

## **Knowledge, Attitude and Practices of Caregivers towards Disabled Children under- Five Years and It's Influence on Clinical Outcome**

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**ABSTRACT:-** Delays in seeking appropriate medical care is one of the major factors contributing to severe disease among children presenting to hospitals with severe forms of malaria, pneumonia and diarrhoea (UNDP, 2015). This study therefore explored the knowledge, attitude and practice of caregivers towards sick disabled children under- five years in a local indigenous setting of Bawku. A cross-sectional descriptive study design which was quantitative in nature was used and a convenient sampling technique was used to sample 200 caregivers seeking health care for their sick-disabled children at health facilities at the Bawku township of which they responded to questionnaires which were analyzed using the Statistical Package for Social Sciences (SPSS) version 21. A Pearson's correlation test was done to test variables with a significance of p value of  $\leq 0.05$  being considered statistically significant. There is a significant relationship between age ( $p=0.03$ ), educational status ( $p=0.001$ ), marital status ( $p=0.05$ ) as well as religious affiliation ( $p=0.003$ ) and the three variables. Findings of the study also showed that all respondents were aware that their children were sick and they have been sick for some days but thought their children's illness to be mild/moderate due to the combined symptoms that was exhibited (78%) and hence 80% did not stop their daily routine to take care of their children and sought treatment after the father made the decision. Economic factors such as low income levels, lack of transport during illness, high cost of medical care and high cost of transport whilst socio-cultural factors such as low level of education, lack of adequate health information, lack of support from partner and cultural barriers/beliefs all influenced caregivers' choice of care and practices for their sick children under five years. The study recommends that there is the need to have an effective and functioning referral system in the health care delivery system to ensure children are attended to promptly in health facilities at the onset of any illness.

**Key Words:** disability, children, caregivers

### **I. INTRODUCTION**

Despite the significant progress that has been made in reducing mortality in children under-five years of age, about 6.9 million children of under-five years died in 2011 worldwide (World Health Organisation [WHO], 2012). Children in Sub-Saharan Africa (SSA) are about 16.5 times more likely to die before the age of five years than children in developed region (WHO, 2011). About half of under-five deaths occurs only in China, Democratic Republic of the Congo, India, Nigeria and Pakistan. More than a third of all under-five deaths accounted by India (21%) and Nigeria (13%) (WHO, 2013).

The practice of appropriate health care seeking has a great potential to reduce the occurrence of severe and life-threatening childhood illnesses. However, varieties of factors have been identified as the leading causes of poor utilization of primary health care services by caregivers. Poor socio-economic status, lack of physical accessibility, attitude to modern treatment, low literacy level of the caregivers, large family size, number of symptoms, previous experience of child death, and perceived severity of illness have been the predictors of care seeking behaviour as well as lack of health insurance coverage especially among the low-economic status families (Abdulraheem, 2009; Assefa et al., 2008).

Acheampong (2013) noted that in Ghana, most caregivers are not well informed about the risk factors and prevention of childhood illnesses, its home management, good feeding practices and seeking of early medical attention. Acheampong noted that most cases that are presented for treatment at the hospitals are poorly managed at home. Hence she concluded that generally, there was a perception that most of the caregivers who lack knowledge in the causes and the associated danger signs of childhood illness as well as their management practices have low level of education.

This study therefore intends to assess the knowledge, attitude and practice of caregivers towards sick-disabled children under- five years and how these factors can be addressed to reduce childhood illness which results in disabilities, morbidity and mortality among children under five.

### **THE DISABILITY CONCEPT**

The UNICEF in 2007 estimated that, overall, between 500 and 650 million people worldwide live with a significant impairment. They further quoted that with respect to the World Health Organization (WHO), around 10% of the world's children and young people, some 200 million, have sensory, intellectual or mental health impairment. Around 80 per cent of them live in developing countries (UNICEF, 2007). Statistics such as these demonstrate that to be born with or acquire impairment is far from unusual or abnormal. The reported incidence and prevalence of impairment in the population vary significantly from one country to another. Specialists, however, agree on a working approximation giving a minimum benchmark of 2.5% of children aged 0-14 with self-evident moderate to severe levels of sensory, physical and intellectual impairments. An additional 8 can be expected to have learning or behavioural difficulties, or both. These estimates were found to be useful in the detailed analysis of statistics on incidence and prevalence of childhood disability in the UNICEF study on Children and Disability in Transition in CEE/CIS and Baltic States (UNICEF, 2005). They are based on research and data gathered over years in countries with the highest human development rankings.

### **ATTITUDES TOWARDS SICK -DISABLED CHILDREN**

It is important to note that culture plays an important role on how children and adults with disabilities are identified and served in a country.

For instance in Tanzania, they believe that the basis of life lies on the values and norms of the society, where every person regardless of the differences has dignity, equal opportunity to education and respect. A study done in Tanzania by Polat (2011) stresses that, inclusive education aims to build a society that promotes equal opportunities for all citizens to take part in and play their role in development of the nation. Based on principles of indigenous customary education and traditional African socialism, everybody was included and was assigned roles according to their abilities. Those principles and values have been emphasized in Tanzania's "Development Vision 2025 (1-3)" where the goal is to build a society that promotes the same chance for all residents to participate in and contribute to the improvement of the nation. Special attention is directed to women, children, the youth and disabled persons (Polat, 2011).

Durand (2010) also reported that in Tanzania, children with disabilities were thrown away, killed or being locked inside the house cages because of being associated with bad luck in the family. Most of the children with disabilities in Tanzania and in developing countries like Ghana are still out of school because of social and cultural reasons attached to them. Such cultural beliefs have largely affected disabled children's rights to education, social living and justice. But it was not until the transitional period when new understanding and knowledge raised concerns about persons with disabilities in the communities where humanity resulted into the attempt to serve these children (Skojorten, 2001)

### **PRACTICES OF CAREGIVERS**

In responding to their children's illness, caregivers institute presumptive treatment which may occur at all levels of the healthcare system, but is most common within the informal sector, which includes self-treatment at home or at a local drug shop (Chibwana et al., 2009). At home, caretakers typically diagnose their children based on the presence of fever, and self-treat with medicines stored in the house (Assefa et al., 2008). In local drug shops, caretakers purchase any available drug of their choice without a prescription (WHO, 2010). Presumptive treatment may also occur at local health facilities when diagnostic capabilities are not available, but there is a professional health worker present to make a more informed diagnosis (WHO, 2010).

### **PERCEPTION OF CAREGIVERS TOWARDS CHILDHOOD ILLNESS**

Cultural beliefs and attitudes especially affect how a family perceives a child's illness as well the healthcare and treatments options available to them (Ogunrinde et al., 2012). It also affects what they decide about, where and when to seek help. Many societies have their own beliefs and classification for illnesses. Diarrhoea for example, may not always be described as a single disease. Different types of diarrhoea can have local names and there may be local beliefs about symptoms, causes and treatment. Families may seek treatment for some types of childhood diarrhoea depending on how they think the illness is. When a child becomes ill, a family may seek advice from several sources and try a variety of treatments. The first is usually home medication based on local beliefs about the illness and the advice from family, friends and neighbours. Only later will they visit a traditional healer, a pharmacist or a physician (Hoan et al., 2009).

**METHODS**

This study was a quantitative research design which was descriptive in nature. This study utilised the convenient sampling technique. As such, in this study, the caregivers who were met first were sampled till the target sampling size of 200 was met and this took from August to September of 2019.

A set of questionnaire was used to collect data. The questions on the questionnaire consisted of both closed and open-ended questions.

Data analysis was carried out using the Statistical Package for Social Sciences (SPSS) software version 21. Descriptive analysis was performed and the results expressed as means and percentages. The Pearson’s test was used to test the difference between two independent groups.

**RESULTS PRESENTATION AND DISCUSSIONS**

Table 4.1 shows the demographic characteristics of the respondents, 57% were females. This supports the Ghana Statistical Report in 2014 which revealed that the within the Bawku Municipality females are more than males. Also, 8% had primary level education, 15% had middle school education whilst 12% had no formal education As a native area with indigenes, the Statistical Report indicated that the populates are less educated and this is in line with this study. Also, 49% been Muslims. Likewise, the Ghana Housing and Population Census in 2010 revealed a Muslim dominant society but with less to no education rates.

**Table 4.1: Socio-Demographic characteristics of the respondents**

Socio-Demographics	Freq (N=200)	Percent (%)
<b>Level of Education</b>		
Primary	16	8.0
JHS	30	15.0
Secondary	62	31.0
Tertiary	68	34.0
None	24	12.0
<b>Gender</b>		
Male	86	43
Female	114	57
<b>Religion</b>		
Christian	82	41.0
Muslim	98	49.0
Traditional	20	10.0

Source: Field Survey, (2019)

Recognizing and responding to childhood illness should be evaluated and treated by a trained health care provider is very important to averting death (WHO, 2013). Likewise in this study, all respondents were aware that their children were sick and they have been sick for some days. Caregivers according to the World Health Organisation should recognize when children displays signs of severe disease. Similarly, the first sign they noticed was fever (32%) whilst 65% noticed other signs such as not feeding well (92.3%), weakness (92.3%), shivering (92.3%) cough

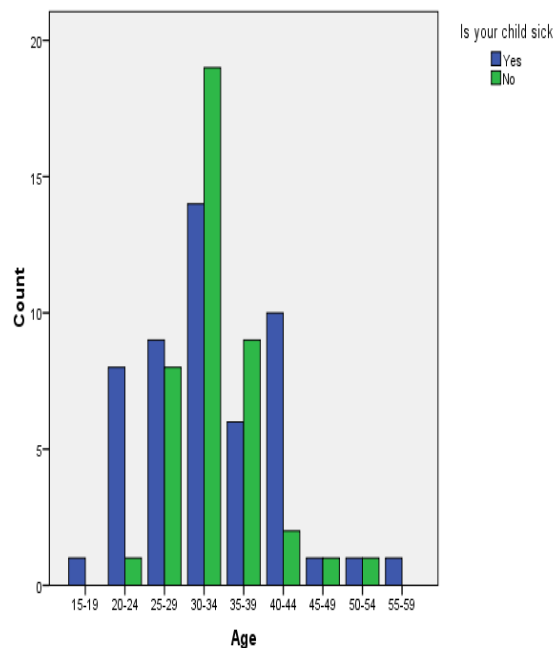
**Table 4.2 Respondents Knowledge on Childhood Illness**

Variable	Freq (N=200)	Percent (%)
<b>Duration</b>		
Days	200	100.0
<b>First sign notice</b>		
Cough	30	15.0
Not feeding	32	16.0
Weakness	12	11.0
Difficulty in breathing	18	9.0
Fever	64	32.0

<b>Vomiting</b>	18	9.0
<b>Diarrhoea</b>	8	4.0
<b>Shivering</b>	4	2.0
<b>Convulsing</b>	4	2.0
<b>Any other sign</b>		
<b>Yes</b>	130	65.0
<b>No</b>	70	35.0
<b>What other signs</b>		
<b>Cough</b>	60	46.2
<b>Not feeding</b>	120	92.3
<b>Weakness</b>	120	92.3
<b>Difficulty in breathing</b>	60	46.2
<b>Fever</b>	14	10.8
<b>Vomiting</b>	100	76.9
<b>Diarrhoea</b>	100	76.9
<b>Shivering</b>	120	92.3
<b>Convulsing</b>	110	84.6
<b>Cause of the illness</b>		
<b>Germ/microorganism</b>	121	60.5
<b>Spiritual</b>	4	2.0
<b>Wrong medication</b>	28	14.0
<b>Poor feeding</b>	10	5.0
<b>Dirty water</b>	37	18.5
<b>Severity of illness</b>		
<b>Severe</b>	55	27.5
<b>Moderate</b>	78	39.0
<b>Mild</b>	67	33.5
<b>Identify severity of illness</b>		
<b>Combined symptoms</b>	156	78.0
<b>Illness continues for long time</b>	44	22.0

**Source: field Survey, (2019)**

and difficulty breathing (46.2%), vomiting and diarrhoea (76.9%). Likewise, 72.5% of respondents thought their children's illness to be mild/moderate due to the combined symptoms that was exhibited (78%). This is in line with a WHO sponsored survey in which they reported that most mothers saw the child's behaviour which interfered with household activities such as crying or restlessness. Only a few that took notice about signs associated with eyes and changes in the appearance of stools as some of the vital signs to serious ailment. Webair & Bin-Gouth (2013) and Assefa et al. (2014) revealed similar findings.



**Source: field Survey, (2019)**

**Figure 1: Stratification of Respondents Age against Knowledge about Child Illness.**

Figure 1 gives a stratification of respondents’ age against knowledge about child’s illness. All age groups knew their child was sick.

Studies by Mwenesi et al. (2005), Nyamongo (2002) and Thind & Cruz (2003) as well as Beegle et al. (2011) found results which corroborates with this study. They found that understanding the signs and symptoms of the child results in prompt medical treatment.

**Table 4.3 Respondents’ Perception on Causes of Illness**

Variable	Frequency (N=200)	Percent (%)
<b>Child’s illness is due to</b>		
<b>Witchcraft</b>	8	4.0
<b>Sorcery</b>	16	8.0
<b>Curse</b>	12	6.0
<b>Cultural practices</b>	18	9.0
<b>Orthodox medication</b>	22	11.0
<b>Herbal medication</b>	114	57.0
<b>Incurable disease</b>	8	4.0
<b>Partner conflict</b>	27	13.5
<b>Complimentary feeding</b>	24	12.0
<b>Poor maternal hygiene</b>	30	15.0

**Source: field Survey, (2019)**

Cultural beliefs and attitudes especially affect how a family perceives a child’s illness as well the healthcare and treatments options available to them (Ogunrinde et al., 2012). This assertion supports this study in that from table 4.3, respondents perceived that their children’s illness was due to herbal medications (57%), complimentary feeding (11.0%), partner conflict (13.5%), orthodox medication bought from vendor (12%), cultural practices (9%) and sorcery (8%).

In responding to their children’s illness, caregivers institute presumptive treatment which may occur at all levels of the healthcare system, but is most common within the informal sector, which includes self-treatment at home or at a local drug shop (Chibwana et al., 2009). This is in line with this study since 75% sent their ward to a health facility after three days of illness (70%) when presumptive treatments have failed.

Respondents (30%) sometimes and usually seek treatment at traditional homes when child is ill and hence 84% usually use herbal remedies as home management for their wards whilst 11.5% have ever been to the traditional healer to seek treatment for their child. This is in line with the World Health Organisation affirmation that in most rural African areas and elsewhere in developing countries, people rely on traditional medicines. Caregivers continue relying on traditional medicine because they live in remote areas where modern medicine is not accessible hence they have the habit of seeking traditional medicine. Furthermore, people prefer traditional medicine to modern medicine because they believe that they are effective and have few side effects (Gyasi et al., 2011).

During childhood ailment, the father makes decision on the choice of treatment (94.5%) to be instituted. This corroborates with the conclusion of Mbagya 2005 and Howard et al. (2010).

Economic factors influencing respondents' (Table 4.5) choice of care and practices for their sick children under five years were their low income levels (81.5%), lack of transport during illness (61%), high cost of medical care (51.5%) and high cost of transport (43.5%). The study findings are in line with those of Ajibade et al. (2013), Taffa & Chepngeno (2005), Ouathara et al (2011) and Littrell et al. (2011).

**Table 4.4 Respondents' Practices during Child Illness**

<b>Variable</b>	<b>Freq (N=200)</b>	<b>Percent (%)</b>
<b>First response to child illness</b>		
Health facility	150	75.0
Traditional treatment	18	9.0
Self-treatment at home	10	5.0
Buy from pharmacy without prescription	16	8.0
Treat with holy water	4	2.0
Did nothing	2	1.0
<b>Duration before seeking medical care</b>		
Same day		
After a day	30	15.0
After two days	30	15.0
After three or more days	140	70.0
<b>Seek treatment at traditional homes</b>		
Yes	32	16.0
No	140	70.0
Sometimes	28	14.0
<b>Treat child using herbs</b>		
Yes	168	84.0
No	32	16.0
<b>Decision for child's treatment</b>		
Father of child only	189	94.5
Both parents	11	5.5
<b>Ever consulted a traditional healer</b>		
Yes	23	11.5
No	177	88.5

Source: field Survey, (2019)

**Table 4.5 Respondents' Economic Factors Influencing Choice of Care**

Variable	Freq (N=200)	Percent (%)
Lack of transport during illness	55	61.0
Low income levels	115	81.5
High cost of medical care	103	51.5
High cost of transport	61	43.5
Lack of insurance	57	16.5
Employer not permitting caregivers	54	7.6
Busy nature of job of care giver	26	13.0
High cost of orthodox medicines	40	20.0

Source: field Survey, (2019)

Socio-cultural factors influencing respondents' choice of care and practices for their sick children under five years were their low level of education (37.5%), lack of adequate health information (42%), lack of support from partner (34%) and cultural barriers/beliefs (18%). The findings support those of Kaatano et al. (2010), Davy et al. (2010) and Getahun et al (2010).

**Table 4.6 Respondents' Socio-Cultural Factors Influencing Choice of Care**

Variable	Freq (200)	Percent (%)
<b>Socio-cultural factors</b>		
Low level of education of caregiver	75	37.5
Lack of adequate health information	84	42.0
Marital conflict	22	11.0
Polygamous marriage	26	13.0
Conflict with other family members	7	3.5
Large family size	47	23.5
Lack of support from partner	68	34.0
Lack of support from relatives	46	23.0
Cultural beliefs/barriers	36	18.0
Religious beliefs/barriers	30	15.0
Single parenthood	28	14.0
Infidelity	9	4.5

Source: field Survey, (2019)

#### IV. CONCLUSION

This research study aimed at assessing the knowledge, attitude and practice of caregivers towards sick children under- five years in a local indigenous setting of Bawku and concludes that there is a significant relationship between age, educational status, marital status as well as religious affiliation and the three variables. Caregivers are usually aware of their children's illness through the signs they exhibit but they usually term it as a mild illness.

Caregivers do not seek prompt treatment unless after the child exhibit the symptoms for more than three days and this decision is solely that of the child's father.

Caregivers are reluctant to stop their daily routine to take care of their child since they see the symptoms to be minor symptoms for ailment.

Economic factors such as low-income levels, lack of transport during illness, high cost of medical care and high cost of transport influence caregivers choice of care and practices for their sick children under-five years.

Socio-cultural factors such as low level of education, lack of adequate health information, lack of support from partner and cultural barriers/beliefs influence caregivers' choice of care and practices for their disabled sick children under five years.

### 5.3 RECOMMENDATIONS

- Based on the findings of this study, the following are recommended;
1. There is need to have an effective and functioning referral system in the health care delivery system to ensure children are attended promptly in health facilities at the onset of any illness.
  2. Mass communication and vigorous campaign for the population on seeking treatment early in recognized health care institutions.
  3. Socio-economic development of the rural community through income generating can reduce poverty levels hence improve healthcare seeking behaviour during the childhood illness.
  4. Further studies should be carried out to address access and utilization of health care, water sanitation, hygiene, use of herbal remedies and their implications.
  5. Scope for further longitudinal study design to address specific management of childhood illness.

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