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Traditional and complementary approaches to health for children: Modelling the parental decision-making process using Andersen's Sociobehavioural Model

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Child

Summary

Objectives: Traditional and complementary approaches to health (TCA) are common for children. Andersen's Sociobehavioural Model (SBM) is often used to explain healthcare decision-making. This study aimed to identify the prevalence and determinants of traditional and complementary approaches to health (TCA) in a multi-ethnic child population, and to explore whether the SBM explained TCA health care decision-making in this population.

Design: Cross-sectional questionnaire survey. NHS ethical approval was given.

Setting: GP waiting rooms, Northwest London.

Main outcome measure and analysis: All carers/parents (with children under 16), attending GP appointments on specific days, were asked to complete a questionnaire about TCA use; primary outcome 12-month child TCA use. Forward stepwise logistic regression tested appropriateness of the SBM.

Results: A total of 394 questionnaires were returned, representing 737 children; a quarter White British. Prevalence of 12-month TCA use was 45.4%, mainly food-based herbs/spices for minor illnesses which were used prior to GP consultation. Over half identified that TCA was part of their ethnic/cultural background. Only 29% had discussed TCA with their GP. The strongest predictor of child TCA use in the SBM was carer TCA use, itself influenced by carer gender and ethnicity, and GP advice. Need factors were not influential.

Conclusions: Child TCA use was common in this multi-ethnic community, particularly the use of food-based remedies for minor illnesses, and carers' experience and background are central in deciding to use TCA for a child. TCA appears practiced as part of cultural background, with implications for GPs to be aware of their role in guiding patients to ensure safe practice.

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Introduction

Complementary and alternative medicine (CAM), ''a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine'',[1] is commonly used for children, with prevalence estimates varying from 12% in the USA,[2] to

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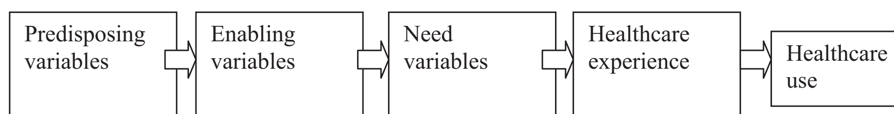

Figure 1 The SBM.

51% in Australia[3] and between 17.9%[4] and 37%[5] in the UK. Patients often also include traditional or ethno medicine such as home remedies in their definitions of CAM, and such approaches are commonly used.[6] Little attention has been paid to the role of such traditional medicine use in the developed world and research has rarely combined CAM and traditional medicines. The term traditional and complementary approaches to health (TCA) encompasses both CAM and traditional medicines, and is the focus of this paper.

As with all healthcare, the decision to use TCA involves many factors, such as perceived risks and benefits,[7] desires, personal values, beliefs and expectations[8] and other practical considerations such as access. These influences can be structured using a variety of models, including healthcare utilisation models of factors which enable and encourage healthcare 'consumption', either sequentially or as determinants; and health behaviour models based on social and psychological factors, mainly cognitive. Andersen's Sociobehavioural Model (SBM) is one of the most commonly and successfully used healthcare utilisation models, including for CAM.[9,10] The SBM[11,12] groups determining factors into three sequential components which mitigate healthcare use (see Fig. 1). Predisposing factors include beliefs and sociodemographic characteristics, enabling factors allow and give access to healthcare services and the final most proximal components are medical need and healthcare experience.[11] We refer readers to our previous systematic review for more information on the factors included in the SBM.[9]

For children, decision-making is likely to include the whole family not just the patient, with children reliant on carers' decision-making.[13] Other factors in decision-making may include being a 'good' carer,[14] being more cautious with children's health[15] and having a greater dissatisfaction with conventional healthcare,[16] all of which may mean carers use different treatments for children compared to themselves.[17] Also, women/mothers are more likely to be the decision makers, and are higher users of healthcare services than men, including CAM.[18,19] Much of the research on parental decision-making in CAM is based on cross-sectional surveys which are often atheoretical [i.e. not theoretical] and not based in a conceptual framework.[20] Findings from these studies suggest that a range of predisposing, enabling and need factors influence child use of CAM, as well as possibly healthcare experience.[21] Only one study has used the SBM for child CAM use and found support for the model.[16]

Research using other theoretical models has added further insight into the influence of the factors in the SBM on TCA use.[9] This study aimed to identify the prevalence and determinants of traditional and complementary approaches to health (TCA) in a multi-ethnic child population, and to explore whether Andersen's Sociobehavioural Model explained TCA health care decision-making in this population.[12]

Methods

Design

A carer completed questionnaire survey was developed, which was based on the results of 11 focus groups with 92 parents.[21] The focus groups provided detailed information, particularly on the choice of factors which appeared important in parents' decision-making to use TCA.[21] Ethical approval was given by Harrow Research Ethics Committee, reference 06/Q0405/92.

Participants

Four North West London Primary Care Research Network GP practices agreed to participate, two in Brent and two in Harrow. Both Brent and Harrow have some of the highest proportions of ethnic minorities in the UK; Brent 54.7% are non-White and 41.3% in Harrow; Asian/Asian British accounts for 28.7% (Brent) and 36.9% (Harrow). For comparison, in London, the proportions are 29% are non-White and 5% Asian/Asian British.[22] A convenience sample was obtained from GP waiting rooms by inviting all patients to participate who: attended GP appointments on specific days over a 1-month time period; had children under 16; indicated that they were able to complete the survey in English. Participants read the information sheet, had the study explained to them by the researcher, and provided written consent. The target sample size was 400, based on our previous survey in paediatric outpatients.[5]

Outcomes

The carer-completed questionnaire was designed based on the results of 11 focus groups with 92 parents held in NW London, the same geographical area as the survey.[21] Questions included child health, use of TCA with specific examples, reasons for non-use, access to TCA, details of discussion with GPs, carer's use of TCA, and demographics. The primary outcome was 12-month child TCA use, based on an open-ended question which required insertion of free text. Additionally two questions asked about lifetime use: a yes/no question and a tick-list of common TCA. Twelve-month use was chosen as the primary outcome as lifetime use may have been biased as a result of recall and may be correlated with child age. In addition an open question was felt to be more reliable.

Statistics

Data were cleaned by identifying missing responses and deleting data from any children over 16 or any incomplete

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