

SOCIO-ECONOMIC INFLUENCE ON TOBACCO USE AMONG MALE YOUTH IN KERALA

Praveen Lal C.J.* and Sajini B. Nair**

ABSTRACT

Addictions like smoking and alcohol consumption among adults are quite common. Prevalence of tobacco use among adolescence in India has been high. Data for the current study have been taken from the Global Adult Tobacco Survey (GATS). Ten variables those were included in GATS survey, were used to estimate the SLI. Based on available secondary data, the annual death toll due to tobacco use in Kerala is estimated to be close to 24,000. In Kerala, one in five male youth aged 15-24 years are tobacco users. The prevalence of tobacco use among the sample respondents is 21.7 per cent. Prevalence of tobacco use is comparatively more among the rural male youth population (23%) than their urban counterparts (17.4%). It is seen that standard of living has its influence to a great extent on the use of tobacco among the youth. Proportion of tobacco users among the non-working group is much lesser (3.6%) compared to the working class (36.9%) and students (20.6%). Almost 31.4 per cent of the male youth are ignorant about the likelihood of tobacco smoking leading to stroke and a similar proportion being unaware of the possibility of tobacco smoking habit leading to heart attack is indeed a matter of concern. Individual care and attention in the family which is likely to mould the behavioural habits, is perhaps one reason why risk of using tobacco is lesser among the nuclear families. Kerala is already burdened with high morbidity rates and the harmful effects of tobacco use on health tend to increase the morbidity rates in the state. Hence, anti-tobacco programmes and campaigns in the state, especially focusing more on the vulnerable young people from the poor socio-economic setting is suggested.

Key words: Socio-economic influence, Tobacco, Male youth, Kerala, Family, Vulnerable, Habit, Addiction.

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Tobacco use among youth and the subsequent health problems is a much debated topic today. Tobacco consumption is one of the major preventable causes of death. Smoking habit usually begins during adolescence, and the youth population mostly acquires this habit before 19 years of age. Once adolescents experiment with smoking, approximately 50 per cent are found to continue smoking leading to addiction. Some researchers in 2007 opined that out of 300 million young people who are smokers, 150 million would die of smoking-related causes later in life.¹ According to another study, the leading causes of death from smoking include cardiovascular diseases (1.69 million deaths), chronic obstructive pulmonary disease (0.97 million deaths) and lung cancer (0.85 million deaths).² By 2030, tobacco related causes are projected to be the single largest cause of death worldwide.

Studies in India have reported that more than 33 per cent of the disease burden and almost 60 per cent of premature deaths among adults are associated with behaviours or conditions that begin or occur during adolescence. Addictions like smoking and alcohol consumption among adults are quite common, besides systemic disorders like blood pressure, conversion disorders, hepatitis and occasional vision failure. Prevalence of tobacco use among adolescence in India has been high as revealed from some small sample surveys. These studies show prevalence of tobacco use 11.3 per cent among 12-19 year boys,³ 11.2 per cent among students in Noida,⁴ about 29 per cent among adults over 15 years of age⁵ and about 30 per cent among 15 years old or above.⁶ In Western Nepal, the prevalence of ever smoking was found to be 34.2 per cent whereas for current smoking, the figure was 17 per cent. It was higher among the youth of 21 years or older as compared to younger age groups. Few studies in India show the likelihood of tobacco use to be higher among poor, less educated and marginalised population⁶ and among men than women.¹

Kerala has been experiencing an epidemiological transition with an increasing trend in non-communicable diseases. Epidemiological studies in recent years have proved tobacco use to be the major modifiable risk factor of coronary heart disease, obstructive pulmonary diseases, peripheral vascular disease, stroke and peptic disease.^{7,8} Data on tobacco use in Kerala are limited and those available do not focus entirely on tobacco use. Based on available secondary data, the annual death toll due to tobacco use in Kerala is estimated to be close to 24,000.⁹ Although an overall decrease in tobacco use in Kerala was observed from 44.6 per cent among men and 13.4 per cent among women in rural Kerala¹⁰ in 1987-'88 to 34.6 per cent and 6.7 per cent in 1993-'94,¹¹ a slightly higher prevalence of 43.3 per cent among men and 1.8 per cent among women was recorded after

almost ten years.¹² Given such high risk of morbidity following tobacco use, it is imperative to get an insight into the prevalence and the risk factors of use of tobacco in a state like Kerala well known for the paradox of high morbidity and low mortality rates. The nationwide study- Global Adult Tobacco Survey¹³ in India provides ample data base in this regard.

OBJECTIVES

The main objectives of the study include:

- i. Find out the prevalence and risk factors of tobacco use among the male youth population in Kerala, and
- ii. Assess their knowledge on the adverse effects of smoking.

METHODOLOGY

Data for the study have been taken from the Global Adult Tobacco Survey or GATS that provides information on tobacco use. GATS India was conducted in 2009-'10 as a household survey of persons aged 15 years and above in 29 states of India. A nationally representative probability sample was used to provide national and regional estimates by residence and gender. The survey was designed to produce internationally comparable data on tobacco use and other tobacco control indicators using a standardized questionnaire, sample design, data collection and management procedures. A total of 69,296 interviews among males and females aged 15 years and above were completed from 29 states. In the state of Kerala, 1825 completed interviews were documented.

The present study defines youth as those aged 15-24 years. In Kerala, among the respondents aged 15-24 years interviewed in GATS Survey, use of tobacco has been reported only among male youth. No female respondent in this age group reported using tobacco of any kind. Hence, the study is restricted to 233 male youth aged 15-24 years in Kerala. Assuming that the socio-economic and demographic settings have a strong bearing on using tobacco, inequality in prevalence of tobacco use is estimated using concentration index values.

The concentration index and related concentration curve provide a means of quantifying the degree of income-related inequality in a specific health related variable. The concentration index is defined with reference to the concentration curve (q.v.) which graphs on the x-axis the cumulative percentage of the sample, ranked by living standards, beginning with the poorest; and on the y-axis, the

cumulative percentage of the health variable corresponding to each cumulative percentage of the distribution of the living standard variable. In the case where there is no socio-economic income-related inequality, the concentration index is zero. The convention is that the index takes a negative value when the curve lies above the line of equality, indicating disproportionate concentration of the health variable among the poor, and a positive value when it lies below the line of equality. If the health variable is 'bad' such as ill health, a negative value of the concentration index means ill health is higher among the poor. The concentration C index is computed using the formula:

$C = (p_1L_2 - p_2L_1) + (p_2L_3 - p_3L_2) + \dots + (p_{T-1}L_T - p_TL_{T-1})$ where p is the cumulative per cent of the sample ranked by economic status, $L(p)$ is the corresponding concentration curve ordinate, and T is the number of socio-economic groups.

Standard of living index (SLI) was calculated as per the method followed in NFHS Surveys.¹⁴ Ten variables depicting the housing conditions and possession of household assets such as availability of electricity, toilet, possession of car, two-wheeler, television, refrigerator, washing machine, land phone, cell phone and radio, etc. that are included in GATS survey was used to estimate the SLI. Weights were assigned to each variable based on its relative significance of ownership of items ranging from a weight of 2 for the availability of toilet to a weight of 4 for the possession of a car or cell phone.¹⁵ The index was calculated by summing up the weights which have been developed by IIPS.¹⁶ Total weights ranged from 2 to 28. For the purpose of comparison, the index was grouped into 3 quintiles. The first quintile represents the poor group of the population whereas the second one represents the middle group and the third represents the rich group.

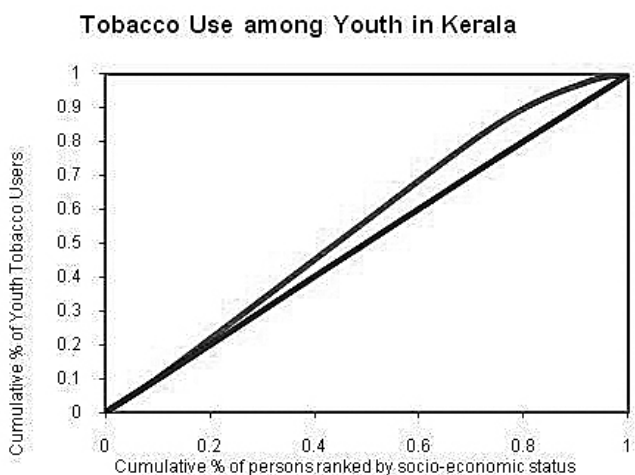
Using bivariate and multilevel regression analysis, the factors that determine tobacco use among youth in Kerala are found out. Regression analysis is carried out in two steps. The dependent variable here is 'use of tobacco in any form (smoke tobacco or smokeless tobacco). Non-user is coded as '0'; and tobacco user as '1'. The first model derives the odds of tobacco use among male youth with the standard of living as the only independent variable. In the second model, other demographic and social variables are included to find out the change in the risk of tobacco use by standard of living controlling the other variables. The independent variables included in the second model are age, place of residence, education, occupation, number of members in the household and the belief that tobacco smoking causes serious illness.

FINDINGS AND DISCUSSION

Socio-economic Inequality in Tobacco Use among Youth in Kerala

Although there is substantial research evidence indicating that poorer sections of the society are more prone to ill-health associated with bad behavioural habits especially among the youth in different countries, evidence to prove this association in India or in the southernmost state of Kerala is rare. Given the association between smoking and poverty as apparent at all levels in various studies,¹⁷ the researchers examine the association between the socio-economic setting (expressed by standard of living index) and prevalence of tobacco use among male youth in Kerala, using concentration index values. Among the youth aged 15-24 years in Kerala, the negative values of concentration index of -0.1003 for tobacco use implies disproportionate concentration of the health variable among the poor or ill-health in the form of tobacco use is more among the lesser advantaged socio-economic groups than the rich. That is, ill-health expressed here in the form of tobacco use is pro-rich or lesser among the rich class and more among the poor and middle class. The concentration curve (Figure 1) explains the inequality in tobacco use among the youth in Kerala.

FIGURE 1
CONCENTRATION CURVE DEPICTING SOCIOECONOMIC INEQUALITY IN TOBACCO USE



Here the illness concentration curve is above the line of equality indicating ill-health (proportion of tobacco users) to be less concentrated among the richer socio-economic groups compared to the poor and middle sections of the youth population.

Prevalence of Tobacco use among Male Youth in Kerala

In Kerala, among the youth aged 15-24 years, 48 per cent are in the age bracket of 15-19 years and the rest 52 per cent are in the age group of 20-24 years. The prevalence of tobacco use among the sample respondents is 21.7 per cent (Figure 2) with equal prevalence among youth population aged 15-19 and 20-24 years (Table 1).

FIGURE 2
PREVALENCE OF TOBACCO USE AMONG MALE YOUTH IN KERALA

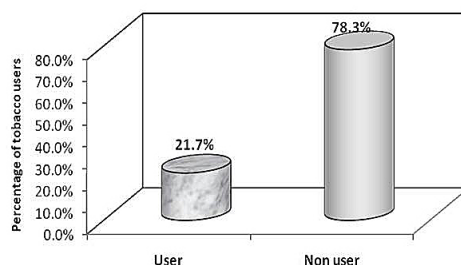


TABLE 1
PERCENTAGE DISTRIBUTION OF TOBACCO USERS BY BACKGROUND CHARACTERISTICS

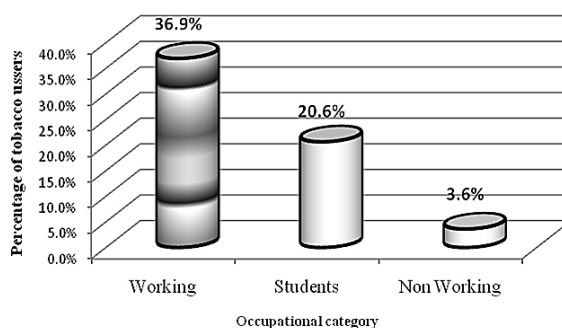
Variables		Youth Population (%)	Tobacco User
Age***	15-19	47.9	21.7
	20-24	52.1	21.6
Place of Residence***	Rural	74.6	23.1
	Urban	25.4	17.4
Education***	Below Primary	3.4	15.6
	Primary and Secondary Completed	63.6	25.8
	Higher Secondary and Above	32.9	14.3
Occupation***	Working	28.1	36.9
	Students	51.1	20.6
	Non-working	20.8	3.6
Number of Household Members***	<=3	19	17.6
	>3	81	22.6

Variables		Youth Population (%)	Tobacco User
Standard of Living *** Index	Poor	41.8	24.3
	Middle	33.5	24.9
	Rich	24.7	12.7
Believe that Tobacco *** USE cause Serious Illness	Yes	96.6	97.3
	No	3.4	2.7
Total tobacco user			21.7

*** Variables that show Chi-square significance at 1% level.

About three-fourth of the youth in the sample population is from rural areas and one-fourth from urban areas. Prevalence of tobacco use is comparatively more among the rural male youth population (23%) than their urban counterparts (17.4%). While considering the level of education, prevalence of tobacco use among the male youth is lesser in the higher educated group. When 15.6 per cent of the male youth population with below primary education are tobacco users, 25.8 per cent of those with primary and secondary education completed, reported of using tobacco. In contrast, among those with education above secondary level, only 14.3 per cent reported of tobacco use. Proportion of tobacco users among the non-working group is much less (3.6%) compared to working class (36.9%) and students (20.6%) (Figure 3).

FIGURE 3
TOBACCO USERS BY OCCUPATION, KERALA



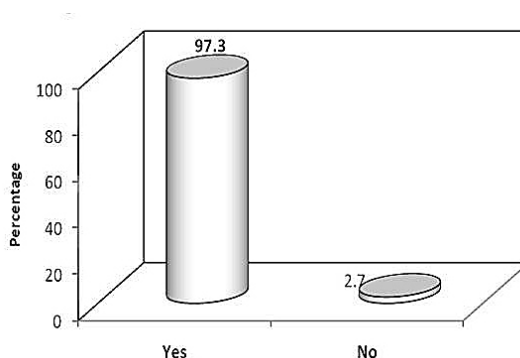
Among Keralites, the type of family is becoming increasingly nuclear in the recent years. Behavioural habits of the youth population also tend to vary between nuclear and joint family. It is seen that in households with more than 3 members,

the proportion of youth population who report tobacco use is more (22.6%) compared to those youth in household with three or lesser members (17.6%). The relationship between socio-economic status and tobacco use has been established by the concentration index values. Bivariate association shows that youth from the poor and medium category of standard living category report more tobacco use (24.3 and 24.9% respectively) compared to the rich category (12.7%).

Knowledge about Adverse Effects of Tobacco Use

The GATS 2009-10 data¹³ also provide valuable inputs into the personal beliefs regarding tobacco smoking among the male youth. Although 97.3 per cent of youth who use tobacco believe that tobacco use causes serious illness (Figure 4), its surprising that one in five male youth aged 15-24 years in Kerala are tobacco users.

FIGURE 4
BELIEF THAT TOBACCO USE CAUSES SERIOUS ILLNESS



Among those who know that tobacco smoking is injurious to health, 97.5 per cent reported using tobacco in any form. Data in Table 2 show that among the youth who reported of using tobacco, almost one-fifth of them believe that tobacco use causes stroke, heart attack and lung cancer. The fact that almost 31.4 per cent of the male youth are ignorant about the likelihood of tobacco smoking leading to stroke and a similar proportion being unaware of the possibility of tobacco smoking habit leading to heart attack, is indeed a matter of concern. Similar observation has also been made in another study¹⁸ that showed that one in five tobacco users was ignorant about tobacco use causing cardiovascular diseases. This suggests that programmes need to be revamped to sensitize the youth about the harmful effects of tobacco smoking.

TABLE 2
PERCENTAGE DISTRIBUTION OF TOBACCO USERS AMONG MALE YOUTH CLASSIFIED BY
THEIR BELIEF THAT SMOKING/SMOKELESS TOBACCO CAUSE SERIOUS ILLNESS

Belief about smoking/smokeless tobacco cause serious illness		User
Stroke***	Yes	18.9
	No	19.7
	Don't know	31.4
Heart Attack***	Yes	21.3
	No	12.0
	Don't know	29.3
Lung Cancer***	Yes	21.7
	No	30.8
	Don't know	16.2
Total user	21.7	

*** Variables that show Chi-square significance at 1% level.

It is worthwhile to find out what factors lead to this risky behaviour among the youth or which group of youth hailing from which background develops this habit. Table 3 reflects a strong association between standard of living of the male youth and the prevalence of tobacco use. The unadjusted odds (Model 1) of tobacco use among youth are determined by regression analysis. The change in this risk after adjusting for other demographic and social factors (Model 2) is also determined. From Model 1, it is evident that youth in Kerala who belong to the middle standard of living category, has only a slightly higher risk of tobacco use compared to the poor socio-economic category (only 3%). But the youth population in the rich standard of living category is almost 55 per cent less likely to use tobacco compared to those in the poor category. When adjusted for other factors like age, education, occupation and awareness regarding tobacco use, the authors do not find much change in the odds ratio (Model 2). The risk of tobacco use among youth in the middle standard of living category increases only slightly (25%) compared to the youth in the low standard of living category. Similar association is discernible among the youth in the rich category who are at 49 per cent lesser odds of using tobacco than the poor sections. This implies that standard of living has its influence to a great extent on the use of tobacco among the youth. These findings support out earlier argument derived from concentration index curve that prevalence of tobacco use is lesser among the rich group compared to the poor or middle income groups.

TABLE 3
REGRESSION RESULTS SHOWING THE UNADJUSTED AND ADJUSTED ODDS EFFECTING
SOCIO-ECONOMIC STATUS ON TOBACCO USE AMONG YOUTH IN KERALA

Background Characteristics	Model 1	Model 2
Measures of Association		
Standard of Living		
Poor [®]	1.032(1.028,1.037)***	1.247 (1.241,1.253)***
Middle	0.452 (0.449,0.455)***	0.514 (0.510,0.517)***
Rich		
Age Group		
15-19 [®]		
20-24		0.933 (0.928,0.938)***
Place of Residence		
Rural [®]		0.677 (0.674,0.681)***
Urban		
Education		
Less than Secondary Education [®]		
Secondary Completed and Above		1.230 (1.225,1.235)***
Occupation		
Non-working [®]		
Student		18.873 (18.67,19.06)***
Working		6.890 (6.818,6.963)***
Number of Household Members		
<=3 [®]		
>3		1.914 (1.903,1.925)***
Belief that Tobacco Use Causes Serious Illness		
No [®]		
Yes		1.242 (1.227,1.258)***

[®] Reference category; ***Significant level at 1 percent N= 233

The adjusted odds ratio of the possible predictors included in Model 2 shows that age, place of residence, education, occupation, number of members in the household and the belief that tobacco use causes serious illness are significant predictors of tobacco use among the youth in Kerala. Bivariate association revealed that prevalence of tobacco use among the youth aged 20-24 years was only marginally lesser than those aged 15-19 years. Here the odds ratio also shows that those aged 20-24 years, have only 6 per cent lesser chance of using tobacco

than those aged 15-19 years. Those living in the urban areas are 32 per cent less likely to use tobacco compared to those in rural areas.

Regarding educational attainment among the youth, those with secondary and above level of education, are at a greater risk to use tobacco by 23 per cent than those with less than secondary level of education. Occupation of the youth is a significant predictor of tobacco use. In comparison to the non-working group, students are almost 18 times more likely to use tobacco and those presently working, are also at greater odds of using tobacco by almost 7 times than the non-workers. So, money to spend in hand earned from work seems to tempt the male youth population to develop the habit of tobacco smoking. The observed likelihood of tobacco use among students could be attributed to the influence of peer groups in spreading the habit. A Korean study revealed similar findings that even after controlling for unobserved individual heterogeneity, youth employment raised the probability of smoking initiation by 4.4 percentage points¹⁹, though employment income or allowance did not significantly explain youth smoking initiation.

Considering the influence of number of members in a household, it is found that the youth living with more than three members have 91 per cent higher chance of using tobacco compared to the persons belonging to the households with three or less members. So, individual care and attention in the family which is likely to mould the behavioural habits is perhaps one reason why risk of using tobacco is lesser among the nuclear families. However, knowledge about the adverse effect of tobacco use does not seem to deter youth from using tobacco as it is found that the youth who know that tobacco use causes serious illness, have higher chance of using tobacco by 24 per cent than those who do not believe that tobacco use causes serious illness.

CONCLUSION

In Kerala, one in five male youth aged 15-24 years are tobacco users. Less than one-fourth of tobacco users in Kerala started using smokeless tobacco daily by the age of 18 years. The fact that socio-economic status has a strong influence on the prevalence of tobacco use among youth, with prevalence being more concentrated among the poorer and middle class, demands the need for revamping the existing anti-tobacco programmes and targeting the poorer sections of the society. Also the finding that tobacco use is more prevalent among the working youth and the students when compared to the non-workers is a cause of concern, given the harmful effects of tobacco use in a state like Kerala. Kerala is burdened with high morbidity rates²⁰ and the harmful effects of tobacco use on health²¹, tends

to increase the morbidity rates in the state. The situation tends to be graver as reluctance among the youth to avail treatment is generally observed²².

The highly literate state does not fall back in its status with regard to knowledge among youth about the harmful effects of tobacco use as only very few are ignorant in this regard. But it is interesting to see that the possibility of tobacco use causing serious illnesses like heart attack, lung cancer and stroke is not known to many young men in Kerala. So, it is important to sensitize the youth about the possibility of tobacco use leading to many chronic non-communicable diseases and increasing the economic burden on the people by way of cost incurred for treatment. The study findings call for strengthening and strict implementation of anti-tobacco programmes in the state, especially the more vulnerable young people from the poor socio-economic setting. Some programmatic efforts could be directed towards making tobacco products less affordable, strictly banning smoking in public places such as workplaces, schools, hospitals and restaurants etc and restricting tobacco marketing. The first step to tackle tobacco use among youth has to start from the family. Role of parents in helping young children cope with their problems, making them to refuse tobacco and last but not the least, setting good example to children by not using tobacco is crucial in this regard. Hitherto, anti-smoking programmes in the state have not been successful to the desired extent in deterring young men in Kerala from smoking. Now a combination of several elements including evidence-based curricula in secondary schools, programmes targeting people at work, students, youth at home, at health care delivery points and in public places, simultaneously should be helpful in addressing the issue of tobacco use among the youth in the state.

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SOCIO-CULTURAL BELIEFS INFLUENCING BREASTFEEDING PRACTICES AMONG PRIMI POSTNATAL MOTHERS RESIDING IN URBAN SLUM AREA OF DELHI

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ABSTRACT

Scientific research studies conducted during the last three decades have clearly proved that breastfeeding provides the most suitable nutrition for an infant. However in India, breastfeeding is inadequately practiced due to prevailing misconceptions and cultural taboos. This study assesses the socio-cultural beliefs influencing breastfeeding practices among 405 primi postnatal mothers in an urban slum area of Delhi. In this study, simple random sampling was adopted. A structured interview schedule was used. Results reveal that breastfeeding was initiated late by mothers mainly due to family rituals and interference of elderly females. More than half gave sugar water as pre lacteal feeding. 56.5 per cent breastfed only for five minutes as they thought longer duration causes soreness of the nipple. 42.5 per cent avoided night feeding for the reason that it causes colic to the baby. Their cultural practices mainly revolve around avoidance of colostrum, certain consumption and avoidance of food after childbirth. Overall the study results indicate that there is a need for dissemination of information and education regarding optimal breast feeding practices and for protecting and promoting healthy practices. Involvement of pregnant and lactating mothers, elderly women in various IEC activities is desirable as they all have an important role in initiation of breast-feeding and other healthy feeding practices at the community level.

Key words: Breastfeeding, Colostrum, Primi postnatal mothers, Prolacteal feeding. Socio-cultural beliefs.

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INTRODUCTION

Breast milk is nature's most precious gift to the new born, an equivalent of which is yet to be innovated by the scientific community despite tremendous advances in science and technology. Breast milk, full of species specific anti-infective factors acts as the first vaccination for babies to prevent diseases.¹

Scientific research studies^{7,8,9} conducted during the last three decades have clearly proved that breastfeeding provides the most suitable nutrition for infants and protects them against infections, allergies and asthma.² It is an integral part of the reproductive process and its effect on child spacing, family health, family and national economy and food production is well recognized.³ These beneficial properties of breast milk though known to mankind for centuries, have been established scientifically during the last few decades.⁴

According to Global data, out of 10.9 million under five deaths, roughly 4 million babies die during the first month of life. In India, out of 26 million children born each year, about 1.2 million babies die during the first month. About 1.9 million die before they see their first birthday and around 2.5 million die by the time they are five years. India has the highest number of under-five child deaths in the world.⁵

In the context of Millennium Development Goal 4, scientific evidences have highlighted initiation of breastfeeding immediately after birth without squeezing out the colostrum (first milk) and exclusive breastfeeding for the first six months as the key to tackle infant nutrition and also survival of infant.⁶ A study conducted by UNICEF (2006)⁷ has reported that if babies are exclusively breastfed for the first six months, an estimated 3500 lives could be saved each day. In India, it will account to saving 250,000 newborn babies annually. Recent research on accelerating child survival published in the Breastfeeding Promotion Network of India (BPNI) Lancet⁸ has clearly established that the universalization of early initiation of breastfeeding within one hour of birth has the tremendous potential in reducing 31 per cent of neonatal deaths, which is about 10 per cent of total child deaths.

The National Family Health survey III (NFHS-III) data⁹ released in India in 2005-06 has revealed that only 23.4 per cent newborns across the country are given breast milk within the first hour of birth. Only 46.3 per cent of babies are exclusively breastfed in India. The rate of exclusive breastfeeding in Delhi is only 34.5 per cent¹⁰. In India, breastfeeding is culturally well accepted but inadequately practiced, partly due to ignorance. Lack of knowledge, prevailing misconceptions

and cultural taboos significantly contribute to undesirable breastfeeding practices such as delayed initiation and discarding of colostrum¹¹. Cultural practices related to lactation and breastfeeding in India primarily revolve around the concept of ritual purity and 'hot and cold' foods, food avoidance, restricted diet after childbirth, and remaining in seclusion for a period of time due to the polluting effects of childbirth.^{12,13,14} This study describes the socio-cultural beliefs influencing breastfeeding practices expressed by primi postnatal mothers residing in urban slum areas of Delhi.

METHODOLOGY

This descriptive study aims to assess the socio-cultural beliefs influencing the breastfeeding practices among primi postnatal mothers residing in urban slum areas of Delhi.

Study Setting: The study was conducted among 405 primi postnatal mothers in an urban slum area called Sundernagri in Delhi. The rationale for selecting this area was availability of the subjects and feasibility of conducting the study. There are about 8956 families living in this area, of which 9427 are eligible couple. Around 60 per cent of people living here own their homes but 40 per cent live in basic rental accommodation or in Jhuggis (make shift houses).

Sampling: List of mothers were collected from the Community health centre and mothers who fulfilled the inclusion criteria, i.e Primi postnatal mothers who had normal delivery, and who were regular, available and willing to participate - were only considered for the study. Total 405 mothers were selected by total enumeration method.

Research Design and Tool: The research design selected for the study is descriptive design. The tools used for data collection was interview schedule. A structured interview schedule consisting of both open ended and closed ended items was designed and used. Kuder Richardson-20 formula was used to establish the reliability of interview schedule.

Ethical Consideration: The consent was obtained from the samples and confidentiality was assured to the samples on the collected data. The procedure of the study was explained to the sample. The right of withdrawal and denial from participation was explained to them. The ethical principles of autonomy, non-maleficence, beneficence, justice, veracity and fidelity were adhered.

Data Collection Process: The main study was conducted in the year 2008. Before

data collection, an informal permission was obtained from the sample subjects. Then the initial rapport was established to them. Consent for participation in the study was obtained from them. Then the objectives of the study were explained to the subjects. Confidentiality of the study was assured to them. After obtaining their consent the validated interview schedule was administered to collect their demographic data and to assess their socio-cultural beliefs on breastfeeding.

Data Analysis: The data collected from the samples were coded and entered into a computer. The data entered were thoroughly checked for the correctness of the entries. Demographic variables in categorical/dichotomous and socio-cultural beliefs on breastfeeding were analysed by using SPSS package.

RESULTS

TABLE 1
DEMOGRAPHIC DATA OF SAMPLES

N-405

Demographic Variables		No. of Mothers	%
Age	<=20 yrs	79	19.5%
	21 -25 yrs	205	50.6%
	26 -30 yrs	111	27.4%
	>30 yrs	10	2.5%
Religion	Hindu	264	65.2%
	Christian	21	5.2%
	Muslim	120	29.6%
Nature of Family	Nuclear	187	46.2%
	Joint	208	51.4%
	Extended	10	2.5%
Education Status	No formal education	164	40.5%
	Primary	132	32.6%
	Middle	79	19.5%
	High school	17	4.2%
	Higher Secondary	13	3.2%
Occupation	Housewives	302	74.6%
	Labourer	67	16.5%
	Employed in private	34	8.4%
	Employed in government	2	0.5%

Out of total 405 families, nearly half of subjects (50.6%) were in the age group of 21-25 years, belonged to nuclear family (51.4%) and had male babies (51.6%). Majority of subjects (65.2%) belonged to Hindu religion and were vegetarian (63%). About (40.5%) subjects did not have formal education. Majority of subjects (74.6%) were housewives. 48.1 per cent of subjects had a per capita income of Rs 2001-4000. About 45.2 per cent of subjects said that they received knowledge of breastfeeding from family members.

TABLE 2
SOCIO-CULTURAL BELIEFS AND PRACTICES ON BREASTFEEDING

N-405

Assessment of Socio-Cultural Beliefs and Practices		n	%
1. Based on your custom, how the pregnant woman is prepared antenatally for breastfeeding?	A) Gently pulling and rolling the nipples while bathing	11	2.7%
	B) Applying hot water massage	34	8.4%
	C) No special care	270	66.7%
	D) By cleaning the breast with soap and water every day while bathing	90	22.2%
2. State the special food items given to the mother during her antenatal period	A) Milk with ghee in the last few days of pregnancy to facilitate easy delivery.	231	57.0%
	B) Extra pulses	63	15.6%
	C) Egg and meat	58	14.3%
	D) No extra food given as it increases the weight of the baby	53	13.1%
3. State the beliefs prevailing in the community with regard to physical activities of pregnant mothers	A) Pregnant women should not sleep in the afternoon as it will increase the size of the baby and make the delivery difficult.	28	6.9%
	B) The pregnant women should work actively till the end of pregnancy as it keep them fit.	108	26.7%
	C) The pregnant woman should do the household work such as sweeping and swapping the floor.	233	57.5%
	D) The pregnant woman should not walk for a long distance as it causes premature delivery.	36	8.9%

Assessment of Socio-Cultural Beliefs and Practices		n	%
4. Till what period the sexual relationship is avoided during pregnancy period?	A) First one month	47	11.6%
	B) First three months	238	58.8%
	C) Till delivery	91	22.5%
	D) No restriction	29	7.2%

Antenatal preparation for breastfeeding: Out of total samples, 270 subjects (66.7%) said that they give no special care during antenatal period for breastfeeding. 11 subjects (2.7%) said that they pull and roll the nipple gently while bathing to prevent nipple problems for breastfeeding.

Special Food Intake During Pregnancy: 231 subjects (57%) said that they drink milk added with more ghee and jaggary in the last few days of pregnancy as it facilitates easy delivery and more secretion of milk soon after delivery. At the same time, 53 subjects (13.1%) said that they do not take any fatty diet in the pregnancy because it increases the weight of the baby in the womb and causes difficult labour.

Physical Activities During Antenatal Period: 57.5 per cent of the subjects said that the pregnant women are encouraged to do household work such as sweeping and swapping the floor during pregnancy as it strengthens the pelvic floor of the women which facilitates easy delivery.

Sexual Relationship With Husband During Antenatal Period: 58.8 per cent of subjects said that they avoid sexual relationship with husband during the first trimester as it increases the chances of abortion.

TABLE 3
ASSESSMENT OF SOCIO-CULTURAL BELIEFS AND PRACTICES

N-405

Assessment of Socio-Cultural Beliefs and Practices		n	%
5. When do you start the breastfeeding?	A) Within one hour of birth	34	8.4%
	B) 6-12 hours	58	14.3%
	C) 12-24 hours	116	28.6%
	D) After one day	197	48.6%
6. Who assists you to feed the baby?	A) Sister- in-law	210	51.9%
	B) Mother- in- law	83	20.5%
	C) Family members	70	17.3%
	D) Any others	42	10.4%

Assessment of Socio-Cultural Beliefs and Practices		n	%
7. What feeding is given to the baby soon after birth?	A) Sugar water	233	57.5%
	B) Honey	95	23.5%
	C) Plain water	40	9.9%
	D) Mother's milk	37	9.1%
8. How do you give first feed to the baby?	A) With spoon	278	68.6%
	B) With finger	51	12.6%
	C) With breastfeeding	42	10.4%
	D) Any other device	34	8.4%
9. State the reasons if artificial feeding is given to the baby immediately after birth?	A) Breast milk is not sufficient for the baby	101	24.9%
	B) The baby needs to be fed with something till the sister-in-law performs the ritual of initiation of breastfeeding	235	58.0%
	C) Does not affect the work of the mother	38	9.4%
	D) It can be given anytime even if the mother is not available	31	7.7%
10. How often do you feed the baby in day times?	A) Every three hours	47	11.6%
	B) Every four hours	55	13.6%
	C) On demand	100	24.7%
	D) Whenever the baby cries	203	50.1%

Initiation of Breastfeeding: Only 8.4 per cent subjects said it is started within one hour of delivery. 51.9 per cent subjects said that they wait for the sister-in-law to come and clean the breasts with grass soaked in raw cow's milk and assists to initiate the breastfeeding.

Assistance for Breastfeeding: 59 per cent of mothers said that the sister-in-law helped in breastfeeding her baby while 29 per cent of them said they received help from mother-in-law.

First Feeding: 57.5 per cent of subjects said that they give sugar water as first feeding. 23.5 per cent of them gave honey to the baby soon after birth. They used spoon (68.9%) for feeding. The reason said was that something needs to be given to the baby to quench the baby's thirst till the sister-in-law comes and performs the ritual of initiation of breastfeeding.

Frequency of Breastfeeding: About 50.1 per cent of subjects said that the breastfeeding is given whenever the baby cries while 24.7 per cent said that they feed their babies on demand.

TABLE 4
ASSESSMENT OF SOCIO-CULTURAL BELIEFS AND PRACTICES

Assessment of Socio-Cultural Beliefs and Practices		n	%
11. Duration of feeding the baby on each breast?	A) 5 minutes (otherwise the nipple will become sore)	229	56.5%
	B) 10 minutes	74	18.3%
	C) 15 minutes	54	13.3%
	D) As long as the baby wants	48	11.9%
12. Number of times the baby is fed at night.	A) Once	64	15.8%
	B) Twice	81	20.0%
	C) Whenever the baby needs	88	21.7%
	D) None because the night feed causes colic	172	42.5%
13. Duration of breast feeding alone given to the baby	A) One month	61	15.1%
	B) Three months	75	18.5%
	C) Six months	66	16.3%
	D) It is not possible	203	50.1%
14. Reasons for discontinuing breastfeeding	A) Baby has diarrhoea	55	13.6%
	B) Mother has breast problems	274	67.7%
	C) Mother suffering from any other ailments	60	14.8%
	D) Baby suffering from any other ailments	16	4.0%
15. Extra nutritive food items taken by mother during lactation	A) Green leafy vegetables	62	15.3%
	B) Extra milk with ghee	139	34.3%
	C) Roti with more butter and dhal	161	39.8%
	D) Regular food items	43	10.6%
16. Food items avoided during postnatal period	A) Consumption of more water	113	27.9%
	B) Consumption of curd	117	28.9%
	C) Consumption of Soya beans (Rajma), Ladies finger, Tubers	123	30.4%
	D) Cold beverages	52	12.8%

Duration of Breastfeeding: 56.5 per cent of subjects said that they feed only for five minutes as the longer duration causes soreness of the nipple. 42.5 per cent said they avoid feeding the baby at night because it causes colic to the baby. Despite vigorous IEC campaign, only 16 per cent of the study population said that exclusive breastfeeding is possible for six months. About 50.1 per cent said it is not possible to give breastfeeding exclusively as it will not fulfill the feeding requirement of the baby.

Reason for Discontinuation of Breastfeeding: In all, 67.4 per cent cited breast problems of the mother to be the main reason for discontinuing breastfeeding. 3.2.15-3.2.16 Consumption and avoidance of food items during postnatal period To increase milk secretion, 31.3 per cent of subjects said that they drink milk mixed with ghee and jaggery. 30.4 per cent said that they don't consume Soya beans (Rajma), Ladies finger and tubers which are sticky in nature to avoid gas problem.

TABLE 5
ASSESSMENT OF SOCIO-CULTURAL BELIEFS AND PRACTICES

Assessment of Socio-Cultural Beliefs and Practices		n	%
17. Time of starting regular household work after delivery.	A) Within 3 days	181	44.7%
	B) Within a week	111	27.4%
	C) Within 15 days	67	16.5%
	D) Within a month	46	11.4%
18. The other beliefs prevailing with regard to breastfeeding.	A) If the breastfeeding is not given for a long time, it should be expressed and discarded.	91	22.5%
	B) Gas forming food items to be avoided by mother	101	24.9%
	C) Mother should bathe only after 3 days in hot water.	110	27.2%
	D) Native medicine to be given to the baby to prevent vomiting	103	25.4%
19. Method of preventing the engorgement of breast during lactation.	A) Less intake of food by mother	58	14.3%
	B) Feeding the baby frequently	66	16.3%
	C) Demand feeding and expressing and discarding the breast milk	190	46.9%
	D) By avoiding fatty diet	91	22.5%

Resuming Household Work: Around 27.4 per cent subjects informed that they start lighter household work after their ritual ceremony called ‘chatti’ on 6th day of delivery in which the baby is given bath and kept in the sunlight for some time and then the mother is allowed to start the regular household chores.

Other Beliefs Related to Breastfeeding: In all, 25.4 per cent said that the native medicine such as asafetida, Ginger juice is given to the baby to increase appetite and prevent vomiting. 24.9 per cent mentioned that the mother is not allowed to take salty diets when the baby has minor ailments such as fever. Almost 22.5 per cent of mothers said eating ‘laddu’ made up of cumin seed powder mixed with jaggery will increase the breast milk production.

Prevention of Breast Engorgement: 46 per cent of the mothers knew that the breast milk needs to be given to the baby on demand and to avoid breast engorgement excess milk need to be expressed and discarded.

DISCUSSION

Breastfeeding is the normal way of feeding infants in all traditional societies. Though lactation is a naturally occurring phenomenon following child birth, the act of breastfeeding has been complicated by numerous social and cultural factors. For successful breastfeeding, mother needs support from all stakeholders, including her husband, family, community, the state, and the country. It was observed in the present study that it is traditional in the study area, not to put the baby to the breast for few days and not to give colostrum. It is essential to distinguish the beneficial beliefs or practices which can be encouraged. Harmful beliefs and practices ought to be discouraged.

In the present study, demographic profile of the subjects is similar to the findings of the study conducted by Ahmed A. A Shoshan¹⁵ (2007) on “Factors Affecting Mother’s Choices and Decisions Related to Breast Feeding Practices and Weaning Habits” at King Saudi University, Riyadh, Saudi Arabia. Regarding sources of knowledge of breastfeeding in the present study, about 45.2 per cent of mothers said that they received knowledge of breastfeeding from family members. This is similar to the findings of the study conducted by Sangole and Durge¹⁶ in 2002. Due to prevalence of certain socio-cultural beliefs and practices, mothers in the study area face problems in initiation of breastfeeding. There are certain beliefs and practices that do not encourage early initiation of breastfeeding, thus creating opportunities to give artificial feed to the newborn baby.

In the present study (Table no 2) 57 per cent of mothers said that they drink

milk added with more ghee and jaggary in the last few days of pregnancy as it facilitates easy delivery and more secretion of milk soon after the delivery. At the same time, 13.1 per cent of them said that they do not take any fatty diet in the pregnancy because it increases the weight of the baby in the womb and causes difficult labour. It is similar to the findings of the study conducted by Sunita Dangia¹⁷ in 2007.

The present study also revealed that the pregnant women (57%) are encouraged to do household work such as sweeping and swapping the floor during pregnancy as it strengthens the pelvic floor of the women. Initiation of breastfeeding after birth is considerably delayed in the study area, and in most cases the valuable colostrum is discarded before putting the child to the breast. About 51.9 per cent of mothers said that they wait for the rituals to initiate the breastfeeding. 58.0 per cent of subjects informed that the pre-lacteal feeding is given to the baby as first feeding because the baby needs something to quench thirst. A study conducted by Sunita Dangia (2007) has similar findings.

With regard to frequency of breastfeeding (Table No 3 and 4) 56.5 per cent of subjects said that they feed only for five minutes as the longer duration causes soreness of the nipple and 42.5 per cent of mothers said, they avoid feeding the baby at night because it causes colic to the baby. 50.1 per cent of subjects said that it is not possible to give breastfeeding alone as it will not fulfill the feeding requirement of the baby. 67.4 per cent of subjects said that the breast problems of the mother are the main reason for discontinuing the breastfeeding. These findings are similar to the findings of the study conducted by Gunay Saka et.al¹⁸(2007).

Cultural restrictions related to food are selectively imposed on pregnant women and women in the initial stages of lactation. These practices are enforced by mothers-in-law and other elderly female relatives in the family.

CONCLUSION AND RECOMMENDATIONS

There is a need for dissemination of information and education regarding optimal breastfeeding practices and for protecting and promoting healthy practices. Involvement of pregnant and lactating mothers, elderly women in various IEC activities is desirable as they all have an important role in initiation of breastfeeding and other healthy feeding practices at the community level.

- The study can be replicated on a larger sample in different settings; and thereby findings can be generalized for a larger population.

-
- Comparative study may be undertaken on primi and multi gravidae mothers, urban and rural mothers to compare their socio-cultural beliefs which influence their breastfeeding practices.

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DYNAMICS OF CHILD TRAFFICKING IN BIHAR

Manoj Varghese*

ABSTRACT

Trading in human beings – historically known as slavery – is now called trafficking. There are two principal causes of trafficking: poverty, which makes people vulnerable to exploitation, and criminality, in the form of agents and employers willing to exploit the poor. Child trafficking is generally attributed to economic crisis at home and big family, falling prey to the agents' tempting offers and an aspiration to lead urban life style in cities. In the context of this study, children who went missing or were trafficked from the rural areas of five panchayats in Madhepura district of Bihar for various purposes have been categorized as a case of 'Child trafficking'. These five panchayats were selected for the reason that in this area Emmanuel Hospital Association (EHA) has its medical and social intervention. The majority of 60 per cent of the respondents in the study identified themselves as child labour/trafficking victims, whereas 22 per cent were identified as bonded labourers and 7 per cent as domestic servants. Over 95 per cent of the respondents were found to be unskilled labour, indicating that they had no opportunity to learn a skill or undergo vocational trainings for their livelihood. This made them vulnerable to trafficking and pushed them to the risk zone of maximum exploitation. Over 50 per cent of the parents had more than 5-6 children and this turn out to be one of the main reasons for the parents to have sent away their 1-2 children to places like Delhi. These children are engaged in hotels, grocery shops and small scale industries like making bangles, envelopes, carpets, crackers, brick kilns, etc. Traffickers help them in connecting these children to the needy employers and in turn receive a huge amount and pay the parents a share of it. Parents justify it saying that their children are learning a skill and making their livelihood.

Over 71 per cent respondents were trafficked at some point of time owing to their financial needs at home. Owing to the

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awareness generated by the Government and several civil society groups, the local people in the villages were scared to mention that their child, below 18 years, has been trafficked. For want of police interrogation and other legalities, they were also cautious to mention that their children do not fall below 14 years and to be working as a child labour. Several cases of “missing child” were reported¹, but the parents were reluctant to share it openly for the fear of any further police interrogations. Due to scarcity of funds at home, many children after the middle school prefer taking up a job in another state and are prone to trafficking. Contractors’ involvement, advance money, school dropouts, engaged in work at an early age, missing children are an indication of child trafficking.

Key words: Trafficking, Debt bondage, Siblings, Labour, Health status.

INTRODUCTION

According to a recent survey made by Walk Free, an Australian-based rights group, (published in almost all the Newspapers recently; Times of India front page lead item, dated October 17, 2013),² 2.98 crore people are enslaved worldwide, trafficked into brothels, forced into manual labour including children, victims of debt bondage or even born into servitude. Almost half of them are in India, where slavery ranges from bonded labour in quarries and kilns to commercial sex exploitation. According to the report, 10 countries alone account for three quarters of the world’s slaves. After India (1.39 crore), China has the most with 0.29 crore, followed by Pakistan (0.21 crore), Nigeria (7,01,000), Ethiopia (6,51,000), Russia (5,16,000), Thailand (4,73,000), Democratic Republic of Congo (4,62,000), Myanmar (3,84,000) and Bangladesh (3,43,000).

Trafficking is the extreme inevitability of a distorted economic system, which fuels inequality and encourages profiteering, greed and the exploitation of the most vulnerable members of society. Trafficking in children is a modern form of slavery that consists in transferring a child for exploitation. Child trafficking is a global phenomenon caused not only by economic drivers but many others like social, cultural, political, environmental, health, education etc.³

Madhepura has no big industries, and the eight small scale industries have limited functioning due to frequent power outages. 2875 very small home-based industries also run. There are 323 registered units under the Factory Act

with 2981 employees. There are 200 marketing societies and 21 markets in the district under market management system. 32 weekly markets are also held in this district. The districts' primary industry is agriculture. About 90 per cent population depend on agriculture and dairy. The entire agricultural operation is divided into two crop seasons Kharif and Rabi. Agricultural labour employment is available during sowing and harvesting season for only three months in a year. A sample study shows 96.3 per cent of villages and 91.8 per cent of households in Bihar report seasonal migration.⁴ In India, the rate of rural male out-migration is highest among the states of Bihar, Kerala, Uttar Pradesh and Rajasthan.⁵

More than 50 per cent people of the target area are landless and they depend on the daily wages. 79 per cent of the work force is either agricultural or casual labourers and they migrate to prosperous states like Punjab, Haryana, and Delhi in search of work. Only 4 per cent of the population is in government or private jobs. Social or caste characteristics are also strongly associated with lack of opportunities: Schedule tribes are thrice likely to be poor as compared with upper castes and significantly so in relation to Muslims and backward castes.⁶

The health seeking behaviour and health care access in this region is awful in the state. Only 52 per cent of the pregnant women received at least 1 TT during their pregnancy. Institutional delivery stands at 4.5 per cent in the target area. At present only 15.9 per cent have access to clean hand pump and only 12.5 wash their hands after defecation or before eating. A rapid survey in the target villages shows 58.1 per cent (age 6-59 months) of incidence.⁷

The villagers were learnt to be self-respecting; the men would never want or allow their female folk for trafficking or to the extent of even sending them for domestic work, unless on the death bed. Also, they would not mind spending the last portion of money, even to the extent of selling their land or an organ for that reason, on their wards who wish to go for higher studies. Several cases revealed that urban life style of owning a bike, mobile, sunglasses, dresses; etc. influenced the child to leave the school and the village simultaneously and falling prey into the hands of the traffickers.

The family size also influences child trafficking. Interactions with the villagers hinted at a steady increase in the frequency and number of trafficking cases. Earlier, it was in bits and pieces, now it happens in groups with the help of a broker/middleman/contractor/agent. The advance paid by these agents to the parents is more often used to meet their basic requirements or is spent on a marriage/funeral ceremony.

METHODOLOGY

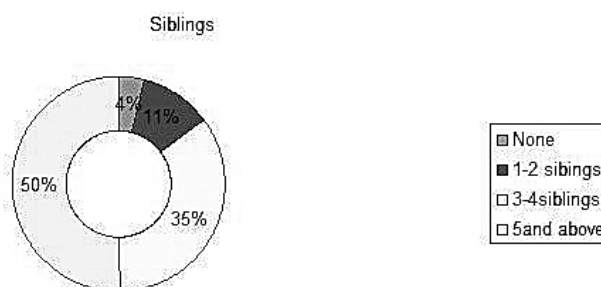
The Snowball method was used to fill in the questionnaire by the respondents, who had been a victim of trafficking in some form or the other. A sample of around 300 trafficking affected people among different social groups ST, SC, and Other Backward Castes was taken. A structured questionnaire, focus group discussion and an interview schedule containing personal, trafficking details were used to understand the dynamics of child trafficking. Local volunteers, decision makers, social and political leaders and victims' inputs were taken to understand the gravity of the problem. The study was parametric and qualitative as well. Based on the inputs from the local volunteers and the field visits a list of around 25 questions were developed and circulated. Based on the responses of the questionnaire, the data was collected, compiled, interpreted and analyzed to understand the dynamics of the situation. The scope of the study is limited to five panchayats of Madhepura district. However because of the socio-economic similarities this finding can be representation of the Koshi region (Madhepura, Saharsa, Supaul, Katihar, Purnia, Araria and Kishanganj).

Data analysis and Interpretation

All the villages under the five target panchayats of Madhepura district in Bihar are prone to natural calamities like flood or a drought anytime and every time. The villagers sow the seed with no hope of reaping the harvest as there may be a drought or a flood which would hamper their entire efforts. Many of them who have received a small plot of land for cultivation from the Government are not very optimistic of surviving on it. They depend upon the Rain Gods for a normal rain throughout the year. Getting the subsidy or the ration is at the mercy of the PDS authorities and the ruling party workers.

Number of Siblings of the Respondents

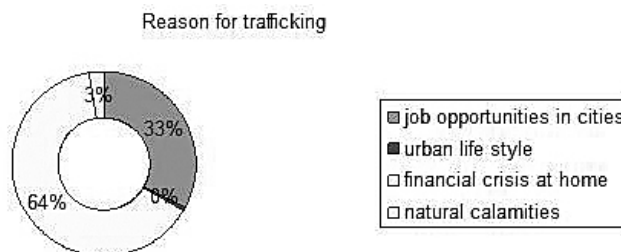
FIGURE 1
PERCENTAGEWISE SIBLINGS AT HOME



Out of 280 respondents, 50 per cent, that is 140 of them have more than 5 siblings. 35 per cent have 3-4 siblings and 11 per cent have 1-2 siblings. 4 per cent of the respondents do not have any siblings. Families with more than 5 children were more prone to child trafficking owing to the financial crunch and an option to send them away to make their own living.

Reasons for Trafficking

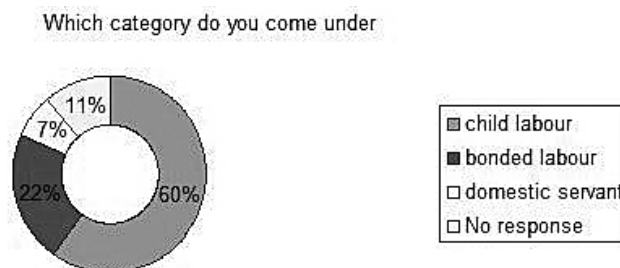
FIGURE 2
PERCENTAGE-WISE REASONS FOR TRAFFICKING



A majority of the respondents comprising 64 per cent felt that financial crisis at home was the main cause of trafficking. 33 per cent of the respondents saw job opportunities in cities as an attractive cause for trafficking while the rest 3 per cent attributed it to natural calamities.

Distribution of the Categories of the Respondents

FIGURE 3
PERCENTAGE WISE CATEGORIES OF TRAFFICKING



The majority of 60 per cent of the respondents identified themselves as child labourers/trafficking victims, whereas 22 per cent identified as bonded labourers and 7 per cent are domestic servants. The rest of the 11 per cent of the respondents have not given any response.

DISCUSSION AND RECOMMENDATIONS

Based on the findings of the present study, withdrawn conclusions and interactions/discussions with stakeholders, some prominent recommendations have been outlined and described to address child trafficking issues in Madhepura district, which is as follows:

- The need for an agency at the panchayat level is seriously felt to address the issue of child trafficking. The agency could play a crucial role in introducing and implementing the Government welfare schemes for the upliftment of poor and downtrodden and debarring them from getting trafficked. At the same time, it can advocate on behalf of the victims as “voice for the voiceless”. Several rescue operations are happening in the cities of Delhi and elsewhere to liberate the trafficked children, but would be more effective if it addresses the root cause of evil at the grass root level in villages itself.
- Provide universal food security through the public distribution system and the supplementary meal schemes at the grass root level through mid-day meal and Anganwadi schemes. This will provide crucial support to vulnerable children and their families. The school mid-day meal is also essential for ensuring that women do not sacrifice their own nutritional needs for that of hungry children in the household. Also, the children will not become a burden for them.
- Geographical mapping of high and medium child trafficking prone areas should be done for targeted interventions. Accordingly, the stakeholders; vulnerable children, child victims, parents, teachers, political leaders, Government authorities, and others need to be involved to address the issue at the local level.
- Planning of livelihood based interventions should focus and consider needs at all stages such as when developing Self Help Groups, focus on their training, production along with their effective linkages to marketing channels for sustenance. Grain Bank model – The released Sahariya community bonded labours in Baran, Rajasthan formed their own self- help group in the village and would store their grains for a time of need. A small portion of the ration received through the PDS is being collected and stored at a place and shared equally when need arises. Also, they cultivate the land received by the Government and the landlord in a collective way. Together they would plough, sow the seed and reap the harvest and store a portion of it so that they may not enter into bondage again for want of food.
- Raise awareness in trafficking prone areas, particularly amongst the vulnerable communities. The villagers need to understand the pros and cons of sending out their children to an unknown city. Violation of human rights under the

legal framework and other exploitation needs to be publicised.

- Impart vocational training leading towards skill development and a sustainable livelihood. This would enable the vulnerable community to restrain from being trafficked for economic reasons.
- Stern action against the culprit parents and contractors/agents/middlemen. Preventative actions are more focused on addressing the actual practice of child trafficking, specifically by implementing legal frameworks that are aimed to both deter and prosecute traffickers. Traffickers can be “caught” at any one of the three steps of trafficking: recruitment, movement, and/or exploitation.
- Empowering the Vigilance committees to monitor and take stock of the situation. They should be given sufficient powers to also take action against the culprits and release the victims. The committee should involve local people and activists and need to meet on regular intervals.
- Rehabilitating the victimised child so that s/he makes a sustainable livelihood and do fall prey to the traffickers again.
- Increase employment opportunities in their local vicinity so that they are not tempted for trafficking. A regular income at home by engaging in some development activities would restrain them from sending their children for a minimal sum of money.
- Strengthen existing public distribution system-PDS, Mahatma Gandhi National Rural Employment Guarantee Act – MGNREGA and Indira AwasYojna to provide affordable quality comprehensive services and care through food, job and shelter. This is possible through strong primary level care which integrated with the secondary and tertiary level through effective referral system.
- Encourage establish Government supported labour recruiters by introducing license mechanism and photo-IDs for every recruiter. Develop recruitment guidelines for all recruiters and formulation of a federation of recruitment agencies.
- Establish the mechanism of undertaking the follow-up of migrants to prevent his or her rights and taking the preventive actions timely. The migrating population is more prone to child trafficking into these big cities.
- The Government welfare entitlements are made available to all villagers, without any conditionality of political party, caste, creed and community.
- Involve civil society in monitoring and evaluation; involve community women in social audit and local monitoring committees.
- Helpline for reporting child trafficking cases.

CONCLUSION

In the beginning of 2013, several activists, NGOs, media men, police and government officials were able to liberate around 27 and 56 children from

the clutches of bondage from the Jama Masjid and Navi Karim area in Delhi respectively.⁶ All the victims were in the age bracket of 12 to 16 years, almost everyone from the state of Bihar and 90 per cent of them from a minority community. What perplexed was the fact that children of this age group could not have come of their own. On interaction they admitted the fact that they have been sent by their parents to learn a skill for their livelihood against an advance money. Most of the children are being trafficked from Bihar for the reason that it is one of the most backward states in terms of development. Lack of opportunities for employment, economic crunch, local goondaism and corruption are the main reasons for its backwardness. Thirdly, the big families on the point of starvation found it wise to sacrifice 1-2 children and make it for survival at both the ends. Exploitation, backwardness and big family are termed to be main the reasons for child trafficking.

Delhi has many illegal placement agencies due to a high demand for live-in maids and cheap labour at small scale industries. Employers prefer young children because they are cheaper and complain less. The traffickers in Delhi supply; domestic labour, child labour for factories, brides to Haryana and Punjab, bonded labour to brick kilns in Haryana, Uttar Pradesh and Punjab and run flesh trade rackets. Although, as per the protection mechanism, the National Capital has: 11 anti-human trafficking units, nine district child protection units, 25 child protection homes, 11 special juvenile police units, six child welfare committees and two juvenile courts.

There are many contributing factors to child trafficking, which include economic deprivation, lack of employment opportunities, social status, and political uprisings. Many of the families in India are unable to afford the basic necessities of life, which forces the parents to sell their children off to gangs, and the gangs to exploit them. Trafficking in human beings, especially children, is a form of modern day slavery and requires a holistic, multi-sectoral approach to address the complex dimension of the problem. It is a problem that violates the rights and dignity of the victims and therefore requires essentially a child rights perspective while working on its eradication.⁴

In the fight against trafficking government organizations, non-governmental organizations, civil society, pressure groups, international bodies, all have to play an important role. Law cannot be the only instrument to take care of all problems. The present study has made an attempt to assess the status of child trafficking, extent of understanding among stakeholders such as law enforcement officials, political leaders and victims. Notwithstanding the commendable gains made by the anti-trafficking movement in the metros over the past years as a result of

various interventions, a lot has to be done at the grass root level in villages.

In the recent past, a lot of anti-trafficking activities and rescues are happening in the metro cities. Hundreds of people are rescued from bondage owing to the interventions made by several civil society groups. But, back home, the starving belly again tempts them to reenter into bondage. With no food, work and engagement they fall prey into the hands of traffickers. The ones who are trapped and rescued again face the real crunch of economic crisis back at home. The need of the hour is to intervene as a voluntary agency and address their basic requirements by giving them a hope to live; and food, shelter and work for their livelihood. The agency could form self-help groups-SHG, provide capacity building, impart vocational training and connect them to some micro finance groups to make their earning. This will make their life pleasant and the villages will follow the route to development.

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PRIVATE HEALTH CARE PROVIDERS AND MEDICLAIM SERVICES

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ABSTRACT

Mediclaime is a cost-supportive option for health risk transfer offered by public and private sector insurers. Of late, it is emerging as a big industry wherein patients, insurers and providers may have their unique positions to influence outcomes, especially the private health care providers (hospitals/doctors) controlling treatment at insurers' costs. This study assessed the role of private health care providers while facilitating mediclaime services for their patients. The study was conducted on a cross-section of in-patients in four selected tertiary-level private hospitals of Delhi, who had availed mediclaime facility for treatment during the Indian Financial Year 2011-12. The sample comprised of 120 patients, 30 from each hospital. Confidential in-depth interview method was used to collect data from the sample respondents. It was observed that all 120 patients in the sample had been facilitated by their private health care providers in availing mediclaime services. However, on probing further to find out any practice of influence/deception by the providers, the respondents revealed various tactics used by the providers during such facilitations. The authors conclude that many private health care providers resort to various tactics of influence/deception while facilitating mediclaime services for their patients. Introduction of corrective regulations and measures for their strict compliance are recommended.

Key words: Mediclaime, Health insurance, Private health care provider, Private hospital, Influence, Deception, Tactics.

INTRODUCTION

Day by day, health is becoming all the more valuable and disease all the more expensive. As a method of risk transfer, many people plan and opt for mediclaime (also called as private health insurance) which is the insurance against the risk of incurring medical expenses.¹ It is seen as a cost-effective way of supporting

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financial resources available for medical care.² Of late, in India too, mediclaim is emerging as a big industry in both public and private sectors which have witnessed tremendous changes and wider coverage over the past few years.^{3,4}

Mediclaim generally covers the insured person's hospitalization expenses and provides medical reimbursement facility for expenses incurred due to sickness. However, patients are generally required to share the costs, because some of the cost components are non-coverable under any given mediclaim policy.^{1,5} In order to avail cashless facility under mediclaim for treatment in a private health care institution, an authorization from the concerned insurer, or its third party administrator (TPA), is required. The procedural formalities for this purpose are generally done by the concerned private health care provider who also gets the payment from the insurer directly for such a treatment.¹ After the insurer issues the final authorization for cashless treatment, the patient does not need to pay anything to the provider (except any bill difference arising over and above the amount thus authorized).

An unfavourable effect on any of the stakeholders of mediclaim may jeopardize the inherent philosophy of risk transfer and can potentially detriment its utility and significance⁶. Under the present scenario of mediclaim services, patients, insurers and providers may have their unique positions to influence outcomes, especially the providers (hospitals/doctors) controlling treatment at insurers' costs. Several case reports have indicated that many mediclaim schemes suffer from high claim ratios, over-utilization and false claims, particularly due to moral hazard and a practice of influence/deception by the private health care providers.⁷⁻¹⁰ This is a serious issue. However, studies assessing the role of private health care providers from this perspective are hard to find, particularly in the Indian context.

OBJECTIVE

The objective of this study was to assess the role of private health care providers while facilitating mediclaim services for their patients.

METHODOLOGY

Type of Study

The present study is a descriptive, cross-sectional, hospital-based study that aimed to gather an in-depth understanding of the role of private health care providers while facilitating mediclaim services for their patients. It focused on the tertiary-level hospitals of Delhi for in-patients with mediclaim facility.

Place of Study

The study was conducted in four selected, registered, tertiary-level, private hospitals located in Delhi and empanelled with mediclaim facilities. Due to practical constraints of the private hospitals' own concerns and acceptability for such kind of study, convenience sampling technique was used and the first four eligible hospitals, which agreed for participation and gave written permissions for conducting this study in their hospitals, were selected and included in this study. In order to maintain privacy and confidentiality in identification of these private hospitals, the study hospitals were coded (as SH1, SH2, SH3 and SH4) and their precise identification data (such as hospital's name, complete address, absolute bed strength etc) have not been disclosed here intentionally.

Period of Study

The study pertained to the Indian Financial Year (FY) 2011-12 (that is, a period of one year starting April 1, 2011 and ending March 31, 2012). This period was chosen as it was the year immediately preceding that in which the process of actual data collection was done.

Study Subjects

The sample comprised 120 in-patients (30 from each of the four study hospitals) who had availed mediclaim facility for treatment during the period of study. Inclusion criteria for selection of patients were: a) the hospitalisation period falling within the period of study; b) complete hospitalised treatment followed by discharge on improvement (as per the medical advice); and c) availing of individual mediclaim facility for the hospitalised treatment. Exclusion criteria were: a) hospitalisation period extending beyond the period of study; b) expired, brought dead, left against medical advice, discharged on request, or referred/transferred out patients; c) hospitalisation for a period less than 24 hours; d) treatment under fixed-cost package deals; e) treatment under social health insurance facility or any other subsidised scheme; f) treatment rendered on complimentary basis; and g) destitute patients. Based on these criteria, a discrete list of patients who were found eligible for inclusion was prepared (arranged in a chronological order from the latest to the oldest time of discharge from the hospital) for each study hospital, from which 30 patients were selected by using systematic sampling technique and included in the study. Informed consents were obtained from the sample subjects for participation in this study.

Tools and Techniques for Data Collection

Suitable pre-tested checklists and semi-structured schedules were used as tools for the present study. Data were collected in a single cross-section during the period from June through October of 2012. Profile data on the study subjects and their hospitalisation details were collected from the concerned hospitals. Confidential in-depth interview method was used to collect data from the sample respondents, which involved focused, conversational, two-way communication on their experiences regarding the role of their private health care providers in facilitating mediclaim services for them. The subjects were probed further to find out any practice of influence/deception by the providers during such facilitations; and in case of affirmation, further details of their pertinent experiences were gathered from the respondents.

Data Analysis

The collected data were analysed by using appropriate statistical techniques and software packages (the Microsoft Office Excel 2013 and the IBM SPSS Statistics version 21.0).

FINDINGS AND DISCUSSION

Profile of the Study Hospitals

General profile of the study hospitals is shown in Table 1. Each hospital was a tertiary-level hospital; registered with the Directorate of Health Services, Government of National capital Territory of Delhi; and processing mediclaim cases also.

TABLE 1
PROFILE OF THE STUDY HOSPITALS

Particulars	Study Hospitals (Codes only)*				Total
	SH1	SH2	SH3	SH4	
Address (location only)*	West	North	North-West	North-West	
Type of hospital (public or private)	Private	Private	Private	Private	
Level of health care services available	Tertiary	Tertiary	Tertiary	Tertiary	

Whether registered with DHS	Yes	Yes	Yes	Yes	
Accreditations:					
• By NABH	No	No	No	No	
• By others	Yes	Yes	Yes	Yes	
[If “Yes”, name of accrediting/ certifying body]	(ISO 9001)	(ISO 9001)	(ISO 9001)	(ISO 9001)	
Bed strength*	>250	101-250	101-250	≤100	627
Whether processes mediclaim cases	Yes	Yes	Yes	Yes	

DHS, Directorate of Health Services; ISO, International Organisation for Standardisation; NABH, National Accreditation Board for Hospitals.

* Precise identification data of these private hospitals viz. their names, complete addresses and absolute bed strengths have not been disclosed here intentionally in order to maintain privacy and confidentiality in their identification.

Listing of In-Patients and Selection of the Study Subjects

In total, 48,310 patients were hospitalised in the four study hospitals during FY 2011-12 (Table 2). About one-sixth of them, that is, 8,339 in-patients had availed mediclaim facility for treatment, which is an observation in support of the fact that the mediclaim is becoming increasingly popular in India, particularly in the urban areas.^{3,4,11,12} About half of the patients with mediclaim facility fulfilled the eligibly criteria for inclusion in the study; and out of them, 30 patients were selected systematically from each of the four study hospitals thereby making a total of 120 subjects in the sample.

TABLE 2
LISTING OF IN-PATIENTS AND SELECTION OF THE STUDY SUBJECTS*

Study Hospitals (Codes only)*	Number of In-patients**			
	Total Patients Hospitalised	Patients Availing Mediclaim Facility	Patients Eligible for Inclusion	Patients Included in the Study
SH1	18518	3584	1753	30
SH2	14019	2335	1170	30
SH3	11294	1043	649	30
SH4	4479	1377	690	30
Total	48310	8339	4262	120

* Names of these private hospitals have not been disclosed here intentionally in order to maintain privacy and confidentiality in their identification.

** During the Indian Financial Year 2011-12.

Demographic Profile of the Study Subjects

The mean age of the study subjects was 41.5 ± 19.9 years (mean $\pm$ SD). There were 82 males and 38 females, making a male-to-female ratio of 2:1. Overall, they had good educational levels (with more than half of them being intermediate or higher qualified), mostly belonged to business-and service-class families, and had good socio-economic status (71% and 14% of them belonging to the upper-middle and the middle socio-economic classes respectively). Based on these observations, the authors consider the respondents reliable enough for the purpose of the present study.

Details of Hospitalized Treatment of the Study Subjects

The study subjects had remained hospitalized for a mean period of 4.6 ± 2.3 days. During such periods, they had received hospitalized treatment for various current illnesses (including acute infections, medical emergencies and other diseases). Some of them had more than one disease (which included the pre-existing diseases and those diagnosed for the first time during their current hospitalizations) and most of these diseases had also needed treatment simultaneously. Coverage of pre-existing diseases under mediclaim has remained an issue worldwide with several surveys showing a very strong opposition to their exclusion whereas others advocating for their inclusion under mediclaim cover for more equitable service delivery.^{13,14}

Mediclaim-related Details

Each of the study subjects stated that their private health care providers had performed the needful procedural formalities to enable them to avail cashless facility under mediclaim for their hospitalized treatments. During these processes, a denial of cashless facility was observed in two patients while an approval of the final authorization for cashless facility was observed in the remaining 118 patients. Many of the study subjects also stated that their insurers (or TPAs) had posed one or other queries to which their providers (hospitals and/or doctors) had then responded to; and after such replies to the queries, their insurers/TPAs had issued the final authorizations for cashless facility. So, all 120 patients in the sample recognized that they had been facilitated by their private health care providers in availing mediclaim services.

However, apparently these providers (hospitals and their doctors) had an authoritarian role while doing such procedural formalities and a possibility of its misuse to facilitate mediclaim services for the ineligible patients in an improper

manner could never be ruled out. Few other studies and reports have raised this issue.^{7-9,13,15}

When the study subjects were probed further to find out any practice of influence/deception by their providers, 112 (93.3%) respondents affirmed, 1 (0.8%) denied completely and 7 (5.8%) refrained from commenting on their experiences. The respondents revealed various tactics that had been used by their private health care providers in facilitating mediclaim services for them and further disclosed that one or more of such tactics had been used in their cases (Table 3). Broadly, the tactics used by these private health care providers were certain manipulations through which they had attempted to project a favourable fact, hide an adverse fact, and/or fabricate a desired situation, thereby making their patients' cases suitable for authorization of mediclaim facility by their concerned insurers/TPAs. In some cases, a given private health care provider had shown the duration of its patient's hospital stay longer than the actual, which could not have been done without conniving with the concerned patient. Similarly, cooking-up, exaggeration or distortion of clinical presentation and hiding facts about any pre-existing disease (or its duration) would also have involved the concerned patient actively. Some of the patients in this study had been kept hospitalized for longer durations, which would have benefitted either their providers (who made more money out of it) or the patients themselves (who otherwise had to bear the costs of their post-hospitalization expenses). A patient availing cashless facility under mediclaim is generally less bothered about the various charges being levied for his/her treatment because these charges are not to be paid by him/her directly. This factor could have prompted some providers to offer extra services unnecessarily, hike charges for the services provided, and/or add charges for the services not even provided to their mediclaim patients in this study. Some providers had concealed those facts, reports and even charge-heads about their mediclaim patients, revelation of which could otherwise have led to denial of cashless facility to them; and even further, they had either not levied any charges on such accounts or had taken such charges separately (without showing them in the medical expenses being billed under mediclaim). Instance of a provider colluding with the TPA was a rarity in this study.

It was inferred from these observations that, apart from doing procedural formalities, many private health care providers had resorted to various tactics of influence/deception while facilitating mediclaim services for their patients in this study. Although some providers may be able to sell some extra services (or rather waste them) or make some extra money by using such tactics, these practices (or malpractices) tend to put undue burden on the insurers and affect the financial resources available for care in future. In the long run, it would impinge upon the

linkage between health demands and provision of services, and increase the cost of treatment under mediclaim.⁶ So, there is an urgent need to address this crucial issue and prevent such practice of using tactics by the providers.

TABLE 3
EXPERIENCE OF THE STUDY SUBJECTS REGARDING PRACTICE OF INFLUENCE/
DECEPTION AND THE TACTICS USED BY THEIR PRIVATE HEALTH CARE PROVIDERS
WHILE FACILITATING MEDICLAIM SERVICES FOR THEM (n=120)

Tactics of Influence/Deception used by the Private Health Care Providers (hospitals/ doctors)		Experience of the study subjects regarding use of these tactics by their private health care providers while facilitating mediclaim services for them		
		Number of responses in affirmation	Number of responses in denial	Proportion of affirmative respondents
1.	Showing duration of the hospital stay longer than the actual	7	17	29.2%
2.	Exaggerating/distorting the clinical presentation	30	75	28.6%
3.	Hiking charges for the services availed	16	42	27.6%
4.	Adding charges for the services not actually availed	18	57	24.0%
5.	Keeping patient hospitalized for longer duration	25	88	22.1%
6.	Offering extra services coverable under mediclaim	23	89	20.5%
7.	Taking payment of non-coverable charges separately and not showing under mediclaim	10	44	18.5%
8.	Concealing undesirable facts coming across during hospital stay	15	68	18.1%
9.	Hiding undesirable charges	7	38	15.6%
10.	Hiding undesirable investigation reports	6	40	13.0%
11.	Hiding pre-existing diseases	12	85	12.4%

Tactics of Influence/Deception used by the Private Health Care Providers (hospitals/ doctors)		Experience of the study subjects regarding use of these tactics by their private health care providers while facilitating mediclaim services for them		
		Number of responses in affirmation	Number of responses in denial	Proportion of affirmative respondents
12.	Concealing correct durations of pre-existing diseases	10	88	10.2%
13.	Cooking-up clinical presentation	1	35	2.8%
14.	Colluding with third party administrators	1	43	2.3%

** Some patients refrained from commenting on practices and/or tactics used by their private health care providers.*

Insurers (or their TPAs) have so far neither monitored mediclaim cases adequately from this perspective nor devoted enough attention to the appropriateness of such claims by the large private health care institutions, both of which indirectly encourage expensive corporate hospital treatment.¹³ Exclusions under mediclaim coverage (such as pre-existing diseases and other specified conditions) are not being regulated sufficiently in India, which are generally left to the decision of the insurers at present.^{13,14} To ensure quality services and check malpractices in private health care institutions, the Clinical Establishments (Registration and Regulation) Act, 2010 has a promising role; however it is yet to be adopted by many state governments.¹⁶ Moreover, the problems of private health system need attention at the very core.^{17,18} In particular, the objective of profit maximization tends to embolden some of the private health care providers to resort to unfair practices and tactics in mediclaim cases. The current delicate situation of these providers requires measures of social development, increased awareness, self-restraint and stringent regulations for punitive actions. Introduction of appropriate corrective regulations for mediclaim in India and measures for their strict compliance are recommended for prevention of such unfair practices and tactics.

CONCLUSION AND RECOMMENDATION

The present study has shown that many private health care providers resort to various tactics of influence/deception while facilitating mediclaim services for their patients. Although these providers may benefit temporarily by doing such malpractices, it would have deleterious effects in the long run as it would result

in an escalation in the cost of treatment under mediclaim. To address this crucial issue and prevent such practice of using tactics by the providers, there is an urgent need for measures of social development, increased awareness, self-restraint and stringent regulations for punitive actions. Introduction of corrective regulations and measures for their strict compliance may be more practical, feasible and implementable on short-term basis and are highly recommended for prevention of such unfair practices and tactics.

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