

Mary Kay Whelan. WHAT WORKING MOTHERS USE OR PREFER FOR CHILD CARE FOR THEIR MILDLY SICK CHILDREN. (Under the direction of Maryellen McSweeney) School of Nursing, May 1988.

The purpose of this study was to determine what type of child care working mothers use and prefer for their mildly sick children and how employers view employee absenteeism for the care of mildly sick children.

A questionnaire for working mothers included questions pertaining to the type of sick child care used and preferred and the perceived impact of employers' policies on child care arrangements. A pilot study was conducted to assess the clarity and appropriateness of the questions in this questionnaire developed by the researcher. Questionnaires were distributed at staff meetings to all eligible women employees with children under age seven at 22 schools and two hospitals in four counties in a southeastern state. All those eligible completed and returned the questionnaires. A total of 240 women answered the questionnaires.

Working mothers were the single most likely caregivers for their own mildly sick children (34.6%). The next most commonly used caregivers were grandparents and fathers (26.7% and 10.8%, respectively). When working mothers were asked to select the type of care they preferred for their mildly sick child, they indicated in-home care by family

members, relatives, or friends (88.5%) as a first choice. Their second preference was for in-home care by trained caregivers (52.7%). The type of mildly sick child care used and preferred was not significantly related to age of mother, marital status, or occupation. Although 71 of the 240 working mothers used day care centers for regular child care, only 8.4% indicated that the regular day care center continued care of their mildly sick children.

Structured interviews were conducted with 22 principals from 22 schools and 9 head nurses from two hospitals. The employers were interviewed in regard to the effect absenteeism of female employees for care of mildly sick children had on the employing organization. All employers indicated that absenteeism for care of mildly sick children was not a financial or staffing problem. This may be a consequence of hospital and school system policies regarding the use of sick leave. Research is needed to identify ways of educating employers regarding the impact of sick leave policies on child care and educating communities concerning possible options for mildly sick child care.

WHAT WORKING MOTHERS USE
OR PREFER FOR CHILD CARE
FOR THEIR MILDLY SICK CHILDREN

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Mary Kay Whelan

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by

Mary Kay Whelan

APPROVED BY:

DIRECTOR OF THESIS

Maryellen McSweeney

Maryellen McSweeney, Ph.D

COMMITTEE MEMBER

Dorothy L. Merrow

Dorothy L. Merrow, M.S.

COMMITTEE MEMBER

Helen Faller

Helen Faller, Ed.D

COMMITTEE MEMBER

Charles Snow

Charles Snow, Ph.D

ASSISTANT DEAN,
GRADUATE PROGRAM

Gaye Poteet

Gaye Poteet, Ed.D

DEAN OF THE GRADUATE SCHOOL

Joseph A. Boyette

Joseph Boyette, Ph.D

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CHAPTER I

INTRODUCTION

Approximately "31.8 million children, 54% of American children, have mothers who are employed" (Rogers, Morgan, & Fredericks, 1986, p. 131). Of the 31.8 million children with working mothers, 7.8 million are under the age of six (Haskins & Kotch, 1986). All children, whether their mothers work or not, become ill from time to time. Upper respiratory illness accounts for 60% to 70% of illness among the preschool age group (Jordan, 1986). Typically, preschool age children have from six to nine viral infections a year, which can last from three to seven days each (Jordan, 1986; Rogers et al., 1986). Even minor illnesses such as colds can create anxiety for the working mother, because alternative child care arrangements may be necessary (Rogers et al., 1986).

An assessment of child care needs conducted in 1970 in Berkeley, California, found that 83% of working parents did not have an adequate solution to the problem of providing child care when a child was ill (Jordan, 1986). In a more recent study, conducted in Charlotte, North Carolina, 80% of the working parents surveyed do not have an adequate solution to the problem of providing care for the mildly sick child of working parents (Council for Children, 1985). In the last 16 years, from the Berkeley study in 1970 to the Charlotte study in 1985, there is little evidence of

amelioration of the problem of care for mildly sick children of working parents.

Absenteeism from work due to care of mildly sick children is a problem for employers. According to Landis and Earp (1986), absenteeism from work will "cost employers anywhere from 6.25 days to 28.8 days" (p. 362) per working mother per year. Haskins and Kotch (1986) calculated a \$400 million loss due to working mothers being absent from work to care for children with upper respiratory infections.

The problems of care of mildly sick children, mothers being absent from work, and lost man-hours for employers will increase by the end of this century. It is estimated that 80% of the mothers in America will be working outside the home (Zigler & Muenchow, 1986). There will be an increase from 4.7 million to 6.3 million children in out-of-home care by 1990 (Haskins & Kotch, 1986). Therefore, it is important to start assessing the need for and planning of care for the mildly sick child.

In North Carolina, there were 223,379 working mothers with children under the age of six in 1980 (North Carolina Census, 1980). In 1986, approximately 158,140 children were cared for in 2535 child day care centers and 5867 home care centers throughout the state. An additional 755 day care centers accommodating 24,586 children and 123 child day care homes accommodating 681 children were approved for licensure in 1986 (Personal Communication, May 1987). The

licensed day care centers and home care centers are licensed by the state of North Carolina and governed by the laws of the North Carolina Day Care section, a Division of Facility Services, Department of Human Resources. The law governing state licensed day care centers and home care centers states that "any child who becomes ill at the center and is suspected of having an infectious or contagious disease shall be separated from the other children until parents...come for the child...and not return to the center until the disease is diagnosed...as not being infectious or contagious" (Child Day Care Center Standards, 1987, p. 361). The contagious diseases are those listed by the American Academy of Pediatrics: conjunctivitis, streptococcal infections, varicella, rubeola, mumps, tuberculosis, pertussis, and diarrhea (Landis & Earp, 1986).

Day care regulations require each child care center or day care home to have written policies dealing with mild illnesses. The most commonly occurring illness among children is upper respiratory infection. It is also the most commonly listed illness in exclusion policies in day care centers (Haskins & Kotch, 1986; Jordan, 1986; Rogers et al., 1986; Shapiro, 1984).

To understand the impact of inadequate child care resources for mildly sick children of working mothers, one needs to understand how each component of society is affected. The use of the human ecological health system

model (Hancock, 1985) aids in understanding the pattern of reciprocal influence of the various components of society. The human ecological health system model encompasses all aspects of an individual's life and how these aspects influence society as well as how the components of society influence the individual.

The lack of child care for the mildly sick child of working mothers has caused numerous problems throughout the human ecological health system (Parents in the Work Place, 1983). Anxiety may be present within the family unit because of the need to find some form of child care for the mildly sick child. The family may impose pressure on the child's regular day care center, which is governed by regulations from federal, state, and local agencies (Mohlalane, undated). The work site is also affected by absenteeism and an attendant loss of money (Miller & Norton, 1986). The absenteeism also affects the psychosocial aspect of work. Co-workers of working mothers may find that they take on extra tasks when the working mother is absent to take care of her mildly sick child. The co-worker may become resentful, adding to lowered productivity. If the working mother remains at work, increased stress due to concern for her mildly sick child may cause decreased productivity (Work/Family Directions, 1986). As more women return to the work force, the need for child care of mildly sick children of working mothers will increase (Work/Family

Directions, 1986).

Purpose

The purposes of the present study are to determine:

1. What child care arrangements working mothers use for the care of their mildly sick children;
2. What arrangements working mothers would prefer to use;
3. How employers view employee absenteeism for the care of mildly sick children.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Chapter II is divided into four sections. The first section discusses diseases contracted in child care centers and preventive measures to keep the disease contained within the day care center. The second section reviews policies from federal, state, and local levels concerning exclusion from child care facilities due to illness. The third section focuses on current practices for ameliorating the problem of care for sick children. The final section discusses the human ecological health system and the effect a mildly sick child has on the system.

Diseases Present in Child Care Facilities

Doyle (1976) studied the rate of reported illness of children between the age of 6 to 36 months that were enrolled in a group day care center. The rates of reported illnesses were compared to those of children in family day care homes and home-reared. It was found that children under the age of 3 years lost 2.4 days per month at the center related to mild illnesses. The results indicated that children under the age of 3 years in day care centers had more mild illnesses--upper respiratory and gastrointestinal diseases--than children in family-care homes or home-reared ($F = 7.38$, $P < .01$). There were significant negative correlations of total illness to both age and history of group exposure ($r(12) = -.73$, $P < .01$; $r(12) = -.56$, $P < .05$) respectively).

this particular study used a small population but each group was matched, eliminating extraneous variables. Data were collected over a relatively short period (February to March).

The results of this study substantiated the results found in similar studies done by Loda, Glezen, and Clyde (1972) and Strangert (1976). The studies confirmed that younger children (less than 1 year of age) have more upper respiratory infections than older children. There were more reported upper respiratory infections in children in child day care centers as compared to children in home-care facilities or family-reared. These studies were cited in the descriptive study conducted by Haskins and Kotch (1986).

Haskins and Kotch (1986) conducted an extensive review of the literature on studies concerning diseases that are contracted in child day care facilities. Four diseases that are discussed in this chapter are upper respiratory infections, diarrhea, measles, and tuberculosis.

Haskins and Kotch (1986) reviewed seven studies pertaining to respiratory tract infections. The first study cited was conducted by Frisell in 1948 and the last was conducted by Doyle in 1976. The conclusions drawn from the seven studies were (1) children, especially younger ones, in a child care facility had slightly more respiratory infections than children cared for at home; (2) the more serious respiratory illnesses were not excessive in day care children; and (3) the pathogens found to cause respiratory

tract infections in children cared for at child care facilities were the same as in children cared for at home.

From 1972 to 1984, six Scandinavian studies cited by Haskins and Kotch (1986) were conducted to determine the prevalence of otitis media in children attending child care facilities. The findings indicated that children in child care facilities "are at two to three times the risk for persistent otitis media as children reared at home" (Haskins & Kotch, 1986, p. 955). In 1984 an American study by Visscher, Mandel, and Batalden substantiated the Scandinavian findings that child care attendance was one of the top risk factors for otitis media in the United States (Haskins & Kotch, 1986).

One conclusion from the studies on respiratory infection and otitis media indicated that "children in day care, as compared with children at home, experience more illnesses in early childhood but, as a result, acquire partial immunity to these conditions and may have reduced illness rates, relative to children reared at home, after they enter public schools" (Haskins & Kotch, 1986, p. 955).

Another disease that excludes children from child care facilities is diarrhea, which is part of the general diagnosis of gastroenteritis. Haskins and Kotch reviewed 12 studies from 1973 to 1984 that indicated the rate of occurrence for diarrhea is much higher (85%) in children who attend child care facilities when compared to children who

do not attend (48%). It was also found that children attending day care were more likely to infect their families than children who did not attend. The major risk factor for diarrhea in day care settings involved infants and small children in diapers. Changing and disposing of diapers by caregivers seemed to be the means of spreading the pathogens (Haskins & Kotch, 1986).

Two other studies were briefly mentioned. One from Morbidity and Mortality Weekly Report concerned an outbreak of measles in a day care center in 1980, where 17 children contracted the disease during a two-month period (Haskins & Kotch, 1986). A study by Kaupas (1974) reported an outbreak of tuberculosis in a family day care home (Haskins & Kotch, 1986). Eleven of the 36 children at the center had positive skin tests for tuberculosis after being exposed to the proprietor's husband who had active tuberculosis.

Two conclusions can be drawn from the literature reviewed by Haskins and Kotch (1986). One is children who attend child care facilities are at greater risk for contracting diseases such as respiratory tract infections, diarrhea, measles, and tuberculosis than children who stay at home. A second conclusion stated that these diseases, once evident, exclude the child from attending the child care facility even though the need for alternative care was brought about by disease contracted within the day care center.

Descriptive studies done by Kendall (1983), Goodman,

Osterholm, Granoff, and Pickering (1984), and The Child Day Care Infectious Disease Study Group (1984) and those reported by Haskins and Kotch (1986) were concerned with diseases that were in child day care centers. The focus of these studies was on "pathogens most frequently associated with infections in day care setting; the pattern of occurrence of these infections; principles related to their control and prevention; controversies concerning infectious diseases in child day care facilities; and aspects of this problem that may warrant further research" (Goodman et al., 1984, p. 134).

The pathogens most frequently associated with infections in day cares are: Hepatitis A; hemophilus influenzae type b; diarrheal diseases caused by Shigella, Giardia lamblia, and rotavirus; and respiratory tract diseases caused by parainfluenza virus, adenovirus, rhinovirus, and enterovirus (The Child Day Care Infectious Disease Study Group, 1984).

The Child Day Care Infectious Disease Study Group (1984) discussed vaccine-preventable diseases. These diseases (measles, mumps, rubella, polio, and diphtheria) are contracted by children and can have serious effects for adults who come in contact with the infected children. Since pertussis affects only children under the age of 6 years and tetanus affects only the individual, they are not as hazardous to the general population as the other

vaccine-preventable diseases. All of these diseases can be prevented by proper immunization.

Cytomegalovirus is another disease that has been linked to day care centers, especially those centers with children in diapers. This disease may be asymptomatic in other children and adults who are infected. However, pregnant women who contract the disease will have a 5% to 10% chance of having a congenital disease in their infants even though the mother may be asymptomatic (The Child Day Care Infectious Disease Study Group, 1984). Good handwashing technique is one means of preventing contamination. This is especially necessary after diapering or toileting since the virus is present in urine, feces, and saliva of infected children.

The authors of the studies previously discussed concur that exclusion of children contaminated by the pathogens discussed is a means of controlling an epidemic of these diseases in the day care center (Goodman et al., 1984; Kendall, 1983; and The Child Day Care Infectious Disease Study Group, 1984). However, they also concur that the child with the disease may be contagious before symptoms appear, thereby already infecting unsuspecting others.

The pattern of disease occurrence can be characterized four ways: (1) infections that occur mainly in children attending day care centers and that occasionally affect close family members or personnel of day care centers;

(2) infections that cause illness in children, day care staff and family members; (3) infections that may be asymptomatic in day care staff and adult members of the child's family; and (4) infections that may be asymptomatic among children and staff of the day care but have serious consequences for the fetuses of pregnant women. Diseases that are present in a day care setting may be spread to the community at large. It is important for day care providers to be aware of diseases that are present in the day care facility. To prevent spreading the disease to the community, preventive measures need to be taken by the day care staff.

The day care staff and parents need to understand the principles related to prevention and control of disease to keep infections contained within the day care facilities. Prevention and control of infections in day care centers should be focused on several practices: maximum hygienic standards; education of parents, staff, and owners; detection of illnesses within the center before they spread; and appropriate medical intervention (The Child Day Care Infectious Disease Study Group, 1984).

Hygiene is probably the most effective method of infection control. Since most infections are passed by the oral-fecal route, stringent handwashing is of major importance. In centers with a large population under the age of 2 years, diapering is the leading cause of contamination. Kendall (1983) recommends that hands be

washed after diapering, all containers for soiled diapers be covered, changing areas be cleaned after each diapering, feeding and diapering not be allowed in the same areas, and children in diapers be separated from children no longer in diapers. Moreover, smaller groups of children in diapers will decrease contamination.

Parents, staff, and owners need to be educated on how to prevent infections and how to treat their occurrence. They also need to know about basic hygiene. Parents should recognize when sick children need to be seen by medical personnel. Not all infections are medical emergencies, but illnesses that do not seem to improve after an appropriate time span need to be medically evaluated. Staff members need to understand symptoms of illness and procedures to follow to control the situation (Goodman et al., 1984; Kendall, 1983; and The Child Day Care Infectious Disease Study Group, 1984). The final suggestion for prevention of spread of infection within a day care center is exclusion of the sick child.

The authors of these studies concur that exclusion of mildly sick children from the day care may cause a hardship to the working mother. "Exclusion of ill or infected children from the center frequently forces a parent to lose time from work. If the parent's employers cannot allow the flexibility required by such a policy (exclusion of ill child), the parent may lose his or her job; in any case the

parent is likely to lose income while away from work" (The Child Day Care Infectious Disease Study Group, 1984, p. 684).

Birchfield (1986) conducted a study to identify the illnesses preschool children developed and the care they received while at school. The settings for the study included one Headstart program (two half-day sessions) and one day care program (7:30 a.m. to 5:00 p.m.). A daily health log was kept on each child from October 30th to June 4th. The log contained information on the illness and how the incident was handled (e.g., return to classroom, parent called, sent home, or taken to the hospital). The illnesses were identified by verbalizations and/or physical symptoms.

There were 241 children participating in the Birchfield study: 124 in the Headstart program (half-day) and 117 in the day care program (all day). There were 161 illnesses, 104 accidents, and 101 observations reported on 150 of the 241 children. Some children had more than one occurrence of illness, accident, or observation. The 161 illnesses were experienced by 95 children, a rate of approximately 1.7 illnesses per child. A total of 79.6% of the children from both settings developed illnesses. The most frequently occurring illness was respiratory conditions (73 cases). The illnesses are reported in order of prevalence: pain (62 cases), fever (47 cases), gastrointestinal symptoms (39 cases), skin changes (38 cases), and contagious conditions (13 cases). The distribution of illnesses totals

more than 161 because some reported more than one illness at the same time. These illnesses, when contracted by the child, exclude the child from attending either of the day care programs.

The studies reviewed in this section discussed the types of diseases found within the day care centers-- Hepatitis A, campylobacter enteritis, streptococcal group A, cytomegalovirus, mumps, measles, and rubella. Since adults as well as the fetuses of pregnant women can be affected by these diseases, the illnesses of children within day care centers have a definite impact on the community. Suggestions for controlling the spread of these diseases included good hygiene practices and exclusion of the infected child from the day care facility. The next section discusses exclusion policies for mildly sick children from day care centers.

Policies of Exclusion

Policies concerning day care originate at all levels of government--federal, state, and local. Logue (1978) reviewed federal and state regulations for the ill child in the child care setting. Federal interagency day care requirements apply to all federally funded centers or homes for child care. The Federal Panel on Early Childhood established the regulations for federally funded day cares. Guidelines include "(a) space for isolation of a child who becomes ill; (b) monitoring by a qualified physician; (c) medical evaluations appropriate to child's age upon entering day

care;... (g) advance arrangements for care of child who becomes ill, including isolation, if necessary, and/or notification of his/her parents;... (h) awareness of all staff members of the hazards of infection;... (i) periodic medical assessments of all staff members; (j) maintenance of health records;... and (k) arrangements for health-related treatment for each child" (Logue, 1978, p. 237).

Logue (1978) reviewed state regulations and found them to be similar to federal regulations. However, no two states, counties, or cities interpreted the federal regulations in the same way. Eighty percent of the states require physical examinations at admission, an isolation area for ill children, immunization, and daily health checks at all child care facilities. The policies that varied the most from state to state were those concerning the methods of handling ill children.

Twenty-eight states (56%) had published guidelines directing that children with communicable diseases be sent home. There were 16 (32%) states that left the exclusion of mildly sick children to the discretion of the individual day care program (Shapiro, Kuritsky, & Potter, 1986). Those states that excluded sick children from day care facilities based their decision on the 1931 White House Conference on Child and Health Protection (Logue, 1978; Rogers et al., 1986). This conference established the guidelines for public schools: children who were ill could not attend

school. Another argument for exclusion of younger children was based on medical grounds. The young child (under two years of age) lacks the natural protection against illness and must be protected from contagious diseases (Logue, 1978).

The states that argue for inclusion of the sick child base their response on the fact that the sick child has been contagious before the symptoms develop; therefore, other children have already been exposed to the illness (Haskins & Kotch, 1986; Logue, 1978; Rogers et al., 1986; Shapiro et al., 1986).

Six (12%) of the states have no specific regulations for the care of mildly sick children in day care programs (Shapiro, Kuritsky, & Potter, 1986). Many of the states that have previously isolated, excluded, or had weak regulations concerning mildly sick children in day care facilities are reviewing their regulations to help answer the need for sick child care (Work/Family Directions, 1986).

The American Academy of Pediatrics supports inclusion of the mildly sick child within the day care setting. This organization believes closer observation and more rest will occur in an isolation room (Logue, 1978).

Shapiro (1984) conducted a study concerning exclusion policies used by licensed day care centers in New Haven, Connecticut. A questionnaire was sent to 89 centers. Sixty percent of the centers returned the questionnaire. The

centers consisted of part-time and full-time participation of children. The part-time centers did not find exclusion of sick children a problem because there was at least one nonworking parent at home.

The centers excluded children with fever or vomiting (100%), diarrhea (73%), cough (30%), runny nose (30%), and sore throat (75%). In three centers, the sick child was able to return to the center at the parent's discretion; in 12 centers, the child could return when symptoms had improved for a least 24 hours; and in eight centers, a doctor's note was required before the child could return. The findings in this study indicate that policies for exclusion and return to centers after illness vary from center to center.

Aronson (1986) reviewed the question of exclusion criteria for ill children in day care facilities. The consensus of her findings was exclusion in most cases of illness was not necessary. If exclusion of the sick child is to prevent spread of disease, then the action is rarely appropriate. Children within the day care setting have already been exposed to the disease prior to the symptoms appearing in the ill child.

If the purpose of exclusion is for the sick child, then the action may be appropriate. In these cases the child may receive better care elsewhere or the attention the child needs may exceed the resources of the child's usual

caretaker or group. Diseases that would be appropriate to exclude are infectious diarrhea, infectious conjunctivitis (until 24 hours after treatment begins), hepatitis A (use of gamma globulin to stop epidemic), haemophilus influenza type B (consider rifampin to eliminate organism, especially in day care facilities with children 18 months to 5 years), vaccine preventable diseases (until noninfectious), and strep throat (until 24 hours after treatment).

To prevent difficulties from arising between parents and child care providers, establishing and communicating clear policies are important. The parents need to know and develop a plan for alternative child care for the time their child will become sick. The parents need to understand what resources are available in the center or community for the care of sick children (Aronson, 1986).

Landis and Earp (1986) reviewed North Carolina Day Care Center illness policies. The North Carolina Day Care Center regulations exclude sick children from attending their regular day care facilities (North Carolina Department of Human Resources, 1987). The individual day care centers are required to have an illness policy stipulating how sick children are to be managed with mild illnesses (not classified by the state as contagious). Day care centers in three counties in North Carolina were used in the Landis and Earp (1987) study. The day care facilities were divided into "uncertified" and "Level II" certified centers. The

"Level II" center received reimbursement from the Department of Social Services for participation of poverty level children. These centers are required by the Department of Human Resources as well as the state to have written illness policies. Thirty day care facilities from each group were randomly selected for the study. A questionnaire was given to the director of each center. There was an 87% (52) response rate.

Of the 24 uncertified centers, 4 (17%) had printed illness policies while 17 (61%) of the 28 certified centers had written policies. From the responses on illness policy, three categories were identified. There were nonspecific guidelines which state if the child was ill and/or feverish the child would be isolated until the parents could pick the child up. The second type of guideline specifically stated signs of illness and temperature that excluded children from the center. The third set of guidelines was behavioral-based policies. Those emphasized the ability of the child to participate in the activities of the center. The readmission guidelines were more specific. The children were to be free of fever and symptoms of illness for 24 hours. This study indicates that written guidelines vary from center to center within the same given area.

As indicated by the studies in this section, policies for exclusion of the mildly sick child from child care facilities vary from state to state as well as from center

to center. Practices other than exclusion are discussed in the next section.

Current Practices for Ameliorating the Problem of Care of Sick Children

The previous sections reviewed the prevalence of illnesses in child care facilities and the policies regulating exclusion of children because of illness. This section consists of current practices for ameliorating the problem of care for the mildly sick children. The solutions reviewed occur in all areas of involvement: federal, state, and local governments, employer, working mothers, day care centers, and types of alternative care for mildly sick children.

The first potential solution would be governmental involvement. At the federal level, a possible solution could be increasing the funding to the Center for Disease Control to expand its efforts to form committees to assess scientific evidence and make recommendations to day care centers about health issues (Haskins & Kotch, 1986). In addition, the federal government could fund research programs to examine questions about the health of children in day care. More research is needed in the areas of time lost from work by parents of ill children, medical cost, frequency of various types of illness in day cares, and the long-term effect of these conditions (Haskins & Kotch, 1986).

Another area that needs to be explored for a solution to care of mildly sick children is the employment policies and practices. *Parents in the Work Place* (1983), a joint venture of the Greater Minneapolis Day Care Association and Resources for Child Caring, Inc., cited the survey (Plant Policy Survey, 1982) conducted by Stanton and Associates in the Minneapolis/St. Paul, Minnesota area. Stanton Associates surveyed 50 manufacturing plants concerning sick leave policy for plant employees. The findings indicated that 20 of the 50 manufacturing plants did not have a sick leave policy for their plant employees. In another survey (The Office Policy Survey, 1982), cited by *Parents in the Work Place* (1983), 93 firms were surveyed in the Minneapolis/St. Paul, Minnesota area on policies and employee benefits relating to nonexempt employees (hourly wage earners). Thirty-one percent (29 of the 93 firms) allowed employees to take sick leave, with pay, to care for immediate family members who were ill.

The lack of adequate sick leave benefits indicated by these two surveys prompted the *Parents in the Work Place* to make some recommendations to employers to help solve the problem of care for mildly sick children. *Parents in the Work Place* (1983) recommended that the corporations (1) expand policies in the area of sick leave to include care for family members who are ill, or provide flexibility in taking time off through some other mechanism--no fault

personal days, discretionary time off; (2) offer flexibility in the workday, where the employee could take time off to make arrangements for sick child care without penalty and then make up the time by taking work home; (3) provide anticipatory guidance for employees by explaining sick leave policies, providing information about sick child care alternatives, and encouraging employees to be prepared to make arrangements for sick child care before it is needed; (4) provide anticipatory guidance for working parents by sponsoring parent seminars at work designed to help them make informed decisions about their children's illness, and assisting in finding in-home and out-of-home sick child care; and (5) consider wellness programs designed to help prevent illness.

There are advantages and disadvantages in using personnel policies to solve the problem of care for sick children. The advantages are that mothers may need to care for their children during the acute stages of illness; working mothers do not have to make excuses to take time off to care for their sick children when employers are sensitive to their problems; and the more liberal sick leave policies that allow mothers to stay home to care for their sick children have a positive effect on employees' morale and productivity. A final advantage of more liberal policies is mothers may be able to attend more closely to job demands when they know that care for sick children is allowed

(Parents in the Work Place, 1983). The corresponding disadvantages are that absenteeism through sick leave can affect productivity; other employees who do not have children may feel use of sick time is not equitable; and employers may lose more in benefits due to liberalized use of sick time (Parents in the Work Place, 1983).

The working mother is usually the one faced with providing the solution to mildly sick child care (Council for Children, 1985; Parents in the Work Place, 1983; Work/Family Directions, 1986). The solution that she usually uses is staying home to care for her ill child. Work/Family Directions (1986) cited the survey conducted by the magazine Working Mothers. The magazine surveyed over 1000 of its readers and found that 69% of the respondents stayed home to care for their sick children. Twenty-five percent of the working parents took turns staying home with their sick children. The advantages of working mothers staying home to care for their sick children are that the parent is present to care for the sick child and to seek medical attention if needed; the parent's guilt is decreased by being home with the sick child; and the child is able to recuperate in a familiar environment.

On the other hand, loss of income and anxiety over job security may result because the working parent is at home instead of work (Parents in the Work Place, 1983). If both parents share the responsibility for caring for the sick

child, then less time is taken off from work by one of the parents. However, priorities must be set as to which parent will lose work time (Parents in the Work Place, 1983).

Another area that could offer a possible solution to the problem of care for mildly sick children is the revision of exclusion policies at the state and local government level and at the day care centers. The policies could be altered to allow for inclusion of mildly sick children. Aronson (1986) suggested that exclusion is only appropriate when it is for the benefit of the sick child. The exclusion policies need to be clear and precise as to what symptoms and illnesses exclude sick children from attending their regular day care. The day care providers can help the working mother by identifying sources available in the community for the care of sick children (Aronson, 1986; Work/Family Directions, 1986).

There are advantages and disadvantages concerned with revision of the exclusion policies for sick children. Their revision and clarification may result in improved communication between working mothers and care providers and decreased guilt relating to responsibility of caring for sick children. Moreover, awareness of the policies will provide time for working mothers to plan for alternative care for their sick children. Revision of the policies may be hampered by state-mandated exclusion policies, difficulty

in obtaining liability insurance for sick child care, and care providers may resent caring for sick children (Aronson, 1986; Mohlabane, undated).

Landis and Earp (1987) conducted a survey of working mothers with children currently in day care centers. The purpose of the survey was to find the preference of the working mothers for care of their sick children. A sick child is defined as any child with a new runny nose, ear pain, sore throat, new cough, or diarrhea. A total of 134 working mothers with children under the age of 5 years responded to the questionnaire. The children were divided into two groups by age, those under 2 years of age and those 2 to 5 years of age. Some of the results were grouped according to the children's age.

The options given the mothers for sick child care were in-home care (parents, relatives, or trained workers), care at the regular center (get well room, incorporated into regular classroom), and separate programs for sick children (family care satellite, infirmary at work, infirmary serving the community). Eighty-four percent of the working mothers selected in-home care by parents. The second choice was in-home care by relative, babysitter or friend (71%). Fifty-three percent of the mothers endorsed a "sickroom" at the regular day care. The sick room at the mother's work site was acceptable to 38% of the working mothers. The least desirable care mode was an infirmary serving the

community (11%). A conclusion that may be drawn from this study is that working mothers prefer to care for their mildly sick children at home.

There are a few programs for the care of mildly sick children operating in the United States. Some studies have reviewed the different programs available in the United States. These studies are Council for Children (1985), Landis and Earp (1987), Parents in the Work Place (1983), and Work/Family Directions (1986). The type of programs reviewed consisted of in-home care, family care centers, infirmary setting, pediatric unit in hospitals, get well rooms at the child's day care, and inclusion of mildly sick children within the regular day care class.

The first type of program to be considered is in-home care. In-home care refers to the sick child being cared for by an adult in the child's home or in the home of another sick child. The care provider can be a parent, relative, neighbor, an individual provided by an agency, or an individual from the child's regular day care. Landis and Earp's (1987) survey indicated that 84% of the working mothers endorsed in-home care by the parent, 76% by relative, babysitter, or friend, and the least desirable was by a trained care provider (21%). In contrast to Landis and Earp's (1987) findings from Chapel Hill, North Carolina, the Council for Children from Charlotte, North Carolina, found 48% of working mothers preferred a trained care worker

to do the in-home care.

An example of in-home care by trained care providers can be found in Tucson, Arizona. The Sick Child Care Program was started in 1980 to care for sick children from birth to high school. The only illnesses excluded from this program are temperatures over 103⁰ F (not under medical management) and unmanaged or uncontrolled vomiting and diarrhea in young children. The parents contact the base and give information concerning the child's age and illness. Aides are then dispatched to the home to care for the sick child. The aides review with the parents information about the child's illness and medications. At the end of the day a written report is given to the parents about the child's progress.

The aides receive training in behavior management, child development, first aid, and communication skills. The actual cost of having a trained care provider from this program at the time the information was reported was \$7.87 per hour. The program, however, is subsidized by the United Way, so the cost is charged on a sliding fee scale based on family size and income. The fees range from \$1.00 to \$4.25 per hour. In addition to the hourly charge, a \$2.00 travel expense is added to the cost (Work/Family Directions, 1986).

There are similar programs located in Minneapolis, Minnesota (Mohlabaue, undated; Parents in the Work Place, 1983) and Chapel Hill, North Carolina (Landis & Earp, 1987).

The advantages of in-home care provided by trained workers are that the child receives individualized care in a familiar environment, and the transmission of infections to others is decreased. The negative impact on the working mother's job is decreased because the mother is less anxious over her child's illness. If the mother does not have to take time off from work, she can concentrate on her job.

The disadvantages are that the worker is usually unknown to the child, and service utilization is unpredictable because parents are anxious about leaving their child with an unfamiliar worker. The cost of such care is high and outside funding to defray the cost may be hard to find. The environment in which the care provider works is unpredictable, unfamiliar, and often unpleasant. Moreover, the worker is alone and does not have emergency backup (Mohlabahe, undated; Parents in the Work Place, 1983; Work/Family Directions, 1986).

In-home care provided by the child's regular day care is similar to the care provided by individual agencies. The difference between the programs is that the in-home care provided by the agency can be utilized by anyone in the community who meets the entrance criteria. The in-home care connected with the child's regular day care can only be used by the children enrolled at the center. Some of these programs are the Recuperative Child Care Program in Palo Alto, California, and the Sick Child Care Program in Berkeley,

California (Council for Children, 1985; Mohlsbane, undated; Work/Family Directions, 1986). The main advantage to this program is that the care providers are known to both the child and the parents.

Sick care in family care centers is another possible solution to the care of mildly sick children. Wheezles and Sneezles in Berkeley, California, is an example of this type of program. This particular program is housed in a three-room apartment in the midst of the University of California's student housing. Children enrolled in the Albany Children's Center utilize the Wheezles and Sneezles when mildly sick. The parents call the center and reserve a spot for their mildly sick child. The children are screened by a registered nurse when they arrive at the family care center. Children diagnosed with measles, mumps, chicken pox, strep throat, or other highly contagious illnesses are referred to the in-home worker component of the Albany Children's Center (Work/Family Directions, 1986).

The staff is required to have 12 units in early developmental education and health care training. The new workers also have one week of on the job training. The center has training classes in hygiene, first aid, home nursing practice, childhood illnesses, and child growth and development (Work/Family Directions, 1986). The staff members serve as resource people by providing the parents with information on hygiene and preventing infections, and

referrals to health care services. When there are no sick children at the family care center the staff assists in the in-home program.

The program is funded by the State of California Development funds, the City of Berkeley Community Service Block Grant, foundation grants, and parent fees. Parents pay on a sliding scale based on income. The fee range is \$0 to \$3.50 per hour. The overall cost of the program without sliding scale would be \$6.66 per hour (Work/Family Directions, 1986).

The advantages of family care centers for care of mildly sick children are that the child knows the staff prior to getting sick and receives more individualized care. The staff is utilized in the day care center when no children are at the family center. The working mother does not have to take time off from work, so there is less conflict between parents and day care staff over responsibility of sick child care. Parents are more likely to use the family care center because it is part of the child's regular day care.

There are also some disadvantages of family care centers for mildly sick children. Even with a sliding scale the cost is high, since regular day care also has to be paid. It is difficult to find external funding to defray costs. Most state regulations exclude sick children from family day care centers (Parents in the Work Place, 1983).

The use of a freestanding or infirmary center is a

possibility in solving the mildly sick child care problem. Landis and Earp's (1987) survey indicated that 13% of the working mothers surveyed preferred this method of sick child care. The San Juan Bautista Child Development Center in San Jose, California, extended its services to care for mildly sick children enrolled in the regular day care center. It was decided in 1981 to open the sick care component to the community as a means of filling the 15-bed unit. The sick care unit also includes care for post-surgical and hospitalized patients. Observation of children newly diagnosed with conditions like diabetes and asthma is also provided (Work/Family Direction, 1986).

The parents call the center when sick care services are needed. The parents are given a time to bring the sick child to the center. Legal forms are signed, arrangement for payment are made, and plans for the child's care for the day are made. At the end of the day the parents are given a written record of their child's progress.

The staff consists of registered nurses and sick care aides. They received a 25 module training course prior to working with sick children (Work/Family Directions, 1986).

The fees are based on income and family size. The range is \$0 to \$20.00 a day with an actual cost of \$30.00 per day. Funding comes from the United Way, the Community Development Block Grant, parent fees, and consultation services (Work/Family Directions, 1986).

Another infirmary setting, Chicken Soup, is located in Minneapolis, Minnesota. Chicken Soup serves children from 6 months to 12 years of age. It cares for children with respiratory illness, gastrointestinal illness, and chicken pox. The room for chicken pox has its own entrance and ventilation (Personal communication, May 1987).

These programs seem highly feasible as a solution to sick child care because they employ a highly trained staff for comprehensive sick child care and enable working mothers to remain on the job. However, the cost is high for this type of care and supplementary funding is difficult to find. This type of center and the staff that works there may not be fully utilized because of low census. There is also the possibility of cross contagion when serving children in a regional sick child care center (Mohlabaane, undated).

The hospital-based sick child care center is similar to the freestanding infirmary. In the study conducted in Charlotte, North Carolina, the Council for Children (1983) found only 23% of the working mothers preferred using a hospital setting for care of their mildly sick children. The Bannock Regional Medical Center in Pocatello, Idaho, provides services to children from 6 weeks to 14 years of age. Using unoccupied beds on the pediatric unit not only solves the problem of mildly sick child care but also aids the hospital to diversify the pediatric department. The regular pediatric nurses are utilized in taking care of the mildly

sick child (Summers, 1988).

This type of mildly sick child care includes children with minor illnesses and injuries and those recuperating from minor surgery. If isolation is necessary, accommodations are available. The service is available 24 hours a day, seven days a week.

Parents preregister their children in this hospital program. The pediatric floor is notified one hour before the child is brought to the hospital. When the child is picked up, the parents receive a written report of the child's symptoms and activities. Since existing pediatric staff and beds are being utilized, outside funding is not necessary. The parents are charged \$1.50 per hour per child.

Advantages to using the hospital setting are that empty beds and existing staff are used. The staff is highly trained to care for sick children. The cost of care is extremely reasonable and working mothers do not lose wages due to taking time off from work to care for their mildly sick children. The hours are convenient to any working mother's schedule. Another advantage to this type of mildly sick child care is the hospital already has liability insurance to care for sick children (Council for Children, 1985).

The disadvantage to hospital care of mildly sick children is that the mildly sick child is in an unfamiliar

and highly stressful environment and is being cared for by unfamiliar people. The availability of hospital beds is unpredictable. Lastly, there is a strong possibility of cross contamination (Parents in the Work Place, 1983).

Another possible solution to care for mildly sick children is a special sick room in the child's regular day care. A get well room within the child's regular day care center was preferred by 53% of the working mothers surveyed in the study by Landis and Earp (1987). An example of this program is the Get Well Room at Fairfax-San Anselmo Children's Center in Fairfax, California. The Get Well Room is available to the children enrolled at the Fairfax-San Anselmo Children's Center. The center serves 115 children between the ages of 3 months and 9 years. The room is provided on a first-come, first-serve basis. A total of six children can be accommodated. Parents call to reserve a space. However, children who get sick during school hours are picked up and cared for in the Get Well Room.

A written record of the child's progress during the day is given to the parents when they pick up the sick child. Children with temperatures over 102°F, communicable diseases such as chicken pox, untreated pink eye, or those appearing extraordinarily distressed or uncomfortable are excluded from the Get Well Room (Work/Family Directions, 1986)

The staff works in the Get Well Room as well as the regular day care rooms. The staff members have a background

in child development as well as special training to recognize signs of childhood illnesses. Medical back up is available to the staff (Work/Family Directions, 1986).

The Fairfax-San Anselmo Children's Center is a state funded program. The parents are not charged for the services of the Get Well Room. Most of the parents using the center have low or moderate incomes and could not afford the high cost of other sick child care programs (Council for Children, 1985).

The advantages of a sick room at the regular day care are that the child knows the environment and staff; the parents have more confidence in the staff since they are known to them; and there is better communication between staff and parents because there is no guilt over sick child care. There is no extra cost because the fee for the sick room can be incorporated into regular care fees. The staff can be utilized in the regular care rooms if there are no sick children.

The disadvantages to the sick room within the regular day care are that liability insurance could be difficult to obtain; most states' day care regulations exclude sick children from day care; and cost could be expensive for parents if the center is not funded by the state (Mohlabahe, undated; Parents in the Work Place, 1983; Work/Family Directions, 1986).

Another possible solution to care of mildly sick

children is a sick room at the mother's work site.

Thirty-eight percent of the working mothers surveyed by Landis and Earp (1987) preferred an on-site sick room for care of mildly sick children. This type of program would be similar to the infirmary. The main advantage would be the availability of the working mother if her child's illness worsens (Mohlabaane, undated).

The final possible solution to the problem of care of the mildly sick children of working mothers is leaving the mildly sick child in the regular day care room. This type of care was preferred by 13% of the working mothers surveyed by Landis and Earp (1987). An example of this type of program is the Frank Porter Graham Child Development Center (FPG) in Chapel Hill, North Carolina. The Child Development Center is unique in that it is operated as a research project at the University of North Carolina School of Medicine.

Since illness is considered as part of child development, the mildly sick child is not excluded from the classroom. The only illnesses that do exclude a child from attending the center are measles, chicken pox, or serious illnesses.

When a sick child comes to the center or becomes sick during the day, a nurse practitioner examines the child and determines the care the child will receive. Routine medical and screening tests are done at the center by the nurse

practitioners.

The staff members at FPG are required to have a college degree in the area of child development and two years of experience. The aides have less preemployment education and experience. In-house training sessions, statewide workshops, and regional conferences are attended by the staff.

The center is funded from a variety of sources. The sick child care is not a separate part of the research project. The parents pay a sliding scale fee from \$14.00 per month to \$215.00 per month. There is no extra cost for sick child care (Work/Family Directions, 1986).

There are advantages to including the mildly sick child in the regular day care room. The child is familiar with the staff and environment. Parents and staff do not have guilt feelings over responsibility of sick child care. The cost would be included in the regular day care cost and the expense of having specially trained staff to care for sick children would be eliminated (Council for Children, 1985; Mohlabane, undated; Work/Family Directions, 1986).

The disadvantages of including a mildly sick child within the regular day care setting are that state regulations may exclude sick children from day care centers and the staff may be concerned with other children getting sick. Liability insurance may be a problem for the day care center with inclusion of sick children (Council for

Children, 1985; Mohlabaane, undated; Work/Family Directions, 1986).

The different types of care available for mildly sick children have similar advantages and disadvantages. The main advantages are that working mothers would not have to take time off from work and the staff in all the different types of care programs for mildly sick children are well trained. The disadvantages that are common to most of the different types of mildly sick child care are high cost for care, state regulations that exclude sick children from family and day care centers, state regulations that make no provisions for mildly sick care components, unfamiliar staff and environment for the sick child, underutilized staff, and difficulty in obtaining liability insurance. Each community needs to evaluate the type of programs available to decide which would be the most compatible for their area and needs (Council for Children, 1985).

The preceding sections have reviewed the type of diseases present within day care facilities and ways of preventing the spread of those diseases; policies of excluding mildly sick children from day cares; and current practices for ameliorating the problem of care of sick children. The next section will demonstrate how mildly sick children affect the human ecological health system.

The Human Ecological Health System

Sick child care for working mothers not only affects

the immediate family but also has repercussions at all levels of society. The family is affected because someone needs to care for the sick child. The child's regular day care center is not able to care for the mildly sick child because of federal, state, and day care regulations. Since the child's day care center cannot care for the mildly sick child, the working mother may have to take time off from work to care for the child.

If the only solution to mildly sick child care is for the working mother to take time off from work, then both the mother and employer lose man-power hours and experience monetary loss due to decreased productivity. These losses will eventually affect society by the increase in the cost of products.

In order to understand how the mildly sick child affects all levels of society, two different health systems were reviewed: the human ecological health system and the holistic medical system. The human ecological health system "implies that the health of individuals is intimately bound up with their physical and social environments and that action within a community and a broader culture are important determinants of health" (Hancock, 1985, p. 4). Holistic medicine, an expanded medical model, also incorporates different systems in proposing solutions to health-related problems (Guttmacker, 1979).

The holistic medicine system recognizes that health

involves the mind, spirit, and body. It is limited in that it fails to recognize the "influences of family, community, society, and planet" (Hancock, 1985, p. 3). The holistic medical system also neglects to take into consideration the influence that the economical and political systems have on the health of the individual (Guttmacker, 1979). Since the holistic medicine system does not take into consideration the political and economical influences on the individual, it has not been used as the framework for this study.

The human ecological system is represented by the mandala model. The mandala model can be defined as "the interaction of man and human society with the environment. It is concerned with the philosophy and quality of life in relation to the development of biological and geological resources, of urban and rural settlements, of industry and technology and of education and culture" (Hancock, 1985, p. 1).

The mandala model embodies "an holistic, interactive, hierarchic system" (Hancock, 1985, p. 1). It is useful in analyzing the needs of the individual at all levels. The mandala model was "developed by the Department of Public Health, City of Toronto, to conceptualize and explain public health at a time when the Department was undergoing reorganization and revising its roles and priorities" (Hancock, 1985, p. 2).

In the mandala model the individual, composed of body,

mind, and spirit, is the central focus around which the other components revolve. An individual within a family unit is constantly influenced by family members in developing attitudes, health beliefs, and habits. The individual in turn influences the health of the other members in the family. The family not only acts as an influencer on the individual but also acts as a buffer between the individual and social institutions.

There are four factors that affect the health of the individual and family: (1) human biology, (2) personal behavior, (3) psychosocial environment, and (4) physical environment (Hancock, 1985). In this model, life-style refers to personal behaviors that have been influenced, changed, and restricted by a life-long socialization process. Life-style may be altered by the influence of family, community, cultural values, and standards.

The medical care system also exists within this model. It is part of and accountable to the community. The medical care system is concerned primarily with human biology and personal behavior. As viewed by Hancock (1985), this system is a less important determinant of health than other elements such as the work site. "Both physical and mental health are influenced by the physical state of the work site and the psychosocial aspects of work, including the work role, social relations and the quality of work life" (Hancock, 1985, p. 3).

Health is also greatly influenced by the community. The community is made up of support systems, values, standards, and networks that influence health. In addition, there are two other components that influence health. The first is the cultural value system which finds expression in the community and human-made environment. The second component is the biosphere, the ultimate determinant of health.

The mandala model is a holistic model of health. It recognizes that the community, family, society, and planet affect health. Health involves the body, spirit, and mind. The mandala model also takes into consideration the need for social and political action to deal with problems in the social and physical environments. Actions within the community and encompassing culture are determinants of health.

"The model acts in two directions: (1) the health of the individuals is influenced by any or all factors in the model, and (2) each factor can be influenced by the person acting alone or in concert with other people" (Hancock, 1985, p. 4). All the various components of the model interact or act on each other, thereby reinforcing or cancelling out one another.

The interaction of culture and environment, which are major components of the mandala model, plays an important part in the care of a mildly sick child. A child that is mildly sick introduces disharmony into all levels of the

ecological system. When a child becomes sick, the mother usually has the main responsibility of the child's care. This becomes a critical problem if the mother is working. In this situation all components of the ecological system are involved. If the mother stays home from work to care for her sick child, she may lose pay and possibly her position. Her economic environment will change. This change in economic environment will affect the personal behavior life-style of both the mother and the family. If the mother decides to go to work, anxiety results because of social environmental changes--perceptions of a good mother because she left her sick child. Work may be affected because the physical and mental health of the worker influences the physical state of the work site as well as the psychosocial aspects of work. The medical care system becomes involved in the act of taking care of the sick child. Mothers call their family physician more often over minor illnesses (Birchfield, 1986). The community is also affected. The community is used as a support system by providing facilities for the care of sick children. If there are no facilities for the care of sick children at the community level, then eventually the social and political nature of health will be confronted.

Political issues are involved at various levels of the ecosystem. Federal, state, and local legislation has regulated who can and cannot attend regular child care

facilities (Jordan, 1986; Rogers et al., 1986). Sick children cannot attend most child care facilities. Conflicts arise between the day care staff and the mother over responsibility for the child's illness (Birchfield, 1986).

The presence of a mildly sick child in the family of a working mother affects the entire ecological system. The mother is pressured from work, economics, society, community, politics, and culture. To help solve the problem of alternative child care for mildly sick children of working mothers, all components of the ecological system must alter in some way. This can occur through legislation, available sources of sick child care, policy changes at work, or community involvement.

Prior to advocating or initiating change for the care of mildly sick children, policy makers and researchers need to understand what arrangements are currently being used by working mothers as well as how the working mother and employer view alternative arrangements for care of mildly sick children. The next chapter discusses the methods of a descriptive study designed to provide such information.

CHAPTER III

METHODS

Chapter III is divided into six sections. These sections include research questions, definition of terms, setting and sample, instrumentation, data collection, procedure, and data analysis.

Research Questions

The first purpose of this study was to determine what child care arrangements working mothers use for the care of their mildly sick children. Several specific research questions were addressed to elaborate on this purpose:

- (1) What are the actual child care arrangements reported by working mothers for the care of their mildly sick children?
- (2) How do these arrangements compare with the mothers' regular child care arrangements?
- (3) What constraints do day care center policies regarding sick children place on these arrangements?
- (4) What impact do employers' policies have on these arrangements?

The second purpose of the study was to determine the preferences of working mothers for various arrangements to care for their mildly sick children. The corresponding research question was

- (5) What arrangement would working mothers favor using for the care of their mildly sick children?

The third purpose was to determine how employers view employee absenteeism for the care of mildly sick children. The pursuit of this purpose resulted in the study of two research questions:

- (6) Do employers view employee absenteeism to care for mildly sick children a problem in the workplace?
- (7) What do employers view as their role in addressing the problem of employee absenteeism to care for sick children?

Definition of Terms

A mildly sick child is defined as a child between birth and 7 years of age having any of the following diseases or conditions: fever (99° to 101° F), conjunctivitis, rashes, viral infections, and treated bacterial infections.

Flexible working hours are defined as working hours that can adapt to the needs of the working mother. For example, a working mother may be able to come in 4 hours late and work 4 hours over her normal quitting time.

Setting and Sample

The original plan for this study was to distribute questionnaires to mothers working in hospitals, school systems, and industry. The school systems readily gave permission to distribute the questionnaires. The industries contacted were totally uncooperative to having questionnaires distributed to their female employees. The hospitals contacted had varied responses. Two hospitals

readily agreed to the distribution of the questionnaires, although one of these limited distribution to female employees of the nursing department. The nursing departments of these hospitals requested copies of the results to evaluate their employees' needs. Two other hospitals had policies that prohibited distribution of questionnaires because it was considered as coming under the heading of "solicitation."

Facilities in four counties in the southeastern part of the United States were used in this study. The facilities consisted of hospitals in each of two counties and school systems in each of two counties. Hospitals and school systems were chosen because both are mainly staffed by women, many of whom are mothers. County A had a population in 1980 of 59,819 (Personal communication, Chamber of Commerce, December 1987). The county is a rural area, made up mainly of farming communities. There is some industry. The facility used in this county was a school system consisting of 11 schools with kindergarten to 12th grade, and employing 562 women (Personal communication, Superintendent's Office, December 1987).

County B is also a rural county with a population of 64,388 in 1980 (Personal communication, Chamber of Commerce, December 1987). There is some industry but farming is the main source of income. The facility used in this county was a school system consisting of 11 schools with kindergarten

12th grade, and employing 563 women (Personal communication, Superintendent's Office, December 1987).

County C is a rural area, made up mainly of farming communities. There is also some industry. This county's population was 120,220 in 1980 (Personal communication, Chamber of Commerce, February 1988). The facility used in this county was a 150-bed hospital that employs about 200 women in the nursing department (Personal communication, Director of Nursing, February 1988).

County D is also a rural county with little industry. The county population in 1980 was 70,338 (Personal communication, Chamber of Commerce, February 1988). The facility used in this county was a 250-bed hospital that employs about 881 women (Personal communication, Director of Nursing, February 1988).

The sample consisted of working mothers who met the criteria for inclusion in this study:

1. Mothers working 20 to 40 hours a week outside the home in either a school system or a hospital.
2. Children living at home and under the age of 7.
Children under the age of 7 are unable to care for themselves when they are sick and need supervision.
3. Mothers' consent to participate in the study by their completion of a questionnaire.

Instrumentation

Questionnaire Content. A 22-item, self-administered

questionnaire with four additional demographic items was used in obtaining data from the working mothers for this study (Appendix A). The instrument was developed by the researcher with content being drawn from the literature reviewed earlier. The questionnaire was in three parts. The first part contained completion, multiple choice, and two-choice questions about child care. The questions dealt with the following topics: type of child care being used; who actually cares for the mildly sick child during working hours; type of ill child care that is preferable to the working mother; type of mildly sick child care presently used; and the number of days per year that mildly sick child care has been needed in the past.

The second part consisted of two-choice items about job policies. Questions were concerned with feelings about how the organization views absenteeism and organizational policies for sick leave.

The last part consisted of completion and multiple choice items. This part had demographic information concerning mothers' age range, marital status, present occupation, and number of children living at home under 7 years of age. The questionnaire took approximately 10 to 15 minutes to complete.

Questionnaire Refinement. The questionnaire was submitted for assessment to a committee of four experts to review items for clarity, response format, and

appropriateness of subject matter covered. The director has a background in survey research, two of the members are maternal-child instructors at a university, and the fourth member, also an instructor at the university, specializes in child development. A pilot test was done to test the feasibility of the survey procedures and the reliability, clarity, and ease of response to the questionnaire. The population for the pilot test consisted of 15 working mothers at each of the two sites in a neighboring community not used in the main study. The sites were a city school system and a 150-bed county hospital. At each of the sites five mothers were given the questionnaire with the investigator present, and they were debriefed on completing the questionnaire. The purpose was to identify any problems with the phrasing of the questions. Changes in the instrument and method of administration were made on the basis of the pilot study.

Structured Interview. The purpose of the interviews with a representative of each organization was threefold: (1) to receive permission to use the facility for the study; (2) to collect data for the study; and (3) to discuss the time and location to distribute and collect the questionnaires of the working mothers. The interviews consisted of 18 questions for the school representative and 15 questions for the hospital representative (Appendix B and Appendix C, respectively). The questions related to the

type of sick leave policy; number of man-hours lost yearly due to working mothers' taking time off to care for mildly sick children; how from a policy point of view the organization is attempting to solve the problem of absenteeism for sick child care; and future plans, if any, to answer the problem of care for mildly sick children. These items had short, open-ended answers.

Data Collection Procedure

Permission from the University Policy and Review Committee on Human Research (UPRCHR) was obtained to conduct this study.

At each agency selected for the study, an interview was scheduled with either the Superintendent of the Schools or a representative of Personnel. At the time of the interview, the investigator gave a copy of the cover letter and questionnaire to the representative, and permission to use the facility for this study was sought. After permission to do the research had been obtained from within the organization, interviews were scheduled with middle management personnel (i.e., head nurses and school principals). Permission to use the interview responses of these representatives of the organizations was also obtained at this time. The investigator obtained the data for the employers' study, and discussed distribution and collection of the questionnaires from the employees. This procedure was followed at all agencies considered for participation in

the study.

Procedures for the distribution of the employee questionnaires were individually negotiated with each agency. A cover letter (Appendix D) explaining the purpose of the survey and where to return the questionnaire (a sealed box in a designated spot) was attached to the questionnaire. The cover letter informed the individual that participation in the study was voluntary and completely confidential. No names or numbers were required for identification. The individual did not have to participate but if she chose to do so any question that she did not feel comfortable answering could be omitted. Since no names had been given to the investigator, each participant had total anonymity. If results were required by the facility, they were given as group results. Consent was assumed if the questionnaire was answered and returned to the investigator. The investigator's home phone number was on the cover letter for any participant who wanted more information about the use of the data. Only responses that were received within four weeks after distribution of the questionnaires were reported in the data analysis.

Data Analysis

The data were analyzed by the investigator by coding the responses and entering them into an SPSSX computer program (SPSS Inc., 1986). An IBM 3161 mainframe computer was used. The following were used to describe the data from the

survey: means, percentages, and frequencies.

The mothers' survey questions were related to research questions (RQ) as follows:

RQ1: Survey questions 2-4. Descriptive statistics were used in analyzing the results.

RQ2: Survey question 1; question 1 vs. 3. The response to survey questions 1 and 3 were compared. Response categories on the individual questions were combined to facilitate comparison across questions using descriptive statistics and multiresponses.

RQ3: Survey questions 5-10. Descriptive statistics were used to analyze the data.

RQ4: Survey questions 17-21. Descriptive statistics were again used to analyze the data from these questions.

RQ5: Survey questions 11-16. Descriptive statistics were used to analyze the data from these questions.

In addition, the sample was characterized on the basis of Survey questions 22-25 (demographic variables) and Responses to RQ1 (mothers' current arrangement for sick child care) and RQ5 (mothers' preferred arrangements for sick child care) were analyzed by the demographic variables. The demographic variables were analyzed using descriptive statistics, multiresponse, and chi-square where appropriate. The employers' interview was used as the basis

for answering RQ6 and RQ7. Illustrative quotations and percentages and frequencies were used to analyze data from RQ6 and RQ7.

CHAPTER IV

FINDINGS

The findings of the study consider both the questionnaires of the working mothers and the personal interviews conducted with their employers. The first section reports data pertaining to the working mothers' questionnaires; the second section reports data pertaining to the employers' interviews. The section dealing with working mothers includes a summarization of the results of the questionnaire distribution, a description of the sample, and the findings relative to several of the research questions.

The research questions, previously stated on page 47, focus on child care arrangements for mildly sick children, comparison of regular and mildly sick child care arrangements, day care center exclusion policies, and lastly, working mothers' preferences for care of the mildly sick child. Additional incidental information pertaining to working mothers' preferences for methods of payment for mildly sick child care is also reported.

The second section summarizes the interviews of the employers. The following research questions deal with the employers' interviews:

1. Do employers view employee absenteeism to care for sick children a problem in the workplace?
2. What do employers view their role in addressing the problem of employee absenteeism to care for

sick children.

The questionnaires were distributed to each facility by the investigator. Sufficient questionnaires were given for distribution to all female employees. The principals at the schools and the head nurses at the hospitals distributed the questionnaires in staff meetings. The questionnaires were given only to those women who met the criteria (working mothers with children under the age of seven years). The questionnaires were filled out and returned at the end of the staff meetings. The only questionnaires received by the investigator were those of women eligible to be included in the data analysis. Nonrespondents would be those women eligible to complete questionnaires who were either absent from the staff meetings or who declined to complete the questionnaires distributed to them at the staff meetings. Because the number of returned questionnaires closely approximates the number of eligible employees estimated by the employers, the nonresponse rate is assumed to be negligibly small.

The school system in County A received 562 questionnaires for the female employees and returned questionnaires for 82 eligible respondents. In County B, the school system received 563 questionnaires and returned questionnaires for 63 eligible respondents. The hospital in County C was given 209 questionnaires for the female employees in the nursing department. There were 304 women

employees in the hospital who were excluded by their employer because they were not assigned to the nursing department. A total of 18 questionnaires were eligible for inclusion in the study. In County D, the hospital received 881 questionnaires and 77 were eligible for the study. The total sample studied consisted of 240 working mothers with children under the age of seven years of age. See Table 1.

Insert Table 1 about here

Sample Characteristics

The sample of working women with children under age seven who participated in this study can be described as follows: most of the women were currently married (87.1%); only (8.7%) were either divorced or widowed; and only 3.3% had never been married. Marital status was not reported by 2 respondents (.8%). The number of children under age seven most frequently reported was one child (160 respondents, 67.5%); however, two such children were reported by 70 respondents (29.5%) and three young children were reported by 7 respondents (3.0%). The working mothers of these young children varied in age from under 20 years of age to 50 years of age, with the most common age being 31 to 40 years (141 respondents, 59.2%) followed by 21 to 30 years (81 respondents, 34.0%). As a consequence of the sampling of school systems and hospitals and the further restriction in county C to a sample of working mothers employed by the nursing department of the hospital, the respondents were

Table 1

Summary of Eligible Female Employees in Sample by
Facility Studied

Facility	Number of Schools	Number of Female Employees	Eligible Female Employees Completing Questionnaires
School System A	11	562	82
School System B	11	563	63
Hospital C (a)	--	209	18
Hospital D	--	881	77
Total	22	2215	240

(a) Only persons assigned to the nursing department of Hospital C were included at the hospital's request

most typically either teachers' aides (32 respondents, 13.3%), teachers (95 respondents, 39.6%), nurses (41 respondents, 17.1%), or secretaries (21 respondents, 8.7%).

Child Care Arrangements for Care of Mildly Sick Children

The next section of the findings reports the working mothers' characterization of the actual child care arrangements they make for the care of their mildly sick children. Mothers were asked to identify all of the caregivers they used to care for their mildly sick children during working hours. Their replies are tabulated in Table 2. Because multiple caregivers could be named, the percentages of respondents naming each caregiver role are reported. The percentages sum to a value in excess of 100%.

Insert Table 2 about here

Examination of Table 2 suggests that multiple caregivers, especially family members, were used to care for the mildly sick child during the mother's working hours.

In addition, the mothers were asked to identify the one person most likely to care for their mildly sick child during the mothers' working hours. These results appear in Table 3. The mother herself was the single most likely

Insert Table 3 about here

caregiver as reported in Table 3. While fathers and grandparents were named with equal frequency as caregivers when multiple caregivers were cited, grandparents were more likely than fathers to be named as the single most likely

Table 2

Frequency and Percentage Distributions for Persons
Who Care for the Mildly Sick Child During Mother's
Working Hours (multiple responses allowed; responses
cited in descending order)

Person	Frequency	Percentage
Myself (mother)	145	60.7%
Father	113	47.3
Grandparent	113	47.3
Paid caregiver/her home	43	18.0
Paid caregiver/child's home	24	10.0
Day care center	20	8.4
Elder sibling	10	4.2
Other unnamed person	8	3.3
Child by self	3	1.3
Total	479 responses; 239 respondents	

Table 3

Frequency and Percentage Distributions of One
Caregiver Most Likely to Care for the Mildly Sick
Child (descending order)

Person	Frequency	Percentage
Myself (mother)	83	34.6%
Grandparent	64	26.7
Father	26	10.8
Paid caregiver/her home	25	10.4
Paid caregiver/child's home	13	5.5
Day care center	11	4.6
Child by self	5	2.1
Total	240	100.0

caregivers (26.7% of the mothers named grandparents while only 10.8% of the mothers named fathers). Regardless of their marital status, many of the working mothers relied on grandparents as either sole or shared caregivers for the sick child during the mother's working hours.

Paid caregivers, either inside or outside of the child's home, were infrequently cited as either shared careproviders or as sole careproviders. The child's regular day care center was very unlikely to be mentioned as the most common careprovider for the mildly sick child (n = 11, 4.6%). Only 2.1% (n = 3) of the working mothers indicated that sick children under age seven were most likely to care for themselves.

Additional information regarding the arrangements made by mothers for the care of their mildly sick children was available in the questionnaire responses. Of the 240 working mothers who answered the questionnaire, 97 (40.4%) had been called at work one to three times in the past year to pick up their sick child from the regular child care arrangement. A substantial percentage of the mothers (n = 103, 42.0%) did not have prearranged care for their mildly sick children. Since many of the mothers (29.%) were not able to use sick leave benefits to care for sick family members, they lost a day's pay or a day of vacation. Most of the women in this group were employed by the hospitals.

Comparison of Regular and Mildly Sick Child Care Arrangements

To provide a baseline for consideration of the child care arrangements working mothers made for their mildly sick children, the mothers were also asked to describe the type of child day care that they regularly used. These results are reported in Table 4.

Insert Table 4 about here

The most commonly used child care arrangement on a regular basis was a day care center (n = 71, 29.6%). Home care at the caregiver's home was the next most commonly used child care arrangement (n = 56, 23.3%). These findings contrast sharply with those reported in Tables 2 and 3 in which day care centers and care provided at the caregiver's home were infrequently cited choices for the care of mildly sick children. Children who are regularly cared for in day care centers or in the careprovider's home are usually cared for by their mothers, fathers, or grandparents when they are mildly ill. For example, among the 71 mothers who reported a day care center as their regular child care arrangement, 48 (67.6%) indicated that they cared for their children who were mildly sick during their working hours. Care was provided by the fathers for 39 families (54.9%) and by the grandparents for 36 families (50.7%). Once again, multiple caregivers have been cited so that the percentages sum to more than 100%. When a similar identification was made of the sick care providers for the 56 families who regularly

Table 4

Frequency and Percentage Distribution of the Most
Common Child Care Arrangements Used on a Regular Basis
(descending order of use)

Type	Frequency	Percentage
Day care center	71	29.6%
Paid caregiver/her home	56	23.3
Relative's home	25	10.4
No child care arrangements	23	9.5
Relative in child's home	22	9.2
Combination of caregivers	17	7.1
Paid caregiver/child's home	16	6.7
Other	10	4.2
Total	240	100.0

use paid child care in the child caregiver's home, the corresponding results were that care for sick children was provided by the mothers (n = 36, 64.3%), the fathers (n = 24, 42.9%), and the grandparents (n = 17, 30.4%). In only 19 cases (26.8%) did the day care center care for the sick child. In 33 cases (58.9%) the paid caregiver continued to care for the sick child in her own home. Thus, no matter what type of child care arrangement the mother used on a regular basis, the mother, father, and/or grandparents most frequently cared for the child or shared that care when the child was mildly ill. This phenomenon was more pronounced when the regular care was provided by day centers than when it was provided by paid caregivers in their own homes.

Day Care Center Exclusion Policies

Those mothers who reported the use of a day care center for the regular care of their child were asked for information and perceptions about the sick child care policies of their respective day care centers. Although 71 mothers had reported the use of a day care center for regular child care, varying numbers of mothers (82 to 87 mothers) provided information about various sick care policies of the day care centers. See Table 5 for the

Insert Table 5 about here

percentage distribution of exclusion criteria by day care agency and by stated reasons.

A substantial number of mothers who reported use of a

Table 3

Frequency and Percentage Distributions of Symptoms That Exclude Children from Attending Their Regular Day Care (responses cited in descending order)

Symptom	Count	Percentage of Stated Reasons	Percentage of Day Care
Temperature over 100° F	77	30.9%	95.1%
Vomiting	58	23.3	71.6
Diarrhea	32	12.9	39.5
Rash	30	12.0	37.0
Earache	14	5.6	17.3
Sore throat	14	5.6	17.3
Other	10	4.0	17.3
Cough	7	2.8	8.6
Runny nose	4	1.6	4.9
Not feeling well	3	1.2	3.7
Total	249	100.0	307.4

day care center indicated that their center had a written sick child policy (n = 65, 75.7%). Only 3.8% indicated that there was no written policy pertaining to sick child care. The policies were identified as clearly written by 80.5% of the respondents and as strictly enforced by 58.6%. Some mothers were unsure about the strict enforcement of sick child exclusion policies by the day care centers (n = 22, 25.3%). Attendance by mildly sick children is not allowed by 17 (20.2%) of the day care centers for which the mothers reported. The most commonly cited cause for exclusion from the day care was a temperature over 100 F. Almost all of the day cares (95.1%) excluded the child for this reason. Moreover, when the multiple reasons for exclusion were tallied, a temperature over 100 F remained the dominant exclusion criterion; 30.9% of all stated reasons for exclusion included a high temperature. The least common cause of exclusion was "not feeling well," which was reported for 3.7% of the day cares and 1.2% of all of the stated reasons for exclusions.

Use of Sick Leave

Most of the mothers needed one to six days off from work in the past year to care for their sick children. Most of the mothers (59.6%) were allowed one day off per month for sick leave. This sick leave was cumulative at all four organizations. Out of the total working mothers surveyed (N = 240), 60% (n = 144) were allowed to use their sick leave to

care for sick family members. The two hospital settings did not allow sick leave to be used for sick family care (29.2%). More questionnaires were returned from the two school settings than from the two hospitals. This restriction should be kept in mind when noting that 47% (n = 113) of the working mothers indicated that their sick leave policy was either partially satisfactory or not at all satisfactory. Only 47.5% (n = 114) described their sick leave policy as completely satisfactory. When asked how they would prefer to take time off to care for their sick child, 200 (83.3%) selected sick leave in preference to the other response options. The least preferred way of taking time for sick children was taking work home to make up the time. See Table 6.

Insert Table 6 about here

Preferences for Care of the Mildly Sick Child

Mothers were asked to select any of nine listed methods of care for their mildly sick child that would be acceptable to them. They were also asked to indicate their first, second, and third choices among the nine listed methods of care. A total of 598 choices of acceptable methods of care were made by the 233 mothers who responded to the initial question. These appear in Table 7. In-home care of the sick

Insert Table 7 about here

child by a family member, relative, or friend was endorsed by almost all of the mothers (98.3%). The least frequently

Table 6

Frequency and Percentage Distribution of Time Off Policy
Preferences of Working Mothers to Care for Sick
Children (multiple responses allowed)

Ways	Frequency	Percentage
Sick leave	200	83.3%
Make up missed hours	83	34.6
Vacation time	82	34.2
Flexible time	69	28.7
Take work home	63	26.2

Table 7

Frequency and Percentage Distribution of Acceptable
Methods of Care for the Mildly Sick Child (multiple
responses allowed)

Method of Care	Percentage of Mothers Selecting That Method
Own home by family, relative, friend	98.3%
Own home by trained caregiver	19.6
Home of family known to care of sick children	15.5
Home of day care staff member	10.7
Regular room of day care center	9.4
Supervised sick room at day care	27.0
Supervised sick room at mother's workplace	34.3
Empty hospital bed at local hospital	6.9
Community infirmary for sick children	4.3

Total responses 598; total number of responding mothers 233

chosen methods of care were community infirmary (4.3%) and empty hospital beds (6.9%). First choice preferences were provided by 226 mothers, second choice preferences by 167 mothers, and third choice preferences by 107 mothers.

The majority of working mothers chose in-home care as their first choice for care of their sick child. They preferred the caregiver to be a family member, relative, or friend for the first choice (n = 200, 88.5%). The second choice of caregiver was a trained individual providing care in the child's home (n = 88, 52.7%). The third choice was a supervised sick room at the mother's work site (n = 31, 29.0%). See Table 8 and Figure 1. There were no significant

Insert Table 8 about here

differences between the mothers' choices of sick child care according to the mothers' age, marital status, number of children, organization, or county of residence when chi-square tests at the .05 level were used to search for differences.

Insert Figure 1 about here

Payment for Mildly Sick Child Care

This section of the findings reports on the methods working mothers would consider to pay for mildly sick child care. Mothers were asked to identify all of the methods they would consider using to pay for mildly sick child care. Their replies are tabulated in Table 9. Because multiple methods of payment could be selected, the percentages of

Table 8

Percentage Distribution for First, Second, and Third
Choices of Methods of Care for the Mildly Sick Child
 (respondents = 226, 167, 107, respectively)

Method of Care	First Choice	Second Choice	Third Choice
Own home by family, relative, friend	88.5%	9.6%	2.8%
Own home by trained caregiver	4.9	52.7	12.1
Home of family known to care for sick children	0.0	3.6	19.6
Home of day care staff member	0.4	3.0	7.5
Regular room of day care center	0.9	3.6	5.6
Supervised sick room at day care center	2.2	7.8	22.4
Supervised sick room at mother's workplace	2.7	17.4	29.0
Empty hospital bed at local hospital	.4	1.2	.9
Community infirmary for sick children	.0	1.2	0.0

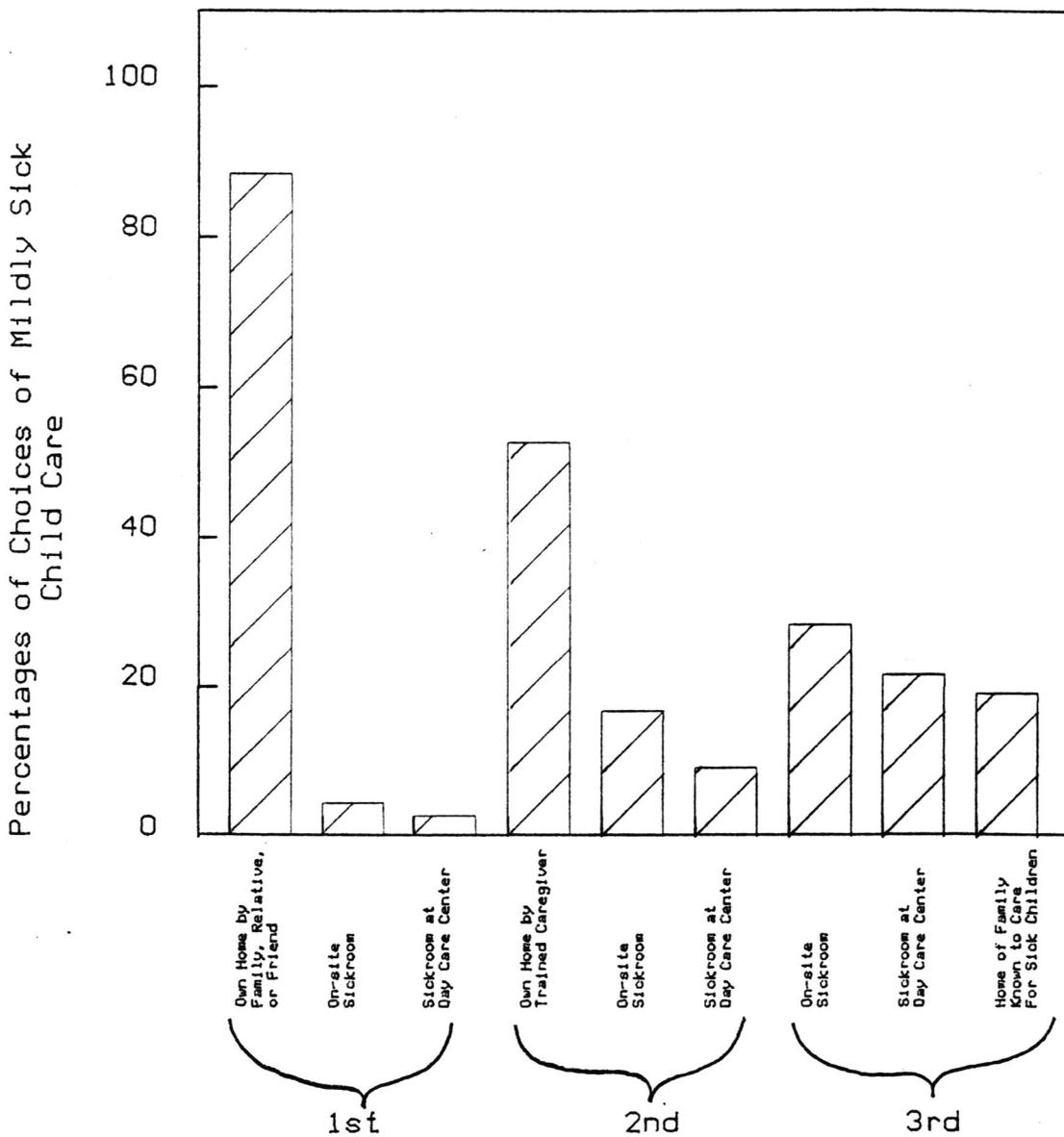


Figure 1. Percentages of 1st, 2nd, and 3rd choices of care of mildly sick children by working mothers. Top three selections in each choice category.

respondents naming each method of payment are reported. The

Insert Table 9 about here

percentages sum to a value more than 100%. The most commonly selected method of payment was the family pays full fee by hourly use of mildly sick child care (n = 109, 45.4%). The least selected method of payment was the family and federal government funds pay for the cost of mildly sick child care (n = 35, 14.6%). In addition, the mothers were asked to identify the methods of payment for mildly sick child care they would prefer. The results appear in Table 10. The method of paying for mildly sick child care that

Insert Table 10 about here

was least selected was family and federal government pay fees. Only 1.7% (n = 4) selected this method as their primary method of payment for mildly sick child care. Most working mothers seemed to prefer paying the entire cost of mildly sick child care. The second most often selected method of payment was the family and employer paying the fee (n = 44, 18.3%). The methods least likely to be selected as a primary means of paying mildly sick child care were family paying and either local and state, community or federal government paying part (n = 12, 5.0%; n = 5, 2.1%; n = 4, 1.7%, respectively).

Employers' Interview

The interviews with the principals and head nurses are summarized in this section. The research questions that these

Table 9

Frequency and Percentage Distribution for Methods of
Paying for Mildly Sick Child Care (multiple responses
allowed; responses cited in descending order)

Method of Pay	Frequency	Percentage of Respondents
Family pays fee/hour	109	45.4%
Family/employer pay fee	80	33.3
Family/local & state pay fee	44	18.3
Family higher fee for well/sick combo	42	17.5
Family/federal government pay fee	40	16.7
"Insurance" plan	39	16.2
Family/community pay fee	35	14.6
Total	389 responses; 240 respondents	

Table 10

Frequency and Percentage Distributions for 1st Choice
of Paying for Mildly Sick Child Care (descending order)

Methods of Pay	Frequency	Percentage
Family pays fee/hour	54	22.5%
Family/employer pay fee	44	18.3
Family higher fee for well/sick combo	19	7.9
Insurance plan	18	7.5
Family/local & state pay fee	12	5.0
Family/community pay fee	5	2.1
Family/federal government pay	4	1.7
Total	240	100.0

findings address are as follows:

1. Do employers view absenteeism to care for sick children a problem in the workplace?
2. What do employers view as their role in addressing the problem of employee absenteeism to care for sick children?

Each of the 22 principals was interviewed either at the time the questionnaires were distributed or picked up. Four head nurses from the hospital in County C and five head nurses from the hospital in County D were interviewed, giving a total of nine head nurses in the sample. Not all the head nurses at the two hospitals were available to be interviewed for various reasons (day off, in other meetings). Since the responses to the questions were similar, it was assumed that the nine head nurses were representative of all the head nurses in both hospitals.

Of the 22 principals and 9 head nurses interviewed, none indicated that absenteeism for sick child care was a problem. Absenteeism in general was a problem reported by the employers but none knew exactly how many days were used by the typical female employee with young children for sick child care. The principals indicated absenteeism for sick children was not a problem because the sick leave policy included care of sick family members, and substitutes were provided for the absent teacher. The only time absenteeism became a problem was when there was not a substitute and the

principal needed to take over the classroom. There was not a financial concern for sick leave pay because the funds came from state education funds and not a local budget. All of the principals indicated their perception that the sick leave policy was adequate. Each employee received one day per month of sick leave and the leave could accumulate.

The hospitals had a much stricter sick leave policy. In both hospitals sick leave was only for personal use. It did accumulate but it was not to be used for care of sick family members. Vacation time could be taken to care for sick family or the employee could be docked in pay for the time off. The head nurses did not know how many days were needed for sick child care because the employees did not have to indicate why they needed the time off. If the employees were out of work for more than three days, they needed a return to work slip signed by a physician to return to work. The head nurses agreed with the principals that absenteeism in general was a problem but could not indicate the extent to which it could be attributed to the need to care for sick children. The head nurses suggested that absenteeism for sick child care was not a financial burden for the hospital because the employees would either be using their vacation time or having their pay docked.

The employers in general did not see a need to change any of the existing policies. Only one hospital had considered a day care facility for the children of employees

with possibly a sick room component. The other three facilities did not have plans to open a day care center for their employees. None of the employers had resources available to help new employees find day care or sick child care.

CHAPTER V

SUMMARY, DISCUSSION, AND IMPLICATIONS

This chapter is divided into five parts. The first section summarizes the major findings of the study. The second section includes speculations about the causes of the findings. Limitations and assumptions are discussed in the following section. Implications are discussed as they are applied to theory, research, and clinical practice. The final section states the conclusions of the entire study.

Summary

The responses from the questionnaires indicate that working mothers relied on multiple providers of care for their mildly sick children. Typically, the working mothers cared for their mildly sick children. The fathers and grandparents shared in the care of the mildly sick children. It is important to note that grandparents were more likely to care for the mildly sick child than the fathers, regardless of the marital status of the working mothers. Paid caregivers, whether inside or outside the home, were seldom used for mildly sick child care. This was in contrast to patterns of care for the well child. Paid caregivers, whether agencies or individuals, were used substantially more by working mothers for well child care than when their children were ill. Mothers who used day care agencies reported that their agencies had clearly stated exclusion policies for mildly sick children and that

these policies generally were strictly enforced. The major causes of exclusion were a temperature over 100 F and vomiting more than once.

Mothers' first choice for care of their mildly sick children was in their own home with care provided by a family member, relative, or friend. Their second and third choices were care in their own home by a trained careprovider, and care in a supervised sick room at the regular day care center or at the mothers' workplace, respectively. The mothers' first choice of care for their mildly sick children parallels the current practice of providing care for their children when they are sick.

Employers were interviewed to learn how absenteeism for care of mildly sick children impacted on the organization. Absenteeism in general was identified as a problem, but the specific impact of absenteeism for mildly sick child care was not separated from the whole. Sick leave policies varied between the school system and the hospitals. The school systems had a lenient sick leave policy, which allowed the mother to use sick leave for care of sick family members as well as for personal illness. The school systems also utilized substitutes paid by state funds, which minimized the effect of absenteeism. The hospitals, on the other hand, did not allow sick leave to be used for sick family members nor did they use substitutes for the absent personnel. None of the employers indicated that absenteeism was a financial

burden for the organization. The hospitals were not affected financially because the mothers either used vacation leave or were docked a day's pay for absenteeism. Since the employers did not identify absenteeism of mothers for the purpose of caring for their mildly sick children as a problem, there were no strategies for addressing such absenteeism; nor were the employers particularly responsive to possible strategies (e.g., employer financed day care centers, resource lists of child care facilities) mentioned by the researcher. It was noted that one of the hospitals had contemplated a day care program for employees, but there were no plans for such a program in the near future.

Discussion

There may be contributing factors that explain the discrepancy between the mothers' pattern of care for their well and their mildly sick children. The communities in which the organizations were located were relatively small cities, in largely rural, traditionally conservative areas of the Southeast. They had relatively few good quality day care centers and none that specialized in the care of mildly sick children available to them. The working mothers' reliance on family and friends to care for their mildly sick children may be reflective of the limited resources available in their communities and of the availability of extended families. Because there is a lack of resources available within the counties surveyed (e.g., child care,

transportation), the extended family is an important resource. It is common for grandparents to take the responsibility of raising the grandchildren. Therefore, it is not unusual for working mothers to rely on grandparents and other family members to care for their mildly sick children. Numerous possible sick child care arrangements such as sick rooms in the regular day care setting, supervised sick rooms at the workplaces, and even the use of empty pediatric beds at local hospitals had not been implemented in these communities.

The lenient sick leave policies of the school system may have fostered the working mothers' continued involvement with care of their mildly sick children during working hours. However, mothers who work within the hospital settings where stricter sick leave policies exist (e.g., sick leave only for personal illness not family) still chose to remain at home to care for their mildly sick children. This may be another indication of the more traditional views of the mother's role in this geographic area.

Finally, many of the mothers had not made prior arrangements for care of their children should they become ill during working hours. This lack of prearranged care suggests that mothers may be forced into relying on personal resources and family members to serve as caregivers for the suddenly ill child due to the limited options available.

Even when given the opportunity to choose from a

variety of mildly sick child care options, the mothers chose in-home care with care provided by family or friends. This too may be reflective of their limited exposure to other models of child care, of their realization of the actual sick child care options currently available in their communities, and of the generally traditional orientation of their communities.

The mothers' reliance on their own resources and those of the fathers and grandparents to care for their mildly sick children is likely to result in disruption of work schedules for either or both parents and perhaps even for grandparents who may be employed. According to the mandala model described earlier, it would be reasonable to expect the disrupted work schedules to impact on the employers and to sensitize them to the implication of employee absenteeism for the care of sick children. Since this did not seem to occur, it may be reflective of the limited impact absenteeism of the mothers for care of the mildly sick children had on the financial and staffing concerns of the employers. In the school system, the financial burden is less noticeable because funding for substitute teachers and sick leave pay come from state and not local funds. Substitute teachers eliminate stress placed on the school system by replacing absent staff. Hospitals are protected financially from absenteeism by shifting the financial burden onto the absent mother through loss of wages. Staff

losses are not likely to be separated from the more general problems of staff turnover and understaffing in the hospitals.

The mothers working in hospitals were more likely to be dissatisfied with their sick leave policies than were those working in schools. Since absenteeism for sick child care had limited impact on finance or staffing of the organizations studied, it is not surprising that the employers had little incentive to provide working mothers with information or day care options for the care of their mildly sick children.

The mothers' reliance on their own resources and those of other family members may be a result of the exclusion policies of the regular day care arrangement, as well as a lack of alternative child care arrangements available within the communities surveyed. It is reasonable to assume that working mothers will rely on themselves and family or friends to care for mildly sick children when mandated state regulations of day care centers exclude mildly sick children from attending the regular day care and there are no alternative methods of care for sick children in the community.

Application of the mandala model created the expectation that exclusionary state regulations and lack of alternative sick child care methods will have a direct effect on the mothers' choice of mildly sick child care. The mothers'

actual care choices and their preferences for sick child care appear to be consistent with these expectations. Almost half of the mothers surveyed did not have prior arrangements for sick child care. Thus, last minute arrangements were necessary to care for the sick child. About a third of the mothers used day care centers for regular child care arrangements which had clearly written and strongly enforced exclusion policies for sick children. Since neither the community nor organizations had programs for mildly sick child care, there were no alternative methods of care for sick children other than reliance on the mothers, other family members, and friends. This may have had stronger implications for mothers working in hospitals than for mothers working in the school systems. Mothers within these hospitals either lost wages or used vacation leave to care for their mildly sick children.

Limitations

The following were limitations of this study:

1. The counties were not randomly selected. The counties in which the schools and hospitals were located had limited child care resources. These restricted resources gave the working mother limited exposure to more creative approaches to sick child care and little opportunity to evaluate programs other than those offering traditional child care. Consequently, the mothers may not have been able to make informed expressions of preference based on

knowledge or experience. Their patterns of actual child care use and their preferences may have reflected the influence of their geographic area and may not generalize beyond that area.

2. There were almost twice as many respondents from the school systems as the hospitals. The sick leave policy of the school systems was more lenient than that of the hospitals. Consequently, the employees' perceptions pertaining to policy may be skewed by the overrepresentation of school system employees among the respondents.

3. There were only two types of employing institutions used. Limiting the types of employing institutions makes it impossible to generalize the findings of this study to all working mothers. Mothers employed in other types of organizations may respond differently.

4. The majority of the participants were middle class as judged from their occupations. This limits the generalization of the findings. Responses from other social classes may be different, especially to questions concerning different methods of paying for mildly sick child care.

5. The sample was limited to working mothers with children under the age of seven. Mothers with older children may respond differently to the type of sick child care used or preferred.

6. Due to the difficulty the researcher had in obtaining

permission to use hospitals, there may be some associated bias in interpreting the hospitals' results. Those hospitals which readily agreed to participate may differ from those which refused to participate.

Assumptions

For the purpose of this study the following assumptions were made:

1. The working mothers responded honestly to the questions about child care and sick leave benefits.
2. The working mothers willingly participated in answering the questionnaires.
3. The representatives of the organizations honestly responded to the interview questions about sick leave benefits.
4. Only mothers who met the criteria filled out and returned the questionnaires, and a majority of those eligible to complete the questionnaire actually did so.

Implications

Theory. According to the mandala model, discussed earlier, if the working mother takes time off to care for her mildly sick child, then the employer will experience monetary loss due to decreased productivity. This response did not seem to occur within this study. The representatives of the employers at the schools and hospitals did not seem to view absenteeism of female employees to care for mildly sick children as a financial burden. This may be due to the

fact that the financial burden is placed on mothers within the hospital and the state financial budget in the school system.

The mandala model states that political action may affect the ecosystem. State day care exclusion policies prevent the mildly sick children from attending their regular day care centers. This policy affects working mothers who need to make alternative child care arrangements for their sick children. This disruption has a direct effect on the economic standing of the family. Mothers within the hospital settings lost pay for the days they were absent. The mandala model was an effective means of evaluating the reaction of the state exclusion policy for child day care centers.

Research and Clinical Practice. Researchers need to identify what working mothers of children older than seven use for the care of mildly sick children, as well as for child care of chronically ill children and of children recently discharged from hospitals. The number of "latch-key kids," defined as children in self-care, is rising as more mothers return to work, and few facilities are available to care for older children. If child care arrangements are not being used for regular care of the healthy older child, provision of care for the older child during illness may be of critical concern for the working mother. Older children may object to being "baby sat" even if sick. Actual usage

patterns and preferences for child care for this group need to be explored.

With early discharge from hospitals becoming more prevalent, working mothers will need qualified caregivers to provide care for children who are no longer seriously ill. Options need to be explored as to what would be a more feasible arrangement of care: in-home care by qualified careprovider or day care center equipped with qualified staff and facilities for children that have recently recovered but are still convalescing from a serious illness.

Chronically ill children are another group that may need special facilities or careproviders. Working mothers with chronically ill children may need more time off from work to care for such children during an acute crisis. At times the exacerbation of the disease may not be critical, requiring the mother's presence. At these times other qualified careproviders could be utilized, thereby allowing the working mother to remain at work. This method would allow the mother to work during less critical times, saving leave time for more stressful situations. Research is needed in this area to identify what is available to the working mother for this special population of children and what they would prefer to use for child care. There has been very little research done in this particular area.

The communities used for this study were rural with limited resources available to the working mother for sick

child care. Also, only two types of organizations were surveyed. Surveying more industrial, metropolitan areas will broaden the base of inferences about working mothers' child care options and preferences. Other organizations may find absenteeism for care of mildly sick children more of a financial and staffing burden than the two organizations surveyed in this study did. In which case, these organizations may have developed strategies to ameliorate the problem of absenteeism of working mothers to care for mildly sick children. Research needs to be conducted to find what these strategies are and how effective they are.

The mothers' second choice of care for their mildly sick children was in-home care by a trained careprovider. In order to provide qualified caregivers for mildly sick children, training programs need to be developed. Such programs will need to incorporate not only signs and symptoms of illness but also courses in child development, communication skills, and observational skills. The caregivers need to know what to do in case of emergencies and if the child's condition changes for the worse. They need to have a basic understanding of normal child development and how illness may alter the child's normal development pattern. Research will need to be conducted that evaluates the effectiveness these training programs have on the quality of care provided by the caregiver. Research will also need to be conducted concerning the

effectiveness of trained caregivers versus nontrained caregivers in providing quality care for mildly sick children.

Another area that needs to be addressed is the availability of referral sources for in-home careproviders. There may be more available in-home careproviders than this study indicated based on the mothers' selection of well/sick child care. If more referral sources were available, working mothers may have selected this option more often for mildly sick child care. Research needs to be done to determine the feasibility of establishing local referral resources for care of well or mildly sick children.

Education of mothers and the general public is another area that needs to be addressed in regard to the availability of various types of sick child care programs. The findings in this study indicated that working mothers used and selected more traditional types of well and sick child care. Two factors may have affected these decisions: one which has previously been discussed is the lack of alternative well and sick child care arrangements within the communities. The other factor which is addressed here is a lack of knowledge of other types of mildly sick child care. There are approximately 40 to 50 programs specifically targeted for care of mildly sick children within the United States. With so few programs available, mothers may not have heard of the more creative care available for mildly sick

children. Mothers need to receive information that explains the purpose of the programs, type of careprovider, effectiveness of the careprovider, and if the care is provided in-home or out-of-home. This information may make a difference in the demand for mildly sick child care. It would also provide the mothers with information on which to base a decision regarding the use of mildly sick child care if it becomes available in the community. Research needs to be concerned with the most effective methods of distributing the information, the effect the information has on the mothers' selection of mildly sick care options, and the mothers' use of available sick child care programs based on the information.

Information about the more creative child care arrangements needs to be available to the communities. Not all programs are desirable to all communities, and communities need to base their decisions to foster particular kinds of child care on sound knowledge basis. Research could be conducted to evaluate available resources in the community; how the community views its involvement in ameliorating the problem of inadequate child care including sick child care; what type of mildly sick child care programs would best meet the needs of the community; and how such programs could be implemented and supported.

Conclusion

The purpose of this study was threefold. The first purpose was to determine what child care arrangements working mothers use for care of their mildly sick children. The findings indicated that working mothers are the main careproviders for their mildly sick children. Grandparents and fathers are the next most frequently used careproviders. The second purpose was to determine what working mothers selected to use for mildly sick child care. The majority of working mothers, when given a choice, preferred in-home care by family, relatives, or friends. In-home care by a trained caregiver was the second choice most commonly selected by working mothers for care of their mildly sick children. The final purpose of the present study was to determine how employers view absenteeism of their female employees for care of their mildly sick children. Neither the employers from the school systems nor hospitals viewed absenteeism of female employees for care of mildly sick children a problem. This finding is in direct contrast to studies discussed in the literature review section. The reason for this finding may be due to the fact that neither the hospitals nor the school systems experienced financial or staffing difficulty from this type of absenteeism. In conclusion, the need for care of the mildly sick child creates a problem for almost half of the working mothers surveyed for this study.

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APPENDIX A

QUESTIONNAIRE FOR WORKING MOTHERS

Please complete this questionnaire if you are a woman employee and you have at least one child under 7 years of age who lives with you. Please put the completed questionnaire in the sealed box by_____. If you have received a questionnaire, but you are not a woman employee with at least one child under 7 living with you, please put the blank questionnaire in the sealed box. Thank you for your help.

DIRECTIONS: Circle one number for your answer to each question or fill in the blank provided unless the directions for the question allow multiple answers.

The first questions ask about your present use of day care and your use of day care when your child is mildly ill (as with a sore throat, runny nose, stomachache, etc.).

1. What type of regular child day care do you use?

- (1) none
- (2) at home care in own home by family member, relative, or friend
- (3) at home care in own home by paid caregiver
- (4) home care at a relative's or friend's home
- (5) home care at the home of a paid caregiver
- (6) day care center
- (7) combination of care types, specify _____
- (8) other, specify _____

2. Do you have regular standing arrangements for your child's care if he/she becomes mildly sick?

- (1) yes
- (2) no

3. If your child is mildly sick, who cares for your sick child during working hours?

Circle all that apply.

- (1) child is old enough to stay by self
- (2) myself
- (3) child's father
- (4) child's older brother/sister
- (5) child's grandparents
- (6) paid caregiver in my home
- (7) paid caregiver in her home
- (8) day care center
- (9) other, specify _____

4. Of the choices made in number 3, which one person is most likely to care for your mildly sick child during your working hours?
List the number of that person_____.
5. In the past year how many times have you been called at work to pick up your mildly sick child from his/her day care center?
- (1) 0 times
 - (2) 1 to 3 times
 - (3) 4 to 6 times
 - (4) more than 6 times

If you use a day care center for regular child care, please answer questions 6 to 10.

If you do not use a day care center, please go to question 11.

6. Does your child care facility have a written sick child policy?
- (1) yes
 - (2) no
 - (3) do not know
7. Is the policy of your regular day care about the attendance of sick children clear or not clear?
- (1) clear
 - (2) not clear
 - (3) do not know
8. Is the policy at your child care facility about the attendance of sick children strictly enforced or not strictly enforced?
- (1) strictly enforced
 - (2) not strictly enforced
 - (3) do not know
9. Does the sick child policy let the mildly sick child attend the regular day care?
- (1) yes
 - (2) no
 - (3) do not know

10. The sick care policy at my regular child care facility does NOT let children stay if they have: (circle all that apply):

- (1) runny nose
- (2) temperature of 100⁰F or more
- (3) rash
- (4) diarrhea but no temperature or vomiting
- (5) no sign of illness but are not feeling well
- (6) earache
- (7) sore throat
- (8) cough
- (9) vomiting more than once
- (10) other reasons, specify _____

Questions 11 to 16 ask about your preferences for the care of your mildly sick child.

11. Mildly sick children can be cared for in numerous ways. Listed below are some of those ways. Circle all the ways you would consider for your sick child.

I would consider care for my sick child in:

- (1) own home by family member, relative, or friend
- (2) own home by trained caregiver
- (3) home of family known (by day care center) to care for sick children
- (4) home of regular day care center staff member
- (5) regular room of day care center
- (6) supervised sick room at day care center
- (7) supervised sick room at mother's work place
- (8) empty hospital bed at local hospital
- (9) community infirmary for sick children drawn from many day cares

12. From the above choices, list the number of your:

- 1st choice _____
- 2nd choice _____
- 3rd choice _____

13. If you chose care in your own home as one of your choices in #12, which caregivers would you accept? Circle the numbers before those caregivers you would accept.

- (1) none, child able to care for self
- (2) child's mother or father
- (3) child's older brother/sister
- (4) child's grandparents
- (5) other relative
- (6) neighbor or friend
- (7) caregiver trained in health care and first aid
- (8) licensed practical nurse (LPN)
- (9) registered nurse (RN)
- (10) other, specify _____

14. If your child was in his/her own home while sick, would he/she be comfortable with a stranger taking care of him/her?

- (1) comfortable
- (2) uncomfortable
- (3) do not know

15. Sick child care could be paid for in different ways. Circle all that are acceptable to you.

- (1) family pays a higher fee for day care that includes regular and sick care
- (2) family pays a monthly "insurance" fee for sick care whether it is used or not
- (3) family pays the full fee for sick care by hour of its actual use
- (4) family pays part of the hourly fee for sick child care; other part is paid for by the parent's employer
- (5) family pays part of the hourly fee for sick child care; other part is paid for from community grants
- (6) family pays part of the hourly fee for sick child care; other part is paid for from local or state funds
- (7) family pays part of the hourly fee for sick child care; other part is paid for from federal funds

16. From the above choices list the number of your first choice of payment for sick child care. .

Question 17 to 22 ask about work policies and time off for the care of your sick child

17. About how many days in the past year did you need time off from work to care for a mildly sick child.

- (1) 0 days/year
- (2) 1-3 days/year
- (3) 4-6 days/year
- (4) 7-9 days/year
- (5) 10-12 days/year
- (6) more than 12 days/year

18. How many days per month does your organization allow for sick leave? Specify_____.

19. Does the sick leave policy at work include days off for care of sick children or is it limited personal illness of the employee?

- (1) no sick leave at all
- (2) sick leave includes care of sick children
- (3) sick leave is limited to personal illness of employee
- (4) do not know

20. How satisfactory do you perceive the sick leave policy at work?

- (1) completely satisfactory
- (2) partially satisfactory
- (3) not at all satisfactory

21. If the following were allowed at work, which would you use if you needed to take time off to care for a sick child. Circle all that apply.

- (1) use sick leave
- (2) use vacation time
- (3) come in late and work late
- (4) take work home
- (5) make up missed hours over a period of time

Finally some questions about you to help in explaining the study results:

22. Your age:

- (1) under 20 years
- (2) 21 to 30 years
- (3) 31 to 40 years
- (4) 41 to 50 years
- (5) over 50 years

23. Marital status:

- (1) single
- (2) married
- (3) divorced or separated
- (4) widowed

24. Occupation: specify _____

25. Number of children under 7 who live with you _____.

APPENDIX B

QUESTIONS FOR SCHOOL REPRESENTATIVE

1. What are the regular working hours of the employees?
If clarification is needed the following questions will be asked:
 - (a) How many female employees work per year in
 - (1) 10 months full time positions
 - (2) full time 10 months during school year, part time during summer
 - (3) 12 months full time
 - (b) Do all female employees work 8 to 5 or 7:30 to 4:30?
 - (c) Do the working hours vary according to position- secretary, teacher, teacher's aide, position in administrative office?
2. About how many full-time female employees work for the organization?
For these full-time female employees about how many days of sick leave per year are used for care of mildly sick children? Please give me your best estimate of what that total would be for all of your full-time female employees.
3. How many part-time female employees does the organization have?
Do part-time female employees have sick day leave benefits?
For these part-time female employees about how many days of sick leave are used for care of mildly sick children? Please give me your best estimate of what the total would be for all of your part-time female employees.
4. Is this loss of work time a substantial financial concern for the organization?
5. Are teachers and teachers' aides both provided with substitute lists?
6. When a teacher is unable to come into work must she find a substitute or does the administrative office call in the substitute?
7. How does providing substitutes decrease the effect of absenteeism for the school system?

8. Does providing substitutes for teachers seem to decrease the teachers' anxiety of missing work?
9. Are employees allowed a certain number of days off per year for sick leave?
10. Does the sick leave policy allow time off to care for sick family members?
11. If sick leave cannot be used for sick family members, can leave be taken from other leave areas (e.g., vacation, personal leave days)?
12. From the employer's point of view, does the number of sick leave days per year seem adequate to cover most of the employee's needs?
13. Is sick leave paid leave?
 - (a) for full-time salary personnel
 - (b) for part-time salary personnel
 - (c) full-time hourly personnel
 - (d) part-time hourly personnel
14. Are employees able to make up missed time and wages by working vacation days?
15. Are flexible working hours possible within the organization's working hours?
16. Does the organization provide resources at work to help working mother find sick child care
 - (a) list of child care facilities with lenient sick child policies
 - (b) list of individuals willing to care for mildly sick children
17. Has the organization considered an on-site child care room or facility?
18. If there are plans for an on-site child care center, will there be a sick room component?

APPENDIX C

QUESTIONS FOR HOSPITAL REPRESENTATIVE

1. What are the regular working hours of the employees?
If clarification is needed the following questions will be asked:
 - (1) How many female employees work flexible shift hours of 8 to 12 hours?
 - (2) How many female employees' hours vary according to unit-intensive care unit vs non-intensive care units?
 - (3) How many female employees' hours vary according to position (e.g., head nurse, assistant head nurse, floor nurse, aid, unit secretary)?
 - (4) How many female employees' hours vary according to full or part time employee?

2. About how many full-time female employees work for the organization?
For these full-time female employees about how many days of sick leave per year are used for care of mildly sick children? Please give me your best estimate of what that total would be for all of your full-time female employees.

3. How many part-time female employees does the organization have?
Do part-time female employees have sick day leave benefits?
Of these part-time female employees, about how many days of sick leave are used for care of mildly sick children?

4. Is this loss of work time a substantial financial concern for the organization?

5. When women employees need time off to care for their sick children, are substitute personnel provided for their floor?
 - (a) If yes, does the employee have to make the arrangements for the substitute or does the personnel department?
 - (b) If no, could this be a possible solution to the problem of absenteeism, why or why not?

6. Are employees allowed a certain number of days off per year for sick leave?

7. Does the sick leave policy allow time off to care for sick family members?
8. From the employers' point of view, does the number of sick leave days per year seem adequate to cover most of the employee's needs?
9. Is sick leave paid leave?
 - (a) for full-time salary personnel
 - (b) for part-time salary personnel
 - (c) full-time hourly personnel
 - (d) part-time hourly personnel
10. If sick leave cannot be used for sick family members, can leave be taken from other leave areas (e.g., vacation, personal leave days)?
11. Are flexible working hours possible within the organization?
12. Which shift seems to have a higher rate of absenteeism of working mothers to care for their sick children?
13. Does the organization provide resources at work to help the working mother find sick child care?
 - (a) list of child care facilities with lenient sick child policies
 - (b) list of individuals willing to care for mildly sick children
14. Has the organization considered an on-site child care room or facility?
15. If there are plans for an on-site child care center, will there be a sick room component?

APPENDIX D
COVER LETTER

Dear Employee,

I am conducting a survey of working mothers who have children under the age of 7 years living at home. If you do not meet these requirements please return the unanswered questionnaire by putting it in the sealed box at..... Please return the questionnaire within two weeks. If you do meet these requirements, please complete the enclosed questionnaire and place it in the sealed box. Your response to this questionnaire is important in helping to understand what working mothers are doing to solve the problem of child care for mildly sick children. It is also important to know what working mothers would prefer to use for such child care.

I am a graduate student in the School of Nursing at East Carolina University. The information from this survey will be used as part of the requirements for my thesis.

The questionnaire should take about 10 to 15 minutes to answer. There are no right or wrong answers; it is your opinion that is of interest. Any questions that you do not feel comfortable answering can be omitted. All answers will be confidential so do not put your name or an identification number on the questionnaire. The information obtained from this questionnaire will be reported for the group not the individual.

I will assume that by answering and returning this questionnaire that you have given me permission to use the information for my thesis. If you have any questions about the questionnaire or use of the information obtained from it please call me at (919) 946-4472. Thank you for taking your time to fill out and return this questionnaire.

Thank you,

Mary Kay Whelan