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Original Research Article

A study of factors which determine health seeking behavior of mothers for their under five children in rural area of Gujarat

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ABSTRACT

Background: Childhood illnesses present a major public health challenge for developing countries like India which is aggravated by a suboptimal health seeking behaviour by the parents or guardians. Appropriate medical care seeking could prevent a significant number of child deaths and complications. The present study aims to determine the factors affecting health seeking behavior for childhood illnesses, thereby improving child survival.
Methods: This was a cross-sectional study conducted in rural area of Gujarat. Study subjects were patients aged 2 months to 5 years of age who presented to the outpatient department of Rural Health Training Centre. The health seeking behavior of mothers for their child's illness and the factors affecting it were analyzed.
Results: Regarding utilizing the curative aspect of healthcare-seeking behavior, out of total 147 male children, treatment was not received by 31 children (21.09%), while those who received treatment, 71 males (48.30%) get treatment at the public sector and 45 males (30.61%) get treatment at private sector. It indicated the promptness, concern and utmost care for male children by their mothers. Out of 90 female children, in 30.00% of the cases, no treatment was received. 42 females (in 46.67% cases) receive treatment at public sector and 21 females (in 23.33% cases) receive treatment at private sector. The association between mass media exposure and health care seeking behavior was found to be statistically significant. The association between working status of mother and health seeking behavior was not found statistically significant.
Conclusions: For the preventable childhood illnesses, appropriate health seeking behaviour is low. Intervention programs focusing on educational improvement of the caretakers, introduction of community based integrated management of childhood illness are likely to contribute to improve the health seeking behaviour and child survival.

Keywords: Health seeking behaviour, Under five children

INTRODUCTION

At present, a priority area for governments, policy makers and international agencies is child health. It is also a critical area of discussion in international forums, as well as a subject of great social appeal. Most of developing countries had make significant improvement in child health indicators but still each year 13 million infants and children die in developing countries.[1] The major causes for these deaths are various infections, parasitic diseases and presence of malnutrition. Aggressive implementation of child survival strategies in the developing countries is the need of the hour to improve the wellbeing of children. We are now using integrated approach for the management of childhood illness which mostly relies on primary health care services for the management of childhood infections. But for impact of this approach, it should be utilized by community. In recent years, the

relationship between illness and health seeking behavior has come under the scanner of epidemiologists & social scientists.[2,3] Review of literature shows that more mortality and morbidity in rural areas is due to inadequate utilization of health services. Major factors responsible for delay in accessing medical facilities will be poverty, understaffed and underequipped health care system. There are other factors which also contribute to it.[4]

Studies indicate that a range of other factors such as, cultural beliefs and practices, perception of the cause of the illness, severity of the illness, age, sex, birth order of the child, mother's education, working status of mothers, may contribute to this delay for parents to access medical care for their children. Based on these aspects we can say that socio- cultural factors are playing very important role in determining health seeking behaviour (HSB). Most of the child deaths and complications due to ill health can be prevented by taking medical care at appropriate time. So we must study various factors responsible for delay in HSB which in turn could reduce the impact of severe illness on children's growth & development. The present study therefore planned with objective of determining factors affecting HSB for child hood illnesses, thereby improving child survival.

METHODS

The present cross-sectional study was conducted in the Rural Health Training Centre of Department of Community Medicine over a period of six months, from July 2014 to December 2014. All patients between the age of 2 months and 5 Years who visited the outpatient department were included in the study. Patients below the age of 2 months and above 5 yrs were not included in the study.

Data was collected using in depth interviews. After obtaining informed consent, mothers were interviewed and the answers obtained using a pretested structured questionnaire. Information was collected regarding the patient's name, age, sex, address, birth order, mother's and father's educational status, number of persons and children in the family, monthly per capita income, type of family, severity of the illness, type of the illness. Data was analysed using SPSS software version 16. Chi square was statistical test used to find out factors responsible for delay in taking health seeking behavior for children.

RESULTS

A total of 237 children between the age of 2 months and 5years who attended rural health training centre were included in the study. Out of 237 children, Most of them were males i.e. 147 (62.03%) and 90 (37.97%) were females. Regarding age distribution of children, 47 (19.83%) were infants (Table 1). Remaining children were aged between one and five years i.e. 190 (80.17%). Primary immunization coverage was completed by 76% of the males and females children. Thus we can say that mothers were aware regarding preventive healthcare-seeking practice which was an encouraging finding.

Table 1: Distribution of male and female children according to their age.

Sex of child	Less than one year	Greater than one year	Total (%)
Male	29	118	147 (62.03)
Female	18	72	90 (37.97)

Table 2: Distribution of male and female children according to the type of curative healthcare-seeking behavior received.

Curative health seeking behaviour	Perceived sick males (n=147) (%)	Perceived sick females (n=90) (%)	Total perceived sick children (n=237) (%)
No t/t	31 (21.09)	27 (30)	58 (24.47)
T/t at public sector	71 (48.30)	42 (46.67)	113 (47.68)
T/t at private sector	45 (30.61)	21 (23.33)	66 (27.85)

Regarding utilizing the curative aspect of healthcare-seeking behavior, out of total 147 male children, treatment was not received by 31 children (21.09%), while those who received treatment, 71 males (48.30%) get treatment at the public sector and 45 males (30.61%) get treatment at private sector It indicated the promptness, concern and utmost care for male children by their mothers (Table 2). However, same promptness, concern was not found for treatment of female children. Out of 90 female children, in 30.00% of the cases, no treatment was received. 42 females (in 46.67% cases) receive treatment at public sector and 21 females (in 23.33% cases) receive treatment at private sector (Table 2). In the Table 3, we study the association of various factors with the health care seeking behavior of mothers. Mass media exposure was categorized as not exposed and exposed. Out of the 59 mothers (24.89%) not exposed, healthcare behavior was sought by 29 mothers (49.15%)

and among 178 mothers (75.11%) exposed to mass media, 126 mothers (70.79%) sought health care. This association was found to be statistically significant (p<0.005, df=1, $\chi2$=9.16). The working status of the mother was categorized as non-working and working mothers. Among 129 (54.43%) non-working mothers, 81 (62.80%) had health-seeking behavior. Among the working mothers, 62.04% had healthcare-seeking behavior. This association was not found statistically significant (p>0.05, df=1, $\chi2$=0.90). Regarding educational status, the mothers were categorized as literate and illiterate mothers. Of 74 illiterate mothers, 28.38% had healthcare-seeking behavior, whereas, among 163 (68.78%) literate mothers, healthcare-seeking behavior was present in 68.71% of the cases. The association was found to be statistically significant (p<0.0001, df =1, $\chi2$=33.62).

Table 3: Table showing possible factors associated with the healthcare-seeking behavior among mothers (*n*=237).

Factors	Category	Health seeking behaviour		X^2 value
		Yes	No	
Mass media exposure	Present	126 (70.795)	52 (29.21)	X^2=9.16
	Absent	29 (49.15)	30 (50.85)	
Working status of mothers	Not working	81 (62.80)	48 (37.20)	X^2=0.90
	Working	67 (62.04)	41 (37.96)	
Educational status	Illiterate	21 (28.38)	53 (71.62)	X^2=33.62
	Literate	112 (68.71)	51 (31.29)	
Type of family structure	Joint family	83 (45.86)	98 (54.14)	X^2=1.54
	Nuclear family	31(55.36)	25 (44.64)	
Mothers according to gender of their child	Male	121 (82.315)	26 (17.69)	X^2=40.63
	Female	38 (42.22)	52 (57.78)	

Among 181 mothers (76.37%) living in joint families, 45.86% had healthcare-seeking behavior, whereas, among 56 mothers (23.63%) living in nuclear families, 55.36% mothers sought health care. The association was found to be not statistically significant (p>0.05, df=1, $\chi2$=1.54). The association between the healthcare-seeking behavior of the mothers and gender of their child was found to be statistically significant. Among 147 mothers having a male child, 82.31% sought healthcare services, whereas, among 90 mothers having a female child, 42.22% mothers sought health care (p<0.0001, df=1, $\chi2$=40.63). Unfortunately, out of the studied 237 mothers, with each having a perceived sick child, health care behavior was not sought in 24.47% of the cases. The reasons stated by their mothers for not seeking health care behavior were noted. Multiple responses were given; 64.12% of the mothers opined that ignorance, lack of awareness, fixed firm cultural beliefs, male-dominated society, more concern for the well-being of the male child, as he was the future bread winner of the family, and the final word of the head of the family, were contributory factors; 54.31% of the mothers stated the cause to be dissatisfaction with the health care services, along with lack of accountability and humaneness of the healthcare providers. According to 36% of the mothers, inconvenience of transport facilities, religious misinterpretations, socioeconomic constraints, and women's restricted movements played a role.

DISCUSSION

The multidimensional growth of a nation is primarily dependent on its health, manpower, and effective service utilization, and extends beyond the narrow limits of curative care, encompassing the preventive and promotive aspects as well. For effective health outcomes, it is mandatory that women utilize the services at par with men, more so because they are the prime caregivers to the children in the community. Starting from immunization coverage to accessing curative health care, health-seeking behavior largely displays the needs felt and awareness generated in the individual as well as the community. The existing literature on care-seeking in India, quantitatively displays the female disadvantage in healthcare use-rates [5]. However, there is a lack of quantitative data on the potential gender disparities existing in household recognition of illness, type of care used, and monetary expenditure for the health services, making it difficult for policy makers to formulate gender-sensitive interventions. Community-based studies have also found a significant gender differential of healthcare use in rural India. They have found that the proportion of sick female and male newborn infants receiving any treatment is 28.8 and 63.1%, respectively.[5] Similarly, in the Matlab area in Bangladesh, girls are less likely to get even free treatment than boys.[6] Cross-sectional surveys of practitioners and care providers have reported discriminatory care-seeking for boys and girls in India and Bangladesh.[7,8] Regional and gender differences in the health-seeking behavior among the migrants from Tamil Nadu and Uttar Pradesh in Delhi are observed.[9] The maternal education and living standard of the household have positive effects on the Oral Rehydration Treatment rate for boys, but not for girls, especially in the central and eastern regions of India.[10] Prevalence of visits to the medical facilities is highest among children aged six to twenty-three months,

children of lower birth orders, children in urban areas, children of mothers with at least secondary education, and children of mothers exposed to any sort of mass media. Additionally, factors related to the place of residence, socioeconomic status, cost, quality, and location of health services may account for variations in the use of maternal health care. Women's age, ethnicity, education, religion, culture, clinical need for care, and decision-making power interact in different ways to determine the health-seeking behavior.[11,12] Another study showed, that mothers often did not perceive neonatal illnesses serious enough for the use of a healthcare provider. However, for effective and favorable health outcomes a responsible, productive, and competent health workforce is an essential prerequisite.[13] Sadly, rural health bears the maximal brunt. The prevalence of infant mortality rate is two and a half times more, prevalence of malaria is three times more, and malnourishment among the reproductive age group females is three times more in the rural population than in the urban population.

However, illiteracy, ignorance, lack of awareness of the necessity of services provided, customs, beliefs, deep rooted faith in traditional healers and TBAs, lack of accountability of health care providers, lack of credibility of public health facilities, concern over cost of medicine, reputation of healthcare provider, and access to a healthcare provider (covering geographical, socioeconomic, and gender distances) act as hindrances in the effective service utilization by the beneficiaries.[14-16] Recall bias may also lead to inaccurate or underestimation of the care-seeking behavior, for newborns. However, as Sudman and Bradburn have found, it is likely to be minimized through a face-to-face questionnaire format, which aided memories of the respondents. Another bias is the misclassification bias, which occurs because mothers may misrepresent the actual to create a more socially-desirable impression.[17]

CONCLUSION

In the present study regarding curative healthcare-seeking behavior, 21.09% males and 30.00% females received no treatment. Factors like mass media exposure of mothers, literacy status of mothers, and gender of child were found to be significantly associated with the healthcare-seeking behavior of the mothers. A majority of the mothers opined that ignorance, lack of awareness, fixed firm cultural beliefs, male-dominated society, more concern for the well-being of the male child (he being the future torch bearer of the family), and the final word of the head of the family, compounded with the lack of account-ability of the health workers, were a few factors for their not seeking curative health care services.

These findings may have implications in future, with health planners and policy makers formulating more gender-sensitive and culturally appropriate health interventions for promotion of healthcare-seeking behavior in rural India — seeking behavior irrespective of gender differences.

Recommendations

Intense awareness generation through a mass media approach, stressing on female literacy, improving the overall socioeconomic conditions through various income generation schemes, along with counseling the local people of eminence and head of the families on the benefits of timely and appropriate healthcare-seeking behaviors, both in preventive and curative aspects, may lead to the desired health outcomes and favorable health indicators.

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