

Primary Caregivers Health Seeking Behaviour for Under-Five Children: A Study in a Rural Block of Assam, India

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ABSTRACT

Introduction: Proper health seeking behaviour of primary caregivers can reduce delay in diagnosis of illness of young children, improve treatment compliance, improve the health, reduce child mortality and morbidity. The present study was conducted with the objectives to study the prevailing health seeking behaviours of caregivers for the under five children.

Methodology: Total 375 primary caregivers of under 5 children were included in our study. Each caregiver was interviewed after taking informed consent using pretested pre-designed semi structured schedule.

Results: Out of 283 episodes in 31% cases the caregiver approach govt hospital while 23.7% went to private clinics, 17% practiced self medication for the child. 16% primary caregivers sought no outside advice and 5% went to traditional healers. Lack of money was cited by 75% caregivers as the reason for not getting outside treatment while 84% caregivers felt that the morbidity episode of the child was not severe enough to seek care.

Conclusion: The study findings includes government sector is still the preferred choice for rural population for treatment for their children, self medication practices were forced on children by some caregivers, education of the caregivers significantly influenced care seeking behaviour, lack of money and caregivers' perception of mild illness were some reasons for not seeking appropriate care.

Key words : Health seeking behaviour, under 5 children, morbidity, Primary caregivers, self medication

INTRODUCTION

In India out of 1.21 billion population, number of children in the age-group of 0-6 years is reported as 158.79 millions or roughly 13% of total population.¹ Every year an estimated 26 millions of children are born in India which is more than the population of whole of Australia. ² On the other hand each year 1.83 million children under five years of age die in India, in absolute numbers it is highest in anywhere in the world. ³ Assam one of the seven North Eastern states of India contributes significantly to the national infant and child mortality rates.⁴ Latest figures indicated that in Assam infant

mortality is 48 deaths per thousand live births and under five mortality rate is 56 per 1000 live births, which are quite high. ⁵ Apart from the other causes child mortality in India are found to be greatly influenced by maternal age, her education, social group, family type and economic status of the family. ⁶ These factors also influence care seeking behaviours of parents. As India is a diverse country by demography and population therefore factors influencing child mortality and health seeking are different in different region which need to be ascertained for implementing specific strategies to tackle the problem of child mortality. But there are

very few literatures available regarding the social factors of mortality and care seeking behaviours of parents of under five children from North East India including Assam. Therefore it is the need of the hour to determine the factors responsible for higher mortality rates of children as well as study the care seeking behaviours of parents in this part of the country. Since child mortality is found to be more in rural areas of Assam than urban areas⁵, Therefore the present study was organized in a rural setting of Kamrup district of Assam with the following objectives, to study the prevailing health seeking behaviours of primary care givers for the under five children in rural areas and to analyse the various factors influencing the health seeking behaviours of the care givers.

METHODOLOGY

Our study was conducted in Sonapur Block Primary Health Centre (BPHC) area which is situated around 25 km away from Guwahati city. We randomly chose 5 Sub Centres (SC) under that Block PHC. From each SC we randomly chose 3 numbers of villages. In each village we interviewed 25 primary caregivers of under 5 children who gave informed consent to be part of our study. Hence total 375 respondents were included in our study. Each caregiver was interviewed in their home by an investigator using pretested predesigned semi structured schedule. The schedule was pretested in 50 local mothers who were not part of our study later. Data collected through this manner were compiled, tabulated and analysis using Microsoft Excel software. For statistical analysis SPSS version 18 was used. Mainly percentage proportions were calculated and bivariate analysis was done. Study period was from January to July 2013. Ethical clearance for the study was obtained from Institutional ethics committee. All mothers or primary caregiver having a child under 5 years of age, who were permanent residents of the study area and gave verbal informed consent were included in our study. Those mothers or primary caregiver having children whose age not known, not gave consent to be part of our study, gave incomplete information and those who were not permanent residents of the village were excluded from the study. In our study mothers and other primary caregivers were enquired about all self-reported morbidities of the children such as fever, cough, difficult breathing and diarrhoea or any other morbidity during the preceding two month. We also collected information on choice of healthcare professionals of caregivers, reasons for their choices and reasons of some caregivers' for not seeking any help from healthcare professionals. For this study Health seeking behaviour was defined as sequence of remedial actions taken by caregivers to rectify per-

ceived ill-health of the child.⁷ Appropriate health seeking behaviours among caregivers in this study was defined as seeking treatment and health advice either through doctors (both allopathic and AYUSH) or health workers (pharmacist/ ANM/ ASHA) from public or private health facilities (Govt hospital, private clinic). Self medication practices of caregivers without any consultation with registered pharmacist were excluded from appropriate health seeking behaviour. Primary caregiver in this study was defined as any adult mainly female person who is responsible for the routine care and wellbeing of a child. The definition included biological mothers, fathers, grandparents, aunts. For each child investigator identify only one primary caregiver from the family.⁸ Modified BG Prasad classification was used for determining the socioeconomic status.⁹

RESULTS

Our study conducted among 375 primary caregivers in a rural setting of Kamrup district, Assam obtained some useful information on health seeking behaviour of caregivers regarding their children.

Out of 375 primary caregivers 352 (93.8%) were their mothers, 13 (3.4%) were fathers and rest were grandmothers. (Table 1) Among the mothers majority (68.2%) belonged to 20 to 29 age group, while 43 (12.2%) were teenage mothers. As for the educational status of the primary caregivers 64 (17%) of them were illiterate, while majority 165 (44%) were educated up to middle school level and 13% were high school pass or above. Out of the 375 respondents most (63.5%) belonged to nuclear families of lower socioeconomic class (52.3%). Most of the primary caregivers in our study were housewives (74.4%). Table 1 also revealed that out of the 375 children, 54.4% were male. Among the children 23.2% were less than 6 months of age and most were (44.5%) in the age group of 2 to 5 years.

In table 2 we showed the distribution of children according to their different morbidity episodes in the last 2 months and health seeking behaviours of their caregivers. It was found that diarrhoea (29%) was the most common morbidity among children followed by Acute Respiratory Infection (ARI) and Fever. Total 283 episodes of different morbidities were documented among 375 children in that period of 2 months. While analysing the health seeking behaviours of the caregivers during those morbidity episodes we found that in 31% cases the caregiver approach govt hospital for treatment while 23.7% caregivers went to private clinics. 16% primary caregivers sought no outside advice for the child and 5% went to traditional healers for their children.

Table 1: distribution of the primary caregiver and their children according to some socio demographic characters

Variable	Frequency (%)
Child Characteristics (n=375)	
Sex of the child	
Male	204 (54.4)
Female	171 (45.6)
Age of the child	
0 to 6 months	87 (23.2)
6 months to 1 year	75 (20)
1 to 2 years	46 (12.3)
2 to 5 years	167 (44.5)
Characteristics of Prim ary caregiver (n=375)	
Types of primary caregiver	
Mother	352 (93.8)
Father	13 (3.4)
Grandmother	10 (2.8)
Age of the mother (n=352)	
Less than 19 years	43 (12.2)
20 to 29 years	240 (68.2)
30 years or more	69 (19.6)
Education status of caregiver (n=375)	
Illiterate	64 (17)
Just literate /no formal education	27 (7.3)
Primary	70 (18.7)
Middle and up to class 10	165 (44)
High school pass and above	49 (13)
Characteristics of Prim ary caregiver (n=375)	
Religion	
Hindu	310 (82.6)
Muslim	54 (14.4)
Others	11 (3)
Type of family	
Nuclear	238 (63.5)
Joint	137 (36.5)
Socioeconomic status	
Upper & upper middle Class (1&2)	65 (17.3)
Middle class (Class3)	114 (30.4)
Lower class (Class4 & 5)	196 (52.3)
Occupation of caregiver	
House wife	279 (74.4)
Service; govt or private	61 (16.2)
Daily wage labourer	23 (6.2)
Own business	12 (3.2)

We also analysed the different factors influencing health seeking behaviours of the caregivers in our study (Table 3). It was found that literacy significantly influence the health seeking behaviours of the caregivers, as in our study those who demonstrated appropriate health seeking behaviours (N=176) maximum (41%) belonged to the group who were at least educated up to high school. We also analysed factors like sex of the child, socioeconomic status of the caregiver, family structure and numbers of children of caregivers and found that none of these factors showed any statistically significant association with the primary caregiver's health seeking behaviour.

In the table 4 we describe the different reasons of the primary caregivers (N=45) of not seeking treatment outside home for their children. One important cause found in our study was that most caregivers felt that the morbidity episode of the child was not severe enough to seek outside care (84.5%). While lack of money was another important factor (75%) that influenced not getting outside treatment for the child.

DISCUSSION

The findings of our study are important in many aspects as it is one of the few studies done in North Eastern part of India and it was conducted in a rural community. Our study respondents were mostly mothers from lower socioeconomic background had less education, from nuclear families and most were less than 25 years of age. In India infant and childhood mortality is influenced by certain socio demographic factors which include lower economic status of the family, less education and age of the mother, rural urban variation etc.¹⁰ Unique social factors were found to be influencing high IMR and child mortality in Assam.¹¹ Therefore information obtained in our study on care seeking practices by these vulnerable groups for their under 5 children would be valuable for analysis of child mortality and morbidity in this region.

Table 2: distribution of children according to morbidity status and health seeking behaviour of caregivers

Morbidity types	Episodes of different morbidities (%)	Health seeking behaviour of caregivers					
		Govt Hospital	Private Clinic	Local pharmacy	ANM /ASHA	No treatment/ Home remedies	Traditional healer
ARI	64(22.6)	24	12	10	5	10	3
Diarrhoea	82(29)	23	16	15	8	16	4
Fever	55(19.4)	18	12	12	3	5	5
Skin infections	38(13.4)	10	8	4	4	10	2
Eye problems	12(4.2)	5	6	--	--	1	----
ENT problems	23(8.2)	6	9	5	--	3	-----
Others	9(3.2)	3	4	2	--	--	----
Total	283 (100)	89 (31.3)	67 (23.7)	48 (17)	20 (7)	45 (16)	14 (5)

Table 3: Different factors in influencing health seeking behaviours of the caregivers

Variables	Health seeking behaviour of caregivers (n=283)		P value
	Appropriate (n=176) (%)	Not appropriate (n=107) (%)	
Sex of the child			
Male	94 (53.4)	63 (58.9)	0.43
Female	82 (46.6)	44 (41.1)	
Education of caregiver			
Illiterate or up to Primary	34 (19.3)	53 (49.5)	0.001
Up to middle school	70 (39.7)	36 (33.5)	
High school or above	72 (41)	18 (17)	
Socioeconomic status			
Upper & upper middle Class(1&2)	23 (13)	8(7.5)	0.34
Middle class (Class3)	66(37.5)	43(40.2)	
Lower class (Class4 & 5)	87(49.5)	56(52.3)	
Type of family			
Joint	78(44.3)	40(37.4)	0.3
Nuclear	98(55.7)	67(62.6)	
Number of children			
1	76(43.2)	38(35.5)	0.27
2-3	55(31.2)	43(40.2)	
4 or more	45(25.6)	26(24.3)	

Table 4: reasons for not seeking treatment outside home for their children (n=45)

Reasons	Number (%)
Feel not necessary	38 (84.5)
Lack of money	34 (75.5)
Waiting for recovery	33 (73.3)
Distance of health facility	23 (51.1)
No one to take care of other children	12 (26.7)

Our study found that that diarrhoea was the most common morbidity among under five children followed by Acute Respiratory Infection (ARI) and fever during the study period. Similar findings were obtained by previous studies conducted in this region.¹² Govt hospitals were the first choice among the caregivers for treatment and advice during these morbidity episodes of their children. It might be due to free services and drugs available there. Majumdar A et al, Chandwani H et al also observed that majority caregivers preferred govt sector for consultation and treatment of children in rural areas.^{13, 14} Practice of self medication was also seen in 17% caregivers for their children. Lower socioeconomic condition of parents might influence self medications for the children rather than get appointments with doctors. Nazir S et al in their study had found prevalence of parents induced self medication practices as 57% among under 5 children.¹⁵

Apart from parent induced self medication for their children, 16% of our study population did not seek any outside care for the child during illness while 5% caregiver took help of local faith healers. Similar findings obtained by previous studies.^{13, 16, 17} Lower socioeconomic status of the parents could have resulted in the inappropriate health seeking behaviours of a part of our study population.

On analysis of the different factors influencing health seeking behaviours of the caregivers we found that education influenced the health seeking behaviours significantly, those having more education demonstrated appropriate health seeking behaviour while in the non appropriate care seeking behaviour group maximum were either illiterate or educated up to primary school. Ghosh N et al, Borah H et al in their studies also found significant association between education of parents and care seeking behaviour.^{18, 19}

One important positive finding of our study was that we did not find any gender discrimination regarding health seeking behaviour of the parents and caregivers. Respect to women and mothers in rural tribal societies of Assam might be the cause for absence of gender discrimination in our study. Sudharsanam MB et al in their study conducted among rural mothers in Pondicherry India revealed that there was no gender bias, but Ghosh N et al reported a significant gender bias in health seeking behaviour.^{20, 18}

When we asked the primary caregivers the reasons for not showing appropriate health seeking behaviours, most felt that the morbidity episode of the child was not severe enough to seek outside care. While lack of money was another important factor that influenced not getting outside treatment for the child. Lower educational status and ignorance on the part of caregivers might be other influencing factors for inappropriate health seeking behaviours in our study. Earlier studies conducted by Chandwani H et al, Ghosh N et al found that that ignorance, cultural beliefs, more concern for the well-being of the male child, were a few factors for their not seeking curative healthcare services.^{14, 18} Webair H et al in their study observed that the

major reasons for not seeking medical care were caregivers' perception of illness were mild and not needing any treatment.²¹ Similar to our study findings a study conducted in Nigeria observed that one of the main reasons for not seeking immediate treatment was cost of treatment.²²

CONCLUSION

The study conducted among primary caregivers of children under 5 years of age in a rural community of Assam found that government sector is still the preferred choice for treatment of their children, self medication practices were forced on children by some caregivers, education of the caregivers significantly influenced care seeking behaviour, lack of money and caregivers' perception of mild illness were reasons for not seeking appropriate care outside home. The findings of our study would be a catalyst for a bigger study on health seeking behaviour of rural parents in North Eastern India so that the data obtained would enhance health promotion activities among the parents and also useful for child health programs.

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