International Journal of Medical Research Professionals
P-ISSN: 2454-6356; E-ISSN: 2454-6364
DOI: 10.21276/ijmrp

Original Research Article.

Care Seeking Patterns for Under Five Children in Urban Slum Udaipur: A Prospective Study

Nilesh Gothi[1], Gorav Kumar[2*], Aditi Gothi[3]

[1]Senior Specialist (MD, Pediatrics), Haridev Joshi Hospital, Dungarpur, Rajasthan, India.
[2*]Medical Officer (MD, Pediatrics), Haridev Joshi Hospital, Dungarpur, Rajasthan, India.
[3]Senior Demonstrator, Department of PSM, Medical College, Dungarpur, Rajasthan, India.

ABSTRACT

Background: Children of this group (pre-school) are not only vulnerable to death, but also to malnutrition, since they are largely dependent of caretakers for appropriate nutrition. This study is therefore being conducted to investigate care seeking patterns for sick young children in urban slums in Udaipur.

Material & Methods: A Study was carried out in urban slums of Udaipur city. There were 32 slums clusters in the city. Each slum was visited. Families encountered with under five year children that had an illness episode in the last one month were interviewed. Subsequently six more similar families were selected by moving in a zig-zag manner, leading to total of six families per cluster (a total of 34X6=204). All the families were interviewed using a pretested questionnaire.

Results: In our study showed that the 80% of the families had a family income less than 300 per capita per month, and 16% of mother had not received any formal education. In general, a provider was consulted more promptly for males than for females. Poorer families delay seeking care as compared to richer families, the difference was statistical significant.

Conclusion: Hence imparting the recommendation in the health care package for the urban slums would help in improving the health status of the poor urban slum and would be enable us to decrease the morbidity & mortality in these children, which would subsequently help in our goal of health for all.

Keywords: Slums, Socioeconomic Status, Health Care System, Danger Sign.

***Correspondence to:**

Dr. Gorav Kumar,
Medical Officer (MD, Pediatrics),
Haridev Joshi Hospital, Dungarpur, Rajasthan, India.

Article History:

Received: 05-12-2017, **Revised:** 04-01-2018, **Accepted:** 28-01-2018

Access this article online	
Website: www.ijmrp.com	Quick Response code
DOI: 10.21276/ijmrp.2018.4.1.114	

INTRODUCTION

Under five year children represent 15% of general population In India. Children in this age group are especially vulnerable to disease and death, particularly those living rural areas and urban slums. Under five mortality in India is as high as 90/1000 births and contributes to 35% death of all ages.[1]

Children of this group (pre-school) are not only vulnerable to death, but also to malnutrition, since they are largely dependent of caretakers for appropriate nutrition.

Large numbers of preschool (0-6 years) children continue to suffer from infections, severe malnutrition and resultant death, despite the availability of effective interventions to prevent or treat these conditions. Over the past decade, infant and child mortality has stagnated in several states of country, and as per the National Family Health Surveys (NFHS-I & II) it has actually increased in Rajasthan.[2] In the last few decades, significant decreases in child mortality have occurred following general improvement in primary health care. Such decrease has been mainly the result of improvement in antenatal care and vaccination coverage and better management of childhood illness.[2]

Various studies have suggested that care seeking for sick young children is often inappropriate in rural areas. It has been estimated that mortality due to ARI can be decreased by almost 20% if the families seek timely advised and appropriate care. There is however limited information on care-seeking patterns of seeks children among urban slums. In urban slums, where health facilities are likely to available close by, care-seeking may be more appropriate than that in rural areas.[3]

This study is therefore being conducted to investigate care seeking patterns for sick young children in urban slums in Udaipur.

MATERIALS & METHODS

A Study was carried out in urban slums of Udaipur city. There were 32 slums clusters in the city. Each slum was visited. Families encountered with under five year children that had an illness episode in the last one month were interviewed. Subsequently six more similar families were selected by moving in a zig-zag manner, leading to total of six families per cluster (a total of

34X6=204). All the families were interviewed using a pretested questionnaire. From each cluster, we interviewed six families leading to a total of 204 families. Four forms were rejected due to incomplete information. The results were based on analysis of the remaining 200 families and all observation was recorded in a printed protocol and after compiling the datas the analysis was done.

RESULTS

In our study showed that the 80% of the families had a family income less than 300 per capita per month, and 16% of mother had not received any formal education (table 1). Integrated management of childhood illness program, the 27.5% of children had one or other these symptoms.

Even in illness episodes where danger signs were present, 25.5% of families consulted an untrained provider. However, mostly of them consulted a qualified practitioner, as compared to for those illnesses that did not have a danger sign (table 3).

In general, a provider was consulted more promptly for males than for females (table 4). Poorer families delay seeking care as compared to richer families, the difference was statistical significant (table 5).

Table 1: Background profile (N=200)

Age in month		Subjects (N=200)	Percentage
	0-11	62	31%
	12-23	27	13.5%
	24-35	19	9.5%
	36-48	66	33%
	48-60	26	13%
Sex	Male	100	50%
	Female	100	50%
Maternal Education	Nil	32	16%
	Primary	70	35%
	Above primary	98	49%
Income level (in Rs)	<100	82	41%
Per capita per month	100-299	77	38.5%
(Prasad Classification)	300-999	41	20.5%

Table 2: Occurrence of danger signs among reported illness episodes

Sign	Number (N=200)	Percentage
Increased respiratory rate	22	11%
Blood in stool	12	6%
Convulsion	5	2.5%
Severe vomiting	8	4%
High grade Fever	8	4%
Total	55	27.5%

Table 3: Type of provider consulted, by presence or absence of danger sign

Provider	Danger sign present (N=43)	Danger sign not present (N=157)
Quack	11 (25.5%)	99 (63%)
Physician	28 (65%)	21 (13.37%)
Others	4 (9.5%)	41 (26.11%)

Table 4: Delay in seeking care, by gender

Type of illness	No. of days between recognition and consulting first provider	
	Females	Males
Diarrhoea	2.21±0.96	0.92±1.09
Fever	0.94±1.09	1.00±0.82
Other	2.231±0.63	1.72±0.66
Pneumonia	1.14±1.46	1.00±0.55
All	1.91±1.09	1.22±0.95**

P<0.001**

Table 5: Delay in seeking care, by socioeconomic status

Type of illness	No. of days between recognition and consulting first provider		
	<100	100-299	300-999
Diarrhoea	2.12±1.06	0.89±1.12	0.80±0.77
Fever	1.50±0.71	1.33±1.12	0.50±0.71
Other	2.28±0.46	1.83±0.51	1.17±0.72
Pneumonia	1.00±0.00	1.00±1.00	1.33±0.58
All	2.14±0.92	1.21±1.04**	0.88±0.76**

P<0.001**

DISCUSSION

All area was situated at peripheral end of Udaipur city and was chosen so as to eliminate any bias for personal selection. Being slum area the areas were with poor civil amenities. There were no sanitary methods, no disposal of excreta, no portable water supply and poor housing condition.

A total 200 families were examined in 0-5 years of age group and male to female ratio was 1:1 in our study. 80% of the families had a family income less than 300 per capita per month, and 16% of mother had not received any formal education.

Leading cause of morbidity among children were diarrhea (39%) and respiratory illness (36%). This is accordance with Udani RH et al[4] observed that highest incidence of children morbidity was due to diarrhea and respiratory tract illness.

Several studies have shown that delay in care seeking or no care seeking contributes significantly to high level of child mortality in developing countries. In a study done in Indonesia, 22% children who later died never sought care (Sutrisna et al 1993).[5]

Our observation clearly indicate that 49% took care from non-qualified and remaining consulted qualified doctors. Reason for preference to non-qualified doctor in present study being nearby (19%) and cost (31%). Seeking care from unqualified practitioners to almost 50% economic than seeking care from qualified practitioners. Our findings supported by previous workers.

Patel et al (1971)[6] reported that only 2.2% of all sick children in the community had sought care from the PHC. Gupta & Walia (1977)[7] also showed that only 6.5% of rural children were taken to Government health facility when they fell ill.

We know that people living in urban slums mostly belong to poor socioeconomic class and they do not have proper conveyance and being economically poor they cannot effort private conveyance to approach government provider who are available at long distance.

While the girls unqualified providers (61%) are consulted more often and in case of boys only 41%. Dandekar et al[8] observed in their study percentage of male getting medical treatment was much higher than percentage of females. Our data are in conformity with other studies that females are more often neglected during their illness as compared to male children. Since ancient time males have been given preference in every aspect of life including health care. This concept is still persisting in slums, hence the preference for the male in comparison to female, for seeking medical advice can be explained.

The high morbidity in the poor socioeconomic status could be explained on the basis of lack of knowledge and their limited resources for improvement of child health. On the top of it malnutrition and inadequate immunization could be precipitating factor for increased morbidity.

CONCLUSION

Hence imparting the recommendation in the health care package for the urban slums would help in improving the health status of the poor urban slum and would be enable us to decrease the morbidity & mortality in these children, which would subsequently help in our goal of health for all.

REFERENCES

1. Chandra R & Bagga L et al. Utilization of services of community health workers by the rural population. Indian J Med Res. June 1980;71:975-84.

2. Chandra S. Health manpower development in an Indian state. Regional health forum 1997;2:35-40.

3. Kakar DN, Murthy KS, People's perception of illness and their use of medical services in Punjab. Indian J Med Educ. 1972;11:286-98.

4. Udani RH, Patel RB, Tapaswai AM, Rathi VT, Mahkarkar PK, Shah PM. Morbidity and nutritional status of pre-school in Bombay slums. Pediatr Clin India 1982. p. 22-6.

5. Sutrisna B., Reingold A., Care seeking for fatal illness in young children in indramayu, west Jawa, Indonesia. Lancet 1993;342:727-729.

6. RB Patel. Care of low birth weight babies in slums. The Indian Journal of Pediatrics. March 1989; Volume 56, Issue 2: pp 231–237.

7. Gupta KB & Walia BNS; Utilization of health facilities by rural children. Indian Paediatric 1981;18:217-21.

8. Dandekar VM. Poverty in India. Pune: Indian School of Political Economy; 1971. vii, 159 p. p.

Source of Support: Nil.

Conflict of Interest: None Declared.

Cite this article as: Nilesh Gothi, Gorav Kumar, Aditi Gothi. Care Seeking Patterns for Under Five Children in Urban Slum Udaipur: A Prospective Study. Int J Med Res Prof. 2018 Jan; 4(1):539-41. DOI:10.21276/ijmrp.2018.4.1.114