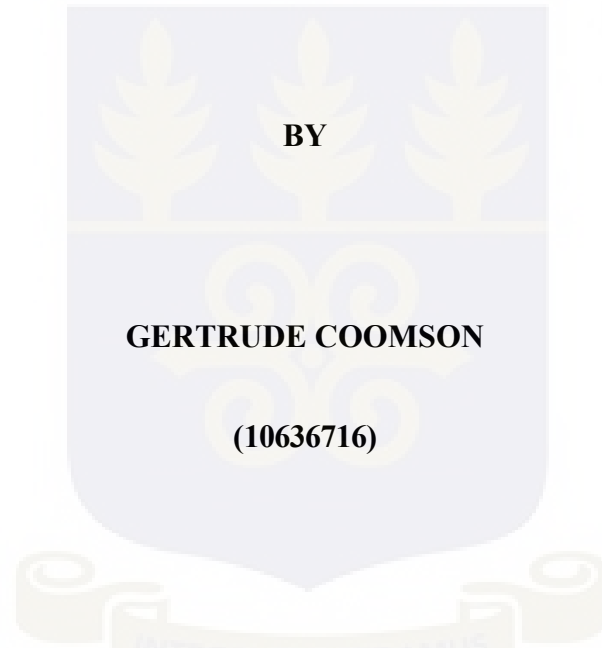


UNIVERSITY OF GHANA
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

**PERCEPTIONS AND PRACTICES RELATED TO CHILD WELFARE CLINIC
ATTENDANCE AMONG WOMEN ATTENDING DANSOMAN POLYCLINIC**



**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF
MASTER OF PUBLIC HEALTH (MPH) DEGREE.**

JULY, 2018

DECLARATION

I do hereby declare that apart from references to other people's works, which have been duly acknowledged, this proposal is result of my own independent work. I further declare that this proposal has not been submitted for award of any degree in this institution or other universities elsewhere.

.....

GERTRUDE COOMSON
(STUDENT)

.....

DATE

.....

DR.RICHMOND ARYEETAY
(ACADEMIC SUPERVISOR)

.....

DATE

DEDICATION

This thesis is dedicated to my husband, Eric Coomson, who has been a constant source of support and encouragement. To my children, Meyenhyira, Eyeadom and Nana Kow, you are my inspiration to achieve greatness.

To Almighty God, for a successful completion of my Masters' degree and Thesis.

ACKNOWLEDGMENT

This accomplishment would not have been possible without God Almighty.

I would also thank my thesis supervisor, Dr. Richmond Aryeetey of the University of Ghana, PFRH Department. He constantly allowed this paper to be my own work, but steered me in the right direction whenever he thought I needed it.

I would also like to thank all the Nursing Mothers and Nurses who took part in the Focus Group Discussions and filled my questionnaires. I am grateful to my research assistant who help in organising the Focus Group Discussion and the Interviews.

I must express my profound gratitude to my husband for providing me with unfailing support and continuous encouragement throughout my year of study and through the process of researching and writing of this thesis.

Finally, I thank everyone who made it possible for me to finish this Masters course and complete this thesis.

Thank you and God bless you all.

ABSTRACT

The research was conducted to identify reasons why women attend Child Welfare Clinic (CWC) for a shorter duration as recommended. The study had three objectives and these were, to establish nursing mother's perception of the benefits of CWC, determine factors that motivate mother's to continue to attend CWC until the fifth birthday of their child or children and determine factors that influence the duration of CWC attendance. The study used both qualitative and quantitative methods. Research design was cross sectional and sampling method was Purposive. A sample size of 50 research participants were selected. 40 for qualitative and 10 women were interviewed by using questionnaires. Inclusion criteria were women with children below five years. Care givers coming from homes with mothers having children more than one and health professionals (nurses) stationed at the Dansoman Polyclinic. Data collection tools that were used for this study were: Focus Group Discussion interview guide.

The study established that, mothers were aware about the benefits of CWC and were kept abreast with the services provided at CWC. The findings showed that, there are a lot of factors that motivate mothers to attend CWC such as early detection of diseases and treatment. Information on growth monitoring, immunization, treatment of minor ailments and counselling caregivers. The cost of transportation, caregiver's busy schedules and negative attitudes of health professionals are reasons for caregivers limiting duration of CWC attendance. In conclusion, although mothers were aware of benefits of CWC, there are barriers such as long waiting hours, distance from home to clinic, cost of transportation which makes them stop attending before recommended five years.

The study recommended that, there should be more home visits, health facility managers/matrons should send mothers text message reminders and or run CWC on weekends . There should be continuous public education by community health nurses on the benefits of CWC to encourage parents, particularly mothers to take their children to the CWC. There should also be arrangements to provide CWC services at nursery schools and market places which will serve as alternative means and matrons should ensure that, nurses on duty at the CWC comply with the policies on customer service.

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LIST OF ABBREVIATIONS

ANC	-	Ante Natal Clinic
CWC	-	Child Welfare Clinic
GDHS	-	Ghana Demographic Housing Survey
WHO	-	World Health Organization
FGD	-	Focus Group Discussion,
KII	-	Key Informant Interview
GHS	-	Ghana Health Service
DD	-	Developmental Delay,
RCH	-	Reproductive Child Health,
EPI	-	Expanded Program on Immunization

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Sufficient nourishment and wellbeing during the initial few years of a baby's existence is key (Atimo & Oyewole, 2008). Development during the primary time of existence is superior than other area of life. A baby's birth weight will usually double by four to six months of age and triple by the first birth day. Good diet during the period of speedy development is important to ensure that the baby grows both physically and intellectually to the completest potential. Inadequate nutrition during the critical formative years has both immediate and long-time consequences (Engberg-Perderson, 2007; WHO, 2003).

Child Welfare Clinics (CWC) forms an important component of the health care system in Ghana and renders invaluable health care services to children under-five years. Despite the numerous advantages associated with CWC attendance, there are reported cases of low attendance among children 24-59 months. Few studies done in Ghana established that CWC attendance declines by age of the child, due to schooling, completion of immunization schedule, distance to CWC among other factors. Ghana as a developing country is making conscious effort to promote child health through active implementation of programs which could help achieve the United Nations Millennium Development Goals. Goal four which seeks to reduce the under- five mortality rate by two-thirds, between 1990 and 2015. Globally, more than 600 million out of 7 billion world population are children aged below five years. Ghana has population of 24,658,823 and out of this 3.5 million are children below five years.

The consistent decline in CWC attendance cannot be attributed to one specific factor. Perceptions and practices by caregivers and mothers may affect attendance negatively. Immediate consequences of not attending CWC include morbidity, death and hindered mental and physical growth, while the long-time penalties include weakened rational activity, reproductive performance, work size and increased risk of lingering illnesses. Because of these and many more, many nations the world over have placed child health promotion high on their developmental agenda (WHO, 2003).

CWC provides services to ensure ideal progress and improvement of babies. These clinics are typically situated in hospitals, clinics etc. in both cities and villages and are operated by qualified health professional. Although CWC is performed at the district level, the bulk of the work is carried out at the health centres and in the communities (Antwi-Dennis and Bam, 2002). The key purpose of CWC is to avert and control the root causes of death, including illness, unintended wounds, contaminations, learning and behaviour difficulties (Last, 1986). The services provided by CWC include immunisations, exclusive breastfeeding for the first six months, growth promotion, nutrition rehabilitation, insecticide treated net use and Vitamin A supplementation which have the possibility to reduce child sickness and death (Darmstadt et al. 2005).

Child Welfare Clinics also provides treatment, health surveillance and health education into a system of comprehensive health care. (Ministry of Health, 2007; Centre for Community Child Health, 2008). It has been observed that Child welfare clinic attendance at the Dansoman Polyclinic reduces as the child grows older. In 2009, Child Welfare Clinic attendance for children below 12 months was 28,776 and subsequently reduced to 10,609 for children 12 to

23 months and further dropped to 3,608 for children 24 to 59 months (ANMHD, 2009). Preventive care during early childhood is critical to survival and development which can be achieved through CWC.

1.2 Statement of the Problem

Although CWC participation is expected during the first five years, it has been observed that mothers only participate until immunization is ended and after that they don't report to the clinic. According to WHO, more than 10 million children under-five die each year in developing countries of preventable diseases which is a problem. In Ghana, data from 2003 Ghana Demographic and Health Survey (GDHS) suggest that one in every nine Ghanaian child dies before reaching age five. Under-five mortality is high and should not be ignored. There is currently no evidence on child welfare participation and the reasons for early cessation by caregivers. Apart from children age 15 months and older, who patronise the health facility and are recognized as being at danger, most of the attending babies are attended to after receiving their second dosage of vitamin A at 15 months. Elsewhere, Davis (2011) has reported that space between the dwelling place of a mother and the CWC is a decisive issue in patronising CWC. Factors including mothers' busy schedules contribute to low CWC attendance which may be an important determinant. However, no evidence on this exists in the Ghanaian context. The study therefore seek to explore the perceptions and practices related to child welfare attendance among women attending Dansoman Polyclinic.

1.3 Conceptual Framework

In this conceptual framework, four major issues have been presented as the main factors that contribute to the perception and practices related to CWC attendance among women attending Dansoman Polyclinic. These were (a) Socio-economic and demographic factors (b) Causes of Low CWC attendance (c) Benefits of CWC (d) Motivational factors to increase CWC attendance. All these four factors were interrelated in a way and determined whether a woman would continue to bring her child to the CWC before the baby's fifth birthday.

1.4 Conceptual Framework

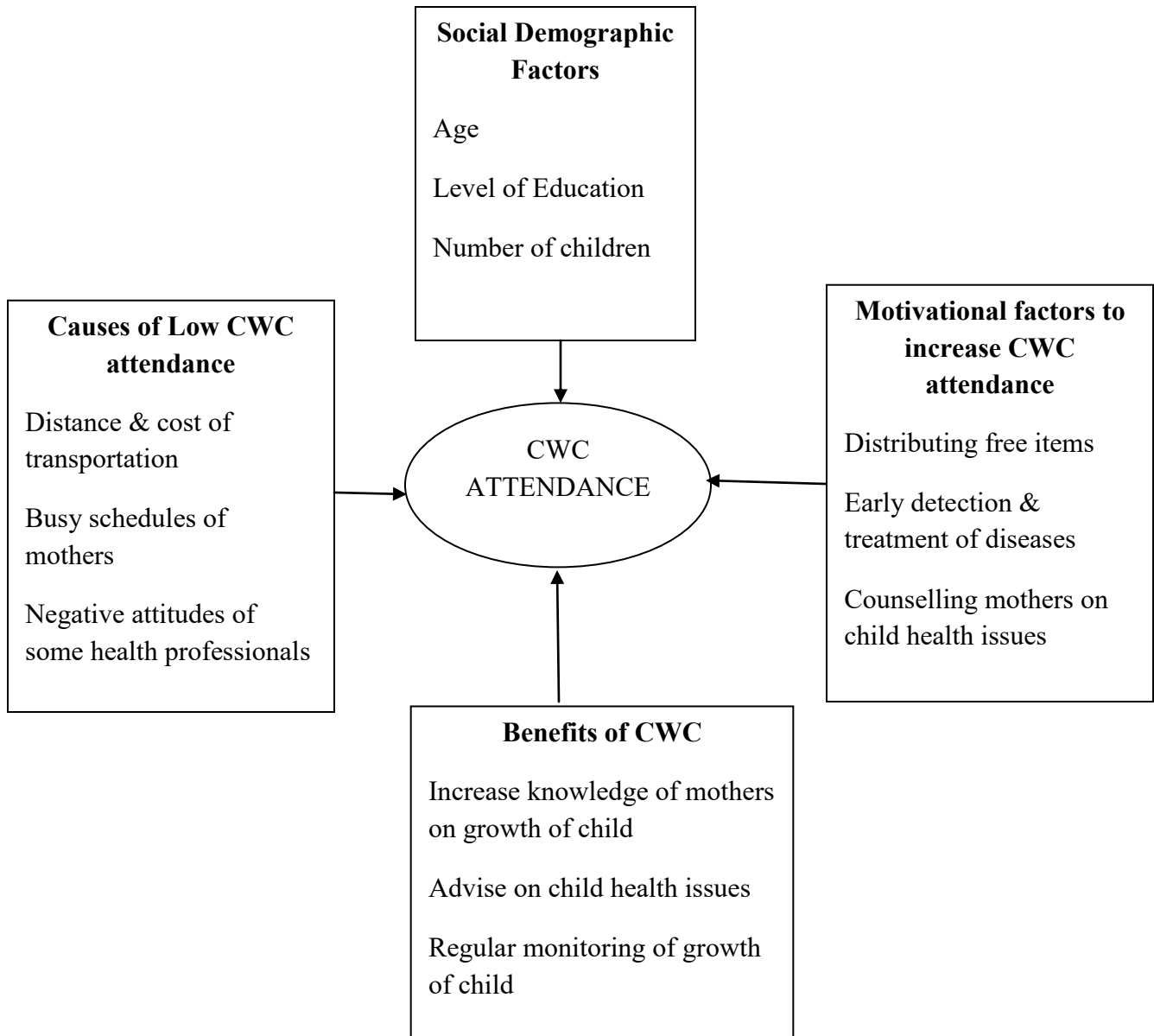


Figure 1: Conceptual Framework on Perceptions and Practices related to CWC Attendance among Women attending Dansoman Polyclinic (Developed by the Researcher)

1.5 Justification of the Study

Under five mortality remains a major issue that should not be ignored. Early detection of illnesses during Child Welfare Clinic will save a child from dying before age five. The primary goal of child welfare clinic is to ensure continued participation by young children under five years in order to avert illnesses during childhood (Last, 1986). The outcome from the study will help bring out evidenced based information on the perceptions and practices related to CWC attendance among caregivers. It is expected that the study results would help public health officials with evidence to formulate strategies to be able to address the reasons that account for the low patronage of the CWC. This will also inform facilitators of health educational programs on better ways of educating mothers and caregivers on CWC attendance, benefits to the child, family and the nation as a whole.

1.6 Research Questions

The study's research questions were

1. What are the women's CWC participation intentions?
2. What are nursing mother's perceptions on CWC attendance?
3. What factors motivate mothers to continue to attend CWC?
4. What are the factors that influence duration of CWC attendance?

1.7 General Objectives

The overall purpose for the research was to determine perceptions and practices of Child Welfare Clinic (CWC) attendance among women with young children under five years.

1.8 Specific Objectives

Specifically, the study sought to:

1. Establish nursing mother's perception on the benefits of CWC.
2. Determine factors that motivate mother's to continue to attend CWC until the fifth birthday of their child or children
3. Determine factors that influence the duration of CWC attendance.

1.9 Organization of the Study

This thesis was organized into five sections. Chapter one gives a summary of the context of the study, declaration of the problem, research questions, general and specific research objectives and organisation of the study. Chapter two defined key concepts and reviewed related research works.

Chapter three examined the general design of the study and key methods of analysis whilst the fourth chapter presented the results of the data collected. Chapter five centered on the discussions of the findings. Chapter six was made up of the summary of the findings, deductions and recommendations from the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter contains the review of related research, concepts and theories that are related to the research topic.

2.2 Definition of Concepts

The following key concepts have been defined to give meaning to their usage in the study.

2.2.1 Child Welfare Clinics

According to Popple & Vecchiolla (2007), child welfare is seen as the wide range of activities linked to the health of children while child health services are events focused at encouraging and sustaining the ideal progression and growth of children from birth to 19 years. Child welfare can be viewed under various perspectives including health, formal education and care of children at the household level. From the health perspective, people have different perceptions in caring for their children. For various reasons, some people believe in the use of traditional medicine to cure their sick children instead of using orthodox medicine (Ghana Health Service, 2003).

In addition, some immunizations may not be accepted by parents due to lack of knowledge and understanding, for example oral polio (Andrews, Kearns, Connors, Parker & Carville, 2009).

These forms of perceptions and practices can have serious consequences on the welfare of the child. Therefore parents, families and opinion leaders are considered as key stakeholders in the pursuance of programmes that seek to improve the welfare of the child (Olson & DeFrain 2000) must be consulted in order to gain their confidence and persuade them to patronize child welfare clinics (Andrews, Kearns, Connors, Parker & Carville, 2009).

2.3 Related Works on Child Welfare Clinic

2.3.1 State of CWC in Ghana

The Ghana Demographic and Health Survey (GDHS) 2008 and MICS (2011) disclosed a 30% decrease in the under-five death rate, as it dropped from 111 per 1000 live births in 2003 to 80 per 1000 live births in 2008, while infant death rate as at 2008 stood at 50 per 1000 live births as against 64 per 1000 live births in 2003. Neonatal death rate has seen an unhurried reduction from 43 per 1000 live births in 2003 to 30 per 1000 live births in 2008. According to the GDHMS (2008), the new-born death ratio is higher in Volta, Brong Ahafo, Upper West, Northern and Upper East regions. The principal reasons of neonatal deaths are contaminations (32%), choking (23%), and prematurity and low birth weight (27%). Statistics from DHS and MICS indicate that, it can be realized that, motherly caution pointers have been increasing progressively from 1988 to 2011.

2.3.2 Purpose of a CWC

Child Welfare Clinic's main purpose is to improve children's bodily, intellectual and communal well-being as well as clan health, especially in clans with exceptional requirements. Within this group, it is imaginable to decrease disparities amongst families. CWC aims at achieving improved wellbeing and nurturing of babies, providing defence to all dangers to the child's well-being.

Another purpose is to improve family-centred method to labour and to reinforce nurturing by varied advising, training and upkeep procedures. In adding to the effort done with babies and families, the work at CWC comprises of work with health facilities, local assemblies and the society (Armanto & Koistinen, 2007). The goal in clan based-work is that the customer and the communal health professional labour in partnership. Partnership indicates a collaborative and effective association that is founded on voluntarism and secrecy.

The clan is the expert of their own life and the aspect of the health professional is to heed, comprehend and share new knowledge (Haarala et al. 2008, 282). CWC facilities are used by diverse categories of clans; including new and older parents, numerous, sole parents and migrant families (Hakulinen-Viitanen & Pelkonen, 2009). CWC are envisioned to encourage wellbeing, which upturns families' chances at improving their own wellbeing and the fundamental issues and as an outcome, advance the family's wellbeing (STM 2004).

2.3.3 Healthcare Services under CWC

Access to health care for babies below 5years is a key national growth issue. Even the most influential investigative tests, medications, and injections do not reach the people that need those services (Gillespie & Packard, 2003).

Five proportions of admission, impact the option of action and these are: accessibility, approachability, easy to afford, suitability, and suitability (Obrist, Iteba & Lengeler (2007). Rural inhabitants are particularly susceptible for a several reasons. Difficulties of approachability, comprising distance, long travel times to the hospitals, rare communal carriage, and absence of cycles, remain key blockades to many residents in rural areas. Amenities are fewer probable to have well trained staff with right medications and apparatus than facilities situated in towns (Gillespie & Packard, 2003).

Low points of tutoring and cultural blockades may equally make wellbeing data or other health-related Information, Education and Communication (IEC) inaccessible (Mukuka, Siame, Kalwasha & Mwinga,2004; WHO, 2007; Kiwanuka, Ekirapa & Peterson, 2008) ; Issues related to easy to afford are major difficulties. Even where health services are accessible, the charge of pursuing care may inhibit poor households from accessing the services (Malama, Chen, Vogli,& Birbeck, 2002).

2.3.4 Services offered under CWC

Child health services are targeted at babies under the age of five years. The package of services aims at promoting healthy growth and development through growth promotion, immunization against childhood diseases, vitamin A supplementation, and treatment of minor

ailments, referral and group and individual counselling of caregivers (GHS, 2005). The main purpose of child health services is to avert the main sources of demise, problems and illnesses during childhood, unintentional wounds, and contaminations, instructive and behavioural difficulties (Last, 1986). CWC attend to all families with children in every area of child health. The purpose of a CWC is to promise that the child develops and stays strong. It is also to assist families to comprehend that healthy ways of life are significant for a child from the early years on. A CWC also directs families into making right choices for achieving healthy ways of life.

Child growth formed part of the core modules of the Millennium Development Goals. Nevertheless, this worthy aim can merely be fully accomplished with great reflection of health scrutiny of pre-school age babies. Developmental Delay happens when a baby does not attain age-related landmarks at the predictable age (Simeonsson & Sharp, 1992). Four main fields of growth are evident for babies under five years and these are motor, communication, reasoning and social/personal events (National Infant & Toddler Child Care Initiative, 2010). These are predictable variations in skills that a baby must pass through at predictable eras and in an expectable means.

In view of the importance attached to the well-being and expansion of children services for instance in Ghana (Adu-Gyamfi & Adjери, 2013), CWC have been established in all parts of the country to deliver the desirable services to babies. These health facilities are typically sited in health care centers in both cities and villages and are operated by trained health care professionals. Babies aged 5 years are accessed at CWC for various child welfare and health services. Among the child health activities at CWC are growth checking, immunization

against childhood killer illnesses, vitamin A supplementation, handling of minor infirmities, transfer of complicated illnesses, health dialogues and counselling of mother and care takers on health issues. CWC also provide preventive, management, health investigation and instruction into a system of inclusive health care (Centre for Community Child Health, 2008).

2.3.4.1 Breastfeeding

Good breastfeeding and well-being are important for growth of children in the early years of life. The World Health Organization (WHO) and United Nations Children's Fund recommends only breastfeeding for the first 6 months of life, charted by adequate coordination of feeding and breastfeeding until the child is at least 2 years old (Azubuike & Nkwangineme, 2007). This nutritious plan is likely to provide the desirable nutrients needed for optimum progress of the baby (Azubuike & Nkwangineme, 2007).

Worldwide, a projected 1.3 million babies die each year, because of the absence of exclusive breastfeeding and another 600,000 from not continuing breastfeeding with proper harmonising feeding (WHO, 2003).

In Ghana, breastfeeding education is an aspect of Child Health Programmes and supervised by the Reproductive and Child Health (RCH) unit of the Ghana Health Service (GHS) (GHS, 2013). This unit is replicated in all public hospitals in the country. Sole breastfeeding is encouraged for the baby's first it is expected to continue until two years of age, alongside the introduction of family foods. Several campaigns have been embarked upon to publicise breastfeeding in Ghana.

Key are the Baby Friendly Hospital Initiative (BFHI) started in 1993 and re-inaugurated in February 2013 with agency (Baby Friendly Hospital Initiative Authority (BFHIA)) to supervise the

operationalisation of all related policies (Ghana News Agency, 2013). The task is that, most Ghanaian mothers moderately breastfeed their babies (GDHS, 2003). Ghana documented 61% progress in exclusive breastfeeding from 1992-2003 (Ministry of Health (2007)). However, the report of the 2011 Multiple Indicator Cluster Survey (MICS) indicates that sole breastfeeding has reduced from 63% in 2003 to 46% in 2011 (GSS, 2011).

2.3.4.2 Immunization

In Ghana, the expanded programme on Immunization (EPI) was established in 1978 with six antigens which have increased over the years to twelve in 2013 (GHS, 2014). Ghana has achieved a lot. For instance, immunization analysis from 60% in 1988 to 89.9% in 2014 using the third dose of the pentavalent vaccine as a proxy. The challenge is how to prolong the improvement made (GDHS 2008; GDHS 2014).

In 2014, only 69% of districts achieved 80% and above for the third dose of pentavalent vaccine, which falls short of the 80% target (GHS, 2014). and blockages affecting reaching every child with live saving vaccines.

2.3.4.3 Growth Monitoring

One key activity undertaken at CWC is to closely watch the development of the baby. It is an important part of the precautionary health care in Finland. The key purpose is to identify and treat any diseases in its primary stage. Growth monitoring programmes (GMP) include height measurement, weight and head circumference (Mäki, Wikström, Hakulinen-Viitanen & Laatikainen 2011). The facility-based CWC are stationary health facilities situated within

hospitals whereas the community-based CWC are usually mobile and outreach clinics. The key challenges associated with GMP in Ghana, include inaccessibility of and unreachability to weighing centres, high participant drop outs and slow growth in reducing malnutrition rates (GHS, 2008).

2.4 Benefits of CWC

During the last 10 years, although Ghana has attained a decrease in the child death rate, the levels still continue to be high. The utilisations of the various interventions have not led to the desired level (Last, 1986). According to WHO (2006), the child health goal is measured by; under five mortality, infant mortality rate and the proportion of one year-old children immunised against measles. Research has shown that high coverages of effective interventions such as immunisations, exclusive breastfeeding for the first six months, growth promotion, nutrition rehabilitation, insecticide treated net use and Vitamin A supplementation have the possibility of reducing child deaths. (Darmstadt et al. 2005).

The 2001 World Bank Report although indicates that mortality of children aged less than five years has improved slightly in sub-Saharan African countries, the levels still remain very high. The utilization of the various planned interventions has not yielded the desired results. However, in theory, reduction of the under-five morbidity and mortality is said to be simple and cost effective. High coverage of effective interventions such as immunisations, exclusive breastfeeding for the first six months, growth promotion, nutrition rehabilitation, and insecticide treated net use and Vitamin A supplementation should lead to a reduction.

It is estimated that immunizations prevent three million child deaths a year (World Bank, 2001).

2.5 Factors affecting CWC attendance

Factors including mothers' busy schedules contribute to low CWC attendance in many parts of Africa and Ghana in particular. In addition factors impeding the attendance of the CWC include business activities, forgetfulness and frequent travel of caregivers and lack of knowledge on CWC. Davis (2011) asserts that distance between the residence of a mother and the child welfare clinic is a determining factor in CWC attendance. This is confirmed by Nwaniku, Kabiru and Mbugua (2002) who found in Kenya that mothers living less than five kilometres to a health care facility utilise CWC services than those who live beyond five kilometres of the a facility. Similarly, Feikin, et al, (2009) found in their research in Kenya also concluded that the rate at which young children access health services decrease by distance. An earlier modelling attempt by Gething et al, (2004) also found that utilization of health care facilities decrease by distance. Nigeria has one of the highest level of illness and death among children in the world with overall children under five years mortality rate (U5MR) estimated to be 143 deaths per thousand live births and ranked 12 in the world (2010).

Other health indicator include Infant Mortality Rate (IMR) of 88 deaths per 1000 live births (2010) and Maternal Mortality Ratio (MMR) of over 550 maternal deaths per 100,000 live births (2006-2010 reported) (UNICEF, 2012). In Nigeria, children suffer from short and long-term adverse consequence of illnesses, malnutrition and injuries that impact their well-being and options in life, including fewer educational opportunities and diminished future economic prospects (Rantham-McGregor et al, 2007). These conditions are further aggravated by poor utilization of available child health services (Katung 2001; Sule et al, 2008).

This poor utilization has been reported to be due to household practices such as family barriers, parental, attitudes about professional health services and providers, their receptivity to engagement in services and their precious experiences with the health systems. Recent findings on utilization of child health services in Nigeria have been reported to be confronted with many problems, like availability, accessibility, affordability, service quality and awareness and orientation of the public on the need for child health services (Hughes & Wingard, 2008). Utilization of child health services in Nigeria has also been reported to be influenced by cost, distance and level of education (Sule et al, 2008). It is also characterised by shortage of manpower, poor staff attitude, dissatisfaction with maternal services, long waiting hours and unavailability of drugs or vaccines (Sule et al, 2008; Chukwuani et al 2006).

2.6 Perception of Mothers on CWC

In addition, some immunizations may not be accepted by parents due to lack of knowledge and understanding, for example oral polio, if mothers are aware that polio is given to prevent poliomyelitis, they will accept it (Andrews, Kearns, Connors, Parker & Carville, 2009).

These forms of perceptions and practices could have serious consequences on the welfare of the child. Therefore parents, families and opinion leaders considered as key stakeholders in the pursuance of programmes that seek to improve the welfare of the child (Olson & DeFrain 2000) must be consulted in order to gain their confidence and persuade them to patronize child welfare clinics (Andrews, Kearns, Connors, Parker & Carville, 2009). The Integrated Management of Childhood illnesses is one of the key strategies carried out for improving child

health and reducing mortality in children less than five years of age (Ghana Health Service, 2007).

At the CWC, caregivers are guided and counselled on good infant feeding practices which help to strengthen the immune system and promote the growth and development of children. Similarly, minor health problems are treated as they arise so that they do not deteriorate into more complex conditions (Starr & McMillan, 2003; McMeniman, et al, 2011). Thus, regular supervision of the child at the CWC goes a long way towards maintaining his health and is perhaps one of the central functions of the child welfare clinic. Child health is one of the important indicators for describing mortality conditions, health progress and overall social and economic well-being of a country.

The 2001 World Bank Report although indicates that mortality of children aged less than five years has improved slightly in sub-Saharan African countries, the levels still remain very high. The utilization of the various planned interventions has not yielded the desired results. However, in theory, reduction of the under-five morbidity and mortality is said to be simple and cost effective. High coverage of effective interventions such as immunisations, exclusive breastfeeding for the first six months, growth promotion, nutrition rehabilitation, and insecticide treated net use and Vitamin A supplementation should lead to a reduction (Darmstadt et al, 2005). It is estimated that immunizations prevent three million child deaths a year (World Bank, 2001).

2.7 Social Factors of Child Health

Communal issues of well-being include the situations in which people are born, live, work and grow as well as means that are put in place to curb disease (WHO, 2008). The circulation of currency, social incomes, economies and party-political power shape these circumstances at all levels (Marmot et al, 2010). Although previous researches were aimed at largely on examining social class and clan income, fresh research have widened the limitations of what comprises social factors of health (WHO, 2008; Hafron et al, 2010). Communal class includes issues persuading health and ranges beyond simple measures of profession and revenue; it includes clan prosperity, health knowledge, education, occupation, degree of independence in one's job and quality of housing (Marmot et al, 2010). Ethnicity is also observed as a social factor although emphasis is usually placed on setups defined by race, culture, clan structure and sex (Baker et al, 2005).

Moreover, social associations impact well-being and are consequently involved in communal factor frameworks through concepts such as communal backing systems, communal unity and communal elimination (Raphael, 2008). Also, features of the ordinary setting such as climate modification and the value of water, air and soil are sometimes regarded as causes of child well-being (Marmot et al, 201; Baker et al, 2005). For example, it has been reported that contamination by helminth during gestation could affect motor and intellectual development among one-year-old babies (Mireku et al, 2015).

Many child health researchers now consider a wide range of initial life know-hows in research on communal factors: these include nursing and excellence of nurturing, motherly dejection, family establishment, and being open to domestic violence and neighbourhood security (Hafron et al,

2010). People possess a great deal of softness during the first years of life, helping to ensure rapid reactions to changing ecological issues. Babies are then particularly vulnerable to both right and wrong exposures (Hafron et al, 2010). Thus, when wide-open to hardship, some of the ensuing changes can be maladaptive, potentially leading to high challenges later in life (Gluckman et al,2008).

For instance, hopeless mothers are less dedicated and responsive to their new-borns, failing to appropriately respond to the babies' emotive signs (Dawson et al, 1994).

2.8 Conclusion

The chapter contained a review of related studies on reasons for reduced patronage of child welfare clinics, using the Dansoman Polyclinic as a study site.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methods and procedures that were used for the research. This chapter covered the research design, study area, research population, sampling technique and sample size, data processing and analysis, data collection tools and conclusion.

3.2 Study Design

Both qualitative and quantitative research design were used for this study. Focus Group Discussion (FGDs) were used to collect data among women with children under five. Key Informant Interviews (KII) were also used among service providers. This was done to provide a detailed understanding of perceptions and practices related to Child Welfare Clinic (CWC) attendance among women with children under five. Few questionnaires were administered to women with older children just to get their perceptions and practices on CWC attendance.

The cross-sectional design was used for this study. The cross-sectional study design is the type of design where researchers observe a phenomenon at one point in time (Kreuger & Neuman, 2006). This approach takes a snapshot approach to the social world. This design was adopted because it is the simplest and in this design, standardized information is collected from a sample chosen to represent a pre-defined universe or population for the purpose of analyzing relationships and testing of hypotheses. An interview using questionnaire therefore tries to provide knowledge about a defined group of people by selecting a sample to represent the whole.

A questionnaire was used and the descriptive analysis method was used in presenting the data that was gathered from the field. Apart from having the advantage of completing the study within a limited time frame, this method is also easy and quick to conduct and it is good for descriptive analysis. An important limitation of this design is that it provides data only of what a person or organization says and this may differ from what he/she actually does. However, this limitation was checked by using questions as control variables to approximate the exact results that experiments in the natural sciences achieve.

3.3 Study Area

The study area for this research was the Dansoman Polyclinic. Dansoman is one of the oldest and largest neighbourhoods in Accra, popularly known as D.C or Dansoman City. Dansoman is known to be the largest estates in West Africa with quite a number of modern structures. The Dansoman area was created in the 1970s to serve the accommodation needs of flood victims but in recent times, it has developed to include many suburbs including –Akoko Foto, –Exhibition”, –Glefe”, –Mataheko”, –Sahara”, –Roundabout”, –Last Stop”, –Asoredanho”, –SSNIT Flat”, –Agege”. The Dansoman Polyclinic is the only public health facilities that attends to the health needs of residents. It provides 24 hour general services in areas as OPD, Antenatal, Child Welfare Clinic, Emergency Service, Family planning. On an average, about 150 children are attended to at the Child Welfare Clinic on a daily basis.

3.4 Study Population

The research population for this study was made up all women who visit the CWC with their children (under five years) and caregivers with more than one child at the Dansoman Polyclinic. The research population also included health workers at the same facility.

3.5 Sampling Technique & Sample Size

The researcher adopted a non-probability sampling method, precisely the Purposive Sampling Technique. A total of three Focus Group Discussion (FGDs) were conducted. It was made up of 10 women in each group with similar characteristics. One selected based on educational background of women. There was one group discussion for care givers, another for nursing mothers .These women were purposively selected into these categories. This was done by explaining the purpose of the study to the women, who came to the child welfare clinic A total of 8 to 10 women who meet inclusion criteria and consented to be part of the study were selected for each FGDs.. This was made up of 30 nursing mothers who have children aged between 0-5 years, 10 caregivers, 10 health workers stationed at the Dansoman Polyclinic and questionnaires administered to older women in the Dansoman community.

3.6 Data Collection Tools

Three data collection tools were used: a Focus group discussion (FGD) guide, Interview Guide and a questionnaire. A total of three Focus Group Discussions were conducted with 10 mothers in each group. Participants for the group discussion were selected purposively at Child Welfare Clinic (CWC) .An interview guide with questions on perceptions and practices related to CWC

attendance was used for the FGDs. Participants were taken to a secluded and private place in the facility. A research assistant facilitated the discussion due to language barrier on the part of principal investigator. Investigator understands the local language (Twi) but not fluent. The note taker controlled the audio recording of the discussion as well as taking notes of the discussion. The discussion took approximately 35-45 minutes. An interview guide was also used to guide Key Informant Interviews which was conducted on health workers in the facility. Interviews lasted approximately 20-35 minutes.

3.7 Quality Control

To check for accuracy, interviews were audio recorded in the local language (Twi) and written in English. The audio recorded scripts were transcribed and translated into English and compared with the hand-written field notes prepared during the FGDs and Interviews. After proof-reading and corrections, the transcripts for FGDs and interviews were saved on a password-protected computer and external drive.

3.8 Data Processing and Analysis

Interviews were recorded digitally and the audio files labelled appropriately for easy retrieval. Each recording was transcribed into English. I validated the transcripts by listening to a sample of the tapes to check accuracy and translation quality. The transcribed and verbatim translated recordings were entered into the computer using Microsoft Word.

Data collected through the FGDs and the Key Formant Interviews transcribed, edited and grouped according to the research questions. The transcriptions were coded using identified themes from

the interview guides and themes that emerged from the data. The data was later presented in relation with the research question and analysed vis-à-vis the reviewed literature.

3.9 Ethical Considerations

Ethical approval was secured from the Ghana Health Services Ethics Review Committee (GHSERC) Permission was obtained from District Director of Health Service and heads of facilities before the study. The study population was made up of women with children below age five as well as health workers from the Dansoman Polyclinic. Participants were told about the study during recruitment and their consent were sought. Consent was in a written form. Those who agreed to take part in the study were made to either sign or thumb print the appropriate informed consent forms. No participant was coerced to take part in the study. It was made known to them that participation in the study is voluntary. The participants were informed that, they have the right to refuse or withdraw from the study at any time they want to.

The study was conducted in a manner that ensured the privacy of participants. All participants who gave consent were assured of anonymity. Data was reported in a manner that did not bear names of participants to ensure confidentiality of information being collected from participants. Participants were assured that information given cannot be accessed by any unauthorised persons. Participants were also informed that information obtained from the study would help inform policy, which would intend improve services rendered by nurses in the facility. They were also informed about any changes that were made. There was no financial compensation for participants in the study. However participants of the Focus Group Discussion were given can malt with biscuit.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter examines the data collected from the research grounds and has been presented under each research objective of the study.

4.2 Demographic Characteristics of Respondents

The characteristics of the 50 respondents who took part in the study have been presented in the table below under the following sub-headings: Age range of respondents, level of education, and number of children and category of respondents.

Table 1: Demographic Characteristics of Mothers of children below 5 years attending Child Welfare Clinic at Dansoman Polyclinic.

Issues	Responses	Frequency	Percentage
Age Range of Respondents	25-29years	7	14
	30-34years	13	26
	35-39years	15	30
	40-44years	10	20
	45 years and above	5	10
	Total	50	100
Level of Education	First degree holders	14	28%
	Completed SHS	12	24%
	Completed JHS	9	18%
	Masters' degree holders	8	16%
	No Education	7	14%
	Total	50	100%
Number of Children	1 child	8	16%
	2 children	17	34%
	3 children	14	28%
	More than 4 children	11	22%
	Total	50	100
Category of Respondents	Nursing mothers with children aged 0-5years	30	60%
	Nursing mothers with children above five years and caregivers	10	20%
	Health Professionals	10	20%
	Total	50	100%

Out of the 50 respondents, who took part in the study, 15 respondents were aged between 35-39 years. They represented 30% of the study's research population. This was followed by 13 respondents who were between the ages of 30-34years and they represented 26% of the research population. A set of 10 respondents aged between 40-44years, representing 20% of the research population. Seven (7) respondents were between the ages of 25-29years and 5 respondents were

aged 45 years and above. They represented 14% and 10%, respectively of the research population for this study.

Fourteen respondents out of the 50 respondents, representing 28%) of the research population had completed higher education. Twelve respondents had completed Senior High School and they represented 24% of the research population. A group of 9 respondents, representing 18% were Junior High School graduates. Eight respondents had others (Masters' degree) and they represented 16% of the research population. The remaining seven (7) respondents had no education. They represented 14% of the study's research population

On the number of children that each respondent had, the data indicated that, out of the 50 respondents, 17 respondents had 2 children and they represented 34% of the study population. This was followed by 14 respondents who had 3 children, representing 28% of the research population. A set of 8 respondents had a child and they made up 16% of the study's population. With the remaining 4 respondents who had more than 4 children. They represented 22% of the research population.

Out of the 50 contributors who participated in the study, thirty (30) were nursing mothers with children aged 0-5 years. A set of ten (10) were health professionals working at the Dansoman Polyclinic and they represented of the research population.- The remaining ten (10) respondents were older mothers and caregivers living in Dansoman, Accra.

4.3 First Objective: Perception of benefits of CWC

The 30 nursing mothers who took part in the study noted that, CWC exposes them to the stages of growth of their children and what they should expect and do at each stage. They also noted

that, they receive pieces of advice anytime they attend CWC. Their views have been captured under the following themes:

Gains from attending CWC

This is what one mother had to say, *–Ever since I started attending CWC with my daughter, we have gain so much. Apart from the free items we receive, they advise me on how to properly feed my daughter, even to the extent of advising me on the various combinations of food to ensure a balanced diet.*”

Receiving of Vaccines & Child Monitoring at CWC

Another mother added, *–The administration of relevant vaccines at CWC is one of the benefits that, my two children have benefited from, since we started attending CWC. We also receive regular updates o on the growth of my children and this is important to me”* she concluded.

Motivation to attend CWC until 5th birthday

The themes emerging from the findings indicated, the motivation to attend CWC until the child was five years included good inter personal relationship with health professionals, continuous education on the benefits of attending CWC and supply of treated mosquito nets.

Friendly Service at CWC

One mother noted that, *“If nurses are very friendly and open to us, we will keep attending the CWC even after the 5th birthday of my son. I remember one time I visited the CWC with my second child, this nurse was so friendly and warm and will actually call you two days before*

your scheduled visit to remind you. I always looked forward to my visit to the CWC. Unfortunately, she has been transferred. For me, her good inter-personal relationship was the motivating factor.”

Potential Benefits

Another mother added that, –Anytime I go to the CWC, the nurses remind me of the importance of regularly attending CWC and the benefits to my child. I leave the Clinic also reminded and poised to attend the CWC and if I am not available, I also arrange for my sister or niece to take my son to the CWC. On some occasions, I have also received two free treated mosquito nets and this adds up to why I will keep attending CWC till the recommended 5years old of my son.”

On the part of the health professionals, some of the factors that motivate mothers to continue to attend CWC until the 5th birthday of their children is because at CWC, there is early detection of diseases and treatment follows immediately. This is what one health professional had to say, –*At the CWC, the growth of the child is monitored and should there be any negative trend, the mother can be advised. We actually advise the mothers on the importance of exclusive breastfeeding for the first 6 months, immunization, importance of using treated mosquito nets, completion of vaccination among others. Nurses here are extremely friendly and are willing to go the extra mile to ensure that children who come to the CWC receive the best of care.”*

On the part of the older nursing mothers and care givers, 6 out of the 10 respondents, noted, the care given to the children should be good enough to urge mothers to continue to attend the CWC with their children till their 5th birthday. The remaining 4 respondents noted that, the kind of information/education given them at the CWC should be the motivating factor to continue to

attend the CWC till their children are 5years old. They noted that, at CWC, mothers receive information/education on the growth monitoring, immunization against childhood killer diseases, treatment of minor ailments and counselling parents/caregives on health issues for the child. This has been captured in the graph below:

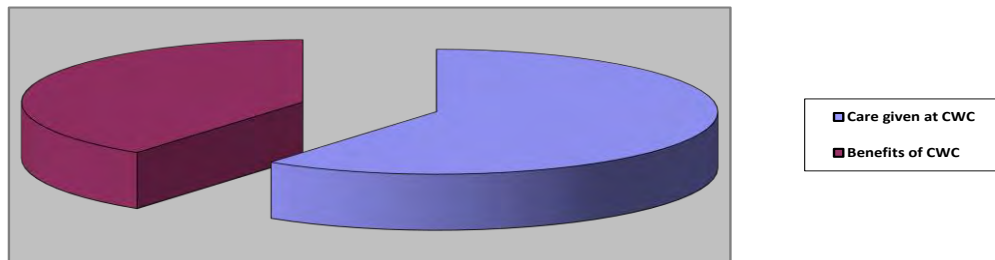


Figure 2: Factors that motivate mothers to continue to attend CWC until 5th birthday

4.4 Second Objective: Why reduce duration of attendance at CWC

On the methods section, nursing mothers with children aged 0-5 years, noted that, the cost of transportation, the busy schedules of the mothers and some negative attitudes of some health professionals. One mother noted that, *“I personally reduced the number of times I took my child to the CWC because sometime when we go, they actually do not do much. So I look at the days that my daughter will be given an injection or something else and then we attend”*.

On the part of the health professionals, they noted that, some of the reasons that account for the reduction in attendance at CWC include distance to the health facility, poor attitude of some health professionals towards the mothers. One nurse noted that, *“Sometimes, these mothers are busy and therefore instruct caregivers to bring their children to the CWC but unfortunately these*

caregivers do not. Some others complain that, when they come to the CWC, they are made to pay money but that is not true. We have asked them to report those nurses but we are yet to receive any such complaint.”

On the part of 10 older nursing mothers and care givers, 4 respondents attributed the reduction of the attendance at CWC to the distance to CWC. Three respondents stated the poor attitude of nurses as being the reason for reduction in attendance at CWC. The remaining 3 respondents stated that, the reduction of the attendance at CWC is due to busy schedule at work as their reason for the reduction in attendance at the CWC. This has been captured in the graph below:

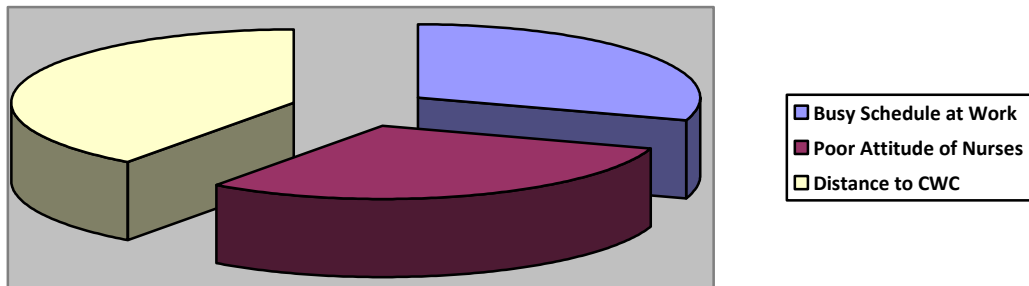


Figure 3: Reasons for reduction in attendance at CWC

4.5 Third Objective: Factors that accounts for nursing mothers’ stop attending CWC so early.

The researcher wanted to know the factors that account for nursing mothers who stop attending CWC so early. On the part of the nursing mothers, they noted that, distance to the health facility, cost of transportation and bad attitude of health professionals towards mothers were the key

reasons that account for nursing mothers who stop attending CWC before the recommended time.

This is what one nursing mother had to say, *“I know there are a lot of benefits of attending CWC but sometimes other things compete for my attention. I am a market woman and I usually leave the house by 4am. I leave my 2 year old son with my mother so she can take care of him. My mother has brought him to CWC about two or three times, but complained about the distance and the fact that, for each time you want to attend CWC, you have to spend so much on transport, which is also very expensive.”*

Another nursing mother added that, *“Why should I bring my child to the CWC if the nurses there will speak to me anyhow? During one of such visits, one of the nurses asked me, why I have refused to feed my child with good food. Is that, a better way of finding out what the challenge is? Her way of handling me and my child made me loose interest in attending CWC and that is, why for me, I have stopped attending CWC.”*

Another mother adds her voice, *“I know of the importance of attending CWC with my child but the amount of time I spend waiting is really my lost. I have tried getting to the clinic early on my scheduled dates but I still end up spending close to 40 minutes or more waiting. This is my only problem and I know others too, have touched on the cost of transportation to the clinic.”*

On the part of the health professional, they also noted that, most mothers complained about the number of hours they have to spend waiting for their turn at the CWC especially during the rush hours of the day. They also noted that, some mothers also come to the CWC on the wrong dates and therefore feel reluctant to attend CWC on the scheduled date. According to the older nursing

mothers and care givers, most mothers stop attending CWC because of cost of transportation and distance to the health facility where they registered to attend the CWC and this is especially for those who have had to relocate to another area during the 5years of their child. This was supported by 6 respondents. The remaining 4 respondents noted that, the negative attitude of nurses can cause mothers to stop attending CWC so early. This has been captured in the graph below:

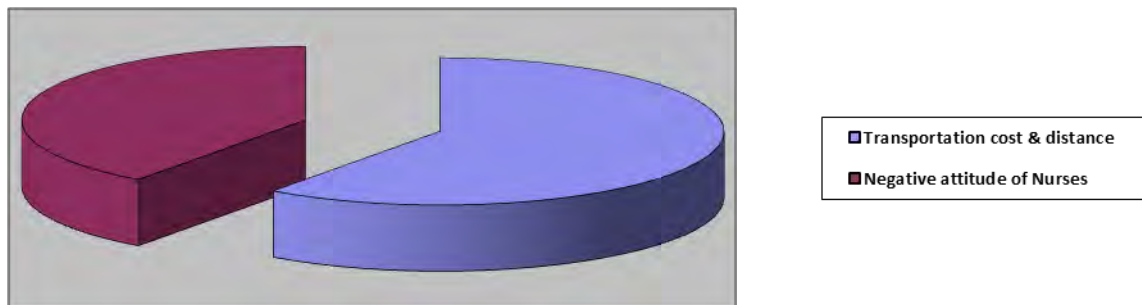


Figure 4: Factors that account for nursing mothers' stop attending CWC so early.

CHAPTER FIVE

DISCUSSIONS

5.1 Introduction

This chapter contains the discussions arising from the data scrutiny that has been done in chapter four of this study.

5.2 Discussions

The study findings point out that, there are some reasons why nursing mothers living in and around the Dansoman Polyclinic reduce their attendance to CWC. The findings are meaningful as it gives stakeholders especially health service providers a further insight into the problem, the perception of mothers about the CWC and what mothers would want to be done to motivate them to attend CWC with their children till their children are 5 years old. The study used the mixed research method to as to gather more statistics and experiences of the various categories of individuals who formed part of the study. The findings therefore provided both statistics and lived experiences of nursing mother with children aged 0-5 years, health professionals as well as views of nursing mothers with older children and caregivers. It can be stated that, the research method used was appropriate.

The findings are not surprising as it goes to support already existing research in this field. On the first objective which was to understand the perception of the respondents on the benefits of CWC, the study findings pointed out that, CWC exposes them to the stages of growth of their children and what they should expect and do at each stage. They also noted that, they receive pieces of advice anytime they attend CWC. A careful analysis from the literature that was

reviewed in Chapter two, indicated that, this finding is not a new finding, as it already exists. The findings corroborate a study conducted by Armanto & Koistinen (2007) which pointed out that, CWC has a variety of objectives with the main aim aiming at improving children's bodily, intellectual and communal wellbeing as well as that of the family, particularly those with special needs. With this target it is possible to decrease disparities between families. The authors also added that, the overall objective is to achieve better wellbeing and nurturing means in the next generation.

Further supporting this finding is a research conducted by STM (2004) which noted that, CWCs are envisioned to encourage wellbeing, which promotes chances to influence their own wellbeing and the fundamental reasons and as a result advance the family's wellbeing (STM, 2004). Other studies also support this finding and these include a study by Last (1986) who stated that, the main purpose of child health services is to avert the key roots causes of demise, complications, and sickness during infancy, unplanned wounds, contaminations, educational difficulties and conduct difficulties (Last, 1986). Finally, a study conducted by the WHO (2006) also noted that, the child health goal is measured by; under five death, infant mortality rate and the quantity of one year-old children vaccinated against measles.

Moving unto the second research objective, which was to find out why there has been a reduction of attendance at CWC at the Dansoman Polyclinic. The findings from the data analysis showed that, the the cost of transportation, the busy schedules of the mothers and some negative attitudes of some health professionals were the main reasons for the reduction in attendance at CWC.

Supporting this finding is a study conducted by Davis (2011). He asserted that distance between the residence of a mother and the child welfare clinic is a determining factor in CWC attendance. He further identified that, in addition to mothers' busy schedules, other reasons such as business activities, forgetfulness and frequent travel of caregivers and lack of knowledge on CWC account for the low attendance at CWC. Further supporting this finding is a study by Nwaniku, Kabiru and Mbugua (2002) who found in Kenya that mothers living less than five kilometres to a health care facility utilise CWC services than those who live beyond five kilometres of the a facility.

5.3 Study Limitations

This study was limited to mothers and caregivers with more than one child, who visited the hospital for Child Welfare Clinic. However, mothers in the community who may not visit Dansoman Polyclinic are limited to this study. Future studies should consider conducting a study including women within the Dansoman community.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents a summary and deductions of the study as well as recommendations that have been suggested grounded on the results and discussions of the study. These recommendations are based on the findings from the data that was obtained from the field.

6.2 Summary

The research findings indicated that, mothers acknowledged that, CWC exposes them to the stages of growth of their child or children and what they should expect and do at each stage of their growth. They also expressed that, they receive pieces of advice anytime they attend CWC and also receive free items such as mosquito nets. The findings established that the factors that motivate mothers to continue to attend CWC until their child/children are 5years old included, the good inter-personal relationship between mothers and nurses, nurses visiting mothers/child at home to check on them, continuous education on the benefits of attending CWC and supply of free items such as insecticide treated mosquito nets. Other factors included, early detection of diseases and treatment, the kind of information/education given to mothers at the CWC which included information/education on the growth monitoring, immunization against childhood killer diseases, treatment of minor ailments and counselling parents/caregives on health issues for the child.

The findings indicated that, the cost of transportation, the busy schedules of the mothers and some negative attitudes of some health professionals accounted for the reasons for reduction in attendance at CWC. Other reasons included distance to the health facility and busy schedules of mothers at work. The findings showed that, the main reasons that account for nursing mothers who stop attending CWC before the recommended time distance to the health facility included, cost of transportation, distance to the health facility where they registered to attend the CWC and this is especially for those who have had to relocate to another area during the 5years of their child/children. Other reasons included bad attitude of some health professionals towards mothers, long hours of waiting at the clinic and mothers who come to the CWC on wrong dates feeling reluctant to attend CWC on the scheduled date.

6.3 Conclusion

It can be established that, mothers have the knowledge of the benefits of CWC and are abreast with the services provided at CWC. It has been recognized that, there are a lot of factors that motivate mothers to attend CWC, though there are reasons that contribute to mothers reducing the number of times they attend CWC as well as reasons that account for nursing mothers stop attending CWC early. Efforts should be made by policy makers and health providers to address these reasons so that mothers can attend CWC till the recommended time and give their children, the opportunity to enjoy all the benefits of CWC.

6.4 Recommendations

From the outcome of the analysis of the data gathered, the following recommendations have been made to Management of the Dansoman Polyclinic and the Ghana Health Service as well as nursing mothers living in and around Dansoman.

- The Management of Dansoman Polyclinic should explore the opportunity of organising CWC can be provided at nursery schools and market places as an alternative means so in case, children whose mothers or parents are unable to bring them to the CWC can also receive CWC services and grow very well.
- To respond to mothers with busy schedule, it would be recommended that, health facility managers/matrons should send mothers text message reminders on their next visit to the CWC.
- Hospital management can create a form of nursery school at the facility for mothers with busy schedules and others who wish to leave their children .
- Nursing mothers should be motivated by nurses and hospital management to attend the CWC till the 5th birthday of their children by giving them baby foods, mosquito nets, diaper, wipes depending on the age of children and cooking oil. Mothers who continued to attend the CWC till their children are 5years old, should be given awards to encourage their continuous participation as a form of motivation.

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APPENDICES

APPENDIX A: PARTICIPANT INFORMATION SHEET

Title of study: Perception and practices related to child welfare clinic attendance among women attending Dansoman Polyclinic.

Researcher ; Gertrude Coomson

Department: Population, Family and Reproductive Health **Tel No.** 0260759068

Background

Dear participant, Gertrude Coomson is my name, a student of the School of Public Health, University of Ghana; I am undertaking a study on perception and practices related to child welfare clinic attendance in Dansoman Polyclinic. The study hopes to explore why mothers stop attending CWC by 12 months .This research forms part of my work for the award of a Master of Public Health Degree. It is my honour to have you as part of my study.

Procedures

The study will involve 3 Focus Group Discussions with women who have children up to or under five years to find out their perception and practices related to child welfare clinic attendance as well as interview health staff to find out their views on the topic.(KIIs) at the CWC.

You have been selected to be part of the study and we would be grateful to know your opinion on the subject. There is no right or wrong answers. Your assistance in providing responses to questions will help us better understand the perceptions and practices of child welfare attendance. To help me remember all that you say, I would with your permission tape record the interview and also take notes as the discussion go on.

I will have two assistants, a facilitator and the other to take notes. All that you say will be kept confidential. Your names will not appear in any reporting of this study. The interview will last between forty five minutes and an hour. You are free to opt out at any stage of discussion and there will be no consequences to you.

Risks and Benefits

There are no risks to the study. An inconvenience of this study is the time needed to participate in focus group discussion this study will help public health and other concern institutions to formulate strategies to be able to address the reasons that account for the low patronage of the CWC and perception of mothers concerning attendance.

Right to refuse

Participants can choose not to answer any particular question or all questions. Participation in this study is voluntary. You are at liberty to withdraw from the study at any time. On the other hand, your opinion is important for the outcome of the study.

Anonymity and Confidentiality

I would like to assure you about confidentiality of the data obtained and would be used for purposes of the research only.

Compensation

If you agree to participate in the focus group, you will be refreshed with a can of drink and pie after participating.

APPENDIX B: INFORMED CONSENT

Before Consenting:

Do you have any issues for clarification? You may contact the principal Investigator Gertrude Coomson on 0260759068 or Hannah Frimpong of Ghana Health Service Ethical Review Committee (0243235225/0250704223)

CONSENT FORM

Participant Statement and Signature

I have read the foregoing information, or it has being read to me .I have had the opportunity to ask questions about it and question I have asked have been answered to my satisfaction. The purpose of the study has been thoroughly explained to me in English language and Twi and I have understood. I consent voluntarily to participate as a subject in the study and understand that I have the right to withdraw from the study at any time without any consequences.

.....

Signature or thumbprint of participant (thumbprint for those who cannot read or write)

.....

Date

Interviewer's Statement and Signature

I, the undersigned, have explained this consent form to the subject in the English or Twi language that she understands the purpose of the study, procedures to be followed as well as risks and benefits involved. The subject has freely agreed to participate in the study. All questions and clarification raised by the participant has been addressed.

.....
Signature of Person who sought Consent

.....
Date

APPENDIX C: FGD GUIDE

FGD Facilitator.....

FGD Note taker.....

Date:

No. of Participants.

Time.....

Facility.....

Identify respondent according to selection criteria

Introduce topic (length of FGD approx. 45 minutes, confidentiality, and informed consent)

Personal Details

Age range 25-29 30-34 35-39 40-44 45 and above

Level of Education No Formal Education JHS SHS First Degree Other, please state.....

Number of Children 1 2 3 More than 4

Main Questions

1. What are the benefits of CWC?
2. How long after delivery did you attend CWC with your last/current child?
3. Why did you stop attending CWC?
4. What other factors do you think can motivate mothers to continue to attend CWC until the fifth birthday of their child/children?
5. As a mother, how does CWC affect your child's health?
6. What explains the attendance at CWC?

APPENDIX D: INTERVIEW GUIDE

Section A: Socio Demographics

Age range 25-29 30-34 35-39 40-44 45 and above

Level of Education No Formal Education JHS SHS First Degree Other, please state.....

Number of Children 1 2 3 More than 4

Questions

Objective 1

- 1 Are you aware that, every child must attend the CWC till the 5th birthday?
- 2 How long did you attend CWC with your last child?
- 3 Why did you stop before the mandated 5 years?

Objective 2

- 4 What are nursing mother's perception on CWC attendance?
- 5 Do you think it is important for every child to attend the CWC?
- 6 What are some of the benefits?

Objective 3

- 7 What factors motivate mothers to continue to attend CWC?
- 8 What can be done to make it easy and simple for you to continue to bring your child to the CWC till the child is 5 years?

Objective 4

- 9 What are the factors explain that accounts for duration of CWC attendance?
- 10 What will make you, a mother, stop bringing your child to the CWC?

APPENDIX E: QUESTIONNAIRE

This is a questionnaire from a student of the School of Public Health, University of Ghana, Legon, who is conducting a research on the topic –Perception and Practice related to Child Welfare Clinic attendance In Dansoman Polyclinic”. Any information you provide will solely be used for academic purpose and confidentiality is highly assured. Kindly answer the following questions by ticking or providing answers.

PART I

1. Age range 25-29 30-34 35-39 40-44 45 and above
2. Level of Education No Formal Education JHS SHS First Degree Other, please state.....
3. Number of Children 1 2 3 More than 4

PART II

4. Are you aware that, every child must attend the CWC till the 5th birthday? Yes No
5. How long did you attend CWC with your last child? For a year For 2 years For 3 years For 4 years For 5 years
6. Why did you stop before the mandated 5 years? Busy schedule at work Distance to the CWC Nothing significant was done anytime I brought the child to the CWC Non-availability of drugs at CWC Others, please specify.....
7. Listen two services that are available for your child at the CWC.....

.....

8. As a mother/healthcare provider, do you think it is important for every child to attend the CWC till age 5? Yes No

9. Kindly explain your response to question 5.....

.....

.....

10. What are some of the benefits of attending CWC? growth monitoring immunization against childhood killer diseases vitamin A supplementation treatment of minor ailments, Counselling parents/caregives on health issues for the child None of the above all of the above

11. What factors motivate mothers to continue to attend CWC? Useful and timely advice Monitoring of the growth of the child Postive attitude of health professionals

12. What can be done to make it easy and simple for you to continue to bring your child to the CWC till the child is 5 years? Send mothers a text message reminders Visit children at their homes Run CWC on weekends

13. What will make you, a mother, stop bringing your child to the CWC? Distance to the CWC Negative attitude of health professionals Nothing significant happens at the CWC

THANK YOU