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Original Research Article

Health care seeking behavior of parents of under five in District Kanga, Himachal Pradesh

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ABSTRACT

Background: Health seeking behavior denotes the process involved in seeking a particular health state. Whereas, the healthcare seeking behavior of any individual denotes the end point contact of care. The objectives of the study were to understand the health seeking behavior and health care seeking behavior of parents of children, 0-5 yrs of age in Himachal Pradesh.
Methods: A community based cross- sectional study on 2400 children of age less then and equal to 59 months was conducted. Morbidity profile and socio demographic indicators along with other variables were defined as indicators of health and health care seeking behaviour. The study was conducted using 30 cluster techniques with 80 participants from each cluster of district Kangra.
Results: Water and sanitation was taken as one of the indicators of health seeking behavior and majority of our study population was dependent on 'bavdi' as water source. Earthen and steel pots were the most sought after storage vessel. In slums however plastic buckets were used. More than 80% of the households did nothing for purification. Majority responded that (82.6%) their child took bath daily. Institutional delivery was prevalent among 81.2% cases and lowest among rural slum. Nutrition was also taken as an indicator. Exclusive breast feeding was prevalent in 51.1% cases. In case of health care seeking behavior in our study around 47.0% parents visited the health facility, but also 24.0% were dependent on home remedies. Majority (30.5%), took treatment from secondary level of health care followed by 28.4% from private Ayurvedic doctor.
Conclusions: The system needs to understand its weaknesses as to why the population still practices unsatisfactory behavior across various areas. Especially in case of institutional deliveries, breast feeding and seeking treatment from a quack.

Keywords: Behavior, Parents, Under five children, Sickness, Health

INTRODUCTION

There is growing recognition, in both developed and developing countries, that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behavior**.** Utilization of the formal system in case of illness is also known as health care seeking behavior and the process involved in achieving a health state has been termed as health seeking behavior. Studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service.[1]

Thus there is growing acknowledgement that health care seeking behaviors and local knowledge need to be taken seriously in programme and interventions to promote health in a variety of contexts.[2,3]

Health seeking behaviors more generally are factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviors or their use of medical care and treatment.

Child health is one area of research where both the health and health care seeking behavior can be well understood as it involves the behavior of family which decides for their children. The health seeking behavior studies which are either facility or household based miss the opportunity of capturing the wider community picture, which could be all important in understanding why, when and how people use health system facilities. Where health systems are characterized by high out-of-pocket payments and a wide range of public and private health care providers, understanding the health-seeking behaviors of different communities and population groups is essential if adequate access to services and protection against unaffordable health costs are to be achieved.[4] There is literature from the country focusing on health care seeking behavior of parents but in our analysis we aimed to understand the health seeking behavior and health care seeking behavior of parents of children, 0-5 yrs of age in Himachal Pradesh.

METHODS

Study area

This study was carried out in urban, rural and slum population of district Kangra, of Himachal PradeshThe majority of population of district (94.3%) resided in rural areas. In this study, 9 towns of district Kangra heaving 68 wards, with population of 86, 281 along with its slum population were included as urban and urban slum population, while rest of the district Kangra, with a population of 14, 23,794 were taken as rural and rural slum population.

Study design

A community based cross- sectional study

Study population

The study population included children in the age group of 0 to 59 completed months of age from the selected areas.

Study period

The study was carried out for a period of one year from April 2014 through March 2015.

Sample size

Estimated population of children less than five years in district Kangra is about 1, 20,000. Taking margin of error 2%, confidence level 95% and 50% response distribution, minimum sample size was calculated to be 2354 which was round figured for continence to 2400.

The study population of 2400 was divided in a proportion of 90% and 10% between rural and urban areas respectively in accordance with the demographic distribution prevalent in Himachal Pradesh hence we recruited 2160 from rural areas and 240 from urban.

Study tool

A semi structured questionnaire with various variables was used and details from respondent were recorded.

Health seeking behaviour has been studied using following variables:

1. Water and sanitation
2. Delivery preferences
3. Breast feeding
4. Immunization practices
5. Sleep and play habit of children

Health care seeking behaviour has been studied about children who fell sick in last two weeks from the date of interview. This has been interviewed as the first point of contact in case of illness and the type of health facility approached if any present.

Following terms have been used whose operational definition is as follows:

Bavdi: It is Hindi name of water reservoir used in local dialect in the state of Himachal Pradesh. Historically this term has been used for step well however in this state the water from mountains collect in plain areas and are used for different purposes.

Quack: He/ She is a fraudulent or ignorant pretender to medical skill or a person who pretends, professionally or publicly, to have skill, knowledge, or qualifications he or she does not possess.

Witch craft: The religious practices involving ritual, spells, and nature worship, usually within a pagan tradition.

Primary level health care: involves primary health centers, sub centers, dispensaries and *anganwadi* centers from where treatment is sought.

Secondary level health care: It comprises community health centers, sub-district hospitals district and zonal hospitals.

Tertiary level heath care: It comprises public sector apex referral institute generally a medical college and hospital.

Ethical justification

The ethical approval for the initiation of the study was sought by Institutional Ethics Committee of Dr. Rajendra Prasad Government Medical College, Kangra at Tanda (H.P.).

Sampling technique

For this study 30 Cluster sampling technique, by World Health Organization for immunization surveillance was used. The study participants from rural areas (2400) were distributed among 30 clusters, which come out to 80 participants per cluster. District Kangra's population is catered by 440 Health Sub Centres and each sub centre was considered as cluster or primary sampling unit and children from 0 to 59 months of age was secondary sampling unit.

440 Health sub centres were divided into 331 rural and 9 urban Health centres. Rural and urban Health Centres were arranged alphabetically and a numerical number was allocated to each health sub centre of rural and urban area. Among these heath sub centres 27 serving rural population and three serving urban were selected randomly by using online software for randomization. The Chief Medical officer of District Kangra was briefed about the study and prior permission was sought. The respective Block Medical Officers of the blocks in which the sub centres were located were informed and due permission was sought to carry out the study.

The clusters were mapped and first cluster was picked up randomly by using the lottery method. To mark the starting point of the survey an empty bottle was twisted in the courtyard of Health Sub centre. First house in the direction pointed by the bottle was marked as first starting point of that cluster and the subsequent adjacent houses were visited till the required sample size of 80 participants was completed in that cluster. Respondent (mother or care taker of child) was explained about the purpose of study and an informed consent from either parents or legal guardian any adult of household of age more than 18 years of age was sought. If any child was found absent at the time of first visit, that house was visited twice again. During third visit if child is found absent, he or she was excluded from the study and next eligible study participant from other household in the same cluster was included in the study to complete the sample size of 80 in that cluster. Similar procedure was adopted in the remaining 29 clusters. The questions were asked by the interviewer in the language spoken by the natives.

Statistical analysis

Data collected on the variables, entered on Microsoft excel sheets and summarized in form of proportions.

RESULTS

Health seeking behavior

The health seeking behavior was determined by various parameters depicted in Table 1. Residence wise distribution shows that majority of the households of children of the study used *baudi* (water reservoir) as source of drinking water. Well was also used by 29.9% of rural population and 21.3% urban. Water filter was used by 24% of urban and 12.3% of rural population for storage of drinking water. Majority of rural population (37.4%) used earthen pot with cover for storage of water. Slum population in majority used plastic buckets with cover. All the households in slum and majority in rural (85.4%) and urban (71.0%) areas did nothing actively for purification of water. All the respondents washed their hand before feeding the child. Majority responded that (82.6%) their child took bath daily. However this proportion reduced in urban (10.5%) and rural slums (58.8%). Almost equal proportion of respondents said that they fed their child on demand and on fixed interval. Exclusive breast feeding was prevalent in 51.1% cases. This was highest among urban residents (62.9%) and lowest among rural slum (35.3%). Institutional delivery was prevalent among 81.2% cases and lowest (44.1%) among rural slum. Adequate sleep and play was present in more than 90% of children. All children were vaccinated till date and their parents took them for regular health check up.

Health care seeking behavior

Type of health systems in which study participants had faith

The health facility selection for treatment of their children who were sick in last two weeks has been shown in Table 3. Around 47.0% parents visited the health facility, but also 24.0% were dependent on home remedies. Around 16% did nothing during sickness period. Out of 962 respondents 8.3% used allopathic medicines which were already present in their home without consultation with doctor. It was observed that in rural slum majority (81.2%) of the patients gave home remedies only. Among the urban study participants, majority (50.7%) of parents took the treatment from health facility.

Type of health facility service

Out of 603 participants who took treatment from any health facility, majority (30.5%), took treatment from secondary level of health care (community health centers and government civil hospital) followed by 28.4% from private Ayurvedic doctor. A good proportion of 13.1% visited Quacks. Same trend was observed among rural respondents. Study participants from urban areas preferred taking treatment from secondary level health centers (56.9%). In the urban slum all took treatment from private Ayurvedic practitioner.

Table 1: Environmental, social and nutritional characteristics determining health seeking behavior of parents' of children under the age of five years.

Characteristics		Residence				Total
		Rural	Urban	Rural slum	Urban slum	
Source of drinking water	Baudi	1235	143	16	17	1411
		58.1%	64.7%	47.1%	89.5%	58.8%
	Well	636	47	15	2	700
		29.9%	21.3%	44.1%	10.5%	29.2%
	Hand pump	30	23	0	0	53
		1.4%	10.4%	0.0%	0.0%	2.2%
	Tap water	225	8	3	0	236
		10.6%	3.6%	8.8%	0.0%	9.8%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Storage of drinking water	No storage	36	6	0	0	42
		1.7%	2.7%	0.0%	0.0%	1.8%
	Steel bucket with cover	78	22	2	1	103
		3.7%	10.0%	5.9%	5.3%	4.3%
	Plastic bucket with cover	346	29	28	18	421
		16.3%	13.1%	82.4%	94.7%	17.5%
	Earthen pot with cover	795	54	1	0	850
		37.4%	24.4%	2.9%	0.0%	35.4%
	Metal pot with cover	610	57	3	0	670
		28.7%	25.8%	8.8%	0.0%	27.9%
	Water filter	261	53	0	0	314
		12.3%	24.0%	0.0%	0.0%	13.1%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Hand washing	Before feeding the child	2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Purification measures of drinking water	Do nothing	1816	157	34	19	2026
		85.4%	71.0%	100.0%	100.0%	84.4%
	Boil	22	2	0	0	24
		1.0%	.9%	0.0%	0.0%	1.0%
	Manual water filter	242	45	0	0	287
		11.4%	20.4%	0.0%	0.0%	12.0%
	Electronic water filter	19	8	0	0	27
		.9%	3.6%	0.0%	0.0%	1.1%
	Let it stand and settle	27	9	0	0	36
		1.3%	4.1%	0.0%	0.0%	1.6%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Daily bathing of child	Yes	1769	191	20	2	1982
		83.2%	86.4%	58.8%	10.5%	82.6%
	No	357	30	14	17	418
		16.8%	13.6%	41.2%	89.5%	17.4%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%

Characteristics		Residence				Total
		Rural	Urban	Rural slum	Urban slum	
Child delivered at	Institution	1728	196	15	10	1949
		81.3%	88.7%	44.1%	52.6%	81.2%
	Home	398	25	19	9	451
		18.7%	11.3%	55.9%	47.4%	18.8%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Exclusive breast feeding	Yes	1069	139	12	7	1227
		50.3%	62.9%	35.3%	36.8%	51.1%
	No	1057	82	22	12	1173
		49.7%	37.1%	64.7%	63.2%	48.9%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Feeding frequency	At fixed intervals	1059	90	21	4	1174
		49.8%	40.7%	61.8%	21.1%	48.9%
	On demand	1067	131	13	15	1226
		50.2%	59.3%	38.2%	78.9%	51.1%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Sleep	Adequate	2085	219	34	18	2356
		98.1%	99.1%	100.0%	94.7%	98.2%
	Not adequate	41	2	0	1	44
		1.9%	.9%	0.0%	5.3%	1.8%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Play/interact with child	Yes	2112	221	34	19	2386
		99.3%	100.0%	100.0%	100.0%	99.4%
	No	14	0	0	0	14
		.7%	0.0%	0.0%	0.0%	.6%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Regular health check up	Yes	2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%
Vaccinated till date	Yes	2125	220	34	18	2397
		100.0%	99.5%	100.0%	94.7%	99.9%
	No	1	1	0	1	3
		.0%	.5%	0.0%	5.3%	.1%
Total		2126	221	34	19	2400
		100.0%	100.0%	100.0%	100.0%	100.0%

Table 2: First point of care given to children in case of illness among those who fell ill in last two weeks.

	Did nothing	Only home remedies	Gave allopathic medicines at home without consultation	Allopathic medicines and home remedies without consultation	Took child to health facility	Took child to health facility and also gave home remedies	Other than allopathic medicine	Witch Craft	Total
Total	149 (15.5)	231 (24.0)	80 (8.3)	4 (0.4)	453 (47.1)	40 (4.2)	3 (0.3)	2 (0.2)	962 (100)
Rural	133 (15.32)	211 (24.31)	70 (8.06)	3 (0.35)	411 (47.35)	36 (4.15)	3 (0.35)	0	867 (100)
Rural slum	1 (6.25)	13 (81.25)	0	0	2 (12.5)	0	0	0	16 (100)
Urban	12 (16.91)	13 (18.31)	9 (12.68)	0	36 (50.70)	0	0	1 (1.41)	71 (100)
Urban slum	3 (37.5)	0	1 (12.5)	0	4 (50)	0	0	0	8 (100)

Table 3: Distribution of sick participants according to type of health facility service taken during sickness period.

Type of health facility	N (%)	Rural	Rural slum	Urban	Urban slum
Allopathic (public sector)					
Tertiary level care	3 (0.5)	2 (0.4)	0	1 (1.9)	0
Secondary level care	184 (30.5)	154 (28.4)	0	29 (56.9)	0
Primary level care	78 (12.9)	76 (14.0)	1 (50)	0	0
Allopathic (private sector)					
General physician	12 (2.0)	11 (2.0)	0	1 (1.9)	0
Specialist	31 (5.1)	30 (5.5)	0	3 (5.9)	0
Ayurveda (public sector)	12 (2.0)	11 (2.0)	0	1 (1.9)	0
Ayurveda (private sector)	171 (28.4)	164 (30.2)	0	5 (9.8)	4 (100)
Homeopathic (private sector)	3 (0.5)	3 (0.6)	0	0	0
Quack	79 (13.1)	70 (12.9)	0	5 (9.8)	0
Chemist shop	30 (5.0)	23 (4.2)	1 (50)	6 (11.8)	0
Total	603 (100)	544 (100)	2 (100)	51 (100)	4 (100)

DISCUSSION

The boundaries of health services are broad and include all activities whose primary purpose is to improve or maintain health. It includes multi-sectoral interventions which include health care services as one of the domains.[5] Hence in the current analysis health seeking behavior included all the modifiable determinants of health which promote, maintain or restore health. Health care seeking behavior on other end is for an individual to respond to an illness episode by seeking first and foremost help from a trained allopathic doctor, in a formally recognized health care setting.

The underlying assumption is that behavior is best understood in terms of an individual's perception of their social environment. When an individual makes a decision in relation to their health, they weigh up the potential risks or benefits of a particular behavior. But they do so in a way that is mediated by their immediate practical environment, their social rootedness and their whole outlook on life more generally. Individual healthcare-seeking pattern in a community is determined by complex interrelationships between socio-economic and physical environment along with individual characteristics and behaviors.[6]

Health seeking behavior

Poor water, sanitation and hygiene conditions are the primary routes of exposure and infection. Hence water source, storage and purification determine ones health and illness. Majority of our study population was dependent on 'baudi' as water source as majority of the state of Himachal Pradesh has hilly terrain. Earthen and steel pots were the most sought after storage vessel. In slums however plastic buckets were used. More than 80% of the households did nothing for purification.

Majority responded that (82.6%) their child took bath daily. However this proportion reduced in urban and rural slums. Probably due to shortage of water in slums and majority of population from slums in our study belonged to lower or lower middle socio economic status. This is an important predictor of behavior in terms of sanitation and hygiene. Exclusive breast feeding was prevalent in 51.1% cases. This was highest among urban residents and lowest among rural slum. The prevalence was lower than that reported by National family and health survey, Himachal Pradesh 2015-16 (67.2%) and higher than reported by another study from same region.[7,8] Exclusive breast feeding also acts as a primary prevention intervention against morbidity and mortality related to three major conditions i.e. neonatal infections, diarrhea and pneumonia. Breast feeding is regarded as a good health practice maintaining positive health of mother and child both. Institutional delivery was prevalent among 81.2% cases and lowest among rural slum. This was comparable to that reported by NFHS- 4.[8] Adequate sleep and play was reported by more than 90% of respondents. All children were vaccinated till date and their parents took them for regular health check up. Evidence suggests that adequate sleep is associated with growth, maturation, and health during growing years of child.[9]

In terms of some parameters the health seeking behavior of attendants of our study participants is quite satisfactory. However sanitation and hygiene still remains a major area of concern.

Health care seeking behavior

In our study around 47.0% parents visited the health facility, but also 24.0% were dependent on home remedies. Around 16% did nothing during sickness period. Results of cross-national surveys of a number of developing countries all over the world have revealed that

the prevalence of visits to medical facilities is highest among children aged 6-23 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.[10] According to Khalid et al, out of 217 children who had diarrhea, fever, ARI and other illnesses two weeks preceding the survey, higher proportion (87.6%) were taken to health facilities or health care provider. No care was sought for 12.4% children. The private sector was preferred source of care for illnesses followed by unqualified practitioner. Only 26.8 percent went to government health facility where as in our study overall government health facilities were the most preferred health institutions for treatment.[11] More than half of the ailments were treated by non-qualified practitioners in a rural setting of West Bengal. Only about 13% visited qualified physicians from Govt. sector.[12] The scenario was similar in other parts of India, Vietnam and Bangladesh. Easy availability, less fees and better responsiveness were probably in favor of visiting non-qualified practitioners.[13-15] Multiple studies from Nepal reported that 26% of people visited traditional healers exclusively while only 19% first visited formal health care institutions, medical shops without consultation were common source of medicines, and around half of episodes of childhood illnesses were treated by pharmacists.[16-18] In a study by Gera et al, from on women of Uttarakhand all respondents went for traditional/home remedies/other remedy initially and only 6.5% opted allopathic medicine as the first choice.[19] In a survey on females of tribal area of Gujarat more than half approached public sector and 14.3% to private sector in case of illnesses of their children.[20] In rural West Bengal private sector was the first choice in seeking health care in 32% childhood illnesses and 11.4% believed in homeopathic medicine.[21] Our study reported majority of treatment seeking from secondary level of health care (community health centers and government civil hospital) followed by private Ayurvedic Doctor. A good proportion also visited Quacks.

Despite the ongoing evidence that people do choose traditional and folk medicine or providers in a variety of contexts which have potentially profound impacts on health, few studies recommend ways to build bridges to enable individual preferences to be incorporated into a more responsive health care system.[22]

Rahman demonstrates that a woman's decision to attend a particular health care facility is the composite result of personal need, social forces, the actions of health care providers, the location of services, the unofficial practices of doctors, and in some contexts has very little to do with physical facilities at a particular service point. The complexity of such findings is rarely traced in detail, and is usually disaggregated, losing all sense of the actual reality.[23] Thus what seems to be missing in much of the literature around health seeking behaviour is a sense of how that process of 'seeking' extends over time, space and the health system in complex ways, and cannot be picked out as something intrinsic to the individual and their social, economic or cultural circumstances alone.

Health seeking behavior of our study participants in terms of water and sanitation was satisfactory however poor among slum population. Similarly in terms of institutional delivery the behavior is improving. Nutrition of children in terms of EBF shows that still a low proportion practice the behaviour. Immunization was very much satisfactory among children. In case of healthcare seeking behavior the population in majority visited public sector but first point of contact in rural and slum areas was Ayurvedic practitioner or quack. This denotes that there is still a lack of faith in public sector among the population.

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