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## Young families' utilisation, self-perceived requirements, and satisfaction with child health services in the City of Belmont, Western Australia

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School of Nursing

YOUNG FAMILIES' UTILISATION, SELF-PERCEIVED REQUIREMENTS, AND  
SATISFACTION WITH CHILD HEALTH SERVICES IN THE CITY OF BELMONT,  
WESTERN AUSTRALIA.

by

AILSA M. MUNNS

BACHELOR APPLIED SCIENCE (NURSING)

This thesis is presented as part of the requirement for the degree of Master of Nursing,

Edith Cowan University, Perth, Western Australia

1998

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## ABSTRACT

The expectations of young families regarding care they would like to receive from community nurses working in the child health area is affected by the relationship between those expectations, utilisation and sociocultural factors such as family type, family composition and ethnicity. These factors influence family dynamics, needs, functioning and interactions with the wider community.

A descriptive study with both quantitative and qualitative components was used to identify and analyse the self-identified requirements of young families utilising Child Health Services in the Belmont area, Western Australia, and their patterns of utilisation. Twenty five women who had a child or children under 5 years of age were interviewed. The study was guided by a conceptual framework provided by the Ottawa Charter (World Health Organisation-Health and Welfare Canada-Canadian Public Health Organisation, 1996).

The three main themes that emerged from the data showed that the young families identified knowledge acquisition, reassurance of normal growth and development and accessibility as their key self-perceived requirements of Child Health Services. Family type, family composition and ethnicity were examined within the contexts of these themes, resulting in a greater understanding of the child health issues relating to all types of family groups.

The challenge for the providers of Child Health Services is to provide culturally appropriate Child Health Services based on the principles of primary health care within an environment experiencing fiscal restraint. The long term benefits to the families and the health care system are not easily evaluated but have important and wide ranging positive effects on the health and wellbeing of the community.

**DECLARATION**

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for any degree or diploma in any institution of higher education, and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text.

**SIGNATURE..****DATE.....** 10.8.98



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## CHAPTER 1

### INTRODUCTION

The health of a community is a multifaceted, dynamic and challenging concern...

The challenge for anyone concerned with community health lies in the process of becoming familiar with a community, discovering its uniqueness, learning what its particular needs and concerns are, and enabling change or the maintenance of health. This is the challenge of community nursing (McMurray, 1993, p.3).

This study seeks to examine the expectations of clients regarding the care they receive and would like to receive from community nurses working in the child health area.

Previous studies have not fully explored the relationship between client expectations and utilisation and sociocultural factors such as family type, family composition and ethnicity. These factors influence family dynamics, needs, functioning and interactions with the wider community, and are thus crucial in any assessment of health needs. This research will provide a current perspective on the self-identified requirements of young families utilising Child Health Services and patterns of utilisation. Women in the City of Belmont were interviewed to elicit their views on these matters. The information has importance for child health nurses, public health policy makers and administrators.

The literature shows that while there is agreement that client participation in population centred community nursing programmes is necessary for effectiveness, there is little supporting evidence of client identified needs being used in the development of these programmes (Douchette, 1989; Kreger, 1991; McMurray, 1993; Public Health

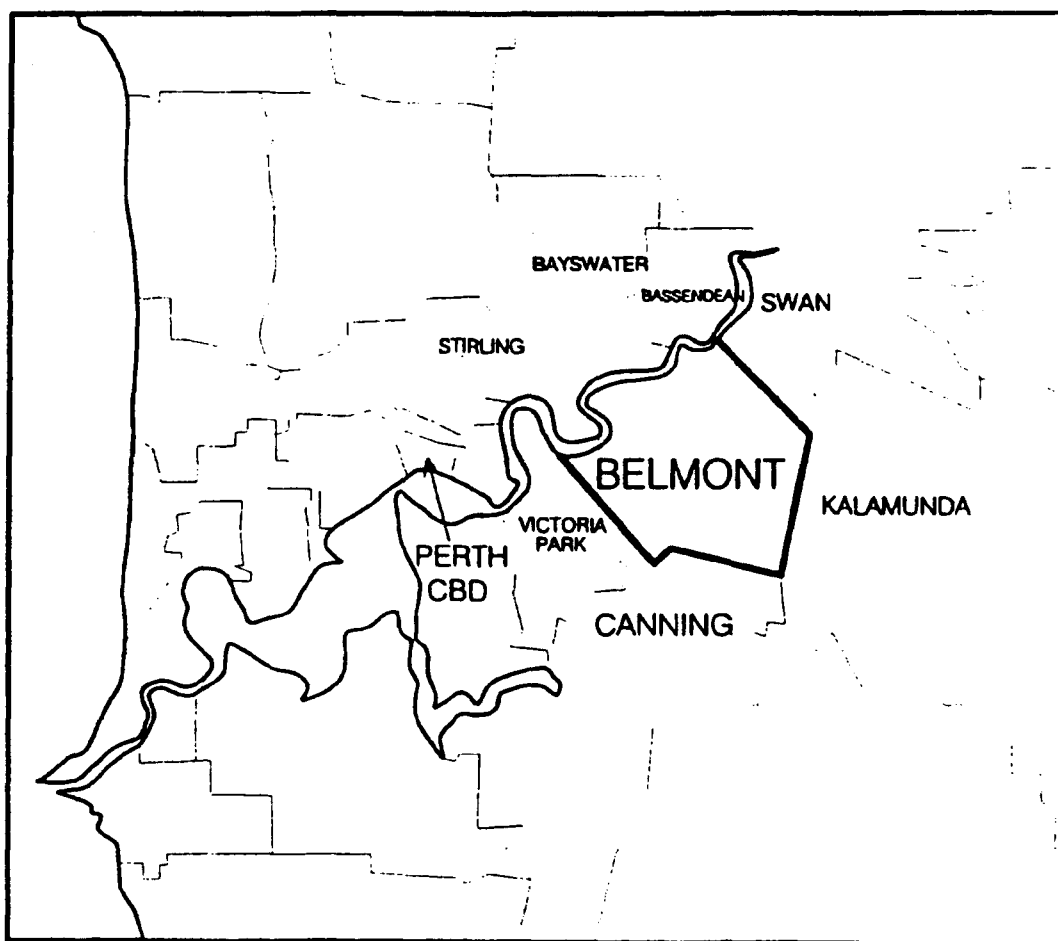
Association of Australia, Western Australian Branch, 1992). This study seeks to add to a body of data which will facilitate consideration of client identified need in the development of policy with regard to one specific area of community nursing. The data was gathered from the City of Belmont in Perth, whose characteristics will now be described.

### The City of Belmont

#### Location

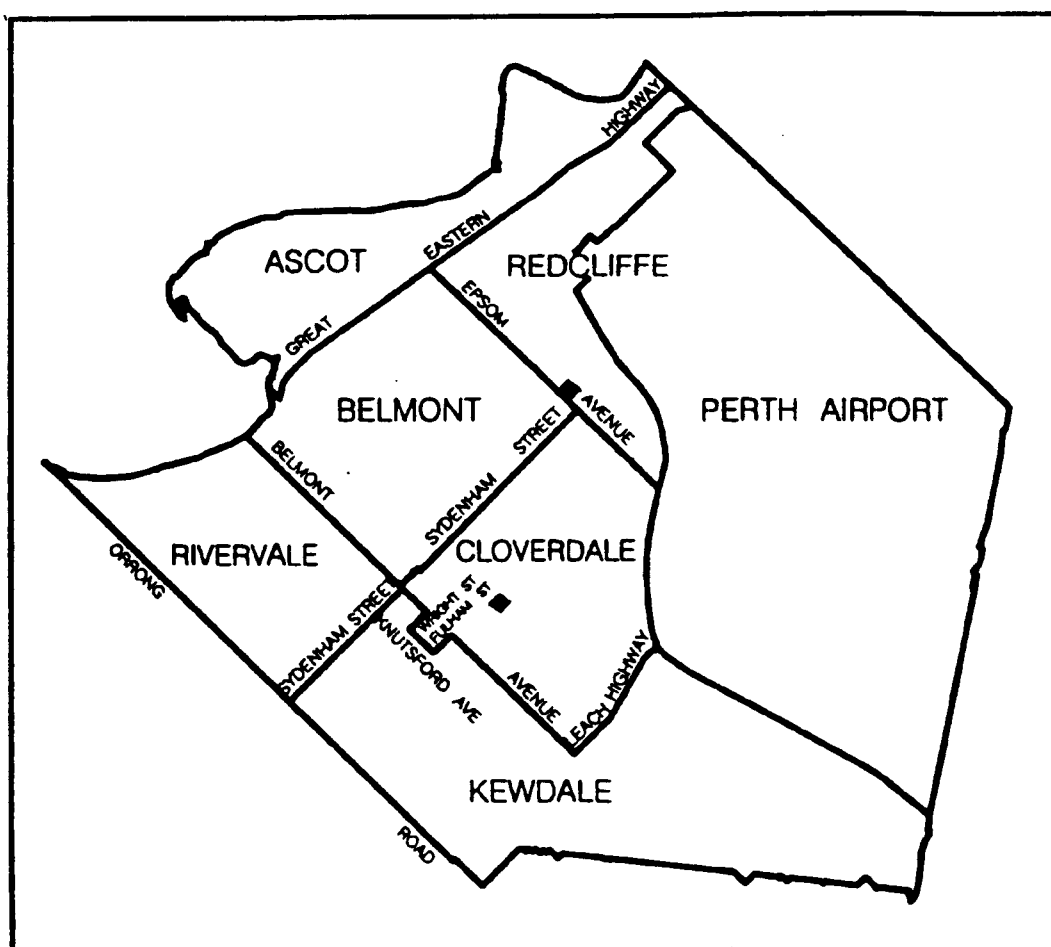
According to a recent population survey of the City of Belmont (the City) undertaken by Mazzarol and Doss (1995), the City can be described as one of Perth's more established municipalities, comprising the suburbs of Belmont, Rivervale, Cloverdale, Kewdale and Redcliffe. Figure 1 shows the proximity of the City of Belmont to the neighbouring areas and to the City of Perth, while Figure 2 shows the suburbs and the location of the child health centres. The City is located approximately 5.5 kilometres east of the Perth central business district and encompasses an area of approximately 40 square kilometres, blending residential, commercial, industrial and recreational areas. Its western boundary is the Swan River and the north eastern boundary is the Perth International Airport. The eastern boundary of the City is bordered by the standard gauge railway line, and the Kewdale Freight Terminal and Victoria Park Ward of the Perth City Council are its southern boundaries.





**Figure 1. The City of Belmont and Surrounding Districts.**

Note. From City of Belmont. Facts and Figures (p. 3), by City of Belmont, 1997, Perth: Author. Copyright 1997 by City of Belmont. Reprinted with permission.



**Figure 2. Suburbs in the City of Belmont and Location of Child Health Centres.**

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■ Child Health Centre

## Population

The population of the Belmont City area was 27,066 in the 1996 census (Australian Bureau of Statistics, 1996). Table 1 shows the age distribution of the City of Belmont together with gender. The distribution of males and females within all age categories is relatively even. There is a broad spread of ages, with the highest percentage of the population aged between 20 and 39 years, representing 32% of the total Belmont population. Those aged 0-4 years represent 6.5% of the 1996 population (City of Belmont, 1997).

The June 1996 census figures do not take account of the potential population growth resulting from recent residential developments in the City of Belmont area. The total number of new lots and units which will be available in the near future represents an estimated 1,463 dwellings. Based on an occupancy ratio of 2.3 persons per dwelling, the population of Belmont can be expected to increase by 3,368 persons in the near future, bringing the estimated population to approximately 30,400 persons (City of Belmont, 1997).

An examination of the ethnic composition of the City of Belmont reveals that the majority of the population are Australian born, with the ratio between those born in Australia and those born overseas remaining relatively constant over the past twenty years. In 1991, 66% of the population was born in Australia, with 32% born overseas. This compares with the Perth metropolitan average of 65% and 34% respectively. Of the

Table 1

**Age Distribution of City of Belmont, 1996**

<b>Age</b>	<b>Male</b>	<b>Female</b>	<b>Persons</b>	<b>% of population</b>
0-4	908	827	1735	6.5
5-9	812	764	1576	6.0
12-14	687	719	1406	5.3
15-19	796	812	1608	6.0
20-24	1054	1093	2147	8.1
25-29	1178	1115	2293	8.6
30-34	1114	1037	2151	8.1
35-39	1028	923	1951	7.3
40-44	850	842	1692	6.4
45-49	893	844	1737	6.5
50-54	740	732	1472	5.5
55-59	694	782	1476	5.5
60-64	641	725	1366	5.1
65-69	651	665	1316	5.0
70-74	512	611	1123	4.2
74-79	352	450	802	3.0
80-84	169	304	473	1.8
85+	85	206	291	1.1
<b>TOTALS</b>	13164	13451	26615	100

.Note. From City of Belmont. Facts and Figures (p.7), by City of Belmont, 1997, Perth:

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overseas born City of Belmont residents, 16% were of English speaking origin and 15% were of non-English speaking origin. Within the Perth metropolitan area, 19% were of English speaking origin and 14% were of non-English speaking origin. In the home, 85% of City of Belmont residents speak English as the first language of choice.

Of the residents born overseas, 13% were from the United Kingdom or Ireland, 4% from South East Asia, approximately 3% from Southern Europe and 2% each from South Asia (India, Pakistan etc) and Western Europe. The proportion of residents of Aboriginal origin in the City of Belmont was 1.8% as compared to 1.0% in the Perth metropolitan area (Mazzarol and Doss, 1995).

In summary, the City of Belmont's population has been a stable one. Approximately the same proportion of residents were born overseas as in the rest of Perth, but it has more residents of Aboriginal origin.

### Family Composition

Table 2 shows the composition of family types in the City of Belmont for the years 1991 and 1996. The figures show a decrease in couples with dependents and an increase in the number of persons who live alone.

According to the 1991 census, two parent families made up the majority of family types in the overall Perth population. Couples without children were the second most common

Table 2

**Family Types, City of Belmont**

	1991 (%)	1996 (%)
Couple with dependants	30	25
Couple only	25	25
One parent with dependants	13	13
Persons who live alone	24	30
Group household	6	5
Other families	2	2

Note. From City of Belmont. Facts and Figures (p.9), by City of Belmont, 1997, Perth:

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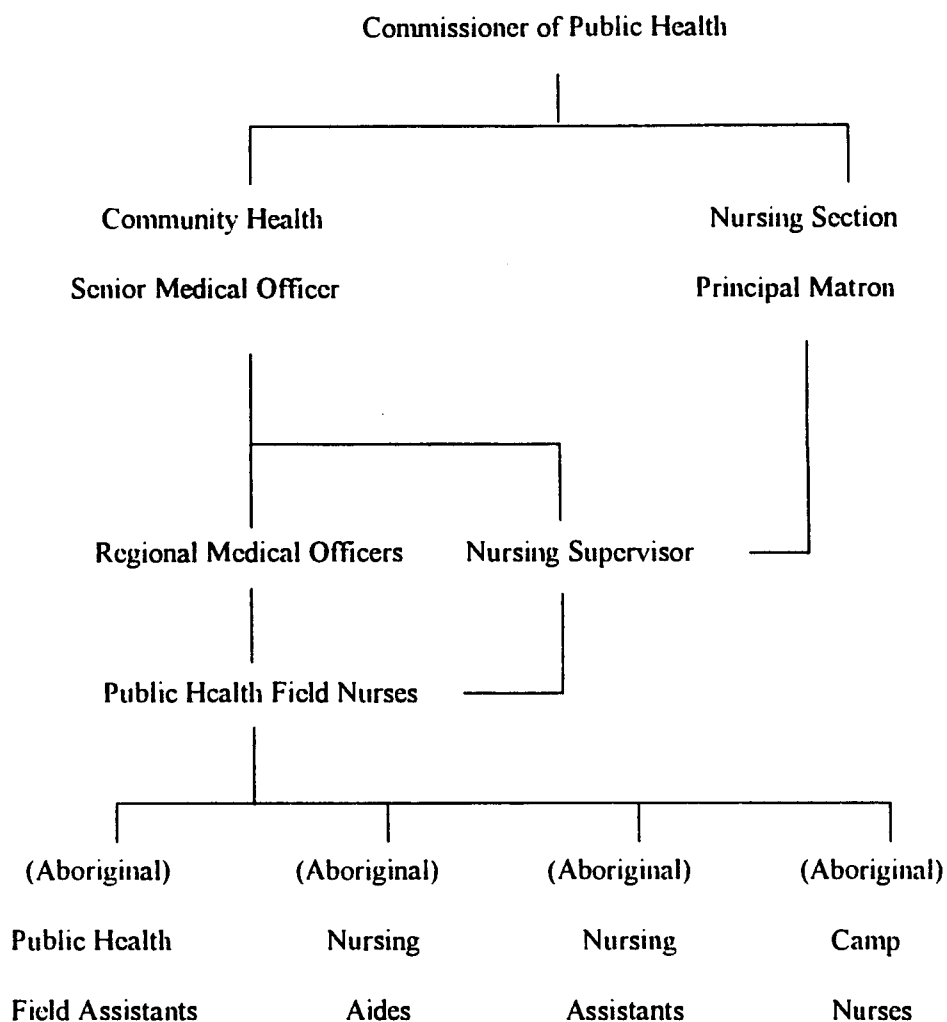
type, followed by one parent families. In comparison, the City of Belmont had slightly more couples and single parent families and slightly fewer two parent families than the Perth average. The demographic statistics concerning families in Belmont (1996) cannot be compared with those of Perth, as the City of Perth has been sub-divided into different geographic entities since the 1991 Census.

The changes in family composition in Belmont are in part a reflection of national and state trends. The categories of couples only, one parent families and persons who live alone represent an aggregate of 54% of families at national and state levels (City of Belmont, 1997). The changing role of the Health Department in Western Australia, with

special reference to public health nurses, will now be discussed in the light of this local community profile.

### History of Health Department of Western Australia

Holman (1991) produced a three volume report as the Special Consultant on Community and Child Health Services in Western Australia and in so doing extensively documented the history of Community Nursing in this state. Community Nursing in Western Australia began in 1911 with the creation of the Office of Public Health, which appointed the first school nurses (Rauschenberger, 1993). In 1923, the Infant Health Service was formed and the first three infant health centres were opened. The Medical Department and the Public Health Department were separate entities for administration purposes. In 1930, infant health training commenced at King Edward Memorial Hospital, followed by registration of Infant Health Nurses in 1941. The inclusion of toddlers into the Infant Health Service was undertaken in 1947 and of pre-school children in 1955. In 1957, the Service was given responsibility for the health of children in kindergartens. The first Public Health Nurse, Pat McPherson, was appointed to the Australian Inland Mission Hospital at Fitzroy Crossing, in the state's north-west in 1965, while the first Medical Department Public Health Nurse, Mary Reid, commenced at Derby in the Kimberley Region in 1968. Public Health Nurses were not employed outside the Kimberley and Pilbara regions until 1970. At this time, the Infant Health Service and School Medical Service were placed under one Director of Child Health Services. Two years later, Community Health Services were established as a branch of the Public Health Department. The organisational structure was as follows:



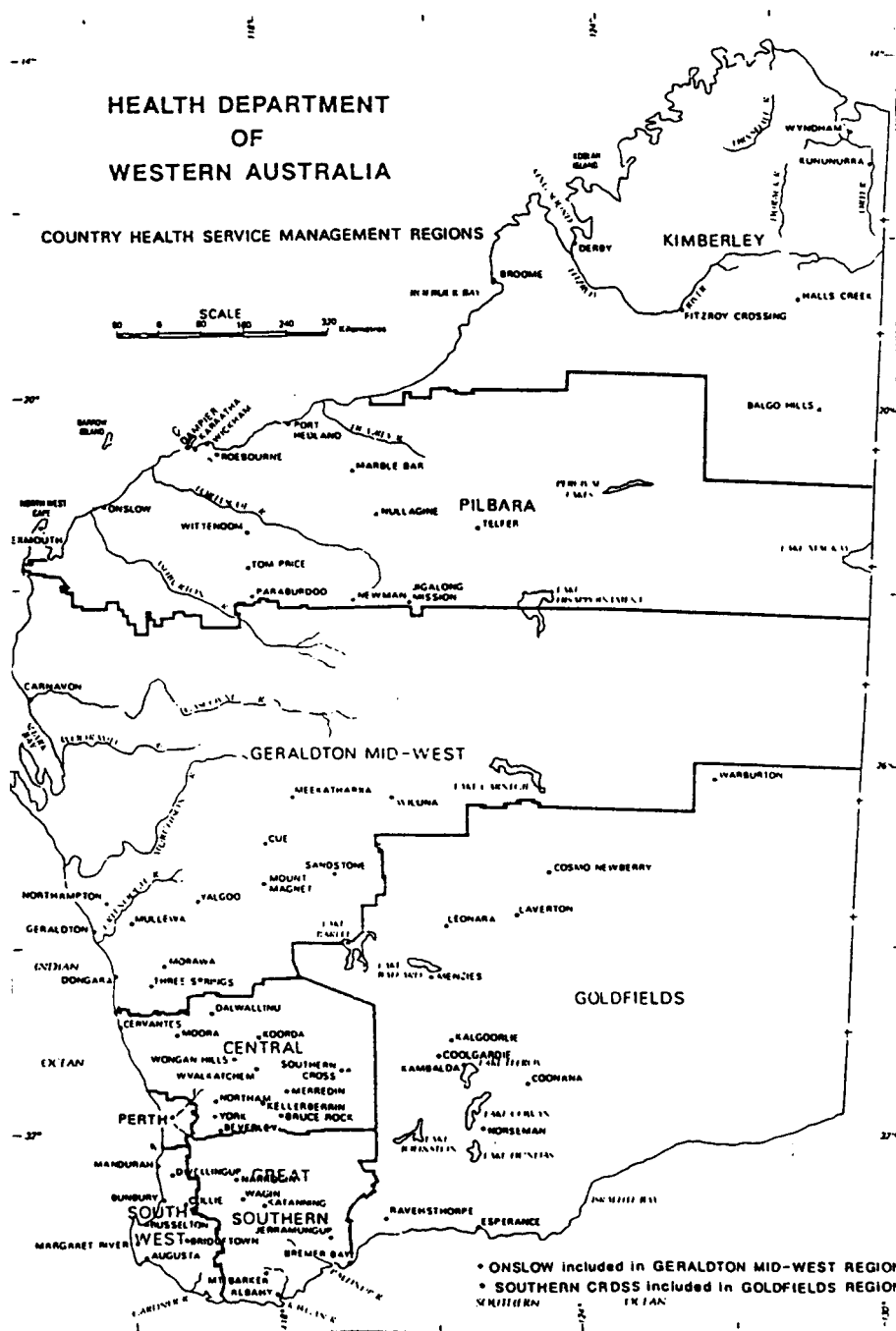
**Figure 3: Organisational Structure, Community Health Services 1972**

Note. From Report of the Special Consultant on Community and Child Health Services. Volume 1. The History of Community and Child Health Services in Western Australia (p. 115), by C. D'Arcy J. Holman, 1991a, Perth: Health Department of Western Australia. Copyright 1991 by Health Department of Western Australia. Reprinted with permission.



The first Community Health Centres were opened in Mandurah and Busselton, towns in the south-west of Western Australia, in 1974 and in 1976 when Community Health Services and Child Health Services amalgamated. Three years later, the Public Health Department merged with the Medical Department to become the Department of Health and Medical Services. However, two years later, this department was again divided into the Public Health Department and the Department of Hospital and Allied Services, each with a Commissioner of equal standing.

Regionalisation in the Public Health Department commenced in 1980 with the Kimberley region becoming an autonomous entity. The Pilbara and Central Public Health Regions followed suit in 1983 (Figure 4). Regional Nursing administrators were also appointed for Community and Child Health Services. The following year another major change saw the amalgamation of the Public Health Department, the Hospital and Allied Services and Mental Health Services into the current Health Department of Western Australia. As shown in Figure 5, there were seven executive directors, each administering separate departments. However, these departments were linked by the necessity for staff to relate to many of them simultaneously. Various components of the Community and Child Health Services (C&CHS) were now split across at least five of the seven divisions, and in particular, community medical officers, allied health, nursing and administrative staff in the field now reported through separate lines to the Executive Directors of Personal Health Services, Nursing Services and Administrative Services (Holman, 1991a).



**Figure 4: County Health Service Management Regions, Health Department of Western Australia, 1990.**

**Note.** From Report of the Special Consultant on Community and Child Health Services. Volume II (2). Community and Child Health Services Today: Roles, Resources and Issues (p. 32). by C. D'Arcy J. Holman, 1991b. Perth: Health Department of Western Australia. Copyright 1991 by Health Department of Western Australia. Reprinted with permission.

The existing corporate ethos experienced significant changes resulting in corporate management philosophies that stressed value for money (economic rationalism), planning towards a stated set of objectives (corporate planning), responsiveness to the Government's platform ('loyalty to the Government of the day') and the superiority of managerial prowess above professionalism and subject matter knowledge (managerialism). In addition, the proportion of non-health professionals in branch head positions or higher was increased significantly from 30% to 49%, followed by an additional increase in 1988 to 55% (Holman, 1991a).

In 1988, as a result of a task force review, the Health Department of Western Australia was regionalised, with the creation of seven country and four metropolitan regions. The following year, there was a reorganisation of Community Health Services throughout the State, and the Model 3 structure (Figure 6) was put into place. The aim of this model was to provide for Community Health management at a regional level. The Regional Team comprised:

- Director of Community Nursing;
- Medical Officer;
- Allied Health Officer;
- Administrator;
- And where already available, a Regional Health Liaison Officer.

Also during this time, the Health Department was working towards the integration of Community Health, Psychiatric and Hospital Services. In the metropolitan area, all

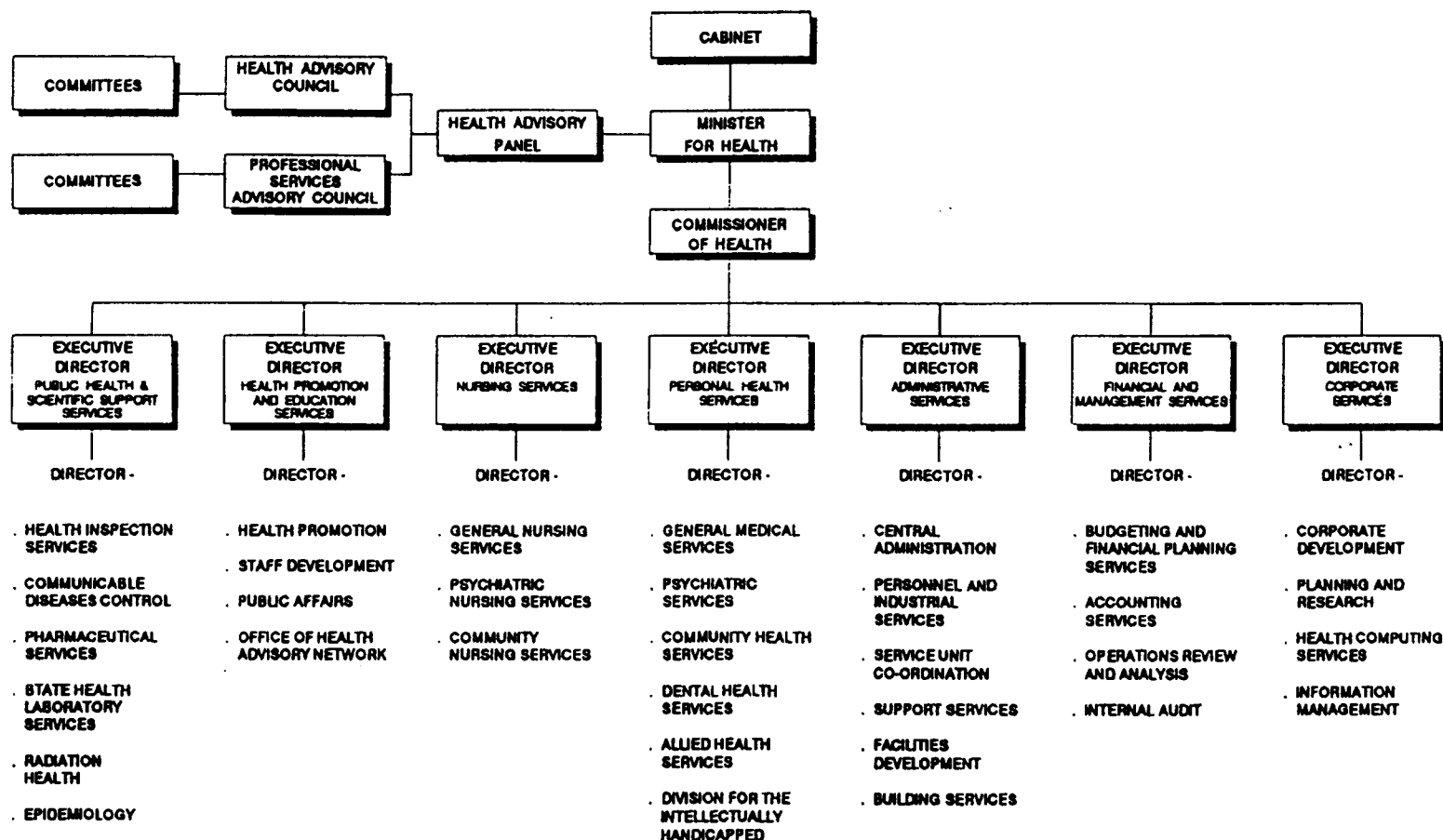


Figure 5: Health Department of Western Australia Organisational Chart June 1985

Note. From Report of the Special Consultant on Community and Child Health Services. Volume 1. The History of Community and Child Health Services in Western Australia (p. 38), by C. D'Arcy J. Holman, 1991a. Perth: Health Department of Western Australia. Copyright 1991 by Health Department of Western Australia. Reprinted with permission.

services at the Armadale/Kelmscott, Swan, Osborne Park, Fremantle and Bentley sites are now managed by integrated teams representing all areas, including community and acute clinical nursing services.

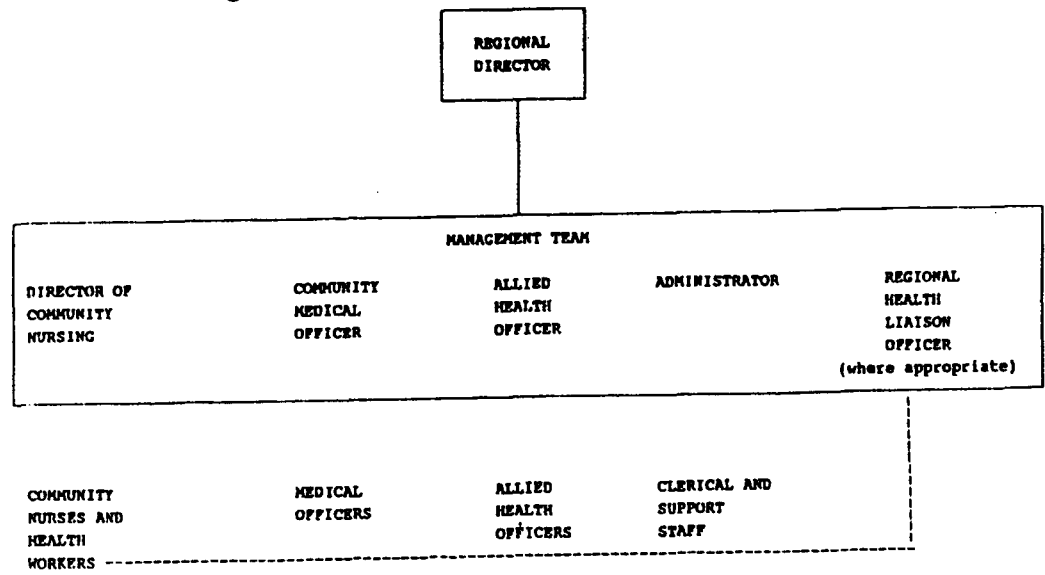


Figure 6: “Model 3” Organisation Structure of a Regional Community Health Management Team.

Note. From Report of the Special Consultant on Community and Child Health Services. Volume 11 (2). Community and Child Health Services Today: Roles, Resources and Issues (p. 36), by C. D’Arcy J. Holman, 1991b, Perth: Health Department of Western Australia. Copyright 1991 by Health Department of Western Australia. Reprinted with permission.

A. Liebenberg, (personal communication, December 1, 1997) who was a senior community nurse with the Health Department of Western Australia, recalls the Regional Management Structure which was introduced in 1991 as marking the beginning of autonomous regions with different approaches to implementing health care. The ten

statewide regions were altered following the Metropolitan Health Services Review undertaken later that year. This review was conducted by consultants outside the Health Department and their recommendations oversaw the implementation of three metropolitan and seven non metropolitan health regions. Regional management structures were also created, necessitating the transfer of the staff from the Central Office to regional centres. There was little collaboration between the regions. Community nurses had no central staff development office to which they could refer for policy and information updates. Staff development was regionalised with each region having different priorities. The three metropolitan regions were amalgamated with teaching hospitals and the Southern Region was subsequently associated with Fremantle Hospital, the Northern Region with Sir Charles Gairdner and Osborne Park Hospitals and the Eastern Region with Royal Perth Hospital.

A. Liebenberg (personal communication, December 1, 1997) states that boundary adjustments which followed this restructuring caused a weakening of Child Health Services as the regions' different operating policies complicated the professional responsibilities of the staff affected by transfers to other regions. These alterations occurred relatively frequently. Child health nurses often found that the experienced senior staff to whom they could refer had been transferred to a particular region or had retired. An additional problem was the financial costs associated with these changes, which left little money for equipment for the nurses in the field.

In 1994, the Health Department of Western Australia introduced the health purchaser/provider split. The health purchaser was deemed to be any government department wanting a health service; and health provider, an individual or group who was able to provide the health service for a fee from the purchaser. The health regions were under review again, with separate districts emerging within each region.

These districts tended to be organised differently from each other and were being continually rearranged, with an increase in professional and personal stress for staff as a result. Full integration of hospital and community health management was also implemented. Staff Development nurses now had generic positions where they were responsible for all hospital staff, including non-nursing personnel and community nurses. A. Liebenberg (personal communication, December 1, 1997) appreciated that there were both positive and negative perceptions by community nurses during this period, but perceived that both hospital and community based nurses felt under threat because nurses from either discipline felt they could be requested to undertake the other's professional duties. During 1993 to 1994, the Community Nursing Career Structure was implemented along with associated industrial issues. The Hospital Career Structure had been completed in 1992.

During 1997 there were further alterations to the health regions and the Central Office of the Health Department in East Perth. The overwhelming perception by A. Liebenberg and her associates is that the fear of constant change has had a destabilising effect on the nurses which has impacted on their ability to fulfill their professional responsibilities.

### Community Nursing

Thus, it is clear that this study was undertaken against a background of changing circumstances for all community nurses. The need to increase economic efficiencies has led to differences of priorities between health administrators and health practitioners. Health regionalisation in Western Australia has been combined with microeconomic reform, resulting in separation of health purchasers and providers. The health purchasers closely examine costs and benefits of health programmes. This economic rationalism has involved a winding back of traditional State provided services (Cook, 1995). For example, the criteria for the availability of home care nursing and home support for the elderly and disabled has been reduced and increased cost considerations on the part of the recipients have been necessary. The restructuring of the Health Department of Western Australia has also seen community nursing lose its autonomy and become incorporated into the district hospitals, where the hospital and community based nursing services are under the direction of health and nursing managers who may have had little experience with community nursing.

Nevertheless, a comprehensive knowledge base is needed for planning of community programmes and community nursing is integrally involved in the participation and coordination of primary health care. Primary health care has a broad, holistic focus involving interdisciplinary decision making. The scope of professional disciplines is wider than that encountered in the hospital setting (McMurray, 1993). There is, therefore, a need to consider strategies which will identify and link primary health care need to the restructured health system. A policy has yet to be introduced that would



require the nursing administrator to have community nursing qualifications or experience.

The provision of primary health care has the ideal aim of maintaining and improving the health care of individuals, families and populations. It is important for community nurses, as providers of health care, to know which services are being rationalised by the health care administrators and to understand the impact on primary health care delivery. Professionally, community nurses are committed to the long term perspective of quality health care and should be encouraged to take a more participative approach in health strategy planning. Goodwin (1994) suggests a framework to guide the effective purchasing of family and child health care. The four core areas are: effectiveness, efficiency, equity and humanity. These areas can be used as criteria for child health nurses in their advocacy for quality care.

### Significance

This study has an important role in informing child health nurses and health planning agencies, such as the Health Department of Western Australia, with information related to client expectations of care to be received from child health nurses and the utilisation patterns of Child Health Services in one fairly typical area of Perth. An understanding of what women perceive to be important in maintaining the health of their children is crucial before appropriate support and the creation of an environment conducive to maintaining health of children can be accomplished. This study will contribute to such an understanding by demonstrating the patterns of young families' use of these services,

describing their needs, expectations and satisfaction, and investigating whether a range of family variables can predict health service utilisation. It provides information that will assist the agencies in planning and financing child health nursing in order to meet client requirements. It will also assist nurses to effectively plan, implement and evaluate health programmes appropriate to their clients' needs and provides a framework for similar surveys which might be undertaken in other locations in order to increase the overall body of available data.

### Purpose

The purpose of this study is, firstly, to describe the women's perceptions and self-perceived requirements of Child Health Services in the City of Belmont. Secondly, it will show the way families use these services.

### Objectives of the Study

This descriptive study has the following objectives:

1. To describe self-reported child health care needs of women with young families residing in the City of Belmont.
2. To identify patterns of utilisation of a group of clients of Child Health Services in the City of Belmont.
3. To describe this group's self-reported satisfaction with Child Health Services in the City of Belmont.
4. To correlate self-reported child health needs, concerns, satisfaction with and patterns

of utilisation of Child Health Services with family characteristics (type, composition and ethnic background).

### Definitions

Primary health care is essential health care based on practical, scientifically sound methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health care system, of which it is a central function and main focus, and of the overall social and economic development of the community (World Health Organisation, 1978).

The Registered Nurse is the first level nurse who is licensed to practise nursing in the field(s) in which she/he is registered without supervision and who assumes responsibility and accountability for her or his own actions. The International College of Nursing Council of National Representatives (1973) describes the fundamental responsibility of the nurse as being to promote health, to prevent illness, to restore health and alleviate suffering. Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.

The Community Nurse is a Registered Nurse whose primary responsibility is to provide direct care to the individual, family or community in their usual environments, taking into consideration the social, cultural and ecological influences on those they serve. The

community nurse fosters and shares with others the objectives of health promotion and health preservation (Health Department of Western Australia, 1989).

The Child Health Nurse is a Registered Nurse and a Community Nurse practising in the child health field. These nurses (from their education and experience in the community) act as facilitators and resource persons, promoting a greater knowledge and understanding of the needs and development of pre-school children, and the needs of parents (Health Department of Western Australia, 1990).

The Young Family is classified as the family in the early childbearing stage and/or with pre-school children (Duvall, 1977).

Family type refers to the range in cohabitation, marriage and kinship patterns, which all have the potential to be viable (Robertson, 1981). This study will focus on one parent, two parent, blended, extended and other self-described types of families, along with the marital status of the parent(s).

Family composition refers to the range of generational family structures and kinship patterns. This study will focus on the number of family members in the surveyed household, along with their ages, genders, relationships and the rank order of the age of pre-school children as compared to the other children in the household.

Child Health Services are those services conducted by the Health Department of Western Australia which aim to improve the quality of family health and wellbeing. These services are varied and encompass such areas as child health clinics/centres, community health centres, the Child Development Centre and immunisation clinics. The services offered by general practitioners are not included in Child Health Services.

Child Health Clinics/Centres are the centres from which child health nurses operate.

### Organisation of the Study

Chapter One introduced the research topic and discussed the background, significance and purpose of the study. The research objectives are identified and a glossary of definitions is provided. Chapter Two comprises a literature review. Chapter Three describes the theoretical framework which guides the study. Chapter Four describes the method of investigation and Chapter Five presents the results. Discussion of the results are presented in Chapter Six and Chapter Seven contains the conclusion and recommendations arising from the study.

## CHAPTER 2

### REVIEW OF LITERATURE

The purpose of this literature review is to describe reported studies which examine young families' requirements of Child Health Services, their patterns of utilisation of these services and the need for client involvement in the planning of these services. It will begin with a discussion of the meaning of health and health promotion, followed by the requirements and expertise of community nursing, the utilisation of Child Health Services and the need for family based research.

#### Health and Health Promotion

The concept of health as applied to child and family health care can be defined as the capability of the family to act within the boundaries of its life changing situation, enabling children and adults to experience a general feeling of wellbeing and welfare (Lauri, 1994). According to McMurray (1993), health is seen as a state of wellness, being a balance between the people concerned and their physical, psychosocial and cultural environments. Similarly, the Australian Institute of Health and Welfare (1996) comments that health can be seen as a major contributor to total wellbeing which itself includes health, social, economic and environmental wellbeing, life satisfaction, spiritual or existential wellbeing and other characteristics valued by humans.

Community nursing fosters the objectives of health promotion and health preservation. Amongst other objectives, it aims to assist parents to keep their children physically, mentally and emotionally healthy, to detect potentially handicapping conditions early and

to initiate action to minimise or eliminate later disability (Health Department of Western Australia, 1990).

Hawe (1996) has highlighted the debate about, and criticism of, health promotion models that compete with other health services. The objectives and outcomes of health promotion services are less obvious than those relating to acute health services. The definition of health adopted by health promotion units differs from the World Health Organisation's popular view of health which includes a sense of physical, mental and social wellbeing. The World Health Organisation has, however, also endorsed and defined health promotion, describing it as the process of enabling individuals and communities to have greater control over the determinants of health, thereby improving their health (World Health Organisation, 1986). It can be seen, therefore, that programmes conducted under the health promotion banner have the potential to be very diverse.

Acknowledgment of health requirements requires a willingness to understand the perceived health needs of the clients, along with recognition of the sociocultural contexts that impact on their environments. The Ottawa Charter (World Health Organisation, 1986) has placed great emphasis on the need to develop very broad health promotion strategies to bring about changes in the physical, social and economic environment in which people live (Australian Institute of Health and Welfare, 1996).

A primary health care approach is based on the assumption of a holistic view of health. The World Health Organisation (1978) has described primary health care as essential health care available to both individuals and families in the community. In 1978 the World Health Organisation's Report and Declaration of Alma Ata resulted from the International Conference on Primary Health Care, where the concept of 'Health for All by the Year 2000' was articulated. The conference identified primary health care as the key to achieving this goal. When the 'Health for All by the Year 2000' global strategy was launched by the World Health Organisation in 1979, the International Council of Nurses accepted the policy and pledged the support of the nursing profession. Primary health care is integral to the application of the strategy, in support of which nurses are able to provide information, support and care to persons of all ages, classes and income groups, who live throughout the community, rather than just in institutional settings (Percival, 1989).

In 1986, the World Health Organisation held an International Conference on Health Promotion in Ottawa, Canada to develop guidelines to assist industrialised countries to implement primary health care (Wass, 1994). The Ottawa Charter for Health Promotion was developed and affirmed. The Charter supported a primary health care philosophy and also stated that to achieve Health For All, the prerequisite health promotion action was the building of healthy public policy, creation of supportive environments, strengthening of community action, development of personal skills and reorientation of health services (World Health Organisation, 1986).



Several conferences related to the Ottawa Charter have been held since, with the World Health Organisation's 4th International Conference on Health Promotion taking place in July 1997 in Jakarta, Indonesia. The three main themes were: identifying the keys to success in existing health promotion; developing practical strategies for future action; and building a broad new alliance for health promotion for the 21st Century. The conference research and case studies confirmed the continuing need for the five Ottawa Charter strategies, with several additional approaches being required to optimise the strategies' effectiveness. Comprehensive approaches to health development were considered to be rendered most effective by the use of combinations of the five strategies rather than single track approaches. The use of varied settings was seen to offer practical opportunities for the implementation of comprehensive strategies. Relevant settings include local communities with their markets, schools, workplace and health care facilities. Participation by people is considered essential to sustain health promotion efforts, with people having to be at the centre of health promotion action and decision making processes for them to be effective. Health learning was viewed as fostering participation. Access to education and information is considered integral to the achievement of effective participation and empowerment of people and communities ("The Jakarta Declaration," 1997).

These approaches to health promotion contributed to the Jakarta Declaration, which formulated the priorities for health promotion in the 21st Century. These priorities were: promotion of social responsibility for health, increase in investments for health development, consolidation and expansion of partnerships for health, increase in

community capacity and empowerment of the individual, and securing of an infrastructure for health promotion. Participants in the World Health Organisation's 4th International Conference also endorsed the formation of a global health promotion alliance, with the goal of advancing the priorities for health promotion as set out in the Jakarta Declaration ( "The Jakarta Declaration", 1997).

The need for primary health care to be client-centred or population focused has been well documented. Several studies show that the implementation of policies conforming with professional advice in attempting to alter health behaviours has had limited success when people are unable to participate in their own health care planning (McMurray, 1993; Schroeder, 1994). Maltby (1996) furthers the discussion by pointing out that creative strategies for health promotion need to be developed in collaboration with the target communities. Douchette (1989), Kreger (1991) and the Public Health Association of Australia, Western Australian Branch (1992) all confirm that primary health programmes are more beneficial when the health issues are identified by the clients and the resources are directed towards community driven projects. The World Health Organisation has identified an integral component of primary health care as being individual and community participation which promotes the idea of self-care and self-reliance within a shared responsibility with the service provider (Collado, 1992). The National Centre for Epidemiology and Population Health (1992), when reviewing the possibilities for strengthening the role of primary health care in health promotion in Australia, believes that where services and programmes conform fully to the primary health care model, consumers should actively participate in their own health care to a degree with which

they are comfortable and should be fully supported in doing so. There should be opportunities and support for consumer and community involvement in the planning, management and evaluation of the health services used by them. Effective contribution, however, requires information support and a continuing relationship between health service management and the consumers.

General practitioners are considered to be in a unique position to undertake health promotion to individuals and groups. According to Girgis and Sanson-Fisher (1996), general practitioners are endorsed by the general public as the preferred source of health information. Their study, however, raises some issues about the appropriateness of that perception. Girgis and Sanson-Fisher subsequently undertook a survey to assess general practitioners' perceived role in one type of health promotion: community health education. A random sample of 181 general practitioners in rural and urban New South Wales, Australia, was selected, with a 66.5% response rate. Of these participants, 38% had undertaken community based education in the previous 12 months, with lack of time, lack of earnings while away from the practice and lack of confidence in public speaking being the main reasons for not undertaking health education. Skin, cervical and breast cancer, blood pressure and cholesterol and asthma were the topics on which most general practitioners would be willing to speak. The researchers conclude that while some general practitioners would be willing to undertake community health education, research is needed on whether they are the most appropriate and effective group to do this.

Richmond, Kehoe, Heather, Wodak and Webster (1996) concur that doctors are commonly perceived by community members as the most credible source of health information. In a study conducted in all regions of metropolitan Sydney, Australia, they undertook the first large scale Australian study of patients' attitudes to general practitioners' involvement in the promotion of healthy lifestyles. One hundred and nineteen general practitioners and 13,017 patients participated in the study. There were discrepancies between patients' expectations of the doctors' roles in promoting healthy lifestyles and the likelihood that they would in fact receive advice, with few patients reporting that they received advice related to their lifestyle habits. These researchers suggest that general practitioners could take more opportunities to promote public health initiatives.

Currently in Western Australia, the Liberal government tends to suggest a philosophy that the responsibility for child and family health is a parental rather than a state responsibility. Sims (1997) shows that the family support services tend to operate on a crisis response level and interaction and assistance services are available only to those in severe need. The Taskforce on Families in Western Australia has stated that "not only is parenting critical to the wellbeing of children and the family, but its immediate and long term value to the quality of our social fabric is beyond measure...however, in order to meet this challenge, parents must be provided with support, encouragement, status and respect" (1995 p. 88).

On the other hand, new approaches which are contributing to the primary health care needs of young children and families are being piloted in Western Australia. Under the coordination of the State Department of Family and Children's Services, the Parenting Plus campaign is introducing strategies aimed at supporting parenting and strengthening families. Parenting Information Centres and the Parent Link Home Visiting Service are now operating on a two year pilot basis. The Parent Information Centres will offer information and resources to parents, aiming to enhance parental knowledge. Information will be available at easily accessible locations such as shopping centres. Various mediums such as pamphlets, videos and touch screens will be available. The Parent Link Home Visiting Service will rely on parent volunteers to provide support, assistance in the development of parenting skills and links to the local community (Sims, 1997).

Immunisation is a cornerstone of modern public health, as has been recently documented by the Public Health Association of Australia (1998), which has advocated an ongoing commitment to immunisation programmes at the highest political levels to ensure continued fundraising for the purchase of vaccines, service delivery and programme evaluation. Particular attention should be given to continuing professional education, community education campaigns and the evaluation of immunisation coverage. The Public Health Association believes that all medical practitioners should be encouraged to review their knowledge on immunisation procedures by attending educational update programmes on immunisation on a regular basis. Immunisation information provided by the National Childhood Immunisation Programme should be regularly updated and take

into consideration the optimal methods for conveying essential information to busy medical practitioners.

### Consumer Participation

Governments, professional organisations and consumer groups confirm the need for consumer participation in health care, as well as for policies geared to health promotion. The Commonwealth Department of Human Services and Health (1994a) documents the processes following the 1992 Medicare Agreements Act which required the Australian Commonwealth, States and Territories to have agreed national health goals and targets by 30 June 1994. During March, April and May 1994, extensive consultation was undertaken with State and Territory governments, consumers, medical colleges, professional organisations and peak community groups in order to identify such goals and targets. The consumer groups argued that health goals and targets only make sense when seen as part of a comprehensive approach to health as contained in a national health policy, emphasising that the current health system was too orientated toward treatment of ill health and not sufficiently orientated towards health promotion. There was endorsement of the World Health Organisation's view that consumer participation at all levels of health decision making, policy and service delivery was critical to the maximisation of health outcomes. It was recommended that governments actively promote consumer participation as a counter to the perceived dominance of service providers. It was also considered important that consumers, practitioners and policy makers should be able to look at the combined effect of strategies on any particular

aspect of health care they are interested in. The necessity for consumer participation was expressed in terms of both social and individual needs.

The health of individuals is enhanced when feelings of powerlessness are reduced by being a partner in treatment, with a provider who respects consumer rights. It is also enhanced if the health providers demonstrate a consumer-first orientation and promote people's self-esteem by initiating participatory processes.

The operations of the health system are improved in such a context because consumer input allows the services to be directed more accurately to what people want. As a result, health services provide greater consumer satisfaction. The operations of the health system are also improved through closer interaction with community support services (Commonwealth Department of Human Services and Health, 1994a, pp. 296-297).

The potential benefits of consumer participation in the planning and delivery of health goals and targets raise the issue of equity for and access by all participants in this process. The integration of health professional expertise and consumer focused outcomes would provide comprehensive, appropriately utilised and financially advantaged health services available equally to all members of the population.

### Community Nurses

Consumer participation in health care, however, is likely to be less effective without the active involvement of appropriately qualified and experienced nurses. Deal (1994) discusses the ways in which the broad spectrum of services offered by community nurses reflects the diverse roles in which nurses can be effective in improving the health of communities. With intimate knowledge about major public health problems and expertise in community focused health interventions, community nurses are an essential resource in the rapidly changing health system.

Nurses' ability to create positive changes in the health of communities, however, depends on support from legislators, policy makers, practice agencies, professional organisations, educators, and research institutions. Recommendations for supporting community health nursing practice include the following suggestions:

For legislators and policy makers, include funding to support community health nursing in state and local budget proposals; and increase funding for outcome based research on the effectiveness of community health nursing practice.

For practice agencies and professional organisations, use qualitative information gathered by community health nurses in the assessment, planning and evaluation phases of community health programmes; promote interdisciplinary collaboration with other professional groups; and generate and disseminate data on outcomes of community health nursing interventions (Deal, 1994, p. 316).



Joint support from policy makers, legislators, practice agencies and professional organisations would enhance the positive outcomes associated with the primary health care approach taken by community nurses.

Research shows that community nurses are aware of the multiple roles through which they can function as a resource for the community. Chambers, Underwood, Halbert, Woodward, Heale and Isaacs (1994) surveyed 1,849 public health nurses in Ontario, Canada, to determine whether their perceptions of their roles and activities concurred with a 1990 Canadian Primary Health Association report which described the roles and qualifications of Canadian primary health care nurses. A survey was completed by the nurses in which they listed their professional activities under eight broadly defined areas, these being caregiver/service provider, educator/consultant, facilitator/communicator/collaborator, community developer, social marketer, policy formulator, researcher/evaluator, and resource manager/planner/coordinator. Non-specified demographic questions were also included. The survey showed that Ontario primary health care nurses as a group are involved in all the activities outlined in the Canadian Public Health Association document "Community Health: Public Health Nursing in Canada: Preparation and Practice". A substantial consensus exists among the primary health care nurses in Ontario about their role. The authors recommend that health care strategists carefully consider the contribution that these nurses are able to make to the planning and promotion of primary health care, which would include their research capabilities.

Harper (1986), Kreger (1991) and McMurray (1993) suggest that community health nurses are restricted in client-centred health care planning by the bureaucracy of the health care system, with many health care programmes being predetermined by the employer. Other factors such as nurses' lack of involvement in the policy and planning process has limited their ability to respond optimally to community needs.

More research is needed if consumer participation in health care is to be effective. Bryan and Wirth (1995) suggest that goals and recommendations of health policy need to reflect not only a focus on the family but also on family choice. Research into the extent to which there is client consultation and collaboration in health programmes appears, however, to be limited. Research initiatives in primary health care need to address the complex nature of access, utilisation and health outcomes, including consideration of non-financial barriers. Few studies have developed models that predict the extent to which these barriers would affect access to primary health care (Carey, Goldberg, Jobe, McCann, Skupien, Troxel & Williams, 1995).

### Child Health Service Utilisation

There are few studies available which consider young families' self-perceived child health requirements and variables which may predict patterns of service utilisation. In Australia, Ochiltree (1991) examined the use of Child Health Services by 8,456 mothers in three Australian cities. A survey was completed by the mothers when their children were in the first year of school. To make the sample representative of the population, figures from the 1986 Census for the number of five year olds in the capital cities were

compared with the sample figures for each of these cities. The majority of those mothers using the service considered they received worthwhile support. Others stated that the nurses did not individualise their information or appreciate the diversity of Australian families. Mothers from non-English speaking homes or those from low income groups, and the number of maternal working hours outside the home in the first year of the child's life were found to be the characteristics associated with under utilisation of Child Health Services.

Maltby (1996) undertook a comparison of health care practices of Vietnamese and Anglo-Australian women where the differences and similarities in health promotion, illness management and health care access between the two groups was explored. Suggestions from the study included the provision of immunisation clinics either early in the morning or later in the evening. This would enable fathers to undertake the child minding of siblings not attending the clinic or to attend the clinic in order to be more involved. The Vietnamese women would also prefer flexibility in the hours as they felt their husbands had better understanding of the English language and would be able to interpret more effectively. The women in this study preferred to use friends or family members to interpret at clinics as, in their view, the official interpreters tended to change what was said to the child health nurse or immunisation doctor to avoid giving offence and to make it 'more acceptable' to the health worker. Maltby also discovered that the families wanted more health information, along with information on the availability of community resources. She recommended that information pamphlets written in different

languages should be available at accessible places in the community such as clinics, shopping centres and chemists.

Blair, Davies, Nebauer, Pirozzo, Saba and Turner (1997) conducted a study into care giver understanding and use of childhood immunisation, in order to build a profile of the characteristics of carers presenting their children for vaccination at six free immunisation clinics run by the Brisbane City Council. The purpose of the study was to assess influential demographic variables affecting immunisation compliance, care giver understanding of childhood immunisation and knowledge of vaccine preventable diseases and the sources of information used by care givers. A convenience sample was selected, consisting of 248 caregivers who presented 253 children for vaccination. The caregivers were asked to respond verbally to a researcher administered questionnaire.

The major findings indicated a very low level of knowledge among carers, with only 13.7% able to accurately name the diseases against which their child was being immunised and 26.6% having no knowledge of either the disease or the vaccination. The child's personal health record had limited use as an educational resource. Only 8% of the carers referred to it, the others preferring to use the child health nurses (44%) and hospital midwives (30%) as their major sources of information. These nurses thus represent the major potential source of health education for these carers. The study also found there was a high need by the carer for support during the vaccination procedure which may be perceived as a stressful experience by the carer. The authors recommended this as an area for further research along with carer information and the

value of the personal health records. In another immunisation study undertaken by Bazeley (1992) in New South Wales, Australia, the results demonstrated that care givers were requesting an immunisation service which provided a convenient location, privacy, lack of crowding, personalised service and individual attention, expertise of the provider, low cost, and pleasant, informative staff.

In studies conducted outside Australia, Sefi and Grice (1994) surveyed 525 mothers from Oxfordshire, England, to ascertain their views of child health clinics. They all had children aged either eight months or eighteen months who had been born in the Oxfordshire district. Their names had been selected in a controlled random sample from the birth register. The survey was conducted during 1988/89 and compared with some of the results of those from a 1981 survey in which 999 mothers were interviewed at a child health clinic. Comparing the 1988/89 findings with the 1981 survey, it would appear that the majority of mothers highly value the clinic service, especially receiving the clinic nurses' advice (62%), a general check of their child (61%) and reassurance (51%). Many mothers would prefer more privacy when talking to the clinic nurse (32%) and the provision of refreshments and toys (27% and 26% respectively). The survey did not address utilisation rates according to family or ethnicity variables.

A group of mothers from Subiaco and Shenton Park, located in suburban Perth, have been interviewed regarding their concerns at the possible closure of their local child health centre. They expressed satisfaction with the amount of time the child health nurse spent with the mothers and babies, and the ability of the nurse in early detection of

postnatal depression and developmental problems. They stated that “we can ring the nurse with a problem and she can see us within the hour...it was the accessibility and supply of information that gave mothers peace of mind and their preference for a child health nurse instead of general practitioners” (“Child Centre’s Fate,” 1998, p. 17).

Equality of access is a vital issue in the consideration of utilisation patterns of Child Health Services. The identification of health problems is only a partial solution to discovering inequality in health care access. Socioeconomic factors play a crucial role in determining access to and utilisation of health services. An example is the emergence of multiculturalism within Australia which has not taken place without some impact on child health (Vimpani & Parry, 1989). According to Kanitsaki (1993), mainstream health services fail to provide culturally appropriate social support for a considerable proportion of the Australian population, as the services are to a large extent monocultural.

Manderson and Reid (1994) advocate research into educational levels, income, cultural practices, English as a second language and use of health services as a guide to determining how people think about and access health facilities. Due to their close relationship with their clients, child health nurses are in a unique position to research factors having negative impacts and to devise frameworks enabling equitable access to appropriate health care.

Patterns of utilisation of health services differ among various social, cultural and economic subgroups. Harper (1986) contends that the health and wellbeing of specific subgroups need to be known to enable their health status to be compared with that of the

whole society. As the health of subgroups is studied, it becomes easier to focus attention, resources and management choices on groups with the most need, and to tailor health programmes to specific requirements.

Plunkett and Quine (1996) have discovered that the use of health services by members of the community from non-English speaking backgrounds is proportionately lower than for other Australians, suggesting a particular need among such clients for community health services. In a study undertaken to document experiences of carers using health and other support services in order to understand the reasons for underutilisation of the services, 40 women with little or no English skills who were caring for a family member at home were interviewed in Sydney. It was found that informal networks of family and friends were very important in the provision of information to carers about available services. However, such information may be inadequate or incorrect. There were indications that information may not be passed on if it was believed by the family and friends that the women carers should be unaided by support services. Hospitals, community and early childhood centres were cited by the carers as places where they could receive reliable information. Plunkett and Quine suggest that contrary to common belief, carers of non-English speaking backgrounds do not necessarily receive appropriate or adequate support in Australia from extended families in the provision of care. Consequently, there is an important need for support from formal community services.

The need for culturally appropriate health and support services is reinforced by the Taskforce Report on Families in Western Australia (1995), where the implications of

cultural differences in migrant families and accommodation of health status, needs and appropriate services are highlighted. People are discouraged from using available services by language differences and perceived cultural insensitivity of services. Almost three times as many parents from non-English speaking backgrounds do not use Child Health Services as compared with English speaking families. Families from non-English speaking backgrounds have very specific problems, and can find themselves isolated without the support of extended family after arrival in Australia.

Another group with specific requirements are those women suffering from postnatal depression. Balcome (1996) suggests the setting up of support networks through antenatal groups involving both informal and professional contact. Community nurses and midwives should aim to promote a more positive and realistic concept of motherhood. Holden, Sagovsky and Cox (1989) (as cited in Balcombe, 1996) reviewed 60 women in England who had depression at six weeks postnatally. A treatment group was formed and given counselling. Eighty-eight percent of those who recovered stated that talking to a health visitor had been the most valuable factor in their recovery. In England, the health visitor is a primary health care nurse with child health qualifications who visits families in their home environments.

Level of utilisation of health services is a particularly critical issue in relation to immunisation, an area of great relevance to community health. The challenge of achieving high levels of immunisation coverage for the population of Australian children has involved both the setting of national immunisation standards and research into factors



affecting compliance. The Commonwealth Department of Human Services and Health (1994b) reviewed the national standards (Appendix A), stating that it was essential that all service providers adopt a community based approach to immunisation services and view every health care encounter as an opportunity to assess a child's immunisation status. Also highlighted was the need for public consultation in a culturally appropriate manner, to determine community needs and implement necessary changes. Included in the standards was the requirement that immunisation services should be readily available, have no barriers or prerequisites to availability and be offered at no cost. Providers were to educate parents about immunisation, use accurate and complete recording procedures and report adverse effects immediately. Vaccines were to be administered by properly trained individuals who were to receive ongoing education and training on current immunisation recommendations. The application of these standards by all immunisation providers would provide high levels of protection against potentially serious diseases.

Early in 1997, the federal Minister for Health and Family Services announced that as of August 1998, monetary incentives will be offered through funds from the Better Practice Programme (BPP) to encourage general practitioners to take responsibility for ensuring children in their care are fully immunised. These payments would support the general practitioners to enable them to take on this role and follow up to ensure that children who would otherwise not be fully immunised receive the appropriate immunisation either from themselves or from the local health service responsible for the provision of immunisation services. It is also anticipated that general practitioners would be encouraged to set up infrastructure to monitor the immunisation status of their clients and

to put into place appropriate recall/reminder systems (Commonwealth Department of Health and Family Services, 1997).

Record keeping and reminder systems have been the target of several research projects related to immunisation. Bazeley and Kemp (1995) conducted a trial to assess the effects of a baby enrolment programme on attendances at local government immunisation clinics. Over 2,700 leaflets were distributed to the mothers in maternity hospitals, encouraging them to register in order to receive immunisation reminders from their local councils. The trial failed to increase attendances at public clinics. Mothers' reasons for choice of service, particularly their desire for what they perceived to be a more personalised service, and the attitude of the professionals (particularly community nurses) with whom they interacted were considered to have greater influence in determining their level of use of public immunisation services. It was shown that the enrolment at the public immunisation clinics is only effective where there is willing cooperation of all stakeholders in supporting immunisation services.

This view is supported by Henderson (1995) who contends that the most important lesson that successful immunisation programmes have provided is that they demand a highly collaborative, well integrated strategy. This extends from the vaccine manufacturer, to the community organisations which promote immunisation, to the physician and nurse administering the vaccines.

In a survey of children's immunisation status in the Northern Sydney area in 1992, Skinner, March and Simpson (1995) examined the immunisation uptake and factors associated with immunisation status in the area and addressed the parents' reporting of immunisation status as compared with council and general practitioners' records. One thousand and four questionnaires were given out with a 58% response rate. The full immunisation rate was 86%, 14% were partially immunised and only four children had received no immunisations. All councils in the Northern Sydney area have a reminder system. However, most immunisations were found to be done in general practices (64%), where reminder systems were not usual.

A further study conducted in 1992 in the Northern Sydney Health Area examined the provision of immunisation services in general practice. Rixon, March and Holt (1994) investigated provider knowledge of vaccine storage, the ages of patients administered measles-mumps-rubella (MMR) vaccine, the use of reminder systems for subsequent vaccinations and whether maternal and family health were discussed at immunisation visits. An anonymous postal questionnaire was sent to 987 general practitioners in the Northern Sydney Health Area, from which there were 394 participants (40%). Only 30% of the participants used temperature monitors in their vaccine refrigerators and 26% correctly identified the period after opening that Sabin may be used. Forty one percent used the correct injection site for infants and 40% administered the MMR vaccine by the recommended age of twelve months. Other maternal and child health issues were discussed during immunisation visits by 41% of the participants. Reminder systems were used by 16% of the general practices. However, this survey was unable to determine if

the lack of reminders altered the immunisation rates in this area. The low response rates from this survey mean the results should be interpreted with caution and cannot be generalised to all general practitioners who provide immunisations. However, Rixon, March and Holt consider that important deficiencies in knowledge and practice of immunisation among general practitioners have been identified.

### Family Research

Families have diverse characteristics providing challenges to researchers. They are structurally, ethnically and culturally diverse, varying also in their interaction patterns and styles of relating to other social systems. Ganong (1995) summarised nurse research on the family since 1984 and found that family nurse researchers have focused more attention on internal family dynamics than on the relationships between family and other social systems. The areas identified as needing more study include the social and economic context of ethnic minority families and of non-nuclear families, transactions between the family and the community and health promotion within the family.

### Summary of Literature

This literature review examined the concept of health and health promotion as applied to child and family health care. The need for community health care to be client-centred is clear. However, there is little available Australian or overseas research conducted by nurses, medical practitioners or organisations which considers young families' self-perceived child health requirements. The failure of mainstream health services to provide culturally appropriate health and social support has been identified in the literature.

Manderson and Reid (1994) support the need for research into this area, showing how the lack of these supports affects the use of health facilities.

Access to health services and information is an important feature of primary health care. Vimpani and Parry (1989) have discussed how socioeconomic factors are crucial in determining access to and utilisation of health services. Kanitsaki (1993), Plunkett and Quine (1996) and the Taskforce Report on Families in Western Australia (1995) have all demonstrated how members of the community from non-English speaking backgrounds are not adequately provided with culturally appropriate health services resulting in less access to health care. Consequently more research is required on the development of services which are able to provide more equity and access.

Chambers et al. (1994) and Ganong (1995) identified the need for family centred, primary health nursing research. Carey et al. (1995) recommend research into a systematic infrastructure and process capable of developing models to predict the extent to which non-financial barriers can affect access to primary health care.

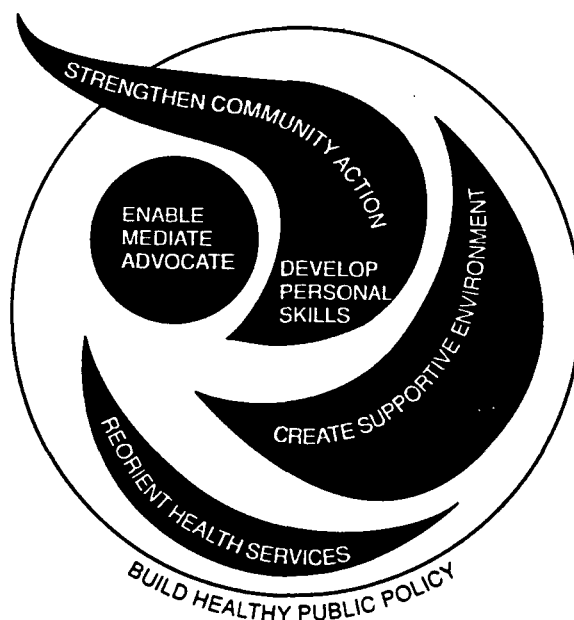
The literature review indicates the need for nurses, who are in the best position to do so, to conduct primary health care research. In particular, it is shown to be necessary to investigate client requirements and the variables affecting clients' utilisation of primary health care services.

## CHAPTER 3

### THEORETICAL FRAMEWORK

The Ottawa Charter for Health Promotion (World Health Organisation-Health and Welfare Canada - Canadian Public Health Association, 1986) guides this study and will be used to examine the areas in which child health nurses interact with their clients.

The charter identified fundamental conditions and resources for health as including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (McMurray, 1993). The separate but interlinked sections in the Ottawa Charter for Health Promotion demonstrate how health professionals in primary health care delivery can assist communities to build healthy public policy in order to achieve the fundamental conditions and resources necessary for health. The emphasis is on empowerment, to enable people to be their own advocates and to plan and implement their own health care strategies, an outcome also advocated by the World Health Organisation (1986), McMurray (1993), Schroeder (1994) and Maltby (1996). The development of creative health strategies in collaboration with communities can be directed and focused by the use of the Ottawa Charter, even though differing communities have differing requirements.



**Figure 7: The Ottawa Charter for Health Promotion.**

Note. From “Ottawa Charter for Health Promotion,” by World Health Organisation, Health Canada and Canadian Public Health Organisation, 1986, Canadian Journal of Public Health, 77,(12), p. 425. Copyright 1986 by Health Canada. Reprinted with permission.

McMurray (1993) has described how the Ottawa Charter has been used as a strategy for the implementation of primary health care on a national basis in Australia. The Charter has guided community health nursing practice as it is underpinned by the fundamental principles of primary health care. It also influences the care delivered by hospital based nurses, as primary health care is based on an holistic approach, which should influence all levels of health care delivery.

The Charter describes five major strategies that are designed to enable health professionals to assist in the achievement of health promotion. The five strategies will be used to guide this study. They are listed below, together with comments demonstrating how the present study contributes to their fulfilment in the Western Australian context.

1. Building healthy public policy. This study will inform policy makers of the child health requirements of young families and whether the variables of family type, family composition and ethnicity can be predictors of Child Health Service utilisation.
2. Strengthening community action. This study provides data and recommendations of how young families in the community identify their self-defined child health goals and to enable them to undertake collaborative planning with child health nurses in order to achieve these goals.
3. Development of personal skills. The information derived from this study will provide feedback for nurses on the education and opportunities for skills development which young families utilising Child Health Services require.
4. Reorientation of health services. The implementation of recommendations from this study will allow child health practitioners and planners to provide programmes appropriate to young families' requirements.
5. Creation of a supportive environment. The study identifies ways in which existing Child Health Services promote the creation of an environment supportive of young families and suggests ways in which this strategy can be more fully implemented in physical, social, cultural and economic terms.



## CHAPTER 4

### METHOD OF INVESTIGATION

#### Research Design

This is a descriptive study with both quantitative and qualitative components. A field study was proposed to survey by interview at least one family member who had preschool children from at least twenty households in the City of Belmont, Western Australia, throughout a period of six months. According to Powers and Knapp (1990), the quantitative method has the better properties with which to describe precise measurement, prediction and control. Its emphasis is on structured and objective measuring techniques and it can be used for quantification of data. The demographic data obtained during the interviews with the 25 women in this study included ages and numbers of family members, frequency of marriages and countries of origin. Quantitative analysis of these data is able to employ objective measurement, and this can summarise and assist in prediction of information.

In contrast, the purposes of qualitative research are description and interpretation of human experience in ways that promote understanding, provide insight, or challenge existing beliefs about social situations and human experience. Qualitative research is interpretive and inductive in nature, aiming to generate theory, insight and understanding (Powers and Knapp, 1990). Many aspects of health are social, behavioural or community orientated in nature, and, as such, deserve an inquiry model which takes into account the multiple meanings that individuals perceive to be a part of their own care, behaviours, attitudes and practices. Complex behaviour and social patterns ought to be investigated

using inquiry models that allow for the display and consideration of complex interactions. Complex behaviours that are investigated using simplistic, linear models of statistical origin usually provide simplistic, linear results which can prove usually useless (Lincoln, 1992).

The use of qualitative methodology for the major part of this study allowed a personal involvement with the participants, with the researcher being able to take time to establish rapport, and the participants able to reveal experiences, feelings and perceptions which are difficult to obtain through statistical inquiry. Patton (1990) recognises the use of open-ended questions as a valuable tool in qualitative research in that they permit the researcher to understand the world as seen by the participants. The young families represented in this study were better able to verbalise their self-perceived requirements and level of satisfaction with the existing Child Health Services through a qualitative interview style which aimed towards insight and understanding. However, Benoliel (as cited in Cobb & Hagemaster, 1987) considers a qualitative study does not preclude the inclusion of some quantitative measures. This mix of research methodology was advocated by Lincoln (1992), who indicated that while qualitative inquiry cannot provide demographic answers to many questions, it has enormous power and subtlety when used for questions of human behaviour, belief systems and meaning attribution.

### Sample

The convenience sample of 25 families was drawn from the population in the Belmont area in Perth (Western Australian Office of Multicultural Interests, 1994). One adult

member from each of the families who volunteered to take part was interviewed. The participants were recruited from child health and playgroup centres in the City of Belmont. The essential criteria for inclusion in the survey were residence in the City of Belmont and the presence of one or more pre-school children in the family. As for the question of the adequacy of sample size, Patton (1995) states that “the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with the sample size” (p. 185). The sample size of 25 in this study has provided a range of in-depth material from each participant, which has provided valuable data for analysis.

### Instrument

An interview guide was developed for use with young child-bearing families. It consisted of 2 parts; the first was a highly structured section necessary to obtain demographic data while the second section consisted of open-ended questions designed to present the participants with the freedom to respond with greater flexibility and individuality than in the previous section (Appendix A). Closed instruments direct participants to fit their knowledge, experiences and feelings into the interviewer’s categories. In contrast, qualitative interviewing is able to provide a framework within which participants can express their own understandings in their own terms (Patton, 1990).

The guide was adapted and developed from one used in a larger study on health and health services utilisation (Family Health and Health Service Utilisation in Belmont,

Western Australia. A Community Case Study) undertaken by researchers from Edith Cown University (McMurray, Hudson-Rodd, Al-Khudari and Roydhouse, 1998, publication pending). The guide was reviewed by three Community Nurse Specialists, including a Professor of Nursing, the Director of Community Nursing for the Bentley Health Region and a practising Senior Community Nurse. The two community nurses conducting the child health clinics where the interviews were originally scheduled were also given copies of the interview guide and invited to comment. The closed and open-ended questions were subsequently refined in light of their comments.

### Reliability and Validity

A credible qualitative study needs to address the issues of reliability and validity. However, these have been interpreted in a variety of ways by different authors involved with this type of research. As Brink (1991) points out, the notions of measurement and error are key concepts relating to reliability and validity. Measurement refers to a series of researcher's judgements about information in relation to its truthful representation of the desired content, its comparability with known information, and its verifiability across subjects and situations. "Error that occurs anywhere during the research process compromises the outcomes of the study and limits the usability of the data" (Brink, 1991, p. 166). Constant error can affect the validity of measurement or its capacity to indicate the true differences between subjects, and can be manifested by, for example, research participants who offer their perceived preferred social response, regardless of its truth. The participants can also consistently agree or disagree with questions, with the questionnaire being the source of this pattern of response. If a questionnaire attempts to

elicit agreement or disagreement with the interviewer, this type of error is likely to occur (Brink, 1991).

The question of generalisability of research findings from qualitative methods is a debated issue. Findings based on samples are often stripped of their context when generalisations are made (Patton, 1990). Cronbach (1975) has concluded that social phenomena are extricably linked to variables and context and are therefore not susceptible to valid generalisation. However, he advocates giving consideration to factors unique to local situations, thus turning a generalisation into a working hypothesis, rather than a conclusion. Guba (1978) concurs, supporting the attempt to change the use of generalisation. Guba considers the evaluator should do all that is possible to establish the generalisability of findings. Each possible generalisation should be regarded only as a working hypothesis, to be tested repeatedly in any subsequent encounters.

In this study, care was taken in constructing the questionnaire to minimise the likelihood that participants would offer responses perceived to be the most socially desirable, or would simply agree or disagree with the interviewer. It is recognised that generalisations arising from this study must be applied to other contexts with caution. However, in a number of areas, generalisations arising from this study would make viable working hypotheses for the investigation of other communities. The detailed description of the characteristics of the City of Belmont should allow other researchers to identify and allow for variables which may not characterise their own research area.

### Procedure

The study was conducted in two stages. In the first, the study was publicised and volunteer participants requested through the Belmont Child Health Centres. People were aware of the main study being undertaken by Edith Cowan University researchers and it was anticipated that families with young children would be interested in expressing their opinions on Child Health Services. Volunteers registering interest with the nurses at these centres were to be contacted by telephone to schedule personal interviews. Persons responding to the researcher had the purpose of the study explained, along with the estimated time of involvement and the right to withdraw from the study at any stage without prejudice. The consent form was signed at the first interview (Appendix C).

The second stage involved personal interviews, of about one hour in length, conducted in the family's home or at a mutually convenient location. The estimated length of time for this stage was six months. Interpreter services were offered to participants who wished to use them.

At the commencement of the study, permission was requested from the Director of Community Nursing in the Bentley Health Service to undertake the research. Following this verbal approval, formal permission was sought from the Ethics Committee of the Bentley Health Service (Appendix D). After this was granted, the two child health nurses in the Belmont area were visited in order to discuss the purpose of the research and to explain how it would be conducted. Their consent for participation was obtained. Publicity posters were placed in prominent positions in the clinics. However, after three

weeks, no one had indicated their willingness to participate. The researcher consequently made arrangements to sit in the waiting rooms of the two clinics where the parents were made aware of the study and their involvement was invited. There were only three mothers who agreed to be interviewed at home. The majority of mothers gave the impression that they were not able to give the researcher the time at their residence, but if the interview could be conducted at the clinic, they would be willing to participate. Unfortunately, only two had adequate time for this prior to their appointment with the nurse and all had other commitments following. The lack of interest in home visits was generally stated to be due to lack of time in the family's daily routine and also at times perceived by the researcher as the parent/s not wanting an 'official' person inside their house.

Because of these low recruitment numbers, the remaining research interviews were subsequently undertaken at playgroups in the Belmont area. The mothers who attended these playgroups, either at centres or in people's homes, were interested in participating if the interviews could be carried out during the playgroup sessions. This was possible as the children of the women being interviewed could be cared for by others in the group, leaving the women unencumbered for the interview time.

The second stage took approximately ten months to complete due to the delayed starting time. The interpreter services were not required.

### Analysis

The first step in the data analysis was to group participant families according to family variables such as type, composition and ethnic background. Relative frequencies were calculated for the utilisation variables of child health needs and concerns, frequency and reasons for Child Health Service utilisation, and the expectations of the clients. These data were analysed to identify significant relationships between family variables and health service utilisation. Content analysis was conducted on the qualitative data to examine open-ended comments. Where possible, these data were substantiated by frequencies and subsequently analysed in relation to family characteristics.

### Ethical Considerations

Permission for this research project was given by the Ethics Committees at Edith Cowan University and the Bentley Health Service (Appendix D). Informed consent was obtained from each research participant prior to the interview (Appendix C).

Participants were informed of the estimated interview length prior to giving consent. They were assured of confidentiality, anonymity and the right to withdraw without penalty at any time during the study. No identifying data such as names were used on the transcripts or recorded data. The research data has been locked in a filing cabinet accessible only to the researcher and will be destroyed by incineration after five years. No emotional distress was anticipated or encountered during the research interviews.



### Limitations

An anticipated limitation of this research study was that potential participants may have decided not to participate due to the interview length. This did occur when only three women agreed to participate in home interviews. The research was subsequently conducted in child health clinic waiting rooms and at playgroup centres. There was a high degree of goodwill towards the existing system of Child Health Services and there may have been a desire by the participants to defend it against perceived threats, which raises the possibility they might have deliberately sought to give favourable responses as part of their strategy to defend the system. However, the overall consistency of responses throughout the 25 interviews suggests that there has been no serious degree of distortion, and tends to validate the general conclusions of this study.

## CHAPTER 5

### RESULTS

The purpose of this study was to gain an understanding of how parents utilised Child Health Services and other preferences relating to these services. Each question from the questionnaire will be considered separately. Common themes across questions will then be identified.

#### SECTIONS 1 AND 2 OF THE INTERVIEW GUIDE

Demographic information concerning the participants is given here, followed by data from questions which were formulated to discuss what parents actually thought about Child Health Services and which services they sought out for their children.

#### Demographics

##### Age and Family Composition

All of the families in the study had two parent households. The number of family members ranged from three to six with no extended family members reported sharing the household. Twenty one of the parents were married while four were living in a de facto relationship. The majority of these mothers had experienced one marriage (19) while the other two had been married twice.

The average ages of the mothers and fathers were similar: 31.2 years for the women and 33.2 years for the men. The ages for the women ranged from 20 to 46 years and for the men from 23 to 46 years (Table 3).

Table 3

Maternal and paternal ages

	N	MINIMUM	MAXIMUM	MEAN	STD DEVIATION
MOTHER AGE	25	20.00	46.00	31.1600	5.6323
FATHER AGE	25	23.00	46.00	33.2000	6.3048

The number of children in each family ranged from one to four. The average number was 2.1. Fifteen families (60%) had two children, with the lowest representation being two families (8%) with three children (Table 4). Their ages were varied, ranging from two weeks to 19 years. Seventeen (68%) of the families had all their children in the preschool age group.

Table 4

Number of children

NUMBER OF CHILDREN	FREQUENCY	PERCENT
1.00	5	20.00
2.00	15	60.00
3.00	2	8.00
4.00	3	12.00
TOTAL	25	100.00

### Ethnicity and Language

The majority of the parents and all the children had been born in Australia. Eight of the fathers (32%) had arrived from various overseas countries while five mothers (20%) had their origins in England. All the families classified themselves as ethnically Australian.

Table 5

#### **Maternal and paternal ethnic origins**

<b>COUNTRY OF ORIGIN</b>	<b>FATHER (%)</b>	<b>MOTHER (%)</b>
AUSTRALIA	17 (68%0	20 (80 %)
ENGLAND	2 (8%)	5 (20 %)
JORDAN	1 (4%)	
AFRICA	1 (4%)	
BURMA	1 (4%)	
YUGOSLAVIA	1 (4%)	
IRELAND	1 (4%)	
NEW ZEALAND	1 (4%)	
<b>TOTAL</b>	<b>25 (100%)</b>	<b>25 (100%)</b>

Only one of the women classified herself and her husband as being Aboriginal, from the Nyoongar family group. Throughout this study, this family has not been differentiated from the Australian ethnic grouping in order to preserve confidentiality.

English was the usual language spoken at home in all but one of the families, where French was the primary language. All the women and their partners spoke English as did all but two children who spoke only French fluently. Five of the fathers and one mother spoke another language fluently. One father spoke Arabic and another Serbo-Croat due to their ethnic origins and two spoke Dutch as their parents had been of Dutch nationality. One father had been born in an area of Africa where French had been one of the primary languages. His Australian born wife spoke fluent French as the family had recently spent a year in Africa.

All of the adults could read English as could all of the children who were capable of reading. Those people who were identified as speaking a language other than English were also able to read their respective languages. No adults required assistance with the English language. The two children who spoke only French fluently were helped by their parents in translation and in the acquisition of spoken and written English.

### Utilisation and Preferences for Child Health Services

The researcher invited participants from child health centres and playgroups to be interviewed to investigate their utilisation of Child Health Services along with their requirements and preferences. A series of open-ended questions was designed in order to elicit qualitative information for use in the development of common themes.

## Awareness and Use of Child Health Services

### QUESTION 1: “WHAT CHILD HEALTH SERVICES ARE AVAILABLE IN YOUR COMMUNITY?”

The first question in this section sought the knowledge of participants concerning what Child Health Services were available in their community. It was designed to investigate people’s awareness of services they were able to access. Of the 25 participants, 100% were aware of the services provided by the child health clinics and the location of their nearest clinic. Almost half of the women (48%) knew of the immunisation clinic which was located at the child health clinic or at the Central Immunisation Clinic at Rheola Street in West Perth, and Community Health Services was named by two people (8%). No participants mentioned either the Child Development Centre in West Perth or its suburban centre at Queens Park. However, later in the questionnaire, two people (8%) stated that they had used the services of the Queens Park Child Development Centre. They also identified a group of services which, although not officially a part of Child Health Services, were considered by some women as such. These were Ngala Family Resource Centre, Family and Children’s Services, the community based services of Belmont City Council, the Nursing Mothers’ Association, Dental Health Services and Princess Margaret Hospital for Children. No one identified their general practitioner as being a source of information on child health issues. The majority of the women were aware of more than one Child Health Service, while only eight could recall only the child health centre when questioned. An overview of responses to this question is shown in Table 6.

Table 6

**Use of Child Health and related services in the Belmont area**

CHC	IMM	CHS	NGALA	F&CS	BCCBS	NMA	DH	PMH
25	12	2	6	1	1	1	1	1
(100%)	(48%)	(8%)	(24%)	(4%)	(4%)	(4%)	(4%)	(4%)

CHC	Child Health Centre
IMM	Immunisation Clinic
CHS	Community Health Services
NGALA	Ngala Family Resource Centre
F&CS	Family and Children Services
BCCBS	Belmont Council Community Based Services
NMA	Nursing Mothers' Association
DH	Dental Health Services
PMH	Princess Margaret Hospital for Children

**QUESTION 2: "HOW OFTEN HAS YOUR FAMILY USED CHILD HEALTH SERVICES IN THE PAST 12 MONTHS?"**

Of the 25 participants, 20 (80%) had contact with some Child Health Service in the past 12 months. Four of the women had not attended any of the services during this time, although they brought their children for regular assessments to the child health clinic once every 12 months. There was great variation in the frequency of use for the remainder of the women.

Child Health Clinic

Table 7

**Use of the child health clinic in the past 12 months**

<b>NUMBER OF VISITS</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
0.00	5	20.00
1.00	3	12.00
2.00	1	4.00
3.00	5	20.00
4.00	4	16.00
7.00	2	8.00
9.00	1	4.00
10.00	2	8.00
12.00	1	4.00
26.00	1	4.00
<b>TOTAL</b>	<b>25</b>	<b>100.00</b>

As can be seen in Table 7, the 15 women (60%) making between 1 and 4 visits to the child health clinic were the most frequent users of the service. The four (16%) making between five and ten visits were the next largest group, followed by two (8%) who attended more than ten times. It is interesting to note that the child health nurse is able and willing to assist parents no matter how frequently or infrequently they wish to attend, as is highlighted by the above statistics. Some women were satisfied with one or two



visits per year while others made up to 12 or even 26 visits. Maternal age and numbers of children appear not to have a direct relationship with frequency of clinic visits. The woman who came 26 times was 32 years of age and had three healthy children aged five years, three years and three months. Those who visited only once a year were 31 and 28 years and had children aged between eighteen months and three years.

Immunisation Clinic

Table 8

**Use of immunisation clinic in past 12 months**

LOCAL	RHEOLA STREET	GP
7 people (28%)	1 person (4%)	16 people (64%)
TOTAL	24 (96%)	

The remaining person in this study had kept her children’s immunisation status current, but had not required any immunisations in the previous 12 months.

The families in this survey had an immunisation rate of 96%. However, the figures exclude four women who regularly attend the local and Rheola Street clinics but had no requirement to do so in the preceding 12 months. The women who elected to attend their general practitioners for immunisations gave several reasons for so doing. They preferred the flexibility of general practitioners’ hours against the infrequent, short time sessions available at the local child health clinic. If their child had been unwell and

unable to receive an immunisation at the local clinic, they were not willing or were unable to travel to a neighbouring clinic on an alternate day.

Table 9

Availability of immunisations for Belmont residents

IMMUNISATION CLINIC  LOCAL	ONCE A MONTH  MORNINGS OR  AFTERNOONS	NO COST
IMMUNISATION CLINIC  RHEOLA STREET	MONDAY TO FRIDAY  8.30am to 5pm	NO COST
IMMUNISATION  GP	MONDAY TO SATURDAY  SURGERY HOURS	COST/BULK BILLING

Tables 8 and 9 refer to immunisations provided at the local child health centres, the Health Department of Western Australia’s (W.A.) Central Immunisation Clinic at Rheola Street in West Perth and general practitioners (G.P’s.). The local child health centre programme is funded jointly by the local shire and the Health Department of W.A.

The flexibility of times at their doctor’s surgery meant that they could accommodate child minding requirements for other children and also more easily plan their transport to the surgery. Rapport with their doctor was another reason for not attending local or Rheola Street immunisation sessions. These women expressed a preference for having the same person for as much of their health care as possible and consequently preferred visiting their general practitioner.

The women had attended immunisation clinics or their general practitioner between one and three times in the past twelve months. Frequency of visits vary according to the children's ages and the number of children within each family requiring immunisation.

#### Child Development Centre

The Child Development Centre at Queens Park has been utilised by two women (10%) in the past 12 months. One child was assessed for a developmental delay with walking while the other had hearing testing via audiometry and subsequent speech therapy.

#### Other Services

Six of the women interviewed indicated that in the preceeding 12 months they had used services for their children which were not officially part of Child Health Services. One child had attended the Dental Health Service caravan which is available to preschool and school age children at varying suburban locations. Two children had been seen privately at the Bentley Health Service, one having an occupational therapy assessment and physiotherapy and the other having speech therapy. Two children had required treatment at Princess Margaret Hospital for Children, one having a kidney ultrasound while the mother of the other child declined to elaborate. One of the children had seen a podiatrist in private practice.

### Self Perceived Requirements

#### QUESTION 3: “WHAT ARE THE MAIN THINGS YOU WANT FROM THESE SERVICES?”

This question was designed to address the self perceived requirements of Child Health Services by the participants. Qualitative responses were sought to gain an understanding of what women wanted. Following the above question, the participants were asked what they wanted from the following specific services offered:

- child health clinic;
- immunisation clinic;
- Child Development Centre;
- speech therapy;
- hearing assessment and
- other.

#### Child Health Clinic

When the responses from this question were analysed, the two main categories which emerged concerned developmental advice and telephone contact.

#### Growth and Developmental Advice

Developmental advice was related to children’s developmental progress. Advice sought consisted of two main areas of information: advice resulting from developmental checks and information on the different stages of development. Ninety six percent of the

participants wanted assistance and advice in this area. Examples of their comments are as follows:

- I like to check their development is all right.
- It's hard to tell. I like to know about the children's development - if they are growing OK - growing properly and doing all the right things. I also like to keep an eye on their weight to see if it's all right.
- It's good to have someone to give reassurance for the baby's weights and measurements.
- I suppose I like to ask questions about the kids and how they are going. I want to know their weight and growth.
- Then I suppose I wanted to know if they had reached their proper milestones, to know their weight and growth.
- I liked the advice on what they were doing.
- The big checks that the sister does at certain ages (are what I like). Then the children can be referred if necessary. It's good to have the nurse to talk to. I like the weight and length checks as I get worried about their feeding. Then I know everything is all right.

These responses reflected both general and specific requirements. The most common of the specific requests (50%) was to gain knowledge concerning the weight and height measurements of the children. The need for hearing checks was commented on by two participants while only one acknowledged the need for vision and speech assessment. One participant thought it important for small babies to have their hips checked.

The following statement made by one of the participants indicates the importance she placed on the developmental checks. This statement implies that even though this woman has more than one child, she still sought advice from the nurse for reassurance that her children are growing normally.

- There should be reminder calls or letters for the important checks for the mums who have two or more children. You don't tend to come as often and you might forget these checks.

Ten people (40%) indicated a need for general reassurance, advice and support. They were unable to specify which particular need they had, but acknowledged that the child health clinic was the appropriate source of information for their needs. Examples of their comments include:

- Let me think. I suppose talking to the nurse about the children (is what I value). Getting clarification of things that concern me.
- The main things I want are knowledge and advice. I want to know where I can go for different problems.
- Information is the main one. It's the first base for information and referral if it's needed.
- Generally I like to know everything is going all right.
- Information I suppose.

First time mothers constituted a significant sub-group. There were six women (24%) who sought assistance as first time mothers. Their comments were positive about the assistance offered by the nurse at the child health clinic.

- The support the nurse gives the first time parent is wonderful. The home visiting is really good.
- I really liked the new parent information the nurse gave me.
- The clinic was great helping when she was a newborn.
- Well, (I like) all sorts of things really. I like to get advice on everything I need to know about. As he's my first, I like to ask about things such as sleeping, eating, teething, colic. I like to get reassurance that I'm doing the right thing.

Four women required dietary assistance for their children and families. Breast feeding advice was sought by two participants while one requested general advice for her baby and one requested general dietary information for the whole family.

- Support when breast feeding is important. The nurse must be understanding and willing to listen.
- When the kids were young I needed help with breast feeding and with comp (complementary) feeding. I really needed that at that stage.
- I appreciate the advice on feeding ...
- The thing that I want the most would be up to date information. I'd like new information that's available, such as the effects, either good or bad, of zinc in people's diet. It would be good to be able to keep abreast of changes.

There were two women (8%) requesting advice on sleeping problems.

- Support for breast feeding is important, as well as support for managing the baby's sleeping problems. The nurse must be understanding and willing to listen.
- I really appreciate the advice on feeding and sleeping.

Written reassurance, advice and support was indicated as a need by one respondent (4%), although others requesting general information could also be interested in the written form rather than, or in conjunction with, the verbal advice.

- ... (I) appreciated the pamphlets that I could take home and read when I had a few spare minutes. They were good because these days I need to read and reread things before I can remember them. Can't possibly remember all the things I get told by the nurse.

### Telephone Contact

The second main category which emerged from the women's self perceived requirements of the child health clinics was telephone contact. This was emphasised by two of the participants. It would appear that telephone contact is equally as important during the hours when the child health nurse was working as it was in the evening and night periods when the clinics are not operational. One person preferred this form of contact for quick advice during child health clinic hours while the other regarded it as an important service to have during the out-of-hours period.



- The phone contact is good when I can't get to the clinic or for something quick where it's not worth coming down.
- It's good to have a place like Ngala for the out-of-hours problems. (Ngala Family Resource Centre conducts an after hours telephone service).

### Immunisation Clinic

The question "What do you want from the immunisation clinic?" investigated the women's expectations of the immunisation clinic. Qualitative responses were sought, analysed and divided into three main categories based on their responses. As to be expected, the majority of people stated that they went to the clinic to have their children immunised. Others mentioned the importance of affordability of immunisations at clinics, and the accessibility and availability of clinics.

### Immunisation Only

This category was developed from those responses where no further information or advice was sought. There were 16 responses, showing that 64% of the participants primarily wanted immunisation for their children. Examples of their comments are as follows:

- Only immunisations really.
- Immunisations. That's all.
- Only immunisations.
- The main thing I need is immunisations really.

- Just immunisations. It's pretty straightforward.

### Affordability

The fact that immunisation was given at the clinics free of charge was mentioned by 10% of the participants, who indicated that they preferred not having to bear a cost. Examples of their comments were:

- ... (I) like the fact there's no cost involved.
- I like the fact you don't have to pay.

### Accessibility/Availability

This category was developed from five of the participants (20%) who believed that the immunisation clinics are inaccessible and unavailable. The difficulty in getting to immunisation clinics at convenient times was mentioned by four people who stated:

- I'd like the clinic staff to be there when the clinic advises that it will be open.  
They didn't turn up twice.
- When the immunisations are due, often the clinic isn't available and you have to travel to find one that is.
- I'd like the clinic to remain in the suburbs. It's far more convenient than going to West Perth.
- Yes. (The clinic should be open more often).

Only one person mentioned that she was pleased with accessibility.

- The clinics are accessible.

The participants were asked about the main things they wanted or needed from the Child Development Centre, speech therapy, hearing assessments or any other service. No one chose to comment on these special divisions of Child Health Services and it would appear that this lack of comment resulted from these services not being required or that the women were not familiar with them.

QUESTION 4: “ARE YOU ABLE TO ACCESS THESE SERVICES WHEN YOU WANT TO?”

This question was designed to investigate the accessibility of Child Health Services. It was explained to the participants that the question related to the services provided by the child health clinic, immunisation clinic, Child Development Centre, speech therapy, hearing assessments (audiometry) or other unspecified service. The women were requested to give answers in relation only to the services which they had used. There were five categories developed from the responses to this question: Child Health Clinic Accessibility, Phone Accessibility, Immunisation Accessibility, Speech Therapy Accessibility and Yes with no Elaboration.

### Child Health Clinic Accessibility

Overall, the child health clinic was viewed as being accessible to the clients. This category comprised the greatest number of responses to this question (88%). The majority expressed appreciation of the clinic accessibility in these terms:

- The clinic is accessible ... easy to get to.
- Yes. No trouble. I can get to the clinic easily.
- We live close enough. If I remember the opening hours it's OK.
- At the clinic ... the open clinics are good. Sometimes have to wait two weeks for an appointment.

Six women expressed their concern over the restrictions on availability of the clinic due to inappropriate hours of operation.

- No, not really. (The clinic is not accessible). It's sometimes hard to get in as the Rivervale clinic has been closed. The parents were just absorbed into the existing clinics. They should increase the opening times.
- I find the hours that the clinic is open is restrictive.
- It would be good to have appointment times in the evening when the toddlers are asleep. I think appointment times are needed for the main checks and it's easier when older ones aren't around.

### Phone Accessibility

The majority of the women were pleased with phone availability in that the nurses could be reached by telephone at all hours of the day. This category elicited 14 responses

(56%). Eleven of the participants were positive in their assessment of phone availability of the clinic nurse, while the remaining three wanted adjustments to the system. Two of the participants were referring to the out-of-hours telephone services provided by Ngala Family Resource Centre, which they had incorrectly perceived as being a part of Child Health Services. Examples of their comments are as follows:

- If I'm unable to go, I ring the nurse and go to the other clinic where she is that day. I can always ring if I can't get down.
- The nurse is always available on the phone if I need to speak to her.
- The advice I get from over the phone is OK.
- Yes. (Able to access child health nurse). Especially contacting Ngala out of hours.
- It would be good if the sister could ring in wherever she is and find out what is on the answering machine and if anything needs attending to. That would save messages getting left until she's next back in the clinic.
- I would also like to know where the nurse is when she's not there so I can ring her if I need to.
- I've used the 24 hour phone line at Ngala. When we first brought her (the baby) home from hospital she wouldn't sleep at night so I used their emergency number. The trouble was that twice all I got was a recorded message asking me to leave my number, and the nurse didn't get back to me until the next morning. By then it wasn't much good.

### Immunisation Accessibility

This issue was mentioned in only two responses (8%). The lack of appropriate opening times for immunisation clinics was raised by one person while the only other woman who mentioned this clinic stated:

- With the immunisations, the Rheola Street clinic is good as it's there all the time. The local clinics are good as we have a variety and choice between venues and times. I can get to them in a few areas.

### Speech Therapy Accessibility

There was only one person who had used the speech therapy clinic and her experience was a negative one as demonstrated by the following comment:

- With the speech therapy there's a long waiting list ... about nine months ... that's very frustrating.

### Yes With No Elaboration

These responses were given in relation to the services provided by the child health clinic. Three participants were positive about the clinic but declined or were unable to formulate specific reasons for their replies.

### QUESTION 5: "ARE YOU SATISFIED WITH THE HELP AND INFORMATION YOU RECEIVE FROM CHILD HEALTH SERVICES?"

No satisfaction scale was used with this question. There was only one participant who was not satisfied with her contact with Child Health Services, while another expressed a

similar opinion regarding Ngala Family Resource Centre. The explanations can be divided into five categories: Understanding and Support; Relevant and Helpful Advice; Pamphlet Advice; Out-Of-Hours Help and Information and Yes with No Elaboration.

### Understanding and Support

There were five responses (20%) which comprised this category. All of the participants made reference to the child health clinic and nurse with no other services being mentioned. All of the responses were positive, as indicated by the following comments:

- I always have a good rapport with the nurses. The nurses seem understanding of what I'm going through.
- Yes. The centres are easily accessible. I find the nurses are very supportive of me.
- Yes. The nurse is very understanding.
- Yes. I like the reassurance I get from the clinic.
- Yes. I have a good rapport with the clinic nurse.

### Relevant and Helpful Advice

The majority of people expressed satisfaction with the service as it was helpful to them and gave them useful information. Eighteen participants (72%) answered this question. Seventeen of the responses related to the child health nurse, while one referred to the assistance given at a Child Development Centre. The only negative comment was that the service varied between clinics.

- No not always (satisfied with the help and information). It varies from clinic to clinic.
- She's (the child health nurse) good as she's down to earth and logical.
- She's realistic and isn't too much by the book.
- The advice she gives me is always helpful.
- The nurse at the clinic is also OK. She's been very helpful.
- The clinic is OK. The nurse has helped me a lot.
- Yes. I like the way the nurse gives out information. Not too much at once.
- Yes. The help I got from the (Child Development) centre at Andrea Way was OK.

### Pamphlet Advice

Six people (24%) who answered this question were positive regarding the value of the advice they received through pamphlets. One person offered a suggestion to enable improvement.

- I would like the brochures to be updated a bit more often.
- Yes. The pamphlets are very helpful as they keep me in touch with what I need to know and what's going on.
- Yes. I particularly like the pamphlets. I can never remember all the nurse tells me about a lot of things and I prefer to have a pamphlet that I can go away and read quietly later.
- There's also the information on the notice board. I found that I got too much information overload at the hospital.



### Out-of-Hours Help and Information

The two women whose answers fell into this category referred to services not directly provided by Child Health Services but which were perceived by the participants as being part of them.

- The backup help is also good. She referred me to the Nursing Mothers' Association for out-of-hours help when I was having trouble breastfeeding with both the kids and they were great.
- Ngala was not so good. (Referring to the 24 hour counselling line).

### Yes with No Elaboration

The five participants (20%) in this category were not willing or were unable to elaborate on the reasons for their satisfaction with Child Health Services, simply stating that they were pleased and had no problems.

### QUESTION 6: "WHAT TYPES OF THINGS DO YOU MANAGE AT HOME RATHER THAN SEEK HELP FROM THE CHILD HEALTH SERVICES FOR?"

This question was designed to elicit from the study's participants which of the child health service facilities and services they considered not necessary. These would be the services which could possibly be considered a non essential health service when fiscal management became an issue.

Of the 25 participants, 100% of the responses referred to services provided by the child health clinic and child health nurse. Clarification as to the meaning of the question was

requested by nine participants (36%), raising the possibility that the question was not explicit enough in its original meaning and intent. The categories which were developed from this question were Child Health Service Use and Child Health Service Value.

### Child Health Service Use

This theme has been subdivided into two groups: Self Management and Parent Nurse Management.

#### Self Management

The participants who have been classified in this group chose to have limited contact with the child health nurse and made most of their child management decisions autonomously from the child health nurse. Some of the women are reassured to know that the child health nurse is still available for backup. Most of these were women who had the experience of having more than one child and were confident in their care of their second or third children. Responses to the question “What types of things do you manage at home rather than seek help from the Child Health Services for?” included:

- Most things really. I haven't been much since he was three months old. I've just managed at home.
- Oh I've sought advice for everything for my first child. Now I manage things like diet, sleep and the like at home.
- Not being a first time Mum, I manage most things at home myself.

(Interviewer) What would be the main reason for coming to the clinic then?

For the big checks I suppose and I can see how she's going.

- I do everything myself now. The kids are older and I don't take them as much.
- I don't have the new parenting syndrome, so I manage most things at home, like sleep, behaviour and discipline, and what they eat. Mostly everything's fine.
- Well I visit less as the children grow and end up doing more things myself, such as what they eat.
- Well, I suppose I manage most things myself but I use the clinic as a backup. It's good to know they're there.

### Parent Nurse Management

In response to the question of what types of things the participants manage at home rather than seeking help for from the child health nurse, there were six responses (24%) in this category. These women consistently sought the advice of the child health nurse when making decisions on the care of their children, for a variety of reasons.

- This is my first baby.
- She's only seven weeks old. I rely on the nurse for everything.
- Oh, I use the service for most child advice. My Mum isn't in Perth.
- I like all that the clinic has to offer.
- Oh, I use everything on offer at the clinic.
- I mostly check with the nurse with what I'm doing.

### Child Health Service Value

The participants who contributed to this category addressed their own Child Health Service use and also commented on the value of the Child Health Services in general.

- I think all the services are well used. Obviously I can manage at home for things but it's nice to know I can see the nurse for anything.
- Well I do a lot of things at home as I have four children now and I don't have to come as often, but I think all the services are relevant.
- I think everything at the clinic is valuable. Different people come for different reasons.
- I think everything that's available is needed.
- I think everything at the clinic is important.
- From my point of view, I think all the services are necessary.
- I think all the services at the clinic are relevant.

### **SECTION 3 OF THE INTERVIEW GUIDE**

This section was designed to investigate participants' feelings about their own and their family's health status, as well as provide an opportunity to offer further comments regarding Child Health Services that may not have been appropriate to the preceding questions.

QUESTION 7: “DO YOU HAVE ANY CONCERNS OR WORRIES ABOUT YOU OR YOUR CHILDREN’S HEALTH AND WELLBEING?”

This question was included in an attempt to discover if participants’ health concerns, or lack of concern were identifiably linked to Child Health Service use. Six participants (6%) responded to this question with general concerns. These included the following:

- Yes. Diet. Trying to get them to eat the correct diet is a hassle. Then I realise that they are healthy and this helps me keep all the concerns in perspective.
- Yes. My husband is a diabetic. We had counselling on this before I became pregnant. My mother has kidney disease. We talked about that as well. I find it difficult to get Ben (husband) and other family members to understand the proper diet for him (son) which would help prevent diabetes. You’d think that having a son with it would make them wary but my in-laws have all the lollies and sugar for Ben when he goes there.
- The main thing is I hope their (the children’s) English improves.
- Yes. I’d like to have hearing and vision checked out at an early age. You can never be too careful as all sorts of problems can happen later on.
- There’re a couple of things. The boys have had chronic diarrhoea which has been a worry ... still is. I still get concerned about their speech.
- Yes. Sleep! It scares me to think that no one will be out there to help me out. It scares me to think of coping alone with children who are getting up five or six times a night. Diet for my two and a half year old is a worry as well. I worry about the amount of food he eats. It’s not much ... and the type of food he eats. He’s pretty fussy right now.

The responses of 19 participants (76%) indicated that they had no concerns or worries about the family's health and wellbeing.

QUESTION 8: "WOULD YOU LIKE TO MAKE ANY FURTHER COMMENTS ABOUT THE CHILD HEALTH SERVICES YOU HAVE USED OR THAT YOU REQUIRE?"

This question was designed to gather any further information which the participants may have thought of after they had responded to questions but were not inclined to return to the original question to elaborate on. There were three categories that emerged: Child Health Service Issues; General Concerns and No Comment.

Child Health Service Issues

There were 11 responses (44%) in this section. From the differing issues raised, a further three subsections to this theme were created.

Financial Issues

Three participants (12%) were concerned that budget constraints would adversely affect the quality of services provided by child health clinics.

- I want to know how to keep what we've got now. I'd like to get some community action to stop any of this disappearing.
- I don't like the cuts to screening, such as the five year old's hearing checks. Also I like individual appointments rather than group clinic sessions. Can't think of much else. Overall I'm happy with the service.

- I don't want to see it diminished from its present standard.

### Child Health Clinic Availability

There were four responses (16%) in this section indicating women's concern at the limited operating times of the child health clinics.

- I'd like more clinic time, especially in the first six months when the child has colic and is irritable.
- I think that the hours that the clinic operate are too limited. I don't know if anything can be done about that.
- The thing I would really like to see is home visiting for those parents who have no transport and can't get to the clinic when it's open. Or, open the clinic more often.
- Well I'd like something to be done about the 24 hour line. That's about all though.

### Child Health Service Provision

There were eight responses (32%) in this section where the participants commented on their perceptions of the quality of services provided by Child Health Services. Six of the responses were in relation to child health clinics while the remaining one was directed at the immunisation services.

- I like the clinic nurses because they are calm. They do everything I expect they would expect for not being there more often. The nurse where I go allows

enough time during visits and is thorough. I would say she fulfills my expectations.

- Yes, they're OK. The main thing is being able to make contact. It's nice to be able to contact the sister straight after discharge from hospital.
- I would like to see mature nurses in the clinic. I had a bad time when my second child was born - the first, our girl, was very jealous. I felt that the nurse at the time was not able to help as she didn't understand family dynamics. I'm sure that a mature nurse who had children would have been able to understand better and help me.
- Everything I've needed has always been there. The only other thing is that the nurse in the clinic when the boys were first born was not very experienced with twins and didn't know all the services that were available to me. That's about all I can think of for now.
- I'd like nurses to respond to an answering machine when absent from the clinic to keep in touch with parents' concerns.
- If clinics were expanded to family health, people would perhaps use them for health education and referrals, but would be more likely to go to their GP where they have better rapport.
- A system is needed to contact the mothers with postnatal depression as those people don't feel able to phone or answer the door.
- Reminder cards for checks and immunisations (are needed). That's about all I think.



### General Concerns

There were two participants (8%) who made comments relating to this section.

- I would like some information on the dental services available to children. I'd also like to have the clinic used as a place where we could get information on preschool and the rest of the education system. The nurse wouldn't have to know all the information, just be a central point where we can be referred to the right people. This would be especially good for parents who are new to an area.
- What would be helpful would be a referral list of volunteers willing to do child minding. That would help a lot of people, especially those without close family. I think I've said just about everything I wanted to say.

### No Comment

There were 10 responses (40%) in this section. The participants had nothing else to add to what they had already said on issues relating to Child Health Services.

### Overall Themes

This study is designed to explore primary health care needs as identified by clients themselves. It was, therefore, considered important to develop analytical categories directly from the participants' responses rather than using categories externally and to an extent arbitrarily imposed by the researcher on the basis of previous studies. Thus the themes below summarise the concerns most often raised by the participants themselves and they can, therefore, be considered as an expression of self-identified health care needs.

#### Knowledge Acquisition

The first theme refers to the need for relatively specific information covering a wide area. The most common questions concerned developmental issues, but advice on diet, breastfeeding, sleep patterns and so on was also sought, particularly by first time mothers.

#### Reassurance of Normal Growth and Development

This theme is closely linked with the category of Knowledge Acquisition, and there is considerable overlap in the information provided by participants. However, while reassurance can be seen as a form of knowledge acquisition, many women were very specific in requesting advice on what constituted normal growth and development, and hence it is appropriate to create a separate category to cover this response. Desire for general reassurance of normal growth and development, rather than specific advice of the

type required by first time mothers, was a typical characteristic of the responses of more experienced mothers.

### Accessibility

The accessibility of clinics, both in terms of location and operating hours, was the strongest theme to emerge from this study in relation to rate of utilisation of Child Health Services, especially for immunisation. Accessibility is also considered in terms of which sub-groups in the population appear readily able to use Child Health Services and which do not, and in terms of the availability and extent of telephone contact.

## CHAPTER 6

### DISCUSSION

In this chapter, participants' responses to each question will be discussed and compared with the findings of previous research. The relation of participants' responses to the three themes elaborated at the end of the previous chapter will be shown and the responses will then be analysed in terms of the conceptual framework provided by the Ottawa Charter.

#### QUESTION 1: "WHAT CHILD HEALTH SERVICES ARE AVAILABLE IN YOUR COMMUNITY?"

The fact that 100% of participants were aware of the services provided at the child health clinics is noteworthy, since the majority of them were contacted and interviewed outside the clinic setting. Awareness by half the interviewees of the provision of immunisation specifically at the local clinics and the Central Immunisation Clinic at Rheola Street in West Perth can probably be attributed to the promotion of immunisation by the child health nurses during regular attendances at the clinics for other reasons. At the same time, this result also suggests the need for repeated reinforcement of the message, since half the participants were unaware of, or had forgotten about the availability of immunisation at the clinics.

Awareness of Child Health Services is not an issue that has been emphasised in comparable studies, so it is not possible to assess the representativeness or otherwise of this result in overall terms. However, Ochiltree (1991) showed that mothers from non-

English speaking homes and those from low income families were more likely to be associated with underutilisation of Child Health Services. Kanitsaki (1993) concluded that lack of culturally appropriate social support is a significant factor in access to mainstream health services. These studies highlight the fact that patterns of utilisation of health services differ among various sub-groups of the population, a finding that is strongly confirmed by the absence in the present study of at least two categories of clients: non-English speaking women and parents with disabilities.

This study shows that, though non-English speaking participants were not proactively sought, families from a non-English speaking background are benefiting from the Child Health Services. However, all such families covered by this research included an English speaking mother; it was their partners who came from different language backgrounds. There were no non-English speaking women available for interview while recruiting for this study was taking place. According to Mazzarol and Doss (1995), in 1991, 32% of the City of Belmont population was born overseas, with 15% of those being of non-English speaking origin. From these figures, it is reasonably likely that a number of non-English speaking young families live in this community. The questions arise as to whether there is a lack of knowledge of the Child Health Services, with the child health and immunisation clinics being of particular note, and whether there is a perception that there will not be culturally specific assistance available. It is also possible that non-English speaking parents did not volunteer because they were unaware of the research project as the study was only advertised in the English language.

Likewise, consideration needs to be given to access to the range of Child Health Services by disabled members of the community. There were no women with physical or intellectual disabilities in the sample interviewed for this study and again this poses the question of awareness by those with disabilities of the range of Child Health Services, as well as accessibility. The majority of the women interviewed were from the local playgroups, but it is also a fact that there were no women with intellectual or physical disabilities in attendance at the child health clinics while recruitment for this study was being attempted there. Once again, it can be assumed that a proportion of young families in the Belmont area includes parents with disabilities, whose needs are probably not being fully met by the existing service.

#### QUESTION 2: "HOW OFTEN HAS YOUR FAMILY USED CHILD HEALTH SERVICES IN THE PAST 12 MONTHS?"

The two main Child Health Services are the child health clinic and immunisation clinics. These will be discussed first, then all other Child Health Services will be discussed.

#### Child Health Clinics

Awareness of the need for developmental checks and the good reputation of child health nurses in terms of approachability are the most likely reasons for the high rate of use of child health clinics amongst the participants in this study. It is possible, too, that playgroups, from where most of the participants in this study were recruited, are likely to attract mothers who also attend, or who are aware of, child health clinics, in that they have a relatively high awareness of community activities and resources and a willingness

to take their children out of the house. Playgroups themselves, in addition, act as forums in which information about the services available at the clinics is informally exchanged.

At the same time, the fact that 20% of participants had not used the clinics in the previous twelve months is attributable to the lower frequency of use by experienced mothers, together with the older age of their children who thus needed fewer vaccinations and developmental checks. Previous studies provide little information about the rate of use of child health clinics, making comparative evaluation of the figures from this study difficult, though it can be presumed that several factors addressed in other studies, notably accessibility, greatly affect the rate of utilisation of health services, as will be discussed in greater detail below.

### Immunisation Clinics

While the proportion of participants in this study who had had their children immunised must be rated as excellent at 96%, it is significant that only about half these immunisations took place at clinics associated with Child Health Services. The greatest number of those who had not attended the clinics had their children immunised by their general practitioner instead. The major reason cited for this was accessibility, meaning both location and number and flexibility of hours of operation, a finding which confirms the results of research by both Maltby (1996) and Bazeley (1992). Twenty percent of the participants in the present study agreed that accessibility was an issue that restricted their use of the immunisation clinic held at the child health centre or at the Central Immunisation Clinic in West Perth, with the main issue being that the clinic was not

open often enough. Having to travel to a neighbouring suburb to find one that was available was not a realistic option for most people and thus the likelihood that immunisation will be delayed arises. One participant complained that the immunisation staff had not been at the clinic when advertised. Such situations entail the real risk that immunisations might not be delivered according to schedule.

Rapport with individual doctors and preference for continuity of treatment by the same practitioner were other reasons given for non-attendance at the clinic for immunisations. The latter factor suggests a similarity with the findings of the research undertaken by Bazeley (1992), which show a distinct parental preference for an immunisation service characterised by personalised service and individual attention.

#### Other Child Health Services

The low level of utilisation of Child Health Services other than those mentioned above suggests that knowledge about these services among potential clients may be limited. Referral from the local child health clinic is the most likely reason for attendance at the Child Development Centre at Queens Park, which served as a major source of information for two women in this study on developmental delay in walking, speech and hearing. Other studies provide little information to suggest reasons for the relative lack of use of these services. On the other hand, the fact that six participants in the present study had used services over the past twelve months which, though relevant to their child health needs, were not officially part of Child Health Services, suggests that in some areas, other organisations such as Ngala Family Resource Centre and the Dental Health



Services are providing effective and comparatively well publicised care which is accessible to clients. There would thus appear to be a possibility of some form of collaboration between Child Health Services and these organisations, particularly in view of the need to rationalise services and reduce costs.

### QUESTION 3: "WHAT ARE THE MAIN THINGS YOU WANT FROM THESE SERVICES?"

#### Child Health Clinic

Virtually all participants primarily sought reassurance of their child's normal growth and development, as well as specific advice, confirming and indeed exceeding the requests for advice as presented in the findings of research conducted by Sefi and Grice (1994), who found that 62% of mothers in their English study valued the clinic nurse's advice and 61% requested a general developmental check.

The prominence of the desire for reassurance in participants' responses can be partly attributed to a continuing perception in the community that general practitioners and other health providers are primarily to be consulted in cases of illness rather than as part of ongoing promotion of health. Apart from the child health clinics, there are few if any other sources of information on growth and development, and other child and family health issues which can be readily accessed in a non-acute situation, as indicated by Girgis & Sanson-Fisher (1996) and Richmond et al. (1996).

First time mothers, 24% of participants, were the major group requesting specific advice, reassurance and support. The role of the child health nurse in assisting clients towards self-management takes high priority in this area. Emotional and physical reactions to being new parents are varied in nature and intensity. An important focus during this time is a health professional who is able to offer research based, objective information for clients. The knowledge and assistance of the child health nurse is crucial in such cases.

The study's participants who were first time parents all gave positive feedback on the role and importance of the child health nurse. Home visiting was mentioned by two women, who were enthusiastic regarding the information given by the nurse when they could not readily attend the clinic. Difficulties in attendance can be due to various reasons, including inability to organise activities outside the home following discharge from hospital, sleep deprivation, lack of transport and ill health of the mother or baby. Most of the remaining responses were not particularly specific about what the participants found helpful. Support, advice and information were cited, with the single most specific response mentioning problems relating to the child's sleeping, eating, colic and teething.

The need for advice and support in written form was also an issue raised, with some women stating that they retained more of the information by being able to read it at a quiet time and also able to read it several times over. It should be noted that having more information in written form can enhance knowledge acquisition not only by the main caregiver, usually the mother, but also by the other parent, the children's grandparents

and other members of the extended family. Consequently, there is the potential to reduce the pressure of child care in the family away from the main caregiver. On the other hand, the point about written material raises the issue of language. While all women who participated in this study spoke, read and comprehended English well, there is a clear need, as noted by Maltby (1996), to provide material in other languages as appropriate in order to facilitate greater awareness of health services within communities of non-English speaking origin.

Some of the participants believed that written information was not always up-to-date, and pointed to the need for it to keep abreast of changes. Taking into consideration the cost of researching and printing new information, it is highly probable that the most recent information is indeed coming not from pamphlets available at the clinic but rather from the electronic media and popular magazines. Nevertheless, every effort must be made to provide clients with the most current information possible.

The availability of telephone contact with the child health nurse emerged as one of the major issues in this study. The telephone was a preferred form of contact during clinic hours for quick advice and was also considered an important service to have during the out-of-hours periods. One of the participants was grateful for being able to have telephone contact immediately following her discharge from hospital. The out-of-hours service is provided by Ngala Family Resource Centre, though it is perceived by many women as part of Child Health Services.

Out-of-hours help and information was generally favourably received by the women, who used both the Nursing Mothers' Association for breastfeeding difficulties and Ngala Family Resource Centre for all types of child care problems. The child health nurses refer their clients to these services even though they are not officially part of Child Health Services. One of the women experienced difficulty accessing a nurse at the Ngala Family Resource Centre during the night. It is appreciated that there may have been insufficient information left on the answering machine to enable the nurse to return the call but parents depend on this service for calm advice given during the early evening and night and, as such, it needs to be a reliable service. One of the women requested that when child health nurses have more than one clinic to operate, they should call their answering machines in their non-operational clinics each day to keep in touch with parents' concerns. It should be noted that the majority of the nurses do include their daily location and an emergency child health contact number in the machine's recorded message. By the same token, if parents are worried, a recorded message does little to allay their concerns.

### Immunisation Clinics

The single most frequent response when participants were questioned on what they wanted from immunisation clinics was simply an emphasis on the need for their children to have the immunisations. It is acknowledged that the study did not specifically ask about immunisation knowledge. However, the fact that no participant stated that she wanted more information on immunisations may suggest a lack of awareness of the need to find out about such issues as side effects, changes to immunisation requirements and

so on, as has already been suggested by Blair et al. (1997), who concluded that caregivers in Brisbane had a very low level of understanding of both diseases and vaccinations. In the context of the present study, the problem arises as to the level of immunisation education which the participants are receiving even if they are not specifically requesting any, and it is in this area, as well as in the actual provision of immunisations, that Child Health Services have an important role to play.

This study has shown, however, as noted above, that many people have their children immunised outside the clinic system, which raises a particular set of issues connected with immunisation education. The Commonwealth Department of Human Services and Health (1994b) recommended that the national immunisation standards include the requirement that providers are to educate parents about immunisation, use accurate recording procedures and report adverse effects immediately. Vaccines are to be administered by properly trained individuals who are to receive ongoing education and training on current immunisation recommendations. Though nearly all participants in this study had their children immunised, many used their general practitioner rather than Child Health Services, and it cannot be guaranteed that general practitioners are receiving the recommended immunisation updates and further training. The study by Rixon et al. (1994), for example, raised significant doubts about the proportion of general practitioners in the Northern Sydney Health Area whose knowledge relating to immunisations was current and comprehensive. The Health Department of Western Australia is able to closely monitor the situation in relation to its own medical and nursing personnel but has more limited opportunities to do likewise with general

practitioners. Encouraging immunisation through the clinics, then, appears to be a worthwhile goal.

### Other Child Health Services

The two women who attended the Child Development Centre wanted information related to specific difficulties their children were experiencing at the time, but could not suggest ways in which the service provided by the Centre could improve. This response is probably attributable to their view of the Centre as a place where they could seek solutions to a specific problem rather than as a resource for ongoing use. It also suggests the need for greater publicity about the role of the Centre amongst the general client population, including those who do not attend child health clinics, and amongst health care providers outside the clinics. At present, referral by a clinic nurse is the usual reason for attendance at the Centre, but there is certainly scope for self-referral and referral by general practitioners. Lack of use of the Centre and other Child Health Services apart from the child health and immunisation clinics strongly suggests that these latter types of referral are not taking place to any great extent, and education campaigns aimed at parents and doctors would probably prove efficacious in broadening the community health base.

#### QUESTION 4: "ARE YOU ABLE TO ACCESS THESE SERVICES WHEN YOU WANT TO?"

##### Child Health Clinics and Immunisation Clinics

These two services are considered together in this section because the immunisation clinics are run from the child health clinics. Accessibility to both services has definite implications for rate of attendance, and, thus, for public health in general. Government agencies should be aware of this in the current climate when temptations to cut costs by reducing the services available in local communities are strong. By their very nature, the advice and support offered by child health clinics are valuable to the extent that they are immediately available, and at close range: in particular they must be accessible to parents with limited mobility. Mothers featured in a report on the possible closure of a child health centre in suburban Perth emphasised this point: "At the moment we can ring the nurse with a problem and she can see us within the hour" ("Child Centre's Fate," 1998, p. 17).

It is also evident from the literature that the participation of young families in their own health care, a goal now being widely advocated, is dependent to a large degree on the accessibility of appropriate health care. Bazeley (1992), for example, indicates the need for ready availability and accessibility of immunisation services in enabling families to effectively immunise their children. The World Health Organisation (1978) has identified the accessibility of health care as an integral part of primary health care. The Commonwealth Department of Human Services and Health (1994b) recommended that immunisation services should be readily available, with no barriers or prerequisites to

availability, and that they should be offered at no cost. The planning and promotion of all primary health care should thus include the criterion of accessibility as a priority when considering community participation.

Child health clinics were viewed as being relatively accessible by the majority of women in this study. The high level of satisfaction expressed by participants in the study with the location of the clinics can be considered a positive reflection of their local character. While participants strongly approved of the local nature of the child health clinics, a few suggested that the clinics' role as sources of local, decentralised information should be further strengthened.

On the other hand, a number of participants in this study were dissatisfied with either the extent or the flexibility of the clinics' opening hours, expressing a desire for evening clinics in particular and a wider choice of possible attendance times in general, especially in the case of immunisation clinics. Currently, most child health clinics are open from 8.30 a.m. or 9.00 a.m. to 5.00 p.m., Monday to Friday. Immunisation clinic hours are varied, as shown in Table 9.

The increasingly diverse ethnicity of the Australian population is one reason for the demand for more flexible hours. Evening hours would facilitate attendance by the partners of those parents whose comprehension of, or ability to communicate in English is limited, as is clearly demonstrated by the research undertaken into the Vietnamese community in Perth by Maltby (1996). The selection of health providers by the



participants in this study appeared to be overwhelmingly driven by preference of hours of availability. In the case of those who chose general practitioners, the flexibility of the general practitioner's sessions was perceived to accommodate such needs as child minding and obviate the need to travel to immunisation clinics outside the women's own area.

Increasing the hours of immunisation clinics poses difficulties associated with increased staffing and associated costs and there would appear to be a case for the child health clinic nurses being able to administer their own immunisations on a more regular basis. However, according to S. Bursill (personal communication, January 22, 1998), the Senior Nurse at the Central Immunisation Clinic at Rheola Street in West Perth, a certification of competency in Immunisation Administration is required by nurses employed by the Health Department of Western Australia, and there is also a legal requirement in this state for a medical practitioner to be at the site where immunisations are taking place. These immunisation requirements become financial issues for the Health Department, especially in view of the location of the immunisation centres. Currently, most of the child health centres are situated away from medical facilities. If the child health nurses were located in centres in which health professionals such as medical practitioners practised, the legal requirement for medical attendance could be more easily accommodated in terms of cost.

At the time of this study, one of the child health clinics in the Belmont area had been closed and the clients had to find an alternative location. Problems arose not so much

because of the travelling to the other centre, but rather because the nurse in the other location had to serve more families under the new arrangement and so had less time to spend with each client. The request by another participant in the study for home visiting for those parents without transport or who were unable to attend during clinic hours can be linked with the desire for evening clinics, as many women only have access to a vehicle in the evenings and weekends. Public transport is generally available but can be a problematic experience for those responsible for babies and toddlers and their equipment and is more difficult in times of rain and intense heat.

In terms of telephone access to the clinic, participants in this study pointed out that with the nurses operating at a number of different venues on different days, there was a need for them to stay in touch with all their clinics on each day in order to assess the priority of messages left. There is also a need to ensure an emergency number is left for parents during the periods when the child health nurse is not in attendance, together with advice as to the nurse's location for that day. This is currently provided in most clinics, but in order to ensure a consistent and reliable service, it must be provided in all clinics as a matter of priority.

When considering issues of accessibility, it is important to remain alert to the question of who is not using Child Health Services. As has been pointed out above, neither non-English speaking women nor parents with disabilities are represented in this study because they were not present either in the venues where recruiting took place or where it was attempted. Additionally, the study was only advertised in the English language.

There is a need to ensure not only that the existence and location of child health and immunisation clinics are widely known in the general community, but also, that community members and appropriate interest groups are aware that information and support can be provided even when the parent or parents are housebound or have limited ability in English, as recommended by Maltby (1996). It will be particularly important to provide information about which clinics are accessible to clients with physical disabilities.

In order to attract parents of young families who are not currently using Child Health Services at all, it seems worthwhile to consider extension of the child health and immunisation clinics into venues likely to maximise potential for contact with such clients, as advocated by Maltby (1996) and Bazeley (1992). Nurses need to go where young mothers and children are, rather than always expecting parents to come to fixed venues which may not be conveniently located. One of the most obvious and regularly accessed of such venues would be shopping centres, which present several potential advantages in terms of reaching a broad client base. Holding clinics in shopping centres would enable young parents to combine shopping and consultation with child health nurses, thus permitting them to use their limited time with the greatest effect. A further advantage is that being situated in a place with heavy passing traffic serves as a constant reminder of the existence and availability of Child Health Services, and provides good opportunities for health education and publicity campaigns. The provision of Child Health Services during shopping hours should include both child health and immunisation clinics during evening and weekend shopping times, as requested by the

Vietnamese women in the research undertaken by Maltby (1996). Shopping centre venues and flexible opening hours would probably also enhance attendance of parents from non-English speaking backgrounds as the fathers, who in many cases have a better understanding of English, could attend more easily, a finding again confirmed in Maltby's (1996) study.

**QUESTION 5: "ARE YOU SATISFIED WITH THE HELP AND INFORMATION YOU RECEIVE FROM CHILD HEALTH SERVICES?"**

The uniformly positive response to this question is primarily a tribute to the good reputation and dedication of the child health nurses, as can be seen from the strong level of approval by clients of the understanding, support, and relevant and helpful advice they receive from the clinics. These results confirm those from the research of Ochiltree (1991), who found that the majority of clients using Child Health Services in three Australian cities considered they received worthwhile support, as well as the results of Sefi and Grice (1994), whose research showed that the majority of the mothers in their English survey highly valued the clinic service.

There is a high level of goodwill amongst participants in the present study towards the existing clinic system, and an evident commitment amongst parents from a variety of backgrounds to the continued availability of local, readily accessible sources of practical advice. Indeed, several participants voiced their desire to defend the clinics against cutbacks to funding, through some form of community action. Others suggested ways in which the clinics' services could be expanded and improved, indicating once again their

feeling that the clinics were the most appropriate sources of local assistance. Aspects which were specifically mentioned by participants in terms of services they particularly valued included telephone contact, especially out-of-hours contact, and the availability of advice in written form through pamphlets, as noted above. In relation to immunisation services specifically, two women also indicated that they preferred clinic services to other options because they did not have to bear a cost; by contrast, some general practitioners charge for vaccinations.

The reason for this strong level of support for the child health clinics appears to be a widespread perception among the study's participants that the clinics provide practical, relevant advice in a supportive, non-judgmental manner. The clinics are also perceived as readily accessible places where clients can receive ongoing guidance, encouragement and support, rather than treatment for illness, and where ample time will be allowed for discussion during visits. Several participants felt that this situation was preferable to that encountered during visits to their general practitioner. The aspects of the Child Health Services valued by participants in this study are quite similar to the positive features, which included convenient location and personalised service, cited in the immunisation study undertaken by Bazeley (1992). One mother featured in a recent Perth newspaper report also confirmed that accessibility, the adequate amount of time the nurse spent with each mother and baby and the supply of information available at the local clinic was reassuring to the mothers and made the child health nurses preferable to a general practitioner ("Child Centre's Fate," 1998).

While participants in this study thus exhibited a high level of satisfaction with existing services, it must be acknowledged that it has been a challenge for child health nurses to maintain a high level of adaptability in the face of constant structural changes to the Health Department of Western Australia in recent years, and that such concerns have inevitably constrained their ability to concentrate on serving clients more effectively. The frequent structural changes have contributed to a fragmentation of health service delivery and have had a destabilising effect on the definition of nurses' professional responsibilities, as has been shown by Holman (1991a) and A. Liebenberg (personal communication, December 1, 1997). The drive for economic efficiencies has seen community nursing lose its autonomy to become incorporated into hospital based nursing in regional areas. Unfortunately, there appears to be little coordination between the Health Department of Western Australia, the Western Australian Health Promotion Foundation, regional health management and community nurses in such areas as the development and direction of primary health projects, health promotion planning and implementation, and fiscal planning, even though, as Deal (1994) demonstrates, nurses' knowledge of major health problems and community expertise should be considered an essential resource in the rapidly changing health system.

Support for the clinic system was especially strong amongst one of the groups with special needs, that is, the first time mothers. New mothers were particularly enthusiastic in seeking primary preventative care following the birth of their children. They appreciated the support, understanding and willingness to listen shown by the nurses, and indicated in the course of this study that they did not wish the clinic service to be

diminished in any form. Two were very much in favour of the home visiting service. Home visiting has tended to decrease in the past few years due to budgetary constraints, and the fact that only two participants made this comment may suggest that there has been little exposure to this service by the other women. Revitalisation of home visiting would seem worth considering in view of its value to first time mothers and others with special needs, such as multiple-birth parents, parents with disabilities and others with limited mobility.

While 40% of participants particularly valued the general reassurance, advice and support they felt they received from child health nurses, they found difficulty in describing their particular needs, though they positively identified the child health nurse as the person with whom they could relate on issues affecting their children. Such a result indicates the strong role still required of the nurse, even in a context where health care providers wish to strongly encourage self-definition of goals by health care consumers.

Fifty percent of the responses demonstrated that parents wanted confirmation that their children's weight and height measurements were appropriate. This is one of the most basic and regular services provided by the clinics, and in that sense, consumer expectations are being met. Unfortunately, the perceived need for other aspects of health assessment was low, with only 9% of parents commenting on the need for hearing assessments, 4.5% on the need for vision, speech and hip assessments.

Many disabilities in later life relate to these areas of health, and as the Health Department of Western Australia (1990) argues, early detection of potentially handicapping conditions enables effective management to be undertaken to reduce or eliminate long-term effects. It is not possible from the results of this study to state definitively whether parents are using their general practitioners rather than clinic nurses for such health screening. However, the study by the Commonwealth Department of Human Services and Health (1994a) demonstrates the belief by consumer groups that physicians are primarily oriented towards cases of ill-health rather than towards health promotion. Such a community perception makes it unlikely that many clients are using mainstream medical facilities for checks on such areas as vision, speech and hip placement. Thus the implications of the low awareness among participants in this study of the importance of these assessments should direct attention towards the need for health education programmes to address such issues. Education programmes will assist parents in realising the value of requesting these assessments. Primary prevention of this nature would positively impact on the numbers of children requiring secondary and tertiary treatments in these areas. Considering the current difficulties in health budgets, it would, therefore, appear to be a viable option in financial as well as ethical and strategic terms to promote the primary prevention approach in this context more vigorously.

A number of participants in the study cited areas of concern or potential areas for improvement in Child Health Services. While it is not always practicable and may not even be desirable to implement the actual changes advocated by these participants, the fact that they voiced concern on particular matters indicates a need for greater attention



to those areas. For example, three women with special needs commented on their preferred type of child health nurse and also on the initial system for making contact with those with postnatal depression. One wanted a mature nurse who had had children of her own, perceiving that this characteristic would enable her to better appreciate the participant's family dynamics and to offer better information than she had been given previously by a younger nurse. Whether this would, in fact, have helped in this case, or whether such personal factors should be considered to outweigh educational expertise, could not be assessed. However, her comment does indicate a need for sensitivity to the complexities of different family compositions and circumstances. Another of the women, who had twins, would have preferred a nurse who was more experienced with the management of multiple births and the support services which were available to the family. While not all nurses can be expected to have a high level of experience in managing multiple births, greater provision of written information on such matters might help to alleviate the feelings of vulnerability apparently experienced by such clients. Another felt there was a need for a system to contact mothers with postnatal depression, as she stated that these people do not feel able to phone for assistance or even answer the door if a home visit is made. Unfortunately, she was not able to suggest a method for so doing, but the problem to which she alludes is, again, a serious one worthy of careful consideration. The recommendations of Balcome (1996) highlight the importance of antenatal education, in particular, the establishment of support groups to enhance the women's coping mechanisms in the postnatal period. The encouragement of realistic concepts of parenthood is another critical antenatal educational step for the promotion of positive postnatal health. The importance of home visiting and the allocation of long

periods of time to be spent with women with postnatal depression has been identified by Holden et al. (1989) (as cited in Balcombe, 1996) as a valuable factor in their management and recovery.

Two participants commented on their desire to see the child health clinic develop as a central source of information on areas other than those currently provided by Child Health Services. They referred to information on paediatric dental health services, the education system and child minding. There was no expectation that the child health nurse would be able to offer expert advice, but rather that the nurse would be a point of referral to the appropriate people or agency. Many child health nurses are, in fact, able to refer clients to the above services on request. The question arises as to whether these types of services should be asked to provide advertising material to demonstrate to people that the nurse is aware of them, or whether the present system of giving information on request should remain. Child minding is an example of one area which creates legal and other difficulties and is realistically a referral service which should not be organised by child health nurses.

However, the thrust of the comments cited above is that clients desire a multi-purpose clinic system to serve a variety of needs. There are good reasons to consider such suggestions seriously, in view of the fact that the clinics already have high visibility, a good reputation for helpfulness and ready accessibility. Any such proposal must, of course, be considered in the context of partnership with the community and other agencies. As Douchette (1989), Kreger (1991) and the Public Health Association of

Australia, Western Australian Branch (1992) show, community driven projects are more likely to succeed in the health care context.

A number of participants had quite practical suggestions for improvement of Child Health Services, especially in relation to communication between nurses and clients. Comments on the telephone contact system and the need for it to be comprehensive have been noted above. Similarly, one of the women requested a reminder card system in order to alert parents as to when they next needed to attend the clinic. Such measures are to be encouraged in view of findings discussed above that half of the participants in this study did not know about or had forgotten about availability of immunisation services at the child health clinics. On the other hand, studies such as those by Skinner et al. (1995), Bazeley and Kemp (1995) and Rixon et al. (1994) show that reminders sent to clinics have had varying success in enhancing attendance at child health and immunisation clinics, indicating that factors such as accessibility, reliability, credibility and personalised service are more important.

**QUESTION 6: "WHAT TYPES OF THINGS DO YOU MANAGE AT HOME RATHER THAN SEEK HELP FROM THE CHILD HEALTH SERVICES FOR?"**

The original purpose of this question was to identify if any areas within Child Health Services were considered by clients to be unnecessary. All who referred to the child health clinic, however, agreed that none of the services available should be removed or diminished. This result accords with the finding of the research undertaken by Sefi and

Grice (1994), where the majority of the mothers interviewed highly valued a broad range of services available at the child health clinic.

The interesting and rather unexpected result to emerge from responses to this question in the present study was an insistence that services were important even if not currently a priority for the particular family concerned. Thus, even women with more than one child who used the services less frequently considered the full range of services to be essential either as a back-up when home management proved inadequate, or as an integral part of other parents' requirements. In this sense the participants showed a marked level of concern for the welfare of young families at a different stage of family development from their own. Three participants were directly concerned at budget constraints which had the potential to affect the services provided by the child health and immunisation clinics.

The present study also shows that a desire for self-management does not preclude clinic attendance. Reassurance offered to parents, especially first time parents, is in itself empowering, producing beneficial on-going effects including greater autonomy. Appropriate and timely reassurance creates confident and competent parents, empowering people to take more responsibility for the health of their families as described by Collado (1992). As noted above, some of the experienced mothers amongst the interviewees in this study indicated a decreased need to use the services of the clinic and a greater tendency to self-management, which might appear to suggest that the clinic was unnecessary for them. Their comments in this study, however, clearly suggest the centrality of the clinic itself in promoting the self management they have achieved.

Experienced mothers usually indicated that they had used the clinic more with their first child or when their children were younger. It can be presumed that the clinic's role in reassuring them, giving them confidence and improving their parenting skills at that earlier stage probably played an important part in their later willingness and ability to monitor their children's development and solve parenting difficulties autonomously.

Accordingly, while the desirability of a high level of consumer involvement in primary health care is well established in the literature, this study makes clear that consumers need professional guidance at the level of prevention as well as at the secondary and tertiary levels. Community health nurses are in the ideal position to provide this guidance, as was indicated by the participants in this study when they expressed their approval of the provision of local clinics, approachability of the nurse, availability of telephone contact and so on. In particular, the community nurse was seen as the most appropriate source of reassurance that children were "growing properly".

QUESTION 7: "DO YOU HAVE ANY CONCERNS OR WORRIES ABOUT YOU OR YOUR CHILDREN'S HEALTH AND WELLBEING?"

There were only six responses to this question, which were varied and did not demonstrate any common requests for information regarding the participants' health or that of their children. Two participants wanted information on diet but their requests related to differing aspects of nutrition. The comparatively weak response to this question appears to reflect a lack of general health awareness and the need to encourage proactivity among health care consumers. It could also suggest that families were

healthy and there were no concerns at present. However, there was no indication from the participants of wanting information on how to maintain their health or to discuss influencing factors. Thus once again there appears to be a need for health providers to engage actively in health promotion and health education within the community.

A coordinated approach among all health providers, especially the Health Department of Western Australia and Child Health Services, would be essential to the success of any such programmes. Child health nurses have a particular role to play in any such joint approach, being in a unique position to promote positive changes in the health of the community, as described by Deal (1994). However, as noted by Harper (1986), Kreger (1991) and McMurray (1993), child health nurses in the past have been restricted in their health care planning by the bureaucracy of the health care system. Hence, extra care must be taken to ensure that the nurses' intimate knowledge of the community's health needs is given appropriate emphasis during all stages of health care planning and implementation.

**QUESTION 8: "WOULD YOU LIKE TO MAKE ANY FURTHER COMMENTS ABOUT THE CHILD HEALTH SERVICES YOU HAVE USED OR THAT YOU REQUIRE?"**

In response to this question, clients tended either not to answer or to repeat information given elsewhere - for example, concerning accessibility. The major exception related to actual and anticipated budget restraints which were perceived to be likely to diminish the quality of services provided by child health clinics. One person commented on the need

for community action to prevent such reduction of services. At the time that the interviews for this study were conducted, government fiscal restraint was a major theme and a source of concern throughout metropolitan Perth and elsewhere. Health services were perceived to be particularly vulnerable; and as has been seen, major restructuring of the Health Department of Western Australia had already occurred. Hence, it is not surprising that participants in this study raised the issue of the likely impact of present and future cuts on Child Health Services, particularly in view of the high value they placed on those services. The lack of other responses to this question may be partly attributable to the general and open-ended nature of the preceding questions, which had allowed participants to cover a variety of issues and concerns under other headings.

### Overall Themes

It will be evident that the three major themes previously outlined are identifiable throughout the responses discussed above. The relation of these themes to the results of the study will now be briefly summarised.

### Knowledge acquisition

Local child health clinics have a major role as a source of advice, whether concerning immediate problems or of a more general nature. It is significant that the desire to seek information from a local child health nurse was common to all family types and ethnic groups represented in this study. Those from non-English speaking backgrounds may have experienced additional difficulties in using the clinic's facilities, but they, or at least their partners, nevertheless continued to attend. More experienced mothers might attend

less often, but they wanted to know that the clinic is available as a back-up. The clinics, then, have the potential to function as a resource for the community with relevance to a broad range of clientele, ideally both reflecting and responding appropriately to the great diversity of the current Australian population. At the same time, as confirmed by Maltby (1996), the challenge is to provide information and assistance, whether verbally or in written form, that is sensitive to the different needs of different sub-groups of the population, rather than simply reflecting an outdated and increasingly less accurate and less useful monocultural model of society.

#### Reassurance of normal growth and development

The desire for reassurance of children's normal patterns of growth and development was again a theme strongly reflected by all sub-groups represented in this study. Participants regarded the child health nurse as more appropriate as a source of such reassurance than any other health professional. At the same time, it is clear that people should be encouraged to seek more information regarding normal growth and development outside the usual parameters of height and weight, in order to optimise their children's future potential.

#### Accessibility

Accessibility, in terms both of location and of operating hours, is a key determinant of rate of use of Child Health Services and was a major concern raised by participants in this study. The clinics are perceived as accessible, but improvements can be made, especially in providing greater flexibility of hours and in operating from non traditional



venues as described by Maltby (1996). No primary health care activities undertaken by the clinics can be effective unless clients can readily access the clinics and their services. Thus the promotion of self-management and all other goals of primary health care are dependent in a basic sense on this requirement. Particular care must be taken to ensure accessibility is extended to groups of clients with special needs, such as those whose comprehension of English is limited or non-existent, and those with physical or intellectual disabilities.

### Relation to Conceptual Framework

The Ottawa Charter for Health Promotion (World Health Organisation-Health and Welfare Canada-Canadian Public Health Association, 1986), which provides the theoretical framework guiding this study, has five major strategies which potentially contribute to the goal of achievement of health for all by the year 2000. The relation of the Ottawa Charter to this study will now be analysed.

### Building healthy public policy

The present study contributes to the goal of building healthy public policy by providing information to government services on the needs of young families in relation to child health, on the actual use by young families of existing Child Health Service facilities and on young families' views on how those facilities can be developed and improved. It thus emphasises the empowerment of the community to determine the priorities and direction of health policy.

### Strengthening community action

McMurray (1993) and Schroeder (1994) both highlighted the limited success of health professionals' attempts to alter health behaviours when individuals are unable to participate in their own health care planning, and indeed there is a broad consensus in the literature on the improvement in health care which results from involvement of the individuals most directly affected. The present study contributes to the goal of strengthening community action in that the data and analysis offered here seek to enable young families in the community to identify and define their individual child health goals and to undertake collaborative planning with child health nurses in order to achieve their goals.

### Development of personal skills

This study contributes to the goal of developing personal skills for parents by providing feedback for nurses and government agencies on the types of education and competency development required by parents of young children. The emphasis throughout has been on clients' self definition of their health requirements, rather than on an analysis derived from externally imposed categories. Such an approach seeks to further the goal of empowerment and self management.

### Reorientation of health services

This study contributes to the implementation of this strategy by providing information about how users of Child Health Services believe that those services can and should be improved. More broadly, the study as a whole suggests the importance of preventative

child health care in any overall health strategy, and the need to protect these services in the long term interests of community health.

#### Creation of supportive environments

This study contributes to the creation of supportive environments promoting the health of young families by identifying those aspects of the existing Child Health Services which are already highly valued and considered supportive by the individual women who were interviewed. In addition, it suggests ways in which the creation of supportive environments can be furthered and strengthened, for example, by a move towards multi-purpose child health clinics, by improvements in accessibility of the child health clinics for existing clients, and by extension of accessibility to encompass those not currently attending, particularly those people with special needs.

Given the findings of this research and the areas of focus, certain recommendations can be made which have the capacity to enhance the delivery of Child Health Services and to offer suggestions for future research. This will be described in the next chapter.

## CHAPTER 7

### CONCLUSION AND RECOMMENDATIONS

Recommendations arising from this study fell into three major categories. Participants showed a concern with long term policy goals of Child Health Services, and with health education and health promotion generally. They also frequently commented on specific procedural points which they felt were in need of improvements. Recommendations will now be discussed according to the responses which arose from the course of this study.

#### Long term Policy Goals

##### Retention and extension of existing services

A strong theme to emerge from this study is the need to retain at least the present level of Child Health Services. Child health nurses have the expertise to remain as the primary person responsible for information on child and family health issues, and they must continue to be regularly and reliably available in accessible local venues. Closing even a few local clinics is likely to have serious effects on overall attendance rates, which in turn has the potential to cause long-term problems in community health. Governments should, therefore, not fall prey to the temptation to save money by cutting such basic public health facilities. Furthermore, there is a perceived need for all the present services available from Child Health Services to remain. One specific recommendation is that the Child Development Centre should retain its suburban branches. Their location as compared to the main centre in West Perth provides greater means of access with a concomitant higher probability of attendance.

In fact, this study shows a need to increase the provision of both child health and immunisation clinics: by extending existing facilities into non-traditional venues such as shopping centres; by providing more flexible hours of operation, especially in the evenings; and by making extra efforts to accommodate services and facilities to people with special needs, such as those with limited comprehension of English and those with physical or intellectual disabilities.

Consideration should be given to revitalisation of the home visiting service, which has declined in recent years. While it is undoubtedly expensive, home visiting has the potential to reach particularly vulnerable groups in the community and thus to reduce the possibility of health problems in the long term, as emphasised by Holden et al. (1989) (as cited in Balcombe, 1996).

#### Coordination and collaboration among health care providers

Another consistent theme which emerges from this study is the need for coordinated action among the various agencies responsible for primary health care. As has been noted above, fragmentation has characterised the provision of primary health care in this state and has been compounded by the repeated restructuring of the Health Department of Western Australia in recent years. Such fragmentation is damaging to the smooth delivery of appropriate health care to all sectors of the community. A coordinated approach in health education programmes, for example, between the Health Department of Western Australia, Community Nursing Services and the Western Australian Health Promotion Foundation, would be more efficient and cost effective in terms of both time

and money. At present, campaigns are often implemented by the Health Department of Western Australia or the Health Promotion Foundation without any input from child health nurses, despite the unique access to the local community enjoyed by the nurses.

Other opportunities for collaboration exist in areas which could promote savings without any compromise of basic services to the community. For example, some aspects of child health are more closely associated with organisations outside of Child Health Services, as has been noted throughout this study. The Ngala Family Resource Centre, for instance, is frequently used by parents for out-of-hours telephone contact and difficulties with breast-feeding, and in fact, child health nurses routinely refer clients to this service.

Collaboration on a more formal level, with appropriate cost-sharing arrangements, has the potential to maximise the expertise available to the public while reducing the cost which Ngala currently recovers from clients. A greater level of collaboration at the administrative level might also be considered with the Nursing Mothers' Association and Dental Health Services, two other organisations which are routinely promoted by child health nurses.

#### Promotion of multi-purpose clinics

Several participants in this study pointed to the potential of the clinics to strengthen their existing role as local sources of information and advice by expanding the range of support services and information offered. The Commonwealth Department of Health (1994a) supports this goal when advocating closer interaction between the health care system and community support services. Clinics could function as a central point,

providing information on a range of child and family related issues, including the education system and specialist health services. Such information is often provided under the existing system by individual nurses and organisations, but a more systematic, planned and comprehensive approach would better serve health consumers, contributing to the goal of creating supportive environments for young families, as advocated in the Ottawa Charter for Health Promotion (World Health Organisation-Health and Welfare, Canada-Canadian Public Health Association, 1986).

#### Greater provision of relevant printed material

The results of this study have indicated that health information has the potential to be enhanced by a combination of verbal and written delivery. There needs to be a review of the availability of pamphlet information on a range of issues, such as dietary advice, issues for first time parents and sleeping problems. Participants have also made clear that the information conveyed in written form must be as current as possible if it is to meet their needs; and the building of health public policy is dependent on regular review of all information provided. Written information should also be provided in appropriate languages to facilitate communication with clients and potential clients from non-English speaking backgrounds, and should be available from a variety of venues, such as pharmacies and shopping centres, rather than solely at the clinics, as suggested by Maltby (1986).

## Health Education and Health Promotion

### Child health clinic and immunisation services

There is a need for reinforcement of information about clinics and immunisation services and for greater efforts to increase awareness of these facilities among those who do not currently attend or who have forgotten that certain services are provided. Particular efforts should be made to increase awareness of Child Health Services amongst groups of people with special needs, through contact with organisations representing and serving people with disabilities and people of diverse ethnic origins. The provision of promotional material in non-traditional venues would further this goal.

The systematic and comprehensive provision of immunisation has a high priority in community health. This study points to the fragmentation of the current situation in terms of where vaccinations are being delivered, the times available for vaccinations and the amount and type of immunisation education being provided to clients. There are significant advantages in advocating the provision of immunisation through the child health clinic system rather than through other health providers, especially in terms of immunisation education; and education programmes should be directed to this end. This is supported by the findings of Rixon et al. (1992). However, if child health clinics are to deliver the bulk of immunisations then they must provide a more frequent service in a greater variety of accessible venues. Greater use of the child health clinic system for immunisations would also provide appropriate opportunities for the child health nurses to conduct their regular clinics at the same time and, in view of the high rate of



immunisation within this community, would presumably enhance the nurses' opportunities for contact with more potential clients.

### Other Child Health Services

Low awareness of Child Health Services other than child health and immunisation clinics indicates a need for promotion of other services available at such places as the Child Development Centre. This is reinforced by Maltby's (1996) study where participants requested information on the availability of resources. The promotion of the available range of Child Health Services needs to be made not only through the traditional venues such as child health clinics and general practitioners' surgeries, but also through a variety of community venues. Shopping centres, playgroups and day care centres are examples of accessible places where young families are likely to have good exposure to this information. This is again supported by Maltby (1996) who recommended that multi-lingual information pamphlets on community resources be made available in locations such as shopping centres, clinics and chemists.

### Greater involvement of child health nurses in planning for and implementation of health education and health promotion programmes

This study concurs with the recommendations by Deal (1994) concerning the need for the expertise and community involvement of the child health nurses to be utilised more effectively in the planning for and implementation of a wide variety of programmes associated with health education and health promotion. Such involvement is highly likely to improve the outcomes of these programmes in terms of identifying and reaching

the most appropriate target groups in the community and providing them with the information most relevant to their health care requirements.

### Provision of reminder cards

While notification sent to clients to remind them of the need for health appraisals and immunisations has proven in other contexts to have varying success as a tool to enhance attendance at the child health clinic, reminders would appear to offer potential for improved health promotion and health education if offered in combination with a credible, personalised, reliable, accessible Child Health Service (Bazeley and Kemp, 1995). The monetary cost of reminder systems must be assessed in relation to their potential for increased use of Child Health Services.

### Procedural Matters

More attention needs to be paid to basic issues, such as ensuring that staff are, in fact, available at the times and venues advertised, and ensuring that emergency numbers and details of the nurse's current location are always left on answering machines when personal service cannot be provided. Such practices must be followed if attendance rates at the clinics are to be maintained and increased, and the credibility of Child Health Services is to be enhanced.

### Suggestions for Further Research

The major need suggested by this study is for further research into methods of identifying and attracting those families who are currently not attending any of the Child Health

Services, especially child health and immunisation clinics. Investigations also need to be directed towards a broader range of families to determine what would enable them to create and live in environments supportive to children's healthy growth.

It is not clear that nurses and parents have the same concept of what is important. Future research could compare nurses' and parents' perspectives of health care delivery.

Research should also be undertaken into the provision of more effective and comprehensive written material, and into the most effective venues for distribution of material and for the location of clinics. Strategies for promoting improved levels of inter-agency collaboration and cooperation are essential to the effective provision of primary health care, especially in a context of budgetary constraints, and need to be investigated in detail by future researchers.

Research into cooperative models between general practitioners, community and child health nurses, parents and other associated professionals and community members, has the potential to enhance primary health care and create supportive environments.

### Summary of Recommendations

1. Retain the full range of existing levels of Child Health Services.
2. Extend operating hours and make them more flexible.
3. Extend Child Health Services into non-traditional venues such as shopping centres.

4. Work to make Child Health Services relevant and fully available to those with special needs, especially parents with disabilities and those from non-English speaking backgrounds.
5. Revitalise the home visiting service by child health nurses.
6. Promote multi-purpose clinics.
7. Promote inter-agency collaboration in primary health care services.
8. Increase the provision of relevant and current written information, including pamphlets in appropriate languages.
9. Promote awareness of child health clinic and immunisation services, particularly amongst groups with special needs.
10. Encourage parents to have their children immunised through the child health clinic system rather than through other health providers.
11. Promote awareness of Child Health Services other than child health and immunisation clinics.
12. Promote involvement of child health nurses in the planning for and implementation of health education and health promotion programmes.
13. Investigate provision for a system of reminder cards for clients of child health and immunisation clinics.
14. Ensure that child health and immunisation nurses are always available at the advertised times and places.
15. When personal attendance by child health nurses at the clinic is not possible, ensure that full information regarding the nurse's whereabouts and availability, together with an emergency number, are provided through recorded messages.

### Conclusion

The aim of this research was to describe self-reported child health care needs of women with young families residing in the City of Belmont, to identify patterns of utilisation of a group of clients of Child Health Services in the City of Belmont, to describe this group's self-reported levels of satisfaction with Child Health Services in the City of Belmont and to correlate self-reported child health needs, concerns, level of satisfaction with and patterns of utilisation of Child Health Services with the family characteristics of type, composition and ethnic background. The findings of this research showed that the self-reported child health care needs of the women could be categorised as being the desire for knowledge acquisition related to child health issues, reassurance of normal growth and development related to their children's present and anticipated developmental progress and accessibility of Child Health Service venues and professional staff.

The challenge for Child Health Services is to provide a relevant and accessible service to all young families in the community. Issues raised by the participants in this study represent self-identified client needs and, as such, contribute a vital perspective to the making of policy supportive of the principles of primary health care and ultimately to the promotion of the health of the community.

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## **APPENDIX A**

### **Standards for Childhood Immunisation**

## APPENDIX A

### STANDARDS FOR CHILDHOOD IMMUNISATION

- Standard 1      Immunisation are readily available.
- Standard 2      There are no barriers or prerequisites to immunisation services.
- Standard 3      NHMRC recommended childhood vaccines are offered free, without cost to parent or guardian.
- Standard 4      Immunisation providers utilise all clinical encounters to assess immunisation status and, when indicated, vaccinate children.
- Standard 5      Providers educate parents and guardians about immunisation.
- Standard 6      Providers question parents or guardians about contraindications and, before vaccinating a child, inform them in specific terms about the benefits and risks of the vaccines their child is about to receive.
- Standard 7      Providers withhold vaccination only for true contraindications.
- Standard 8      Providers offer and administer, where possible, all vaccines for which a child is due at the one visit.
- Standard 9      Provider are accurate and complete recording procedures.
- Standard 10     Providers report adverse events following immunisation promptly, accurately and completely to State or Territory health authorities.
- Standard 11     Providers adhere to appropriate procedures for vaccine cold chain management.
- Standard 12     Immunisation providers maintain current and easily retrievable immunisation guidelines at all locations where the vaccines are administered.
- Standard 13     Vaccines are administered by properly trained individuals who receive ongoing education and training on current immunisation recommendations.

Note: From The Australian Immunisation Procedures Handbook (5<sup>th</sup> ed.) (p. 2), by Commonwealth Department of Human Services and Health, 1994b, Canberra: Australian Government Publishing Service. Copyright 1994 by Commonwealth of Australia. Reprinted with permission.

**APPENDIX B**

INTERVIEW SCHEDULE

## APPENDIX B

### INTERVIEW SCHEDULE

I'd like to know a bit about your family members who live at home and what your family thinks about the Child Health Services in your area.

#### SECTION 1: DEMOGRAPHICS

1. Tell me about the members of your family who usually live in your household.

##### The Family

Number of family members in household:

---

Type of family:

One parent

Two parents

Blended

Extended

Other

Marital status:

Single

First marriage

Other marriage

Defacto

<u>Family Members</u>	1	2	3	4	5
-----------------------	---	---	---	---	---

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Parent/Son

Daughter/Other



2. Where were your family members born?

Adult(s)

---

Child(ren):

---

2.1 What ethnic groups do your family belong to:

---

2.2 Is your family Aboriginal? YES/NO

If YES, which Aboriginal groups do your family belong to:

---

3. Which language is usually spoken at home?

---

3.1 Do all family members speak English? YES/NO  
Please explain:

---

---

3.2 Do all family members read English? YES/NO  
Please explain:

---

---

3.3 Which languages other than English are spoken by family members?

---

3.4 If they need help, who assists non-English speaking family members?

---

## SECTION 2: HEALTH SERVICES

1. What Child Health Services are available in your community?

---

2. How often has your family used Child Health Services in the past 12 months?

No service used

Child health clinic

Immunisation clinic: Local Rheola Street

Child Development Centre:

Please explain:

---



---

Speech therapy

Hearing assessment (audiometry)

Other:

Please explain:

---



---

3. What are the main things you want/need from these services?

Child health clinic

---



---

Immunisation clinic

---



---

## Child Development Centre

---



---

Speech therapy

---



---

Hearing assessment (audiometry)

---



---

Other

---



---

4. Are you able to access these services when you need to: YES/NO  
Please explain:

---



---



---

5. Are you satisfied with the help and information you receive from  
Child Health Services? YES/NO  
Please explain:

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---



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6. What types of things do you manage at home rather than seek help from the Child Health Services for?

Please explain:

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### SECTION 3: HEALTH CONCERNS

7. Do you have any concerns/worries about you or your child(ren)'s health and wellbeing? YES/NO  
Please explain:

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---

8. Would you like to make any further comments about the Child Health Services you have used or that you require?

---



---



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Thank you for your valuable assistance. Do you wish to know the results of the study?

---

AILSA MUNNS



## **APPENDIX C**

### **INFORMED CONSENT FORM FOR RESEARCH PARTICIPANTS**

## APPENDIX C

### CONSENT FORM

YOUNG FAMILIES SELF-PERCEIVED REQUIREMENTS OF CHILD HEALTH SERVICES.  
THEIR SATISFACTION WITH AND PATTERNS OF UTILISATION OF THESE SERVICES.

Dear Community Resident

I am a Master's student in Nursing at Edith Cowan University and am conducting a research study into young families' requirements of Child Health Services and the way the services are used. The Ethics Committee at the Bentley Health Service has given approval for this study. The results of this study will assist in the future planning of Child Health Services and your information would be valued and appreciated. I would, therefore, like to interview you (with the assistance of an interpreter if you like) about your use of the Child Health Services in your area. The interview will be conducted by me at your home or your place of choice, and will last approximately one hour.

All the information you provide will be kept in confidence in a locked cabinet in my home or office. The information will be analysed using a code for each family, so that your name will not be identifiable.

If at any time you wish to withdraw from the study, you are free to do so without prejudice. I am available to answer any queries about the study and can be contacted on 9273 8333 during office hours. If you wish to contact an independent person regarding queries or problems, please contact the supervisor of this study, Dr Nancy Hudson-Rodd on 9273 8333. Please read the form below and, if you wish to be involved, sign your consent.

I (the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising I may withdraw at any time. I understand that the study will be submitted to Edith Cowan University as a requirement for a Master's Thesis. I agree that the research data gathered for this study may be published provided I am not identifiable.

I am 18 years of age or older.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's signature: \_\_\_\_\_ Date: \_\_\_\_\_

I \_\_\_\_\_, interpreter for \_\_\_\_\_, agree to maintain all information with respect to this study in confidence.

Interpreter's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you.

Ailsa Munns

## **APPENDIX D**

### **APPROVAL FOR RESEARCH FROM ETHICS COMMITTEES**

**Committee for the Conduct of Ethical Research**

Ms Ailsa Munns

Dear Ms Munns

Re: **Ethics Approval**

Code: 96-15


**Project Title:** *Young Families 'Self-Perceived Requirement of Child Health Services. Their Satisfaction with and Patterns of Utilisation of these Services.*

This project was reviewed by the Committee for the Conduct of Ethical Research at its meeting on 29 March 1996.

I am pleased to advise that the project complies with the provisions contained in the University's policy for the conduct of ethical research, and has been cleared for implementation.

Period of approval is from 29 March 1996 to 30 June 1997.

Yours sincerely

  
ROD CROTHERS  
Executive Officer

2 April 1996

*Please note: Researchers are required to submit an ethics report as an addendum to that which they submit to their Faculty Research Committee or to the Office of Research and Development.*

cc: Dr Nancy Hudson-Rodd  
Mrs Gerrie Sherratt, Higher Degrees Committee





## Bentley Health Service

Mills St., Bentley W.A. 6102 P.O. Box 158  
Ph: (09) 334 3666 Fax: (09) 356 1632

### ETHICS COMMITTEE

#### LETTER OF AGREEMENT

INVESTIGATOR : Ailsa Munns.

TITLE OF STUDY : *Young Families Self- Perceived requirements of Child Health Services, Their Satisfaction with and Patterns of Utilisation of These Services*

REF. NO. : 8/96

Your proposal has been approved by the Bentley Health Service Ethics Committee. You may now proceed with your research activities.

The following guidelines are provided for you prior to undertaking your study.

1. Notify, by letter, the Chairperson and appropriate others the commencement date of the study.
2. Notify the Chairperson if any problems are being experienced during the implementation and process of the research activity.
3. Submit progress reports to the Committee at 12 months and on completion of the study and a copy of the publication related to the research as they are published.
4. Follow any specific criteria or instructions as suggested from the Ethics Committee during the research activity.

CHAIRPERSON.

DATE 9.7.96

CHIEF INVESTIGATOR.....

DATE.....