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WORDCOUNT: 5000

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https://www.rti.org/impact/luzonhealth-maternal-neonatal-child-health-nutrition-family-planning

Abstract

Background

The Philippines is home to a comparatively high percentage of stunted children. Little research is available on child health checks in the Philippines. The importance of such a service is outlined by the WHO. An NGO in the Philippines provides health checks for 'looked after' children and this study explores the health check experience and its effectiveness in identification of, and response to, malnutrition.

Methods

Purposive and convenience sampling was used to recruit nineteen participants, who took part in observations and interviews. These were audio recorded and then transcribed. Transcriptions were thematically analysed.

Findings

The majority of children showed both positive and negative emotions during a check. Reasons for negative emotions include fear, originating from a lack of understanding of the health check. Previous bad healthcare experiences contributed to a lack of understanding.

The proforma's height/weight prompts are effective in identifying malnutrition. Health professionals discussed difficulty in interpreting growth charts in the local context. Visual inspection and diet-related questions are not prompted by the proforma.

Knowledge of malnutrition was limited. Senior staff displayed superior knowledge. Responses included using a doctor and diet change. Disparity in knowledge exists within the staff hierarchy and between children's homes. Training in malnutrition was positively discussed.

Discussion

Previous healthcare experience predicts future healthcare behaviour, this can be moderated by patient optimism. It is important to improve child experience in future health checks to minimise negative impact on future healthcare use.

The importance of the use of growth charts, diet-related discussion, visual inspection and foot oedema is outlined in the literature. The latter three are not included in the proforma and their addition is recommended.

Inconsistencies between participants confirms the need for training to standardise malnutrition knowledge. An understanding of appropriate response is particularly necessary as barriers are in place preventing access to healthcare.

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Glossary

Malnutrition: Malnutrition is the condition that develops when the body does not get the right amount of the vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function (1)

Stunting: A consequence of severe and long-lasting malnutrition in which a child fails to achieve the expected height for his or her age (2)

Tagalog: The Austronesian language of the Tagalogs, with over 17 million speakers. Its vocabulary has been much influenced by Spanish and English, and to some extent by Chinese and Arabic, and it is the basis of a standardized national language of the Philippines (Filipino) (3)

Underweight: Weighing less than is normal, healthy, or required (4)

Wasting: Denoting a disease characterized by emaciation (5)

Abbreviations

HCP: Healthy Child Programme

HIC: High Incomes country

HPx= Health professional x (x= a, b or c)

IMCI: Integrated Management of Childhood Illness

Integritas: Integritas Healthcare

LMIC: Low and middle-income country

NGO: Non-governmental organisation

CHM: The care home manager

POCM: Philippines Outreach Centre Ministries

SIQCCYA: Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities

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Working in a pair

All data was collected together and shared, however only data on health check experience and participant demographics will be the same. We had separate focuses; malnutrition and infectious disease and this will differentiate our projects. Shared data should therefore be seen only under the first objective and in participant demographics, as all our participants were the same.

We attended all observations and interviews together. In observation stages we both recorded child experience related observations, and for both focuses. For each participant we completed an observation guide each and then we merged the results into a single completed observation guide, which was appropriately split into our respective foci for independent data analysis. We alternated who was lead interviewer but would individually ask questions related to our own focus regardless of this. Whoever was not asking questions would scribe. Transcriptions were split evenly between both researchers, doing half of the interviews each. We both coded the first three completed observations guides and first three transcripts independently before discussing potential frameworks. We repeated this for two more observations and interviews before agreeing on a final coding framework for all data. We then split the rest of the completed observation guides and transcripts between us and coded them independently, whilst coming together to discuss any further potential emerging codes before adding them to the framework. Data analysis was undertaken independently, even for the shared data on heath check experience.

It is worth noting that we both found that we had too much data and independently decided what to cut from the report. This may have resulted in further differences in data not explained by this paragraph that we could not predict.

Research partner student number: 201178113

Acknowledgements

I would first like to thank my research partner for their support and constant positivity throughout the research process!

I would also like to thank my supervisor, Helen, for her continued support and enthusiasm from project design through to the final write up and the many emails full of questions in-between.

Thank you to my host, Rachael Pickering. Her help and support during the data collection, data analysis and more was invaluable. She provided myself and the researcher team with home away from home for us, whilst we were working in an otherwise very unfamiliar environment.

Thank you to all of the participants, firstly for kindly and willingly agreeing to take part in the research. This thank you extends to everyone at Integritas and POCM for making myself and the other researchers feel so welcome in the time we spent there.

1. Introduction

1.1 The Philippines and Child Health

The Philippines is a country located in the WHO Western Pacific region with a population of 103 million (6), most of whom live on eleven of the country's 7000 islands (7). The life expectancy at birth is 73 years for women (6). Comparatively, this figure is 83 years in the UK (8). The under-five mortality rate in the Philippines was 27 per 1000 live births in 2016, the same as the UK in 1960 (now four per 1000 live births) (9). This outlines the stark difference in child health between the Philippines and high-Income countries (HIC).

1.2 Malnutrition and The Philippines

Malnutrition is the incorrect intake of energy and/or nutrients in a person's diet (10). It can be in the form of wasting, stunting, being underweight, vitamin and mineral deficiencies, being overweight and/or being obese (11). Undernutrition, particularly in children, increases susceptibility to disease and death (11). Malnutrition, and more specifically undernutrition is prevalent in the Philippines. The Philippines suffered a major economic crisis between 1983 and 1985; this resulted in an increase in the prevalence of underweight school children, against the previous downward trend (12). In 2013, 30.3% of children aged 0-5 were stunted (13). In comparison, rates in neighbouring countries Vietnam and Thailand are lower at 24.6% (2015) and 10.5% (2015-16) of children aged 0-5 respectively (13). Stunting is a well-known indicator of malnutrition (14), and thus it is clear that malnutrition in children is a prominent issue in the Philippines.

1.3 Child Health Checks

Very little research is available on child health checks in the Philippines. The WHO's Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities (SIQCCYA) recommends that every child should be routinely checked for pain or symptoms of distress and receive any appropriate management (15). It also suggests that effective health checks should focus on both provision, and experience of, care (Figure 1) (15). Low-quality care can lead to disability and death as a result of avoidable causes (16). It

is therefore important to evaluate, reflect on, and appropriately adapt current child health care check practice.

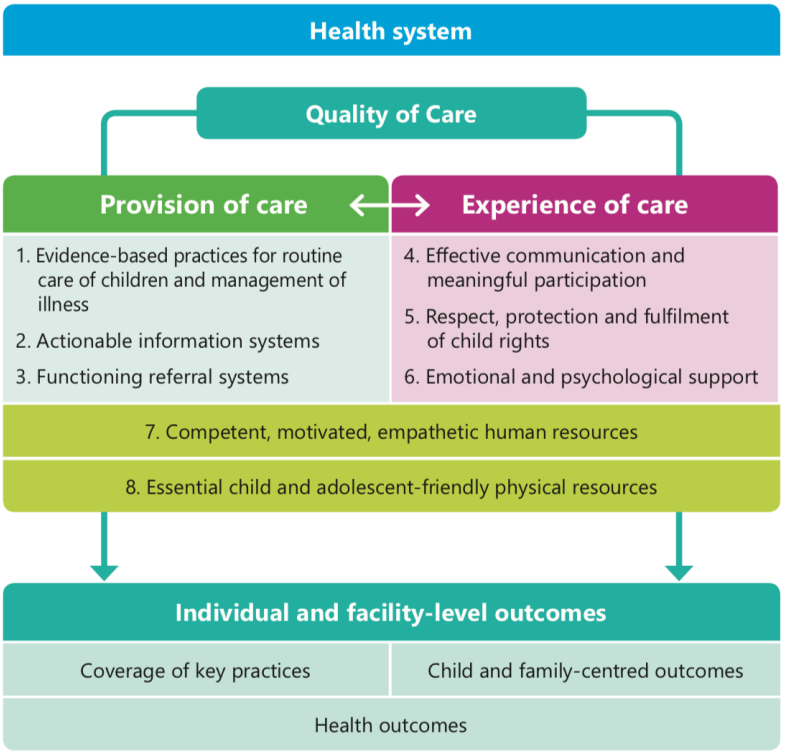


Figure 1: The WHO's Framework for improving the quality of paediatric care. Obtained from (15).

1.4 Integritas Healthcare

Integritas Healthcare (Integritas) is a British non-governmental organisation (NGO) which primarily provides healthcare to prisoners in the Philippines through a partnership with Philippines Outreach Centre Ministries (POCM), a local NGO based in Subic (Figure 2). POCM also houses children of prisoners in two homes. The children receive minimal free healthcare. As a result, Integritas also provides a free annual health check for these children. The service has been running for three years and is yet to be evaluated.

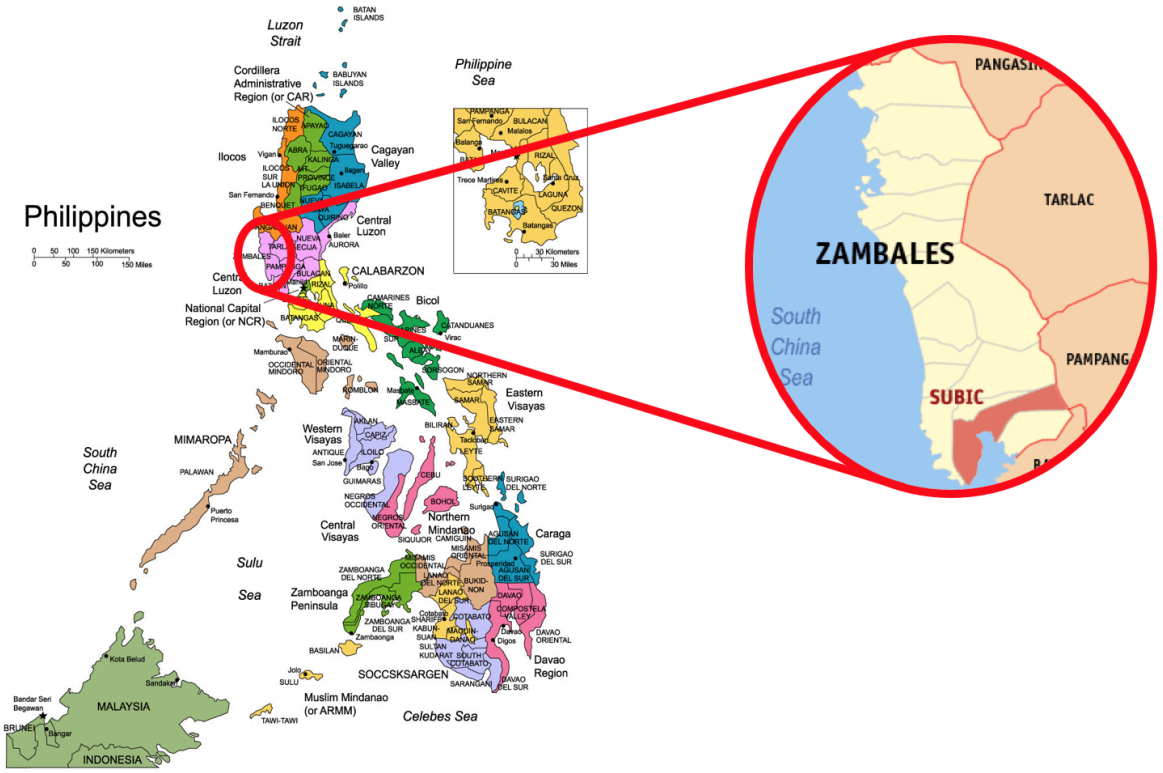


Figure 2: A map showing the study location (17,18).

2. Aim and Objectives

2.1 Aim

To assess child health checks in two children's home in The Philippines, in terms of child experience, identification of malnutrition and the response of the care home staff to its diagnosis.

2.2 Objectives

- To understand the child's emotional experience in the health check from the child's, carer's and heath professional's point of view
- To analyse the perceived effectiveness of the health check proforma in identifying malnutrition
- To investigate the knowledge of, and response to, malnutrition at both the carer and management level

- To make recommendations to improve the health check in terms of child experience and identification of, and response to, malnutrition

3. Methods

3.1 Study Design

A qualitative approach was taken in order to obtain comprehensive, in-depth data. This choice of method allowed the researcher to understand 'how' current practice is conducted and 'why' (19). The study design incorporated observation and interviews. Observation immersed the researcher in the health check experience, allowing an understanding of the 'how'. Interviews encouraged participants to share their thoughts and opinions freely in a confidential environment, helping the researcher develop an understanding of the 'why'.

3.2 Sampling

Convenience sampling was used for the observation stage. Ongoing health checks of 5 boys and 5 girls, each with their respective carer, were observed.

Purposive sampling was used to select 'information rich' interview participants, all of whom have experience with the health check (20). One health professional, the medical director of Integritas, was asked an additional set of questions to gain a better understanding of the health check process.

Inclusion criteria:

- Children aged 0-18 years
- Children of the care home
- Employees of the care home of at least one year
- Employees who have attended a health check
- Health professionals working with Integritas

3.3 Data Collection

The ten health check observations and nine private interviews were conducted in May and June 2018. All health checks and interviews were undertaken at Integritas House, the NGO's base, or the care homes, both at most a five-minute walk from all participant's daytime location.

All Integritas health checks are conducted in English, with interpreters. Therefore, interpreters were already present for observations. Three interview participants required interpreters. Participants were familiar with the interpreters, who were trained by Integritas in UK standard medical interpretation techniques and confidentiality. The same interpreters translated (and back translated) the information sheet and consent form into Tagalog, allowing them to become familiar with the research. A research colleague was present in all but one interview.

Observation and question guides (appendix 1 and 2) were used to ensure relevant information was captured. Key focus areas were:

- Emotional experience in the health check, the importance of which is outlined by the WHO (15) (observation guide).
- Health professional views on proforma (appendix 3) (observation guide).
- Knowledge of, and response to malnutrition (question guide).

The interviews were 30 to 60 minutes in length and adopted a semi-structured nature.

Participants were briefed in a group talk at least 24 hours before participation (with some exceptions; see section 3.5). All participants were given time alone to consider the information sheet and consent form (appendix 4 and 5). Carers consented on behalf of children. Participant demographics are summarised in tables 1 and 2.

	Age group (years)	Sex	Type of health check	Duration of time at NGO (years)
Child 1	6-10	Male	Annual	>5-10
Child 2	11-15	Male	Annual	>5-10
Child 3	11-15	Male	First check	<1
Child 4	11-15	Male	Annual	>10
Child 5	11-15	Male	First check	>10
Child 6	11-15	Female	Annual	>5-10
Child 7	6-10	Female	Annual	>1-5
Child 8	6-10	Female	Annual	>1-5
Child 9	16-20	Female	Annual	>10
Child 10	11-15	Male	Annual	>10

Table 1: Participant demographics: children

	Age group (years)	Sex	Occupation	Duration of time at NGO (years)
Carer A	46-50	Female	Boys Houseparent	>1-5
Carer B	31-35	Female	Girls Houseparent	>1-5
Carer C	31-35	Female	Girls Houseparent	>1-5
Carer D	36-40	Female	Boys Head-houseparent	>1-5
Carer E	26-30	Female	Girls Head-houseparent	>10
Care-home Manager (CHM)	26-30	Female	Care home manager	>10
Health Professional a (HPa)	46-50	Female	Medical Director	>5-10
Health Professional b (HPb)	21-25	Female	Junior Doctor	<1
Health Professional c (HPc)	21-25	Male	Medical student	<1

Table 2: Participant demographics: staff members

3.4 Data Analysis

The audio was transcribed naturalistically and manually, allowing participants' accounts to be accurately represented and the researchers to familiarise themselves with the data (21). Thematic analysis was used, selected due to its flexibility and ability to provide in-depth interpretation of data (22). A-priori codes were selected based on themes laid out within the observation and question guides. The first observations and transcripts were read through with a-priori codes in mind. They were then reread, individually by each researcher, and annotated with a-priori and potential emerging codes (appendix 6). Both researchers discussed emerging codes and created a thematic framework (appendix 7), utilising the advantages of investigator triangulation. All further coding was conducted on NVIVO, a qualitative analysis software (23). Researchers discussed further emerging codes and added them, as appropriate, to the framework. Transcripts were referred to continuously to preserve an understanding of the 'bigger picture'.

3.5 Limitations

The Philippines is home to a 'hot climate' culture, where people and relationships take priority over efficiency and time (24). Consequently, the translation of research documentation was not completed prior to the researcher's arrival, as was planned. This delayed the start of the research by one week. As a result, participants attending the first health check clinic were given at least 3 hours to consent, not the planned 24 hours. However, these participants still had time alone to consider the information and ask questions. The researcher also stressed that non-participation had no negative consequences.

Convenience sampling was used to maximise participant numbers in the limited time available. This may not give an accurate representation of those attending health checks, as random stratified sampling would, for example (25,26). However, the impact of this is minimised as in effect Integritas select children for checks randomly: the only criteria used is the child's birth month.

The researchers were inexperienced in qualitative research. This resulted in some leading questions being asked in interviews. This unintended deductive element may have restricted

the number of emergent themes appearing, resulting in potential researcher bias in the data analysis process (27).

4. Findings

4.1. The health check experience

4.1.1 Engagement and Emotion

Eight out of ten children showed signs of Engagement (e.g. '*makes jokes*', '*leaning forward*' and '*good eye contact*') at some stage of the check.

Seven out of ten children showed signs of disengagement (e.g. '*quiet', 'silent' or 'little speech')* at some stage.

Children 5 and 8 showed only signs of disengagement (e.g. '*looking down during conversation*')

Nine of ten children displayed positive emotions (e.g. '*smiling*', '*happy*' and '*excited*').
However, nine of the children also displayed negative emotions (e.g. '*shy*' and '*nervous*'). Overall, five children showed more positivity than negativity and two showed more negativity than positivity. See Table 3.

During the interviews, Carer E and HPb commented children's excitement about the checks, explaining the positive engagement and positive emotions recorded:

> *"when you said I am going to bring you to the doctor. They said "yeah!""* - Carer E
>
> *"We'll get a whole continuum of children who are excited to go and get* [echocardiograms]*"*- HPb

HPb, HPc and CHM discussed the impact of the health professional's behaviour and approach on child emotions.

> *"I've definitely found kind of anecdotally that playing a game a little at the beginning seems to make the children more relaxed and open"*- HPb.

Two carers also commented on the positive impact of good communication, patience and kindness on the child's emotions.

Child	Positive	Negative	Overall (Positive – Negative)
1	1	4	-3
2	7	2	5
3	4	4	0
4	2	2	0
5	0	4	-4
6	3	2	1
7	1	0	1
8	1	2	-1
9	2	1	1
10	2	1	1

Table 3: Number of positive and negative emotions observed in each child

These mixed results may be explained by a change in the emotional state of the child during the health check. Examples include child 1, 6 and 8 becoming increasingly relaxed throughout the check and child 6 and 7 improving eye contact. This reasoning was reinforced by the carers B and C in interview.

> *"before the check-up they are kind of frightened because they don't know what are they going to do in the check-up. But after, one of the things they experience, they are not afraid anymore"*- Carer B

This suggests that as the child's understanding of the health check develops, their experience becomes increasingly positive.

Conversely children 3, 4 and 5 became '*sad*' and '*quiet*' when sensitive issues arose. Carer C and E, and HPb and HPc also discussed the link between negative emotion, engagement and sensitive topics.

"There's a huge amount of depression and anxiety etc etc. And I think we've found it difficult at first to kind of broach those subjects because Filipino culture is not very open about those"- HPc

Another explanation for the negative emotions observed is fear of health checks. Carer E suggested a link between fear and age of the child: an older child is more likely to have had previous negative healthcare experiences, which may fuel preconceptions about the health check. The link between understanding of, and fear for, the check will be discussed in section 4.1.3.

4.1.2 Understanding of health check importance

Four of the five carers interviewed felt that the children understood that the checks were related to health, but that the depth of understanding varied, as summarised by Carer C:

"I think some of them understand it a lot… but the other ones they have a health check it's because of routine… and then sometimes they do it because it's 'mama said you go to the doctor'. So that's why mixed emotions."

4.1.3 Understanding of health check content

Three carers and HPb stated that the children were fearful of health checks, and a possible reason for this is a poor understanding of what a health check involves.

"Some of them might be scared, or don't know what we're doing, or we're going to cause them pain or something"- HPb

One child manufactured new symptoms to distract the doctor from her toothache, due to the belief that intervention would cause further pain to her teeth.

"I think she was afraid to tell the doctor so she invent another ache"- Carer C

A previous bad experience in a healthcare setting may explain a child's fear of the health check.

They probably bring preconceptions about what's going to happen. So, you know there's no way we're torturing anybody by pulling out their teeth without anaesthetic but if that's been their experience in the past then of course they're going to be scared about coming to see us"- HPa.

Two carers also suggested that the language barrier hindered understanding, indicating that children would have a better understanding of a Tagalog consultation, despite the presence of interpreters.

Four participants reported age as a factor that influences understanding of both health check importance and content. However, no patterns were seen between observed child's age and their displayed emotions.

4.2 Proforma effectiveness in identifying malnutrition

4.2.1 Height and weight

All three health professionals agreed that the height/weight measurements and growth charts can be used to indicate malnutrition. HPa and HPc discussed the effectiveness of the growth chart in monitoring child growth relative to the chart's norms.

However, the health professionals expressed concern about interpreting the growth charts in a low and middle-income country (LMIC) context:

> *"I don't feel completely comfortable that I know what in this setting what level of weight drop off you'd be concerned about"*- HPb

This is particularly relevant as many of the health professionals are volunteers with little experience working in a low-income setting. Only the two health professionals on short term placements, HPb and HPc, spoke of confusion in interpreting growth charts in this way.

HPc also suggested a prompt for a visual inspection of a child for weight loss.

4.2.2 Diet

Whilst discussing the lack of diet related questions on the proforma, HPc said:

> *"Well this is the issue with not having the proforma, if you're not reminded you don't always do it"*

There was a reliance on the individual health professional to remember to ask about diet.

"A proforma is only as good as the clinician who uses it"- HPa.

HPa implied that a proforma cannot cover everything and relies on high quality staff. She stated that Integritas take great care in recruiting high quality health professionals to minimise this issue. HPa also suggested that diet is best dealt with in the care home as a whole rather than with individual children, as indicated by previous research and education.

4.3 Care home staff knowledge of, and response to, malnutrition

4.3.1 Knowledge

Carer knowledge of malnutrition was generally poor. All carers and CHM linked malnutrition with a child being thin and a child's diet. However, only one carer understood that malnutrition could also result in being overweight. This may be explained by the local setting: no overweight children were observed, and HPc stated that he saw no overweight children in all his health check clinics.

Only one carer and CHM discussed the importance of weight in context of age

"when you see a child it's very thin and then their weight is not great with their age"- Carer C.

Furthermore, only CHM knew malnutrition was linked with child height. Three carers and CHM agreed that malnutrition was rare in the children's homes, despite all but one of them recognising that it is a common issue in the Philippines. The researcher was unable to gain an understanding of malnutrition prevalence in the children's homes, due lack of protocol/appropriate growth charts for classifying undernutrition, as disused previously.

CHM was most knowledgeable about malnutrition. This was expected as she is the most senior care home staff member. Carers' knowledge was mixed, and so it appears they have received no formal training in malnutrition.

4.3.2 Response

Table 4 details staff's first response to malnutrition when identified. Carers' reliance on doctors may stem from a lack of confidence in their knowledge to act at home, as CHM outlines:

"I would not put to risk just because of personal knowledge…I would prefer to go to a professional to find out the best thing, vitamins, food supplements that the child needs at the time"

Participant	First action
Carer A	Take to doctor
Carer B	Ensure child is eating and consider doctor
Carer C	Report to senior (which she believed would result in the child being taken to the doctor)
Carer D	First action not clear
Carer E	Take to doctor and buy vitamins
CHM	Take to doctor

Table 4: Participant's first response to a child being identified by malnutrition

In terms of independent action at home, four of five carers and CHM said they would like to change the diet of the child. The head-houseparents (Carer D and E) provided further information which included monitoring the eating, vitamins supplements, regular checking of height and weight and buying medicines. CHM suggested the additional intervention of management of worms and malnutrition via collaboration with another NGO. All care home staff would consider taking the child to a doctor. Only Carer B did not consider using Integritas' services, and only Carer C did not discuss using a local health service. Where Integritas was considered, it was always prioritised over using a local doctor.

Three carers and CHM raised an issue with changing the diet of an individual child within the care home.

"Every child is fed the same, so we would have to change it for everyone else"- CHM

"I think it comes down to the mentality that this is a children's home, you can't show favouritism of one child over another. And a big part of what we're trying to do is to get them to see that… treating a child differently is not favouritism, it is actually necessary"- HPa

HPa suggests that Filipino culture is limiting carer response to a malnourished child, providing a far greater challenge than simply improving carer knowledge. Examples of changing every child's diet include increasing vegetable content (by Integritas' recommendation) and changes in response to food allergies.

A further issue is the carers lack of understanding of the importance of long term intervention in chronic disease.

> *"If I said, "that child needs more chicken", yeah, they'll give that child more chicken for one day."*- HPa

Carers A and B, the least qualified, had less depth of knowledge; they relied on senior advice rather than acting independently:

> *"So if she/he just came from the check-up I am sure that the doctor will say what her condition is and also give remedies about the condition, and that I will do"*- Carer B

More senior staff members, such as CHM, expressed greater knowledge and confidence to act independently. All care home staff expressed delight at the idea of training.

CHM specified that carers in the boys' house were generally older and had received less education. As a result, they tended to practise traditional healthcare. In comparison, the carers knowledge was greater in the girls' house; the carers were younger with more up to date knowledge and the head house parent was a graduate in care giving. Paradoxically, the only mention of a traditional remedy was by a carer working at the girls' house.

4.3.3 Barriers to accessing healthcare

HPa considered money to be a barrier to accessing healthcare; suggesting that only severely ill children were taken to local doctors. However, Carer C and D indicated that POCM has a budget for doctors' visits, accessible during normal office hours, suggesting money was only a barrier at night. Furthermore, four carers indicated that they would take a malnourished child to a local doctor if Integritas were not present. It is not clear whether the carers are unaware of the financial constraints or if HPa is misinformed. However, given HPa's senior position and involvement with POCM, the latter is unlikely.

Another factor preventing access to healthcare is lack of awareness of the seriousness of malnutrition.

> *"Oh is it really needed to go to the doctor, maybe just need food"*- Carer E (quoting a carer).

4.3.4 Malnutrition training

Whilst no carers had received training on malnutrition, Carer D spoke of 'papers' given to the care homes by Integritas encouraging home cooked meals. All carers expressed interest in learning more about malnutrition, both how to identify it and remedial action to be taken. All said this would be best achieved by a training day. It was made clear that carers had received previous training from Integritas on CPR and valued it highly.

> *"Actual training would help, it will help also if we can define malnourished, so we can do check-ups also"*- Carer B.

Whilst HPa stated that carers did not have the knowledge or experience to use growth and weight charts, she did suggest that it would be both valuable and achievable to train carers to use other methods to recognise when a malnourished child needs medical attention.

5. Discussion

5.1 Child experience

The findings in this study suggest a link between previous health care experience and emotional response to the health check. This is in line with previous studies that show prior healthcare experience predicts future healthcare behaviour (28).

A further study found that the impact of negative healthcare experience on future healthcare is less in children with high levels of optimism, increasing the likelihood of them accessing healthcare when appropriate (29). In this study, the health professionals discussed the prevalence of psychological disorders in the children, including depression (suggesting low levels of optimism (30)).

This makes it particularly important that remedial action is taken to improve child experience in future health checks, especially in the case of those who are depressed, dealing with sensitive issues or have had previous negative healthcare experiences. This should include appropriate, child specific emotional support, the importance of which is outlined by WHO (15).

5.2 Proforma

The UK Healthy Child Programme (HCP), a government framework that promotes child health, is an example of a 'gold standard' health policy (31). Healthy lifestyle, which includes diet, is listed as a priority topic (31). This emphasises the importance of diet in child health and enforces the opinion of participants in this study that the proforma should incorporate diet.

The growth chart element of the proforma proved necessary in identifying malnutrition. WHO growth charts are specifically outlined in the HCP as a crucial tool to recognise malnutrition (31). The proforma's inclusion of these is therefore appropriate. However, interpretation of growth charts, and further identification elements such as diet-related questions appeared to be health professional dependent, resulting in possible health check inconsistencies.

The WHO's Integrated Management of Childhood Illness (IMCI) lays out a universal standard to assess and classify a sick child (32). The chapter on malnutrition and anaemia is summarised in Figure 3. HPc discussed the lack of a visual inspection prompt, and the importance of this is confirmed here with 'look for visible severe wasting'. None of the HPs discussed foot oedema as an indicator of malnutrition, nor did they reference it in the proforma.

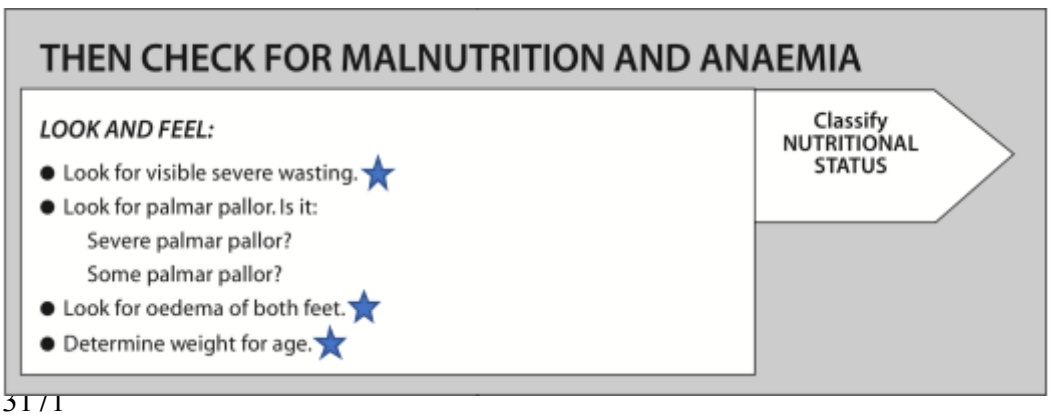


Figure 3: An extract of WHO's IMCI handbook showing key symptoms to check for malnutrition (starred) and anaemia. Adapted from (32).

5.3 Malnutrition knowledge and response

More senior POCM staff had better knowledge of malnutrition. However, no participants exhibited an awareness of the complete range of malnutrition symptoms. Accessing a doctor is an appropriate action when managing malnutrition because it is complex and may be an indicator of underlying disease (33). However, a doctor may not always be accessible, due to barriers discussed and consequently it is important that carers have a base knowledge on common conditions, enabling them to act appropriately at home. Furthermore, the WHO's SIQCCYA states staff should be competent in providing routine care of childhood illness (15).

Staff knowledge of malnutrition varied within and between care homes, as did actions taken in response to diagnosis of malnutrition. Previous research carried out at POCM found that children's knowledge was also limited (34). Staff training has proven popular in the past and is a practical solution to standardise knowledge of, and response to, malnutrition at POCM. Training should stress diet change as an essential treatment for malnutrition, helping to overcome the resistance to change an individual child's diet.

5.4 Limitations

The qualitative nature of this paper limited the investigation of the proforma to perceived, rather than actual, effectiveness. A mixed methods study would assess the actual effectiveness of the proforma in identifying nutrition, whilst retaining the 'how' and 'why' elements of this study.

The participants may have refrained from giving truthful answers about negative aspects of child health check experience, due to a fear that this would offend seniors at Integritas and the researchers. Similarly, participants may also have over-reported their actions to be taken in response to malnutrition identification. This limitation may be exacerbated by the 'hot climate' focus on maintaining relationships (24).

The small number of participants and qualitative nature of this study restricted some elements of analysis. For example, the significance of only a girls' home carer using traditional remedies, contrary to CHM's remarks, could not be determined.

5.5 Conclusion

Child experience varied, but the majority of children exhibited negative emotions in at least one stage of the health check. Consideration should be given to how health professionals conduct health checks, with the aim of improving child experience. The importance of an intervention to counteract past negative experiences has been highlighted to increase the likelihood of a child using healthcare services positively in the future.

The proforma's use of growth charts is appropriate, however a lack of important prompts limit its effectiveness in identifying malnutrition.

Staff knowledge of, and response to, malnutrition was varied, and generally limited. The importance of effective routine care is highlighted. Training will improve knowledge, in turn enhancing care.

6. Recommendations

- Provide a dedicated annual mental health clinic for children affected by psychiatric disease by January 2020. As discussed, this should help to moderate current negative healthcare behaviour in the future.
- Immediately adapt the proforma in order to improve identification of malnutrition by the addition of diet-related questions and prompts for key symptoms such as severe wasting and ankle oedema. Training in interpretation of growth charts in the local context should be provided for less experienced health professionals.
- Provide a day training programme on malnutrition for carers, by January 2020. This should consist of key symptoms for identification, when to contact a doctor and treatment that can be given at home. Emphasis should be given on the importance of individual and tailored diets for malnourished children.
- From January 2019 run quarterly self-facilitated workshops for health professionals to identify behaviours to be used to ensure the child is put at ease during the check,

with an aim to give children a positive health check experience, in turn improving their future healthcare behaviours.

7. Reflection

Planning

The prospect of international research was exciting, yet daunting! The first challenge was ethical approval. This required an in-depth project design to be produced in a limited time. Once completed, however, I felt both more prepared and confident. In the future I will ensure that I have more time, allowing for more relaxed and in-depth research in the early preparation stage (as this time the process felt slightly rushed).

A lot was unknown about the logistics of the fieldwork, and consequently we had to put a huge amount of trust into the information our host provided. Initially this was difficult to do, however the host's skillset and knowledge proved invaluable. Next time I will be more trusting from the outset.

Fieldwork

My first time both carrying out primary research and working in a LMIC certainly provided a challenge. I am glad that we allowed time to relax and adapt to the 'hot climate' before starting research. Our host's advice of 'go with the flow' proved helpful from the start, as we arrived to find our documents had not been translated. As we adapted to the local mindset, work became easier. My host and research partner provided feedback throughout the fieldwork, allowing me to constantly adapt the way I worked. I look forward to applying what I learnt to my next research project.

Write up

Having completed 'Project A', a 5000-word report seemed manageable. However, once the fieldwork was completed, representing the vast and in-depth information collected in a report seemed impossible. As I began to write up my findings, I found myself with too much data. Deciding what data to remove was difficult, but it seemed appropriate to focus on carers and children, rather than the more predictable opinions of western-trained health

professionals. In the future I aim to improve my plan in order to collect an appropriate amount of data.

I enjoyed using primary data. I felt that I had a greater understanding of what I was writing, and I hope that has been reflected in the report. This is the most comprehensive piece of work I have completed; it's something I am immensely proud of. The whole experience was incredible, and I look forward to my next research adventure.

Word Count

Word count: 5000

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9. Appendix

Appendix 1: Observation guide

Area of Observation	Research issue					
	Child		Carer		Health Professional	
	Welcome	During check	Welcome	During check	Welcome	During check
Interaction (between whom, how much, at what points, changes)	Closing		Closing		Closing	
Communication (eye contact, non-verbal signs, checking understanding)	Closing		Closing		Closing	
Expressed emotions (facial expressions, body language, general character e.g. shy)	Closing		Closing		Closing	
Completed elements of pro-forma (by health professional). Relating to malnutrition/ infectious diseases specifically.	Infectious disease:			Malnutrition:		
Other (not predicted elements deemed significant)						
Our overall reflections						

Appendix 2: Question guide (questions altered slightly for different participants, for example health professionals were asked about proforma content)

Question guide- Carers

Age:
Sex:
Length at time at centre:
What is your role at POC?

Health check experience

Anonymous and confidential. Please don't be afraid to answer truthfully! If you don't want to answer any question, that is okay.

How are you?
How has your day been? What have you been up to?
Have you experienced a child health check before?

Participant experience
Describe your experience in health checks to us.
How did you feel during the health check? (emotions, comfort etc.)
How do the children feel before the health check? During? After? (probe behaviour)
How does this compare to how the child behaves/feels normally?
What are the children's understanding of what the health check is and why they are having it?
If you could suggest any changes to the health check, what would they be? (emphasise confidentiality).

Communication skills
How effectively did the health professional communicate with the child? How/ why?
How well did they communicate with you? How/why?
How well did you understand the consultation?
What could the health professional have done better?

Response to Health check
Are you aware of any signs and symptoms were indicators for malnutrition?
Are you aware of any signs and symptoms were indicators for diarrhoea and pneumonia?
What would your next steps be if malnutrition is identified?
What would your next steps be if diarrhoea or pneumonia are identified?
Are you aware of any policies/ support or advice for childcare when illness if identified? (POC? Integritas? Training?)
Do you think you would benefit from something like this? Why?

Appendix 3: Health check proforma

Confidential: Child Health Surveillance

Integritas
values driven healthcare

Surname		**First Name(s)**	
Date of birth dd-Mon-yy	**Age** years	**Integritas number**	**Sex** male / female
Current location Philippines Outreach Centre Children's Homes (POCCH)		**Address** c/o POCCH	
Date & time dd-Mon-yy & hh:mm			

Presenting Complaint Child health surveillance (CHS) +/-
History of Presenting Complaint
Past Medical History
Developmental History Pregnancy: Birth: Neonatal period: Wears glasses? no / yes (details) Hearing impaired? no / yes (details) Normal milestones: Delayed milestones:

Confidential: Child Health Surveillance

Integritas
values driven healthcare

Integritas No.	Surname	Initial(s)

Pubertal History

Concerns: no / yes (details)

Menarche: no / yes @ _____ age LMP: Menstrual cycle: regular/irregular

Psychiatric History

Drug History	**Vaccination History**
Allergies: NKDA / Not known / Yes (details)	

Family History

Social History

Parent(s) still involved: no / yes (details)

Why came to POCCH:

When came to POCCH:

Safeguarding history: no / yes (details)

Other details:

General observations	**Growth**
J / A / C / Cy / O / L	Weight kg
Temp °C	Length (< 2 years) / Height cm
GCS Orientated T / P / P	Body Mass Index (BMI) kg/m^2
	Head Circumference (HC) cm
	Mid Upper Arm Circumference (MUAC) cm (<5 yrs +/-, if malnutrition concerns, >5 yrs)

Integritas No.	Surname	Initial(s)
Mental State Examination		
Neurological – central nervous system (except II)	**Neurological – peripheral nervous system**	
Ophthalmological Right Left Visual acuity Visual fields Fundi Globe  	**Otolaryngeal**	
Dermatological	**Endocrinological**	
Cardiovascular HR BP HS	**Respiratory** RR O_2 sats	
Breasts Tanner stage	**Abdominal**	

Confidential: Child Health Surveillance

Integritas
values driven healthcare

Integritas No.	Surname	Initial(s)
Developmental – non-genital		
Genital – developmental Pubic hair Tanner stage:	**Genital – medical & safeguarding**	
Musculoskeletal		
Investigations		
Impression		
Management Plan *Signature* *Title Initial Surname* *Position* **Continued overleaf?** Yes / No		

Appendix 4: Example information sheet

UNIVERSITY OF LEEDS

The experience of the child health check and its effectiveness at identifying childhood illness and malnutrition in the Philippines

Researcher names

Our names are xxx and xxx and we are carrying out research about the experience of the child health checks and its effectiveness at identifying malnutrition and childhood diarrhoea and pneumonia. This is part of our university studies. This study has been approved by the Ethics Committee of the University of Leeds and you are being invited to take part in the research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish to take part.

Background

This study was proposed because child health checks are important to monitor child health and development. The health checks at this clinic have been running for over 2 years, however there has not been any assessment on the running of the clinic or how patients such as yourself feel about the clinics and treatment of your children. This information could be very useful to improve the clinics for both your experience and the child's.

Why have you been chosen?

You have been chosen to take part in the research because as a carer of a primary user of the service, we think your experience will be very valuable to improving the service for yourself and other carers and children.

Do you have to take part in the study? What will you be asked to do in the study?

Your participation in this study is completely voluntary, it is your choice completely decide whether you would like to participate or not. If you agree, you will allow us to observe one of the child health check consultations. We will not interrupt, just observe in the background. We may then interview you within 2 weeks which should last no longer than an hour. In the interview we will talk about your experience in that consultation on topics such as communication, the child's experience and your response to any issues identified within the consultation. In case you feel very uncomfortable during or after the consultation, you can always leave this study without giving any reason and without there being any negative consequences. In order to do so, please contact one of us or a doctor from the medical team, such as Dr. Pickering.

Who will be present during the observations and interviews?

This observation will involve either Jordanna or Charlie (or both) sitting in the room. There will be no interpreter present in the observation stage. In the interview, either Jordanna or Charlie will be present alongside an interpreter. The interpreter will help to translate your answers into English. Both the observation and the interview will be recorded. This won't be

heard by anyone else than the researcher and interpreter. All the information you provide will be anonymous, that means your name won't appear in any report derived from the study. Please be aware that that this research does not assess your individual ability as a carer because the research focus is on the overall operation of the health check.

What are the risks of being involved in the study?

This research does not pose a risk to your health, but it will involve us observing and questioning you about the consultation between yourself, the child and health professional. If you do not feel like being observed or answering a question you may skip the question or stop your participation. If you feel unwell at any point during or after participation, do not hesitate to contact someone from the medical team.

What are the benefits of taking part in the study?

No payment will be received in return for your participation. However, the benefits are that this study will provide a space for you to voice any opinions or concerns you have about how the health check consultations currently operate. We hope the research may lead to improvements in the health check consultations, in turn benefitting yourself and the children.

What will happen to the research results?

Other carers, children and health professionals, like yourself, will participate in this study. The information you provide will be combined with that of the other participants and analysed in order to summarize your views and experience. A final report will be written, using this information, and may be published on a conference or journal paper. It is important to remember that your name will not appear in any part of this research, now or in the future.

What should you do next if you want to be involved in the study?

If you are interested in taking part in the study please contact xxx, xxx or Dr Pickering. We are happy to answer any further questions.

Thank you for taking the time to read this information sheet.

Appendix 5: Example consent forms (child consent form included to make clear how the carer gave consent on behalf of child)

Faculty of Medicine and Health, School of Medicine,
Leeds Institute for Health Sciences

UNIVERSITY OF LEEDS

Consent for **carers** to take part in a study investigating child health checks	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet/ letter dated _____ explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw my application up to 24 hours after data collection was conducted without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. If you choose to withdraw from the study your data will not be included in the research.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.	
I agree for data to be collected from me, which may be in the form of an audio recording. This is to be stored and used in relevant future research in an anonymised form.	
I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
*I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant	
Participant's signature	

Date	
Name of lead researcher	
Signature	
Date*	

*To be signed and dated in the presence of the participant.
Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

Faculty of Medicine and Health, School of Medicine,
Leeds Institute for Health Sciences

UNIVERSITY OF LEEDS

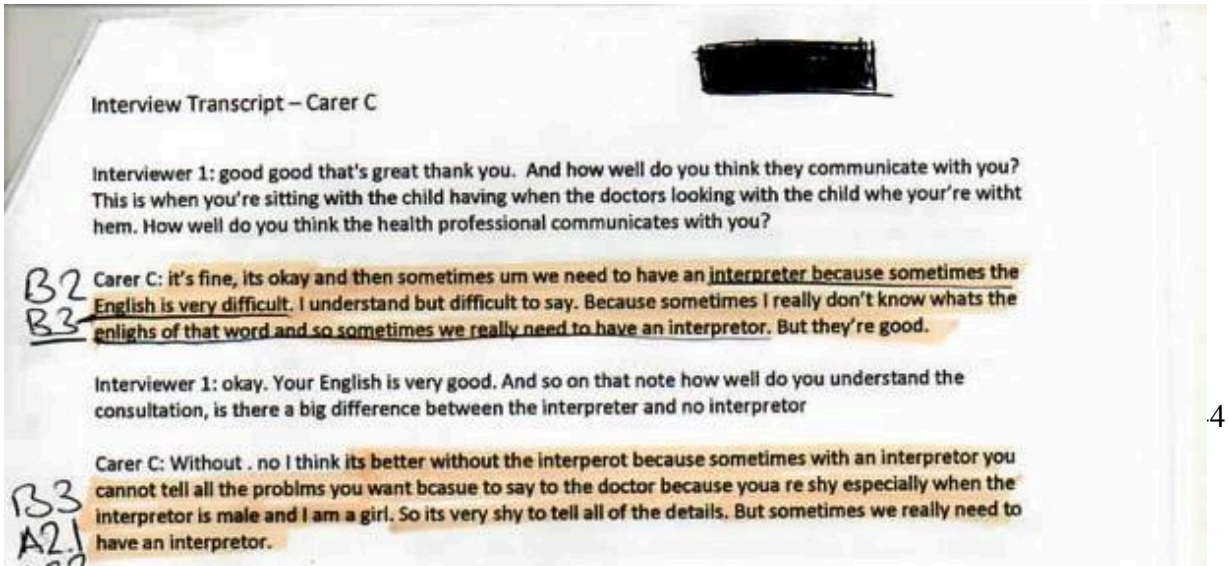
Consent for **children** to take part in a study investigating child health checks	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet/ letter dated _____ explaining the above research project and myself and the child in my care have had the opportunity to ask questions about the project.	
I understand that the child's/children's participation is voluntary and that they are free to withdraw their application up to 24 hours after data collection was conducted without giving any reason and without there being any negative consequences. If the child in your care chooses to withdraw from the study their data will not be included in the research.	
I give permission for members of the research team to have access to the child's/children's anonymised observation recordings. I understand that the child's name(s) will not be linked with the research materials, and they will not be identified or identifiable in the report or reports that result from the research. I understand that the child's responses will be kept strictly confidential.	
I agree for data to be collected from observing the child's health check, which may be in the form of an audio recording. This is to be stored and used in relevant future research in an anonymised form.	
I understand that other researchers may use observation data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the data collected during the study may be looked at by auditors from the University of Leeds where it is relevant to the child taking part in this research. I give permission for these individuals to have access to my records.	

*I agree for the _____ (child's name) take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant (child)	
Name of carer signing on behalf of the child	
Carer's signature	
Date	
Name of lead researcher	
Signature	
Date*	

*To be signed and dated in the presence of the participant.
Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

Appendix 6: Example of coding process



Interview Transcript – Carer C

Interviewer 1: good good that's great thank you. And how well do you think they communicate with you? This is when you're sitting with the child having when the doctors looking with the child whe your're witht hem. How well do you think the health professional communicates with you?

B2 B3 Carer C: it's fine, its okay and then sometimes um we need to have an interpreter because sometimes the English is very difficult. I understand but difficult to say. Because sometimes I really don't know whats the enlighs of that word and so sometimes we really need to have an interpretor. But they're good.

Interviewer 1: okay. Your English is very good. And so on that note how well do you understand the consultation, is there a big difference between the interpreter and no interpretor

B3 A2.1 Carer C: Without . no I think its better without the interperot because sometimes with an interpretor you cannot tell all the problms you want bcasue to say to the doctor because youa re shy especially when the interpretor is male and I am a girl. So its very shy to tell all of the details. But sometimes we really need to have an interpretor.

Appendix 7: Example of final coding framework



A priori codes are red, emerging codes are blue