University of Southampton

CHILD HEALTH CLINICS -

PARENTAL AND PROFESSIONAL VIEWS

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CONTENTS

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCES

SOCIAL WORK STUDIES

Master of Philosophy

CHILD HEALTH CLINICS - PARENTAL AND PROFESSIONAL VIEWS

by Pamela Gastrell

One-hundred families and their health visitors participated in a project designed to compare the expectations and satisfaction of mothers attending child health clinics, with health visitors' perceptions of what they thought clients wanted from clinics.

Postal questionnaires were sent to mothers of new babies to ascertain their previous experience with health visitors; their intentions of visiting a child health clinic and their expectations from such visits. Fifty of these respondents were subsequently interviewed after they had had the opportunity of attending a clinic. The health visitors with the highest number of clients participating in the study were also interviewed.

Results indicate that the majority of parents expected clinic staff to weigh their baby and to confirm that all was well. Clients' expectations coincided with what they actually received; weighing being the most frequently mentioned service. The health visitors also thought that parents expected their baby to be weighed and to be reassured of their own ability to cope.

A small discrepancy appeared between the clients' perceptions and those of the health visitors in so far as twenty-five (50%) expected clinics to provide the opportunity to meet and talk to other mothers; whereas all the health visitors thought that for most mothers this would be an important aspect of their visit to clinic.

A few clients expected more specific information as to the purpose of clinic, and guidance as to what is expected of them when they attend.

All of the health visitors stated that health education was an integral part of their work in clinic. Yet, this was not understood by the clients, only fourteen (28%) of whom reported receiving this service.

Suggestions for change made by both groups included flexible opening times, improved facilities - in particular the waiting area, toys and play place, and the need for privacy.

ACKNOWLEDGEMENTS

I would like to express my gratitude to the many people who have offered me encouragement and advice throughout this study. Particular thanks are extended to Mr. Bryan Glastonbury for his overall supervision and guidance; to Judith Brodie and Ray Barker post-graduate students (Department of Social Statistics) for computation and statistical advice and the Portsmouth and South East Hampshire Health Authority for permission to undertake the study. Also the health visitors and families who gave unstintingly of their time and expertise.

My thanks are also due to my colleagues, June Collis and Margaret Buttigieg whose continued interest helped to ensure the completion of the study; To Eileen Upward, who typed the first draft and Doreen Davies who made sense of the final draft, and lastly to Auriel for her patience and understanding.

CLARIFICATION OF TERMS

In the course of writing this study it has become clear that often people may use the same words, but their understanding of the meanings differ. Thus, there is a need to clarify the meaning which certain words have in the context of this study.

Glossary

Centre	-	The premises or building in which child health or other activities are carried out.
Clinic	-	The activity or sessions conducted in the centre.
Child health clinic	-	Child health clinic, infant health clinic, provided by the Health Authority
Well baby clinic	-	A term used to describe a well baby clinic held in a general practitioner surgery.

Client

Throughout this study the Oxford Dictionary definition has been used; "a person who employs the services of a professional or businessman/woman in any branch of business, or for whom the latter acts in his professional capacity; a customer."

Attachment

"A system which enables nurses, health visitors and midwives to work in partnership with doctors, providing medical services and preventive services to the population they serve defined not by a geographical district but by patients on the doctor's list." (DHSS 1969, On the State of the Public Health 1968, London, HMSO)

Primary Health Care Team

"An interdependent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service."
(DHSS The Primary Health Care Team, May 1980, London)

Perinatal Mortality Rate

Stillbirth and deaths of infants under one week of age per 1,000 live and stillbirths.

Infant Mortality Rate

Deaths of infants under one year of age per 1,000 live births.

Maternal Mortality Rate

The number of deaths registered during the year of women dying from causes attributed to pregnancy and childbearing, per 1,000 registered total (live and still) births, in the year.

Abbreviations

CHC	-	Child Health Clinic
CMO	-	Clinical Medical Officer
DHSS	-	Department of Health and Social Security
FPC	-	Family Practitioner Committee
GP	-	General Practitioner
HV	-	Health Visitor
HVA	-	Health Visitor Association
IMR	-	Infant Mortality Rate
NHS	-	National Health Service
MOH	-	Medical Officer of Health
RCN	-	Royal College of Nursing
RCOG	-	Royal College of Obstetricians and Gynaecologists
RCOGP	-	Royal College of General Practitioners

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INTRODUCTION

A review of the literature suggests that most of the preventive child health services in Britain developed in a piecemeal fashion, in response to pressure from social reformers, central and local government (Robinson 1982, Russell 1980, Baly 1980). Commenting on the early days of child welfare, Lewis (1980) p.311 identified a gap between official policy and the providers of health care who: "equated improvements in maternal and child health with the development of a closely defined set of social services" and the women's groups of the day who were fighting for financial assistance to help them feed their children. She argues, that from the early days the question of whose needs the services were designed to meet is pertinent, as some of the major needs articulated by women themselves had been overlooked.

In the Report of the Committee on Child Health Services (Court Report 1976) it was stressed that the present services are fragmented and 'provider' led, shaped and influenced according to the views of the professionals who work in the service. The Committee recommended that the views of the consumer were obtained in an attempt to ascertain the accessibility and comprehensibility of the service from the point of view of the user. The Committee detected a groundswell of client dissatisfaction with many features of the child health service. In particular there were feelings of uncertainty about how to use a service and parental resentment at their lack of involvement in the health care of their children. (para 4:6)

Thus, whilst child health centres will never reach all children and were never intended to replace domiciliary visiting by health visitors, there is a need to investigate how clients and

health visitors view the service provided, particularly as some of the recent organizational changes may have influenced and shaped health visiting practice.

The main role of the health visitor has been defined in "An Investigation into the Principles of Health Visiting (1977) as "planned activities aimed at the promotion of health and the prevention of ill health" (para 1:5) and child health centres are of considerable importance to this role. (Appendix J contains a summary of the role of the health visitor) In the past the client has been relatively free to attend a centre of her/his own choosing; however, recent changes in the organization of health visiting, for example, the change from geographical to general practitioner attachment work patterns, may have limited client choice and possibly affected the role of health visitors in relation to their work within centres. A further influence may also be a gradual shift in the distribution and organization of child health centres away from small local clinics in, for example, church hall, into larger purpose built premises or general practitioner (GP) practices.

Changes in staffing patterns may also be significant, as over the past few years more GPs have accepted responsibility for preventive work and are providing and staffing their own 'well children' clinics, whilst clinical medical officers (CMO) employed by the Health Authorities continue to be in short supply. The Department of Health and Social Security (DHSS) paper 'Health Service Development: Court Report on Child Health Services' published in 1978 pointed out that the range and quality of service provision may vary considerably and that, "differing patterns of service will be needed depending on local conditions, the needs of the community and the availability and interest of existing professional staff". (para 3) Whilst this is true there is also a need to ascertain whether or not clients derive benefit from attending clinics. Mitchell (1976) suggested that in general mothers only attend clinics if they perceive benefit therefrom.

Parents' initial definitions and perceptions of child health clinics influence whether they take their children there in the first place; parents' experiences at child health clinics and their satisfaction with the service provided will influence whether they subsequently return to them. Studies in related fields have shown that previous experience with health professionals has much bearing on people's readiness to turn to these professionals for advice when the need arises again (Cartwright, Hockey and Anderson, 1973; Stimson and Webb, 1975). One of the biggest problems with regard to the continued health surveillance of children under five, according to the Court Report, is the decrease in attendance at child health clinics as children grow older. While 80% of children aged under one year attend, only 28% of those aged 2 - 4 years do so (Court Report, 1976, p.74). Many factors are likely to contribute to the pattern of decreasing attendance; for example, the availability of alternative advice from the lay group and parents' increasing self-confidence as they gain experience. Certainly the evidence of studies of young children points to the possibility of a multitude of influencing factors (Newson and Newson, 1965, Davie et al, 1972, Pringle, 1976) but at the start of this study only limited attention had been paid to the study of parents' perceived experiences at child health clinics and the extent of their satisfaction with the service provided by health visitors.

It was with these thoughts in mind that the idea of carrying out a study to document clients' expectations and levels of satisfaction with child health clinics was generated. At the same time it was planned to collect the views of a sample group of health visitors. It was not the intention to investigate the effects of changes in organisation and work patterns.

From the outset it was hoped that the research findings would provide for health visitors, administrators and others concerned

with child health clinics an analysis of the responses and reactions of service users and providers. It was hoped that this information would be useful in planning a service adapted to consumer needs and would enable health visitors to re-appraise their practice with respect of child health clinics.

Thus, the study was designed to explore two main issues:

1. The expectations and degree of satisfaction of mothers attending child health clinics.
2. The objectives and degree of satisfaction of health visitors working in the clinics.

Given that the study sought to obtain clients' and health visitors' (HVs) opinions on child health clinics, a methodology which allowed for the collection of qualitative and quantitative data was necessary. It was hoped to compare clients' expectations with health visitors' perceptions of what they thought clients wanted from child health clinics.

The nature of the study relied upon clients to say what services they thought they and their children had received. Thus it is essentially an investigation of the consumers' subjective perceptions of the services and not an attempt to evaluate the service.

Areas of Discussion

Chapter 1 gives an historical overview of the way child and maternal welfare services developed in this country. It seeks to show that the policy makers and providers of health care have from the early days, failed to take into account the views of the people who use the service. Ways in which intra-professional rivalries between members of the medical profession, central and local government officials, voluntary workers and health visitors who have all played a part in shaping the service are discussed.

The later part of this chapter describes some of the current issues relating to the provision of child health services which will need to be addressed if the service is to really meet the need of the consumer. Studies which specifically relate to the work of health visitors at clinic do exist and some of these are reviewed in the following chapter.

See Appendix A for a map of the study area and Appendices B and C for tables summarising the infant mortality rates.

Chapter 2 reviews some of the literature relating to consumer perceptions of health visiting and the work of the health visitors at clinic. It seeks to show that whilst there have been several studies aimed at finding out the view of the consumer, comparison between the studies is difficult.

Chapter 3 looks at possible ways of collecting the data together with a discussion of the factors which influenced the study design. The research instruments and actual procedures which were used to collect the information are also discussed.

Chapter 4 gives the results of the postal questionnaire. The objective for this part of the study was to ascertain clients' previous experience with health visitors, their intentions of visiting child health clinics in the future and their expectations from such visits. The results are given in three parts, the first gives background biographical information on the clients and their families. The second set of results gives information concerning confinement details, information about contact with the health visitor during the ante-natal period and the age of the baby when the health visitor made the first visit. The last group of results relate to the client's perceptions of and expectations from child health clinics.

A copy of the postal questionnaire is given in Appendix D.

A copy of the first letter to parents is shown in Appendix E.

Chapter 5 gives the results of client interviews. The clients' views on the accessibility and acceptability of the clinic provision in their locality are discussed. This is followed with an account of the clients' contact with health visitors and general practitioners at the clinic. Other aspects of child care and child development are explored, together with information as to whom clients turn, if they need help and advice concerning their children. The last series of results discussed in this chapter concern the range of services clients expect clinics to provide. This leads into a discussion of clients' feelings about their visits to clinic.

A copy of the client interview schedule is given in Appendix F and a copy of the second letter to parents is given in Appendix G.

Chapter 6 gives the results of the health visitor interviews. The first set of results give background information on the organizational settings from which the health visitors work. Staffing patterns and information on whether or not health visitors see their own families at clinic follows. Views of the health visitors as to the range of services clinics should provide, together with a statement regarding their level of satisfaction with their work in clinic is explored. The later section of this chapter highlights the health visitors' objectives for their work in clinic. This leads into the final chapter which aims to draw together the views of the users of the service (the clients) with those of one of the providers of the service (the NHS).

A copy of the health visitor interview schedule is given in Appendix H.

Chapter 7 examines the findings outlined in the previous chapters. It seeks to compare the clients' expectations with the health visitors' perceptions of what they thought the clients wanted from the child health clinic. On the basis of this analysis suggestions for change are explored. These suggestions form the

basis of the recommendations which arise from this study. These recommendations are given in the final section.

Some of the recommendations for change that stemmed out of this study have already been implemented. Some of the findings relating to the client and health visitor interviews have been published in a book entitled, 'Research in Preventive Community Nursing Care". A copy of this chapter is included in Appendix K.

CHAPTER 1

THE ORIGINS OF THE SERVICE - The Early Years

The infant and child health services in Britain and the original forerunner of the present health visiting service date from the end of the last century. Health visiting was one of the services that emerged in response to the social needs of the mid-19th Century, at this time there was an accelerated population growth and a high death rate amongst infants. Increasing industrialisation had been accompanied by rapid urbanization which in turn had created acute accommodation pressures and the deterioration of sanitary measures within towns. The principal causes of death included those associated with bad sanitation, overcrowding, poverty, ignorance and misery. Epidemic diseases such as typhoid and cholera were common. It was when the link between diseases and the water supply was established that there was increasing demand for more effective environmental controls. (Brockington 1965)

One of the main areas of concern at this time, according to Young (1936) was the high death rate amongst infants, approximately one third of all children did not live to adulthood. The average infant mortality rate in the mid-19th Century was 150, per 1,000, but by 1889 this had risen to 163, the highest ever recorded. This was considered unacceptably high and as early public health measures had been seen to be effective there was demand for some kind of action. Against this background numerous charitable organizations employed 'charitable visitors' to visit poor people at home with the aim of relieving particular cases of distress and giving rudimentary health teaching in hygiene and moral values.

One such body, The Ladies Sanitary Association of Manchester and Salford was established in 1862 to support the employment of "a respectable working woman to go from door to door among the poorer classes of the population to teach and help them as the opportunity offered". (McCleary 1933 p 85) This is generally accepted as the forerunner of the present health visiting service. However, commentators, including Russell (1982) and Graham (1978) suggest that from the start health visiting, with its emphasis on self-reliance and moral respectability, placed the responsibility for both cause and effect squarely in the hands of the mother. Russell suggests that infant mortality was seen as a failure of motherhood and thus the main thrust of the child health service was to teach the skills of motherhood. No mention was made of the inter-related economic and social issues as it was considered that the instillation of "correct" ideas of motherhood would overcome the major problems.

It was nearly a quarter of a century later in 1901 that the health visitor's potential for work with mothers in their own home soon after the birth of their baby was explored. Dr. S.G. Moore, the Medical Officer of Health for Huddersfield in 1901, concerned about the high infant mortality rate in his area, arranged a home visiting service specially to help mothers nurse their infants and to offer guidance from birth onwards, on infant management. Mothers began to use this service, but many babies died before a home visit could be arranged. (McEwan 1959 p.22) At this time there was no legal requirement to notify the birth of a child, but in an attempt to remedy the situation and to bring some order into the recording of previously inaccurate data, the Notification of Birth Act (1907) was passed, but not enforced until the Extension Act of 1915. Baly (1980) argues that this Act improved the reliability of epidemiological data and revealed the need for action in relation to the health of mothers and children.

Legislation passed in 1911 initiated important changes in the organisation of services. Lewis (1980), however, contends that neither changes in medical practice nor social policy can be assumed to be benevolent; she argues that such changes were more concerned with the economic and ideological concerns of the state coupled with the self-advancement strategies of the medical profession than with the welfare of the individual. However, from this date the treatment of sick children became the responsibility of the general practitioner, whilst the preventive services for children remained under the control of the Medical Officer of Health who was employed by and responsible to the local authority. Robinson (1982) suggests that these developments are significant to the present position of health visitors, arguing that in the early days health visiting owed its initial support to its close association with Medical Officers of Health who were able to shape the service and to select individual members of staff according to their own perceptions of need and models of care. She suggests that the health visitors' close relationship with local authorities was viewed with suspicion by many general practitioners who feared a 'take-over' from the Town Hall and jealously guarded their independent professional status. A situation which some would claim continued to dog progress in the development of the child health services for at least the next fifty years.

However, by 1916 the various voluntary bodies and an increasing number of local authorities concerned with the state of maternal and child health were steadily pushing forward their claim of "improved infant welfare". Lewis (1980) commenting on this period, identified a gap between official policy and the providers of health care, who "equated improvements in maternal and child health with the development of a closely defined set of social services," (p.311) and the women's groups who were fighting for financial assistance to help them maintain nutritionally adequate diets. Thus from the early days the

question of whose needs the services were in fact designed to meet is pertinent, as some of the major needs articulated by women were overlooked.

It was not until the Government recognised that an improvement in the quality and quantity of the population was clearly in the national interest that the high infant mortality and morbidity rates were taken seriously. Russell (1982) and others argue that campaigns to improve maternal and child health only became a matter of Government concern after the Boer War and again during the First World War. This was made explicit in "The Carnegie Trust Report on Maternal and Child Welfare" (1917) which states:

> "The value of population has never been appreciated as it is today... a simple calculation shows that had the annual wastage of male infant life during the last fifty years been no greater than it is at present, at least 500,000 more men would have been available for the defence of the Country today." (p.1)

(See appendices B and C for Infant Mortality Rates)

In the following year, 1918, the Maternal and Child Welfare Act was passed and this laid the foundation of the present child health service. Health visitors were acknowledged as an integral part of this new service and for the first time their title was established. (For further discussion see (McLeary, 1935) Local authorities were empowered to make arrangements for safeguarding the health of mothers and children under five years of age; this included the establishment of free ante and post-natal clinics at a time when only the wage earner could claim free medical care by right. However, it was not until the Public Health Act of 1936 that local authorities were obliged to establish Maternity and Child Welfare Committees and even then the establishment of services remained a permissive power (Leff, 1950).

However, the enabling power of the 1918 Act led to an extension of the Health Visiting service and to a re-examination

of the training and qualifications required for the work. In 1919 the Ministry of Health was established and in 1925 this body took responsibility for the Health Visiting service. In the same year The Royal Sanitary Institute became the examining body for the Health Visiting Certificate, but not for sick children's nursing. Court (1976) claims that these changes came about in response to persistent evidence of large numbers of infant deaths from preventable hazards during the ante-natal period and childbirth. From this time the infant welfare centre, later to be known as child health centre, became the focus of ante and post-natal care and for the care of children up to school age. Russell (1982) argues that in those early days the main concern was to promote in the mothers a sense of moral responsibility.

From the onset the service offered was preventive care and advice. If a baby or child was sick the mother was referred elsewhere for treatment. Russell (1980) argues that the educative role may not have been highly valued by the consumers but that concerned mothers were nevertheless pleased to use the service for their own ends - chiefly to purchase subsidised milk.

This fragmentation of curative and preventive services has had an important influence on the way child health centres evolved and were perceived by the users, and it was this theme that years later was to be one of the main arguments running through the Court Report (1976) and the Royal College of General Practitioners Report, Healthier Children - Thinking Prevention (1982).

Robinson (1982) suggests that traditionally mothers viewed these early child health clinics as providing care chiefly for the child under one year of age, the main activity being directed towards the giving of advice concerning hygiene and nutrition. If,however, Russell (1980) is correct and mothers chiefly used clinics to purchase cheap milk, then the need to attend obviously fell away as the child got older. Whatever the reason, the

problem still remains, one of falling attendance at clinic after the child's first birthday;this may well be tied up with the mothers' perception of the service and the age group or groups it appears to serve.

The inter-war years, Robinson (1982) argues, were a time of consolidation. The health visiting services were only marginally affected by social policy legislation.

Whilst the organisation of the service remained much the same during these years, there was a change in emphasis. The infant mortality rate was declining but the maternal mortality rate was on the increase. Russell (1982) suggests that the medical profession and in particular the obstetricians used this situation to advance their own professional interests which up until this time had been neglected specialisms. Lewis (1980) stating that both maternal and infant welfare services could be viewed in terms of "a series of discrete medical problems to be solved by the provision of health visitors, infant welfare clinics and better maternity services". (p.16) The emphasis, she argues, was on the education of "Feckless mothers" and was limited to instruction and inspection. The general practitioners of this time jealously guarded their professional freedom and did not wish to see this eroded in any way. "Issues associated with mortality such as morbidity rates amongst married women were pushed into the background and the social, environmental and biological issues underlying the mortality figures tended to be ignored."(p.16)

For the first time, in 1936, the census was used in a attempt to correlate poor housing conditions with high infant mortality rates. Whilst inequalities were highlighted, no positive action was taken to redress the balance. Much the same situation has been noted in recent years by Townsend (1982) and Black (1980) and others. Lewis (1980) commenting on the early days suggests that as infant mortality was firmly associated with poor mothering, one of the principle aims of the infant welfare movement was to

promote a sense of moral responsibility on the part of mothers and on working class mothers in particular. Poverty was attributed to moral failure and this could be corrected. The purpose of the early ante-natal and infant welfare clinics was to teach the skills of motherhood, however, Lewis (1980) argues that it is hard to determine what part the education of mothers played in the rapid decline of infant mortality. "Pure milk, a better standard of housing and sanitation and improved medical care for premature babies must have all contributed and credit should not be given solely to the education of mothers." (p.107)

Yet, the importance of motherhood continued to be emphasised and the mothercraft classes of the day, Russell (1982) argues, carried a powerful ideology, stressing the duties and responsibilities of motherhood which affected schoolgirls and adult women alike. Against this background the increasing maternal mortality rate between the war years ensured that public and government attention focused on the health of mothers. Lewis (1980) suggests that about this time it was realized that education alone would do little to remedy the situation. Gradually, the aims of maternal and child welfare were shifting, although there is evidence that change was slow in coming and many recommendations, such as improved post-natal care for mothers, were ignored for some considerable time. Yet, Russell (1980) argues that women used this emphasis on maternal health and motherhood to demand an extension of maternal and child welfare services and to this end they were fairly successful, although some would say the health services for women still leaves room for improvement. It was again to be the circumstances of war that over time brought about changes in health visiting practice and the maternal and child health services. Robinson (1982) states that during the years of the Second World War the health visiting service was subject to considerable strain. Evacuation of mothers and children into country areas, away from the risk of enemy air attacks in inner city areas, meant that routine

health visiting became almost impossible, and the service itself was stretched to the utmost. Yet, this movement of children focused public attention on the affects of poverty on the health and well-being of children. Children from some of the poorest inner city areas were evacuated to some of the most affluent parts of the country. The comparison between these evacuees and well-nourished, adequately housed, comfortably off families and children became obvious; the inter-related affects of poverty, housing, health and malnourishment could no longer be ignored or merely regarded as an offshoot of feckless mothering. Robinson (1982), Kay (1983) and others commenting on this period, point out that the level of national concern was unique and the government was forced by the pressure of public opinion to introduce a national nutrition policy, to provide diptheria immunisation and to make provision for the day care of children in the form of day nurseries.

The nutrition policy included a system of priorities for nursing and expectant mothers, and children under the age of five years. Under this scheme these each received a pint of milk a day. Historians suggest that this brought a change in distribution and consumption since for the first time in some areas the basic nutritional requirements were met. Robinson (1982) claims that as a result of this policy the mortality figures fell significantly during the second half of the war. In the years 1942-1944 the rates fell from 52 to 45 per 1,000 live births (Abel Smith, 1978)

The claims made for the nutritional policy and its effect on the health and well-being of children have been well documented. Yet, it is worth noting that at the turn of the century mothers themselves were asking for financial assistance to enable them to provide a nutritionally adequate diet for their family. Maybe if the expressed views of women's groups had been acted upon, the infant mortality rate would have fallen earlier.

Events during this time led to the development of family centred care; government policy, coupled with war time propaganda, emphasised the concept of family unity. Furgusan (1954) pointed out that this factor was vital to the war effort. Robinson (1982), developing this point, argues that this served to re-inforce and re-shape the working ideals of health visiting. As health visitors were directed towards family visiting, so the emphasis on infant visiting had shifted. This principle was recognised when the Joint Committee of Institutions approved by the Minister of Health for the Training of Health Visitors (1943) described the duties of the health visitor as "the care of the family as a unit".

Other influences were also at work during this time. Members of the Court Committee (1976) pointed out that planning for the post-war years aimed to provide a completely new framework of services for the health and welfare of children. The aim of the Social Insurance and Allied Services Report of 1942 (Beveridge Report) was to provide in post-war years a comprehensive system of social security for all, along with family allowances to raise the income of those in need, and a comprehensive medical service for children and their families, free at the time of need.

The Post War Years

The National Health Service Act (1946) repealed the permissive provisions of the Public Health Act (1936) and obliged local authorities to arrange for the care of expectant and nursing mothers and of young children. The thinking at this time was that careful planning of the local authorities services for children under five, school children and for expectant mothers would ensure closer integration with the midwifery, general medical and the hospital and specialist services. However, this did not happen; three quite separate systems involving three administrative authorities evolved. Part II of the National Health Service Act covered hospital and specialist services. Part III, health

services provided by local authorities and Part IV, general medical and dental services, pharmaceutical and supplementary opthalmic services. Under Part III of this Act local authorities employed clinical medical officers to provide preventive services both in clinics and in schools. The clinical medical officers could not prescribe, thus the old problem of division between curative and preventive services was legitimised and perpetuated so that any hope of an integrated health service had gone. The Court Report states that from the start, the tripartite organisation of the service mitigated against integration in so far as:

> "The allocation of responsibilities itself helped to create the belief and practice that primary health care for children could be divided into separate components of prevention and cure, with independent services providing for each." (p.66)

The significance of this for health visiting is that the separation of preventive and curative service gave rise to confusion and concern. The Court Report (1976) commenting on this, argued that parents will use whatever services are available; they are unable and should not be expected to differentiate between curative and preventive aspects of care. (para. 5) This is particularly true in relation to child health clinics and is an issue which will be discussed later.

Under Section 24 of the National Health Service Act the function of the health visitor was extended to include the care of the family as a whole, but as the proposal carried no statutory powers it made very little difference to the range of work undertaken by health visitors. But it is also worth noting that in some ways the National Health Service Act (1946) limited the work of the health visitor as certain aspects of child care, care of the elderly and handicapped were transferred to other agencies. A Royal College of Nursing Working Party reporting in 1983 pointed out that this move could have been the start of role related disputes and interprofessional conflicts, as health visiting tried to "fit in" with the developing empires of social services, hospital

dominated health services and general medical practice. The resulting specialisation, they argue, has produced more benefits for the professionals working in the service than for the consumers. The level of fighting, compromise and debate that accompanied the government's intention of introducing an integrated health service has been well documented. Cartwright (1977) pointing out that the National Health Service Act (1946) represents a massive compromise between the medical profession and the Minister. It could be argued that from the start the system was modified to meet the needs of the medical profession and that some of the consumers' needs were in fact overlooked. Certainly the tripartite system was soon to run into trouble, although it did bring considerable order into a previously fragmented and a sometimes poor quality child health service.

The decade following the Second World War was one of optimism arising from the belief that advances in medicine, prophylaxis, nutrition, housing and education, indeed the benefits of the Welfare State, would bring about demonstrable improvement in the health of the people. Commenting upon this, Professor Jeffreys (1978) pointed out that at this time it was thought to be a distinct possibility that class differences in health and illness could be reversed, as infectious diseases and under-nutrition declined. As in the years before the War existing inequalities in health between the social classes was attributed to maternal ignorance and maternal deprivation in the inter-war years. The cure, as before, was to educate mothers and thus close the culture gap between the classes. Jeffreys (1978) stated that this was thought to be fairly straightforward. Radio and later television were seen as new instruments which by diseminating information would soon bring about change. Against this optimism the work of the health visitor was thought to be unnecessary. Jeffreys (1978) stated that some doctors and social workers, anticipating a much better informed public with ready access to expert opinion through the media, thought that the services of the health visitor would no longer be required. She points out that:

> "Social workers, who can hardly be viewed as disinterested observers, went even further and argued that the health visitor was popularly associated with a form of authority which was no longer acceptable and hence that she would be counter productive as both educator and medical social worker." (p.12)

At this time some general practitioners (also not disinterested) joined in the attack on health visitors, alleging that free access to their own services did away with any remaining need for health visitors.

It was originally thought that the utopia provided by the welfare state would eradicate most social ills and thus there would be little need for the health visitor to seek out problems. Robinson (1982) points out that at this time health visitors were few in number and were to be seen as part of an inefficient and divided past administration that was to be replaced. Child welfare clinics also came in for criticism, some claiming that they had served their purpose and were no longer necessary.

Meanwhile the continuing role conflict, coupled with the shortage of health visitors led to a call for an inquiry into health visiting. A committee was subsequently established in 1953 and The Jameson Report (An Enquiry into Health Visiting) was published in 1956. This was the first report specifically concerned with health visiting; other reports have considered health visiting but only as part of a broader remit. The actual Committee recommendation was that:

> "The functions of the Health Visitor should primarily be health education and social advice; they may usefully undertake other functions but these should arise from or be incidental to their primary functions. In carrying out all their functions, Health Visitors should have full regard to the needs of the family and the part played by other workers." (para. 293)

Robinson (1982) has argued that by defining the health visitor's work in such broad terms, the committee, in the end, did health visitors a disservice. Certainly the role conflict and job uncertainty experienced by some health visitors has continued.

However, health visitors were not the only group to be under attack. The National Health Service itself came in for criticism and scrutiny. Levitt writing in 1976 argued that the problems that beset the health service in the 1950's and 1960's were a reflection of its failure to meet the original hopes of a fully unified and comprehensive health service. Some service provision remained unevenly distributed and the National Health Service had failed to eradicate inequalities in health. The administrative structure favoured the hospital services and the tripartite system lacked co-ordination and was inefficient. The division between curative and preventive medicine served to push social medicine and by definition child health services, into the background.

A Reassessment of Child Welfare Centres

It was against this backcloth that the Minister of Health's Standing Medical Advisory Committee for England and Wales was invited to consider whether the time had come for a reassessment of the medical functions and medical staffing of child welfare centres. Part of the note inviting the committee to consider this item read as follows:

> "While it is well recognised that medical work of great value is carried out in child welfare centres, doubts are sometimes expressed whether the centres are now needed for quite the same type of medical work as they were when they were first started many years ago. It has also been said of some centres that they tend to continue traditional work rather than turn to work that is needed in the circumstances of today. (para. 1)
>
> The relationship of the work done at child welfare centres to that done by general practitioners and by the hospital service certainly needs fresh thought: both general practitioners and paediatricians are taking an increasing interest in the health, growth and development of normal children; and increasing numbers of children are surviving with handicaps which necessitate early detection, full assessment, treatment and follow-up."

As this idea had been around for some time and had been the expressed view of some doctors, the suggestion was welcomed. A committee was subsequently established under the chairmanship of Sir William Sheldon its report (The Sheldon Report) Child Welfare Centres, was published in 1967. The Committee considered written and oral evidence from professional and other bodies, including various women's groups and mothers themselves. In paragraph 27 p.13 of the Report, the Committee stated that, "it is as well to know what the customer wants".

The Report concluded that there was no doubt about the continuing need for a preventive service to safeguard the health of children. It recommended that the name should be changed from Child Welfare Centre to Child Health Centre considering this a more apt description of the range of work clinics would undertake in the future. The Committee expressed the view that in the long term child health clinics would become part of the family doctor service, provided by general practitioners working from health centres; each with their own attached health visitor. Indeed the Committee stated that it was with this concept in mind that they made their recommendations. Mention was again made of the division between curative and preventive services. Yet, then as now, there was evidence from mothers and some professional groups that some general practitioners were too busy to undertake preventive work and some mothers expressed the view that their general practitioner was too busy to bother with the simple problems of well children. Despite these arguments, the Committee stated that the child health services would not remain as distinct and separate entities for long, speculating that in the long term it would become part of a family health service provided by family practitioners.

However, this goal was not to be realized in the way envisaged by the Sheldon Committee. Some general practitioners did accept responsibility for mounting their own well baby clinic but, on the whole, the service itself went on much as before, albeit with a new impetus. The main thrust was once again to be the education

of mothers. As the standard of nutrition had improved the Committee recommended that the 'ritual' of weighing babies apart from at the first attendance and subsequent birthday attendances by discontinued. The Report suggested that, if weighing was considered necessary this task could be undertaken by a voluntary worker. This recommendation was totally rejected by the users of the service. Mothers, then as now, attended clinic to check their child's progress, and this included the recording of the child's weight; thus the scales were never completely abolished. The Committee also considered it inappropriate for clinics to sell baby milk and proprietory foods. They stated that local authority clinics could if they wished, continue to make these commodities available but they doubted if general practitioners would be prepared to take over this task when they assumed responsibility for providing clinics. Thus one traditional function of the clinic was to be disbanded: however many child health clinics disregarded this advice, and mothers in this and other studies continue to value the opportunity of purchasing foodstuffs from the clinics. Nevertheless, Jenkins (1984) puts forward the argument that by providing subsidised foods clinics stigmatise some parents who can be identified as being near the poverty line. Thus the debate as to whether or not this is an appropriate task for clinics continues.

Moves Towards an Integrated Child Health Service

Throughout this time there was growing pressure for closer integration of the health service and in 1974, 25 years after its creation, the National Health Service was reorganised. The intention of the reorganisation was to improve the planning and provision of health care through an integrated approach to the problems of ill health and the prevention of illness. Community health responsibilities were transferred from local authorities to the mainstream health service; indeed this was one of the main aims of reorganisation and it was to have an important influence on health visiting and the organisation of child health clinics.

From this date there was increasing emphasis on the importance of teamwork. Dingwall (1977) argued that the impetus came from administrative changes, and in response to various stimulii from central government general practitioners had joined together in groups to work from the same premises, and health visitors were persuaded to join such groups. Dingwall describes them as aspiring to join: "A group of social equals with distinct and complementary spheres of competence" (p.214), but the vision was not always shared by the general practitioners who did not always appreciate the role of the health visitor, but was usually pleased to use her services. Dingwall suggests that general practitioners saw the move towards attachment as giving them one more auxilliary worker to direct and use.

However one views this change, teamwork is now the normal work organisation for health visitors working outside London. Over 70% of health visitors are now members of a primary health care team (Mitchell, 1980). This factor has had a significant influence on the work of health visitors. They still have their traditional role with mothers and young children, but have more elderly people on their caseload than before. Over time, some general practitioners realised the value of seeing children and mothers registered with their practice and set up their own well baby clinic sited in their practice premises, so realising a goal which some had considered an ideal for a long time. Historians such as Lewis (1980) point out that some general practitioners never had accepted local authority based child health clinics, seeing them as an intrusion and a threat of bureaucratic interference from the "Town Hall". A service over which they had little control was treated with suspicion and with little or no co-operation. In any case, some general practitioners thought themselves to be expert in the oversight of well children: Parson (1952) argued

> "The present-day conception that the family practitioner must concern himself with the positive health of those entrusted to his care, and not only treat them when they are ill, applies with particular force to the child;

> the general practitioner should supervise the upbringing of every child in his practice, so that physical, mental and spiritual health may reach the highest plane. Furthermore, although the home surroundings of the child are often the subject of helpful reports from the health visitor to the child welfare medical officer, the family practitioner has greater facilities than the health visitor to judge the social background of the family." p.12

Others, according to Steiner (1975), were more realistic, whilst acknowledging that general practitioners and health visitors should assume greater responsibility for practice based child health care. General practitioners have been slow to take on this work, and so he argued it will be necessary to maintain community based services without too much reliance on general practitioners for some appreciable further period of time. Indeed, the independence of general practitioners' services maintained by the Family Practitioner Committees prevents total integration.

However, the re-organisation of the administration of the National Health Service provided the long awaited opportunity for the development of a co-ordinated, comprehensive health service for children. As a prelude to such a development it was considered necessary to review the existing services and in the late autumn of 1972 the Secretaries of State for Education and Science and for Social Services, in conjunction with the Secretary of State for Wales, announced their intention to establish a committee to examine these issues. The thinking behind the proposed review of the Child Health Services, Parry Jones, Area Medical Officer - Somerset suggests was vague, there was no major public concern on the care children received from the health service, and indeed the Sheldon Report had only recently been published. Perhaps, yet again, the Government was reviewing the continuing need for some of the public health services for children. A cynic might conclude, Parry Jones suggests, that an instant solution was found by setting up the Court Committee (The Committee of Inquiry into Child Health Services). This Committee was established in 1973 with the following terms of reference:

"To review the provision made for the health services for children;

To study the use made of these services by children and their parents and to make recommendations."

The Committee agreed that an objective should be to provide an integrated service:

"Which follows the child's development from early school years, through school and adolescence (para 5.10)

Provide families with a single identifiable source to which they can turn for skilled advice and where necessary treatment (para 5.12)

Primary and specialist care should also be seen as a co-ordinated service (para 5.13)

The need for an integrated approach to health care is particularly great in the case of the handicapped child" (para 5.11)

The Committee found the services to be uneven and unequally distributed, in fact, little changed since the inception of the National Health Service nearly 30 years earlier. The services remained fragmented and not in touch with those most in need. Although the infant mortality rate had fallen to one twelth of what it was one hundred years ago, they found evidence that many deaths were avoidable and that the infant mortality rate was still high.
Moreover, twice as many children of unskilled workers died in the first month of life as children of professional workers and this gap had been widening over the previous 25 years. They also stressed that children in urban areas were likely to be less healthy than others and that the health service provision was likely to be poorer, a similar finding to that of the Committee of Inquiry into Primary Care Services in Inner London (1981), (The Acheson Report.)

The Court Report also pointed out that whilst infectious diseases are no longer the major health hazard of childhood, chronic ill health, malformation handicap, foetal and perinatal disorders and psychiatric disorders and ill health arising from

family stress continue to give rise to concern. They suggested that in response to this changing pattern of disease there needs to be a closer and continuing relationship between professionals and parents, arguing that expert opinion and advice should be made freely available both in the home and at child health clinics in order to answer parental concern and enquiry, (p.16 and 17)

In an attempt to overcome some of these problems they stressed the need for a fully integrated Child Health Service which includes social workers working from child health clinics. They argue that this is important as the modern diseases of childhood are inter-related health, social and environmental issues including poor housing, poverty, single parents and family stress. This is not a new idea, the Sheldon Report of 1967 also recommended a closer liaison with social workers and Steiner (1975) suggested that perhaps child health clinics should be sited within social services' buildings. These suggestions have been cricized by Orr (1980), and others have expressed the view that families may well feel stigmatized by using facilities once again associated with the "Welfare". Nevertheless whatever the organisational setting there remains a need for health visitors and social workers to work closely together, if children in families with social needs who do not make use of the present child health services are to be contacted and maybe helped.

The Report returns again and again to the issues of the fragmented organisation and delivery of child health services, pointing out that parents sometimes receive different and conflicting advice. They stress that services should not only be readily available to parents, but also easy to use. (para. 5.9) Under their proposals developmental surveillance of pre-school children and school children would become part of comprehensive primary care services given by general practitioner paediatricians. Doctors employed as community medical officers would be phased out and health visitors were to extend their role

to care for sick and well children up to school leaving age. (para. 9.27) They were to be known as child health visitors and would be working along-side child health nurses.

These were just some of the fairly radical proposals put forward by the Court Committee which collectively proved too revolutionary for total acceptance. David Allen (1977) reviewing the reactions to the Court Report found that practically every professional body who commented on the Report expressed doubts of some kind. He writes that general practitioners were undecided as to whether or not the Committee's proposals were a good idea, some expressing the view that general practitioners do not have the time to undertake the extra work that would be needed, and in any case as general practitioners are independant contractors there are few who without payment would opt to extend their horizons. Others were concerned with the need for specialisation and extra training. Health visitors also found the Committee's recommendations unacceptable, and thus the Report was not fully implemented.

However, the Department of Health and Social Services with its publication, Prevention in the Child Health Services (1980) re-affirmed the government's endorsement of the philosophy of the Court Report and suggested for information, not guidance, a modest programme of child health surveillance.

Together these papers provided yet another impetus to team formation and prodded a few more general practitioners into mounting their own well baby clinics in their surgeries. This growth is steady but slow. Jenkins (1984) states that at present 10 - 20% of general practitioners nationally run such clinics, but there are geographical differences; in Oxfordshire for example the figure rises to 72%.

The reluctance of general practitioners to adopt many of the ideas suggested in these reports, Denis Gray (1983) concludes, may have something to do with their timing. They were published at a time when general practice was emerging as a discipline in its

own right and was in the process of creating academic credentials at both undergraduate and postgraduate level. He suggests that some general practitioners may have been less than enthusiastic in responding to the ideas put forward by the Court Report for an integrated child health service as they feared the imposition of a new structure for primary care which could erode their independent contractual status. These fears were exacerbated by the Report of a Royal Commission on the National Health Service published in 1979. (The Merrison Report) Donovan (1981) commenting on this, points out that this Report recommended the abolition of Family Practitioner Committees, who are responsible among other things for the administration of general practitioner contracts, negotiating disputes and generally planning and organising family practitioner services. The Merrison Report argued that the existence of Family Practitioner Committees, being a partially independent sector posed problems of co-ordination, collaboration and integration. It was anticipated that the new district health authorities could be more effective in influencing the distribution and quality of practice premises and the proper co-ordination or primary care as a whole. Donovan suggests that the government, aware of the medical profession's concern to maintain the status quo and if possible to strengthen its position, made it quite clear in the 1980 National Health Service Act that Family Practitioner Committees were here to stay. Since this date they have been granted independent status equal to that of health authorities. Thus one of the principle aims of a simplified administrative structure planned to aid integration and co-operation has been breached.

Organizational Changes

As noted by Lewis (1980) changes in medical practice and social policy cannot always be regarded as benevolent, and can beg the question as to whose needs the service exists to meet. In spite of attempts to achieve financial and organizational integration

of the health service, general practitioners have retained independent contractual status and are relatively independent of the National Health Service administration. Thus some of the present inequalities in the availability and accessibility of primary care services, including services for children which were identified as deficient by the Report; Primary Health Care in Inner London (1981), Black (1980), Townsend (1982) and others seem set to remain. A Working Party of the Royal College of Nursing in their report, Thinking about Health Visiting (1981) argues that the separate development of Family Practitioner Committees promotes the development of primary medical care at the expense of primary health care; and that the division of responsibility between the District Health Authority, which contracts and employs health visitors, and the Family Practitioner Committee means that there is no focus or power base for the development of primary health care as a whole. This they argue limits the contribution which health visiting can make to health care.

However, despite the gloom some good attachments do exist and the inter-dependence between the general practitioner and the health visitor is important, especially in the area of child health. It is the health visitor who is notified of a birth in a family registered on the practice list and she is expected to visit the mother at home in the first weeks after delivery. At this visit she should describe the functions of the child health clinic and invite the parents to attend. Attendance at the clinic will depend upon the way the service is described, the geographical position of the premises in relation to the family home, the hours of opening and the calibre and attitude of the staff who provide the service. As stated the present arrangement is a mix of health authority clinics and general practice based well baby clinics. This arrangement is not considered satisfactory by the Royal College of General Practitioners (RCGP), who, unable to accept the idea of general practitioner paediatricians as proposed by the Court Committee, produced in 1982 a multidisciplinary working party report entitled: Healthier Children - Thinking Prevention.

This Report agreed that therapeutic and preventive child health services should be fused and based within primary care, and makes out the case for general practitioners to provide total care of the child, both sick and well (para 2.38). It suggests that the proposals put forward by the Working Party could be made practical on a national scale within the existing framework of general practice, a claim which has been dismissed as being too idealistic by the Report's critics. The Report examines the present state of child health in the United Kingdom in an attempt to analyse the problems and determine how best they may be tackled. Like the Court Report, the main problems identified are environmental, to do with poor housing poverty and the effects of family stress (para. 2.16). The RCGP Working Party pointed out that within general practice opportunities for prevention are many, claiming that:

> "The child's health is directly influenced by the medical services provided and that if these are to make an impact on the child's environment they must be sensitive to:-
>
> a) his social economic conditions (general environment)
>
> b) his home (physical environment)
>
> c) his family (social environment)" (para 2.36)

The services must be community based, accessible to the whole population and cost effective. Furthermore:

> "The organisation of general medical practice with its comprehensive coverage of virtually the whole British population with its local distribution relatively close to people's homes, gives general practitioners and their colleagues in the primary care team the best chance amongst all the health professionals of being in contact with those children who need most care." (p.11)

In its response to this Report the former Council for the Education and Training of Health Visitors expressed their concern, stating that many health districts where the needs for improved health surveillance are greatest are those where the primary health care teams or group practices are least well developed and have the poorest premises. The Acheson Report (1981) commenting on

the primary health care services in inner London, pointed out that; 59% of general practitioners were not in group practice, compared with 28% elsewhere. Many families living in inner city areas are not registered with general practitioners and thus slip through the net; their health care is identified as a matter of concern. (para 3.2) Health visitors were concerned that some general practitioners would be too busy or disinterested to undertake the task of child surveillance. Their views were summarised by the Health Visitor Association (HVA), in their response to the RCGPs recommendations. They welcomed the interest displayed by some general practitioners in child health surveillance, but argued that in order to undertake surveillance satisfactorily general practitioners must see the child and his parents in an unhurried atmosphere. In some instances it was suggested that it might be more appropriate to undertake the 'assessments' outlined in the Report in the child's own home, where the social and emotional aspects of development are best assessed. The idea that assessment of children can be combined with examination of children with intercurrent illnesses was criticized as an inappropriate combination of activities by some. Some general practitioners regularly offer health education and Professor Bain (1982) suggests, indulge in intuitive monitoring during routine contact with children. However, special sessions for well children are desirable, and this requires a regular commitment of time and resources, and it is these issues that continue to be the subject of debate. Donovan (1983) in a discussion paper based on the Report quoted (para 15.22) "Whilst doctors talk and health departments wait, children suffer." (p.128) He suggests that professional interests and conflicts are at work and that professionals must learn to work together more effectively if child health services are to be improved and unnecessary suffering and illness reduced. He acknowledges that it may have been a mistake not to have worked in co-operation with nursing colleagues, going on to argue that:

> "If all those who care for children give the impression that they are involved in defending their sectional interests, heaven will need to help the children."

The RCGPs described the membership of the Working Party as multidisciplinary although in reality the Report was produced by eight doctors, four general practitioners, a consultant paediatrician, a clinical medical officer, a child psychiatrist and a representative of the DHSS, hardly a multidisciplinary group. Yet, however one views the composition of the Working Party, the mechanism has proved effective in allowing the medical profession to exert their self interests in this current debate and once again serves to illustrate the persuasiveness of their professional power. Their monopoly in the evidence considered by the Working Party made it hardly surprising that the final report viewed child surveillance as a task for doctors and is one which must be combined in continuing family care and which should as soon as possible become part of general practice: A policy agreed by the Conference of Local Medical Committees.

Whilst the debate continues the staffing and organisation of the existing child health service is subject to uncertainty. In some districts community medical officers faced with job uncertainties, and in some instances role conflict and criticism from various quarters, have left the service. Thus there are gaps and conflicts which cannot be in the best interest of the children and their parents. It would appear that as in the early days of the child welfare movement, the emphasis is back to the education of parents; in reality this means the mother. The underlying inter-related problems of poverty, poor housing and environmental stress are acknowledged and then denied or overlooked. Evidence of such thinking is contained in Patrick Jenkins' forward to the Report of the Working Group on Inequalities in Health (1980):

> "The Working Party has reached the view that the causes of health inequalities are so deep rooted that only a major and wide ranging programme of public expenditure is capable of altering the pattern. I must make it clear that additional expenditure on the scale which could result from the Report's recommendations.... is quite unrealistic in present or any foreseeable circumstances, quite apart from any judgement that may be formed on the effectiveness of such expenditure in dealing with the problems identified." (Quoted by Townsend and Davidson, 1982, p.39)

So the debate continues. There is heightened awareness amongst some that the child health services are in disarray, but the policy makers appear unaware or uncommitted. Some see the solution in purely medical terms, others argue for a radical review of the structure of society. Townsend and Davidson (1982) argue that health policies cannot be limited to the provision of medical services alone, but must encompass areasnot traditionally the preserve of the Minister of Health. This is particularly important in relation to the health services for children. Graham (1984) argues that if the situation is to change, policies relating to education, housing, environmental planning and industry must be considered alongside health policies. Only then she suggests will parents on a low income really be in a position to "make healthier choices for themselves and their children". She points out that at present an increasing number living on a low income "whatever their commitment to their children, the structure of their lives forces choices on them in which the health of their family is put at risk". (p.176)

In Summary

This section traces the development of child health services in Britain. A review of the literature suggests that the services developed in a piecemeal fashion in response to pressure from social reformers, central and local government. Professional ideology has also played a part and from the early days the service can be seen to be 'provider' led, shaped and influenced according to the views of the professionals who work in the service.

From time to time various government sponsored bodies have reviewed the health service provision for children, but their recommendations have been largely overlooked or fuelled yet more inter-professional disputes. At the time or writing (1986) very little has changed in this respect, but there is increasing recognition of the need to involve the consumer and to obtain

their opinions, views and reactions to medical and social service provision.

In relation to child health clinics there is a need to find out what the consumer wants from the service, what they like and why they attend. Interest in consumer perceptions of health visiting is growing and the next chapter will be concerned with a review of studies relating to the consumer's views on child health clinics.

CHAPTER 2

THE WORK OF HEALTH VISITORS IN CLINICS AND THE CONSUMER VIEW OF THE SERVICE : A REVIEW OF RELATED STUDIES

This section will be concerned with a review of studies relating to the work of the health visitors in clinics, patterns of attendance, and consumer views of the service provided.

The Work of Health Visitors in Clinics

Clark (1981) in a review of 37 research studies carried out between 1960 and 1980 in the UK, into how health visitors spent their time and who they saw, found that work in clinics accounted for 15% of the health visitor's working time. The range reported by the various studies being 2.1% to 29.2%, but she warned that comparisons between the studies was "impeded by the use of different category systems". (p.45) Some studies specified and defined 'Clinics', others used the term 'sessions' which may have included other group activities such as parentcraft. Some researchers specifically excluded clinics from their considerations, others report their findings related to the health visitor's work in clinics in very broad terms.

One study which explored the work of the health visitor in some detail was conducted by Marris in 1969 at the request of the late Council for the Education and Training of Health Visitors and the Association of London Borough Medical Officers of Health and the Borough Division of the Intelligence Unit of the Greater London Council. The objective of the study was:

> "To examine exactly what it is that London health visitors are engaged upon in their day-to-day activities, be they in the home, in the clinic, in the schools or elsewhere."

Clark suggests that this study probably gives the greatest detail about the health visitor's work in clinic. Marris found that time spent in clinics accounted for 71 minutes of an average working day, or 14% of health visitor time, including the time spent in preparation and clearing up. The clinics studied included school clinics and pre and post-natal clinics, but,

> "half health visitor clinic time was spent at child health clinics and at these each activity took six minutes, so that a proportion of all activities the services to people at CHC represented 16% of the total health visitor time and that it was at clinics that health visitors most often serve members of the public." (Marris, 1971 p.29)

However, the time devoted to individuals at clinic was only nine minutes per person, on average, compared with 12 minutes during domiciliary visiting. Because of this the proportion of all time devoted to individuals was less during clinic sessions than during domiciliary visiting. Specifically, of all the time spent serving individual people, 44% was occupied in domiciliary visiting and 28% in clinic sessions.

Marris' study was mainly concerned with describing gross health visitor activities whilst Dunnell and Dobbs (1982) in their enquiry into the role of nurses working in the community, analysed in more detail the range of professional activities undertaken by health visitors in relation to clinics. They found that much of the health visitor's time was taken up advising, counselling, reassuring and educating those who came. Specifically, 26% of all health visitor time at clinic was taken up with advising on diet and infant feeding, 21% on parentcraft and advising on the care of children, 12% discussing personal problems, 11% on developmental surveillance, 5% on carrying out hearing and vision testing and 4% on investigation, advising and counselling.

Patterns of Attendance at Clinics

Attendance at child health clinics in some areas and for some client groups is often disappointing, but in the first instance will depend in part on the welcome the mother receives at her first visit, the geographical location of the clinic premises in relation to the family home and the clinic opening hours. Hart, Bax and Jenkins (1981) have shown that it is possible to achieve a 97% attendance rate in an inner city area by encouraging mothers to attend and giving a full explanation as to what the service has to offer, arguing that when such details are overlooked the attendance rate is low.

Graham (1979) in a study of child health clinics in York looked at patterns of attendance together with Women's attitudes to the health visitor and the child health clinic within social class groups. She found that mothers' attitudes to the child health services are generally positive, although she noted a decline in the level of satisfaction as the baby got older. At one month after birth, 91% of mothers attending clinic found the visit worthwhile and at five months 64% felt that visits to clinic were important. Initially, attendance rates were high for both middle and working class mothers, but by five months only 40% of working class mothers attended the clinic, compared with 87% of social class 1 and 2 mothers. Also, considerably less working class mothers reported finding the advice of the health visitor helpful.

The key question in understanding patterns of attendance at clinic Graham (p.175) argues

> "is not why certain groups fail to attend the clinic but why after an initial visit or two, they fail to return. Similarly, the key question in understanding attitudes to the health visitor is not why some mothers fail to appreciate her, but why their appreciation declines after the first few visits."

From her interviews with mothers she identified two important factors, one to do with the mothers' confusion about the role and function of clinics and the health visiting service, and the other concerns the approach by the clinic staff which was perceived by mothers as critical, unsympathetic or judgemental. She concludes that mothers will only use a service if they feel that it fulfils a role which they see as important and not easily fulfilled elsewhere. She also suggests that a mother's social situation, particularly her social class, parity and methods of infant feeding, will influence whether or not they use a service and find it useful. The present fragmented child health service, she argues, may not enable parents to use it effectively and thus gain maximum benefit from the services available. A view shared by the Court Committee (1976).

A similar point was made by Zinkin and Cox (1976) when they described an inverse law of care in relation to the take up and use of child health services. They argue that families most in need of care are the least likely to take their children to clinic, and that these same children are likely to be at high risk of developmental problems. These families tend to move house frequently and thus are also least likely to be visited at home by the health visitor, in essence they slip through the 'health visiting net'. Like Graham, they conclude that services will only be used if they are accessible and acceptable to all client groups, findings which have been echoed in other studies.

In an attempt to find out what the client wants, and to acknowledge the strength of these arguments, interest in consumer perceptions of health visiting has grown and there are now several published studies.

Consumer Views on Child Health Clinics

Blaxter and Patterson (1981) in their study of mothers and daughters who were themselves mothers, asked the women for their

views on, and experiences with, child health clinics and health visitors. Whilst warning the reader that the women's attitudes were not necessarily consistent, they found that the majority of mothers greatly valued child health clinics for young babies. However, they note that some clients were confused as to the precise function of the clinic doctor and the general practitioner. Some mothers who they acknowledge may have been using the clinic in an inappropriate way, found it difficult to understand why the clinic doctor could diagnose but not prescribe. These mothers preferred clinics where they could see their own general practitioner. Similarly, they favoured the attachment of health visitors to general practice as this enabled some of them to see the health visitor and the child health clinic as part of an integrated whole, rather than, "As simply visits from someone they could rarely name and whose function they were unsure of". (p.190)

Orr (1980) conducted a study in a small town in Northern Ireland, the sample was made up of 68 families from social class IV and V. This is probably the most significant study of consumer views of health visiting and part of this study was concerned with collecting information on client's perception of child health clinics. She found that as a group the mothers in her study tended to under utilize the clinic, but welcomed seeing the health visitor in their own home.

The most frequent clinic attenders had babies under 6 months old. These attended weekly to begin with but attendance dropped off as the baby got older, a pattern consistent with findings of other studies, e.g. Graham (1979), Court Report (1976). Some mothers attended once but were put off and said that they had no intention of returning. In particular they did not like the lack of privacy, frequent changes of health visitor which interfered with the continuity of health visiting advice, and the brusque behaviour of the doctor. Reasons for attending

included - to get the baby weighed, to meet other mothers, to discuss a particular problem with the health visitor and to buy subsidised foods.

Like Blaxter and Patterson (1981) Orr noted a degree of confusion in some mothers as to why the clinic doctor can diagnose but not prescribe, arguing that this fragmented service may be one of the reasons why attendance drops off as the child gets older as some parents want somewhere to go when the baby is sick other than to their own general practitioner.

In a study conducted by Bolton in 1982, 278 mothers attending child health clinics in Kent were asked about their use of clinics and their opinions of them. The majority of respondents were broadly satisfied with the services provided, almost all had consulted a health visitor at clinic and considered that the purpose of their visit to clinic had been achieved. As in Orr's study the commonest reason for attending was to get their baby weighed, but variations in expectations between clientelle at each clinic and from clinic to clinic was noted. Mothers living in rural areas, who may have been geographically or socially isolated, were more likely than mothers in urban areas to value the opportunity of meeting other mothers at clinic. The most frequent clinic attenders had at least one child under one year of age as did the majority of mothers in the sample. More mothers from social class III attended than from any other social class group. Dissatisfaction was expressed concerning the length of time spent waiting to see the doctor and many mothers (actual numbers not given) were reported to have requested the introduction of an appointment system.

A similar, but smaller study was undertaken in Leicestershire and reported by Biswas and Sands in 1984. Ninety-eight mothers of children under 5 years of age were asked by health visitors why and how they used child health clinics. They found that 74% were satisfied with the child health services and 61% with

child health clinics. As in other studies the clinic was used mainly by mothers with children under the age of one year. Reasons for attending included - to get the baby weighed, to seek advice from the health visitor and to purchase modified milk and vitamin drops. Only 28% of the mothers saw their family health visitor at the clinic they attended. Reasons for non attendance included - transport difficulties, inconvenient clinic times, and no need/no wish to attend.

In an attempt to clarify the exact function of child health clinics, both from the medical profession's and the consumer's point of view, a study was undertaken in Oxfordshire and described by Sefi and Macfarlane (1985). Over a twelve month period, 103 of the counties 113 clinics were visited and 999 mothers interviewed. Information was collected as to why parents attend clinics, their likes and dislikes about the service and what the health visitor and doctor actually did while the child was at the clinic. They found that the majority of mothers liked the clinic and thought that they fulfilled a useful role, the main benefits mentioned were getting advice from the health visitor and gaining reassurance. Nearly one-third valued the social function of the clinic. Criticisms included - the long waiting times, insufficient advice and infrequent clinics.

This study went further than the others and attempted to find out why some parents did not attend clinic, health visitors were asked if they knew of parents living in the area who regularly did not attend. Of the 150 families identified, 31 failed to visit because of difficulty with transport, 54 did not attend either because they did not find the clinic useful, or they disliked the doctor or did not want immunization. 23 did not attend because they were too disorganised or had diverse social problems. Of the remainder either the reason was not known, or they were attending their general practitioner's surgery for developmental checks or immunizations and thus did not come within the scope of this research (Jenkins 1984).

These studies support the generalist findings made by Blaxter and Patterson (1981), Biswas and Sands (1984), Bolton (1984) and McFarlane and Sefi (1985), which suggests that consumers' perceptions of child health clinics are mainly positive. However, as each study chose a different term to describe the attitude of the study population towards health visitors and clinics, comparative work is difficult. Yet, some common trends emerge; in all studies the commonest reason cited by mothers for attending clinic was to have their baby weighed. In all studies, clinics were used mainly by mothers with children under the age of one year. Common criticisms included - long waiting time and inconvenient clinic opening hours. The fragmentation of service delivery between clinic doctors and general practitioners was commented upon by Graham (1979), Orr (1980) and Blaxter and Patterson (1981).

Comparison between the studies is difficult as not all the studies included in this review give precise details as to the methodology used. Although all but Blaxter and Patterson used a survey method some studies give more background information as to the sample size, organisation and method of data collection and data analysis then others. Some of the researchers used a study population of less than 50 respondents and some restricted their study to specific groups, Orr's study was restricted to social class 4 and 5 families living in a small town in Ireland whilst Blaxter and Patterson limited their study to mothers and daughters who were themselves mothers. Thus it is not possible to generalise these research findings across all groups of clinic attenders.

A further consideration is the fact that each of the studies reviewed were conducted within one health authority. As each health authority tends to offer a service shaped and influenced according to its own definitions of need and available resources, the consumers view of the service may well differ from place to place.

CHAPTER 3

METHODOLOGY

In view of the confusion inherent in the design of some of the studies described in the previous chapter, it was decided to design a study specifically for consumers and health visitors living and working within the geographical district covered by the Portsmouth and South East Hampshire Health Authority. This approach could be further justified as each health authority is specifically charged with the task of obtaining the views and opinions from consumers as to how well the services they are responsible for providing are delivered. (Griffiths Report 1984)

Permission to Undertake the Study

The request to carry out the study was made in the first instance to the Director of Nursing Services (Community) and was met with an enthusiastic response. It was agreed in principle that such a study could be useful to the health authority who were about to review their child health services. Subsequently, the Chief Nursing Officer for Portsmouth was approached and asked for her permission to proceed. This permission was obtained in the Autumn of 1983 and formal approval to undertake the study was given by the local ethical committee at about the same time.

The Catchment Areas

These were identified by use of the postal code relating to the geographical locality of the child health clinics selected for inclusion. (See Appendix A for map of the study area)

Child Health Clinics

The choice of child health clinics was influenced by the need to obtain a district wide view of the services, to allow for a variety of service settings and to encompass as wide a range of health visitor working conditions as possible.

Following discussions with nurse managers and at their request, the following centres were planned for inclusion:

Centre A - a newly opened building serving a cross-section of the population

Centre B - a large purpose-built clinic, serving a mainly working class population

Centre C - a general practitioner's child health clinic serving a large naval community

Centre D) - small clinics serving a working class
Centre E) population

Centre F - a general practitioner's child health clinic sited in the middle of the City serving a mixed population.

Preliminary planning meetings were held with senior nurse managers (community) and administrative staff working in the district and possible ways of carrying out the research explored. Before any final decision was made it was agreed to allow a period of two months for discussion with the health visitors working at field level. It is a common complaint amongst health visitors that they participate in many research projects but are not always informed about progress and results. As the researcher is herself a health visitor and committed to the development of health visiting it was hoped that the findings of this study would be used to influence health visiting practice. Thus consultation time was built into the research design and during this period the researcher visited staff groups and talked to as many health visitors as possible, explaining the objectives of the study and asking staff for their views and opinions. Time was also spent in clinics observing and talking to mothers,

doctors and other staff. As a result of these activities it became apparent that the research design would need to incorporate client opinion - quantative data, together with background factual information - qualitative data.

Possible Ways of Collecting the Data

A number of possible ways of collecting this data were considered. These included, participant observation, but as the research had to be undertaken on a part-time basis in addition to regular employment, this method was regrettably rejected as it was likely to be too time consuming. A further consideration was the claim made by Clark (1977) that the introduction of a third person is an intrusion which can distort the content of the conversation to such an extent as to invalidate the data. So, given the nature of the study it was decided to use a combination of questionnaires and interviews.

Following discussion with the health visitor nursing officers it was decided that the first contact with mothers should be by letter and postal survey. This was decided upon partly because of the constraints of time but more importantly in an attempt to avoid professional bias. It was thought that a questionnaire which could be identified directly with the health visiting or midwifery service in the area could bias the results.

According to Drew (1980) the advantage of using a postal survey is that respondents can answer the questions in their own home and are thus able to give a considered response. On the debit side a postal questionnaire has to be understood unaided and thus its design demands particular care. (Moser and Kalton 1971) It is also difficult to determine if those who did not respond, could not or would not.

It was also decided that an interview framework which allowed for the collection of factual quantitative data and also qualitative data reflecting clients views and opinions on a range of related issues would be the most appropriate method for the follow up client interview. Considering that one of the objectives of the study was to talk to health visitors and explore with them their satisfaction with their role in relation to child health clinics, interviewing seemed to be the most appropriate method for the purpose of this part of the study. Even though it was recognised that as a method it would be time consuming.

Planning the Research Design

It was decided that the research sequence should be:

1. A postal survey of mothers of new babies who met the criteria for inclusion in the study.
2. A follow-up interview at home of approximately 50 respondents who agreed to take part.
3. Interviews with health visitors working in the catchment areas of the study. (Those with the highest numbers of clients participating).

In order to achieve this three research instruments were needed - a postal questionnaire, a client interview schedule and a health visitor interview schedule. This section gives some basic information about the research design, reasons for the choice of questions and a discussion of the research instruments.

The way the methods were used in the main study will be discussed under a separate heading.

Postal Questionnaire

(The postal questionnaire is reproduced in Appendix D)

The objective of this part of the study was to ascertain

clients' previous experience with health visitors, their intentions of whether or not to visit child health clinics in the future and their expectations from such visits.

The topics for inclusion were gleaned from a review of the literature and from a number of discussions between health visitors and other staff working in child health clinics. Of particular concern seemed to be questions relating to client contact with the health visitor during the ante-natal period. Field et al (1982) in their study of consumer views of the health visiting service proved an association between the level of contact with the health visitor during the ante-natal period and the degree of client satisfaction with the health visiting services. The Early Parenting Project (1980) also emphasized the importance of health visitors meeting mothers during the ante-natal period in order to make an introduction and to begin to establish rapport. They found that when this was achieved there was likely to be a continuing post-natal health visitor/client partnership which encouraged and enabled clients to utilize services appropriate to their needs. The Court Report (1976 para. 8.29) suggests that one or both parents should be present and involved in the neo-natal examination of their infant and that this occasion should provide an opportunity to begin to develop the parents self-confidence in the care of their child and in their own ability to cope. With this in mind it was decided to ask parents about their level of involvement in the neo-natal examination of their baby.

Other research suggests that whether or not a client is likely to use a service is influenced by a variety of factors including age, social class and family influences. (McKinley 1976) Social networks are also important in this respect. O'Brien and Robinson (1984) argued that those most in need of help often lack any social support systems and that this same group of people may also be low in self-esteem and feel unable to use

professional services, fearing a loss of self respect. On the other hand, Mayer and Timms (1970) cite evidence to suggest that clients with inadequate informal social networks are more likely to seek help and that an individual's interaction with friends and relatives not only affects the likelihood of his/her seeking help in the first place but will also condition later responses to such help. Thus an assessment of the families' attitude towards obtaining and using help both from within the family and from outside sources is a necessary health visiting task. Albeit, acknowledging that a family's failure to utilize a service and child health clinics in particular may well be a reflection of a family's social-structual position within society and may have little to do with the way services are organised and delivered.

With these considerations in mind, it was decided to ask clients to identify from a pre-determined list who they would turn to for help and advice concerning their child and to rank their replies in order of usefulness.

The questionnaire was subsequently designed in three parts, the first was to obtain straightforward background biographical information on the clients and their families. The second was designed to gain information about confinement details, place of birth, contact with the health visitor during the ante-natal period and age of the baby when the health visitor made her first visit. The third part sought to explore the client's perceptions of and expectations from child health clinics. The response required either a tick or ringing of information offered or a short answer, although space was left for comment. This method simplified the coding of the answers but restricted the choice of answers.

The Client Interview

(The client interview schedule reproduced in Appendix F)

The object of this part of the study was to explore with parents their perceptions of, and reactions to child health clinics. It was decided that the interview should be conducted with the parents in their own home, as this was most likely to be conducive to a relaxed atmosphere. In an endeavour to ensure that all parents participating in the study had had an opportunity to attend a child health clinic at least once, it was decided that the infant should be between six and ten weeks old at the time of interview. An invitation to take part in the interview was to be included in the mailing of the postal questionnaire. Parents were given the opportunity to refuse their participation if they wished.

Given that the survey sought to explore clients' views about child health clinics, it was decided to guide the interview around a set of pre-determined factual questions, followed by open ended questions which allowed clients to talk freely. A review of the literature threw up a number of questions which seemed to be appropriate and topical, particularly those relating to whether or not clients see their own health visitor at clinic and whether they perceive the service delivery to be fragmented.

Since the Sheldon Report (1967),the Court Report (1976) and RCGP Report, Healthier Children, Thinking Prevention (1982) argued that given the choice clients would prefer to consult their own GP at clinic, it was decided to ask parents for their views on this aspect of care. As Orr (1981) suggests that the client's perception of the type of situation and help they thought a health visitor could give them is often hazy, it was decided to include a question relating to this topic.

With these thoughts in mind an interview schedule was designed to elicit information concerning: clients' accounts of contact with health visitors and general practitioners and other workers at clinic; their expectations, sources of satisfaction and dissatisfaction with the centres and alternative modes of obtaining advice and help on other aspects of child care and child development and also their perceptions of the work of health visitors.

Health Visitor Interviews

(The health visitor interview schedule reproduced in Appendix H)

The object of this part of the study was to explore with health visitors their interpretation, objectives and degree of satisfaction with their own involvement in relation to their work in child health clinics.

In order not to take up too much health visitors' time, it was decided that the interview should be conducted by appointment at the individuals own work base, sometime during their normal working day. Since the researcher is herself a health visitor and well-known to all health visitor respondents, there was a danger of professional bias creeping into the interview. In an attempt to overcome this problem it was decided that the interview needed to be quite structured, each participant being asked exactly the same question in the same order. Considering the nature of the survey and the need for structure it was decided that the interview schedule should be guided around a set of pre-determined factual questions, followed by open-ended questions which allowed respondents to express their views and give suggestions for change.

In an attempt to identify issues of importance from the health visitor's point of view, the researcher obtained views and opinions from as many health visitors as possible. Meetings

with members of the former Council for the Education and Training of Health Visitors research committee were particularly useful in this respect, and some of the ideas included in the health visitors interview were suggested by this group. The views of the Portsmouth based Community Health Council were also sought.

The interview schedule was designed in three parts, the first was to obtain background information on the organizational setting of the clinic, the staffing patterns and whether or not health visitors see their own families at clinic. The second section sought to explore with health visitors their objectives for their own work in clinic, the degree of health visitor satisfaction with the service provided and their level of involvement in it. The third group of questions were designed to ascertain whether or not the health visitors considered that the clients' expectations with regard to clinic were met. Finally, the health visitors were invited to suggest proposals for change.

The Sampling Procedure

The statutory notification of birth procedure ensures that each Health Authority has a list of babies born to mothers residing within its geographically defined locality. This information is computerised in the research area and thus makes an ideal sample frame. The birth rate across the district averaged 570 new births per month during 1984 and would have been too large a sample given the constraints of time and the limited resources available for this study. The ideal sample size was set at 200. Thus, following discussion with the administrative staff in the District Health Authority computer section who are responsible for recording and computerising details from the notification of birth forms, it was agreed that all mothers of babies born between 19th February and 31st March 1984 residing in the catchment areas of the study would be invited to participate. Mothers whose babies were born with a handicap

would be excluded as they were likely to have special needs and to be part of another research project. Also to be excluded were mothers whose babies had spent time in the special care baby unit as the infant was likely to be older than the anticipated 10 weeks of age at the time of the follow-up interview.

A review of the computer print-outs relating to the birth-rate for the district suggested that the chosen time span would give a sample of approximately 200 births in the six-week period. Although it was agreed to extend this period if necessary in order to build up the sample. In the event this became necessary and notifications of birth continued to be received until the end of May.

The Sample of Clients' Participating in the Follow-up Interview

There were six child health centres selected for inclusion in the study, and the original plan was to build an interview group of approximately eight clients attending each of these centres. In this way it was anticipated that some comparison between client satisfaction within the different clinic organisational settings would be possible.

However, the situation changed after the start of the study and this subsequently influenced the sampling procedure. One consideration was that the health visitor working in the group practice in Portsmouth City left during the year and as continuity would have been affected this practice was dropped from the study. A further influence was the opening of a new health centre in Spring 1984. Because a number of clients participating in the study chose to attend the newly opened child health clinic based within the health centre, it was decided that this centre should be included.

The intention of a balanced group across all clinics also ran into difficulty. The plan was followed for the first 20 interviews and then it became apparent that some form of selection would be required. This was necessary because willingness to be interviewed had a clear social class bias in so far as more new births were notified in the North of the study area which houses predominantly social class 4 and 5 families, yet, a higher proportion of respondents from social classes 2 and 3 residing in the Southern sector agreed to participate. In an attempt at balance, not all in this group were interviewed as it was necessary to include responses from across the Health District. Yet, the end result is that the views of the articulate middle-class are still over represented in so far as they make up slightly more than half of the total responses, 26 out of 50.

The Health Visitor Interview Sample

There are a total of 107 full-time health visitors employed in the Portsmouth and South East Hampshire Health District, of whom 19 were working wholly or partly in the research area. The 10 health visitors with the largest number of clients in the study were interviewed.

Piloting and Revision of the Research Instruments

In the late summer of 1983 a draft questionnaire was designed and circulated via the nursing officer to all health visitors working in the City of Portsmouth. On receipt of their comments, the questions were modified and prepared for piloting.

The specific aims of the pilot studies were twofold:-

1. To test the pilot questionnaire and interview schedules, and amend as necessary.

2. To assess the likely level of client and health visitor co-operation.

It was not considered feasible to send a pilot questionnaire through the post to a group of clients. Instead a pilot study was conducted within the Winchester Health Authority in October 1983. Five mothers were approached and asked to complete the first questionnaire. All readily agreed and were more than willing to talk, in fact, others volunteered to participate but owing to the constraints of time this was not possible. On the whole the questions seemed satisfactory but the language needed modifying in order to assist understanding. Some questions seemed inappropriate and were deleted.

The next stage was to conduct interviews with mothers of new babies in their own home, in order to test the usefulness and structure of the questions and other aspects of the survey design. Subsequently the interview schedule was modified, the main problem concerned questions which required a ranking of preferences - the instructions were imprecise and not clearly understood. More open ended question were needed and more space for the recording of comments since mothers wanted to talk freely.

A group of health visitors in a section of the Health District not included in the main study were visited and volunteers invited to test the schedule. Three health visitors were subsequently interviewed by the researcher. The main difficulties identified centred around the interview schedule itself. The question sequence needed re-arranging and there was insufficient space for additional comments. These difficulties were overcome by changing the layout of the schedule. At this stage, the health visitors interviewed were enthusiastic about the study and willingly co-operated.

The Postal Survey

Clients residing within the catchment area of the study were identified by their notification of birth forms. When the birth notification was received by the District Health Authority computer section, a list was compiled of all mothers who met the criteria for inclusion in the study: It was arranged for this list to be forwarded weekly to the researcher. Once this had been received the following procedure was followed; a letter explaining the aims of the project, an assurance of confidentiality and an invitation to participate were included with the mailing of the postal questionnaire to the participant, together with a refusal slip and a stamped addressed envelope for the reply. (A copy of the letter and refusal slip is reproduced in in Appendix E.)

The timing of the collection of the information was chosen to co-incide with the mother's discharge from hospital or midwifery care and the health visitors first visit.

In the early stages of the survey some questionnaires were posted too soon and were presumably overlooked in the excitement and bustle of a new baby, or more importantly in eight instances showed evidence of midwifery interference. In one instance a midwife collected up the questionnaires from her families and returned them to the DNS Midwifery, stating that they were too long and complicated for her mothers to complete. Some of these problems were overcome following discussion with the nursing officers responsible for midwifery. From this date the questionnaires were posted to co-incide more closely with the likely first visit from the health visitor and the response improved. However, this stage of the survey took longer than originally anticipated; in the first two weeks of the study only five new births had been notified. This was to be the lowest for any two-week period but notifications continued to arrive in batches; some weeks there were many new births and in others relatively few. Thus the pacing of work was difficult and the research timetable had to be extended.

Arranging the Client Interviews

One question on the last page of the postal questionnaire asked clients to indicate their willingness or otherwise to be interviewed by appointment in their own home. As the research plan was to interview parents when their child was aged between six to ten weeks old, a sample of mothers who had indicated their willingness to be interviewed were sent a letter arranging an interview date and time when their child was aged between four to eight weeks old. This gave parents two weeks notice of the date. They were asked to indicate whether or not this date was convenient. If necessary an alternative date and time was offered. A refusal slip and stamped addressed envelope was enclosed with the letter. A few clients refused to participate at this stage and some failed to keep the appointment. A second appointment was offered to those who were out at the time of the visit. In four instances the second appointment was not kept. (A copy of the letter to parents is reproduced in Appendix G)

Conducting the Interview

All interviews were carried out by the researcher between April and June 1984. The average length of each interview was fifty-five minutes. Every interview was preceded by a full explanation of the purpose of the research and it was stressed that all information would be treated in the strictest confidence. After the explanation clients were given an opportunity to ask any questions they liked about the nature and purpose of the research before the interview started.

In five instances the father was present for the preliminary explanation but presumably being satisfied with the nature of the study and the 'character' of the researcher, he left the interview to his partner. As planned, the interview was conducted along semi-formal lines. The individual interview being guided around a set of pre-determined, factual questions, followed by open ended questions which allowed clients to talk freely. Most welcomed

this opportunity and many volunteered information and talked at length. It was clear that the questions asked often triggered the response rather than initiating opinions but this did not appear to detract from the aims of the study. The response varied according to the different interests and backgrounds of the respondents, for example, mothers with more than one child knew what to expect from the child health clinics and this shaped their expectations.

A written record was completed during the interview and as a check of accuracy read back to each respondent at the end of the interview. However, as identified by Orr (1980) interviewing in the home setting is surrounded by difficulties mainly outside the control of the researcher; television, visiting neighbours, telephones ringing and the demands of other family members. There was also a need to pace and phrase the questions in a form which could be understood by the client, some of whom were highly intelligent and eager to participate and others who were harassed and distracted in their thinking. Many mothers chose the interview time to sit and breast feed their infant, thus there was a built in distraction for both the client and the researcher.

As the interview was conducted in one visit it is possible that the answers reflected the moods and strains of the day. A recent positive or negative experience with any branch of service provision, health, housing or social services was reflected in the answer given; for example, two mothers had experienced difficult interviews with official bodies in the previous week. One living with in-laws expected the health visitor to get her a house and was angry and defensive when help was not forthcoming. Another had had a brush with her social worker and to this mother all people from the 'welfare' were the same ... not helpful. Others who had had positive experiences expressed the view that all the services were good and that they could not say anything else about them.

Communication difficulties were experienced with one Sikh family necessitating communication via a small pre-school aged child. This was unfortunately a case in which little information was gained other than "yes" or "no" answers. This interview was not included. In another two instances the maternal grandmother completely dominated the interview and at times it was difficult to determine whose views were being expressed. Subsequently these interviews were discounted.

Arranging the Health Visitor Interview

In the first instance a list of the 10 health visitors with the highest number of clients participating in the study was circulated to the health visitor nursing officers. This was mainly for information but also to remind them of the aims of the study and that individual health visitors on their staff would need to take time to speak with the researcher. Their permission was readily given and the next stage was to contact by telephone the sample group of health visitors in order to arrange an interview. All interviews were carried out by the researcher in June 1984. The average length of each interview was 45 minutes.

As planned, the interviews were held at the individual's own work base sometime during their normal working day. As in the client interviews every health visitor interview was preceded by a full explanation of the purpose of the research and a re-assurance that confidentiality would be maintained. After the explanation, time was taken to discuss the progress of the study to date, and points of general interest to the individual were highlighted. However, no information was given which could have allowed individual clients to be identified as this would have been a breach of their confidence. Each health visitor was given the opportunity to ask any questions they liked before the start of the interview.

As planned the interview was guided around a set of pre-determined factual questions but respondents were also encouraged to express their views. A written record was completed during the interview and as a check of accuracy, read back to each respondent at the end of the interview. Thus following the same format as the one used with the clients.

In one centre actually gaining access to the health visitors was difficult as the receptionist was a 'true gate-keeper' and was determined not to allow anyone she did not know to cross the threshold. After a long wait, the researcher was eventually collected by the individual health visitor concerned and the interview subsequently took place. In another centre there was initial uncertainty amongst the sample health visitor group, but after the first interview any hint of reticence and professional defensiveness disappeared. However, throughout all the interviews the researcher was conscious of the fact highlighted by Meyer and Timms (1970) that an investigation of clients' perceptions can be threatening to the professionals concerned.

The Response Rate

202 questionnaires were distributed to mothers and 100 were completed and returned. 19 declined to participate, 2 were returned to sender (unknown), and 1 mother died and the form was returned. 80 did not reply. The response rate was therefore 49%.

Client Interviews

In total, 55 follow up interviews were conducted but only 50 included in the final study. Five were excluded. In one case

there were language difficulties with a lady who had only been resident in this country for a short time. In two instances previously described, the interview was frequently interrupted by the maternal grandmother and as it was difficult to ascertain who was saying what, these interviews were discounted. A further two mothers were suffering from post-natal depression and were being treated by a consultant psychiatrist, thus, it was not appropriate to complete the interview schedule with them.

Health Visitor Interviews

Ten health visitors were interviewed. There were no refusals.

Non-Respondents: Postal Questionnaire

Due to the pressure of time and lack of funding, those clients who did not complete and return their questionnaires were not contacted again. This is regrettable as the response rate is likely to have been improved if the mothers had been sent a reminder or second questionnaire. A further consideration which may have influenced the response is that new mothers, whatever their age are often tired and always busy and may have little spare time.

There is also evidence that the highly motivated and those with something to say are more likely to respond and this proved true for this study in so far as more middle class clients replied. There was a relatively low response from working class families living in the north of the study area. It may be that the introductory letter which accompanied the questionnaire was inappropriate for some of the sample group. Robinson (1982) and McKinley (1970) suggest that a formal letter headed

introduction is too bureaucratic for some people, in particular the non-form fillers and semi-literate. They suggest that personal encounter or a pick-up contact is less repugnant to this group.

There is also evidence contributed by the midwife who collected up the questionnaires, that the format may have been too long and complicated for some families. However, some respondents said that although they needed time to think about the questionnaire they thought it worthwhile.

The fact highlighted by Moser (1971), and others, that non-respondents are likely to differ significantly from those who do respond is important and the researcher recognises the bias this builds into the study.

CHAPTER 4

RESULTS - THE POSTAL QUESTIONNAIRE

The objective of this part of the study was to ascertain clients' previous experience with health visitors, their intentions of visiting child health clinics in the future and their expectations from such visits.

The results are given in three parts, the first gives background biographical information on the clients and their families; including, information about those relatives or persons in the clients' social network system who were available to give help and advice about child care.

The second group of results gives information about contact with the health visitor during the ante-natal period, confinement details; the place of birth and age of the baby when the health visitor made the first visit.

The last group of results relate to the clients' perceptions of an expectations from child health clinics.

It was shown in Chapter 3 that a total of 100 clients completed and returned the postal questionnaire. These represent the sample group for this part of the study. The convenience of this is that wherever 'n' = 100, both real numbers and percentages are the same.

The Sample Households

The sample of the hundred families who participated in the postal survey, half of whom agreed to be involved in the follow-up interview, lived within the geographical area covered by the Portsmouth and South East Hampshire Health Authority.

The majority of the families had one or two children, the actual figures being:

Table No. 1 Numbers of Children

One child	42 families
Two children	40 families
Three children	14 families
Four + children	4 families

n = 100

Of this group, 94 mothers lived with their husband or partner. Six were single parents, of these one lived on her own in a bed-sitting room and five shared their parents' home.

Housing

Just under half lived in owner occupied houses, owned outright or in the process of buying. (48 out of 100 families) Twenty-three families rented from a private landlord and three from a housing association. Fourteen service families lived in naval married quarters, 5 families shared with other members of the family and 2 families lived in tied accommodation that went with their job.

Three respondents did not reply to this question.

Social Class

An attempt was made to obtain the occupational class of both husband or partner and wife, but there were many incomplete replies. In retrospect this question can be seen to lack precision as clients were invited to indicate their husband or partner's occupation or if a single parent to answer for her/himself. Considering that this question was asked via a postal questionnaire it is not surprising that some clients misinterpreted or failed to understand the instructions and either completed both columns or described their jobs inadequately. Thus, the social class description of the families is not as precise as it should be. However, for the purpose of the study social class has been determined by the head of the household's occupation and categorized as accurately as possible according to the Registrar General's Classification (1970).

The following table gives an indication of the social class mix:

Table 2 The Social Class Mix

Social Class	No.
One - professional	9
Two - intermediate, occupations	14
Three - non-manual, skilled	4
Three - manual, skilled	15
Four - partly skilled	5
Five - unskilled	4
Armed Forces (Royal Navy)	16
Economically inactive	24
	91
No reply	9
n = 100	

The geographical areas selected for inclusion in the study were carefully chosen to represent a mix of social class groups. The sample group is reasonably typical of the total population of the area (1981 Census).

For reasons discussed in Chapter 3 (p.48) the importance of assessing the families' attitudes towards obtaining and using help both from within the family and from outside sources, is a necessary health visiting task. Hence, clients were asked if they had any relatives living nearby and if they looked to their own mother as a source of help and advice. 66% of clients had their own mother living in the vicinity, these all indicated that they would look to her for help and advice about child care. 61% were in regular contact with other members of their extended family, the most frequently mentioned sources of help within this group were, grandparents and sisters.

One third of the sample group, 33 out of 100, had no mothers and 38 had no relatives living bearby. Of this group, 8 had no family member to turn to for help and advice.

The next question asked the clients to identify from a pre-coded list who they would turn to for help and advice concerning their child. They were asked to rank their replies in order of usefulness.

The following table gives the total response and this is followed by a breakdown of replies analysed according to the parity of the mother.

Table 3 Mothers most useful sources of help and advice concerning their child

Total response

	Very useful %	Quite useful %	So-so %	Not very useful %	Not at all useful %	No Response %
General Practitioner	70	17	3	2	0	8
Health Visitor	56	25	6	2	3	8
Husband/Partner	45	28	17	2	2	6
Other family members	31	32	22	4	2	9
Clinic Doctor	28	27	10	2	3	30
Friend	13	32	26	7	5	17

n = 100

Analysis by Parity of the Mother

	No.	No.	No.	No.	No.	No.
General Practitioner						
1st Child	27	8	1	1	0	5
More than one child	43	9	2	1	0	3
Health Visitor						
1st Child	22	10	2	1	1	6
More than one child	34	15	4	1	8	2
Husband/Partner						
1st Child	24	10	3	0	1	4
More than one child	20	20	13	2	1	2
Other family member						
1st Child	14	17	8	0	0	3
More than one child	17	15	14	4	2	6
Clinic Doctor						
1st Child	12	12	3	1	1	13
More than one child	16	15	7	1	2	17
Friend						
1st Child	7	11	13	4	1	6
More than one child	6	21	13	3	4	11

n + 100

The results show that 70% of clients thought that their GP would be a very useful source of advice and a further 17% thought him quite useful. Some commented that the GP would know the family history and thus would always be their preferred source of advice. Comparing the responses of mothers of more than one child with those of first time mothers, the numbers expecting help from their GP was higher for mothers of more than one child.

Advice from the health visitor was considered very useful by 56% of clients and 25% thought this a quite useful source of advice. Advice from the health visitor was rated most useful by mothers with more than one child. This could reflect many things not least that these mothers knew their health visitor and hence were more likely to be aware of her role and function.

Forty-five per cent of mothers found their husband or partner's advice to be most useful and a further 28% thought him to be quite useful in this respect. Mothers of first babies ranked their husbands as most useful more frequently than did mothers with more than one child. In fact the ranking of husband as being most useful fell as the family increased in size. This could reflect the likelihood of increased maternal confidence with second and subsequent children, or indeed a variety of other factors such as the need to work longer hours outside of the home in order to support the family.

Other family members were considered very useful by 31% of the sample and a further 32% thought them to be quite useful. Mentioned most frequently under this heading were mothers and sisters, mainly on the maternal side of the family. The ranking of very useful rose slightly as the family increased in size.

Twenty-eight per cent of clients considered the clinic doctor to be a very useful source of advice and a further 26% thought that he/she would be quite useful. The fact that slightly more second time mothers found this source of advice to be very useful may reflect the fact that some clients were uncertain as to the role and

responsibility of the clinical medical officer. Others knew that he/she could diagnose and advise but could not prescribe, and thus said that they would prefer to consult their own general practitioner.

Although only a few (13%) considered friends to be very useful, 32% thought that friends could be quite useful. This response appeared to be influenced by the social situation of the client, those who lived apart from their immediate family and in close proximity to neighbours, for example on a housing estate, tended to rank friends higher than those in contact with family members. This is particularly true for naval families who were often separated from their husbands and lived some distance away from other members of the extended family.

Contact with the health visitor during the ante-natal period

Acknowledging the importance of early mother/health visitor contact, it was decided to ascertain how many mothers had met their health visitor during the ante-natal period. Fifty-one mothers had met their health visitor before the birth of their baby and 49 had not.

It is possible for pregnant mothers to meet their health visitor in a variety of settings, through classes, at ante-natal clinic or at home. In this study 24 out of 100 mothers met their health visitor for the first time at the ante-natal clinic, 15 at their general practitioner's surgery and 12 at home.

Mothers who had not met their health visitor during the ante-natal period were asked if they would have welcomed the opportunity. Twenty-one said "yes", 18 "no" and 10 were uncertain. Most gave reasons to support their answers. Comments from those who would have liked to meet their health visitor included:

"Asking questions of someone you know, and have met is easier than asking a stranger." (3 clients)

"To get to know her early and to get to know her role." (6 clients)

"I needed health visiting advice."

"I would have liked to meet my health visitor earlier, it's not nice to think of a total stranger calling."

Some mothers with more than one child commented that it was better the second time round as the health visitor was not a stranger.

Of the 49 mothers who had not met their health visitor during the ante-natal period, 18 did not require any help at this time and in retrospect did not feel health visitor contact in pregnancy to be necessary.

Comparing the replies of the first time mothers with those of more than one child, few differences emerge. Of the 49 mothers who had not met their health visitor during the ante-natal period, marginally more first time mothers (13) would have welcomed the opportunity than would mothers of more than one child (8).

However, early in the post-natal period, all mothers were contacted by a health visitor as it is she who is notified of the birth of the baby and is expected to make a home visit.

Place of Birth

Eighty-four mothers had their baby in hospital, 15 in the GP Unit and one at home.

The age of the baby when the health visitor made her first visit, together with the place of the first meeting is summarised in the following table:

Table 4 Age of baby when the health visitor made her first visit

Age	No. and %
0 - 4 days	5
5 - 10 days	8
11 - 12 days	13
13 - 15 days	37
16 + days	18
Nil Reply	19

Place of First Meeting	
Seen in Hospital	1
At home	77
At the GP Surgery	2
At Clinic	1
Nil Reply	19
Total (n = 100)	

Reference to the above table shows that the handover period varied slightly but was approximately 2 weeks after the birth of the baby for 37 clients, earlier for 26 and later for 18.

The Medical Examination of the New Born Infant

The Court Report (1976) and the Health Visitor Association in a policy statement on the health visitor's role in child health surveillance, published in 1985, stress the importance of the early medical examination of the new born infant being conducted by an appropriately qualified doctor in the presence of one or both parents.

Both reports suggest that this occasion should provide an opportunity to begin to develop the parents' self-confidence in the care of their child and in their own ability to cope. They point out that the doctor carrying out this examination should always communicate his/her findings to the mother of the child or adult responsible for his care.

It was with these thoughts in mind that parents were asked if their baby had been examined at birth or soon after. If "yes"; were they told the results of the examination and were they able to ask questions in order to aid their understanding or out of interest.

The following table summarises the replies:

Table 5 Mothers' recollection of examination of baby at birth or soon after

	Yes	No	Don't Know	No Reply
	%	%	%	%
Examined by doctor	78	6	16	-
Told the results	56	22	5	17
Able to ask questions	49	9	5	37
Would have liked to ask questions	21	5	7	33

Total n = 100

Table 6 Results by Parity

	Yes		No		Don't Know		No Reply	
	No.	%	No.	%	No.	%	No.	%
Examined by doctor								
First Child	33	78	1	2	8	19		
More than one child	45	77	5	9	8	14		
Told the results								
First Child	24	21	9	7	3	7	6	14
More than one child	32	55	13	23	2	5	11	15
Able to ask questions								
First Child	19	45	3	7	4	9	16	38
More than one child	30	51	6	10	1	2	21	36
Would have liked to ask questions								
First child	8	19	1	2	6	14	27	64
More than one child	13	22	4	7	1	2	40	68

Total n = 100 42 first time mothers - 58 more than one child

Seventy-eight out of the 100 clients knew that their baby had been examined by a doctor at birth or soon after. Of this group 56 had been told the results of this examination and 49 given the opportunity to ask questions.

Of the 22 mothers who knew that their baby had been examined but claimed that they had not been told the results, 21 would have liked to have asked questions of the examining doctor.

Sixteen mothers did not know if their baby had been examined at birth or soon after. Some said that they were too dazed to recall anything but most did not give a reason to support their answer! However, one mother who had experienced a difficult labour which resulted in a general anaesthetic expressed feelings of rage and disbelief that her baby had been examined before she felt able to fully appreciate what was happening. This mother was quite depressed and anxious at the time of the follow up interview, returning again and again to this topic.

Six mothers said that their baby had not been examined at birth or soon after.

Comparing results of first time mothers with those of more than one child, few differences emerge. More mothers with more than one child were both able to ask questions or would have welcomed the opportunity than would first time mothers. This could reflect the fact that first time labours are likely to be more prolonged and thus more tiring for the mother than for second and subsequent births. Alternatively it could simply be that more experienced mothers have more self-confidence and know what to ask.

Intentions to visit a child health clinic

Clients were given the address of at least two child health clinics near to their home and asked if they thought that they would attend one. In reply 83 said that they would attend, 9 indicated that they would not attend and 8 were not sure.

The final question asked clients to select from a pre-coded list the range of services they would expect from a child health or well baby clinic. The results are shown in the following table:

Table 7 Range of services clients expected clinics to provide

	No. of Replies	%
Monitoring of child's height and weight	93	
Routine check up of babies developmental progress	90	
Confirmation of child's progress	85	
Immunisation	76	
Advice about a particular problem	69	
Discussion with health visitor re infant feeding	63	
To talk to health visitor about child/ children	62	
To buy food or vitamins	49	
General discussion with GP about baby	35	
General health education teaching	34	
To see clinic doctor about child	26	
To meet other mothers	25	
Consultation with health visitor about personal matters	13	
Consultation with health visitor about family matters	12	

n = 100

The results show that most clients expected clinics to provide facilities for weighing and monitoring their child's developmental progress. The range of services they least expected can be readily identified. Whether or not clients received the service

they expected, together with a statement as to which services they subsequently found to be the most useful will be discussed in the next chapter.

One question on the last page of the questionnaire asked clients to indicate their willingness or otherwise to be interviewed in their own home when their child was aged between six and ten weeks old. The results of these interviews are given in the next chapter.

CHAPTER 5

RESULTS - THE CLIENT INTERVIEW

The objective of this part of the study was to explore with parents their perceptions of, and reactions to child health clinics.

The results start with the clients' views on the accessibility and acceptability of the clinic provision in their locality. This is followed with an account of the clients' contact with health visitors and general practitioners at the clinic. Other aspects of child care and child development, including information about the clients' sources of help, if they felt that they needed to know more about their child's growth and development, follows. The clients' perceptions of the work of health visitors, together with the father's view of clinics and their likely use of this service leads into a discussion as to what services clients expected clinics to provide.

The last series of results relate to information concerning the consumers' feelings about their visits to clinic.

The sample group for this part of the study was comprised of fifty clients who agreed to be interviewed. Percentages are therefore the number of responses times two.

Journey Time

In an attempt to identify the accessibility and acceptability of clinic provision, clients were asked how long it took them to get to clinic (single journey) and why they chose to attend a particular clinic. The results are shown in the following tables:

Table 8 Time usually taken to get to clinic - (single journey)

Time taken	No.of replies	Mode of Transport
Approx. 5 mins. or less	15	All walked
" 10 " " "	16	" "
" 15 " " "	9	7 walked - 2 by taxi
" 30 " " "	6	All walked
" 45 " " "	2	" "
Over 45 "	2	1 walked - 1 by taxi

n = 50

They were asked for their reasons for going to a particular clinic

Table 9 Reasons for choosing to attend a particular clinic

Reasons	No. of Replies
Nearest to family home	32
Own health visitor suggested she attended this centre	8
Own health visitor based there	6
Own GP based there	6
Own GP and health visitor based there	5
Other reasons - on way to shops, near mother's, can go with friends	4

(Some gave more than one reason)

n = 50

Analysis shows that over half this group of clients attended a clinic nearest to their own home. The journey took marginally less than fifteen minutes each way and was within walking distance.

Clinic Hours

The question of clinic hours was also considered. Out of a total of 50, 34 clients were satisfied with clinic hours, many saying that they fitted in nicely with collecting older children from school. Sixteen were dissatisfied with clinic opening time for a variety of reasons, typical comments included:

> "Our clinic is only open for an hour at a time. It is not long enough... it should open less days for longer times. It takes me a long time to get ready to go and it's closed when I arrive."
>
> "Not open for long enough. It gets over crowded."
>
> "Clinic only open in the morning. I can't see my own health visitor at any other time. I would like an alternative afternoon session."
>
> "Clinic only open in afternoons. I would prefer a morning session."
>
> "Times too restricted especially if you have to get two children ready. I am rushed and can't make it."
>
> "Clinic only open once a week. If you can't make it on that day there is no alternative."
>
> "One clinic should be open every day - perhaps on a 'drop in' basis."

Other spontaneous suggestions included an appointment system, but only parents of more than one child thought that such an arrangement would be useful to them. Several first time mothers liked the idea but doubted their ability to keep an appointment.

Age Groups the Clinics cater for

The next question asked clients to say which age groups they thought child health clinics catered for.

Table 10 Clients' perception of the age groups catered for by child health clinics

Age Group	No. of Responses
Birth - less than 6/12	1
6/12 - less than 1 year	4
Over 1 year - less than 2 years	3
Over 2 years and less than 3 years	2
All under 5 years	22
Any age group	8
	40
Don't know	10

n = 50

Although only eight clients thought that the clinic catered for children up to the age of two years, some confusion was evident. A few said that they had been told (not clear by whom), that clinics only catered for babies. One mother who expressed this view pointed out that she in fact attended a "Well Baby Clinic". Two others thought that clinics were only necessary for children up to the age of six months and that older children were not welcomed.

Consultation with the Family Health Visitor at the Clinic

Health visitors in the research area no longer work in clearly defined geographical areas but are attached to general practitioner

group practices, some of which are sited in health centres which may be some distance away from the family home. Child health clinics may also be based in health centres, hence there is a chance that the client may not attend a clinic at which her family health visitor is present. It was with these considerations in mind that it was decided to ask clients if they saw and consulted their own health visitor at the clinic, and whether or not they would prefer to consult their own health visitor at the clinic.

The following findings relate to these questions:

> Out of a total of 50, 39 (78%) of mothers did consult with their own health visitor at clinic and all of this group wanted to speak to their family health visitor at clinic. 11 (22%) did not see their own health visitor.

Comments from those who saw their own health visitor included:

> "My health visitor knows me and I know her, this makes it easier to talk and ask questions."
>
> "She (the health visitor) is easy to talk to."
>
> "The health visitor knows me and the family... I respect her, she doesn't even have to look up your name."
>
> "I have been in touch with the same health visitor since ante-natal days. She knows us and the baby."

Several mothers (12) valued the continuity of care seeing their own health visitor gave, a typical comment being:

> "Seeing your own health visitor at clinic makes sure that you only get one opinion, all health visitors have their own ideas don't they?"

This theme was echoed in a variety of ways; the importance of being able to work through a problem with a professional who knew the past history was an example cited by the same group of mothers who valued the continuity of seeing their own health visitor at home and at clinic.

Whilst appreciating the value of consulting their own health visitor at clinic others stressed that such a choice should be up to the mother. One or two, who agreed in principle to the idea of consulting their own health visitor at clinic, felt under undue pressure in this respect. One saying:

> "It should not always be necessary to see the health visitor at clinic... but it's nice to know your own is there if you need her."

Others valued the opportunity of consulting another health visitor and a few felt that they did not really get on with their health visitor and thus a choice was in their own interest.

Consultation with the Family General Practitioner at Clinic

The debate as to whether or not clients would prefer to consult their own GP at clinic is topical and was discussed in Chapter 1 (p.21), hence it was decided to ask the following questions: Did you consult your own GP at clinic? Would you prefer to consult your own GP when you go to clinic?

In reply three clients (6%) did consult their own GP at clinic, 22 (44%) would have liked to consult their own GP whilst 25 (50%) clients were undecided. Comments for and against the proposal included:

> "It is best to see one person really...my GP is very good but busy."
>
> "I would attend clinic more often if my own GP was there; he is very good with the children and nice to me."

Some clients who attended a "Well Baby Clinic" based in their GP practice premises were enthusiastic, they expressed the view that there should be more such clinics. However, not everyone wanted to consult their own GP at clinic, and on analysis the reasons for this response fall into three broad categories, these are summarised below.

Some mothers felt that GP's were only trained to care for sick children although a few qualified their reply with the rider that they would prefer to keep well children and sick children services separate. They feared that if the two were catered for in the same surgery there could be a risk of cross infection.

Eight mothers did not feel happy with their doctor/patient relationship; they felt him/her to be too rushed and busy to bother with minor queries. A few felt that their GP did not like or understand children. A typical comment being:

> "My GP doesn't like children. He makes me feel that they are in the way. I can't talk to him and he doesn't know much about well children."

another:

> "GP's are all-rounders aren't they? They're not specialists in children."

For this last reason two clients expressed a preference for a consultation with the CMO at clinic. However, a few mothers thought that the CMO was difficult to talk to and understand since his speech was indistinct. (This particular CMO came from overseas)

On analysis, a degree of confusion was apparent in so far as some of the clients who said that they would like to consult their own GP at clinic had not understood the difference between well children clinics and ordinary surgeries. Some of these mothers expected their GP to carry out developmental assessments at clinic and to prescribe as appropriate. Two thought that such an arrangement would be cheaper as it would save them taking two expensive bus trips.

However, the majority of clients were able to distinguish between the preventative and curative aspects of the child health service, but for some the division was irritating and irrational.

Developmental Surveillance and Assessment

As one of the stated aims of the child health service is to offer parents a programme of routine developmental assessment of their child's progress, it was decided to ask the following question: Do you think that routine checks on your child's development are important?

The majority, 46 (92%) said "yes", and 4 (8%) were uncertain. The next question asked: Who should carry out these checks? In reply, opinions were equally divided, 24 (48%) clients thought that this should be the task of their GP and the same number expressed the view that the health visitor should undertake this task. The remaining two clients (4%) thought the clinic doctor to be the most suitable person. Comments included:

> "If the health visitor is to do it, she needs to be more thorough than she is now."
>
> "Whoever is present at the clinic."

A very high proportion of mothers expressed their appreciation of this aspect of the service and several made suggestions for improvement; notably, they would have liked the CMO or health visitor to talk through the assessment with them. Remarks included:

> "I would have liked to know what the health visitor was doing... and for her to explain how I, as a mother, could help my child."
>
> "No-one explained what was happening, I would have liked to have been talked through it."
>
> "The assessment is best done at home, 'cos then we can all be involved, toddler as well."

Three mothers were critical of the fact that no-one had adequately prepared them for special tests, such as the six weeks' developmental check at clinic. They would have liked prior warning so that they could have prepared their questions - in the event they were flurried and forgot to ask them. They also asked

if they could be more closely involved and given a more detailed explanation of what was happening.

The next question asked clients whether or not they knew enough about the way children grew and developed? The majority 40 out of 50, thought that they were well-informed about this aspect of child care but many qualified their answer. A typical comment was:

"Yes, but only because this is my second time round."

Others remarked that although they felt confident in their knowledge base they would still read around the subject and would consult professionals as appropriate.

Sources of Help and Advice

Following on from this clients were asked to identify from a pre-coded list, where they would expect to find out about the way children grow and develop. The results are given in the following table:

Table 11 Clients' sources of help if they needed to know more about their child's Growth and Development

	'Yes'		'Maybe'		'No'	
	No.	%	No.	%	No.	%
Books	31	62	9	18	10	20
TV/Radio	24	48	4	8	22	44
Magazines	11	22	11	22	28	56
Newspapers	14	28	4	8	32	64
Leaflets	30	60	6	12	14	28
Relatives	25	50	6	12	19	38
Friends and Neighbours	22	44	12	24	16	32
Health Visitor	46	92	4	8	-	-
GP	42	84	3	6	5	10

n = 50

Reference to the previous table shows that a very high percentage of clients indicated that they would ask their health visitor or GP for help. This response could have been influenced by the nature of the study in so far as participating clients knew that the topic was related to health visiting.

Reading material was considered useful by the majority, 31 (62%), some saying that they wanted to read as much as possible in order to understand the needs of their growing child. One suggested that reading should be more widely encouraged and that clinics should operate a library system.

Leaflets and small booklets available from the clinic, health centre and other health education sources were also considered valuable by 30 (60%) clients. A small percentage specifically stated that clinics should mount health education displays concerned with child care and that these should be supported by appropriate leaflets. However, not all agreed, 14 (28%) stated that for them leaflets had little value, they claimed that they put them straight into the bin. Yet, in one or two of these instances, leaflets were clearly in evidence during the interview. On one occasion I was asked to discuss and talk through a booklet on home safety whilst I was in the house. This mother subsequently denied the value of leaflets but perhaps she needed someone to help her understand them.

Newspaper articles and magazines were not considered very useful by the majority.

Television and radio was thought to be a useful source of information by 24 (48%) clients but almost an equal number, 22 (44%), said that for them this medium had little value. However, those who did feel these to be useful, said that certain programmes were helpful particularly, "Woman's Hour" on Radio 4 and "Baby Talk" on TV.

Relatives were seen by 25 respondents as a useful source of help, for some the maternal grandmother was the main source of advice but for others, sisters were said to be more useful. A typical comment in this respect was:

"Sisters, having had their own, know what it's like."

This reliance on advice and guidance from the extended family was most apparent in social classes 2 and 3a, even if the family lived some distance away contact was maintained by telephone or visiting.

Friends and Neighbours - not everyone found their own family helpful, 19 (38%) clients stated that they definitely would not turn to them for help and advice. For this group friends and neighbours were identified as being more useful. Those living in close proximity to neighbours on, for example a housing estate, tended to rely heavily on each other for the exchange of information and ideas. Several volunteered the fact that friends and neighbours are more accessible, one arguing that:

> "If a neighbour up the road has had a two-year-old, she can tell you what to expect as she has been through it, and all children go through the same stages."

The majority of clients in this group lived in reasonably close proximity to their extended family, but for them family influences appeared minimal.

Clients' perceptions of the work of health visitors

In an attempt to determine whether or not clients understood the range of work undertaken by their health visitor, they were asked to identify the sort of situation they thought the health visitor could help them with.

The following table summarises the responses:

Table 12 Situations Health Visitors could help with

	No. of Replies	%
Babies and Children	40	80
Maternal health and personal matters	19	39
Cares for all the family	12	24
Social issues, e.g. housing	12	24
Other	8	16
Don't know	6	12

Some gave more than one situation

n = 50

The majority had no difficulty in recognising the role of the health visitor as being concerned with babies and young children and nineteen saw the health visitor as someone concerned with maternal health in its widest sense. Issues mentioned under this heading included, breast-feeding, family planning and emotional health. Although a minority of mothers volunteered the information that neither their GP, health visitor or CMO had seemed particularly concerned about their emotional well being. One mother saying:

> "The health visitor seemed unaware that I was at my wits end."

another:

> "If only someone had asked me how I felt instead of asking if I was coping!"

This last statement probably shows a degree of reticence on the part of the mother which is shared by another, who said:

> "I expected someone to talk to me about my health, no-one did and I was too frightened to ask."

One client felt sure that the health visitor could help with personal problems, but said that the clinic was not the ideal place to discuss this kind of issue, she thought that a home visit would be more suitable. Although this question was not intended to be restricted to the work of health visitors in the clinic setting, it is evident that some of the responses were influenced by the nature of the survey.

The Fathers' View of Child Health Clinics

With the rising level of unemployment fathers are more likely to be at home during the day time and thus in a position to attend clinic, alone or with their wife. This together with a recognition of the father's role in child rearing, triggered the question: What does your husband or partner think about child health clinics? The following table summarises the replies.

Table 13 Fathers' Views of Child Health Clinics

	No. of Replies	%
Thinks they are good	6	12
Would/does go himself	20	40
Would not go alone	10	20
Would not go at all	2	4
Thinks they are woman's business	4	8
No opinion/Don't know	8	16

n = 50

Fathers who had attended clinic and were present at the research interview expressed their interest in the service, but two were very critical of the lack of privacy at clinic.

Reasons for attending

Clients were asked their principle reason for attending and what they expected clinics to provide. However, as the survey progressed to became apparent that the principal reasons given by most mothers for attending the clinic coincided with their expectations. This response could have been triggered by the way the question was asked, but for the purpose of analysis the two are combined and described as "Services Expected". Table 14 on the following page shows the principle reason for attending.

Weighing - Of the various services clients expected from clinics weighing was mentioned by the majority. Some also expected a measurement of height and were disappointed that this service was not routinely available. Analysis shows that out of 50, 45 mothers had their child/children weighed (90%), 19 of these felt that this was the most useful and reassuring service that the clinic offered. However, others found the emphasis on weighing irritating, one saying:

> "I wish the health visitor and her scales would jump into the nearest lake, the emphasis on weight makes me feel on trial and inadequate."

From discussion with mothers it would appear that some give the reason for attendance 'to get the baby weighed' yet once in the centre make use of other services. A situation noted by other researchers in this field including McFarlane (1985)and Bolton (1984)

Confirmation of Progress - Confirmation of the child's progress which is part of the process of monitoring weight, and a routine developmental check were services expected by the majority of clients. The fact that only 27 (54%) had received a developmental check at the time of being interviewed may have been influenced by the impact of other research being undertaken in the area.

Table 14 Services clients expected clinics to provide; their actual use of same and what they found most useful

	Services expected	Services expected and received	Services not expected but received	Ranked most useful
Monitoring of child's height and weight	46	45	1	19
Confirmation of babies progress	42	39	-	11
Routine check up of babies developmental progress	37	27	-	-
Advice - i.e. about feeding	42	23	1	4
Advice about a particular problem - sleeping, teething etc.	33	24	1	3
To meet other mothers	28	25	2	-
To get baby immunized	27	17	1	-
Teaching and guidance from staff about health matters	11	14	1	1
To talk to the HV about the baby/children	29	32	1	7
To talk to the HV about personal matters	12	11	-	-
To talk to the HV about family matters	7	7	1	-

continued.....

Table 14 continued

	Services expected	Services expected and received	Services not expected but received	Ranked most useful
To talk to the GP about the baby/children	3	3	-	-
To talk to the GP about personal matters	3	1	-	-
To talk to the GP about family matters	2	1	-	-
To talk to the clinic doctor about the baby children	17	15	1	3
To talk to the clinic doctor about personal matters	1	-	-	-
To talk to the clinic doctor about family matters	1	-	-	-
To buy food or vitamins	25	18	1	1
Don't know	4			

n = 50

That research encouraged health visitors to visit the mother and child at home for the first few weeks of life in order to weigh the baby and to monitor progress and thus an assessment at clinic was not necessary. On the other hand, some mothers were dissatisified with the developmental surveillance programme offered, they complained of feeling uninformed, ill prepared and uninvolved in the whole process.

Discussion with the Health Visitor - The expectations of clients in relation to discussions with the health visitor were generally met, 32 (64%) valued this service. Comments from this group indicated that they saw the health visitor's role in the clinic as positive and helpful. However, for some the lack of privacy and the long wait to see her was considered inhibiting.

Less clients than expected had actually consulted the health visitor about specific problems such as sleeping, or feeding, etc. This could have been influenced by the local pattern of home visiting as health visitors interviewed later in this study indicated that where possible they would prefer to handle this sort of situation at home. On the other hand, clients who did use clinics for this purpose found the Health Visitor helpful.

Those expecting to talk to the health visitor about their personal health and family matters increased slightly between the time of completing the first questionnaire and attending clinic, but only a few clients made use of this aspect of the clinic service. Privacy and the lack of time were mentioned by some as inhibiting factors.

The Opportunity to Meet Others - Mothers completed the first questionnaire soon after leaving hospital and returning home. At this time relatively few expected clinics to provide the opportunity to meet and talk to other mothers. After a time lapse of between six to ten weeks when the same question was asked for the second time the number expecting this service had doubled but was still only about 50% of the total.

It would seem that 25 out of 50 (50%) took the opportunity of meeting other mothers and sharing with them ideas and worries. There is evidence that the atmosphere in some clinics as well as spatial limitations hinder the opportunity for social exchanges. Several suggestions were made for improvement, including improved seating arrangements and the need for someone to be on the look out for, and to welcome new attenders. Those who commented on this topic stressed that it was usually left to mothers themselves to make contact with others and that some did not find this easy. Three single parents thought that the clinic they attended was not at all friendly, one saying:

"Other women just sit and look at you, no-one said hello."

Immunization - This is a matter with which the health visitor is closely involved, and an issue frequently raised by the health visitor with the parents at the first home visit. This could have influenced the high response, 76 out of 100, who initially expected clinics to provide this service. The fact that only 17 out of 50 (34%) actually used this service could be a natural bias in the results as the infants were in the main not old enough for their first injection at the time of the research interview. Alternatively, the same service could have been given by the family doctor.

Consultation with the Clinical Medical Officer - The numbers who expected to consult the CMO are relatively small, however, 15 out of a total of 50 (30%) did consult the CMO and whilst most found this useful, 3 the most useful service, 5 clients complained of difficulty in understanding what was said to them and what was required of them. The CMO in this instance was from overseas. From discussion with mothers and listening to their comments when answering this question it is possible to speculate that a few consult the clinic doctor purely because they cannot get an appointment with their own GP (and thus they may well be bringing unwell children to clinic). Some mothers could not understand why the clinic doctor could diagnose but not prescribe. This is a long standing problem and one which has confused and irritated clinic users for many years. (See p.17 Chapter 1)

Health Education and Teaching from Clinic Staff - Only a small percentage of clients expected to receive health education and teaching about health matters from the clinic staff and only 14 out of 50 (28%) actually did receive this service. Acknowledging that much of the health visitor's advice would consist of indirect health teaching, which may or may not be recognised as such by the recipients, there is evidence that more direct health teaching would be welcomed by some.

The one client who found this aspect of the service to be most useful was taught how to examine her breasts. This was her health visitor's health topic of the week.

Others also expressed the view that there was scope for video playbacks in the waiting areas and for leaflets and poster display in clinics. A few would have welcomed formal small group health education sessions if play facilities had been available for toddler.

Purchase of Cheaper Foodstuffs - About half the mothers in each of the sample groups expected to be able to purchase cheaper baby foods at clinic. 18 out of a total 50 availed themselves of this opportunity and some of this group stated that for them it was one of the main reasons for attending, but others pointed out that baby foods were cheaper in the local shops.

Consumers' Feelings about their Visit to the Clinic

Consumers' definition of their problems and their perceptions of the usefulness of a service will influence when and to what extent, they use the service. Hence it was decided to ask what clients felt about their visit to clinic. From a pre-coded list, clients were asked their opinions on a range of issues connected with their experiences and impressions of the clinic. Their replies are summarised under three broad headings.

The first grouping concerns factors relating to the general organisation of the clinic and the facilities it provides. Included under this heading are; clients views on the provision of play space and playthings, the waiting area, space and seating, waiting time and the degree of overcrowding experienced. Noise levels, directional signs, staff identification labels and the provision of pram shelters are also discussed in this section. Responses are shown in Table 15.

The second grouping concerns factors which contribute to the atmosphere within the clinic. These include, clients' views asto the friendliness or otherwise of the staff, the warmth of welcome they received and opinions as to whether or not any aspect of their visit had been confusing.

Table 15 Factors relating to the organisation of the clinic and the facilities provided

	Good	Satisfactory	Poor	No Reply
Facilities	27	16	7	-
Play space	19	10	20	1
* Play things	2	15	14	19
Waiting area	19	14	16	1
Waiting time	19	18	13	-
Over- crowding	16	14	20	-
Noise levels	16	14	16	

n = 50

* Note: This item was not included in the first batch of interview schedules, it was identified by so many clients that it was included in the later interview.

The third grouping concerns the professionally related activities that take place in clinics. Included here will be: clients' perceptions of the level of privacy within the clinic setting, their views as to whether or not the visit had been embarrassing in any way and whether or not their needs had been met and if they considered that they had received individual attention. Responses for both groupings are shown in Table 16, on the following page.

Table 16 Factors which contribute to the atmosphere within the clinic and professionally related activities

	Good	Satisfactory	Poor	No Reply
Friendliness of staff	34	8	8	--
Welcome received	26	14	7	3
Degree of confusion	33	7	10	-
Level of privacy	30	7	13	-
Embarrassment	37	2	7	4
Individual attention	37	11	2	-
Meeting of individual needs	38	6	6	-

n = 50

Factors Relating to the Organisation of the Clinic and the Facilities Provided

Overall the facilities and organisation of the clinic was seen as broadly satisfactory to the majority (27 clients). Two expressed the view that clinics are something to look forward to and aren't used often enough. Other comments included:

"Clinics are very helpful and well run."

"I would like more of them."

"Clinic is very important for mothers of first time babies, and the health visitor is the first one I turn to for help!"

"All the services are excellent."

"My clinic is really good, they do their best to keep everyone happy. They are also good with toddlers."

However, a number of suggestions for improvement were made and by looking at all levels of dissatisfaction with the organisational aspect of the clinic, one of the principal grounds for dissatisfaction concerned the lack of facilities for toddlers and older children. Twenty mothers felt that the play space provided was inadequate, whilst a further 14 clients thought that more toys, books and structured play should be provided.

The Waiting Area, Space and Seating

This finding would appear to be associated with one of the other main causes of dissatisfaction which was, personal stress experienced by some mothers whilst on occasions enduring quite long waits in crowded and maybe uncomfortable waiting areas.

Twenty clients expressed the view that the clinic was too crowded, but most said that there were usually enough seats provided for everyone attending. There were exceptions to this, and in two centres the waiting area was said by some members of the sample to get over-crowded on immunisation days. The majority of clients found the seating satisfactory, but one thought that it was not suitable for nursing mothers. Six clients said that the chairs were placed in straight rows, too close together. One commented,

"All I saw was rows and rows of chairs."

In one centre the chairs were positioned in rows facing the table where the HV sat and a few mothers felt this to be inhibiting. They pointed out that such an arrangement does not encourage mothers to talk to each other. One stated that:

"I had nothing else to do but listen to what the health visitor was saying to other mothers."

Two clients expressed the view that a more informal setting would encourage mothers to talk to each other. One adding:

> "It is the mothers themselves who initiate contact with others and thus the seating is important."

A further two mothers indicated that since their clinic had changed premises from an old army Drill Hall to a new purpose-built health centre, the situation had worsened in this respect, one said:

> "In our old clinic, mothers used to sit in a circle and the children were safe to play in the middle. Since moving into a new health centre the seating arrangements are more formal. We can't see and talk to each other like we used to."

Waiting Time, Numbers Attending and the Degree of Over-crowding

Opinions as to the waiting time in clinic were fairly evenly distributed. Nineteen respondents (38%) were broadly satisfied, whilst 18 (36%) were not sure. Thirteen clients (26%) were dissatisfied, but some of this group qualified their opinions with the statement that the waiting time varied with the time of day and type of clinic. Immunization clinics were always crowded and 14% of clients said that on these days they expected a long wait. However, waiting to see the doctor was a different matter, one mother said:

> "I had to wait too long. I had an appointment to see my own GP, but in the end I didn't see him. I would have liked to have seen him."

Suggestions for improvement included the plea for a separate immunization session, and for an appointment system that is kept. Block bookings were not popular. However, an appointment system may not solve the problem as some of the mothers interviewed stated that in order to be "first in the queue" they attended clinic some thirty minutes before the session started, so despite pleas that something be "done about it" the solution may not be that straightforward.

Over-crowding, waiting time and noise levels were said to be worse during school holidays. Four clients stating that school children added to the problem and were very noisy. Overall 16 clients found the noise level high although most accepted that by the very nature of the clinic this was to be expected. However, the suggestion from one mother that a loud hailer or public address system should be used for staff to be heard, would suggest an unacceptably high level of noise. Yet only one person expressed total dissatisfaction with the noise level, she said:

> "School children are to blame. They fight and squabble and should not be allowed in."

Other sources of dissatisfaction which were spontaneously identified by some respondents, (the item not being identified from the pre-coded questions) included a concern for the lack of directional signs, the need for staff identification labels and the provision of pram shelters.

The lack of directional signs and staff identification labels were mentioned by 10 clients (20%) whilst a small number of mothers (4) expressed difficulty in actually locating the clinic within the health centre. One saying:

> "I could hear the babies crying and could see the pram park, but couldn't find my way in. I asked a receptionist who wasn't very helpful ... so I went home in tears and rang and asked if the health visitor would call and see me."

Another commented that the clinic was held on the second floor of the health centre, and this was not easy to find, or convenient, even though there was a lift.

Pram shelters were also identified by a few mothers as an area of concern. One found them excellent - whilst three felt that they were not sufficiently supervised. One commented:

"I was worried all the time about theft and vandalism, I couldn't relax at all."

another said:

"Most inadequate, poorly positioned, there were notices everywhere warning you to take care of your belongings - and yet you couldn't see the pram park from inside. It put me off going back."

Other facilities mentioned by mothers concerned the need in some centres for improved refreshment facilities, feeding and changing rooms for mothers attending clinics and the provision of more toilets. One mother stated that:

"There was only one toilet and there was often a queue of mothers and toddlers waiting to use it."

Factors which contribute to the atmosphere within the clinic

The following findings relate to the second group of questions and are concerned with the clients' perception of the friendliness of clinic staff, the welcome they received and the atmosphere within the clinic. Also included is a summary of the degree of confusion experienced by clients when attending clinic.

Friendliness - A high percentage of clients, 34 mothers (68%) thought that their clinic was a friendly place. Favourable comments include:

"All the staff are friendly, it's a jolly nice place to go."

"The staff have been there a long time and they know everyone. They always talk to you, they have time for you."

"They talk to you and play with the baby."

"You aren't made to feel in the way, they are friendly and toddlers are welcome."

"I couldn't speak too highly of my health visitor she is friendly and helpful, the first one I turn to for help."

On the other hand 8 people did not feel their clinic to be friendly. Three specifically mentioned their disappointment in this respect and one described it as a cold, impersonal place suggesting that:

"A few posters and pictures on the wall would add warmth."

Others expressed the view that the atmosphere within the health centre which in this instance was big and newly opened. was not so warm or relaxed as in their old clinic. They described it as:

"Too big and off-putting."

This factor was mentioned several times in different ways and may well have added to the feelings of unease and confusion which was commented on most frequently by clients attending clinics based in one or other of the health centres included in the study.

Warmth of welcome received - There is evidence that the welcome received by clients attending clinic hinged on the reactions of the first person encountered. The majority of clients, 26 (52%) were mainly satisfied with the welcome they received, but several added the rider that for them the first visit to clinic was difficult.

Fourteen (28%) mentioned the receptionist either as being particularly helpful in this respect or "off-putting". One commented that:

"The receptionist is the most important as it is she who sets the tone... mothers want to be welcomed by the first person they meet."

Five thought that the receptionist acting as the clinic booking clerk was helpful and made them feel welcome and at ease.

On the other hand, 9 clients did not feel welcomed, comments here included:

"I went in and these ladies in white were just sitting there. I felt silly and didn't know what to do, they didn't offer to help me... I was embarrassed and stood around."

"The receptionist was not helpful, but not unpleasant, she didn't speak to me or the baby. I didn't know what to do."

"The receptionist was very busy and in a panic, there was too much going on, she didn't help me settle in."

"Health visitors can't see you come in and I waited fifteen minutes before asking the receptionist what to do."

The last comment was mentioned by others, who felt confused and uncertain as to what was expected of them. However, those who knew what to expect before attending felt self-assured and at ease.

Degree of confusion experienced - As before there is evidence that clients who understood the purpose of the clinic and whose health visitor had told them what to expect and what to do when attending clinic were satisfied. Thirty-three (66%) came into this category. For this group their visit to clinic was quite straightforward and not at all confusing. However, a small, but nevertheless significant number, 10 (20%) expressed some frustration about their feelings of confusion and lack of adequate preparation for their first visit to clinic. Comments here included:

"The routine should have been made clear before I went."

"A lot of people don't know what to do at the first clinic ... it's difficult at first no-one around to tell you what to do, but it gets better later."

"Wasn't sure what to do at first but other mothers help."

"There are so many things going on in clinic it is all confusing."

Although the numbers dissatisfied with this aspect of the service is small it would appear to be a relatively simple task to ensure that clients are informed about the purpose of the clinic and know in advance what is expected of them when they attend. Indeed,

one mother suggested that this was essential information which was the right of every mother, but she made the plea:

> "Please don't tell us at the first home visit ... soon after would be better."

Factors related to professional activities that take place at clinic

The following findings relate to the third group of questions and are concerned with the clients' perception of: the level of privacy in the clinic, embarrassing situations experienced, their views on whether or not they had received individual attention and whether or not their needs had been met.

Privacy - Analysis shows that 30 clients (60%) were in the main satisfied that their consultation with either the health visitor or doctor at clinic was private. However, 13 clients (26%) were dissatisfied with the lack of privacy they experienced at clinic. Within this group the main complaint was that they could overhear the health visitor's conversation with mothers whilst they awaited their turn. Two mothers commented that the only attempt at privacy was for the health visitor to sit behind a screen. However, these two did not seem to mind being overheard themselves, but they did not like overhearing other consultations. One mother thought that the big clinics were more private as there was too much going on in them for anyone to hear what was happening!

Although some health visitors were able to consult in the privacy of individual consulting rooms, this was not totally acceptable to all mothers. Two did not like the atmosphere of the individual room, one said it was:

> "Overbearing and authoritarian, too much like school... or the boss's office."

In another centre the health visitor was said to consult in a private room but to leave the door of the room open, two mothers

found this to be embarrassing, one saying:

> "I was forced to listen to what was going on inside... the corridor we were waiting in was too small to do anything else."

It would appear that privacy is an individual concept, and that although lack of privacy is keenly felt by some, not all are bothered by it. It would also appear that solutions acceptable to all may be hard to find.

Embarrassment - This is closely related to the level of confusion felt and the amount of privacy available within the clinic. Again it is a variable concept, some mothers saying that their own baby was the main source of their embarrassment, others feeling acutely embarrassed by their own uncertainty. However, on analysis, the majority, 37 clients (64%) were not embarrassed and a further two found this aspect of the service broadly satisfactory. Seven (14%) did experience embarrassment of one sort or another at clinic. Four did not reply to this question.

The most frequently mentioned source was again lack of privacy and the inability to discuss freely for fear of being overheard. Four Mothers pointed out that, "Things do get better as you get more used to going", highlighting again the importance of preparing clients prior to their first visit to the clinic.

Individual Attention - Under this heading clients were asked whether or not they felt they had been treated as an individual or just another case. In response 37 clients (78%) were satisfied with the level of individual attention they had received and a further 11(22.1%) were broadly satisfied. Only two expressed dissatisfaction in this respect, one commenting that:

> "My health visitor was too busy and rushed to talk to at clinic, a home visit is more useful."

A view shared by a few others who spontaneously mentioned the lack of health visitor time at clinic. One father commented:

> "Our health visitor has more time and is more relaxed at home. We always make a point of asking her to call and see us at home."

However,by far the majority were completely satisfied with this aspect of the service, some expressing surprise that they and their children were known and greeted by name.

Meeting Individual Needs - One of the major criticisms of child health clinics is that they have failed to adapt to the needs of their clients. It was against this bachground that parents were asked to comment on whether or not their needs had been met at clinic. The response was mainly positive, 38 clients (76%) expressed satisfaction with this aspect of the service. Six clients (12%) were dissatisfied, their visit to clinic did not live up to their expectations. One new mother said:

> "There was no individual attention, clinic was more of a group thing and I did not expect this."

Another was satisfied with her first visit, but did not know why she bothered to go back again. One new mother expressed the view that the health visitor was too busy and thus she did not have time to chat and ask questions.

Another expressed the opinion that not all health visitors understood the needs of mothers, who she argued:

> "Were often at their wits end.... does the health visiting service have to end at 5.00 p.m.?"

One mother suggested that health visiting advice is never tailored to the individual needs of mothers, commenting:

> "I would like to know if there are any research facts underlying the advice health visitors give. I like to know 'why' and health visitors treat you all the same, they don't bother to explain they just say 'do'."

An opinion shared by one other who found the health visitor to be patronising and off-putting. She said:

> "She (the HV) gives little credit for a mothers' intelligence, she never gives reasons for her advice - her advice is inappropriate."

General Practitioner Based Clinics

Although the numbers attending clinics based in GP premises were small, (12 clients) all were broadly satisfied with the service offered. However, 4 mothers thought that the surgery waiting area was not geared towards the needs of small children; comments included:

> "The waiting area left much to be desired in the way of space and comfort."

> "The floor is highly polished and dangerous."

All in this group suggested the need for toys and play space, although some acknowledged that the provision of same may be difficult. These clinics were not over-corwded and no-one complained of excessive noise levels.

In Summary

It would appear that the majority of clients were broadly satisfied with the organisation of the child health clinic. However, the environment is important and many clients identified issues which need further attention from the providers of the service.

Privacy and embarrassment are important considerations but are variable individual concepts and as such, solutions acceptable to all may be hard to find. The majority of clients considered that their needs had been met and that they had received individual attention from the clinic staff.

CHAPTER 6

RESULTS - THE HEALTH VISITOR INTERVIEWS

The objective of this part of the study was to explore with health visitors their interpretation, objectives and degree of satisfaction with their own involvement relating to their work in child health clinics.

The results start with background information on the organizational setting of the clinics from which the health visitors work. The staffing patterns and information on whether or not health visitors see their own families at clinic follows. This in turn is followed with an account of the health visitors' views of the range of services clinics should provide and their opinions as to whether or not attendance at clinic drops off as the child gets older.

The degree of health visitor satisfaction with the service provided, together with their suggestions for change leads into the last section which is concerned with the health visitors' objectives for their work in clinic.

The sample group for this part of the study was comprised of the 10 health visitors who had the highest number of clients participating in the study.

Clinic Premises

Against the background of organizational change in the staffing and provision of child health clinics within the study area. (These changes have been described in Chapter 1) It was

considered necessary to establish the type of clinic premises from which the health visitors worked. Information concerning the numbers and range of staff working in child health clinics was also collected. The results for both groupings are summarised in the following table:

Table 17 Clinic Premises from which the Health Visitors worked and Staffing Patterns

	No. of Replies
Health Centre	6
General Practitioner Surgery	2
Purpose Built Clinic	1
Church Hall	1
Clinic Staffing Patterns	
*Health Visitors	10
Clinical Medical Officers	7
*Part-time/Paid Clerks	5
Voluntary Workers	3
Doctor's Clerk	1
Food Sales Ladies	4

* Note: 2 health visitors worked alone
1 clinic had 2 paid, part-time clerks
2 clinics had no clerical help

N = 10

Reference to the above table shows that whilst two clinics are staffed purely by health visitors the others employ a variety of grades of staff, each with a distinct contribution to make. As other researchers, notably Orr (1980) and Hunt (1972) have commented upon consumer confusion with regards to the legitimate concerns of the health visitor, it was decided to ask the health

visitors if they considered that members of the public attending clinic understood the varying roles and functions of the clinic staff. In reply, three were certain that their clients did understand, three felt that theirs did not and two thought that they probably did understand. This question was not appropriate to the two health visitors who worked on their own in clinic.

Comments included:

"They are only uncertain at the first visit."

"If they are confused they will ask the first person they see."

"Well... the first visit is confusing anyway."

"I explain it to them before they come they soon catch on."

Continuity of Health Visiting Contact and Advice

Lack of continuity of health visiting care can result in a fragmented service which is confusing and irritating to the consumer. Fragmentation is most likely to occur when, because of general practitioner attachment, some mothers cannot attend the same clinic as their health visitor. However, in this study eight of the ten health visitors interviewed always saw their 'own' mothers at clinic. The remaining two indicated that they usually did.

Comments included:

"I see about 60% of my own mothers at clinic."

"Not many of my families attend, so I can afford to spend time with those who do."

All ten health visitors were able to refer those clients who needed additional help directly from clinic. The range of

referrals included, liaison with other health visitors, the family's general practitioner, the appropriate clinical medical officer and social worker. However, whilst all ten health visitors could and did refer their clients directly from clinic, four commented that as a general rule they would normally consult the family's general practitioner first.

In order to ascertain whether or not health visitors considered that their clinic currently catered for the needs of the consumer, they were asked their opinions as to the range of services child health clinics should provide. Responses are shown in Table 18.

Table 18 Services Clinics should provide

	No. of 'yes' replies
Monitoring of child's height and weight	5
Confirmation of babies progress	6
Routine check up of babies developmental progress	6
Advice - i.e. about feeding	1
Advice about a particular problem - sleeping, teething, etc.	6
To meet other mothers	8
To get baby immunized	3
Teaching and guidance from staff about health matters	5
Health Visitor advice about the baby/children	6
Health Visitor advice about personal matters	1
To consult clinic doctor about the baby/children	2
To buy food or vitamins	2
Self help	1
Behaviour modification	1
To maintain family contact	1

(Health visitors gave more than one reason)

N = 10

The next question asked the health visitors to suggest the main reasons why they thought that mothers attend clinic. The majority seven out of ten, thought that parents expected most of all to get their babies weighed and to get confirmation of their child's progress and reassurance in their own ability to cope. Responses are shown in the following table.

Table 19 Health Visitors' opinions as to why mothers attend clinic

	No. of Replies
To have baby weighed	7
For reassurance that she is coping	7
For general advice and guidance	3
To monitor babies' progress	6
To sort out problems	6
To see her health visitor	1
To have baby immunized	3
To buy foodstuffs	2
In response to health visitor's invitation	1
To accompany friends	1

(Health visitors gave more than one reason)

N = 10

Patterns of Clinic Attendance

In an attempt to match the clients' perceptions of age groups for whom child health clinics cater, the health visitors were asked if clinic attendance dropped off as the child got older. In reply, all ten said "yes".

Comments included:

"Attendance does drop off as the child gets older, but I often tell the mothers not to come so frequently anyway." (2 health visitors)

"Attendance drops off when the child gets about eighteen months old, but mothers will come back to clinic with friends, or for special tests."

"My mothers don't come regularly but they will always attend for routine developmental tests, etc."

The next question, closely related to the above, asked if health visiting contact declines as the child got older. Again all ten health visitors said yes, their contact did decline as the child grew up.

All health visitors in the study were fairly confident that they could maintain some health visiting contact unless the family moved away. The level of contact was dependent upon the size of the individual's caseload. Some indicated that if they had managed to establish a satisfactory professional relationship with their families, the clients would always request the health visitor to make a home visit or they would return to the clinic when the need arose.

Comments included:

"It is the local health visiting policy that health visitor surveillance should be greater when the child is very young." (4 health visitors)

"I hope to maintain contact with all age groups but due to heavy caseloads, health visitor contact does decline as the child gets older." (3 health visitors)

"Reluctantly health visitor contact does decline as the child grows, but families can always ask for help." 2 health visitors)

"I consider the need for health visitor contact and surveillance is during the baby's first year. Most health visitor contacts are made then."

Health Visitor Satisfaction

Health visitors were asked how satisfied they were with their own level of involvement in relation to their work in clinics. Two were very satisfied, three satisfied, two mainly satisfied, two not satisfied and one did not know. Satisfaction centred around the opportunity to see and talk to all who attended, to advise as appropriate and to send mothers away reassured in their own ability to cope.

Dissatisfaction centred around the lack of privacy, over-crowding, lack of play space and toys and unsatisfactory clinic times.

Comments from those who were dissatisfied included:

"I am only reasonably satisfied, would like more time to talk to clients, if fewer came and clinics were smaller I would be able to do better health visiting."

"Clinics are not sufficiently private, it is difficult to explore some issues."

"Too many people come... too much rush. Some mothers come too frequently, they keep on coming."

Changes Initiated by the Health Visitor

The next question asked if the health visitor had been able to initiate any changes within the clinic. Five had been able to initiate change, five had not.

Changes initiated included: one health visitor who introduced open clinic sessions, mothers can come when they like. Another pressed for and eventually obtained, an extra doctor's session. In one of the busiest clinics the health visitor was concerned that children should be able to play in safety whilst waiting for their mothers, she requested and obtained a door into the play area.

An appointment system was introduced in one centre specifically for mothers who needed more time for consultation.

Changes Health Visitors would like to make

The health visitors were asked to suggest any changes they would like to make. In reply, two did not want any change and eight made various suggestions which are summarised below:

"More space so that I can mount health education displays." (2 health visitors)

"Health education facilities such as display boards and video films should be available for mothers to watch whilst waiting." (2 health visitors)

"Clinics should be a more social gathering, our premises are not conducive to this." (3 health visitors)

"Facilities for toddlers should be improved, more play space, low tables and toys should be provided."

"A library of reference books for mothers would be useful, but perhaps difficult to maintain."

"Immunization clinics should be held on a different day, or as a separate session, at the moment too many people come and there is a muddle."

"Private consultation rooms should be provided. At the moment I have to make an appointment to see a mother at home as we can't talk in clinic." (2 health visitors)

"More flexible clinic times. Earlier start and finish would help."

"An improved heating system in the Church Hall."

"I would like to see the waiting area of the GP surgery more geared to the needs of children." (2 health visitors)

Following on from this the health visitors were asked if they could suggest ways in which the clinic service could be improved. Two said "no", eight made a variety of suggestions which included;

the need for improved facilities, in particular, the waiting area, which they perceived as cramped and unsuitable, the need for play space and playthings and for private consultation rooms.

Two wanted more space in clinics in order to mount health education displays. Three asked for video play-back facilities and five thought that clients should be given the opportunity to watch video films whilst waiting. In this respect, two health visitors commented:

> "That waiting time at clinic should either be reduced or turned to 'positive' good and used for health education purposes, after all... we have a captive audience."

Two health visitors felt that there was a duplication of services, one commented:

> "The duplication of services between the health authority child clinic and general practitioners, well baby clinic should be eradicated. At the moment some babies are checked by the health visitor, GP and CMO, this is expensive and unnecessary."

However, the same two health visitors considered their present GP premises to be unsuitable for clinics. One said:

> "If clinics are to be held in practice premises improved facilities are necessary. At the moment these are hazardous, scales are placed on the desk, the floor is slippery, no separate tables are available and access to cupboards is difficult."

One health visitor thought that the clinical medical officers' notes were too brief to be useful. She said:

> "A better service could and should be given if we are to have accurate developmental records."

Another health visitor expressed the need for more clerical help and one asked for a better supply of health education leaflets.

Clinic Opening Times

Other suggestions for change centred around the clinic opening times and in response to the question, "Would you like to see a 'drop in centre' organised on informal lines open daily?" Eight said "yes", and two "no". This question caused much debate and of the eight who thought it to be a good idea, there was broad agreement that probably it would need to be staffed by a rota of health visitors and open from approximately 9.00 a.m. - 5.00 p.m. However, it was speculated that only mothers who use the present service would 'drop in'.

Comments for and against the suggestion included:

> "Probably a good idea, but it doesn't need to be open all day, mothers should know how to contact us."
>
> "A very useful idea but I can see administrative difficulties in actually getting started."
>
> "Surely we have an open system already, my mothers know when to contact me and they do."
>
> "Does such a centre necessarily have to be staffed by professionals? Have not volunteers got a role here?"

Three health visitors expressed concern about the lack of evening and weekend health visiting cover. One thought that a service that aimed to offer advice and reassurance in response to parental need should be available over the twenty-four hour period. Another thought a 'drop in centre' was particularly needed at weekends when the other services were closed. One other thought that there were usually plenty of people around at this time and the evenings were often a time of parental stress and that a 'drop in centre' open in the evenings may help to alleviate some of the problems associated with bringing up children.

Health Visitors opinions as to their clients' most likely source of non-professional help

As highlighted in Chapter 3, which discussed some of the reasons for the inclusion of certain questions, the influence of the extended kinship network can be an important factor in the take up and use of health care services. Thus health visitors were asked, "Who do mothers turn to for help and advice with their children?" (non-professional) The following table summarises the health visitors' replies.

Table 20 Sources of Non-Professional Help

	No. of Replies
Own mother	5
Grandmother	3
Other family members	6
Friends	6
Neighbours	2
Play Group Leader	1
National Child Birth Trust	1
Self Help Groups	1

(Health visitors gave more than one answer)

N = 10

All ten health visitors felt reasonably confident that most of their clients had satisfactory social network support systems. Five health visitors commented upon the level of extended family contact within their area. Two stated that it was a very matriarchal society and the girl's own mother was very much the centre of child rearing. Those clients who did not have their own family living nearby.

(p.65) were said to be reasonably well-supported by friends and neighbours.

Health Visiting Objectives

The last question on the interview schedule sought to explore the health visitors' objectives for their own work in clinic. A variety of objectives were given, but on analysis the results fall into four broad categories.

The first group of objectives concerns the health visitor's role in surveillance. In this group the following replies were received:

> "To monitor the development of the infant by regular surveillance of weight and height." (4 health visitors)
>
> "To offer a programme of developmental surveillance which includes the oversight of all aspects of development." (4 health visitors)
>
> "To see that the baby is thriving and developing normally."
>
> "To observe the mother and baby interaction."

The second group of objectives related to the health visitor's role in health education. In this group the following replies were received:

> "To provide 1:1 health teaching, I do it all the time."
>
> "To improve the health of the mother and baby."
>
> "To promote the health of mother and baby physically, emotionally and socially ... these are the aims of health visiting and the same goal should apply to the health visitor's work in clinic."
>
> "To inform and teach .... even the most basic things need to be said."
>
> "To offer 1:1 health education as appropriate." (5 health visitors)

Four health visitors commented that whilst they would aim to promote health in clinics, the setting was often not ideal.

The third group of health visitor objectives relates to the health visitor's work with mothers. In this respect the following objectives apply:

> "To send mothers home with increased self-confidence and re-assured in their own ability to cope." (4 health visitors)
>
> "To increase the mother's self-confidence." (2 health visitors)
>
> "To promote an atmosphere which is relaxed enough to develop a sound health visitor/client relationship." (4 health visitors) One added, "This is often difficult in the clinic setting."
>
> "To offer social contact and an opportunity to meet other mothers."
>
> "To see and talk to as many mothers who wish to come."

The fourth grouping concerns the giving of advice on general child care, the immunization programme, feeding etc. and the availability of services. The following objectives fall into this group.

> "To respond to parental concerns and anxieties, especially with regard to advice concerning feeding and weighing." (4 health visitors)
>
> "To help with any problems the client may present." (3 health visitors)
>
> "To refer to other agencies as appropriate ... to act as a liaison person." (2 health visitors)
>
> "To discuss the pros and cons of immunization."

At the conclusion of the interview the health visitors were free to make comments in relation to any aspect of their work in clinics which had not previously been covered. This invitation allowed for an exchange of views and discussion with the researcher. Comments which have not been discussed elsewhere include the views of one health visitor who was experiencing pressure from middle-class mothers. She said:

> "Middle class mums expect to be able to talk and consult freely with the health visitor at the clinic ... now we are in a health centre they expect privacy and more time."

Another two commented on the work of the clinical medical officer, they thought that his role was misunderstood and undervalued by the clients. One health visitor said:

> "Despite not being British our CMO is a good practitioner. He gives a detailed and comprehensive developmental assessment which is well recorded ... Yet mothers can't communicate with him, so they under value his contribution or else don't come."

CHAPTER 7

Discussion of the Findings

What did the clients initially expect from the child health clinic? For some this proved a difficult question to answer: expectations are shaped by one's experience and this also applied to clients participating in this study, whose expectations were influenced by their experiences with, and previous knowledge of, this aspect of health care. Although the differences between first time mothers and those who had more than one child were few, those who had met their health visitor previously had clearer ideas and more sharply focused expectations than those who had no prior contact with the health visitor or child health services. This is reflected in the comments (page 103) of the ten first time mothers who felt confused and uneasy on their first visit to clinic. A similar finding to that reported by Macfarlane and Sefi (1985).

Reference to Table 14 (pp.90 &91) shows that on the whole the clients' expectations were met and that their expectations coincided with what they actually received. The majority of parents expected clinic staff to weigh their baby and to confirm that all was well. A similar finding to that reported by Bolton (1984), Biswas and Sands (1984) and Macfarlane and Sefi (1985). This is in contrast to evidence given to the Sheldon Committee (1967) which suggested that routine weighing at clinic had lost some of its popularity and should therefore be discontinued.

When comparing the clients' expectations with the health visitors' perceptions of what they thought the clients wanted from the child health clinic itself very few differences emerge. The health visitors also thought that parents expected most of all to be able to weigh their baby, to get confirmation of their child's progress and reassurance in their own ability to cope. (Table 19)

There was broad agreement from both groups that the clinic facilities were not always suited to the needs of mothers and children. Whilst this finding related to clinics based in health centres as well as those held in other premises, it is particularly true of clinics based in general practitioner surgeries. Although not overcrowded, G.P. practice premises were considered cramped and in one instance, unsafe for small children. A similar finding to that reported by Sefi and Macfarlane (1985). This finding is not unexpected as most surgeries are not designed to hold clinics and there is usually a shortage of floor and storage space. However, if the majority of clinics in the future are to be based in practice premises, as is the wish of the Royal College of General Practitioners and a recommendation of the Court Report (1976) and the Green Paper on Primary Health Care (DHSS 1986) then this situation will need much more attention if clinics are to be safe and acceptable.

In the main, health visitors as well as clients recognised the need for play facilities and play space at clinic for accompanying children. Although some clinic premises were neither safe nor suitable for children to play unattended. Even in the newest health centre included in the study, adequate consideration had not been given to this aspect of the service provision.

The finding that some mothers found access to the clinic difficult in the absence of directional signs, surprised most of the health visitors. It could be that their familiarity with the

building and premises, made most of them unaware that some mothers felt threatened and uneasy by the sheer size of the building. One health centre housed seventeen general practitioners and a host of other services and was in reality a fairly large institution which the researcher found intimidating. In the Oxfordshire study Sefi and Macfarlane (1985) pointed out that the variety of buildings in which clinics are held together with a diversity of organizational settings within could be confusing to new mothers.

The finding that only five out of the ten health visitors thought that their clients understood the varying roles and functions of the clinic staff, would support the need expressed by some clients that staff should wear identification labels. The receptionist is often the first point of contact when the mother walks into the clinic and the findings show that the welcome received by clients was not always as helpful or welcoming as it should be. (p. 102) This contrasts with one centre where the volunteer receptionist had been attending the same clinic for many years and knew everybody by name, much to the delight of the clients! Whilst identification labels will not of themselves solve problems overnight, their introduction may go some way in helping new mothers attending clinic for the first time find their way through the system.

The lack of privacy, linked with the level of embarrassment experienced by mothers at clinic was mentioned by both clients and health visitors. The health visitors expected that most mothers would be dissatisfied with this aspect of the service but only 26% of clients expressed this view. (p. 104) However, this leaves little room for complacency although, solutions acceptable to all may be hard to find as the health visitors thought that the provision of more private consultation rooms would solve the problem, whilst not all clients saw this to be the answer. Indeed reference to clients' comments (p. 104)

shows that some did not like the idea of private consulting rooms at all, for them these were too uncomfortable, smacking of officialdom and associated with bureaucracy.

Another discrepancy appeared between the clients' perception and those of the health visitors in so far as at the time of the follow up interview only (50%) of clients expected clinics to provide the opportunity to meet and talk to other mothers. Whereas eight health visitors out of a sample of ten expected clinics to provide this facility. Whilst no health visitor cited this as the main reason why mothers attend clinic (see Table 19 p. 112) Eight health visitors commented that most mothers would expect to meet other mothers at clinic and that this would be an important aspect of their visit. One said:

> "Clinics should be a social gathering .... a time when mothers can meet together."

Whilst acknowledging this ideal, some health visitors pointed out that the social organization of the clinic mitigated against the achievement of this goal, a view shared by some of the consumers whose comments were recorded in Chapter 5.

Writers and researchers in this field, including Jenkins **(1984), Polney (1984)**, Macfarlane and Sefi (1985) all agree that clinics should aim to meet the social needs of clients by providing a place for social contact. Certainly health visitors are taught that clinics should help to facilitate meetings with other mothers and that the social aspect of the clinic setting is of the utmost importance if mothers are to come in the first instance and to return for second or subsequent visits.

In this study, relatively few clients expected clinics to provide the opportunity to meet and talk to other mothers. When the question was asked for the first time before mothers had had the opportunity of attending clinic, 25% of clients

expected clinics to provide the opportunity for socialization with other mothers. (p. 74) After a time lapse of between six to ten weeks when the question was asked for the second time, the number expecting this service had doubled, but was still only 50% of the total. Bolton (1984) suggests that there are variations between clientele at each clinic and that what mothers expect from the service also tends to vary from clinic to clinic. She postulates that mothers living in rural areas who may be more socially and geographically isolated are more likely to look upon the clinics as a place to meet other mothers and children. As the present study was conducted within an urban area and most mothers had reasonably satisfactory social network support systems, it could be that for these mothers the social aspect of clinic is not important. In any case some clients found the seating arrangements inhibiting and others who were left to introduce themselves to other mothers found this to be unsatisfactory. (See page 93) Macfarlane and Sefi (1985) in their study found that many mothers greatly valued the opportunity attendance at clinic provided for social contact with other mothers and children. They also found that when health visitors took the initiative in introducing mothers to each other, the social aspect of the clinic improved.

Jenkins (1984) argues that if clinics and the professionals who staff them fail to recognise the social implications of clinics these will cease to be attractive and useful to parents. However, findings from this study suggest that clients may not view the clinic as a social meeting place, mothers and others merely using the clinic for the range of professional services offered. Certainly the seating arrangements and social mileau of some clinics would need modifying if this goal is to become a reality.

The accessibility of the clinic was explored from the point of view of the geographical location of the clinic, the travelling time involved, and the degree of client choice. The results are shown in Tables 8 and 9. There is a natural bias in the results concerning distance travelled to clinic as those living some distance away are unlikely to attend.

The findings that in the main, clients attended a clinic nearest to their own home is consistent with the findings of other studies. (Macfarlane and Sefi 1985, Biswas and Sands 1984)

The question of clinic opening hours and the limitation of the health visiting service to week days between the hours of 9.00 a.m. and 5.00 p.m. was of concern to some clients. Others were satisfied and said that they knew that they could always get in touch with their health visitor if they needed help. Most health visitors agreed that clients would know how to contact them if and when the need arose. The clients that expressed dissatisfaction with the clinic opening times gave a variety of different and sometimes conflicting suggestions as to when the clinic should be open, for example some wanted a morning session, others wanted an afternoon. Thus it may well be difficult to find a solution acceptable to all. However, one theme ran through many of the clients' comments, and this is related to the length of time the clinic session lasted. Some mothers felt that two hours was not long enough, they had to rush to get there and when they arrived the clinic was closing!

The idea of an appointment system was enthusiastically received by the parents of more than one child. First time mothers expressed the view that their routine was such that they would find the keeping of a set appointment difficult. There was, however, broad agreement both by the clients and the health visitors that appointments should be given and kept, for immunisation sessions.

In response to the criticisms voiced in the Court Report (1976) and echoed in many publications since, that consumers would welcome a twenty-four hour comprehensive cover from their health visitor. Health visitors were asked their views on the clinic opening times. The findings (Chapter 6, p. 117) show that whilst they were concerned that the service may not be meeting the needs of some clients, there was no overall concensus as to how the problem could be solved. The notion that because the health visiting service is a preventive service and by definition this rules out crisis and emergency work, was reflected in some of the health visitor's replies and the idea dies hard in some areas. However, eight out of the ten health visitors thought that a 'drop in centre' organised on informal lines would be a good idea. All of this group agreed that it should be open daily, but there was no agreement as to who should staff such a centre. On analysis it is possible to detect a desire for the status quo, despite protestations to the contrary. Albeit, some health visitors thought that the introduction of a rota system so that there is always one health visitor on call would be a way forward. (p. 117) Others argued that this would bring about a fragmented service as mothers could not guarantee to see their own health visitor. A finding similar to that reported by Field et al (1984).

However, the issue of an extension of the hours of health visiting cover is of continuing concern to consumers and professionals alike. It is an issue which becomes increasingly important if health visiting is really to respond to the needs of society in the 'eighties. The present system was set up in response to the social needs of mothers who did not usually work outside the home. Times have changed and there is evidence cited by the Court Committee and others that the present services may be failing those requiring help. Although only a small number of clients in this study voiced the need for extended health visiting cover, those that did so, felt strongly about this issue.

A further discrepancy appeared between the clients' perceptions and those of the health visitors in relation to health education. Just over a quarter, fourteen (28%) of clients expected to receive health education and teaching about health matters at clinic and the same number actually received this service (Table 14). From discussion with parents it appeared that some did not appreciate that health education is part of the health visitor's role. However, one can speculate as to whether or not clients' expectations are shaped by previous experience and in comparing the expectations of first time mothers, prior to their first visit to clinic (Table 7), with mothers of more than one child, important differences emerge. Forty-five per cent of first time mothers expected to receive teaching and guidance from staff about health matters, whereas only 27% of mothers with more than one child expected to receive this service. This seems to suggest that this group of mothers did not perceive health teaching to be part of the health visitor's role after they had attended clinic.

This finding is important as the major principles of health visiting according to the validating body, the English National Board for Nursing, Midwifery and Health Visiting are: 'The search for health needs; the influence on policies affecting health and the facilitation of health enhancing activities. (See Appendix J) Indeed health education is claimed to be one of the major if not the most important task of the health visitor. Health visitors are taught that health education should form an integral part of their day to day work, their major contribution being to provide health education on a one-to-one basis in face-to-face contact with individuals and families. Strehlow (1985 p. 9) suggests that "the essence of health visiting is health education". She argues that health visitors have an unequalled opportunity to be in contact with a wide cross section of the population. She points out that health visitors are generally accepted by the public with whom they come into contact and that usually their advice and opinion is generally respected, even though it may not be acted upon. This may well have been the case in this study,

as certainly much of the health visitor's advice at clinic would consist of indirect health teaching which may or may not have been recognised as such by the recipients. Dingwall (1977), Kay (1983) and others have noted that sometimes the health visitor's agenda of topics to be covered is so loosely structured that some mothers perceive it to be aimless everyday exchanges. However, one views this situation it is questionable as to how effective a method this can be when some clients are unaware of the underlying message. Indeed some researchers and writers including Orr (1980), Goodwin (1982) and Kay (1983) question this whole approach to health education. They suggest that this method of health teaching could be construed by the clients as victim blaming and the imposition of middle-class values. A criticism raised in the early days of the child health movement and discussed in Chapter 1 of this study. Whilst not everyone would accept this rather negative and dismissive view of the role of the health visitor in relation to health education in clinics, these findings point to the need for health visitors to re-examine the effectiveness of such an approach. A similar point was argued by Hicks (1976) in his review of Primary Health Care. (Para. 520)

The health visitors involved in the study were themselves aware of this dilemma and many of their suggestions for change centre around their role in health education. (p. 115)

All of the health visitors interviewed stated that the promotion of health through health education was one of their main objectives for work in clinics; however, a few thought the clinic setting inappropriate for group teaching. Although like those who gave evidence to the Sheldon Committee in 1967 and the Court Committee in 1976, most health visitors considered that clinics should provide the opportunity for group health education for those clients who wish to participate.

In particular, two health visitors asked for more space in order to mount health education displays, three asked for video play-back facilities and display boards and five thought that clients should be given the opportunity of watching video films whilst waiting. As discussed in Chapter 5 (p. 94) a small number of clients also indicated that they would welcome a more formal approach to health education.

A discrepancy also appeared between the clients' perception and those of the health visitor in relation to the preparation of mothers prior to their first visit to clinic. The way in which the concept and goals of the clinic are explained to the mother will influence whether or not she attends. The welcome she receives at her first visit is also important and in this study, ten mothers expressed the view that their health visitor had not adequately prepared them for their first visit to clinic. They expected more specific information as to the purpose of the clinic and guidance from their health visitor as to what is expected of them when they attend. As discussed in Chapter 5 (p.103) some clients complained of waiting for long periods on their first visit to clinic because the routine was unfamiliar to them. Others inadvertantly joined the wrong queue. Yet only two health visitors in the study reported that they specifically prepared mothers for their first visit to clinic. Most thought that the routine was relatively straightforward and that once in the building, the mothers would soon discover what to do. However, other researchers notably, Hart, Bax and Jenkins (1981) have shown that by paying close attention to the needs of the mother and motivating her to attend, the attendance rate in an inner city area can be as high as 97%. Whereas Zinkin and Cox (1976) found that when these matters were overlooked the attendance rate is likely to be poor.

It may well be that when inviting parents to attend clinic, health visitors routinely give this information but because of the excitement and/or stress of the occasion parents fail to take it it. One mother recognised this danger and made the plea: "Please don't tell us at the first home visit ..... soon after would be better, after all it is every parents' right to know in advance, what they are expected to do when attending clinic." (p.104) This, together with the finding from the health visitor interviews discussed in Chapter 6, that only three health visitors considered that the members of the public attending clinic understood the varying roles and responsibilities of the clinic staff, would support the need for a professional re-think concerning the type of information given to parents and also the timing of its delivery.

Comparing the clients' perceptions of the age groups of children catered for by child health clinics with the replies received from the health visitors it would seem that whilst attendance did drop off as the child got older, clinics in the area catered for all pre-school age children. This fact appeared to be understood by the majority of clients. However, some confusion was apparent in so far as clients attending general practitioner 'well baby' clinics thought that the clinic was only for babies and that older children would not be welcome. The confusion may well be related to the name of the clinic, if so, this could be easily remedied.

The fact cited by all ten health visitors, that their contact with families declined as the child got older could well have influenced those clients who were unsure of the role of the health visitor with groups other than children (Chapter 5, p. 79). Indeed the ambiguity which for some mothers surrounds the role of the health visitor will influence what mothers see as the legitimate concern of the health visitor. Looking at this factor from the point of view of this study, it may well be that health visiting policies such as: "Health visiting surveillance should be greater

when the child is very young." (see p.113) suggests to some mothers that the health visitor's main concern is with the care of the very young child. Hence the clients' perception of the health visitor's work with other groups is a mirror image of what they see the health visitor doing.

This is particularly relevant to the clients' perceived role of the health visitor in relation to the health and well being of the mother, whilst 39% of mothers thought that the health visitor could help with their personal problems, only 15% said that they would expect to receive such help. None of the health visitors expected mothers to attend clinic solely for personal matters. Whilst, the health visitor responses may have been influenced by the nature of the survey, this may be a fairly widespread practice as Warner (1984) found that health visitors do not give mothers an opportunity to talk about themselves at clinic, possibly because of the pressure of time and the needs of waiting clients. Furthermore, Williams (1983) suggests that clinic doctors do not allow sufficient time during consultations for mothers to talk about themselves. It is also true that whilst from the early days clinics have been geared to meet the needs of the mother and infant, mothers have not always valued the service in relation to anything other than the care of their children (see Chapter 1).

Only one health visitor in this study thought that clinics should provide an opportunity for mothers to consult with the health visitor about personal matters (Table 18 p.111). These findings would suggest that the situation is unchanged since the early days of child health clinics and whilst the professionals acknowledge the needs of the mother, their efforts and concentration remain directed towards the infant.

In comparing these findings with the health visitors objectives for work in clinics (Chapter 6) a degree of disjuncture

is apparent. Out of a total grouping of four sets of objectives (see p.119) two sets relate directly or indirectly to the work of health visitors with mothers, examples under this heading include the following statements:

"To promote the health of mother and baby ..."

"To improve the health of mother and baby ..."

"To increase the mother's self confidence ..."

Since the majority of parents expected to get their baby weighed and to monitor his/her developmental progress, a goal shared by health visitors in the study area, these findings are perhaps to be expected. Nevertheless, in the light of the Court Report's discussions of new diseases of childhood which are considered to be the result of a parental stress and the breakdown of marriage (see chapter 1) there is arguably a need for health visitors to take the initiative in the planning of social advice and not merely in responding to the problem presented at clinic. A view shared by Jenkins (1984) who argues that clinics of the future will need to take a broad view of preventive health, to meet the needs of young families. She points out that the challenge of the 'eighties will be to resist any weakening of the present service, but at the same time to develop the service in order to more adequately meet the needs of society.

However, in fairness to the health visitors interviewed, five specifically stated that their clinic was too rushed, busy and over-crowded to cope with anything other than the 'presented' problem. If they considered that the mother needed more help a follow-up home visit was arranged. This would suggest the need for either more clinic sessions or more health visitors. It also throws into focus the thought that clinic sessions are in fact viewed by some clients and health visitors as of necessity 'problem' orientated. If this is true it perhaps explains why the health education role of the health visitor and the clinic was not understood by some clients.

The findings that the majority of clients did not complain of a fragmented service could be related to the fact that 78% of clients were able to attend a clinic at which their own health visitor was present (p.80). With two exceptions, the health visitors were also satisfied that they were able to see and talk to their own mothers at clinic. This finding is in contrast to that reported in other studies, notably those carried out by Orr (1982) and Clark (1984). Of the remaining group, which comprised nearly a quarter of the sample, some could not attend a clinic at which their own health visitor was present and others chose not to.

Discontinuity of service delivery may occur as a result of poor communication patterns and inefficient referral and liaison systems. However, the majority of clients were satisfied with this aspect of the service but some clients did not feel that they had been given sufficient information prior to their first visit to clinic. For this group, their movement through the service network was disjointed.

In one centre both the health visitors and clients complained that the Clinical Medical Officer's command of English was so poor that his ability to communicate with clients was limited. (pp.94 & 121) As a result, his services were not considered useful and clients ceased to attend.

Clinic records were commented on by the health visitors, one found the doctors' records to be too brief to be useful, whilst two others complained that the records were not shared.

All the health visitors were satisfied that they had been able to establish satisfactory liaison and referral systems in relation to their work in clinic.

Contact with the Health Visitor during the Ante-Natal Period

The preceding pages are mainly concerned with the health visitors' work in clinic. This section widens the debate and focusses on the clients' contact with the health visitor during the ante-natal period and their involvement in the first medical examination of their infant. It is followed with a discussion of the parents' views on the current developmental surveillance and assessment programmes and concludes with the parents' and health visitors' views on the sources of professional and non-professional help to parents.

Field et al (1982) in their study of consumer views of the health visiting service proved an association between the level of contact with the health visitor during the ante-natal period and the degree of client satisfaction with the health visiting services. The Early Parenting Project (1980) also emphasized the importance of health visitors meeting mothers during the ante-natal period in order to make an introduction and begin to establish rapport. They argue that when this is achieved there is likely to be a continuing post-natal health visitor/client partnership which encourages and enables clients to utilize services appropriate to their needs.

The usual system of ante-natal care in the United Kingdom includes a programme of shared care between the mother's own general practitioner, the community midwife and the staff of the local maternity hospital. Health visitor involvement during the ante-natal period is often limited and this was so in the Portsmouth Health District. However, some midwives and health visitors have established working patterns that have enabled health visitors to make routine ante-natal visits in order to introduce themselves to the mother and to begin to establish a rapport. In this study just over half of the mothers had met their health visitor during the ante-natal period. Albeit, if the pregnant

women had other children it is possible that the health visitor already knew the family and had routine contact during this time because there were pre-school aged children in the family. In this study this was so for 37 out of the 100 families who returned the questionnaire. Of this group, only 11 mothers said that the health visitor contact during this period had been concerned with pregnancy.

The results (p.68) show that some mothers, just under half (49) met their health visitor for the first time when discharged from the care of the midwife. At this time they may be feeling very vulnerable and uncertain as to their new role, arguably least able to establish new relationships. The comments made by some mothers with more than one child (p.69), that this contact is easier the second time around when the health visitor is known to the family, is consistent with this view. However, some mothers did not feel that contact with the health visitor during their ante-natal period would have served a useful purpose.

The whole question of the involvement of the health visitor during the ante-natal period is currently the subject of debate and controversy. Official recognition of health visitor involvement has been around for some time; as far back as 1979 an editorial in the Health Visitor Journal stated that:

> "... the DHSS has accepted evidence of, and is increasingly stating itself, the importance of the role of the health visitor in the ante-natal period."

A view echoed in other official reports including the First Report of the Maternity Services Advisory Committee, published in 1982. Yet, despite such rallying calls, no-one has actually determined quite what the health visitor's level of involvement should be. Thus, in different parts of the country health visitors may be required to visit pregnant women at home, to participate in ante-natal clinics and/or to teach parentcraft classes. As stated, health visitor involvement in the study area was limited and health

visitors were not routinely involved. However, many had established good working relationships with the midwife and where this happened, the hand-over period was less traumatic for the mother. Without a doubt the majority of mothers were full of praise for the midwifery service, but there is evidence that some midwives failed to prepare mothers for the next stage of care (see p. 69). One way out of this dilemma could be the introduction of a joint health visitor/midwife visit in order to handover care to the health visitor. This procedure is already routine in Oxfordshire and has worked well for many years.

Developmental Surveillance and Assessment

Child health surveillance implies a continuing programme of care including screening for certain conditions with specific tests, monitoring of growth and development, parent support, advice on general child care, immunization and if required, parent education. Developmental surveillance and assessment is part of the health visitor's responsibility to families. Paediatric assessment involves a more detailed and extensive investigation of a problem already defined and as such is part of the doctor's role.

The programme of child health surveillance begins at birth and the Health Visitor Association, in a policy statement outlining the role of the health visitor in child health surveillance, published in 1985, states that:

> "The programme in which the health visitors subsequently take part commences in the clinical examination of the new born infant by the midwife or doctor in attendance. This should be followed by a further clinical examination before discharge undertaken by the doctor." (p. 3)

Members of this group, like the Court Committee before them agreed that this examination should be carried out by a suitably

trained and experienced doctor in the presence of one or both parents.

In this study parents were not asked if they were present at this examination, but they were asked if they knew that their child had been examined at birth or soon after. (See Table 5 p.71) As these figures show, 78% of mothers knew that their child had been examined but only just over half were told the results of this examination and even fewer were able to ask questions. It may be that for some the stress and excitement of giving birth is so overwhelming that they are not able to fully 'take in' what is said to them. This was certainly true in some instances in so far as some mothers admitted that this was true for them. However, when this happens, or is suspected, it should be noted and the details picked up and discussed later, preferably by the examining doctor or by the midwife. After all mothers, rather than professionals are the real providers of care for the under-fives and every opportunity should be taken to boost the mother's competence and confidence. A point acknowledged in the Court Report (1976) which stressed that the mere absence of adverse comment is not good enough, mothers require positive advice.

The fact that mothers wish to be informed and involved in the routine developmental assessment and surveillance of their child's progress was highlighted again later in the study when the question of who should carryout these checks was discussed. (See p.83) Whilst the majority of mothers greatly valued this aspect of the service, others felt left out, uninvolved and uninformed. (p.83) A similar finding is that submitted in evidence to members of the Court Committee working party.

This result suggests a possible discrepancy between what health visitors say they do and how their actions are perceived by the consumer. This is so in so far as one of the main objectives stated by health visitors for their work in clinics related to their

work with mothers. If the objective "To send parents away re-assured in their own ability to cope " (p120) is a reality, then it should rarely, if ever, be necessary for a child to be seen and routinely examined at clinic without the mother being given prior warning. These findings suggest the need for health visitors and indeed doctors to re-examine the way they carry out surveillance and assessment programmes in an attempt to more fully involve the parents. Perhaps one solution would be to give each mother a booklet giving details of the surveillance programme, its purpose, structure and content together with a record of their child's developmental progress. This is a recommendation of the Health Visitor Association's working party Report but not a new idea. The Society of Area Nurses launched a similar booklet during the 'Year of the Child' in an attempt to encourage the maintenance of a shared record system by parent and professional. In the event, parents seemed to welcome it, health professionals rejected it for a variety of reasons and thus the ideas contained in the booklet never really caught on. Although similar schemes have been introduced in Sweden and France and these appear to be well accepted by parents and professionals.

As to who should carryout these checks and whether or not parents would prefer to consult their own GP at clinic, opinions were divided. (see p. 81) It is possible to speculate from these results that the long raging inter and intra professional disputes which from the early days have dogged the child health services (see Chapter 1) remain of little central concern to the consumers of the service. This would certainly appear true for the clients in this study who were more concerned with the quality of the service, rather than the status of the individual carrying out the task. This is in contrast to the findings of Donaldson (1974) who reported that mothers would rather that their own doctor performed this task.

As in other studies, Graham (1979), Orr (1980) and Clark (1985), a few mothers found the service fragmented and confusing. They could not understand why the clinic doctor could diagnose but not prescribe. However, unlike the findings of these studies, this issue was not cited as a major source of dissatisfaction by the majority of respondents. (p.82)

It could be that the clients participating in this study were more aware than those who took part in other studies, certainly the majority considered themselves well-informed on the way children grow and develop. Albeit those with more than one child acknowledged that it was easier the second time round as they knew to whom to refer if they needed help and advice. (Table 3 shows that parents with more than one child were more likely to rate the health visitor as helpful than were first-time parents. This could reflect knowledge of how to use a service or even understanding of the role of the health visitor. As stated in Chapter 2, generalization from other research findings are difficult, but this finding appears to be in contrast to that reported by Graham (1979) who found that first time mothers were more likely to rate the health visitor as helpful.

The general practitioner was also considered a useful source of advice on child rearing. A similar finding to that reported by Orr (1980). In contrast to the findings reported by Blaxter and Patterson (1982) there was no evidence that clients used the accident and emergency department of their local hospital in preference to their GP.

Table 11 shows that clients used a variety of different sources of help. Some valued books and health education leaflets whilst others reported finding family, friends and neighbours to be the most useful. A social class bias may be apparent in these results in so far as more clients with a professional background,

such as teachers, nurses, etc. were interviewed. As a group these are more likely to refer to baby care books. In fact some homes had whole shelves of child care books on display at the time of the follow up interview.

Other clients, living on housing estates in close proximity to neighbours or families with young children, tended to refer to their neighbours or friends for help. Indeed, to some this seemed the obvious choice: "After all she's had children and so she knows." seemed to be their rule of thumb philosophy. (See p. 86)

In comparing the health visitor's response to this question to that of the client's, a difference is apparent. Whilst clients reported using a variety of sources of non-professional help, the health visitor expected clients to obtain help mainly from family, friends and neighbours. Voluntary agencies and self-help groups were also mentioned but no health visitor cited the written word or television. However, this finding may not be a true reflection of health visiting practice, as the clients were asked to select their answer from a pre-coded list and the health visitors were left to make suggestions. The researcher as a health visitor herself did not anticipate that the results of this question would vary so much.

Results show that the majority of clients in this study were keen to keep up-to-date with child rearing methods, many were well read and informed. Overall a far cry from the picture of "feckless, ill-informed mothers" so often referred to in the early days of the child welfare movement. However, one views this finding, and it may be that the sample was not representative of the general population; a claim made by the health visitors, it would be wrong to assume that all is well. There is evidence that some mothers wanted more formal teaching and structured health education sessions. Others, albeit a few, needed help to interpret the written word.

The view of the health visitor as having a 'policing' role especially in respect of child abuse was not mentioned, and with one exception, she was not perceived as prying or interfering. All aspects mentioned by Orr (1980), Graham (1979), Blaxter and Patterson (1981).

One of the criticisms that tend to be made of attempts to find out peoples' views on existing services is the charge that they are unlikely to be satisfied and will always want more. The results from this study show that this did not prove true in this instance. Whilst clients responded to questions according to their own knowledge and individual circumstances, their ideas were on the whole positive. Their suggestions for change would be relatively straightforward and cheap to implement. These together with suggestions from the health visitors who participated in the study, form the basis of the recommendations arising from this study. The recommendations are given on the following pages.

RECOMMENDATIONS

That those responsible for child health clinics consider whether their clinics are:

1. Accessible - well advertised, clearly signposted and timed with regard to the needs of their clients. Available occasionally in the evening for both parents to attend together, which may also be more convenient for some working mothers.

2. Providing a service which encourages questions and fully involves parents in all aspects of their child's growth and development.

3. Sensitive to the needs of first time clinic attenders, where clients are advised in advance what is expected of them and are thus able to progress smoothly from one part of the clinic to another without confusion or undue delay.

4. Not time wasting, with appointment systems being introduced for doctors sessions and a separate session for immunisation days in those clinics that are overcrowded.

5. A focus for health education and as such informative and interesting; for example showing video films to waiting clients and mounting planned health education displays in the waiting areas; health visitors claim that they have a role in the promotion of health and health education but unless this goal is shared by the client it is empty rhetoric, thus clinics should only be held in premises suited to this type of activity. This would rule out some of the smaller

clinics held in general practitioner surgeries. Health visitors should be provided with the necessary health education materials where these do not already exist.

6. Sensitive to the needs of mothers; providing an opportunity for the mother to talk about herself, her own feelings and needs; clinics should aim to meet the health needs of the mother as well as monitoring children's developmental progress. Health visitors may need to restructure the clinic consultation in order to devote more time to the mother and to make active enquiries into the health of the family of which the child is a member. Health visitor policies at local level may need widening in order to focus health visitor attention on the whole family and not just the under-fives.

7. Able to provide the opportunity for waiting clients to meet others and to talk between themselves, this means; more flexibility in the seating arrangements, particularly within the larger health centres; health visitors accepting the responsibility for overseeing the way clients are received at clinic and where possible introducing first time clinic attenders to other matters.

8. Cheerful and friendly with play areas and play materials provided for accompanying children.

9. Sensitive to the need for privacy for breast feeding mothers.

10. Able to provide, changing space, improved pram shelters, toilet and refreshment facilities for those who attend.

Other Recommendations

11. The role of the health visitor in the ante-natal period should be re-assessed taking into account client needs, especially those of first time mothers.

12. At the time of the mother's discharge from the care of the midwife, consideration should be given to the midwife and health visitor making a joint home visit.

13. Parents should be informed and involved in the developmental screening of their children and consideration should be given to the introduction of parent held child health record books.

14. The desirability of appointing playleaders should be considered in order that accompanying children can be safely occupied, parents being free to socialise and participate in health education sessions should they wish to.

APPENDICES

(The letter I was not used because of its similarity to the figure 1)

Map of the Study Area

APPENDIX A

APPENDIX B

Table 14 Infant mortality rate per 1000 live births, England and Wales

Year	*Rate*	*Year*	*Rate*
1841	147	1941	60
1851	154	1951	30
1861	153	1960	21·8
1871	158	1965	19·0
1881	130	1970	18·2
1891	149	1971	17·3
1901	151	1975	15·7
1911	130	1976	14·3
1921	83	1977	13·8
1931	66	1980	12·0

(from *Population Trends*, 1982)

APPENDIX C

The changes in infant mortality during the last 130 years in England and Wales are given in Table 14 and are illustrated in Fig. 5. *There is a markedly higher infant mortality in boys than in girls* (see Table 15). There is also a marked social class differential in infant mortality. The *lowest rates are in social class I and the highest in social class V.*

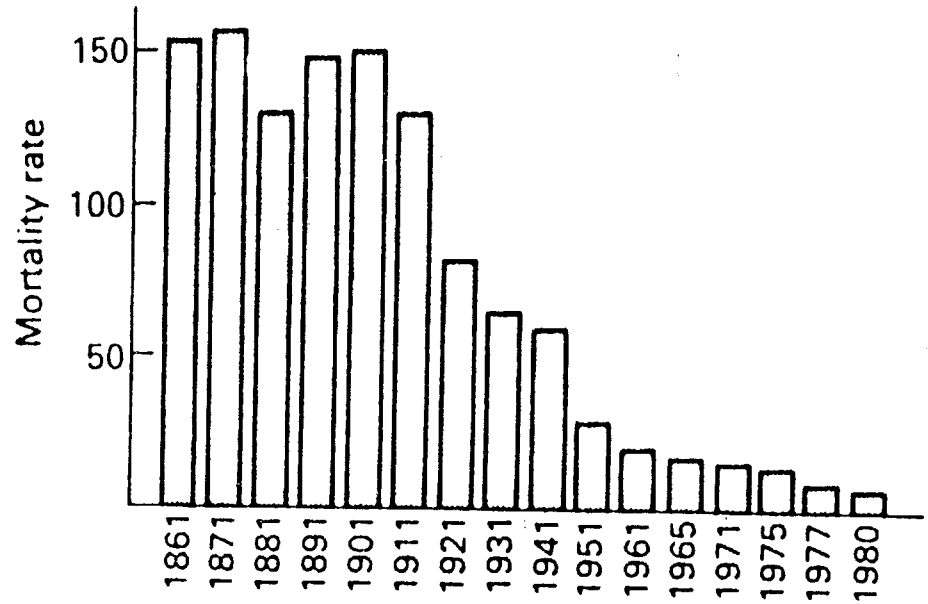


Figure 5 Infant mortality rate, England and Wales, 1861–1980.

APPENDIX D

Postal Questionnaire

STRICTLY CONFIDENTIAL

How to fill in this form:

Please answer the following questions by either ticking the box next to the answer you wish to make or by writing in the answer when needed.

1. Name of New Baby: _____ Date of Birth: / /
   Boy/Girl

   Address: _____
   _____
   _____

---

2. Have you any other children? No ☐ Yes ☐
   If 'Yes' please give:

   Names: _____ Dates of Birth: / /
   _____ / /
   _____ / /
   _____ / /

---

3. Name of your GP: _____

---

4. Have you any relatives living nearby? No ☐ Yes ☐

   Note: for the purpose of this study 'nearby' means within half an hour travelling time using your usual mode of transport.

   If 'Yes' please indicate what relatives they are: you may tick more than one box:

   Mother ☐
   Mother-in-Law ☐
   Grandmother ☐
   Sister ☐
   Other in-Laws ☐
   Others, please write in: _____

5. Do you look to your own mother as a source of advice about child care? Please tick:

No ☐ Yes ☐

---

6. Is there anyone else that you look to for help and advice about child care?

No ☐ Yes ☐

If 'Yes' please tick if any of the following apply:

Mother ☐
Mother-in-Law ☐
Grandmother ☐
Sister ☐
Other in-Laws ☐
Others, please write in: _____

---

7. Examination of baby at time of delivery

Please tick the box next to the answer you wish to make:

Was your baby born in hospital or at home?

Please tick: Hospital ☐ Home ☐ GP Unit ☐

Do you know if he/she was examined by a doctor at birth or soon after?

No ☐ Yes ☐ Don't know ☐

If 'Yes' were you told the results of the examination?

No ☐ Yes ☐ Don't know ☐

If 'Yes' were you able to ask questions either out of interest or to assist your understanding?

No ☐ Yes ☐ Don't know ☐

If 'No' would you have liked to ask questions?

No ☐ Yes ☐ Don't know ☐

---

8. Did you meet your Health Visitor before your baby was born?

Please tick: No ☐ Yes ☐

If 'Yes':

Did she visit you at home?
Did you meet her at parentcraft?
Did you meet her at the ante-natal clinic?
Did you meet her at the GP surgery?
Elsewhere - please say where: _____

If 'No' would you have liked to have met her before the baby was born? Please tick:

No ☐ Yes ☐ Don't know ☐

Please give reasons for your answer: _____

_____

_____

---

9. Have you met your Health Visitor since the baby was born?

Please tick: No ☐ Yes ☐

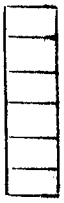
If 'Yes' how many days after having your baby did you meet your Health Visitor?

0 - 4 days
5 - 9 "
10 - 11 "
12 - 15 "
16 - + "

Please place a tick against the correct answer.

Where did you meet her?

GP Unit
Hospital
In your home
At Clinic
At GP surgery
Health Centre
Elsewhere - please say where: _____



Please place a tick against the correct answer

_____

_____

---

10. There are several Child Health Clinics near here that you can use:

Clinic A: _____

_____

Clinic B: _____

_____

Clinic C: _____

_____

Do you think that you will go along to one of these?

No ☐ Yes ☐ Don't know ☐

If 'No' please give reasons: and then go to Question 11:

_____

_____

If 'Yes' please place a tick in the box against the clinic you hope to attend. You may tick more than one if you expect to attend more than one centre:

Clinic A: ☐

Clinic B: ☐

Clinic C: ☐

Please give reasons for your choice of clinic/s:

_____

_____

_____

11. At this time what do you expect from your visit to the clinic?

Please tick any of these suggestions which apply to you; you may tick more than one box:

a) Monitoring of child's height and weight
b) Confirmation of babies progress
c) Routine check up of babies developmental progress
d) Advice - i.e. about feeding
e) Advice about a particular problem - sleeping, teething etc.
f) To meet other mothers
g) to get baby immunized
h) Teaching and guidance from staff about health matters
i) To talk to the HV about the baby/children
j) " " " " " " personal matters
k) " " " " " " family matters
l) " " " " GP " the baby/children
m) " " " " " " personal matters
n) " " " " " " family matters
o) " " " " clinic doctor about the baby/children
p) " " " " " " " personal matters
q) " " " " " " " family matters
r) To buy food or vitamins
s) Other reasons - please say what: _____

_____

_____

t) Don't know

12. If you had a problem or needed re-assurance with your child who do you think would be the most useful?

Please ring a number for each person, indicating usefulness.

	Very useful	Quite useful	So-so	Not very useful	Not at all useful
Your busband or partner	1	2	3	4	5
Other family member	1	2	3	4	5
Friend	1	2	3	4	5
GP	1	2	3	4	5
Health Visitor	1	2	3	4	5
Clinic Doctor	1	2	3	4	5

This last group of questions is about you and your husband or partner; some are of a more personal nature but all answers will be treated in the strictest confidence.

13. What type of housing do you live in?

Please tick the box next to the answer you wish to make:

Owner occupied or in the process of buying ☐
Rented from a local authority ☐
Rented from a private landlord ☐
Rented from a housing association ☐
Housing provided with job ☐
Service married quarters ☐
Shared with other families ☐

---

14. Current Occupation?

Please tick:

If you have no husband or partner, please answer just for yourself.

	Yourself	Husband/ Partner
Maternity leave		
In full time work, please give details: _____		
In part-time work, please give details: _____		
Waiting to take up job already accepted		
Seeking work		
Permanently sick or disabled		
Wholly retired from employment		
Housewife		

Other: please say what _____

What was your own occupation before starting a family?

Please give details, including job and qualifications.

_____

_____

_____

_____

15. Once I receive the completed forms I hope to be able to call on a few parents in order to get a more detailed picture of their opinions re the services they have received. Would you be willing, if required, for me to call upon you by appointment at home?

Please tick: No ☐ Yes ☐

Thank you for answering these questions.

Date: _____

APPENDIX E

DEPARTMENT OF SOCIOLOGY AND SOCIAL ADMINISTRATION
UNIVERSITY OF SOUTHAMPTON, SO9 5NH.
HEAD OF DEPARTMENT: PROFESSOR J. H. SMITH
Telephone: 0703 559122
Telex : 47661

HEALTH VISITOR SECTION
Extension 2573

Dear

I am writing to you as a parent of a new baby to ask if you would be willing to answer some questions which will help me to find out who parents turn to for help and advice about their childrens' health and development, and whether or not child health clinics are felt by parents to be useful.

Any information given will be strictly confidential to myself, nothing will be published that can be identified with any individual.

If you are willing to take part in this study I would be grateful if you would complete the enclosed form and post it back to me using the
*** enclosed stamped addressed envelope. If you do not wish to take part in this study, please fill in the enclosed refusal strip and post
*** it back to me, using the enclosed stamped addressed envelope.

If you have any queries please don't hesitate to contact me. My work phone number is Southampton (0703) 559122, extension 2573.

Thank you for taking time to read this letter, with best wishes.

Yours sincerely,

Pam Gastrell

P Gastrell (Miss)
Lecturer in Health Visiting

*** SAE enclosed

REFUSAL SLIP

I do not wish to help with your study.

Signed: .....

SAE enclosed

APPENDIX F

Client Interview Schedule

1. Name of Clinic most recently attended

   Have you attended more than one Clinic? Yes/No

2. Why did you choose to go to this particular Clinic(s)?

3. How long does it take you to get there by your usual mode of transport? (Single journey)

4. Do the Clinics' opening hours suit you? Yes/No

   If no, what time would suit you better?

   Give reasons.

5. What age groups do you feel the Clinic caters for?

   Birth - less than 6/12
   6/12 - less than 1 year
   1 year - less than 2 years
   2 years and over
   All under 5 years
   Any age group

6. When you went to the Clinic did you speak to any of these people?

	Spoke to	Most welcoming	Most helpful	Mixed or no reaction	Un-helpful	Un-welcoming
Own HV		1	2	3	4	5
Other HV		1	2	3	4	5
Own GP		1	2	3	4	5
Other GP		1	2	3	4	5
Clinic doctor		1	2	3	4	5
Receptionist		1	2	3	4	5
Clerical staff		1	2	3	4	5
Food sales lady		1	2	3	4	5
Other mothers		1	2	3	4	5
Other staff		1	2	3	4	5
No-one		1	2	3	4	5
Don't know		1	2	3	4	5

7. If you spoke to more than one overall, who did you find the most welcoming?

8. Who did you find the most helpful?

9. Did you have a consultation with your own Health Visitor at the Clinic?

No Yes Don't know

Would you prefer to consult your own Health Visitor when you go to the Clinic?

No Yes Don't know

Could you say why/why not?

10. Did you consult your own GP at the Clinic?

No Yes Don't know

Would you prefer to consult your own GP when you go to the Clinic?

No Yes Don't know

Could you say why not?

Using the following list:

11. What services did you expect before your first visit to Clinic? Please tick in the first column any of these suggestions which apply to you, you may tick more than one box.

12. Using this same list, please put a tick in the second column against the services you both expected and used. You may tick more than one box.

13. Using this same list please put a tick in the third column against the services you did not expect but in fact received. You may tick more than one box.

Services Expected	Services expected & received	Services not expected but received	Ranked most useful

a) Monitoring of child's height and weight
b) Confirmation of babies progress
c) Routine check up of babies developmental progress
d) Advice - i.e. about feeding
e) Advice about a particular problem - sleeping, teething, etc
f) To meet other mothers
g) To get baby immunized
h) Teaching and guidance from staff about health matters
i) To talk to the HV about the baby/children
j) " " " " " " personal matters
k) " " " " " " family matters
l) " " " " GP ". the baby/children
m) " " " " " " personal matters
n) " " " " " " family matters
o) " " " " clinic doctor about the baby/children
p) " " " " " " " personal matters
q) " " " " " " " family matters
r) To buy food or vitamins
s) Other reasons - please say what: _____

_____

t) Don't know ☐

14. Which of these services did you generally find to be the most useful?

15. What do you feel about your visits to Clinic?

Please circle the number nearest to your feelings for each item.

			---So-So---			
Poor facilities	1	2	3	4	5	Good facilities
Poorly organised	1	2	3	4	5	Well organised
Too rushed	1	2	3	4	5	Not at all rushed
Very noisy	1	2	3	4	5	Very quiet
Unfriendly	1	2	3	4	5	Very friendly
Confusing	1	2	3	4	5	Not confusing
Unwelcoming	1	2	3	4	5	Very welcoming
Too crowded	1	2	3	4	5	Not at all crowded
Lack of privacy	1	2	3	4	5	Quite private
Embarrassing	1	2	3	4	5	Not embarrassing
Poor waiting area	1	2	3	4	5	Good waiting area
Poor play space for children	1	2	3	4	5	Good play space
Too long waiting time	1	2	3	4	5	No waiting time
Did not meet my needs	1	2	3	4	5	Met my needs
No individual attention	1	2	3	4	5	Individual attention

16. What sort of situations do you think your health visitor could help you with?

Baby - children
Personal
Family
Social
Other
Don't know

17. Do you think that regular checks on your child's development are important?

No Yes Don't know

If yes - who do you think should do these checks?

18. Do you feel that you know enough about the way children grow and develop?

No Yes Don't know

19. Where would you expect to find out about the way children grow and develop? From any of these?

	Definitely Yes	Maybe	Definitely No
Books	1	2	3
TV or radio	1	2	3
Magazines	1	2	3
Newspaper articles	1	2	3
Leaflets	1	2	3
Relatives	1	2	3
Friends/neighbours	1	2	3
Health Visitor	1	2	3
GP or Clinic Doctor	1	2	3

Other sources - please say what:

20. Do you know how to contact your Health Visitor?

No Yes Don't know

If 'Yes' can you give details?

21. What does your husband think about Child Health Clinics?

APPENDIX G

DEPARTMENT OF SOCIOLOGY AND SOCIAL ADMINISTRATION
UNIVERSITY OF SOUTHAMPTON, SO9 5NH.
HEAD OF DEPARTMENT: PROFESSOR J. H. SMITH
Telephone: 0703 559122
Telex : 47661

HEALTH VISITOR SECTION
Extension 2570

Dear Parent,

Thank you for completing and returning my questionnaire asking about your intentions to visit a child health clinic. As you have agreed to be interviewed in your own home I write to offer you the following appointment:

Would you please indicate whether this is convenient to you or not. I enclose a SAE for your reply.

Yours sincerely,

P. Gastrell (Miss)
Lecturer in Health Visiting

APPENDIX H

INTERVIEW SCHEDULE FOR USE WITH HEALTH VISITORS

1. In what type of premises are your CHC's held?

   Health Centre

   GP Surgery

   Purpose built clinic

   Other - please specify

2. Please specify the personnel who work in your clinc.

3. What do you consider to be your main H.V. tasks in relation to CHC's?

4. Do you see your own families at clinic?

5. Are you satisfied with your own level of involvement in CHC's?

6. Have you been able to initiate any changes?

   Specify:

7. Are there any changes that you would like to make?

   Specify:

8. What should CHC's provide?

9. What do you consider to be the main reasons mothers attend clinic?

10. Does attendance drop as the child grows older?

11. Generally does your H.V. contact decline as the child grows older?

12. Who do mothers turn to for help and advice with their children? (non-professional)

13. Can you refer from clinic directly to:

    Consultants - specify

    GP's

    Other H.V.'s

    Medical Officers

    Social Worker

    Others - specify

14. Do you consider that members of the public attending clinic understand the varying functions carried out by various clinic staff?

15. Can you suggest ways in which the clinic service could be improved?

16. Would you like to see 'drop in centres' organised on informal lines open daily?

Who in your opinion should staff such a centre?

What should its opening hours be?

17. What is your overall objective for your work in CHC's?

Health Visitors, Health Visiting Practice and Principles

Health Visitors are based in the community and play a key role in primary health care from the pre-natal period throughout the life cycle. The major part of the health visitors' work is with people in their own homes but some takes place in Health Centres, Clinics, General Practitioners' surgeries and Schools. An essential feature of the work is health education which is effected through individual teaching and through informal and formal group and classroom teaching.

Health Visitors provide a generalist health visiting service but individual health visitors may develop a special interest in a particular aspect of health care and may, in some instances, act as resource persons for colleagues in relation to that interest.

The professional Practice of Health Visiting consists of planned activities aimed at the promotion of health and the prevention of ill-health. It thereby contributes substantially to individual and social well-being by focussing attention at various times on either an individual, a social group or a community. It has three unique functions:

1. identifying and fulfilling self-declared and recognised, as well as unacknowledged and unrecognised, health needs of individuals and social groups;

2. providing a generalist health agent service in an era of increasing specialisation in the health care available to individuals and communities;

3. monitoring simultaneously the health needs and demands of individuals and communities; contributing to the fulfilment of their needs; and facilitating appropriate care and service by other professional health care groups.

The Principles of Health Visiting include:

the search for health needs

the stimulation of the awareness of health needs

the influence on policies affecting health

the facilitation of health enhancing activities.

Research in Preventive Community Nursing Care
Edited by A. While

CHAPTER 5

Child Health Centres—parental and professional views

PAMELA GASTRELL

Introduction

This chapter is based on the findings of a research project and will explore two main issues:

1. the expectations and satisfaction of mothers and infants attending child health centres;
2. the objectives and degree of satisfaction of health visitors working in the centres.

Background

Consumers' definitions of their problems and their perceptions of the usefulness of a service will influence when, and to what extent, they use that service, and indeed whether they use it at all. Studies have shown that it is particularly in the field of preventive services that user definitions and perceptions are liable to be most at variance with those of the professionals (Cartwright, 1970: Milio, 1975; Cartwright and O'Brien, 1976).

As far as child health centres are concerned, a number of recent changes have influenced both service provision and usage patterns. These changes include:

1. reorganization of health visiting from geographical to GP attachment;

2. shift in the distribution of CHCs away from small local clinics towards larger, purpose-built premises or GP surgeries;
3. increasing interest of GPs in providing 'well-children' clinics attached to their practices.

A review of the literature suggests that most of the preventive child health services in Britain developed in a piecemeal fashion, in response to pressure from social reformers, central and local government. (Robinson, 1982; Russell, 1980; Baly, 1973). Commenting on the early days of child welfare, Lewis (1980) identified a gap between official policy and the providers of health care who: 'equated improvements in maternal and child health with the development of a closely defined set of social services' (p. 311) and the women's groups of the day who were fighting for financial assistance to help them feed their children. She argues that, from the early days, the question of whose needs the services were designed to meet is pertinent, as some of the major needs articulated by women themselves have been overlooked.

In the Report of the Committee on Child Health Services (DHSS, 1976) it was stressed that the present services are fragmented and 'provider'-led, shaped and influenced according to the views of the professionals who work in the service. The committee recommended that consumers' views are obtained in order to ascertain the accessibility and comprehensibility of the service from the point of view of the user. They pointed out that, during their inquiry, they detected a groundswell of client dissatisfaction with many features of the child health service. In particular there were feelings of uncertainty of how to use a service, and parental resentment at their lack of involvement in the health care of their children. Much emphasis was put on the role of child health centres in the health surveillance of young children; health surveillance implying a continued process of care including screening for certain conditions with specific tests, monitoring of growth and development, including emotional development, parent support and education (if required) and immunization.

The Court Report (DHSS, 1976), Sheldon (Ministry of Health, 1967), and the Health Visitors' Association in a policy statement (1985), pointed out that health visitors working at child health centres are key personnel in the service provided; that by virtue of their training and experience they are equipped not only to monitor child development but also to counsel, guide and support parents. This latter task was viewed in the Court Report (DHSS, 1976) within the framework of

a family-orientated service in which health professionals 'should see themselves as partners with parents' (p. 86).

Parents' initial definitions and perceptions of child health centres influence whether they take their children there in the first place; parents experiences at child health centres and their satisfaction with the service provided will influence whether they subsequently return to them.

Consumerism in the National Health Service: a review of the literature

The publication of the Griffiths Report has focused attention on the need for NHS management to ascertain how well the service was being delivered by obtaining views and opinions from consumers and the wider community. Health authorities are required to respond directly to this information, to act on it in formulating policy, and to monitor performance against it.

The involvement of the consumers and a recognition of the need to obtain their opinions, views and reactions to medical and social service provision has grown in importance in recent years. Locker (1978), in a review of sociological studies of consumer satisfaction with medical care, suggests that the present emphasis on consumer opinion developed at the same time as the sociological interest in inter-personal relations. This interest was strengthened by government sponsorship of studies such as those undertaken by Cartwright in 1964 and 1977 into 'Human Relations and Hospital Care' and 'Patients and their Doctors', and by a rise in the influence of consumer movements in general.

Earlier changes in the structure of the NHS had begun to establish a role for the consumer in the organization and delivery of care, and this was legitimated in 1974 by the creation of Community Health Councils. These bodies are charged with the specific task of representing the views of the public to the providers of the service. Farrel and Adams (1980), in a study of Community Health Councils between 1977 and 1980, found that three-quarters of Community Health Councils had conducted one survey in that period, and that the average number conducted was two for each Community Health Council. The most popular type of survey was the assessment of need for a specific service, primary care, dentistry or hospital service.

Further indications of a trend to extend consumer participation and protection in the health service—and at the same time make management and the professionals more accountable, Locker argues—is evidenced in the appointment of a Health Service Commissioner, the

setting up of the Hospital Advisory Service and the tightening up of hospital complaints procedures.

In the field of primary care a related development is the establishment of patient participation groups which provide an opportunity for the public to influence the running of general practitioner services. Other groups such as the Patients' Association represent the views of dissatisfied patients, and special groups such as the National Association for the Welfare of Children in Hospital, and the National Childbirth Trust, attempt not only to provide help and assistance to those who need their services, but also to act as pressure groups.

Ham (1985), in a review of consumer groups in relation to the health service, argues that quite a lot of information as to how consumers view the service is already available. However, it is not yet clear what eventual form or focus consumer participation will take in the future; whether the variety of mechanisms which already exist for finding out what the customer thinks will be strengthened or replaced remains to be seen. One thing seems certain: the power enjoyed by the providers of the health service is to be shared, to a greater or lesser extent, with consumers or their representatives.

Interest in consumer perceptions of health visiting is growing, and there are now several published studies which suggest that on the whole the clients' perception of health visiting is mainly positive. Studies which have examined the reaction of mothers with young children include those undertaken by (Bax *et al.*, 1980; Field *et al.*, 1982; Foxman *et al.*, 1982; Graham, 1979 and Orr, 1980) and those all revealed quite a high degree of satisfaction. However, Foxman *et al.* warn that comparison between the studies is difficult, as different terms were used by researchers to describe the attitude of clients towards health visiting. Another factor is that some studies do not distinguish between home visits by the health visitor and contact with her at clinic.

Studies which specifically relate to the work of health visitors at clinic do exist, and the following literature review summarizes some of the main findings.

Consumer views on child health clinics

Blaxter and Patterson (1981), in their study of mothers and daughters who were themselves mothers, asked the women for their views on, and experiences with, child health clinics and health visitors. Whilst warning the reader that the women's attitudes were not necessarily consistent, they found that the majority of mothers greatly valued child

health clinics for young babies. However, they note that some clients were confused as to the precise function of the clinic doctor and the general practitioner. Some mothers found it difficult to understand why the clinic doctor could diagnose but not prescribe. Orr (1980) conducted a study in a small town in Northern Ireland, comprising 68 families from social classes IV and V. This is probably the most significant study of consumer views of health visiting, and part of this study was concerned with collecting information on the client's perception of child health clinics. She found that as a group the mothers in her study tended to underutilize the clinic, but welcomed seeing the health visitor in their own home.

The most frequent clinic attenders had babies under 6 months old; these attended weekly to begin with but attendance dropped off as the baby got older, a pattern consistent with findings of other studies (Graham, 1979; Court Report—DHSS, 1976).

Some mothers attended once but were put off, and said that they had no intention of returning. In particular they did not like: the lack of privacy, frequent changes of health visitor which interfered with the continuity of health visiting advice, and the brusque behaviour of the doctor. Reasons for attending included: to get the baby weighed, to meet other mothers, to discuss a particular problem with the health visitor and to buy subsidized foods.

Graham (1979), in a study of child health clinics in York, looked at patterns of attendance together with women's attitudes to the health visitor and the child health clinic within social class groups. She found that mothers' attitudes to the child health services are generally positive, although she noted a decline in the level of satisfaction as the baby got older. At 1 month after birth 91 per cent of mothers attending clinic found the visit worthwhile, and at 5 months 64 per cent felt that visits to clinic were important. Initially, attendance rates were high for both middle- and working-class mothers, but by 5 months only 40 per cent of working-class mothers attended the clinic, compared to 87 per cent of social class I and II mothers. Also, considerably fewer working-class mothers reported finding the advice of the health visitor helpful.

The key question in understanding patterns of attendance at clinic, Graham argues,

> is not why certain groups groups fail to attend the clinic, but why, after an initial visit or two, they fail to return. Similarly, the key question in understanding attitudes to the health visitor is not why

> some mothers fail to appreciate her, but why their appreciation declines after the first few visits (p. 175).

From her interviews with mothers she identified two important factors: one to do with the mothers' confusion about the role and function of clinics and the health visiting service, and the other concerning the approach by the clinic staff, which was perceived by mothers as critical, unsympathetic or judgemental. She concludes that mothers will only use a service if they feel that it fulfils a role which they see as important and not easily fulfilled elsewhere.

In a study conducted by Bolton in 1982, 278 mothers attending child health clinics in Kent were asked about their use of clinics and their opinions of them (Bolton, 1984). The majority were broadly satisfied with the services provided; almost all had consulted a health visitor at clinic and considered that the purpose of their visit to the clinic had been achieved. The commonest reason for attending was to get the baby weighed. Mothers living in rural areas, who may have been geographically or socially isolated, were more likely than mothers in urban areas to value the opportunity of meeting other mothers at clinic. The most frequent clinic attender had at least one child under 1 year of age. More mothers from social class III attended than from any other social class group (Registrar General's Classification). Dissatisfaction was expressed concerning the length of time spent waiting to see the doctor.

A similar but smaller study was undertaken in Leicestershire and reported by Biswas and Sands, 1984. Ninety-eight mothers of children under 5 years of age were asked by health visitors why and how they used child health clinics. They found that the majority, 74 per cent, were satisfied with the child health services, and 61 per cent were satisfied with child health clinics. As in other studies the ~~child~~ was used mainly by mothers and children under the age 1 year. Reasons for attending included: to get the baby weighed, to seek advice from the health visitor and to purchase modified milk and vitamin drops. Only 28 per cent of the mothers saw their family health visitor at the clinic they attended. Reasons for non-attendance included: transport difficulties, inconvenient clinic times, and no need/no wish to attend.

In an attempt to clarify the exact function of child health clinics, both from the medical profession's and the consumer's point of view, a study was undertaken in Oxfordshire and reported by Sefi and Macfarlane in 1985. Over a 12-month period, 103 of the county's 113 clinics were

visited and 999 mothers interviewed. They found the majority of mothers liked the clinics and thought that they fulfilled a useful role. The main benefits mentioned were getting advice from the health visitor and gaining reassurance. Nearly one-third of mothers valued the social function of the clinic. Criticisms included: the long waiting times, insufficient advice and infrequent clinics.

The main study

The study was designed following a review of the literature, observation at clinics and discussion with the professionals who work in them.

Aims

To explore two main issues:

1. the expectations and satisfaction of mothers attending child health centres;
2. the objectives and degree of satisfaction of health visitors working in the centres.

Location

The study was carried out in the area covered by a health authority in the south of England. This area was chosen as the study was undertaken part-time and it was necessary to restrict the study to a population which could be reached from the research base, and travel limited to about a 30-mile radius.

The catchment areas

These were identified by use of the postal code relating to the geographical locality of the child health centre selected for inclusion. The choice of child health centre was influenced by the need to obtain a district-wide view of the service, to allow for a variety of service settings and to encompass as wide a range of health visitor working conditions as possible.

Following discussion with nurse managers and at their request, the following centres were included:

Child health centres

Centre A a newly opened building serving a cross-section of the population;

Centre B a large purpose-built clinic, serving a mainly working-class population;

Centre C a general practitioner's child health clinic serving a large naval community;

Centre D both small clinics serving a working-class population;
Centre E

Centre F a general practitioner's child health clinic sited in the middle of the city serving a mixed population

Research design and methods of data collection

Postal distribution of a self-administered questionnaire

Using the notification of birth register as a sample frame, *all mothers of babies born between 19 February and 30 April 1984*, residing in the catchment area of the study, were invited to participate. Excluded from the study were mothers of babies born with a handicap, as they were likely to have special needs and to be part of another research project. Also excluded were mothers whose babies had spent time in the special care baby unit, as the infant was likely to be older than the anticipated 10 weeks of age at the time of the follow-up interview.

Follow-up interview of sample client group

A sample was drawn from clinic attenders who agreed to be interviewed in their own home. Babies' ages at the time of interview were between 6 and 10 weeks old.

Interviews were carried out by the researcher between April and June 1984. The average length of each interview was 55 minutes.

Interviews with the health visitors working in the catchment area of study

Interviews were carried out by the researcher in June 1984. Average length of each interview was 45 minutes.

Response rate

Postal questionnaire: 202 questionnaires were distributed, 100 completed and returned. Nineteen declined to participate, two were returned to sender (unknown), and one mother died and the form was returned. Eighty did not reply. The response rate was therefore 49 per cent.

In total 55 follow-up interviews were conducted, but only 50 were included in the final study.

Ten health visitors working in the catchment area of the study who had the highest number of clients participating were invited to take part. There were no refusals.

There are 106 health visitors employed in the research catchment area.

Analysis

The data obtained from the postal questionnaire were processed by means of the university (ICL/4130) computer using a program specially written for the project. Help and advice on statistical analysis was provided by the Department of Social Statistics, University of Southampton.

The data obtained from the follow-up interviews were initially sorted by hand and then partly processed by the university mainframe computer. All health visitor interview schedules were processed by hand. As this study is of a descriptive nature clients' comments have been included.

Findings

Some of the findings relating to the client and health visitor interviews are discussed briefly. An attempt has been made to highlight their implications for health visiting practice.

Expectations and reasons for attending

What did the clients initially expect from the child health clinic? For some this proved a difficult question to answer; expectations are shaped by one's experience and this also applied to clients participating in this study, whose expectations were influenced by their experiences with, and previous knowledge of, this aspect of health care. Those who had

more than one child, and who had met their health visitor previously, had clearer ideas and more sharply focused expectations than those who had no prior contact with the health visitor or child health services. Only 4 per cent of clients said that they did not know what to expect, or that they did not expect any help from the clinic staff.

In an attempt to identify the accessibility and acceptability of clinic provision, clients were asked how long it took them to get to clinic (single journey) and why they chose to attend a particular clinic (Table 1). They were also asked for their reasons for going to a particular clinic (Table 2). Analysis shows that over half this group of clients attended a clinic nearest to their own home. The journey took marginally less than 15 minutes each way and was within walking distance.

Table 1. Time usually taken to get to clinic (single journey) (n = 50)

Time taken	No. of replies	Mode of transport
About 5 minutes or less	15	All walked
About 10 minutes or less	16	All walked
About 15 minutes or less	9	7 walked—2 by taxi
About 30 minutes or less	6	All walked
About 45 minutes or less	2	All walked
Over 60 minutes	2	1 walked—1 by taxi

Table 2. Reasons for choosing to attend a particular clinic (n = 50)

Reasons	No. of replies
Nearest to family home	32
Own health visitor suggested she attended this centre	8
Own health visitor based there	6
Own GP based there	6
Own GP and health visitor based there	5
Other reasons—on way to shops, near mother's (2) can go with friends	4
(Some gave more than one reason)	

Clinic hours

The question of clinic hours was also considered. Out of a total of 50, 34 clients were satisfied with clinic hours, many saying that they fitted in nicely with collecting older children from school.

Sixteen were dissatisfied with clinic opening time for a variety of

reasons, a typical comment being: 'our clinic is only open for an hour at a time; it is not long enough . . . it should open less days for longer times. It takes me a long time to get ready to go, and it's closed when I arrive'. From a pre-coded list, clients were asked to say which age groups they thought child health clinics catered for (Table 3). Although only five clients thought that the clinic catered for children up to the age of 2 years, some confusion was evident. A few said that they had been told (not clear by whom), that clinics only catered for babies. One mother expressing this view pointed out that she is fact attended a 'well-baby clinic'. Two others thought that clinics were only necessary for children up to the age of 6 months, and that older children were not welcomed.

Table 3. Clients' perception of the age groups catered for by child health clinics (n = 50)

Age group	No. of responses
Birth—less than 6 months	1
6 months—less than 1 year	4
Over 1 year—less than 2 years	3
Over 2 years and less than 3 years	2
All under 5 years	22
Any age group	8
	—
	40
Don't know	10

All the health visitors in the study reported that clinic attendance did drop off as the child got older. Two out of the ten stated that they suggested to mothers that there was no need to attend as the child got older. Others indicated that, if they had managed to establish a satisfactory professional relationship with their clients, they would either return to clinic for special things, such as a routine developmental check, or would request a home visit. All health visitors were fairly confident that they could maintain some health visiting contact unless the family moved away. The level of contact was dependent upon case loads.

As the survey progressed it became apparent that the principal reasons given by most mothers attending the clinic coincided with their expectations. This response could have been triggered by the way the question was asked, but for the purpose of analysis the two are combined and described as 'services expected' (Table 4). It can be seen

Table 4. Services clients expected clinics to provide; their actual use of same and what they found most useful (n = 50)

	Services expected	Services expected and received	Services expected received	Not ranked but most useful
(a) Monitoring of child's height and weight	46	45	1	19
(b) Confirmation of babies' progress	42	39	–	11
(c) Routine check up of babies' developmental progress	37	27		–
(d) Advice—i.e. about feeding	42	23	1	4
(e) Advice about a particular problem—sleeping, teething etc.	33	24	1	3
(f) To meet other mothers	28	25	2	–
(g) To get baby immunized	27	17	1	–
(h) Teaching and guidance from staff about health matters	11	14	1	–
(i) To talk to the HV about the baby/children	29	32	1	7
(j) To talk to the HV about personal matters	12	11	–	–
(k) To talk to the HV about family matters	7	7	1	–
(l) To talk to the GP about the baby/children	3	3	–	–
(m) To talk to the GP about personal matters	3	1	–	–
(n) To talk to the GP about family matters	2	1	–	–
(o) To talk to the clinic doctor about the baby/children	17	15	1	3
(p) To talk to the clinic doctor about personal matters	1	–	–	–
(q) To talk to the clinic doctor about family matters	1	–	–	–
(r) To buy food or vitamins	25	18	1	1
(s) Other reasons	25	18	1	1
(t) Don't know	4			

GP = general practitioner; HV = health visitor

that on the whole clients' expectations were met. When comparing their expectations with the health visitors' perceptions of what they thought the clients wanted from the child health clinic itself very few differences

emerge. The majority of parents expected clinic staff to weigh their baby and to confirm that all was well.

Clients' expectations coincided with what they actually received; weighing being the most frequently mentioned service received (A similar finding to that reported by Sefi and Macfarlane 1985; Biswas and Sands, 1984; Bolton, 1984). The health visitors also thought that parents expected most of all to be able to weigh their baby and to get confirmation of their child's progress and reassurance of their own ability to cope.

From discussion with mothers it would appear that the weighing of the baby involved more than a mere recording of weight. Once inside the building the mothers made use of other services. However, not everyone found weighing reassuring; one said: 'I wish the health visitor and her scales would jump into the nearest lake, the emphasis on weight makes me feel on trial and inadequate'.

A small discrepancy appeared between the clients' perceptions and those of the health visitors in so far as 25 (50 per cent) of clients expected clinics to provide the opportunity to meet and talk to other mothers; whereas the health visitors thought that most mothers would expect to meet other mothers at clinic and that this would be an important aspect of their visit. One health visitor commented: 'Clinics should be a social gathering . . . a time when mothers can meet together.' Whilst acknowledging this ideal, some health visitors pointed out that the social organization of the clinic mitigated against the achievement of this goal; a view shared by some of the consumers.

There was some evidence which suggests a link between knowledge of how to use a service and subsequent satisfaction with the service provided, and 10 clients (23.3 per cent) expressed a degree of frustration about their feelings of confusion and lack of adequate preparation for their first visit to clinic. One mother stressed that all mothers should know in advance what they are expected to do when attending, but she made the plea: 'Please don't tell us at the first home visit . . . soon after would be better.' A discrepancy appeared here between the clients' perceptions and those of the health visitors. Ten clients (23.3 per cent) expected more specific information as to the purpose of the clinic, and guidance from their health visitor as to what is expected of them when they attend. Only two health visitors in the study reported that they specifically prepared mothers for their visit to clinic. One said: 'I invite them to come and once there they soon pick up the routine.' However, as the nature of the study relied upon clients' saying what services they thought they had received, it may well be that when inviting parents

to attend clinic this background information had been given without the parents fully realizing it.

Consultations

Out of a total of 50, 32 clients (34.3 per cent) spoke to their family health visitor and found her very helpful and welcoming. A further 22.9 per cent commented on the health visitor's helpfulness, and 14.3 per cent on her welcome. Only 2.9 per cent found the contact with the health visitor to have no value.

A smaller number of clients spoke to a health visitor who was not their own. The pattern of satisfaction with welcome and usefulness was the same as for own health visitor.

The only other member of clinic staff spoken to with such regularity was the receptionist. Most clients had no reaction, but small numbers reported positively and negatively (4 per cent on each side).

Relatively few people spoke to their GP, another GP or the Clinic Medical Officer (five clients spoke to own GP, two to other GP, nine to Clinic Medical Officer). Within this small group the GPs were considered helpful, but there were mixed feelings about the Clinic Medical Officer.

Health education

Just over a quarter, 14 (28 per cent) of clients expected to receive health education and teaching about health matters, and the same number actually received this service. From discussion with parents it appeared that some did not appreciate that health teaching is part of the health visitor's role. Dingwall (1977) and others have noted that sometimes the health visitor's agenda of topics to be covered is so loosely structured that some mothers perceive it to be aimless everyday exchanges. Certainly much of the health visitor's advice at clinic would consist of indirect health teaching which may or may not be recognized as such by the recipients. However one views this situation, it is questionable as to how effective a method this can be when some clients are unaware of the underlying message.

All of the health visitors interviewed stated that the promotion of health through health education was one of their main objectives for work in clinics, although a few thought the clinic setting inappropriate for group teaching. Out of a sample of 10, two asked for more space in clinics in order to mount health education displays, three asked for

video playback facilities and display boards, and five thought that clients should be given the opportunity to watch video films whilst waiting.

Health visitor satisfaction

Health visitors were asked how satisfied they were with their work in relation to child health clinics: two were very satisfied, three satisfied, two mainly satisfied, two not satisfied and one did not know.

Satisfaction centred around the opportunity to see and talk to all who attended, to advise as appropriate and to send mothers away reassured in their own ability to cope. Dissatisfaction centred around the lack of privacy, overcrowding, lack of play space and toys, and unsatisfactory clinic times.

Suggestions for change included flexible opening times, improved facilities—in particular the waiting area—toys and play space, and the need for private consulting rooms. General practitioner premises were considered by two health visitors to be unsuitable for clinics, one said: 'if clinics are to be held in practice premises improved facilities are necessary. At the moment these are hazardous, scales are placed on the desk, the floor is slippery, no separate tables are available and access to cupboards is difficult.'

Eight of the ten health visitors interviewed thought that a 'drop-in centre', open from approximately 9 a.m. to 5 p.m., staffed by health visitors on a rota basis, would be an improvement on the present system, although it was speculated that only mothers who use the present service would 'drop in'.

Conclusion

In summary, the main reasons parents attend clinic is to get the baby weighed and to obtain advice and reassurance. Parents should be told in advance the aims and purpose of the clinic, and from the first visit should feel involved. The environment is important and improvements in this area could be relatively simple and cheap. Health visitors are broadly satisfied with their role in relation to clinics, but there is a need to look further at the health education aspect of their work in clinics.

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