

## Care-Seeking Behavior and Perceptions of Service Receivers Regarding IMCI Services

Dr. Mohammed Hasan<sup>1\*</sup>, Dr. Susmita Podder Irani<sup>2</sup>, Anamika Panthadas<sup>3</sup>, Dr. Shourav Bhattacharjee<sup>4</sup>, Dr. Nishat Barman<sup>5</sup>

<sup>1</sup>Residential Medical Officer, Upazila Health Complex, Gabtoli, Bogra.

<sup>2</sup>Assistant Professor, Department of Community Medicine and Public Health, North East Medical College, Sylhet, Bangladesh.

<sup>3</sup>Lecturer, Department of Anatomy, Parkview Medical College, Sylhet, Bangladesh

<sup>4</sup>Assistant Registrar, Department of Medicine, Parkview Medical College Hospital, Sylhet, Bangladesh.

<sup>5</sup>Consultant, Department of Paediatrics, Lions Children Hospital, Sylhet, Bangladesh

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**\*Corresponding Author:** Dr. Mohammed Hasan, Residential Medical Officer, Upazila Health Complex, Gabtoli, Bogra,

### Abstract

**Background:** Childhood illnesses remain a major cause of morbidity and mortality in low- and middle-income countries, and the Integrated Management of Childhood Illness (IMCI) strategy was developed by WHO and UNICEF to improve child survival through standardized care. Despite nationwide adoption in Bangladesh, gaps in utilization and perceptions of IMCI services persist, particularly in coastal areas. This study aimed to explore care-seeking behavior and perceptions of service receivers regarding IMCI services at Upazila Health Complexes (UHCs).

**Methods:** A cross-sectional study was conducted from January to December 2020 in three coastal UHCs—Pekua (Cox's Bazar), Banskhali, and Anowara (Chattogram). A total of 320 service receivers were interviewed using a structured questionnaire covering socio-demographics, care-seeking practices, accessibility, and perceptions of IMCI services. Data were analyzed descriptively. Ethical approval was obtained from the Institutional Review Board of NIPSOM, and informed consent was secured from all participants

**Results:** The majority of respondents were female (88.8%), with a mean age of  $28.07 \pm 7.80$  years. About 51.9% were regular IMCI users, while 48.1% were irregular. Half (50%) lived within 30 minutes of the UHC, and rickshaw was the most common transport (47.5%). Only 51.7% sought medical consultation for every child illness episode, while others relied on pharmacies or home care. Although 59.4% accessed IMCI services on their own initiative, respondents reported challenges with poor seating (69.4%), long waiting times (56.3%), and unusable toilets (52.8%).

**Conclusion:** While awareness and provider communication were strong, infrastructural gaps and care-seeking barriers remain. Strengthening community engagement, facility readiness, and supportive services may enhance IMCI utilization in coastal Bangladesh.

**Keywords:** IMCI, care-seeking behavior, service perception, child health

### 1. INTRODUCTION

Childhood morbidity and mortality remain major public health concerns worldwide, particularly in low- and middle-income countries where access to quality health services is often limited. Globally, millions of children under five years of age die each year, with the majority of deaths attributed to preventable and treatable conditions such as pneumonia, diarrhea, malaria, malnutrition, and neonatal complications.

Recognizing this burden, the World Health Organization (WHO) and UNICEF jointly developed the Integrated Management of Childhood Illness (IMCI) strategy in the mid-1990s as a comprehensive approach to improve child health through standardized case management, strengthening of health systems, and community participation [1, 2]. The IMCI strategy emphasizes early recognition of danger signs, appropriate classification of illness,

prompt treatment, and health education for caregivers, thereby reducing preventable child deaths and promoting healthy practices within households and communities [3].

In Bangladesh, IMCI was adopted as a national strategy in 1998 and has since been scaled up across primary healthcare facilities including upazila health complexes and union-level facilities. It plays a crucial role in managing under-five childhood illnesses and has contributed significantly to the country's progress in reducing child mortality, in line with Sustainable Development Goals (SDG) targets [4]. Despite this achievement, several challenges remain, especially in coastal and rural regions where health-seeking behavior is influenced by socio-cultural norms, economic constraints, geographical barriers, and perceptions of healthcare quality. Parents or caregivers are the primary decision-makers for sick children, and their care-seeking practices often determine whether timely and appropriate treatment is received [5]. Delayed care-seeking, reliance on informal providers, and dissatisfaction with services may undermine the effectiveness of IMCI interventions [6].

Perceptions of service receivers also play a critical role in the utilization and sustainability of IMCI services. Positive perceptions regarding accessibility, quality of care, provider communication, and availability of essential medicines can enhance trust in the health system and encourage repeated service use [7]. Conversely, negative experiences such as long waiting times, stock-outs of medicines, inadequate provider attention, or lack of privacy may discourage caregivers from seeking care at formal health facilities [8, 9]. In coastal upazilas of Bangladesh, where health infrastructure is often strained by high population density, disaster vulnerability, and limited resources, understanding caregivers' perspectives and behaviors is essential to strengthen IMCI implementation and improve child health outcomes.

Although numerous studies have examined the impact of IMCI on child health indicators, relatively few have focused specifically on the care-seeking behavior of parents and the perceptions of service receivers regarding IMCI services [10]. Exploring these dimensions is vital for identifying service gaps, understanding barriers to utilization, and designing context-specific strategies for improvement [11]. Therefore, this study was undertaken to assess the care-seeking behavior of parents or caregivers of under-five children and to explore

their perceptions of IMCI services in selected coastal upazilas of Bangladesh. Findings from this research will provide valuable insights for policymakers, program managers, and healthcare providers to strengthen IMCI implementation, enhance caregiver satisfaction, and ultimately contribute to better health outcomes for children in vulnerable coastal communities.

## 2. METHODOLOGY & MATERIALS

This cross-sectional study was conducted over one year from January to December 2020 in three coastal upazilas of Bangladesh—Pekua Upazila Health Complex in Cox's Bazar, and Banshkhali and Anowara Upazila Health Complexes in Chattogram. The Institutional Review Board of the National Institute of Preventive and Social Medicine (NIPSOM) approved the protocol, and written informed consent was obtained from all participants. A convenient sampling method was adopted, and the study population included parents or caregivers of under-five children attending IMCI nutrition corners, IMCI service providers (medical officers, staff nurses, NGO workers), and IMCI supervisors (Upazila Health and Family Planning Officer, Resident Medical Officer, and Nursing In-Charge). Inclusion criteria were parents of children under five years, service providers working at least six months in the respective centers, and IMCI supervisors, while sick staff, those on leave, parents of children above five years, and individuals unwilling to participate were excluded. The final sample size comprised 342 respondents, including 320 service receivers and 22 health staff (13 service providers and 9 supervisors). Data were collected from December 20, 2020 to January 7, 2021 through face-to-face interviews using pretested semi-structured questionnaires and direct observation using structured checklists. The instruments, prepared in both English and Bengali and pretested in Kutubdia upazila, included items on socio-demographics, challenges in IMCI implementation, logistics and supplies, supervisors' perceptions, and health education practices. Observation assessed provider use of IMCI chart booklets, consultation time, assessment of major childhood symptoms (cough or difficult breathing, diarrhea, fever, ear problems), nutritional assessment, and facility readiness including signage, logistics, and drug supply. Each healthcare provider was observed for two consecutive consultations with children under five. Data were checked daily for completeness, coded, cleaned, and entered into SPSS version 25 and Microsoft Excel for analysis. Descriptive statistics such as frequency,

percentage, mean, and standard deviation were calculated, while inferential tests including Chi-square, independent-sample t-test, and one-way ANOVA were applied, with statistical significance set at  $p < 0.05$ . Findings were

### 3. RESULTS

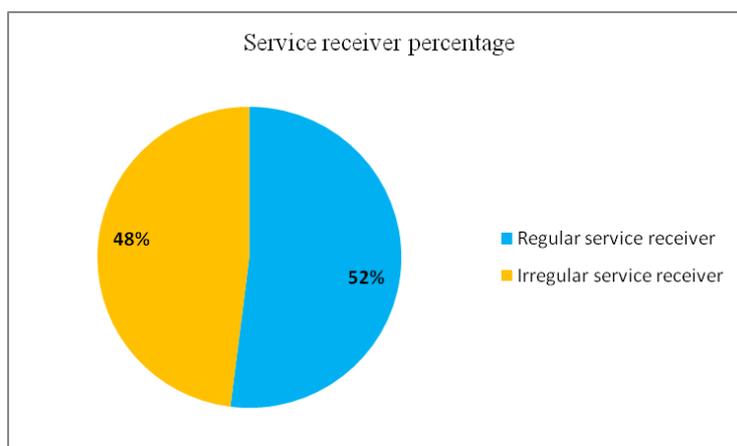
**Table 1.** Distribution of Service receivers by demographic characteristics (n=320)

Characteristics	Category	f(%)
Age of the service receivers (in years)	10-20	48 (15)
	21-30	192(60)
	31-40	61(19.1)
	41-50	12(3.8)
	>50	7(2.2)
	Age (Mean±SD)=28.07±7.797, Range 14-65	
Sex of service receiver	Male	36(11.3)
	Female	284(88.8)
	Total	320(100)

Table 1 shows the distribution of service receivers according to their demographic characteristics. Among the 320 respondents, the majority (60%) were in the 21–30 years age group, followed by 19.1% in the 31–40 years group and 15% in the 10–20 years group, while only a small proportion were aged 41–50 years

presented using tables and graphs, and strict measures were taken to ensure data quality, confidentiality, voluntary participation, and the ethical rights of all respondents.

(3.8%) and above 50 years (2.2%). The mean age of the respondents was 28.07 years with a standard deviation of 7.80, ranging from 14 to 65 years. In terms of sex distribution, females constituted the overwhelming majority of service receivers (88.8%), compared to only 11.3% males.



**Figure 1.** Distribution of regular service receiver of the IMCI corner (n=320)

To fine out the factors related to service receiver for implementation of IMCI in UHC, 320 service receivers interviewed from different socio-demographic and economic background. Among

them majorities 166 (51.9%) often come to UHC IMCI corner for seeking IMCI services and the rest 154 (48.1%) were not regular service receiver of IMCI corner (Figure 1).

**Table 2.** Distribution of the service receivers according to time distance from UHC to their residence (n=320)

Characteristics	Category	f (%)
Time Distance	120min	8 (2.5)
	60min	96 (30)
	30min	160 (50)
	10min	5 (1.6)
	5min	12 (3.8)
	Total	320 (100)

Majorities 160 (50%) of the respondents live within 30 min time distance from their house to

UHC followed by 96 (30%) of them were in 60 min time distance, 39 (12.2%) were 15 min time

distance, 12 (3.8%) were in 5 min time distance, 8 (2.5%) were in 120 min time distance and the rest 8 (2.5%) were in 10 min time distance from

their house. Following table-2 showing distribution of the service receiver according to time distance from UHC to their House.

**Table 3.** Distribution of the service receiver according to commonly used vehicle to come UHC (n=320)

Characteristics	Category	f (%)
Common vehicle	Rickshaw	152(47.5)
	Taxi (CNG)	112 (35)
	Walking	55 (17.2)
	Motorcycle	1 (0.3)
	<b>Total</b>	320 (100)

Majorities 152 (47.5%) of service receiver come to UHC by Rickshaw followed by 112 (35%) of them came with taxi (CNG), 55 (17.2%) of the respondent come by walking and the remaining 1

(0.3%) came to UHC with motor cycle. Table 3 showing the distribution of the vehicle commonly used to come to UHC.

**Table 4.** Distribution of the service receivers according to their care seeking common behavior (n=315)

Common Behavior	Frequency (f)	Percentage (%)
Goes to Doctor/HCP every time for their sick child	163	51.7
Does not go to Doctor/HCP every time	152	48.3

Among 315 service receiver majority 163 (51.7%) of them go to doctor or service provider every time for treatment of their sick child and

the rest 152 (47.5%) do not. Following table-4 is showing the distribution of service providers according care seeking behavior.

**Table 5.** Distribution of the service receivers according to family and financial support (n=320)

Characteristics	Frequency (f)	f (%)
Support	Have supportive member in family	236 (73.8)
	Do not have any supportive family member	84 (26.3)
	Took financial aid or loan	7(2.2)
	Did not take any financial aid or loan	313 (97.8)
	<b>Total</b>	320 (100)

Among 320 service receivers majority 236 (73.8%) of them had supportive family member and the remaining 84 (26.3) of them did not have any supportive family member. 313 (97.8%) of the service receivers among 320 did not take any

financial aid or loan for treatment of their child and the rest 7 (2.2%) took financial aid or loan. Following table-5 is showing family and financial support of the service receivers.

**Table 6.** Distribution of the service receivers according to their perception about IMCI corner (n=320)

Characteristics	Category	f (%)
Perception of service receivers	Aware about IMCI corner	190 (59.4)
	Did not aware of the IMCI corner	130 (40.6)
	Aware by Neighbor about IMCI corner	70 (21.9)
	Aware by Govt. field staff about IMCI corner	40 (12.5)
	Aware by local practitioners	19 (5.9)
	Aware by Physician	1 (0.3)
	Sufficient air ventilation in waiting room	320 (100)
	Light source is good	320 (100)
	No supply of safe drinking water	320 (100)
	Poor seating arrangement	222 (69.4)
	Long waiting time	180 (56.3)
	Toilet is not useable	169 (52.8)
	No soap for hand wash on the basin	169 (52.8)
	HCP told about the home medication of child	247 (77.2)
	Attitude of HCP was good toward child	257 (80.3)
	<b>Total</b>	320 (100)

To review the perception of the service provider, I interviewed 320 service receivers came to UHC U5 IMCI OPD corner, majority 190 (59.4%) of them came by own decision because all of them were aware about the service followed by 70 (21.9%) of them knew about the IMCI service from their neighbor, 40 (12.5%) of from Govt. field staff, 19 (5.9%) of from local practitioners and remaining 1 (0.3%) knew from their physician and among them cent percent (100%) agreed that waiting room of IMCI corner had sufficient air ventilation and light but no supply of safe drinking water, 222 (69.4%) think that seating arrangement in waiting room were poor, 180 (56.3%) think waiting time is too long, 169 (52.8%) think toilet in UHC is not useable, 151 (47.2%) were not aware about the toilet, 247 (77.2%) of the service receivers said HCP told about the home medication of child (Table 6).

#### 4. DISCUSSION

This cross-sectional study was conducted to identify the challenges of implementing IMCI strategy in coastal region. There were 320 service receivers, 13 IMCI-HCP, 9 IMCI supervisors as respondent in this study. The study conducted in selective Primary Health Care Centers of southern coastal region of Chattogram and Cox's Bazar District. The study findings were compared with the findings of other relevant studies within country and abroad. Accordingly logical arguments and explanations were forwarded for the discrepancies of the study findings with that of others.

The study shows that out of 320 service receivers, around 60% of the service receivers were in the age group 21-30 years followed by 19.1% in 31-40 years, 15% in 10-20 years, 3.8% in 41-50 years and 2.2% were more than 50 years age group. The mean ( $\pm$ SD) age of the service receivers were 28.7 ( $\pm$ 7.797) years with the range of 14-65 years. By sex, more than 88% were female and 11% were male.

This study explored care-seeking behavior and perceptions of service receivers regarding IMCI services in selected Upazila Health Complexes (UHCs) of Bangladesh. The findings highlight a mixed picture: while awareness of IMCI services and health care provider (HCP) communication were strong, significant barriers remain related to accessibility, infrastructure, and supportive environments that influence service utilization.

The predominance of young mothers as service receivers is consistent with the global observation that women are typically the primary

caregivers and decision-makers for child health [12]. However, in our study, fathers were reported as the main decision-makers in three-fourths of cases, reflecting entrenched socio-cultural dynamics in rural Bangladesh. Similar patterns of paternal dominance in healthcare decisions were also reported in Afghanistan, where Steinhardt found that male authority often determined whether women and children accessed care, thus delaying timely treatment [13]. This underscores the need to involve fathers in child health education programs to enhance early care-seeking practices.

In terms of health-seeking behavior, our study found that only 51.7% of caregivers sought formal medical services every time their child was ill, while nearly half relied on pharmacies, home care, or previously prescribed medicines. Comparable results were documented by Gilroy in Mali, where caregivers often turned to local practitioners or traditional healers before accessing formal care [14]. Similarly, McBride emphasized that socio-economic constraints and cultural preferences frequently lead to delayed or inappropriate care-seeking in Africa, a challenge mirrored in Bangladesh [15]. These findings highlight the ongoing influence of informal providers and the need to strengthen community-based health education under IMCI.

Accessibility emerged as an important factor influencing service use. About half of respondents lived within 30 minutes of a UHC, while others had to travel up to two hours, mostly by rickshaw or CNG. Distance and transport costs are well-documented barriers in rural and resource-limited settings. Johns reported that travel distance and transport options significantly influenced access to primary health services in low-income countries [16]. Naziri et al., also noted similar challenges in Afghanistan, where geographic isolation and poor infrastructure hindered access to maternal and child health services [17]. Addressing transport barriers through community outreach and mobile health initiatives could improve timely utilization of IMCI services in coastal Bangladesh.

Service receiver perceptions also revealed critical gaps in health facility infrastructure. While respondents appreciated ventilation and lighting, they expressed dissatisfaction with seating arrangements, long waiting times, and poor sanitation facilities. Such dissatisfaction can reduce trust in health services and discourage repeated use. Lesao et al., noted that caregivers' perceptions of facility readiness and provider

professionalism significantly shaped their confidence in neonatal and under-five care in South Africa [18]. Similarly, Legesse highlighted that perceived quality of care, including provider communication and facility conditions, was a stronger determinant of utilization than geographic proximity alone [19]. This suggests that improving waiting areas, sanitation, and patient flow management at UHCs could substantially enhance the acceptability of IMCI services.

A positive finding of this study was that more than three-fourths of caregivers reported receiving instructions from HCPs about home management of sick children. This aligns with the IMCI strategy's focus on caregiver education. Hoque et al., demonstrated that caregiver knowledge and first aid practices significantly improved treatment outcomes in rural Bangladesh [20]. Similarly, Gray et al., emphasized that community engagement and empowerment are central to sustaining health interventions, as informed caregivers are more likely to adhere to treatment and follow-up advice [21]. However, our study revealed that many caregivers still lacked knowledge about follow-up visits, pointing to a need for clearer communication strategies and reinforcement of key health messages.

The role of digital innovations in improving health service delivery is increasingly recognized in Bangladesh and other LMICs. Jabeen et al., and Sabrina et al., showed that digital registers for maternal and child health services improved record-keeping and service tracking in Bangladesh, potentially reducing gaps in continuity of care [22, 23]. Leveraging similar digital tools for IMCI, such as SMS reminders for follow-up visits, could address the knowledge gaps identified in this study and enhance caregiver compliance.

### 5. LIMITATIONS OF THE STUDY

This study was conducted in selected Upazila Health Complexes of coastal Bangladesh, and the findings may not be fully generalizable to other regions with different socio-economic and cultural contexts. Data were collected through caregiver interviews, which may be subject to recall bias and social desirability bias. In addition, the study did not include direct observation of provider practices or facility readiness, which could have provided a more comprehensive assessment of IMCI service quality.

### 6. CONCLUSION

The study highlights that while awareness and utilization of IMCI services are encouraging,

significant challenges remain in accessibility, infrastructure, and follow-up communication. Strengthening community engagement, involving fathers in child health decision-making, improving facility conditions, and integrating digital tools for better communication could enhance the effectiveness of IMCI services. Addressing these barriers will be crucial for improving care-seeking behavior and ensuring better health outcomes for under-five children in coastal Bangladesh.

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### CONFLICTS OF INTEREST

There are no conflicts of interest.

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