondent's predominant views that formed themes and concepts in line with method described by Katzenellenbogen et al [1997]. Pope, Ziebland & Mays (2000), qualitative research produces vast amounts of textual data in the form of transcribed recordings of interviews, observations etc. Data collection and data analysis go hand in hand. The data already collected shape the on going collection of further data.

This process is called interim analysis (a cyclical process of collecting and analysing data during a single research study), and allows for the researcher to refine questions, develop hypothesis and pursue emerging avenues of inquiry in more depth. According to Miles and Huberman (1984), analysis in qualitative research is the process of bringing order to data, organizing categories, patterns, and basic descriptive units.

Interpretation involves attaching meaning and significance to the analysis, explaining descriptive patterns, and looking for relationships and linkages among descriptive dimensions. The researcher under the guidance of the research supervisor did the analysis of the transcribed recorded data.

The data analysis was carried out as follows:

- Each transcribed interview was read over several times to understand the contents and similar ideas were identified and grouped to form themes as suggested by Glaser and Strauss (1967).
- Thereafter the themes were again identified from each interview by word and a list of the main themes was made
- A combined list of themes from all the 8 interviews was drawn up.
- Integration of the themes in the combined list was done so as to establish similarities and differences.
- A model was developed to represent a visual depiction of the linkages and interconnectedness between the themes.

- Thereafter the model was described in words. This represents the main findings of the research.

3.7 Validity and Reliability

Validity is the absence of systematic (bias) and unsystematic errors as well as appropriateness of the results and research methods with the aims (Smaling 1993). A valid method is one that measures what it sets out to measure i.e. the accuracy of the scientific findings.

To ensure validity and reliability, the following measures were adopted:

- Adequate time was being spent on each interview with participants allowed to exhaust the topic till no new information was coming out.
- The exploratory question was drafted so that each participant gets the same and exact question.
- Free attitude interview was used and each participant was given enough time to say all he/she wanted to say.
- At the end of each interview, salient points were highlighted to the participants to confirm that the information gathered from them were exactly what they meant during the interview.
- Information obtained was fed back to the participants for validation.

- The entire recorded interview in local language (SeTswana) was translated to English by the research assistance and an independent assistance.
- The research assistant, a qualified registered midwife was actively involved throughout the various phases of the study. She listened to the tapes independently and went through the all transcribed texts to verify the transcriptions and the themes identified.

Creswell (1994) noted that the uniqueness of a study within a specific context militates against replicating it exactly in another context. However he went further to write that statements about the researcher's positions – the central assumptions, the selection of informants, the biases and values of the researcher – enhance the study's chances of being replicated in another setting.

One of the steps taken to enhance reliability of this study was the use of audio tape recording to preserve the data collected so that others can check the veracity of the conclusions. Another step taken by the researcher to ensure the reliability of the study was the training in qualitative research methods and acquiring skills in interviewing technique.

Though this study's methodological thoroughness does not obviate the restrictive extrapolation inherent on qualitative studies' findings to only population of similar context, it ensured its conformity to qualitative studies' naturalistic stance, as put forward by Hoepfl (1997). However, this study to the extent that findings are based on

information from variety of a diverse population, may be applicable to a larger substantive area within the context of Botswana.

3.8 Bias

Bias can be defined as systematic errors that can influence the process and outcome of a research. Sampling bias is a systematic error due to study of a non-random sample of population (Last, 2001). The fact that the study population includes any parent that qualifies for the study according to the inclusion criteria, the study population does not have any equal chance of selection in the sample and this could lead to sampling bias. Qualitative research uses non-random sampling method that attaches more importance to depth than representative sample (Pope *et al*, 2000). This vindicates qualitative researchers of any prejudice arising from this unavoidable bias.

Qualitative studies are prone to biases since one person is mostly the primary data collection instrument. But as noted by Locke et al (1987), the investigator's contribution to the research setting can be useful and positive rather than detrimental.

Selection bias defined by Ogunbanjo (2001) as a selection method that results in a systematic difference in characteristics between those who participate in a study and those who do not was inherent in this study. This was introduced by:

- Convenience sampling that restricted the study in Francistown city council clinics.
- The study's inability to capture the views of those attending the private clinics
- Medical delivery in Botswana is free in all government clinics and more than 98% of the educated ones are working and these group have medical aids and as such attend the private clinics and this will limit the studies to only poor and non educated ones being identified in this study and this could lead to selection bias

Language/Interpretation bias: The researcher is from a different cultural setting and also having poor knowledge of the local language (SeTswana). This may bring a little bias in understanding very well what the participants are saying and this may lead to bias of interpretation. This researcher tried to take care of this bias by using a research assistant that is from the same background and understands the local language very well.

Participants' bias: There may also be some bias from parents who may understand that they are being judged as inadequate because they are not reporting the lesser illnesses.

Interviewer's bias: Gathering of selective data (Ogunbanjo, 2001) interviewer's bias can arise during the research interview if the interviewer subconsciously or even consciously gathers selective data. This was minimised by the interviewer maintenance of neutrality by only facilitating the interview process without imputations. Data collection was guided by emerging theme and saturation of information. Wolcott's recommendation of

inclusion of primary data (quotes) and all information (including deviant responses) in the final report to expose bias for conclusion (Wolcott, 1990) was also applied.

3.9 Transferability

As is the case with most qualitative studies, the findings of this study are not to be generalized but rather transferable. Findings similar to that of this study would be expected if the research were conducted elsewhere in similar settings (Patton 1987).

3.10 Ethical Considerations

- Ethics and Health Research units' approval

Before embarking on this study, the researcher got approval from the Medunsa Research and Ethics Committee (MREC) {Certificate No. MP 36/2006} of the University of Limpopo and Fransistown City Council district. The protocol was strictly adhered to, however logistic issues compelled some laxity and changes in timing of the research processes which was accommodated without compromising the content and accuracy of the data

- Informed Consent, Voluntariness and anonymity

Participants received information on the nature of the research. A written informed consent was obtained from all the participants. The MEDUNSA modified informed consent format was used. They were informed and assured of the confidentiality. It was

also made clear that they can withdraw from the study at will and this will not reflect on their ongoing health care or professional relationship. They were also informed of absence of immediate individual benefit from the research.

Individual interview process only commenced after ensuring participant understands the research and signs the consent form.

No names were used in the interviews and write-up to maintain confidentiality.

Information like phone numbers and addresses were discarded after the research.

CHAPTER 4

RESULTS

4.0 Introduction

The researcher went through a process of meticulous analysis of the transcribed interviews, field notes and observations. Common ideas in the data were identified and then grouped into themes. A list of the main themes was then drawn up for each interview and then presented in tables.

The themes from the eight interviews were then combined and presented in a combined list of themes, in a separate table. These themes from the combined list were integrated to establish similarities and differences. A model was then developed to represent the linkages and interconnectedness between the themes.

Some of the utterances of the respondents during the interviews have been recorded verbatim. At the end of each interview participants were made to validate the analysis of her responses. The model was described and represents the main findings of this study.

4.1 Participants' Characteristics

There were eight participants out of whom five were grandmothers, two were mothers and one was a relative of the child. Three of the participants never went to school while five left school at or before completing primary education. All of them were either unemployed or unskilled laborer. These social characteristics seem to originate from the fact that this study was conducted in the government clinics that is generally attended by people of low socio economic class. There was also homogeneity in the respondent views about issues around skin infection. The participants were almost from the same socio demographic class and equally had same relative knowledge of skin infection. This made it easy to format themes around the areas of consistence and reoccurrence with minimal deviations and extremes.

4.2 Individual Interview & Main Themes of the Interviews

The participants response to the exploratory question (English) : ***“How much do you know about this skin infection?”*** Exploratory question (SeTswana) ***“O itse go le kae ka bolwetsi jone jo jwa letlalo?”*** Pointing to the skin condition

4.2.1 Respondent 1

This was a 52-year-old woman who brought her grand child to the clinic with cough, fever and she also presented with a skin rash on the child's head and skin (the latter was not mentioned as part of the child's presenting complaint). The interview was around 13.00hrs.

Interviewer: How much do you know about this skin infection?

Respondent: Yah, I always see it on the body of the children and adults, we live with it. It is called skin rash and at times it can itch or cause scratching on the body

Interviewer: Do you have knowledge of its name or what it's called?

Respondent: ..em we call it skin rash

Interviewer: Is it infectious to other children?

Respondent: ‘...according to my knowledge it is infectious to everybody even to the children and nowadays it affects everybody.

Interviewer: **What do you think is the cause?**

Respondent: I think person not taking care of him well, allergy, dirt cause it, not taking bath and what we eat these days. It can also be from bad blood

When asked to clarify what she meant by bad blood, she said

Respondent: “If your blood is infected with a disease like HIV or allergy in the blood then you will get the rash”

Interviewer: **What do you know about the treatment?**

Respondent: I know that it is treatable. Kana we treat it with potash, crushed charcoals with oil and some herbs from the bush.

Interviewer: **Why do you not include it in the child’s complaints?**

Respondent: Because I treat it at home with potash and also with some herbs and as you can see it is now okay and the child is not itching again.

And she went on to say

Respondent: “Another thing I want to say is that it is difficult to treat these days, after treating it, it will come back again. So I feel there is no need complaining about it to the doctor”

4.2.2 Respondent 2

She is a seventeen-year-old girl who brought her junior sister to the clinic with cough, running nose, fever and mixed types of skin fungal infection. Recruitment and interview was done in the same day around 13.10hrs.

Interviewer: **How much do you know about this skin infection?**

Respondent: “em..... I do not know much about it,

Attempt to get probe further she said

Respondent: “ all I can say is that in my house we all have it and we do not see it as a problem. At time it will come and disappear”

Interviewer: Do you have knowledge of its name or what it's called?

Respondent: It is a skin rash

Interviewer: Is it infectious to other children?

Respondent: I do not know but every child has it and we do not see it as a problem. I also have it on my body but it is not causing any problem on me.

Interviewer: What do you think is the cause?

Respondent: I do not know but "I hear people said that it is the virus "HIV" that is causing the skin problem. If you do not take your bath you can also have it and it will be itching. Allergy, dirtiness can also cause it."

Interviewer: What do you know about the treatment?

Respondent: I think it is treatable with calamine lotion from the clinic, brake fluid, and some herbs from the native doctor.

Interviewer: Why do you not include it in the child's complaints?

Respondent: ...eshie I believe it is not a problem and my sister is not complaining about it. My mother has a medicine at home for treating it so we can treat it at home not in the clinic.

And added that

Respondent: Last week I was given calamine lotion in the clinic and I am still using it. The skin problem is not troubling her, it is not scratching on the body and she is not complaining about it

4.2.3 Respondent 3

This is forty two year old woman who lives with the grand child and brought the child to the clinic with history of abdominal pain, loss of appetite, cough, weight loss and skin fungal infection. All were complained except the skin fungal infection on the skin.

Recruitment and interview was done in the clinic around 16.00hrs

Interviewer: How much do you know about this skin infection?

Respondent: I have seen it before, but I do not know much about it. I know that it is common in children at this age. It is not a problem if the child is not itching or if the child is not complaining about it. It is normal in children at this age.

Further added that

Respondent: At this age children change colors on the skin and when they grow up the good color comes out

Interviewer: Do you have knowledge of its name or what it's called?

Respondent: It is skin rash if it is itching. We call it skin rash

Interviewer: Is it infectious to other children?

Respondent: Every child has it at this age but as they grow up it disappears to good skin colour. Yes it is infectious to the children if they do not take their bath.

Interviewer: What do you think is the cause?

Respondent: It is normal in some children;

Quoting other information source

Respondent: I also heard that the Virus “HIV” causes it. My child has the virus and I think it is the virus that is causing it. The brothers at home also have the skin rash.

Interviewer: **What do you know about the treatment?**

Respondent: It is only the AIDS that I know that is not treatable.

On further clarification

Respondent: “Every disease is treatable except AIDS and as such this skin rash is treatable”.

We treat it at home with potash, brake fluid, crushed charcoals with oil and some herbs from the farmers. We only treat it if it is troubling the child and also when it is itching.

Interviewer: **Why do you not include it in the child’s complaints?**

Respondent: Because it is not troubling the child and the child is not complaining about it. It is not itching and also we have the medicine at home for the treatment. It is not a serious problem.

4.2.4 Respondent 4

She is a twenty-year-old woman who brought her child to the clinic with history of cough, right ear discharge and skin fungal infection on the skin. The interview was conducted in the clinic around 13.00hr, for her it was more of a fun as she kept on laughing at interval

Interviewer: How much do you know about this skin infection?

Respondent: Yes I have seen this type of rash before and I know about it.

Went further to emphasize that

Respondent: “Everybody grow up with it and some develop the rash in different parts of the body”.

It is not painful and it is not a serious problem. My other child also has it. At times it will cause scratching and itching on the body.

Interviewer: Do you have knowledge of its name or what it’s called?

Respondent: It has no name we call it skin rash

Interviewer: Is it infectious to other children?

Respondent: I think it is infectious to children when they share cloths or when they sleep together or when they do not wash their body and also when they sweat a lot

Interviewer: **What do you think is the cause?**

Respondent: From my own knowledge it is caused by not taking bath, dirty environment, germs, allergy and some food we eat. These days they said it is also caused by HIV infection

Interviewer: **What do you know about the treatment?**

Respondent: Yes it is treatable. ... We treat it with potash, calamine lotion, brake fluid crushed charcoals with oil and by some traditional doctors.

Interviewer: **Why do you not include it in the child's complaints?**

Respondent: I did not complain about it because the child is not complaining about it and also it is not a big problem. I know how to treat it at home with the brake fluid, though it is difficult to treat. It kept on coming and disappearing.

She went further to say

Respondent: “My grand mother is traditional doctor and she gives us medicine for it when it is itching or when it is troubling the child so there is no need telling doctor about it.”

4.2.5 Respondent 5

She was a fifty-year-old widower who brought her grand child to the clinic with history of diarrhoea, vomiting, loss of appetite, cough and skin fungal infection. The recruitment and interview was done in the clinic around 13.45hrs.

Interviewer: How much do you know about this skin infection?

Respondent: I do not know much about the skin infection; I have seen it in almost every child. It is on and off on children and its common on them because they are children. It makes the child to scratch on the body at times. It is not a problem when the child is not complaining about it. All my children had it when they were small. I also have it at times on the body.

Interviewer: Do you have knowledge of its name or what it’s called?

Respondent: It has no name other than skin rash.

Interviewer: Is it infectious to other children?

Respondent: I do not know, but every child gets it at this stage in life. Even adults also have it but in adults they are always itching and scratching when they have it

Interviewer: What do you think is the cause?

Respondent: When we are small we are told that it is from germs and from the blood when the blood is sick and not good, it will cause the rash and it will come out on the skin. Dirt and not washing cloths can cause it

Interviewer: What do you know about the treatment?

Respondent: I know that it is treatable. ...but it is always on and off. We treat it when it is itching or causing problem for the child. The treatment is difficult. It is treated with potash, crushed charcoals with oil, and some herbs from native doctor.

Interviewer: Why did you not include it in the child's complaints?

Respondent: It is not a serious problem and it is not itching. It is normal color changes on the child at this age,

On further clarification on the issue of color changes she went on to say that

Respondent: “Children change colors till when they grow up”.

If the child complains about it I will apply potash or local herbs on it and it will stop. We have ways of treating it at home without coming to the clinic for it.

4.2.6 Respondent 6

A thirty three year old lady that co-habits with the partner she was recruited when she brought her child with history of chronic septic sores on the legs, cough, fever and skin fungal infection on the body, for her the septic sores and the skin condition are same but the skin condition is normal in a child.

Interviewer: How much do you know about this skin infection?

Respondent: I have seen them before but they are normal in a child. They are on and off since the child was born. It is also on my body. We grow up with it but I cannot say much about it. What I know is that it is not dangerous. Everybody does have it at times. We live with it in the house and it is not causing problem. It can make the body to itch.

Interviewer: Do you have knowledge of its name or what it’s called?

Respondent: It has no special name. We call it skin rash.

Interviewer: Is it infectious to other children?

Respondent: I do not know, it is you and the doctor that will know, but it is common in every child especially these days we have HIV disease.

Interviewer: What do you think is the cause?

Respondent: I heard people say that HIV, or germ or dirty environment causes it and also if you do not take your bath, you can easily get it. Even food and allergy or going to the bush can cause it.

Interviewer: What do you know about the treatment?

Respondent: From my own knowledge I do not think that it is treatable or after treating it still comes back. It comes and disappears. We use some local medicine we get from the native doctor to treat it but after it come back. It is difficult to treat. We do treat it with brake fluid, potash and crutched charcoals.

Interviewer: Why did you not include it in the child's complaints?

Respondent: You see it is like any other skin problem but it is not a serious one and it is not a problem for the child. It is not painful. I see it normal for children at this age. We also treat it at home with other medication from relatives

4.2.7 Respondent 7

She was a thirty-year-old shop attendant, she was recruited when she brought her child to the clinic with history of cough, yellowish eye discharge, fever, the interview was conducted in the clinic at her next convenient time

Interviewer: How much do you know about this skin infection?

Respondent: Yah, I always see it on the body of the children but I do not know anything about it. It has been on my child for over one year now and it come and goes after applying the medicine I got from the clinic last year

Interviewer: Do you have knowledge of its name or what it's called?

Respondent: The name is skin rash

Interviewer: Is it infectious to other children?

Respondent: As I was meant to understand the first time it appeared on my body I was told that it is infectious.

Proceeded to say that

Respondent: “I also still have it on my body now”.

Interviewer: **What do you think is the cause?**

Respondent: I know that if you do not take care of yourself, you can get it. Dirty environment and dirty cloths may also cause it. Bad blood and HIV can also cause it.

Interviewer: **What do you know about the treatment?**

Respondent: I know that it is treatable with the medicine I was given in the clinic last year. At home people treat it with fluid from the car, potash, crushed charcoals with oil, calamine lotion and some herbs.

Interviewer: **Why did you not include it in the child’s complaints?**

Respondent: I did not complain about it because it has been on the child for a long time and it comes and disappears, it is not troubling the child and the child is not complaining

about. I also still have the medicine at home. If the child were complaining I would have told the doctor about it.

4.2.8 Respondent 8

She was a forty five year old woman, unemployed she came to the clinic with two of her grand children with cough, fever, loss of appetite and swollen painful left leg lymph node on one of the children. The interview was conducted in the clinic and for her skin fungal infection is not a disease

Interviewer: How much do you know about this skin infection?

Respondent: Yes I have seen this type of skin disease and I know that it is not a serious problem. The only thing I can say is that long time ago there was no disease such as skin infection.

She went further to elaborate

Respondent: This skin rash was not common before because we ate different types of seTswana food like porridge, beans and milk but these days we eat a lot of things I do not know where they come from and these new things may be the cause of this skin infection or may be this virus “HIV” brought it. I see it like any scratch marks that can disappear on its own when the child grow

Interviewer: Do you have knowledge of its name or what it’s called?

Respondent: It is skin rash

Interviewer: Is it infectious to other children?

Respondent: I think it can affect other children because all my grand children have it and other children around the house have it.

Interviewer: What do you think is the cause?

Respondent: I think it is the food we eat these days, bad blood and the HIV that is every where now that causes it. When we are young we are told that dirtiness causes skin infection, and also one can get it by not taking her bath, not washing cloths and sharing cloths with infected person

Interviewer: What do you know about the treatment?

Respondent: I do not know if it is treatable. I once got calamine lotion from the clinic and another cream but it did not help well. It kept on coming and going. It is difficult to treat. Even at home people use potash and charcoal to treat it but it come and disappears.

Interviewer: Why did you not include it in the child's complaints?

Respondent: Because I know that it is not a serious disease on the child and the child is not complaining about it. People treat it at home with potash and also with some herbs.

On more information for not complaining she said

Respondent: Another thing is that it is difficult to treat these days, after treating it, it will come back again so I am tired of complaining since it is not disappearing completely I want to continue treating it at home with home remedies.

The results of the interviews will be presented as follows:

Firstly, the themes from the individual interviews will be presented then, the combined list of themes, then the model and then, the description of the model. The themes will be given with one or two quotes supporting them.

4.3.1 Main Themes from interview No. 1

1. The skin condition is common

“I always see it on the body of the children and adults”

“We live with it”

2. The skin condition is called skin rash

“..em we call it skin rash”

3. The skin condition is infectious

“...according to my knowledge it is infectious ...nowadays it affects everybody”

4. The causes are known

“I think person not taking care of himself well, allergy, dirt cause it, not ...bath”

“If your blood is infected with disease like HIV.....get the rash”

5. The skin condition is treatable

“I know that it is treatable”

“...we treat it with potash, crushed charcoals with oil.... some herbs from the bush”

6. The skin condition need not be presented as a complaint to the doctor

“Because I treat it at home with....and the child is not itching again”

“..it is difficult to treat....so I feel there is no need complaining it to the doctor”

4.3.2 Main Themes from interview No.2

1. The skin condition is common

“all I can say is that in my house we all have it”

2. The skin condition is not well know

“...but I do not know much about it”

3. The skin condition is called skin rash

“It is a skin rash”

4. The skin condition is normal

“... is normal on the skin”

“We do not see it as a problem, I also have it and it’s not causing problem”

5. The skin condition is treatable

“I think it is treatable with calamine lotion...brake fluid and some herbs from native doctor”

6. The skin condition need not be presented as a complaint to the doctor

“...I believe it is not a problem.....and my sister is not complaining about it”

“The skin problem is not troubling her; it is not scratching on the body”

7. It has a home remedy & treatable at home

“My mother has a medicine at home for treating it”

4.3.3 Main Themes from interview No.3

1. The skin condition is common

“I know that it is common in children at this age”

2. The skin condition is normal

“It is normal in children at this age”

“At this age children colours on the skin”

3. The skin condition is not well known

“I have seen it before, but I do not know much about it”

4. The skin condition is called skin rash

“We call it skin rash”

5. The skin condition is infectious

“Yes it is infectious to the children if they do not take their bath”

6. The skin condition is treatable

“Every disease is treatable except AIDS and as such this skin rash is treatable”

7. The skin condition has home remedies

“We treat it at home with potash, brake fluid, crushed charcoal with oil and some herbs”

8. The skin condition need not be presented as a complaint to the doctor

“Because it is not troubling the child and the child is not complaining about it”

“It is not a serious problem”

9. We have home remedy for the treatment

“We treat it at home with potash, brake fluid, crushed charcoal with oil and some herbs”

4.3.4 Main Themes from interview No.4

1. The skin condition is normal

“Everybody grows up with it”

“My other children has it”

2. The skin condition is called skin rash

“It has no name we call it skin rash”

3. The skin condition is infectious

“I think it is infectious to children when they share cloths or when they sleep together”

4. The skin condition is treatable

“Yes it is treatable....we treat it with potash, calamine lotion, brake fluidand herbs from traditional doctors”

5. The skin condition need not be presented as a complaint to the doctor

“I did not complain about it because the child is not complaining about it”

“...also it is not a big problem”

6. The skin condition has home remedy

“I know how to treat it at home with brake fluid”

7. Traditional doctors treat the skin condition

“My grandmother is a traditional doctor and she gives us medicine for it when it is itching or when it is troubling the child so there is no need telling doctor about it”

4.3.5 Main Themes from interview No.5

1. The skin condition is called skin rash

“It has no name other than skin rash”

2. The cause of skin condition is known

“.....from germs”

“Dirt and not washing cloths can cause it”

3. The skin condition is treatable

“I know that it is treatable. ...but it is always on and off”

“It is treated with potash, crushed charcoals with oil, and some herbs from native doctor”

4. The skin condition is difficult to treat

“It is difficult to treat”

“I know that it is treatable. ...but it is always on and off”

5. Traditional/Native doctors treat skin fungal infection

“It is treated withand some herbs from native doctor”

6. The skin condition need not be presented as a complaint to the doctor

“It is not a serious problem and it is not itching”

“It is normal colour changes on the child at this age”

4.3.6 Main Themes from interview No.6

1. The skin condition is normal

“I have...but they are normal in a child”

“Everybody does have it at times”

2. The skin condition is not well known

“We grow up with it but I can not say much about it”

3. The skin condition is called skin rash

“It has no special name. We call it skin rash”

4. The skin condition is common

“..but it is common in every child especially these days we have HIV disease”

5. The cause of the skin condition is known

“I hear people say that HIV, germ or dirty environment causes it....do not take bath you can easily get it”

“Even food and allergy or going to the bush can cause it”

6. The skin condition is difficult to treat

“...after treating it, it still comes back. It comes and disappears”

“.....to treat it but after it come back”

7. The skin condition need not be presented as a complaint to the doctor

“...it is like any other skin problem but it is not a serious one and it is not a problem for the child”

8. It has home remedy

“We also treat it at home with other medication from relatives”

4.3.7 Main Themes from interview No.7

1. The skin condition is called skin rash

“The name is skin rash”

2. The skin condition is infectious

“As I was meant to understand the first time it appeared on my body I was told that it is infectious”

3. The cause of skin fungal infection is known

“Dirty environment and dirty cloths may also cause it”

“Bad blood and HIV can cause it”

4. The skin condition is treatable

“I know that it is treatable with the medicine I was given in the clinic last year”

5. It has home remedies

“At home people treat it with fluid from car, potash, crushed charcoals etc

6. The skin condition need not be presented as a complaint to the doctor

“It is not troubling the child and the child is not complaining about it”

4.3.8 Main Themes from interview No.8

1. The skin condition is called skin rash

“It is skin rash”

2. The skin condition is infectious

“I think it can affect other children because all my grand children has it and other children around the house have it”

3. The cause of skin fungal infection is known

“I think it is the food we eat these days, bad blood and HIV that is every where now that causes it”

“...not washing cloths and sharing cloths with infected person”

4. The skin condition is difficult to treat

“It is difficult to treat”

“Even at home people use potash and charcoal to treat it but it come and disappears”

5. The skin condition need not be presented as a complaint to the doctor

“Because I know that it is not a serious disease on the child and the child is not complaining about it”

6. It has home remedy

“People treat it at home with potash and also with herbs”

“I want to continue treating it at home with home remedies”

7. Past complains did not help

“I am tired of complaining since it is not disappearing completely”

4.4 COMBINED LIST OF THEMES

Table1: Combined Themes

1.	The skin condition is common
2.	The skin condition is normal
3.	The skin condition is not well known
4.	The skin condition is called skin rash/Not a serious health problem
5.	The skin condition is infectious
6.	The skin condition is treatable
7.	The skin condition has home remedies/Treated by

	traditional doctors
8.	The skin condition need not be presented as a complaint to the doctor
9.	The skin condition is difficult to treat
10.	The cause of skin condition is known

The following themes came out from statements made by the majority of the respondents and therefore represent their knowledge, attitudes and behaviour of the majority of the interviewees towards the skin condition:

- The skin condition is common
- The skin condition is normal
- The skin condition is called skin rash
- The skin condition has home remedy
- The skin condition need not be presented as a complaint to the doctor
- The skin condition is difficult to treat

The entire respondent had similar and varied reasons for not including the skin condition among the complaints of their children. What this means is that they were aware of the presence of the skin condition on their child but they were not concerned about its treatment. The other combined themes are unique to one or minority of the respondents.

1. The skin condition is common

Most of the participants stressed in different ways that skin fungal infections are common skin infection

2. The skin condition is normal

Most of those interviewed believed that skin fungal infection is normal on the skin. One of three of the participants associated it with the cultural belief and explained it as a normal change in colour in childhood. Others used different words to explain it as normal.

3. The skin condition is not well known

A good number of the participants said that skin fungal infection is not well known to them and as such some associate it with allergy, dirt and even food but surprisingly they also mentioned some remedies with other participants

4. The skin condition is called skin rash

The entire participants called skin fungal infection skin rash. One of the respondent said that it has no special name other than skin rash. Others simply called it skin rash.

5. The skin condition is infectious

Majority of the respondents indicated that skin fungal infection is infectious; two stated that it's infectious through contact and sharing of clothes with infected person while three said it's infectious when one does not take care of his/herself in terms of dirt.

6. The skin condition is treatable

A good number of the participants reflected that skin fungal infection is treatable, one of the participants stated that its only HIV disease that is not treatable, though majority believed in their local remedies for the treatment, two of the respondents also were of the knowledge that it can be treated both with local remedies and also with medications from the clinics. Almost all the participants has a good knowledge of the local remedies for the treatment even the two respondents that said that skin fungal infection is not well known to them.

7. The skin condition has home remedies

All the respondents have good knowledge of the home remedies for the skin fungal infection such as brake fluid, potash, crushed charcoal in oil and herbs from the traditional doctors etc. All the respondents were able to mention at least two home remedies; none was ignorant of a home remedy for skin fungal infection.

8. The skin condition need not be presented as a complaint to the doctor

All the participants were optimistic and believed that skin fungal infection did not need to be reported to the doctor, this belief also forms the major reason for this study, and also form part of the inclusion criteria for recruiting the participants. They all had varied and similar reasons why skin fungal infection should not be presented as a complaint to a doctor in clinics. Their perceived reasons for not complaining about it ranges from not being a serious health problem, having alternative remedies for it home, child not complaining about it, being a normal thing to a child, difficult to treat, treated in the clinic in the past and it kept on reoccurring etc.

9. The skin condition is difficult to treat

A few of the participants stressed that skin fungal infection is difficult to treat even with the local remedies. This concept was also identified as one of the reasons why they do not raise it as one of the

child's health problems. Difficulty to treat was also expressed in different ways like reoccurrence, prolonged treatment and poor response to all forms of treatment.

10. The cause of skin condition is known

The majority of the interviewees expressed knowledge of the skin fungal infection. Though they used different terms to express their knowledge of skin fungal infection. However two have difficulty in saying that they knew the skin condition however they mentioned that skin fungal infection is not well known to them. None of the respondents said that she does not have any idea or knowledge of skin fungal infection.

4.5 Divergent Views

Few respondents also expressed some divergent views

One of such views was that HIV virus and bad blood cause skin condition. Another issue worth noting is that there is no word for the skin condition in Setswana. This conception is from the fact that all the respondents called it skin rash (Bogwata). This may be due to the fact that this study was conducted in a local clinic that is commonly being attended by less educated patients

4.6 INTEGRATED THEMES

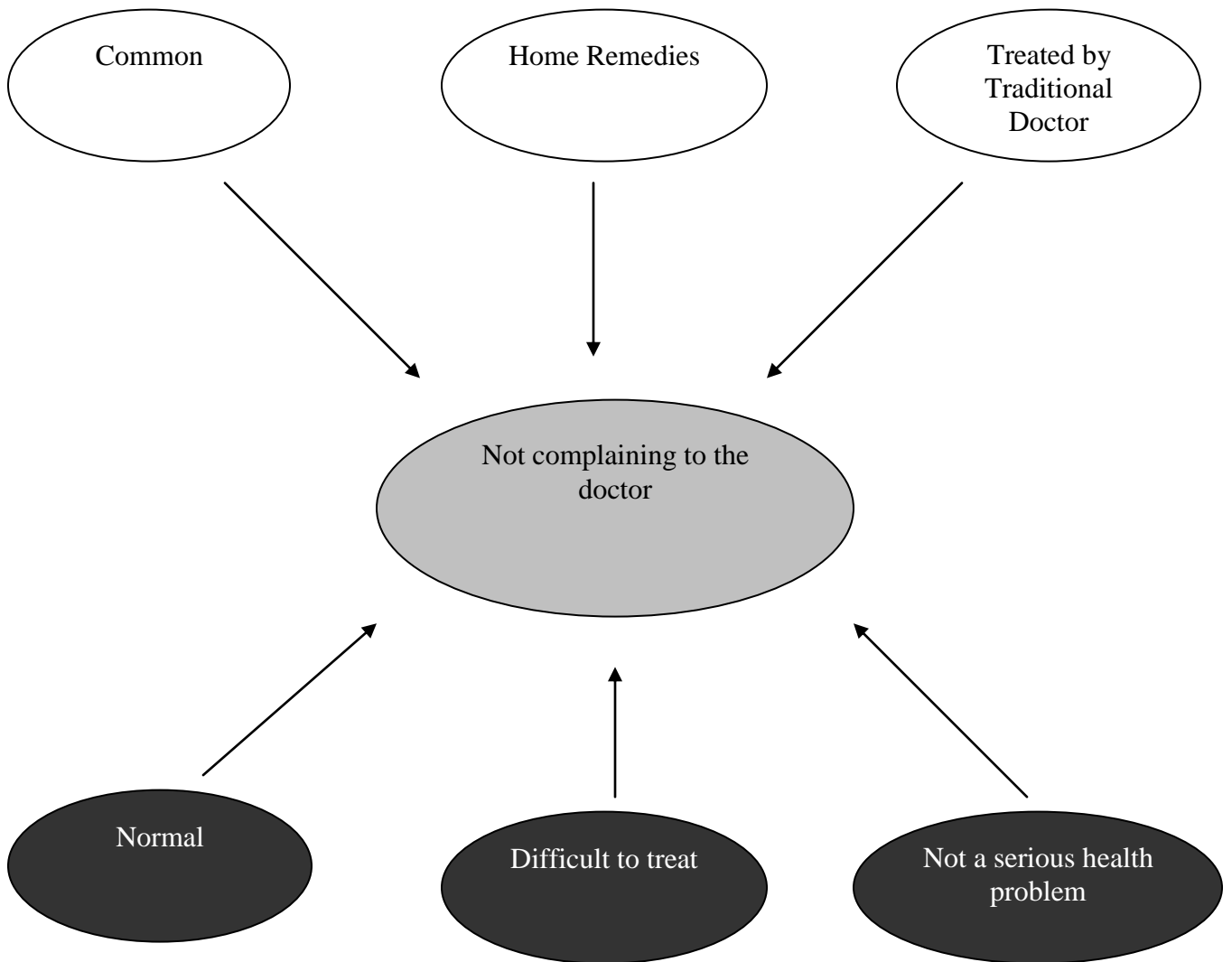
The combined themes were integrated to form the following themes

1. The skin condition is common (Common)
2. The skin condition has home remedies (Home Remedy)
3. The skin condition can be treated by traditional doctors
(Treated by traditional doctors)
4. The skin condition is normal on children (Normal)
5. The skin condition is difficult to treat (Difficult to treat)
6. The skin condition is not a serious health problem (Not a
serious health Problem)
7. Not to be presented as a complaint to a doctor

4.6.1 MODEL OF THE INTEGRATED THEMES

A model was developed from the integrated themes. The model represents the positive and negative interconnectedness of the themes. The model is represented below

Figure 1. Model of the combined list of themes



4.6.2 EXPLANATION OF THE MODEL

The model represents the help seeking behaviour of parents having children with the skin condition, which was elicited from the parent's knowledge, attitude, and behaviour towards the skin condition on their children.

The theme of the skin condition is common (Common). The skin condition has home remedies (Home Remedy), The skin condition can be treated by traditional doctors (Treated by traditional doctors), The skin condition is normal on children (Normal), The skin condition is difficult to treat (Difficult to treat), The skin condition is not a serious health problem (Not a serious health Problem), Not to be complained about to a doctor are presented in words, shapes, colours and are linked by arrows.

4.6.3 INTEGRATION OF THE MODEL

The integrated themes are grouped into positive and negative integrated themes. The positive themes of Common, Home remedy, Treated by traditional doctor are all linked by arrows (not to be presented as a complaint to the doctor). The arrow shows the relationship as a reason for not seeking help from the doctor. The negative themes are represented in black colour to portray the negative attitude that need to be corrected.

The link here is that parents do not seek help for the skin condition on their children because they believe it is normal on the child, it is a common problem, it can be treated by other people, it has a home remedy which they can use, it is difficult to treat and finally not a serious health problem and as such there is no need to present it as complaint to a doctor among other minor health problems.

CHAPTER 5

DISCUSSION

5.0 Introduction

This concluding chapter will discuss the results of this study, making references to the methods used. It also contains a critique from the methodological point of view including the strength and weakness of the study. Free attitude interviews of 8 participants representing the demographic and social variation of the study population have tried assessing their perception on the help seeking behaviour of parents having children with skin fungal infection. Through understanding, interpretation and conceptualization, these unstructured responses produced interesting themes. Insights on the concept of these perceptions also identified by Hall (1977) as an adjunct to voiced practice in determining behaviour were also revealed. They formed basis for comparison between the participants view

The study used maximum variation sampling method described as the most useful strategy for naturalistic approach to overcome the limitation of unavoidable small sample. However, in spite of the manipulation to generate this heterogeneous sample, the consistency and homogeneity of views on major themes were striking and rewarding. According to Patton, “For small samples a great deal of heterogeneity can be a problem because individual cases are so different from each other. The maximum variation

sampling strategy turns that apparent weakness into a strength by applying the following logic: Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program” (Patton, 1990: p.172; cited by Hoepfl, 1997).

Therefore, with sample size driven by conceptual saturation and participants’ selection manipulated to achieve heterogeneity, this study achieves sufficient depth and breadth required to minimize the limitation of generalizability inherent on qualitative sampling method.

The discussion of the result will include their interpretation, implications and comparisons with any related study available.

5.1 Methods

The study was a descriptive qualitative enquiry using a free attitude (one to one) interview technique for data collection (Lofland 1971; Coulson, Goldstein, & Ntuli 1995). The decision to use the interpretive paradigm in this study was to enhance open-mindedness, open-heartedness and maintain dialogical openness (Smaling 1993).

The free attitude interview technique was used because it gives the interviewees more freedom to speak than the focus group interview although; it has the limitation in that it provides “indirect” information filtered through the views of interviewees (Creswell 1994). The large volume of transcribed audiotaped data from the interviews in this study confirmed that the free attitude interview was appropriate for the study.

Majority of the interviewees were relaxed and discussed open-mindedly with the assistant researcher on the research topic.

Different sources of data collection (audio recording, field notes and observations) were used in this study to ensure data collection triangulation and thus enhance validity (Britten 1995).

Limitations of the methods.

Language

The use of SeTswana, which the researcher could neither speak nor understand, very well could be a weakness in this study. This limitation was however reduced by selecting a research assistant that understood both Setswana and English very well.

Audio Equipment

The presence of a tape recorder, used for recording the interviews, could have been a barrier in terms of sharing information by the respondents. This did not prove to be the case since; almost all the respondents' shared information freely.

Research Team

The research team was made up of the researcher, an African male and a senior medical officer at Francistown council clinics and a retired nurse, a female and of MoTswana origin who retired barely two months before she was trained as research assistant. She worked with researcher for over two years in Francistown Council clinics and as such there was no negative impact on the research process.

The Semi-urban context

The semi-urban context of the study and the use of only government clinics where the majority of the patients were attending the clinic were both poor and not well educated because free health delivery makes it inapplicable in urban areas and also in private practice settings.

5.2 Results

All the participants were females and majority were grand mothers aging between forty and sixty years. The responses of all the participants were relatively similar and there was no major deviation from their responses despite the fact that there was a very big gap in age differences among the participants. All the participants had basic and similar knowledge about what they thought was the cause, signs and symptoms of the skin condition and all of them seemed to know the condition as skin rash, no other different name came up through out the interview.

The findings of this study were compared with few studies done elsewhere. However there was no study that was directly related to this study both in Botswana and overseas because no related study was identified during the course of literature review. However studies on health belief, child neglect and health seeking behaviour were identified and reviewed. Comparison and associations were also correlated with this study and few studies done elsewhere. It appears that no study directly related to health seeking behaviour of parents having children with minor health problem has been done.

All the participants agreed that they had seen the skin condition before and that it was common in children, but from further information they all gave it the same name as skin rash, which appears that they could equally be mixing it up with other skin infection. Six of the participants knew the signs and symptoms like itching but two said that despite the fact that they have seen it before, however they did not know much about it.

All the eight participants named it skin rash, none deviated from this name, and from this it appears that SeTswana probably did not have name for skin fungal infection or that due to the fact that participants did not attend school beyond the primary school, they were limited by knowledge of the SeTswana name for skin fungal infection.

On the issue of skin fungal infection being infectious, five believed that it is infectious, the other three said that they did not know whether it was infectious or not, however none of them said that it was not infectious, among those who said that they did not know if it

is infectious went further to say that one can get it from dirty clothes and by not taking bath or sharing cloths.

On the knowledge of the cause, only one of the participants said that it is caused by germ and it can be assumed that was the only simple way she could explain fungal infection, others related the cause to allergy, food and four of the participants related it to HIV infection as the direct cause, this could be a misconception from the knowledge and most literature that suggest that skin infection including skin fungal infection were common in HIV infected individuals. Despite the fact that HIV infection does not cause skin fungal infection it is relatively difficult to explain the relationship to the class of the participants which had to do with the immune system distortion knowing skin to be the window of what was happening inside the body.

In this study seven of the respondents believed that skin fungal infection was treatable but one believed that it is not treatable and went further to say that it is normal in children as they were changing colour at that stage of their life, ironically she went further also to give some alternative remedies for the management. Out of the seven that believe that it is treatable one also said that it was normal in children.

The determinants of help seeking behaviour of parents with this minor problem were largely seen on their reasons for not complaining about the ailment. All the participants had varied reasons for not seeking help for the skin fungal infection and their reasons

tended to coincide with one another. Above all it became clear that the factors that determined the health-seeking behaviour were:

- 1. Availability of alternative remedies (home remedies and native doctors)**
- 2. Whether the child complains about the skin condition**
- 3. Whether the parent/guardian considered the condition as a disease**
- 4. The difficulty in the management of the skin condition (recurrence)**
- 5. The skin condition not viewed as a serious health problem**

The highest among these was the fact that there is availability of alternative medicine or an alternative place to consult for the health problem example the native doctor, despite the fact that majority of them were aware that it is treatable the fact that the children did not complain about it also made them not to see it as a health problem

5.3 The Themes and association/comparison with other studies

The emerging themes built on participants experiences, largely delineated the similarity between insightful public awareness and those of the paternalistic medical elites on issues around health seeking behaviour of parents having children with minor health problems such as fungal skin infection as seen in a community in Francistown Botswana where such minor health problem were not being complained by parents among other minor health problems. However minor deviant and novel views were equally exposed.

The major focus of this study was to understand why parents or guardians do not complain skin fungal infection on their children among other minor health problems and this was not explored in isolation, factors that influence health seeking behaviour as elaborated in Guatemala (Goldman et al 2000) were incorporated into the major themes

Furthermore to enhance the utility of this study in attempting to correlate health seeking behaviour additional themes around illness, cultural and medical beliefs were also revealed as seen in Ghana (Hill Z, *et al* 2003)

5.3.1 Availability of alternative remedies(Home Remedies)

Most respondents identified availability of alternative remedies for the treatment of skin infection such as herbs and break fluids their reason for complaining of the skin infection on their children and this was similarly noted in the study of Hildenwall et al 2007 where it was stated culturally some illness episode may be interpreted as best suited for traditional care. Observation from eastern Uganda showed the emic illness concept “*enhonhi*” (literally translated “bird disease”) to involve symptoms of all three major childhood killers yet the stated treatment preference was herbs.

5.3.2 Recurrence/Past experience & Difficult in managing some health problem

Another dimension of interest in the responses was that few participants cited that their past experience in the treatment of skin lesions without effect or resolving was their main reason for not complaining about the skin fungal infection on their child. Relatively in the study by D'Souza, it was stated that past experience with similar illness can motivate mothers to play a 'waiting game' in seeking for help for the same medical condition. Another issue to this was that when health care are sought the quality of treatment or care received might not be adequate and may cause delay in subsequent seeking for health care. In this study two respondents stated that they had in the past complained and received treatment in the clinics but then the skin infection persisted and that was there main reason for not complaining. Some were able to mention were given calamine lotion to apply on the skin infection. Trans in their study noted that health care system deficiencies include limited human resources, drug supplies and services management capacity (Travis *et al*, 2004). Despite these documentations of health care provision and system deficiencies, little attention has been paid to understanding how users view the quality of care provided and received.

5.3.3 Skin condition not viewed as a serious health problem

All participants had similar understanding of skin fungal and most belief that it is common, normal and not a serious health problem and as such need not to be complained. Similarly some studies have also shown that perceived illness severity, maternal recognition of certain signs and symptoms of childhood illness were critical factors determining health care seeking behaviour (Goldman N, Heuveline P 2000). In

the same manner guardian and caretakers may also not seek for help or abstain from seeking care for their child health if they fail to recognize symptoms or do not consider them dangerous. More over, one disease may be misinterpreted for another; especially where health information has focused on some illness while giving less attention to others. In Uganda, 'Omusudha' (hot body) is used for any childhood fever (Nsungwa-Sabiiti J et al 2004) and is frequently treated with anti-malarial drugs (Kallander K et al 2005), this may delay treatment for other febrile illness, in particular pneumonia since symptoms often overlap with those of malaria.

5.3.4 Cost and Accessibility to Medical treatment

Some studies noted that cost and distance to health centres could be inhibitory health seeking behaviour. However this seem not to same in Botswana where this study was conducted, health services were free and there are clinics well located in the community with associated regular and persistent free transport of patients to and back home to the clinics which were well located with the community yet they fail to seek for help for minor health problem like skin fungal infection. Lack of access to health care due to high cost is perhaps the most common deterrent to optimal health care seeking in both rural and urban communities (Thind A, Cruz AM 2003). This was not obtained in this study.

Also Peterson S et al stated that once a care taker has recognized illness and decides to seek care, household responsibility and long distance to health units may still delay the help seeking behaviour.

5.3.5 Child not complaining about the health problem

A salient but interesting finding was that most parents tend to seek for health problem for their children when the child complains about the health problem and this marked when there is a good relationship/understanding between the child and the parents. Most of the participants stated that their reason for not complaining about the skin fungal infection was because the child never complained about it. This was also noted in the studies conducted elsewhere. The health parent relationships enhance children's good health. For example, positive parent child communication helps children express their health needs to their parents openly and help parents give health knowledge to their children effectively. In contrast negative communication hinders children to tell their illness experiences and block parents to deliver health to the children as well.

In particular so called psychosomatic problems of children are related to certain familial characteristics such as enmeshment, rigidity, over protection and conflict avoidance (Minuchin *et al* 1978). There fore to prevent symptom oriented of children's illness and to understand the illness in their family level is the first step before help for child health is sought.

5.4 Generalisability versus Transferability

The findings of this study as is the case with most qualitative studies might not be generalized to other population groups. But they could be transferable to other population group with a similar cultural background.

Impacts of this study on the community and the researcher

Impact of the study:

- ❑ Creation of awareness that the skin fungal infection needs to be treated
- ❑ That Botswana may not have a Setswana name for the skin fungal infection
- ❑ The study was a learning process about patients' knowledge on the skin condition

Divergent Views

Few respondents also expressed some divergent views

One of such views was that HIV virus and bad blood cause the skin condition. Another issue worth noting is that there is no name the skin condition in Setswana. This conception is from the fact that the entire respondent called it skin rash (Bogwata). This may be due to the fact that this study was conducted in a local clinic that is commonly being attended by less educated ones

5.5 CONCLUSION

“The determinants of help seeking behaviour of parents having children with minor illness: Case study of The skin conditions” was carried out using parents and guardian as the participants assessing their knowledge, beliefs and attitude towards the skin condition and the out come of the study was briefly summarized as follows

Francistown community, which was where the study was carried out perceived the skin condition as a common infectious skin problem, that is treatable.

There is adequate knowledge of the symptoms of the skin fungal infection among the participants.

Some believe that skin fungal infection is common in children as they were changing colours at that stage of life and will get okay when they grow up.

Many of them believe that they do not know the cause and even the few that felt that knew the cause could not give a good account of the exact cause of the skin fungal infection, only one said that it is caused by a germ.

Most of the participants were aware that it is treatable but yet they were not keen seeking for help when they come to the clinics because of one or two of the following reasons: Availability of alternative treatment; Concern of the child especially if the child complains about the problem; Concern of the parents when the parents consider such

minor health concern as a health on the child; Issues around difficult in management of the problem; Health problem being tolerable.

Finally, the current epidemic of HIV/AIDS and the increase of skin fungal infection have made some participants believe or see it as the cause of skin fungal infection, an idea that is seen as a misconception and need to be corrected.

5.6 RECOMMENDATIONS

The findings of this study raised a number of issues that need attention from various role players. In the light of prevailing need to balance parents' knowledge and determinants of their health seeking behaviour the following recommendations were suggested.

- Staged implementation that will start and continue with community education as well as public health program that should enforce the knowledge that the skin condition is treatable and curable not only by herbs, native doctors and the alternatives mentioned but all by the orthodox medicine
- Sustained public involvement and education campaign extended to provide the knowledge that skin fungal infection is contagious and also major health problem in all age group.
- In-depth feasibility assessment taking cognisance of other challenges and concern around the issue of skin fungal infection not responding to orthodox medication

effectively and the need for the awareness that a long term treatment is required for a proper cure of skin fungal infection.

- Capacity improvement to maintain and expand public access to the existing resources and need for the authorities to organise on-going in-service education of the staff member that could as well inform parents help should be sort for all health problem irrespective of whether the child complained about it or not
- Need for further enquiry on whether there is a Setswana word for skin fungal infection in Botswana since all the participants in this study called it skin rash.

5.6.1 Take Home Message from the Researcher:

1. If you suspect you or your child has fungal skin infection, go to your doctor right away for treatment. The sooner it is diagnosed and treated the less likely there will be either temporary or permanent effects.
2. Prevent the spread by
 - a. Stop sharing of personal items e.g. Combs and brushes
 - b. Limit scratching
 - c. Speak to your child teacher
 - d. Cover the scalp with a cap

5.6.2 Complications if neglected:

1. Temporary/Permanent hair loss
2. Long term persistent itching

3. Infected leading to fever, swollen glands and body rash

The average ringworm patient is between four and five years old. In addition to schools, out breaks have been noted in day care centres, as well as in nurseries among infants as young as nine days old, and frequently among high school age athletes. Earlier ringworm is not a reportable disease and hence is not tracked by US Public Health Agencies. Yet there is the belief among paediatricians that the frequency of scalp ringworm (*Tinea capitis*) is on the rise. Sensitivity to the condition and a thorough knowledge of what it looks like is essential to parents, as is screening by school nurses. Because of the extreme contagious nature of the infection, early detection is the key to preventing spread and limiting the degree of problems the infection causes.

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APPENDIX B

Statement by the Researcher

I provided verbal and written information regarding this Study / Project
I agree to answer any future questions concerning the Study / Project to the best of my
knowledge.

I will adhere to the approved protocol.

IFEBUZOR DECIDERIUS CHIKA

.....

Name of Researcher

Delete whatever is not applicable.

.....

Signature

.....

Date

APPENDIX C: APPROVED RESEARCH PROTOCOL

RESEARCH PROTOCOL

TITLE: “THE DETERMINANTS OF THE HELP SEEKING BEHAVIOUR
OF PARENTS HAVING CHILDREN WITH MINOR ILLNESS:
CASE STUDY OF FUNGAL SKIN INFECTIONS”

STUDENT: DR. DECIDERIUS CHIKA IFEBUZOR
STUDENT NO: 200253336

SUPERVISOR: DR. HONEY L. MABUZA
BTh (UNISA), MBChB, MFamMed (MEDUNSA)
Principal Family Physician. Family Medicine & PHC
University of Limpopo (Medunsa Campus)

TO: DEPARTMENT OF FAMILY MEDICINE
UNIVERSITY OF LIMPOPO
MEDUNSA CAMPUS

INTRODUCTION

In Botswana fungal skin infection is a major public health problem among children and more than 50% of children attend the government clinic with either of the parents or guardian. For over three years I have worked in the government clinics in Francistown, I have observed that the majority of the parents bring their children to the clinic with fungal skin infections and other minor health problems without including the fungal skin infections as one of the presenting complaints. This particular behavior or attitude of parents is progressively increasing leading to a situation whereby the fungal skin infections get worse and treatment becomes a source of economic waste.

I have chosen this fungal skin infection as one of the commonly neglected health problems using parents or guardians as the object of this study with particular reference to accessing their knowledge, attitudes and behavior towards such infections. I hope that the information I will obtain from the study will trigger a change from the current situation.

The main aim of this study is to understand why parents ignore certain lesser illnesses e.g. fungal skin infections and to respond appropriately to this knowledge. The commonest of such fungal skin infections are tinea corporis and pityriasis versicolor.

Literature Review

Fungal skin disorders are common and represent a significant component of any primary care practice that involves children. From my little knowledge, Fungi are ubiquitous organisms capable of colonizing almost any environment, including virtually all humans. They grow in irregular masses and can be broadly divided into two basic forms: mold and yeast. Superficial fungal infection in children are usually caused by yeast (for example, *Candida malassezia*) or dermatophytes (eg, *Trichophyton*, *microsporum*, *epidermophyton*) Dermatophytes can be acquired from people (anthropophilic), animals (zoophilic) or soil (geophilic). In the United States the most common source of exposure is other people. The skin responds to this superficial infection by increased proliferation, which leads to scaling and epidermal thickening. ‘The most common dermatophyte in the United States and the world, *Trichophyton rubrum* causes the majority of skin infections that do not involve the scalp. It is estimated that 10% to 20% of the world’s population is infected by a dermatophyte⁽¹⁾

Dermatophyte infections are commonly referred to as ringworm, or tinea. Tinea is further classified according to its locations on the body, the next part of the name describing the area of the body where it is found for example, *Tinea corporis* and *Tinea capitis* meaning fungal infection of the body and scalp respectively, Children primarily get it on the scalp this is uncommon for adults who experience it more on the trunk, neck, extremities and skin folds. It is very much contagious and the incubation period is unknown but however its usually seen 10-14 days after contact depending on the site.

Their appearance on the body depends largely on their location on the body. On a skin surface it usually first appears as small, round, red spots. As these spots enlarge the centre begins to clear, creating the appearance of a ring with a raised border that is red and scaly. Most of the time parents tend to be the first to identify fungal infection on their

children and yet they tend to neglect it often: A parent might discover a small, round dry and flaky patch on a child's scalp or skin while giving the child a bath. In one to two days the same patch may enlarge, appear very circular and begin to develop a raised reddish border. On the scalp the fungal infection can present in several other ways. In a child for instance, brittle hair that breaks off close to the scalp, black dots which are broken-off hairs close to the surface, nodule which appear boggy, inflamed or infected, round white scaling lesions which may or may not be itching or associated with hair loss.

Irritation or itching on the skin does not always mean fungal skin infection. The best plan when the above signs appear to be present is to have the child seen by a physician right away. "Recognizing the common manifestations of pediatric fungal infections is a key part of any primary care practice. Of paramount importance is the clinical acumen of the physician. Drs Berg and Erickson discuss several types of fungal infections in children; identify tools for diagnosis. Newer "off-label" therapies are also examined"²

Dermatophyte infection of the general body surface that is not otherwise named more specifically is termed tinea corporis. The most common organisms responsible are *T. rubrum*, *microsporum canis*, and *Trichophyton mentagrophytes* ⁽³⁾. *T. rubrum* actually causes the majority of non scalp skin infections in the United States and the world.

"Tinea versicolor is an infection of the stratum corneum epidermidis where sebaceous glands are present"⁴, caused by the lipophilic yeast *M.furfur* (previously called *pityrosporum orbiculare*), it is not contagious and in most cases represents a shift in the relationship between a human and his or her resident yeast flora.

Mode of transmission: Fungal skin infection in children cannot be completely avoided, though it is also not extremely common. Fungus is present in almost all areas of our environment and a whole host of fungal sources are present in our everyday lives. The spread is by direct contact with the fungus such as:

- Touching infected people
- Using comb and brushes of infected individuals

- Wearing hats or using head-sets when fungus is present
- Walking bare footed on damp locker-room floors
- Infected pets for example cats.

Immunity to Fungus: Older people are much less likely to contract fungal skin infection than children. For after having had the problem before they may have developed some level of immunity which is protective,. However immunity to fungus occurs far less efficiently than to bacteria and viral skin infections, so recurrent attacks do occur. To complicate things a bit further – because there are a number of different fungus which cause these infections, an immunity to one may not convey an immunity to another.

Complications if neglected:

4. Temporary/Permanent hair loss
5. Long term persistent itching
6. Infected leading to fever, swollen glands and body rash

The average ringworm patient is between four and five years old. In addition to schools, out breaks have been noted in day care centers, as well as in nurseries among infants as young as nine days old, and frequently among high school age athletes. Earlier ringworm is not a reportable disease and hence is not tracked by US Public Health Agencies. Yet there is the belief among pediatricians that the frequency of scalp ringworm (*Tinea capitis*) is on the rise. Sensitivity to the condition and a thorough knowledge of what it looks like is essential to parents, as is screening by school nurses. Because of the extreme contagious nature of the infection, early detection is key to preventing spread and limiting the degree of problems the infection causes.

Take Home Message:

3. If you suspect you or your child has fungal skin infection, go to your doctor right away for treatment. The sooner it is diagnosed and treated the less likely there will be either temporary or permanent effects.
4. Prevent the spread by

- a. Stop sharing of personal items e.g. Combs and brushes
- b. Limit scratching
- c. Speak to your child teacher
- d. Cover the scalp with a cap

Child Neglect:

Neglect occurs when a child's basic needs food, clothing, a home, education, love, protection and health care not met adequately⁵

Health care providers and others have focused on child physical and sexual abuse, paying less attention to child neglect (Wolock & Horowitz, 1984)⁶. There are several reasons why neglect has not received the attention it deserves (Dubowitz 1994)⁷. First the typically vague definitions of neglect have made it an amorphous phenomenon. Many are understandably unclear about what constitutes neglect, how to identify neglect or what course of action is appropriate and effective. Second, health care providers under demands to screen for multiple conditions and also to be aware of cost containment, thus limiting the time they spend with individual families to detect problems such as neglect. Third, the strong associations between child neglect and poverty (Giovannoni & Becerra, 1979)⁸ often evokes a sense of hopelessness and helplessness among professionals, deterring them from becoming involved in the complex issues common among very low-income families. Finally, neglect does not evoke the horror and outrage that abuse does. In defining neglected health, our interest is to adequately protect children and to help ensure their health, safety and well-being. Neglected health care can thus be conceptualized as occurring when children's basic health care needs are not met. This relatively broad definition is based on the basic needs of children that are not met rather than on parental omissions in care. A basic health care need is one in which there is adequate evidence that health is harmed or jeopardized by the specific need not being addressed (for example, death of a child with diabetes due to lack of attention to recommendations) (Geffken, Johnson, Silverstein, & Rosenbloom, 1992)⁹

Many situations may not arise to this standard of actual or potential harm (for example, a missed follow up appointment for an ear infection in a healthy child) Implicit in this definition is the likelihood that the care or treatment will significantly benefit the child. If the benefit is equivocal (for example, an experimental treatment for cancer), not receiving the treatment should not be construed as neglect. This definition of neglect is based on a child's un-met needs and does not include the issues of cause(s), or contributory factors) From the child's perspective, not receiving necessary care is neglect regardless of the reasons why such care is not provided. The causes however are important when considering how best to intervene.

This broad definition of neglect of children's health differs from the narrow framework embodied in Federal and the States laws that limit neglect to omissions in care by a parent or primary care-giver (U.S congress. 1996)¹⁰. Child Protective Services (CPS) accordingly confines its involvement to narrow view. A broad child focused definition has many advantages over a narrow one by examining the role of all the contributory factors; the broad definition should lead to more varied and appropriate interventions. Potentially this broad approach should be more effective in preventing or ameliorating neglectful situations. The broad definition more accurately reflects the array of possible causes not just parental behavior. However, clarification of the parental role remains important: Parents are primarily responsible for their children's care. But professionals, community agencies and social policies also influence the health of children and therefore share responsibility. There are however several other important issues in conceptualizing neglect: actual versus potential harm. Short versus long term-harm. Concern with physical and psychological out comes and continuum of care.

The ecological theory that helps explain physical abuse and neglect is also useful with regard to medical neglect .¹¹

The ecological theory posits that there are multiple and interacting contributors to child maltreatment rather than any single cause, and these factors are at the levels of the individual child and parent, the family, the community and the society. For example, a parent who has lost his or her job and health insurance and is feeling depressed is at high

risk for not ensuring that his or her child with fungal skin infection receives necessary care and medications.

Many of the characteristics of mothers of neglected children may also contribute to children's health care needs not being met. Maternal problems concerning emotional health, intellectual abilities and substance abuse have been associated with neglect. Emotional disturbances, especially depressions have frequently been found among mothers of neglected children. Intellectual impairment, including severe mental retardation and lack of education has also been associated with neglect.¹²

Most illicit drugs pose definite risks to the fetus and child and the compromised care giving abilities of drug-abusing parents are a major concern. High rates of alcoholism and drug addiction have been found among families of neglected children.

Most decisions regarding children's health are made by parents including when to seek professional care. Crittenden's (1993) model helps refine our understanding of parental difficulties by considering four steps:

- (e) Perception of the child's problem
- (f) Interpretation of the problem
- (g) Response to the problem
- (h) Implementation⁽¹³⁾

Difficulties with any of these steps may lead to health needs not being met. The parent first needs to perceive the problem. Parents may perceive the problem but interpret it incorrectly. Lack of knowledge is again an obstacle. A parent may feel moodiness is common in children, unaware that children can be depressed and for this condition parent may be unaware that treatment exists: Popular or folk interpretation of a symptom such as an infant crying frequently because "he's spoils" may lead to a problem being missed. Again parents with limited cognitive abilities or emotional problems may have difficult interpreting their child's cues, determining the care needed and understanding and implementing the treatment plan. Occasionally parents may not appreciate the seriousness of the problem or the importance of the treatment due to inadequate communication with health care providers.

Inadequate knowledge about children and health and inappropriate expectation contribute to neglect for example, parents may not know that a baby with diarrhea risks becoming dehydrated. Parents may not appreciate such needs, particularly if they are cognitively limited. Medical neglect may occur when parents refuse medical treatment for their child based on their religious beliefs, for example Jehovah's Witnesses refuse surgery when the need for blood transfusion is anticipated. ' A child is not to be deemed abused or neglected merely because she is receiving treatment by spiritual means, through prayer according to the tenets of a recognized religion ⁽¹⁴⁾

In some situation parents may be in denial an unconscious defence mechanism about a child's condition. Parents of neglected children are less knowledgeable about developmental milestones and have limited knowledge about parenting, poor skills, and low motivation to be a good parent ⁽¹⁵⁾

Purpose of Study:

Purpose of the study is to understand help seeking behavior of parents having children with minor illnesses such as fungal skin infection and to respond appropriately to such behaviors.

Objective:

- (a) To assess parents knowledge and belief of skin fungal infections on their children.

- (b) To determine why parents do not complain about skin fungal infection among other health problems of their children.

Research question:

What are the determinants of the help-seeking behavior of parents having children with fungal skin infections?.

Method:

This study will be carried out as a qualitative study by interviewing parents or guardians who bring their children with skin fungal infection and other common health problems to the government clinics without including the skin fungal infection as one of the child's health problem. For the purpose of this study the word parent should mean any of the following father, mother or guardian.

The sample population will include any parent who brings a child between the ages of 5 years to 15 years irrespective of gender with a fungal skin infection among other health problems without including this as one of the child's medical problems. The study should be explained to such parents and only those that consent will be used for the study. A free attitude interview will be used and the interview continued until information is saturated. Other criteria for including a parent for the study is that the parent should be resident in Francistown and can communicate freely in the local language (Setswana) and / or English.

Data Collection:

For the purpose of this study, a signed informed consent (Modified Medunsa Consent Form) Appendix 1 will be obtained from the parent and the interview will either be conducted on that day or the person may be invited for the interview on another day in the clinic if every factor is not favorable on that particular day. They will be expected to

fill a short questionnaire, which will be anonymous but will complete information on age, sex, occupation, educational background, marital status and family monthly income.

The interview will be conducted in either English or the local language (Setswana) with the help of two nurses that I will train and who understand English and Setswana very well. Their assistance will be needed when they are on duty and the researcher will be present but dormant during the interview but may occasionally clarify issues. The exploratory question will be: “O itse go le kae ka bolwetsi jone jo jwa letlalo” meaning “How much do you know about this skin infection” while pointing to the fungal skin infection. This will be facilitated to widen the discussion to obtain all the information needed without introducing any new question.

The interviews will be recorded on the cassette and the nurses will do the translation to English.

Data Analysis:

The interviews which are recorded in the local language (Setswana) should be replayed among the trained nurses to agree on the same translation which should be a verbatim transcription and translation after which it will be given to an independent assistant that understands the local language (Setswana) and English very well to verify correctness of the translation of each interview.

At the end of the process, if the researcher is convinced that the relevant information has been obtained from the interview he will then analyze the information obtained and group it thematically by the cut and paste technique. The relevant information along with the participant's personal data will form the basis for the write up of the dissertation.

Reliability/Validity:

For the validity and reliability of this study adequate time will be spent on each interview with participants allowed to exhaust the topic till no new information is coming out. The exploratory question has also been drafted so that each participant gets the same and

exact question. Free attitude interview should be used and each participant should be given enough time to say all he/she wants to say. At the end of each interview, salient points should be highlighted to the participants to confirm that the information gathered from them is exactly what they meant during the interview. Information obtained should be fed back to the participants for validation. The entire recorded interview in local language (Setswana) should be translated to English by the research assistance and an independent assistance.

BIAS:

The researcher is from a different cultural setting and also having poor knowledge of the local language (Setswana). This may bring a little bias in understanding very well what the participants are saying. This we tried to take care of by using research assistance that are from the same background and understands the local language very well. There may also be some bias from parents who may understand that they are being judged as inadequate because they are not reporting the lesser illnesses. Medical delivery in Botswana is free in all government clinics and more than 98% of the educated ones are working and these group have medical aids and as such attend the private clinics and this will limit the studies to only poor and non educated ones being identified in this study.

Ethical Consideration:

For ethical purposes and for the success of this study, I will obtain permission from my employers. I will also explain the purpose of the study to the participants. I will stress confidentiality and also get a signed consent form from them. It will be made clear to them that they may withdraw at any time from the research. I will also obtain permission from the Department Research Committee, Family Medicine Medunsa, and Research Ethics and Publications Committee, Medunsa before embarking on the study.

Dissemination:

At the end of this research study all the relevant information obtained should be locally pasted in the clinics as posters and leaflets. Efforts should also be made to get approval from the local authority for awareness campaign locally in Francistown, Botswana.

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Implementation:

Time Frame for the Project	-	10 months
Completion of Protocol	-	November 2004
Interview of Participants	-	December 2004 – February 2005
Analysis of Data	-	February 2004 – March 2005
Completion of dissertation	-	April 2005 – September 2005

BUDGET

1.	Stationery	-	P700.00
2.	Computer Use	-	P800.00
3.	Project	-	P800.00
4.	Transport	-	P400.00
5.	Incentive to Participants		P0.00
6.	Miscellaneous		P500.00
	TOTAL		P3, 200.00(Equiv. to 670USD)

Appendix 1

Modified University of Limpopo (Medunsa Campus) Consent Form

I _____ hereby give my consent to participate in the research project. Parents Perceptions of their children's skin fungal infection in the government clinics in Francistown, Botswana.

Dr Deciderius Chika Ifebuzor has explained to me the aims and objectives of the study, which were very clear to me.

I understand that participation in this study is completely voluntary, I am not pressurized to participate and I can withdraw at any time without supplying reasons.

I know that the Research, Ethics and Publication of University of Limpopo (Medunsa Campus) have approved this study. I am fully aware that results obtained from this study will be used for scientific purposes and maybe published. I agree to this provided my privacy is guaranteed.

Signature of Participant

Place

Date

Witness

STATEMENT BY THE DOCTOR

I provided verbal information regarding this study. I agree to answer any future questions concerning this study as best as I can.

I will adhere to the approved protocol.

Signature

Date

Place

UNIVERSITY OF LIMPOPO

Medunsa Campus



RESEARCH, ETHICS & PUBLICATIONS COMMITTEE

FACULTY OF MEDICINE

CLEARANCE CERTIFICATE

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MEETING: 03/2006

PROJECT NUMBER: MP 36/2006

PROJECT: Title:

The determinants of the help seeking behavior of parents having children with minor illness: Care study of fungal skin infections

Researcher:

Dr D Ifebuzor

Supervisor:

Dr H Mabuza

Hospital Superintendent:

Dr H Thuku

Department:

Family Medicine & Primary Health Care

Degree:

M Med (Family Medicine)

DATE CONSIDERED: April 05, 2006

DECISION OF COMMITTEE:

REPC approved the project.

DATE: April 05, 2006

PROF GA OGUNBANJO
CHAIRMAN (RESEARCH) REPC OF FBM



Note: i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.

ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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