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Sources for Sick Child Care in India

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The private sector is the dominant source of care in India. Understanding if and where sick children are taken for care is critical to improve case management interventions. This brief presents a secondary analysis of the 2015—16 India Demographic and Health Survey to examine where treatment or advice is sought for sick children who experience at least one of three treatable illnesses: fever, acute respiratory infection, or diarrhea. These illnesses represent some of the leading causes of death in children under five years old.

Key Findings

- 81% of Indian caregivers seek treatment or advice outside the home for their sick children, across all three illnesses.
- The poorest caregivers are less likely than the wealthiest caregivers to seek care outside the home (75% versus 86%, respectively).
- Among caregivers who seek sick child care, 71% use the private sector and 24% use the public sector.
- Private sector use varies across income level and urbanity; use of the private sector is lowest among the poorest urban families (62%) and highest among the wealthiest urban families (82%).
- 91% of private sector care seekers and 97% of public sector care seekers access a clinical facility.

This is one in a series of briefs that examines care seeking in USAID maternal and child survival priority countries.

Illness prevalence

According to mothers interviewed across the country for the India Demographic and Health Survey (DHS), 19 percent of Indian children under five experienced one or more of the following illnesses: fever (13 percent), symptoms of acute respiratory infection (ARI)—a proxy for pneumonia—(3 percent), and/or diarrhea (9 percent) in the two weeks prior to the survey.[1]

Out-of-home care seeking

When children fall ill, most caregivers in India (81 percent) seek advice or treatment outside the home.[2] This level has increased six percentage points since the 2005–06 DHS survey. The current overall care-seeking level is similar to the average level (78 percent) across Asian maternal and child survival priority countries ("USAID priority countries") and is fairly consistent across the three illnesses.[3] Care seeking for ARI increased the most between 2005–06 and 2015–16, from 75 to 86 percent, followed by diarrhea, which increased from 69 to 77 percent.

1 out of 5 children in India experienced fever, ARI symptoms, or diarrhea in the last 2 weeks.

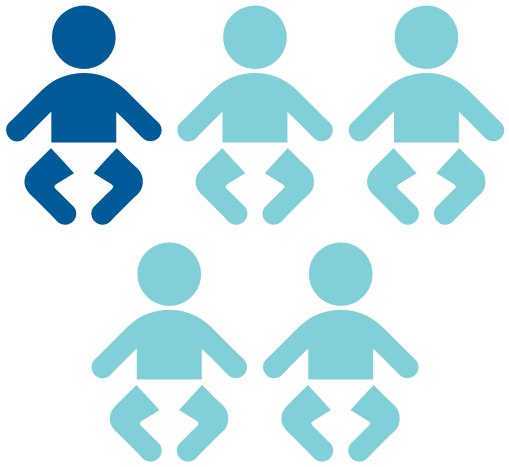
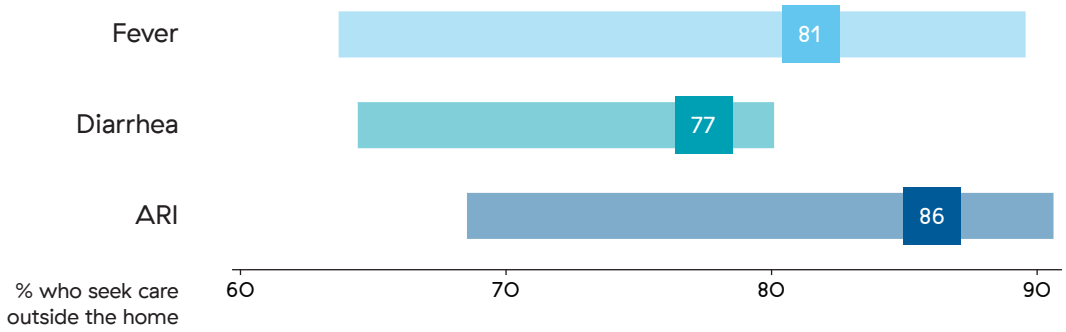


Figure 1. India's care-seeking levels are mid-range compared to its neighbors

The bars indicate the care-seeking range in the region. Squares show the care-seeking rates in India.



[1] All Demographic and Health Survey data used in this analysis are reported by mothers who were asked if their children under age five experienced fever, ARI symptoms, or diarrhea in the two weeks before the interview. These data do not report whether children recently had pneumonia or malaria because both illnesses must be confirmed in a laboratory. Instead, the Demographic and Health Survey reports whether or not children had recent symptoms of ARI as a proxy for pneumonia, and fever as a proxy for malaria. ARI is defined as a reported cough with chest-related rapid or difficult breathing.

[2] In this analysis, out-of-home sources of care comprise public sources (hospitals, rural hospitals, government dispensaries, primary health centers, urban health posts, urban family welfare centers, community health centers, sub-centers, integrated child development scheme centers [anganwadi centers], and mobile clinics; Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy [AYUSH] facilities; accredited social health activists), private sources (clinics, hospitals, doctors, paramedics, and AYUSH facilities; nongovernmental organizations; pharmacies, shops, and drug stores), and other sources (traditional healers, friends, and relatives). This brief focuses on sources of care *outside* the home, not whether or not the child received proper care, which could include at-home use of oral rehydration salts for diarrhea.

[3] The USAID priority countries in Asia are Afghanistan, Bangladesh, India, Indonesia, Myanmar, Nepal, and Pakistan.

Sources of care

The private sector is the dominant source of sick child care in India. Among caregivers who seek treatment or advice outside of their homes, 71 percent use private sector sources while 24 percent go to public sector sources. Very few caregivers (1 percent) seek care from both the public and private sectors. Four percent seek treatment from other sources: traditional healers, friends, or relatives. Almost all public sector care seekers (97 percent) and the majority of private sector care seekers (91 percent) go to a clinical facility such as a hospital or a clinic, rather than seeking care from a non-clinical source such as an accredited social health activist, pharmacy, or shop. These care-seeking patterns have not changed substantially since the 2005–06 DHS survey. This analysis shows where caregivers go for treatment, regardless of their level of access to different sources of care. It does not reflect where caregivers might choose to go if they had access to all sources of care.

Among caregivers who seek sick child care outside the home, 24% seek treatment or advice from public sector sources and 71% from private sector sources.

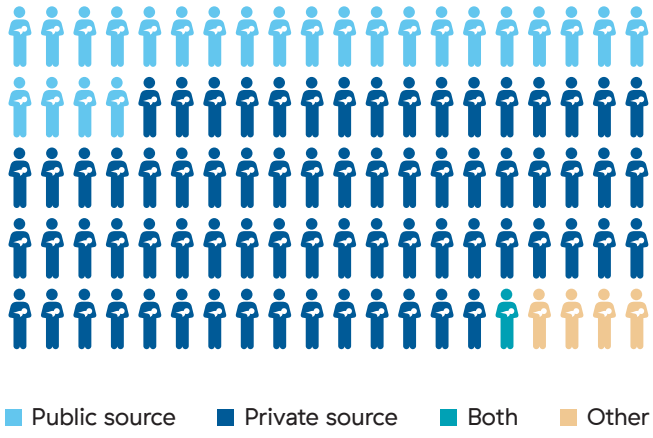
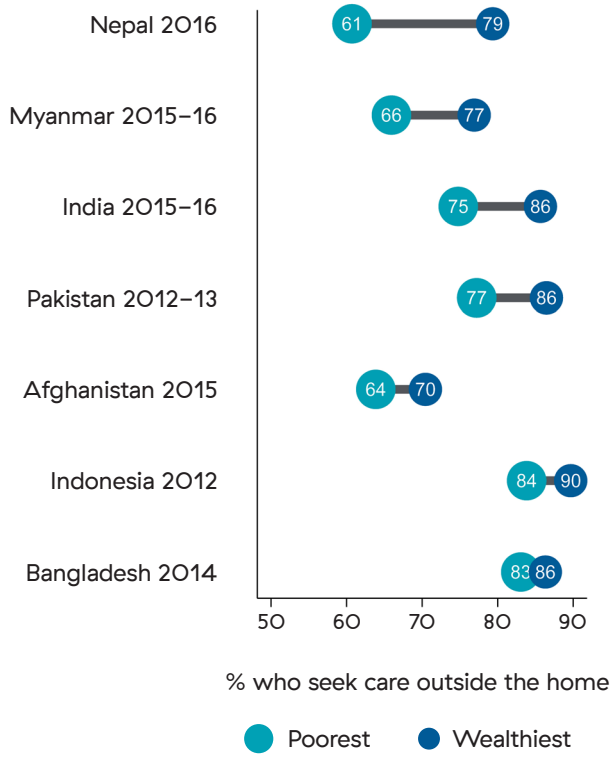


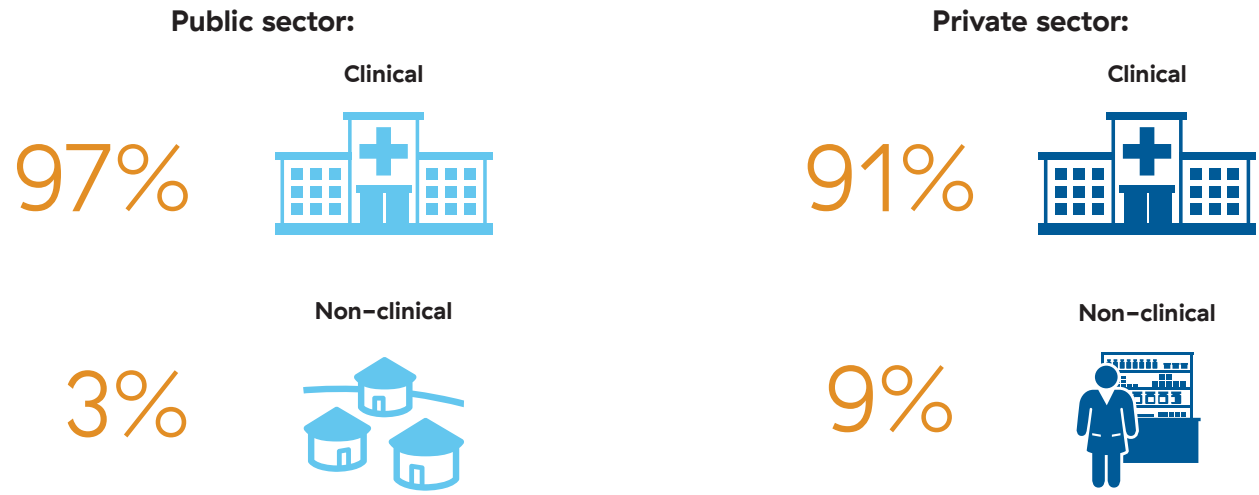
Figure 2. India has a larger wealth disparity in care-seeking levels than many of its neighbors



Equity in illness prevalence and care seeking

In India, the burden of fever, ARI symptoms, and/or diarrhea is similar between the poorest and wealthiest children (19 percent and 17 percent, respectively). However, poorer children in India who experience one of these illnesses are less likely to receive treatment than their wealthier peers (75 percent versus 86 percent, respectively). The magnitude of the disparity in care seeking between the poorest and wealthiest quintiles in India is considerable and larger than four other USAID priority countries in Asia. However, the care-seeking level among the poorest families increased seven percentage points from 68 percent in 2005–06. As such, the magnitude of the care-seeking disparity between the poorest and wealthiest families decreased from 17 percentage points in 2005–06 to 11 percentage points in 2015–16.

Figure 3. Most public and private sector care seekers use clinical sources

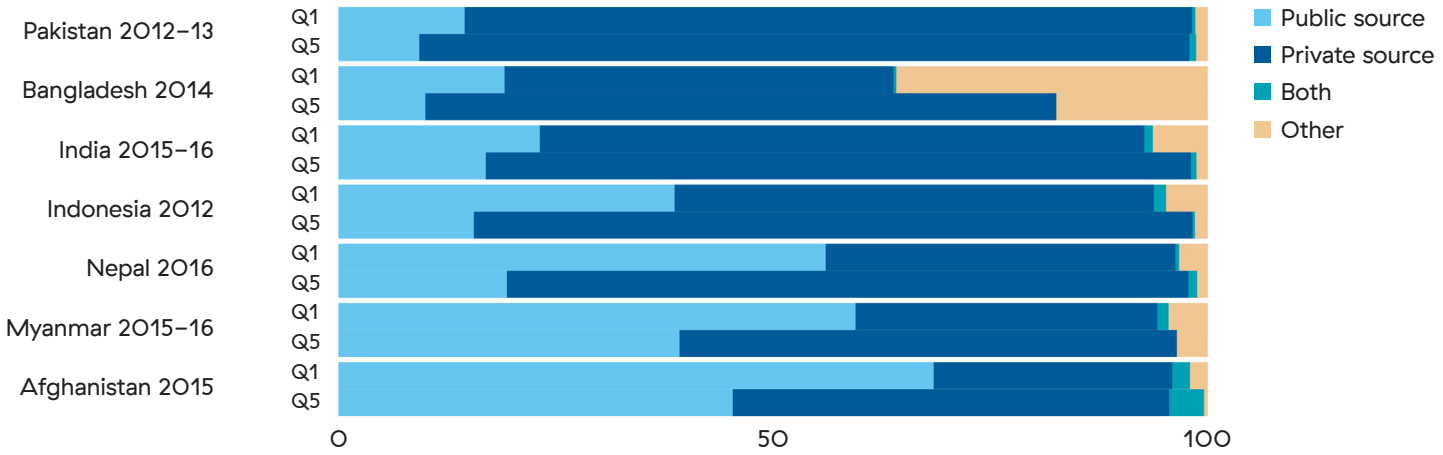


Sources of care categories

Public sector: Hospitals, rural hospitals, government dispensaries, primary health centers, urban health posts, urban family welfare centers, community health centers, sub–centers, integrated child development scheme centers (anganwadi centers), and mobile clinics; Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) facilities; accredited social health activists
Private sector: Clinics, hospitals, doctors, paramedics, and AYUSH facilities; nongovernmental organizations; pharmacies, shops, and drug stores
Other: Traditional healers, friends, and relatives

The large majority of care outside the home for sick children is accessed from the private sector across socioeconomic statuses. Caregivers from the wealthiest quintile of the Indian population are somewhat more likely to seek care from a private sector source (81 percent) than caregivers from the poorest quintile (70 percent). The wealthiest care seekers are somewhat less likely than the poorest care seekers to use the public sector (17 percent versus 23 percent, respectively). Caregivers from the poorest households are more likely to rely on other sources of care (6 percent) compared to caregivers from the wealthiest households (1 percent). Compared to most other Asian USAID priority countries, the poorest caregivers in India are much more likely to seek care from a private sector source. The care-seeking sources used by the poorest and wealthiest families in India have remained fairly consistent since the previous DHS. The largest changes are that the wealthiest care seekers have a somewhat higher reliance on the public sector compared to findings from the previous DHS (17 versus 12 percent) and a lower use of other sources of care (1 versus 4 percent).

Figure 4. Private sector use is high in India among the poorest and wealthiest families



Q1: Poorest, Q5: Wealthiest

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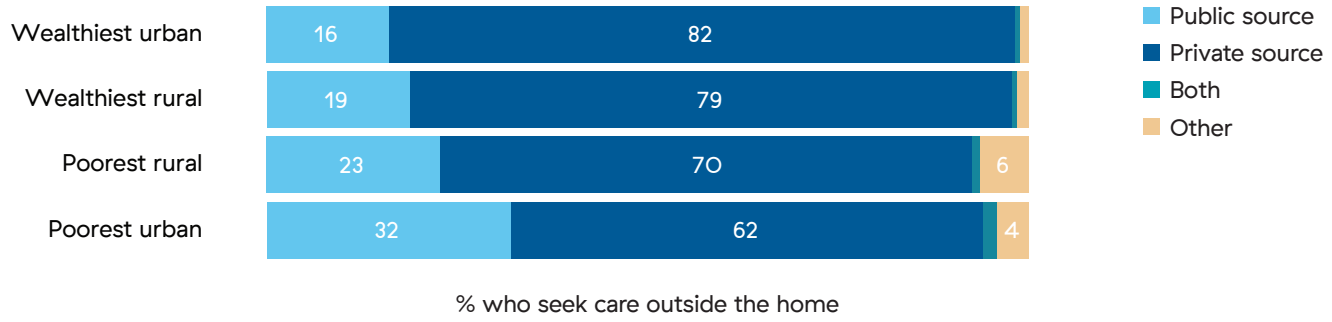
Urban and rural care-seeking patterns

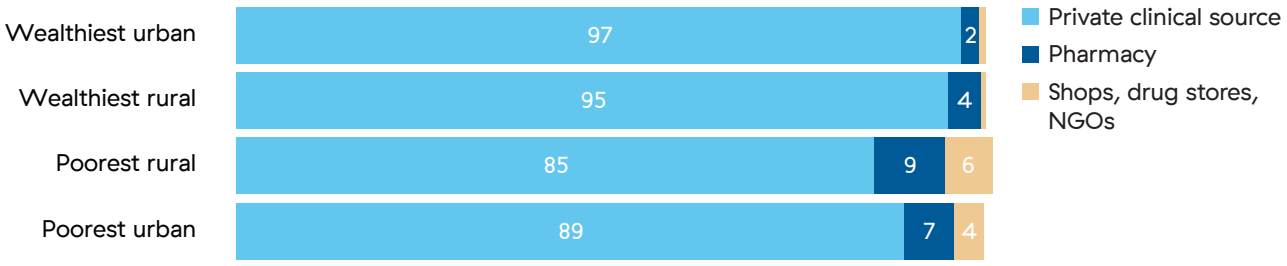
Care-seeking patterns in India are similar between urban and rural populations. Rural caregivers are slightly less likely to seek advice or treatment outside the home (79 percent) compared to their urban counterparts (84 percent). When examining care-seeking patterns in urban and rural areas by socioeconomic status, there are differences in the sources used between the poorest urban and the poorest rural families. Among the poorest urban care seekers, nearly one-third (32 percent) use public sector sources and nearly two-thirds (62 percent) use private sector sources. In contrast, 23 percent of the poorest rural care seekers use public sector sources, while 70 percent use the private sector.

Figure 5. The poorest rural families are more likely to use the private sector than the poorest urban families



Among the poorest families that use the public sector, those in rural areas are more likely to rely on accredited social health activists (a public non-clinical source) than the poorest in urban areas (6 percent versus less than 1 percent, respectively). Very few of the wealthiest urban or rural public sector care seekers use accredited social health activists for sick child care (2 percent). Across urban and rural areas, the poorest private sector users rely more heavily on non-clinical sources such as pharmacies and shops (11 percent of urban dwellers and 15 percent of rural dwellers) compared to the wealthiest private sector users (3 percent of urban dwellers and 5 percent of rural dwellers).

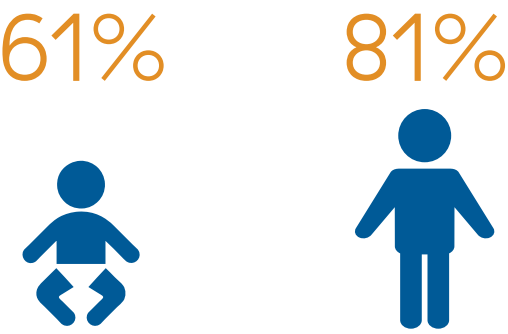
Figure 6. Clinical care is dominant in India among private sector care seekers across urbanities and income levels



Differences in illness prevalence and care-seeking sources by age[4]

The prevalence of diarrhea, fever, and ARI symptoms in India is much lower among neonates (8 percent) than post-neonates (19 percent). The care-seeking level is also substantially lower among neonates (61 percent) than older children (81 percent). This disparity in care-seeking level is greatest for diarrhea: care is sought for just half of neonates with diarrhea compared to 78 percent of post-neonates. Despite differences in the care-seeking levels, sources of care do not vary considerably between neonates and post-neonates.

Figure 7. India has a large disparity in care-seeking levels between neonates and post-neonates.



Interestingly, the combined illness prevalence is greater among infants 1 to 11 months than among older children 12 to 59 months (25 versus 18 percent, respectively). Despite this difference, the care-seeking levels are equivalent for these two age groups (81 percent). In addition, the care-seeking sources are very similar and align with the overall source patterns in India described previously.

[4] The sample size for neonates with fever, diarrhea, or ARI symptoms is small (n = 123), as is the sample size for neonates for whom care was sought outside the home (n = 71).

Conclusion

Fever, ARI, and diarrhea are common illnesses in India, affecting nearly one in five children. Although the prevalence of these illnesses is similar among children of all socioeconomic statuses, caregivers from the wealthiest households are more likely to seek advice or treatment outside the home than caregivers from the poorest households. Additionally, caregivers of neonates have considerably lower care-seeking levels compared to caregivers of older children. This may be explained by the fact that neonates have a lower illness burden compared to post-neonates.

The private sector is the primary source of out-of-home care across all socioeconomic statuses, urbanities, and age groups. However, the level of private sector care seeking among the wealthiest caregivers is somewhat higher than it is among the poorest caregivers. Interestingly, the poorest caregivers in rural areas are more likely to use the private sector than the poorest urban caregivers, suggesting that the rural public sector may need to better target its resources to the poorest families or identify barriers to public sector care among this low-income group. Nearly all caregivers who use the private sector seek treatment from clinical sources. The poorest private sector users, however, are somewhat more likely to rely on non-clinical sources such as pharmacies and shops. India's high use of private clinical care and low public sector reliance, even among the poorest families, are important findings that can inform programs to meet the needs of sick children.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

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