Author's response to reviews

Title: Child morbidity and care seeking for diarrhoea, malaria and pneumonia in four poor rural districts in Sierra Leone in the context of free health care: results of a cross-sectional survey

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Editors
BMC Public Health

Dear Editors:

Enclosed is a re-submission of the manuscript entitled “Child morbidity and care seeking for diarrhoea, malaria and pneumonia in four poor rural districts in Sierra Leone in the context of free health care: results of a cross-sectional survey” thank you for your consideration. .

Modifications were made to the manuscript as requested.

(1) Consent statement: Please state in the Methods section whether written informed consent for participation in the study was obtained from participants or, where participants are children, a parent or guardian.

The explanation of consent procedures are now included on page 5.

“Typically the head of households in Sierra Leone makes decisions for all members of the household, therefore they were asked permission to interview others in the household including girls 15 to 17 years of age. In addition all women/caretakers over 18 years of age and girls under 18 who are married or have children were read a consent form. Girls under 18 years of age who are not married nor have children were read an assent form. Girls under 18 years of age who are not married nor have children were read an assent form. A separate laminated consent and assent forms were provided to all interviewers. Given the high illiteracy rate verbal consent was obtained. The interviewer was required to check off on the PDA whether the consent was read and whether permission was given to be allowed to proceed with the interview.”

(2) Questionnaire: Please include a copy of your questionnaire as an Additional File, properly cited in the Methods section.

The questionnaires and consents have been uploaded. They are referred to on page 5.

(3) Please adhere to RATS guidelines when reporting Qualitative Studies

The qualitative study already followed RATS guidelines but minor additions were made on page 8 for clarity, 2 references were added on qualitative methodology and a description of consent procedures was added. These are highlighted below:

“The purpose of the qualitative study was to provide formative information for the baseline survey and to obtain in-depth information on household recognition and response to child morbidity (illness concepts, terms, causation, prevention, treatment, decision making, barriers to care, patterns of resort, provider preferences, care burdens). The study design was informed by applied qualitative research, that focuses on a specific illnesses (diarrhoea, pneumonia, malaria), addresses programmatic concerns
related to these illnesses (identifying local causes, terminology and treatment for diarrhoea), and draws from experiences of actual cases of sick children. Focus group discussions captured social norms as expressed by specific sub-groups of concern, while in-depth interviews collected narratives of actual cases of care seeking for child illness.

Data collection took place in two stages, first in April 2010 and later in July 2010, by data collectors who received 5 days of training on qualitative methods and research ethics and were accompanied in the field by a qualitative research supervisor. Data collection focused on three types of villages: those with a community health post, those with a community health center, and those without any government facility in the village and typically located 3-10 miles away or five hours distance from a village with a government health facility.

Focus group discussions and in-depth interviews were conducted with mothers, fathers and older caregivers of children under age five. Participants were selected purposively with the aid of key informants including village elders and health volunteers with efforts made to include a diversity of respondents among in-depth interviews including those living near to and far from the village center. Informed, verbal consent was sought and received from all respondents who partook in 36 focus group discussions and 64 in-depth interviews, including 15 follow-up interviews, which were completed and taped across 12 villages in all 4 districts. Debriefing sessions based on field notes were held during and immediately after fieldwork to further explore deviant or unique findings that merited follow up interviews and to support reflective practice and possible differences in interviewing, probing and interpretation among data collectors. One respondent declined consent due to time constraints. Data collection ceased upon saturation of key themes listed earlier. Data were transcribed into English and a list of hierarchical codes developed and validated by a co-investigator before being applied to the dataset using Atlas version 4.1. Thematic analysis was undertaken that compared and contrasted data from different respondents, data collection methods and sites to arrive at triangulated descriptions of illness terminologies, causation, prevention, and treatment patterns. Data summaries were shared with key stakeholders before developing manuscripts. The findings presented here are those that help to further elucidate quantitative findings.”

We appreciate your consideration of this article.

Sincerely,

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