Author’s response to reviews

Title: Do health systems delay the treatment of poor children? A qualitative study on child deaths in rural Tanzania.

Authors:

Helle Samuelsen (h.samuelsen@anthro.ku.dk)
Britt P Tersbøl (briter@sund.ku.dk)
Selemani S Mbuyita (smbuyita@ihi.or.Tz)

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Author’s response to reviews: see over
Coverletter


Dear editors,

Please find attached the revised manuscript. We have edited the entire document to clarify meanings and correct errors. We have used track-changes tool in the revision of the manuscript (insertions marked in blue, deletions marked with strikethrough). Please find below our specific response to each of the two reviews.

Reviewer 1 (Claudia Hanson):

We have restructured the paper in accordance with the reviewer’s suggestions in order to follow the common structure.

1. Revision of layout and structure:

“We in our study, health-workers routinely blamed parents for delay in seeking health care and maintained that this problem remains one of the major challenges in reducing child mortality in their district. In contrast to this, we found that significant delays take place while parents seek care (between different levels of formal health care) and not least at the health facilities itself while parents (mothers) attempt to accommodate demands from health professionals. As Fassin has pointed out, health professionals refer to “cultural beliefs” as the reason why women appear to avoid the bio-medical health system: “In incriminating culture, as certain health authorities willingly do, sometimes supported by anthropological data, they are in fact blaming victims whilst masking their own responsibility in the matter”[8]. Anthropologists may have contributed to this discussion with detailed empirical studies of local perceptions of illness and how these influence biomedical treatment [6, 9-14]”

We have moved the section below from the introduction to the first section of the result section:

The first obstacle, which causes treatment delay, has to do with payment. Despite the Tanzanian exemption policy which should allow all treatment (consultation and medicine) of children younger than five years to be free, parents are often required to pay for medicines and treatment at the health facility. However, as payments are not fixed, but occasional and unpredictable, they might cause delays as the mother first has to provide the money before treatment is initiated. Another important barrier causing delay is that many children are not successfully referred to the required medical expertise. The third obstacle delaying adequate care has to do with the ways in which the health services are
organised within the health facility. Often the sick child and members of its family are instructed to go to several points in and outside the facility before treatment is obtained. Finally, we identify communicative obstacles, with the health staff consistently using specific forms of interaction which compromise the least educated and poorest families.

We have moved the section (second paragraph of the result section) below to the discussion:

Treatment and medication at public-health facilities for children under five are supposed to be free. However, as in just described, when receiving and presenting the prescription at the counter where medicine is issued, many parents find that the prescribed medicine is out of stock. These health facilities receive their medicines and medical equipment through the Medical Stores Department in Dar es Salaam. It is clear that the procurement and distribution system has its shortcomings, as many facilities end up lacking some of the most important medicines for longer or shorter periods of time. If the prescribed medicine is not available, the parents are advised to go to a duka la dawa [drug shop], of which there are plenty [23] and buy the drugs themselves, then to return to the facility to receive instructions on how to give the medicines to the child. Obviously, it causes a lot of frustration if the parents do not have enough money with them to buy the medicines and this uncertainty is most problematic for the poorer segments of the population. In addition, some mothers – as in the case of Agnes – are asked to make the payments for medicines directly to the health staff. Payment of up to Tsh 10,000 is a substantial amount of money for poor families, given that day labourers in agriculture earn Tsh 1200–2000 for a day’s work. When the unavailability of drugs at the dispensary level becomes known to the population, mothers tend to make their own self-referrals to other health facilities or simply treat the child at home thereby delaying treatment.

2. The introduction is revised (see the two first points above). The section including the aim of the study is now at the end of the introduction.

3. The description of the two field studies (in 2006 and 2007 respectively) is revised with an emphasis on a description of the 2007 study. The process of selection of the 16 mothers is now added with the following paragraph:

In each of the three selected villages, the village head was contacted in order to get permission to conduct interviews in the village and to help us identifying women, who had lost a child during the specified period. A total of 16 mothers who had lost a child two months to one year earlier were identified and found to be at home at the time of the visit (see Table 1 for an overview of the women’s accounts).

4. The table is revised now including a total of 16 cases. The following paragraph describing the cases has been added:

The 2007 study included interviews with 16 women, who had lost a child within the previous two years. The women were between 17 and 43 years old. A few of the women had never attended
school, one had completed secondary school, while the rest had from 4-7 (primary level) years of schooling. Half of the women (eight) were not married (three were widows). Most of the households lived from subsistence agriculture, whereas three husbands had some kind of wage income (policeman, watchman and businessman). One of the women did not consult a health facility during the child’s sickness.

5. The discussion has been expanded through a restructuring of the result and discussion sections. The following paragraph has been moved from the result section to the discussion:

The problem of the inadequate referral system has been pointed out in other studies. Walter et al. found that health workers disagreed with the IMCI guide that all severely ill children should be referred [25]. In their study, that among 81 health workers who were interviewed, 68% responded that severe malaria could be managed without a referral, and only 5% reported ever having withheld referral because the child’s condition appeared hopeless [25].

Also the following paragraph has been moved (and slightly rephrased) to the discussion section:

The fact that the district hospital does not have any type of triage, may perhaps not be very different from an out-patients department at a European hospital, but the fact that malaria can kill a child within 24 hours of the onset of symptoms, makes it crucial to perform triage among the many patients in the crowded out patient department and to act promptly if a severely ill child is identified.

We have added the following paragraph in order to address the issue on study limitations:

We would have liked to be able to triangulate mothers’ accounts of the route to and timeframe for seeking health care with other data. Participant observation may not have been appropriate due to the ethical concerns. Prolonged periods of participant observation in the communities and households of informants would have allowed for better contextualisation of mother’ accounts of events leading up to the death of their child. However given that several other scholars have focused on the community level to ascertain health seeking practices and the decision making processes that underlie health seeking [6, 15-18] we prioritised in this study to place our focus at the health facilities to explore constraints and delay experienced by mothers/caretakers here. The part of mothers’ accounts we can triangulate with our observations are the processes and demands that mothers are met with at health facilities.

We acknowledge the point made by the reviewer that our data focus on the delays taking place at the health facilities. We have therefore deleted the third paragraph of the discussion section starting with “all three phases of delay play a role.”

6. We have rephrased the sentence “especially the poorest families experience delay” – to “Our cases, interviews and observations show that many rural families experience delays”
Reviewer 2 (Helen J. Smith)

1. We appreciate the comments and have restructured the introduction (see our response to reviewer 1 above).

   In the introduction, we have added the following sentence acknowledging that the 3 delays model was developed in relation to maternal mortality: **The three delay model was originally developed in relation to studies on maternal mortality, where the focus on the third phase is particularly relevant.**

   Furthermore, we have moved the following paragraph from the end of the introduction to the part of the introduction where we introduce the three delays model: **We are well aware, that there is still much to gain from addressing the other phases of delay described by Thaddeus and Maine. And it is clear that the various types of delays interact with each other as described by Thaddeus & Maine (1994), Gabrysch & Campbell (2009) and Mbaruku et al. (2009).**

   We agree that we need to specify what we mean by “anthropologists may have contributed to this discussion”. We have now moved this section to the discussion (see response to reviewer 1) and added the following sentence: **While these studies of course are justified in themselves, they might contribute to the strong focus on the first type of delay.**

   We have rephrased the Nikolas Rose quote, but have kept a few of the other quotes as they now form part of the discussion.

   We have added that we ‘recognise the power-trust-risk nexus’ as an important characterisation of the social structure of health care systems – and we refer to it again in the discussion.

   The details on the health system have now been integrated into the method section.

2. We have restructured the method section considerably (see response to reviewer 1). We have added information about the sampling procedure in the following paragraph:

   **The mothers were recruited from three different villages: one with a dispensary, one with a Health Care Centre and one close to the district hospital. Villages with a health facility were purposely selected in order to eliminate long distance as a barrier to contact with the primary level**
health care system. In each of the three selected villages, the village head was contacted in order to get permission to conduct interviews in the village and to help us identifying women, who had lost a child during the specified period.

and we have expanded the description of the observations conducted at the health facilities by including the following sentence:

The persons we followed through the facility were randomly selected at the point of registration, we went along with them until they were admitted and the child had received treatment, or alternatively until the child had obtained medication and was heading home with the mother /caretaker.

We have added the following sentence as a response to the reviewers demand for more reflection in relation to the few cases, where we had to intervene:

These interventions did of course impact on the course of treatment in these few cases, but the fact that we for ethical reasons had to intervene illustrate the vulnerability of some families.

We have explained in more detail how we attempted to handle interviews in an ethical manner:

We were initially concerned that it might be traumatic for mothers to talk about the events that led to the death of a child and planned the interviews so we could take up a more informal dialogue after each interview to comfort the informant, if necessary. Great care was taken to develop trusting and open communication and to ensure that the interviewees felt comfortable with the interview situation. During the informed consent process, it was made clear what we aimed to talk about and why, and we specifically asked each woman if she would be comfortable discussing the topic. We also made the women aware that they could withdraw from the interview at any point in time. During interviews, we observed the women carefully to see if they appeared distressed or withdrawn and we frequently enquired they were still comfortable with continuing the discussion. Also, the location for each of the interviews were carefully selected in consultation with the women to ensure privacy and emotional comfort.

We have explained in more detail how we assessed the reliability of data obtained from observations of consultation:

With respect to the negotiated interactive observations in the consultation room and when following cases through the health facilities, we expected health care professionals to change behaviour due to our presence in the consultation room. However, we observed that after a few consultations, the health care staff relaxed more and returned to carry out consultations the way they routinely used to. This was confirmed by the patients when we asked them to compare the observed consultation to previous consultations they have experienced; and in their view, the observed consultations resembled earlier consultation experiences. We also asked informants, those consultations we did not observe, about the consultation procedures they experienced. Their account of the consultation clearly resembled the observed consultations.
3. We have added details to the description of the analytical process in the following paragraph:

All interview material was read by both authors and common themes across the interview cases were identified and analyzed thematically. Themes and codes were thus derived inductively from the material and compared and contrasted to data derived from observations. Dialogues from the consultation room are quoted in this article when they constitute typical examples of consultations either because of their short duration or because they represent a typical style of communication between health professionals and mothers. The four obstacles described in our result section came out as common themes through the content analysis of different types of data (interview transcripts, notes from consultations and from the cases followed through the health facility).

We have rephrased paragraphs in the result section in order to accommodate for the reviewer comment on the “opinion based” phrases.

4. We have restructured the discussion and conclusion sections (see above). Furthermore, we have removed the emotive phrases. We have deleted the comment on use of mobile phones.

5. We have added a new section on Study Limitations (see comment 5 to reviewer 1 above)

Once again, we would like to thank the two reviewers for their constructive comments and suggestions.

Helle Samuelsen

30. August, 2012