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Health care providers counselling of caregivers on their children's condition at Usmanu Danfodiyo university teaching hospital, Sokoto, North-Western Nigeria

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Introduction: Counselling of caregivers about common childhood diseases is an important component of health care services. **Objective:** To assess the quality of counselling offered to caregivers on their children's condition by health care providers at Usmanu Danfodiyo University Teaching Hospital (UDUTH), Sokoto. **Methods**: A prospective cross-sectional study carried out from 1st August 2015 to 30th April 2016. Caregivers with children less than 15 years of age seen in the units of Paediatric Department of UDUTH, Sokoto, were consecutively interviewed. The corresponding case notes of their children were reviewed to obtain data on the child's diagnosis and to check whether the attending physicians have documented the content of the counselling offered to caregivers. **Results**: A total of 420 caregivers were interviewed. Their mean age was 28.9±8.6 years (range of 15-64 years). Only 218 (51.9%) caregivers were counselled, but there was no documentation of the content of counselling in the case notes of their children. 81 (37.2%) of the diagnosis mentioned by caregivers did not tally with the one documented in the case notes of their children ($p=0.0001$). **Conclusion:** This study revealed inadequate counselling of caregivers on their children condition and poor counselling practices among healthcare providers in UDUTH, Sokoto. Hence, there is the need for training and retraining of healthcare providers on counselling of caregivers on their children condition in the hospital.

Keywords: Health care providers, Caregivers, Counselling, Sokoto

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Introduction

Counselling of caregivers about common childhood diseases is an important component of health care services [1]. Patient's rights constitute an important aspect of everyday hospital practice including the right to be counselled and be informed about one's health [2]. Counselling is an integral but overlooked aspect of patient management [1]. Caregivers are often left in darkness because they are not informed about their child's diagnosis, treatment and prognosis [3].

Adequate knowledge of diseases has been shown to improve caregiver's participation in disease management with good and favourable outcome [4]. A doctor communication and interpersonal skill encompass the ability to gather information to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions and establish a caring relationship with patients [5]. Patients reporting good communication with their health care providers are more likely to be satisfied with their care and to share pertinent information for accurate diagnosis of their problems, follow up advice, and adhere to prescribed treatment [6]. Various factors limit the ability of healthcare workers to provide adequate counselling to caregivers, these include forgetfulness, ignorance and communication problems [7,8].

Barriers to effective communication between health care providers and caregivers include environmental barriers such as a lack of privacy, other barriers are the negative attitude of the health care workers, perception of the caregivers and patient about health care providers, as well as client personal barriers such shyness, and administrative barriers because management is responsible for adequate staffing and allocation of work duties and time barrier [9]. The quality of counselling is considered high if it meets the informational needs and expectation of patients and their family members [10].

There is a paucity of studies on quality of counselling offered by health care providers to caregivers in Nigerian Hospitals to the best of investigators knowledge, although researchers have shown that patient and caregivers are not satisfied with the quality of counselling they received from health care providers [10]. little is known about the quality of counselling offered to caregivers by health care providers in Nigerian hospitals, therefore the need for this study.

This study was undertaken to assess the quality of counselling offered to caregivers by health care providers on their children's condition at Usmanu Danfodiyo University Teaching Hospital (UDUTH), Sokoto.

Materials and Methods

Setting: The study was carried out in the units of Paediatrics (Paediatric Medical Ward, Emergency Paediatric Unit, Paediatric Outpatient Clinic and Special Care Baby Unit) of the Department of Paediatrics, Usmanu Danfodiyo University Teaching Hospital, located in the capital of Sokoto State.

It is the major tertiary health facility in the state providing care to children from Sokoto as well as neighbouring states of Zamfara, Kebbi, Niger as well as the neighbouring countries such as Republics of Niger and Benin.

Duration and type of study: This was a cross-sectional study carried out from 1st August 2015 to 30th April 2016 at UDUTH, Sokoto.

Sampling method: Caregivers with children less than 15years of age with childhood illnesses seen in the units (Paediatric Medical Ward, Emergency Paediatric Unit, Paediatric Outpatient Clinic and Special Care Baby Unit) of Paediatric Department, UDUTH, Sokoto were interviewed. The health care providers are the doctors (consultants, resident doctors and nurses) that were involved in the management of the patients.

Sample size determination: The minimum sample size was determined using the formula $n= z^2pq/d^2$ by Araoye [11]. where n= minimum sample desired; z= standard normal deviate at 95% confidence interval =1.96; the prevalence of caregivers that received health information on their children (0-5 years) disease while on admission at the University of Benin Teaching hospital in Nigeria from a previous study by Nwaneri et al [7].

Where p = 23.1%= 0.231; q = complementary probability of p = 1-p = 0.769; d = tolerable alpha error or level of precision = 5% = 0.05. Thus, $n = 1.96^2 \times 0.231 \times 0.769 / 0.05^2 = 273$. A response rate of 95% was anticipated.

The final sample size was calculated using the formula $f= n/0.95_{11} = 272/0.95=287$, but 420 children and caregivers' pair were recruited consecutively until the desired sample size was achieved.

Inclusion criteria: Caregivers and their children that were less than 15years of age seen in the paediatric units of UDUTH, Sokoto with childhood illnesses.

Exclusion criteria: Caregivers that did not give written informed consent were excluded, as well as caregivers that lost their children while on admission.

Data collection procedure: A semi-structured interviewer-administered questionnaire was used to obtain information on demographic data of the respondents, awareness of child's diagnosis, whether or not there was an explanation on how the child got the illness, explanation on the test to be done, whether or not the treatment was explained to caregivers including side effects and health education on preventive measures. Caregivers were also interviewed on where the counselling was done, whether they were satisfied with how the counselling was done, whether they were allowed to ask the question. And whether the healthcare provider introduces him/herself and was polite throughout or not.

The case notes of the children were reviewed to obtain data on a child's diagnosis and to check whether the attending physicians have documented the content of the health information given to the caregivers. Members of the research team interviewed the caregivers consecutively each day after consultation in the clinic and the following admission into paediatric units of UDUTH in a separate room, away from the consulting room and wards, members of the research team were not part of the study, this is to avoid pre-emptying health care providers leading to bias, as they could be more conscious of their counselling. The identity and cadre of each health care provider were further confirmed by the research team, and from the call duty roaster and nurses on duty. Socio-economic class (SEC) of the caregivers was determined using Oyedeji's classification [12].

The researchers counselled caregivers (according to the disease condition of the child) that were not counselled after data collection to prevent missed opportunity. Content of health information given to caregivers included diagnosis, disease aetiology, mode of transmission, treatment modalities and preventive measures of the disease.

Data analysis: Data were analysed using SPSS version 20. Quantitative variables were summarised using means and standard deviation. Chi-square test was used to test for statistical significance, a p-value of <0.05 was considered statistically significant.

Ethical approval: Ethical approval for the study was obtained from the Ethics Committee of Usmanu Danfodiyo University Teaching Hospital, Sokoto.

Results

A total of 420 children and caregivers' pair were recruited for this study. The children were 216 (51.4%) males and 204 (48.6%) females, with an M: F ratio of 1.1:0.9, mean age of the children was 29.79 ±35.1 months, range (1-158). Most of the children 177 (42.1%) were in the age range of 1-<5 years as shown in Table 1. 378 (90.0%) were inpatient while 42 (10.0%) were outpatient.

Table-1:- Demographic characteristics of the patients and caregivers.

Demographic characteristics	N (%)
Gender	
Male	216 (51.4)
Female	204 (48.6)
Age group (years)	
0-<1M	165 (39.3)
1-<5	177 (42.1)
5-<10	54 (12.9)
10-<15	24 (5.7)
Duration of admission	
<72 hours	206 (49.0)
72 hours -<1week	117 (27.9)
>1week	97 (23.1)
Type of caregiver	
Mothers	412 (98.1)
Grandmothers	8 (1.9)
The age group of caregivers (years)	
15 years	3 (0.7)
16 – 25 years	186 (44.3)
26 – 35 years	138 (32.9)
36 – 45 years	75 (17.9)
46 – 55 years	15 (3.6)
56 – 65 years	3.(0.7)
Educational status	
No formal	156 (37.1)
Primary	33 (7.9)
Secondary	102 (24.3)
Tertiary	129 (30.7)
Socio-Economic Class	
Upper	69 (16.4)
Middle	171 (40.7)
Lower	180 (42.9)

The largest proportion of the children, 206 (49.0%) spent less than 72 hours on admission as shown in Table 1.

The mean age of the caregivers was 28.9±8.6 years (range of 15-64years). Majority of the caregivers 412 (98.1%) were mothers, while 8(1.9%) were grandmothers. Most of the caregivers 156 (37.1%) had no formal education, while 33 (7.9%), 102 (24.3%) and 129 (30.7%) had primary, secondary and tertiary level of education respectively.

The largest proportion of the caregivers 180 (42.9%) were in the lower SEC see Table 1.

Disease morbidities of the children: Most common disease condition documented in the folders of the children was complicated malaria in 117 (27.9%) and Neonatal septicaemia in 42 (10.0%), see Table 2.

Table-2: Disease morbidities of the children.

Disease morbidities of the children	N (%)
Complicated malaria	117 (27.9)
Neonatal septicaemia	42 (10.0)
Pneumonia	39 (9.3)
Prematurity	30 (7.1)
Birth Asphyxia	18 (4.3)
Meningitis	18 (4.3)
Tetanus	10 (2.4)
Uncomplicated malaria	6 (1.4)
Others *	140 (33.3)
Total	420 (100.0)

*Meningitis, Measles, Tuberculosis, Pharyngitis, Bronchial Asthma, Ichthyosis, Acute, diarrhoeal disease and sickle anaemia with complications.

Health care providers counselling of caregivers

There were 420 caregivers interviewed, only 218 (51.9%) were counselled by the health care providers, of the 218 caregivers counselled, 214 (98.2%) were counselled by the doctors, while 4 (1.8%) by the nurses, but there was no documentation of the content of counselling in the case notes of all their children nor the nurse's notes about the health information rendered by the nurses.

The highest proportion of the doctors that counselled the caregivers were predominantly resident doctors in 115 (52.8%), while 65 (29.8%) and 29 (6.9%) were counselled by the consultants and house officers respectively as shown in Table 3.

Table-3: Proportion of healthcare provider that counselled caregivers.

Healthcare provider	N (%)
Consultants	65 (29.8)
Resident doctors	113 (32.8)
House Officers	13 (6.9)
Nurses	4 (1.8)
Dr cadre unknown	19 (8.7)
Total	218 (100.0)

Content of counselling offered to caregivers by health care providers

Although 218 of the caregivers counselled were told the diagnosis of their children, 81 (37.2%) of the diagnosis mentioned by caregivers did not tally with what was documented in the case notes of their children. The diagnosis mentioned by caregiver's tally most with the one told by the consultants in 48 (22.0%) and resident doctors in 67 (30.7%), it tallies less when it is the house officers in 4 (1.8%) and nurses 1 (0.5%), ($p=0.0001$) as shown in table 4

Table-4: Tallying of diagnosis in case notes.

Healthcare provider	Diagnosis tally	
	No (%)	Yes (%)
Consultants	17 (7.8)	48 (22.0)
Resident doctors	48 (22.0)	67 (30.7)
House Officers	11 (5.0)	4 (1.8)
Nurses	3 (1.5)	1 (0.5)
*Doctor	2 (0.9)	17 (7.8)
Total	81 (37.2)	137 (62.8)

Df = 4, F = 20.869, P = 0.0001, *Doctors cadre not known

Ninety-one (41.7%) out of the 218 of the health caregivers counselled received explanation on disease aetiology. A majority, 138 (63.7%) of the health care providers explained the test to be done to caregivers and explanation on treatment was not given to 144 (66.1%) of the caregivers. Only 71 (32.6%) out of the 218 of the caregivers counselled received health education on disease preventive measures as shown in Table 5.

Table-5: Content of counselling offered to caregivers by healthcare providers.

Content of counselling	Yes (%)	No (%)
Disease aetiology	91 (41.7)	127 (58.3)
Test	138 (63.7)	80 (36.7)
Treatment	74 (33.9)	144 (66.1)
Prevention	71 (32.6)	147 (67.4)

Health care providers attitude and conduct of counselling

Of the 218 caregivers counselled, 123 (56.4%) were satisfied with how the counselling was done, 107 (49.0%) were allowed to ask questions. Health care providers did not introduce themselves to 126 (57.8%) of the caregivers but the majority, 203 (93.1%) of healthcare providers were polite to the caregivers. See Table 6.

Table-6: Healthcare providers attitude of counselling.

Attitude	Yes (%)	No (%)
Opportunity to ask question	107 (49.0)	113 (32.8)
Self-introduction	92 (42.2)	126 (57.8)
Polite	203 (93.1)	15 (6.9)

The largest proportion of the caregivers 156 (71.6%) were counselled in an open ward and only 6 (2.8%) were counselled in a private consulting room. See Table 7.

Table-7: Place of counselling.

Place of counselling	N (%)
Open ward	156 (71.6)
Open consulting room	53 (24.3)
Secluded area	3 (1.3)
Private room	6 (2.8)
Total	218 (100.0)

Discussion

This study aimed to determine the quality of counselling offered to caregivers by health care providers during their routine work, most of the available studies were in adults, [10.13]. the researcher found only one study that was done in children [7].

The caregivers were predominantly mothers, a finding similar to Nwaneri et al [7] and Nwosu et al [14] in Nigeria where most of the caregivers presenting to the hospital with their children were mothers. Emmanuel et al [15].

Reported that children are more likely to be brought to the clinic by their mothers. In contrast to the finding of Nwaneri et al [7] and Nwosu et al [14], in the present study, the majority of the caregivers had no formal education and belong to lower SEC.

The finding of this study showed that healthcare providers do not routinely counsel caregivers on their children condition, a similar finding was reported by Nwaneri et al [7].

Some studies [10,13] have reported that health care providers do not counsel patients and caregivers. Maguire et al [16] and Jennifer et al [17] has reported that doctors do not communicate with their patients as much as they should, doctors are usually pre-occupied clerking and treating patients and may not have the time to counsel patients and caregivers. Another reason for not counselling caregivers by a healthcare provider in this study may be due to poor communication skills. It has been observed that communication skills tend to decline as medical students progress through their medical education, and over time doctors in training tend to lose their focus on holist patient care [5].

Furthermore, the emotional and physical brutality of medical training, particularly during internship and residency, suppresses empathy, substitutes techniques and procedures for talk [17]. Information is sometimes withheld from patients because health care provider may assume that they may not understand the full explanation, disclosure or full explanation may lead to potential misinterpretation or cause undue anxiety [1].

It has been reported by Bartleson et al [1] that information is not disclosed to patient's caregivers at times because the health care provider may think another healthcare provider will provide the necessary information. This may account for the reason why the majority of the caregivers in this study were counselled by registrars, only a few by the consultants, a similar finding was reported by Nwaneri et al [7]. Most senior physicians delegate the duty of counselling to the junior ones.

Another reason for poor counselling of caregivers in this study can be explained by the fact that majority of the caregivers belong to the lower SEC with poor educational background and the assumption by health care providers that the caregivers and their patients may not have enough educational potential to understand full explanation of the disease [3] or participate in counselling [7], Barrier et al [3] have shown that the higher the educational level of the caregiver the more likely that the caregiver would receive health care provider education.

Evelyn et al [18] also found that patients from lower social classes receive less quality of counselling than those in the higher socio-economic class. Furthermore, there seems to be a growing interest in the patient's perception of doctor-patient communication.

While in the past patient's perception was not taking into account or no differences in perception were found, more recent studies show that lower SEC patients have the feeling that doctors fail to explain things in a way they can understand and spend less time with them [19]. Health care providers should counsel all caregivers and patients irrespective of their social class and in the language that they will understand [20-21].

Lack of sufficient explanation to patients and caregivers results in poor patient understanding, and lack of consensus between doctor and patient may lead to therapeutic failure [22]. Patients reporting good communication with their doctors are more likely to be satisfied with their care, and especially to share pertinent information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment [23]. When there is good doctor-communication, patients are more satisfied and are less likely to lodge formal complaints or initiate malpractice complaints [24].

None of the health care providers documented the content of health information given to the caregivers, although there are few studies on physician documentation, a similar finding was reported by Nwaneri et al [7]. Studies had shown that doctors have poor documentation practices ranging from non-writing of discharge summary [25] to omission of documentation of vital information of patients [26-27]. Inadequate documentation practices were also reported among the nurses, where more than half of the nurses did not document nursing care for patients [28]. The medical record is valuable for research, audit and medico-legal purpose but its primary function is for patient care [29]. Reasons for poor documentation include habit, time restraints, lack of training, and examples being set by others were reasons that were given for poor quality documentation in a study by Raza [30].

This study showed 37.2% of the diagnosis mentioned by caregivers did not tally with was documented in the case notes of their children, this is similar to report by Nwaneri et al [7], where 64.8% of the caregivers correctly mentioned the diagnosis of their children. This disparity may be because the largest proportion of the caregivers in the present study belong to the lower SEC, with the majority having no formal education. Barriers to information retention also include anxiety, denial, memory deficits, pain, stress, or unfamiliarity [31-32].

The ability to comprehend and retain information may decline as patients and family members age [33].

The attitude of some health care providers towards their patients was poor in this study, with the majority of the healthcare providers not introducing themselves to 57.8% of the caregivers counselled, this is consistent with the report by Kebashin et al [34]. Nwosu et al [14] in Lagos reported good initial reception to caregivers of children of 81.3% for the doctors and 25% for the nurses.

Majority of the caregivers 156 (71.6%) were counselled in an open ward and only 6 (2.8%) were counselled in a private consulting room. Lack of auditory privacy is well recognised in hospital settings [35]. Privacy and confidentiality are important components of patient care [36-37]. Overheard disclosures adversely affect patients' trust and can lead to a breakdown in the relationship between the patient and their healthcare team [38].

Personal privacy must be respected, even in the course of medical/surgical treatments, diagnostic examinations, specialist visits, medications and so on, it must take place in an appropriate environment and in the presence of only those who need to be there [39]. Ensuring privacy can promote more effective communication between physician and patient, which is essential for the quality of care, enhanced autonomy, and preventing economic harm, embarrassment, and discrimination [40].

Conclusion

This study revealed inadequate counselling of caregivers on their children condition and poor counselling practices among healthcare providers in UDUTH, Sokoto. Hence, there is the need for training and retraining of healthcare providers on counselling of caregivers on their children condition in the hospital.

What does the study add to the existing knowledge

Training on counselling of patients should be reinforced at both undergraduate and postgraduate medical colleges. A concise handbook on counselling of caregivers on common childhood disease should be developed to guide and help health care providers to improve the quality of their counselling.

There is a need for further studies to explore the reasons for inadequate and poor counselling practices in the hospital.

Author's contributions

Dr. Adamu Asma'u: Conceptualised and designed the study, collected data, analysis, drafted the manuscript.

Dr. Isezuo Khadijat Omeneke: Statistical analysis and revised the manuscript.

Dr. Sani Usman M: Literature searches and revised the manuscript.

Dr. Ibitoye Paul Kehinde: Reviewed the analyses of the study and revised the manuscript.

Dr. Ugege Modupe Omoshalewa: Reviewed the analyses of the study and revised the manuscript.

Dr. Garba Bilkisu Ilah: Study design.

Dr. Ali Muhammad: Statistical analysis and revised the manuscript.

Dr. Ango Umar Mohammed: Study design

Dr. Jiya Fatima Bello: Gave necessary guidance and added intellectual content.

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