Strengthening Child Health through Caregiver Engagement: Advancing Universal Health Coverage in South Africa

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Abstract

Child mortality and morbidity remain significant public health concerns in sub-Saharan Africa, with universal health coverage (UHC) for children under five identified as a critical strategy for addressing these issues. This study explored professional nurses' perspectives on the engagement of caregivers in community- and home-based care practices as a pathway to advancing UHC in Vhembe District, South Africa. A qualitative descriptive explorative design was employed. It involved 15 purposefully selected professional nurses from two primary healthcare centres. Data were collected through semi-structured individual interviews conducted between March and June 2022 and analysed using Braun and Clarke's thematic analysis framework.

Three overarching themes and seven sub-themes emerged. The first theme highlighted the empowerment of caregivers through knowledge dissemination and enhanced decision-making capacity. The second theme emphasised active parental participation in child health, including involvement in assessments, recognition of danger signs, and utilisation of the Road to Health booklet (RtHB). The third theme addressed barriers to effective caregiver engagement, notably the influence of traditional health beliefs and literacy challenges among grandmothers.

Findings revealed the pivotal role of nurses in facilitating caregiver involvement and suggest that strengthening community-based strategies may contribute significantly to achieving UHC for children under five, particularly in low-resource settings. Tailored interventions addressing cultural and educational

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barriers are essential to optimise caregiver participation and improvement of child health outcomes.

Keywords: caregiver; child health; empowerment; engagement; strengthening; universal health coverage

Introduction

Child health is a cornerstone of primary healthcare and a critical determinant of population well-being globally. Over recent decades, significant progress has been made in reducing child mortality, with the global under-five mortality rate declining to 37 deaths per 1,000 live births in 2020 (WHO 2022). Despite these gains, disparities persist, and sub-Saharan Africa continues to bear the greatest burden, recording 74 deaths per 1,000 live births, a rate 14 times higher than in Europe and North America (WHO 2022). These figures highlight the urgent need for targeted interventions in low-resource settings.

Within sub-Saharan Africa, evidence-based interventions such as exclusive breastfeeding (EBF) and childhood immunisation have demonstrated measurable impact on child survival. A meta-analysis spanning 2000–2018 revealed that EBF prevalence increased by approximately 1% annually, accompanied by a reduction of 3.4–5.6 deaths per 1,000 live births each year (Pretorius et al. 2021). Economically, a 10% rise in EBF rates could avert nearly $1 billion in non-health-related GDP losses by 2030, highlighting its broader societal benefits (Pretorius et al. 2021). Similarly, childhood vaccinations are strongly linked to a decline in preventable child deaths. A multi-country analysis across 35 sub-Saharan African nations found that full immunisation coverage was positively associated with maternal education, household wealth, and health insurance access, emphasising the role of socioeconomic determinants in vaccine uptake (Li et al. 2021).

Despite these benefits, progress remains uneven due to systemic challenges such as inadequate health infrastructure, fragmented community engagement, and persistent social barriers. In South Africa, the Integrated Management of Childhood Illness (IMCI) strategy was introduced as a comprehensive approach to improving child health outcomes. IMCI encompasses three core components: strengthening healthcare providers' clinical and communication skills, improving health system infrastructure, and promoting positive family and community health practices through facility-based and community-level interventions (Fick 2017). However, implementation has been inconsistent, constrained by inadequate supervision, poor adherence to guidelines, and limited integration of community-based components (Mnanzana 2020; Jensen and McKerrow 2022; Tshivhase 2024).

These challenges highlight the need to reposition IMCI within the broader framework of UHC. UHC aims to ensure that all individuals, particularly vulnerable populations, can access essential health services without financial hardships, encompassing health

promotion, disease prevention, treatment, rehabilitation, and palliative care (WHO 2023). South Africa has embraced UHC through its National Health Insurance (NHI) framework, signed into law in May 2024, which seeks to consolidate the fragmented health system and reduce inequities.

Despite the adoption of these strategies, a critical gap persists in understanding how frontline healthcare providers, particularly nurses, as they perceive and facilitate the primary caregivers of children under five engagements in community and home-based child health practices. Previous research has largely focused on clinical outcomes and health systems performance, with limited attention to the perspectives of nurses who are uniquely positioned to influence caregiver participation during routine child health visits. This lack of insight represents a condition of ignorance that perpetuates fragmented implementation and missed opportunities for strengthening IMCI and advancing UHC goals. If this gap remains unresolved, systemic challenges such as delayed care-seeking, poor adherence to treatment, and preventable child deaths will continue, undermining progress towards Sustainable Development Goal 3. Conversely, addressing this gap offers significant benefits: it can inform targeted interventions that empower caregivers, enhance nurse-led community engagement, and ultimately improve child health outcomes while reducing health inequities.

Against this background, this study aims to explore nurses' perspectives on the engagement of caregivers of children under five in community and home-based care practices as a means of advancing UHC. Understanding these perspectives is critical for informing strategies that promote caregiver engagement, enhance child health outcomes, and contribute to equitable progress towards UHC, ensuring that no child is left behind.

Methods and Materials

Study Design

This study employed a qualitative, exploratory, and descriptive design to gain an in-depth understanding of nurses' perspectives on caregiver engagement in child health practices within the context of IMCI and UHC. A qualitative approach was appropriate for examining complex social phenomena such as perceptions and experiences that cannot be quantified, providing rich, contextualised insights (Creswell and Creswell 2018; Polit and Beck 2020). The exploratory aspect was justified by the limited empirical evidence on this topic in South Africa, enabling the identification of patterns and contextual factors influencing practice (Stebbins 2001; Grove and Gray 2019). The descriptive component allowed for a detailed account of nurses' experiences without manipulating variables, presenting their views in their own words to inform policy and strengthen IMCI implementation within UHC frameworks (Sandelowski 2000; Bradshaw et al. 2017).

Setting

The study was conducted at two primary healthcare facilities in the Vhembe District of Limpopo Province, South Africa, specifically in the Musina and Thulamela sub-districts. These facilities were selected because they are among the most densely populated in the district, with high headcounts of children under five and a significant number of nurses trained in the Integrated Management of Childhood Illness (IMCI) strategy. Musina is situated near the Zimbabwean border and is characterised by a mix of urban and peri-urban communities, while Thulamela encompasses predominantly rural areas with dispersed settlements. The two facilities are approximately 120 kilometres apart, reflecting the geographic diversity of the district. This context is important as it influences access to healthcare services, caregiver engagement, and the implementation of child health strategies.

Recruitment of Participants

To minimise bias during participant recruitment, the process was conducted by a trained research assistant rather than the principal researcher. This approach ensured neutrality and reduced the likelihood of undue influence. Recruitment took place one week before data collection at the two selected facilities. The research assistant distributed information leaflets outlining the study purpose, eligibility criteria, and the voluntary nature of participation. Nurses were informed of their right to withdraw at any stage without penalty, and no incentives were offered to avoid coercion.

Population

The population for this study comprised professional nurses providing child health services at primary healthcare facilities in the Vhembe District, Limpopo Province, South Africa. These nurses were selected because they play a critical role in implementing the Integrated Management of Childhood Illness (IMCI) strategy and engaging caregivers in child health practices.

Sampling Approach

A non-probability purposive sampling approach was employed. This method was appropriate because the study aimed at gaining in-depth insights from nurses with specific knowledge and experience relevant to the research question (Polit and Beck 2021). Purposive sampling allowed the researcher to deliberately select participants who met predefined criteria, ensuring that the sample was information-rich and aligned with the study objectives.

Inclusion and Exclusion Criteria

Participants were required to meet specific inclusion criteria to ensure relevance and expertise. Eligible nurses were aged 18 years and above, as this allowed them to legally provide informed consent. They held a diploma or degree in Nursing and Midwifery, guaranteeing professional qualification, and were trained in the Integrated Management

of Childhood Illness (IMCI) strategy, which ensured direct experience in child healthcare service delivery. Additionally, nurses had three or more years of experience in child health services, a range selected to reflect sufficient practical exposure to IMCI implementation while minimising recall bias and ensuring current practice relevance. Nurses who were off duty or on leave during data collection were excluded from the study, as they were unavailable for participation.

Data Collection

Data collection was conducted between March and June 2022 at two primary healthcare facilities in the Vhembe District, Limpopo Province. Professional nurses trained in the Integrated Management of Childhood Illness (IMCI) and with at least three years of experience in child health services were recruited during their preferred times to minimise disruption to service delivery. Recruitment was facilitated by a trained research assistant who provided information leaflets and arranged private spaces for interviews with the operational managers of the two facilities.

A semi-structured interview guide, developed by the principal researcher in consultation with two qualitative research experts and informed by relevant literature, was used to guide the interviews. The guide comprised five open-ended questions focusing on nurses' practices and perceptions regarding the promotion of home and community-based care for children under five, as outlined in the community component of IMCI. The participants' responses were followed up with probes for clarity of what had been said.

Interviews were conducted individually to ensure confidentiality and allow participants to share their experiences freely. All interviews were held in private rooms within the selected facilities and conducted in English, the primary language of professional communication in these settings. Each interview lasted approximately 30 to 45 minutes.

Prior to recording, participants were informed about the study purpose, voluntary participation, and their right to withdraw at any time without penalty. Written informed consent was obtained for both participation and audio recording. All interviews were audio-recorded to ensure accuracy, and field notes were taken to capture non-verbal cues. A total of 15 nurses participated in the study, with the sample size determined by data saturation, which occurs when no new themes or insights emerge from additional interviews (Rahimi et al. 2024).

Data Analysis

The data were analysed using the thematic analysis framework outlined by Clarke and Braun (2006). This approach was chosen because it provides a systematic and flexible method for identifying, analysing, and reporting patterns within qualitative data. The following steps were followed:

1. Familiarisation with the Data

Audio-recorded interviews were transcribed verbatim within 48 hours of data collection to ensure accuracy and timely engagement. The researcher immersed themselves in the data by repeatedly reading transcripts and listening to recordings, making initial notes on emerging ideas.

2. Generation of Initial Codes

The transcribed data were submitted to an independent coder to enhance credibility and minimise bias. Coding involved systematically identifying and labelling meaningful segments of text, reducing the data into smaller, manageable units that captured key concepts related to caregiver engagement and IMCI practices.

3. Identification of Themes

Codes were reviewed and grouped into potential themes that reflected patterns across the dataset. This step ensured that themes were grounded in the data rather than preconceived assumptions.

4. Review of Potential Themes

Themes were refined by checking their coherence and relevance against the coded extracts and the entire dataset. Overlapping or weak themes were merged or discarded to ensure clarity and consistency.

5. Definition and Naming of Themes

Each theme was clearly defined and named to capture its essence and scope. Sub-themes were identified where necessary to provide nuanced insights into nurses' perspectives.

6. Production of the Final Report

The final step involved synthesising the themes into a coherent narrative supported by direct quotations from participants. This ensured that the findings accurately represented participants' voices and addressed the research objectives.

This rigorous process ensured transparency, credibility, and trustworthiness in the analysis, allowing for rich interpretation of nurses' perspectives on caregiver engagement within IMCI and UHC frameworks.

Trustworthiness

To ensure rigour and data quality, the study adhered to the five pillars of trustworthiness as described by Polit and Beck (2021).

Credibility
This was ensured through member checking, allowing participants to verify the

accuracy of their responses and interpretations. Additionally, an independent coder was engaged to validate the coding process and enhance reliability.

Transferability
This was ensured by providing detailed descriptions of the research context, sampling methods, and inclusion criteria. These accounts enable readers to assess whether the findings can be applied to similar populations or settings beyond the study context.

Dependability
This was demonstrated through peer debriefing with qualitative research experts and maintaining an audit trail documenting all methodological decisions during data collection and analysis. This process ensured consistency and transparency throughout the study.

Confirmability
This was achieved through triangulation, which included the use of multiple data sources such as interview transcripts and field notes, as well as independent coding. The researcher practised reflexivity to minimise personal bias and maintain objectivity.

Authenticity
This was upheld by accurately representing participants' voices through verbatim quotations in the findings. This approach conveyed the depth and diversity of perspectives, reflecting the genuine experiences of nurses regarding caregiver engagement in child health practices.

Ethical Consideration

Ethical approval for this study was obtained from the Sefako Makgatho University Research Ethics Committee (Reference: SMUREC/H/334/2021:IR). Permission to conduct the study was further sought and granted by the Limpopo Provincial Department of Health, the Vhembe District Manager, and the facility operational managers. The researcher first contacted the Vhembe District Health Research Committee through the District Manager, followed by communication with the operational managers at the two selected primary healthcare facilities. The trained research assistants were sent to physically explain and distribute information leaflets and further arrange for data collection. This process ensured compliance with hierarchical approval procedures.

To access the gatekeeper, the researcher submitted a formal application that included the ethical clearance certificate, study protocol, and participant information sheets. Written approval letters from the Provincial Department of Health, the District Office, and the facility managers were secured before data collection.

The operational managers acted as mediators, facilitating access to the facilities and coordinating suitable times for interviews without influencing participant selection. To maintain ethical standards and avoid bias, information leaflets outlining the study purpose, the voluntary nature of participation, and confidentiality assurances were distributed to potential participants by the research assistant. Written and verbal consent were obtained prior to interviews and audio recordings, in accordance with ethical guidelines (McLeod 2024). Participants were informed of their right to withdraw at any time without negative consequences. Confidentiality, anonymity, and privacy were strictly upheld throughout the research process.

Results

Table 1: Demographic characteristics of the participants

Participant	Gender	Age(years)	Facility A/B	Years of experience in IMCI practice (years)
P1	Female	62 years	A	23 years
P2	Female	63 years	A	25 years
P3	Female	33 years	A	09 years
P4	Male	30 years	A	07 years
P5	Female	38 years	A	09 years
P6	Female	53 years	A	15 years
P7	Female	41 years	B	12 years
P8	Female	39 years	B	08 years
P9	Female	38 years	B	08 years
P10	Female	36 years	B	07 years
P11	Female	47 years	B	16 years
P12	Female	35 years	B	08 years
P13	Female	48 years	B	13 years
P14	Female	55 years	B	20 years
P15	Female	37years	A	10 years

Characteristics of the Participants

Fifteen participants, comprising 14 females and one male, aged between 30 and 63 years, were interviewed. The participants were all IMCI-trained professional nurses. Their years of practising IMCI ranged from seven to 25 years. All had experience of practising as professional nurses in primary health care for seven to 25 years (See Table 1). Three themes and seven sub-themes emerged from the study's findings. Theme one is empowerment of caregivers through knowledge impartation and improved decision-making. Theme two is caregiver engagement in child health through caregiver participation in health assessments, identification of danger signs and use of the Road to Health (RtHB) card. The third theme is barriers to effective participation of caregivers, which were due to beliefs in traditional treatment and literacy challenges among grandmothers. Table 2 presents themes and sub-themes of the study.

Table 2: Themes and sub-themes from nurses' perspectives on caregiver empowerment in child healthcare

Theme	Sub-Theme
1. Empowerment of caregivers	1.1 Knowledge dissemination
	1.2 Improved decision-making
2. Caregiver engagement in child health	2.1 Caregiver participation in health assessments
	2.2 Identification of danger signs
	2.3 Use of RtHB Card/booklet
3. Barriers to effective participation	3.1 Belief in traditional treatments
	3.2 Literacy challenges among grandmothers

Theme 1: Empowerment of Caregivers

Participants perceived the work of IMCI-trained professional nurses as empowering caregivers. Two sub-themes emerged: empowerment through knowledge dissemination and enhanced decision-making in managing childhood illnesses.

Sub-Theme 1.1 Knowledge Dissemination

Most participants illustrated how nurses routinely educate caregivers on early recognition and home management of common childhood illnesses to promote timely intervention and prevent disease progression. In that respect, one participant stated: "As part of our daily routine, we teach mothers to recognise early signs of common childhood illnesses such as diarrhoea, pneumonia and malaria." This is done so that they know what they could do at home before they bring the child to the healthcare centre. Another participant said, "We teach them proper home care practices, such as oral rehydration solution, nutrition, and hygiene to help them prevent diseases and promote health."

Sub-Theme 1.2 Improved Decision-Making

Most of the participants indicated that caregiver empowerment through health education enhances their ability to make timely and informed decisions regarding child health, contributing to improved outcomes and reduced delays in seeking care. One participant said: "Empowered caregivers don't wait; they know when to treat at home and when to seek help, and that saves lives." Another professional nurse similarly said: "When caregivers understand what's normal and what's not, they make faster and safer choices for their children."

Theme 2: Caregiver Engagement in Child Health

All participants described multiple approaches to caregiver engagement in child health, emphasising strategies that encourage parental involvement in promoting child well-being. Three sub-themes were identified: (1) caregiver participation in health assessments, (2) recognition of danger signs, and (3) utilisation of the RtHB card.

Sub-Theme 2.1 Caregiver Participation in Health Assessments

Participants expressed how they actively train caregivers to observe key indicators of child health by teaching them to look, listen, and feel for changes in breathing, behaviour, and feeding, as well as to interpret growth charts. A participant said, "We teach caregivers to look, listen, and feel because noticing changes in breathing, behaviour, or feeding can be the first step in saving a child's life." Another professional nurse stated that: "We explain growth charts in simple terms, so every caregiver can spot when a child needs extra care or nutrition."

Sub-Theme 2.2 Identification of Danger Signs

Most participants emphasised the critical role of nurses in equipping caregivers with the knowledge necessary to identify key danger signs in children under five. This empowerment was viewed as essential for promoting timely health-seeking behaviours and improving child survival outcomes. Participants highlighted the fact that through targeted education and counselling, nurses enable caregivers to recognise symptoms that require urgent attention, thereby reducing delays in accessing care.

A participant said, "These mothers are taught by us to identify danger signs in children. We are seeing caregivers who are taught to bring children immediately to the clinic if the child presents with any of the four danger signs." Another participant said, *"*The majority of mothers can identify danger signs, and this is what we need. Sometimes you could see that the child looks normal, irrespective of having a symptom, vomiting everything after a meal."

Sub-Theme 2.3 Use of RtHB Card

Participants further highlighted the role of nurses in educating literate caregivers on the effective use of the RtHB, enabling them to assess their children's health at home and apply recommended home remedies as outlined in the booklet. A participant said: " We also teach them on how to use that road to health chart for those who can read so they can read when they are at home and be able to assess their kids to tell if and when there is something wrong and then also in there, (I mean) there is that portion with home remedies, yes (yes) that portion also." Another participant supported this: "After every consultation, I teach them. Okay. I show them the page on the RtHB card that there is page number seven, which shows how to do ORS, what food to give to the child." (staggering)

Theme 3: Barriers to Effective Participation

Participants also identified barriers that hinder effective caregiver participation in home and community practices related to child health management. Despite efforts to promote engagement, certain challenges persist. Two sub-themes emerged: (1) reliance on traditional treatments, which often delays timely access to formal healthcare services, and (2) low literacy levels among some grandmothers, which were perceived as significant setbacks to understanding and implementing recommended child health practices.

Sub-Theme 3.1 Belief in Traditional Treatments

Most of the participants revealed that cultural beliefs in traditional healing practices continue to influence caregivers' decisions regarding child health management, often leading to delays in seeking care from healthcare facilities, even with severe illnesses. A participant said:

> The people around here still believe that other childhood diseases can be treated by family traditional healers. Even when we educate them to come when the child is presenting with symptoms suggesting severe disease, they might not come to us but to the traditional healers. The belief may not be wrong, but they need to check if the child can recover. I remember when a mother came with a child with severe dehydration and lacerations over the frontal fontanel. When I asked what was done, I was told the child was treated for vomiting and diarrhoea at the family traditional healer. It was difficult to put a drip as the child was severely dehydrated.

Another participant also said:

> As we engage our caregivers, they usually tell us that they take children for traditional healers' treatment as they do not believe that western medicine can treat all. Sometimes children are brought in with black stuff smeared around the fontanel. If one asks, they are told that it is for ngoma(fontanel) to heal.

Sub-Theme 3.2 Literacy Level among Grandmothers

Participants expressed their observation on low literacy levels among grandmothers that significantly hinder their ability to engage effectively in child health management. One participant said, "Sometimes it is not childhood illness that is a problem, but the grandmother might not understand how to mix six teaspoons of sugar into the solution for oral rehydration as a result of being illiterate." Another participant asserted the following: "It is usually difficult to engage a grandmother in reading the instructions that are displayed on the RtHB card. Most of the instructions on management of childhood illness are there in the child's card, but cannot be read by an uneducated person."

Discussion

This study explored nurses' perspectives on engaging caregivers of children under five in community and home care practices within the framework of advancing UHC. The findings highlight the critical role of IMCI-trained professional nurses in empowering caregivers, particularly within primary healthcare settings. According to the IMCI strategy, nurses are expected to ensure that caregivers adopt community and family practices that prevent childhood illnesses and promote child health (WHO 2023). The findings confirm that nurses routinely provide structured education to strengthen caregivers' capacity for informed decision-making by sharing evidence-based information on common childhood diseases and demonstrating effective approaches for prevention and management at home (Abraham et al. 2025). Practical demonstrations, such as preparing oral rehydration solution and maintaining hygiene, were reported as vital components of this education, consistent with IMCI guidelines (WHO 2023). Through these interventions, caregivers acquire the knowledge and confidence necessary to manage childhood illnesses at home, an approach that aligns with the Family-Centred Empowerment Model (FCEM), which has been shown to reduce caregiver burden and improve child health outcomes (Abdelgawad et al. 2025; Asamani et al. 2025; Dai et al. 2023).

Nurses viewed education as an empowerment strategy enabling caregivers to make timely decisions about whether to manage a child's condition at home or seek care at a health facility. This perspective is supported by evidence that caregiver education enhances recognition of danger signs and promotes health-seeking behaviours (Echendu et al. 2025; Echendu et al. 2023). Our findings indicate that caregivers were taught to identify critical danger signs such as vomiting everything, lethargy, convulsions, and difficult breathing, which are also outlined in the RtHB. Literate caregivers were further empowered to use the RtHB proactively for growth monitoring, immunisation tracking, and home care practices, consistent with WHO recommendations for mentoring communities on IMCI strategies to advance UHC (WHO 2020). The RtHB has been recognised as a tool for facilitating essential packaged health services for children under five (Dietrich et al. 2024; Win et al. 2020). By teaching caregivers to interpret growth charts and apply the booklet's guidance, nurses aimed to support early intervention at home and reduce reliance on facility-based care.

However, the study also revealed significant challenges that may limit the effectiveness of these strategies. Elderly caregivers, particularly grandmothers, often had low literacy levels, which constrained their ability to understand and use the RtHB effectively. This finding is consistent with reports that literacy barriers significantly reduce the impact of health education tools in rural and underserved communities (RHAP 2024). Furthermore, caregivers' health-seeking behaviours were shaped by culturally rooted perceptions of illness, which sometimes led to poor utilisation of healthcare services and increased reliance on traditional remedies (Mabetha et al. 2021). Cultural beliefs played a critical role in delaying formal healthcare, as some caregivers preferred

traditional healing practices such as herbal remedies, spiritual rituals, or faith-based interventions. These delays compromise timely medical intervention and increase health risks for children, thereby undermining progress towards UHC. WHO (2020) emphasises the importance of culturally sensitive engagement and recommends integrative approaches that respect traditional beliefs while promoting evidence-based care.

Recent literature supports the need for integration between traditional and allopathic healthcare systems. Makhavhu (2024) argues that the coexistence of these systems in South Africa presents an opportunity for healthcare transformation, particularly in child health, if integration is approached respectfully and strategically. WHO (2023) also advocates for the inclusion of traditional medicine in national health systems, recognising its potential to enhance healthcare accessibility and cultural relevance when guided by scientific validation. These insights suggest that while caregiver education and empowerment are essential, their success depends on addressing literacy barriers and cultural dynamics through tailored interventions and collaborative models.

Taken together, the results highlight IMCI-trained nurses as central agents in strengthening caregiver involvement and supporting the realisation of UHC objectives. However, structural and sociocultural challenges require adaptive strategies, including literacy-sensitive education tools, culturally attuned communication, and integrative approaches that bridge traditional and biomedical care. Such measures can strengthen community-level health practices, reduce delays in care-seeking, and ultimately improve child survival outcomes.

Conclusion

Empowering caregivers through nurse-led education enhances childhood illness management and support for the broader goals of UHC. Parental participation in assessments and decision-making is vital but must be supported by culturally sensitive and literacy-awareness strategies. Addressing barriers such as traditional beliefs and low literacy is essential for achieving equitable and effective child health outcomes. Ultimately, strengthening primary healthcare and training lower cadres, as well as community healthcare nurses, can be key to reducing child mortality and morbidity and achieving UHC.

Recommendations

To advance UHC through community-level child health management, IMCI-based caregiver education should be strengthened at the primary healthcare level, supported by empowerment strategies such as the Family-Centred Empowerment Model to build caregiver confidence and informed decision-making. Health education approaches must address literacy barriers through visual aids, oral communication, and community health worker involvement, while fostering culturally sensitive engagement that integrates

traditional beliefs with evidence-based care to reduce delays in seeking formal healthcare. These priorities have clear implications for nursing education, which should incorporate IMCI principles, culturally competent communication, and strategies for low-literacy populations into curricula, alongside training in collaborative community-based approaches. For nursing research, future studies should evaluate the effectiveness of literacy-sensitive and culturally tailored interventions, explore scalable models for integrating traditional and biomedical care, and assess the impact of empowerment frameworks on caregiver engagement and child health outcomes.

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