

# Knowledge, attitude and practices of parents regarding child health in field practice area of rural health training centre of govt. Medical college, aurangabad, maharashtra, india

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## Abstract

**Background:** Father and mother as they are regarded as the primary care providers. Father has important role in child health such as companion, care provider, protector moral guide, teacher, bread earner. Ultimately, the family will be responsible for shaping a child and developing their values, skills, socialization, and security. However, there is emerging evidence on the positive outcomes for child nutrition and development of expanding father's involvement beyond their traditional roles. Thus, this study explored the knowledge, attitude, and practices of father's and mother's involvement in child care.

**Methods:** A cross-sectional, community based study was carried out among 400 under five children in field practice area of rural health training center of Dept. of Community Medicine of Govt. Medical College, Aurangabad, Maharashtra, India during the period of Jan. 2017 to Dec. 2018. Data was entered in MS Excel 2007 worksheet and analyzed using open Epi version 3.01.

**Results:** Majority 133(66.50%) of father in urban area think that the father role is important in child health care. 47(23.50%) of father of under five children residing in rural area think that the child health care is the responsibility of mother only. However 40(20%) of father in rural area think that the father role is also important in child health care. Father primarily see themselves as providers, not caretakers, a perception widely held by the larger community as well.

**Conclusion:** Quite significant proportion of fathers had knowledge about child health and practices of taking care of child was found but proportionately higher percentage of knowledge and practices were found in females.

**Keyword:** knowledge, attitude, practices, parents, child health

## Introduction

Parents, not doctors are the primary gatekeepers of their children's health. Parents make choices about the amount & quality of health care their children receive, the food they eat, the amount of physical activity they engage in, the amount of emotional support they are provided and the quality of their environments both before and after birth. These choices are conditioned by parents' material resources, parents' knowledge of health practices and programs, their own health and health behavior, and the characteristics of the communities in which they live. The importance of parental resources and behavior in children's health is evident in the large socioeconomic differences that exist in children's health outcomes <sup>[1]</sup>.

The first two years of life offers a unique window of opportunity for a child's physical growth and development <sup>[2]</sup>. Appropriate child care practices, such as food preparation and feeding, psychosocial stimulation, hygiene practices and care during illness are critical during that period to prevent under-nutrition and impaired development <sup>[3, 4]</sup>. Evidence from sub-Saharan African countries indicates that such activities are most often

performed by the mothers as they are regarded as the primary care providers<sup>[5]</sup>. Similarly father also has important role in child health Such as companion, care provider, protector moral guide, teacher, bread earner. Ultimately, the family will be responsible for shaping a child and developing their values, skills, socialization, and security<sup>[3]</sup>.

However, there is emerging evidence on the positive outcomes for child nutrition and development of expanding fathers' involvement beyond their traditional roles. Thus, this present study explored the knowledge, attitude and practices of father's and mother's involvement in child health care in field practice area of Rural Health Training Centre of Govt. Medical College, Aurangabad, Maharashtra, India.

## Materials and Methods

**Study design:** It was community based, cross-sectional study.

**Study area:** Field practice area of Rural Health Training Centre (RHTC) of Dept. of Community Medicine of Govt. Medical College, Aurangabad, Maharashtra, India.

**Study period:** From Jan. 2017 to Dec. 2018 (Two years).

**Study population:** Children aged between 6 weeks to 5 years residing in the field practice area of Rural Health Training Centre (RHTC) of Govt. Medical College, Aurangabad, Maharashtra.

**Ethical consideration:** Approval was taken from the Institutional Ethics Committee (IEC).

**Inclusion criteria:** Father and Mother of children of age between 6 weeks to 5 years.

**Sample size:** Pilot study was conducted among 30 participants residing in field practice area of RHTC and to get maximum possible sample size, assuming 50% proportion of children having various morbidity and with 5% relative precision and 95% confidence interval, by applying the formula  $(4pq/L^2)$ , So the sample size 384 which was rounded up to 400 for the study.

**Study tool:** All the participants were selected by simple random sampling method with multi-stage sampling technique. After reaching the chosen area, a landmark was identified, then by rotating the bottle, the side which was pointed by mouth of the bottle was selected as a first household and presence of an eligible study participant was ascertained and then each consecutive house was visited in that area. After reaching the household, family members were informed about the purpose of the study and enquired about eligible study participants in the family. A pre-designed, pre-tested questionnaire including data regarding demographic information and parents (mother and father) of under five children were also interviewed regarding knowledge, attitude and practices (KAP) about their role in child health. Parents know much about their child that's why only parents KAP taken into consideration and not the grandfather, grandmother, other members in the family. In case family having more than one under five children, then one child per family was selected by simple random sampling method.

**Statistical analysis:** The data of respondents was collected, compiled and entered in MS Excel 2007 worksheet. It was analyzed using open Epi version 3.01. Percentages were calculated and graphical presentation was used wherever necessary by using Microsoft Office Excel 2007 software.

## Results

### Socio-demographic profile

In our study maximum number of study subjects were of Hindu religion 251(62.75%), followed by Muslim 80(20%) and 69(17.25%) were Buddhist. Educational status of fathers of under five years children depicted maximum i.e. 183(45.75%) completed their middle school education followed by high school education 108(27%), graduate 62(15.50%) and 12(3%) were illiterate. Educational status of mothers of under five years children was observed, Maximum i.e. 227(56.75%) completed their middle school followed by primary school education 67(16.75%). High school education 64(16%), graduate 22(5.50%) and 13(3.25%) were illiterate. Maximum number of fathers occupation were shop owner 160(40.00%), semiskilled worker 128(32.00%), unskilled 83(20.75%), semi profession 13(3.25%). Only 1(0.25%) was unemployed. Maximum number of mothers were unemployed (homemaker) 258(64.50%), unskilled 48(12.00%), Semi-skilled profession 07(1.75%). Socio-economic status shows that maximum number of families were from middle class i.e. 174(43.50%), followed by lower middle class 110(27.50%), lower class 57(14.25%), upper middle class 42(10.50%), 17(4.25%) were from upper class .In urban area maximum number of family belong to middle class 56%, followed by upper middle class 34(17%).Upper class family were 6% only. Lower middle class and lower class family were 23(11.50%) and 19(9.50%) respectively. In rural area maximum number of family belong to lower middle class 87 (43.50%) followed middle class 62(31%). Upper class family were 2.50% and upper middle class were 8(4%) only. Lower class family were 38(19%).

**Table 1:** Father's response to the questions on knowledge, attitude and practices about children health (n=400)

Questions on knowledge, attitude and practices about children health	Response Given		Total
	Urban area (n=200)	Rural area (n=200)	

<b>Questions about knowledge</b>		<b>Yes</b>	<b>No</b>	<b>Neutral</b>	
1	Know nearest Government health facility	199 (99.50)	197 (98.50)	-	396 (99.00)
2	Know Immunization schedule for child	10 (05.00)	03 (01.50)	-	13 (03.25)
3	Insurance schemes for schemes	01 (00.50)	00 (00.00)	-	01 (00.50)
<b>Questions about attitude</b>		<b>Yes</b>	<b>No</b>	<b>Neutral</b>	
1	Child health care is responsibility of mother only	47 (23.50)	139 (69.50)	14 (07.00)	200 (100)
2	Father role is also important in child health care	133 (66.50)	65 (32.50)	02 (01.00)	200 (100)
3	Habit of smoking, drinking, tobacco chewing has bad impact on child life	174 (87.00)	22 (11.00)	04 (02.00)	200 (100)
<b>Questions about practices</b>		<b>Yes</b>	<b>No</b>	<b>Neutral</b>	
1	Have addiction of Smoking/Drinking	23 (11.50)	57 (28.50)	-	70 (17.50)
2	Play with child	107 (26.75)	23 (05.75)	-	130 (32.50)
3	Teaches child at home	40 (10.00)	13 (03.25)	-	53 (13.25)
4	Insured child	01 (00.25)	00 (00.00)	-	01 (00.25)

It was seen from Table 1 that 99% of fathers of under five year children know the nearest government health facility. However only 0.50% knows about the various insurance schemes for children. 47 (23.50%) of fathers of under five children residing in urban area think that the child health care is the responsibility of mother only. However 133(66.50%) of fathers in urban area think that the father role is important in child health care. 174(77.00%) fathers in urban area think that habit of smoking, drinking, tobacco chewing has bad impact on child life, however 22 doesn't agree with this. 47(23.50%) of fathers of under five children residing in rural area think that the child health care is the responsibility of mother only. However

40(20%) of fathers in rural area think that the father role is also important in child health care. 134(67.00%) fathers in rural area think that habit of smoking, drinking, tobacco chewing has bad impact on child life, however 61(30.50%) doesn't agree with this.

**Table 2:** Mother's response to the questions on knowledge, attitude and practices about children health (n=400)

<b>Questions on knowledge, attitude and practices about children health</b>		<b>Response Given</b>			<b>Total</b>
		<b>Urban area (n=200)</b>	<b>Rural area (n=200)</b>		
<b>Questions about knowledge</b>		<b>Yes</b>	<b>No</b>	<b>Neutral</b>	
1	Exclusive breast feeding should be given for many months?	139 (69.50)	98 (49.00)	-	237 (59.25)
2	At what age weaning should be started?	83 (41.50)	53 (26.50)	-	136 (34.00)
3	Do you know the place in your area where immunization takes place?	197 (98.50)	198 (99.00)	-	395 (98.75)
4	Do you know the immunization schedule for your child?	11 (06.50)	03 (01.50)	-	14 (03.50)
5	Do you know how to prepare homemade ORS?	19 (09.50)	09 (04.50)	-	28 (07.00)
6	Do you know nearest government hospital	197 (98.50)	196 (98.00)	-	393 (100)
<b>Questions about attitude</b>		<b>Yes</b>	<b>No</b>	<b>Neutral</b>	
1	For first 6 months of child life only mother milk should be given	109 (54.50)	82 (41.00)	09 (04.50)	200 (100)
2	All vaccine as per national immunization schedule should be given on proper date	177 (88.50)	13 (06.50)	10 (05.00)	200 (100)
3	It is necessary to wash your and before cooking and feeding to children	200 (100)	00 (00.00)	00 (00.00)	200 (100)
4	It is necessary to wash the hand of child before feeding	191 (95.50)	02 (01.00)	00 (00.00)	200 (100)
<b>Questions about practices</b>		<b>Yes</b>	<b>No</b>	<b>Neutral</b>	
1	Exclusive breastfeeding given up to 6 months to your child after birth?	129 (69.35)	99 (54.10)	-	228 (100)
2	Started weaning after 6 months child age	121 (65.05)	97 (53.01)	-	218 (100)

3	Do you wash your hand before cooking	200 (100)	200 (100)	-	400 (100)
4	Do you wash your hand before feeding to child?	199 (99.50)	199 (99.50)	-	398 (100)
5	Do you give bath to child daily?	197 (98.50)	193 (96.50)	-	390 (100)
6	Do you give homemade ORS to your child at home when he has diarrhoea?	07 (03.50)	11 (06.50)	-	18 (100)
7	Have given the vaccines as per national immunization schedule taken on due date?	109 (54.50)	89 (44.50)	-	198 (99.00)

As Table 2 shows that 237(59.25%) mothers of under five children residing in field practice area of RHTC knows that the exclusive breastfeeding should be given for 6 months and 395(98.75%) mothers know where immunization takes place. 177(88.50%) mother of under five children in rural area think that all vaccine as per national immunization schedule should be given on proper date. 228(57.00%) mothers of under five years children residing in field practice area of UHTC have practiced exclusive breastfeeding for 6 months after child birth. 218(59.07%) mothers have started weaning after 6 months completion of child age and 198(49.50%) have given vaccines on due date as per national immunization schedule.

## Discussion

In our study, maximum study subjects were of Hindu religion 251(62.75%), followed by Muslim 80(20%) and 69(17.25%) were Buddhist. Educational status of fathers of under five years children depicted maximum i.e. 183(45.75%) completed their middle school followed by high school 108(27%), graduate 62(15.50%) and 12(3%) were illiterate. Educational status of mothers of under five years children was observed maximum i.e. 227(56.75%) completed their middle school followed by primary school 67(16.75%). High school 64(16.00%), graduate 22(5.50%) and 13(3.25%) were illiterate. Maximum fathers occupation were shop owner 160(40%), followed by semiskilled worker 128(32%), unskilled 83(20.75%), semi profession 13(3.25%). Only 1(0.25%) was unemployed. Maximum number of mothers were unemployed (homemaker), 258(64.50%), unskilled 48(12%), semi-skilled profession 7(1.75%). Distribution of socio-economic status shows that maximum number of families were from middle class i.e. 174(43.50%), followed by lower middle class 110(27.50%), lower class 57(14.25%), upper middle class 42(10.50%), 17(4.25%) were from upper class. In urban area maximum number of family belong to middle class 56%, followed by upper middle class 34(17%). Upper class family were 6% only. Lower middle class and lower class family were 23(11.50%) and 19(9.50%) respectively. Similarly in rural area maximum number of family belong to lower middle class 87(43.50%) followed middle class 62(31%). Upper class family were 2.50% and upper middle class were 8(4.0%) only and lower class family were 38(19.0%).

Similar demographic pattern was observed in a study by Mogusu HK *et al.* [6] from Ramnagar area revealed that 154(38%) of the fathers of under-five belonged to age group of 22-26 years, 128(32%) of them belonged to 27-31 years and 118(30%) belonged to 32-36 years respectively. Most of the participants 206(51.5%) were Hindus

followed by Muslims 145 (36.5%) and Christian 49(12%). Majority of the participants 246(61.5%) belonged to the joint family followed by nuclear family 154(38.5%). A large proportion of the participants 242(60.5%) were working as a labourers and more than one quarters 158(39.5%) were educated upto PUC level. According to modified B.G. Prasad Classification, majority of the participants 220(55%) belonged to class IV, followed by class III 130(32.5%) and class V 50(12.5%). None of the participants belonged to high socio-economic class.

In our study, 99% of fathers of under five year children know the nearest government health facility. Only 0.50% knows about the various insurance schemes for children and 47(23.50%) of fathers of under five children residing in urban area think that the child health care is the responsibility of mother only. However 133(66.50%) of fathers in urban area think that the father role is important in child health care. 174(77.00%) fathers in urban area think that habit of smoking, drinking, tobacco chewing has bad impact on child life, however 22 doesn't agree with this. 47(23.50%) of fathers of under five children residing in rural area think that the child health care is the responsibility of mother only. However 40(20%) of fathers in rural area think that the father role is also important in child health care. 134(67.00%) fathers in rural area think that habit of smoking, drinking, tobacco chewing has bad impact on child life, however 61(30.50%) doesn't agree with this.

Similarly a study by Mogusu HK *et al.* [6] found that majority 207(52%) of the fathers were having good knowledge on under five child care, 107(26.5%) had average knowledge and only 86(21.5%) had poor knowledge. Out of 400 participants, 322(80.5%) were having positive attitude towards child care, 78(19.5%) had average attitude and none of the fathers had poor attitude. Regarding practice 183(45.5%) of fathers had poor practices on child care, 121(30.5%) had average practices and only 96(24%) had good practices towards under five child care.

Fathers primarily see themselves as providers, not caretakers, a perception widely held by the larger community as well. Other qualitative studies in LIMCs also reported similar findings where men's responsibility was limited to providing financial support for their families [7-8]. A similar study done by Sarkadi A *et al.* [9] Revealed

that there is evidence to support the positive influence of father engagement on offspring social, behavioral and psychological outcomes. Another study conducted by Earl J *et al.*<sup>[10]</sup> on father's care revealed that fathers are less involved in the care of children than mothers. Another study by Parke RD *et al.*<sup>[11]</sup> also found that the father's attitude of caring is often circumscribed by family, child arrangements, cultural and social expectations. In this study, 237(59.25%) mothers of under five children residing in field practice area of RHTC knows that the exclusive breastfeeding should be given for 6 months and 395(98.75%) mothers know where immunization takes place. 177(88.50%) mother of under five children in rural area think that all vaccine as per national immunization schedule should be given on proper date. 228(57.00%) mothers of under five years children residing in field practice area of UHTC have practiced exclusive breastfeeding for 6 months after child birth. 218(59.07%) mothers have started weaning after 6 months completion of child age and 198(49.50%) have given vaccines on due date as per national immunization schedule.

Similar findings were observed in a study by Dinh Thac *et al.*<sup>[12]</sup> there were nearly 89% of mothers in their KAP study practicing exclusive breast feeding during the first 6 months of life. Majority 395(98.75%) mothers know where immunization takes place. Also 149(74.50%) mother of under five children agree that exclusive breast should be given for 6 months. 191(95.50%) mother of under five children in urban area think that all vaccine as per national immunization schedule should be given on proper date.

## Conclusion

The present study was carried out to study the different roles of father and mother in health in under five years children in field practice area of rural health and training centre. Quite significant proportion of fathers had knowledge about child health and practices of taking care of child was found but proportionately higher percentage of knowledge and practices were found in females. Education and socio-economic status may be factor responsible for the differences in rural areas.

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