International Journal of Allied Medical Sciences and Clinical Research (IJAMSCR)

ISSN:2347-6567

*IJAMSCR |Volume 9 | Issue 1 | Jan - Mar - 2021*
www.ijamscr.com

*Research article* *Medical research*

# Factors influencing the health-seeking behavior of the street children in indonesia

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## ABSTRACT

### Background
Assessing the health-seeking behaviour is a key aspect for planning healthcare programmes. Yet, this aspect remains understudied in the street children population in Indonesia.

### Objective
To identify the social factors that affect the health-seeking behaviour of the children-on-the-street aged 15-20 years in urban areas in Indonesia.

### Method
This study used a cross-sectional design. A total of 115 street children were recruited by using simple random sampling method in five shelters in different cities of Indonesia. Data were analysed with descriptive analysis, cross tabulation with $\chi^2$ Yates corrections, and double logistic regression

### Results
Family support was the strongest factor affecting the health-seeking behaviour of the street adolescents (OR = 4.926).

### Conclusion
The results show that strengthening family functioning could be an effective strategy to improve the health outcomes of the street adolescents in the large urban cities of Indonesia.

**Keywords:**Street children; adolescent; health-seeking behaviour; family support; Indonesia

## INTODUCTION

Indonesia is home for around 43 million adolescents aged 10-19 years, out of 261 million total population.[1] A fraction of the Indonesian children under 18 live or work in the street in some major urban areas, mainly due to extreme poverty.[2] There are 420,000 street-involved children and youth in Indonesia and 200,000 of them have received some supports from the government.[2] Yet, the issue of street children demands a more serious attention as it has multilayered implications that include the socioeconomic, physical and psychological dimensions.[3]

Adolescents are in a critical developmental period that their health behaviours may have a lasting impact on their adulthood, apart from their

current health status.[4] A systematic review shows that street adolescent are more prone to health problems which are mostly associated with the health-related behaviours, i.e. substance abuse infectious diseases, sexually transmitted infections, HIV-AIDS, and work-related injuries.[5] It is also highlighted that depressive symptoms, hopelessness, and suicidality are prevalent among street adolescent because of chronic exposure to stressors.[5] A prior study in Indonesia finds that 52% of the street children in Jakarta Indonesia are stunted.[6] Furthermore, being in younger age, having lower socio-economic position and marginalised status, stigmatisation by the health care providers, poor health-sick perception, and long waiting time are found to be barriers of the street children to access health care when needed.[5] However, there is a dearth of literature about health-seeking behaviour in street children, especially in Indonesia. Assessing health-seeking behaviour is of particular importance to planning health programmes.[7] Given the magnitude of the vulnerability of the street children and their risk of developing health-related problems, it is necessary to develop healthcare service that is sensitive to the needs and situation of the street adolescents. Otherwise, this group of adolescents will remain an under-served group of people in the wheels of misfortune.

A review suggests that the social factors in the family, community, and nation levels strongly influence the health of the adolescents.[4] This present study aimed to identify the external factors influencing health-seeking behaviours of the street adolescent in five urban areas in Indonesia, i.e. Jakarta, Bogor, Depok, Tangerang, and Bekasi. Jakarta province is the capital of Indonesia in which the country's economic activities are centralized and it hosts the highest number of Indonesian street children (21.9% of total street children in Indonesia).[2] Four other cities were selected because they are the buffer zones of economic activities in Jakarta where the people are mostly commute in and out of the capital everyday.[1] This study may serve as an evidence for the policy makers and practitioners to address the health care issues of the street children in Indonesia.

## METHODS

A cross-sectional design was used to examine whether the support from peer, family, community, government, and mass media were associated with the street adolescents' health-seeking behaviour. We recruited street adolescents from five shelters located in five Indonesian urban areas, during July-September 2017. The sample size was calculated with Lemeshow's formula[8] and was added by 20% to anticipate for dropping out of participant, therefore we had a total sample size of 115. Afterwards, we calculated the sample size needed in every shelter in proportion with the total number of street children population in each setting. Finally, we used a simple random sampling method by drawing out the names of prospective participants. The shelter's officials assisted us for the participant recruitment. All approached street adolescents agreed to participate in the study.

The inclusion criteria were the street adolescents who were willing to participate in our study, aged 12-20 years old, and fell into United Nations Children's Fund's (UNICEF) category of the 'children on the street'. According to UNICEF the street children can be defined into three categories: (1) 'children of the street' who both live and work on the streets with no regular contact with family members; (2) 'children on the street', those who work on the streets to help support the family but live in families; and (3) 'children from street families' who live with their families in the streets.[9] As many as 76.58% of street children in Indonesia are children on the street, thus we focused on this street children population.[2]The children-of-the-street are most likely to have substantially different health outcomes and determinant factors than the children-on-the-street [5] that warrant a further individual study.

The instrument used in this study was developed based on the World Health Organization's framework of health-seeking behaviour assessment of sexually transmitted disease,[7] combined with King's system theory and McLeroy's multilevel intervention theory. The instrument set was piloted at a shelter in Jakarta and yielded reliable results. Cronbach's alphas of the questionnaires are as follows, peer support: 0.813; family support: 0.833; society support: 0.775; government support: 0.692; mass media support: 0.820; and health-seeking behaviour: 0.810. The first author administered the

questionnaires to all participants and stayed around to help with any emerging queries from the participants.

Prior the commencement of the study, ethical approval was issued by the Ethical Committee of the Health Polytechnic of Ministry of Health Republic of Indonesia Jakarta I. We conformed to the ethical principles throughout the study. All street adolescent in the shelter were given thorough information about the study, including their right to consent or decline their participation in the study. Informed consents were obtained from all participants. Data were treated securely and confidentially.

Every variable in the instruments were analyzed with descriptive analyses. Further, cross tabulation using $\chi^2$ Yates corrections were performed to identify the association between independent variable (health-seeking behaviour) and dependent variables (support from peer, family, government, and mass media). Finally, double logistic regression tests were carried out to assess the determining factors of health-seeking behaviour among the Indonesian street adolescent. All data were analyzed using SPSS software (Version 20.0. Armonk, NY: IBM Corp, 2011) Statistical significance was set on 0.05.

## RESULT

The street children in this study ranged in age from 12-20 years, with the majority (60%) aged 14-16 years (table 1). Most of them were male (63.5%), currently attended school (77.4%) and worked on the street (79.1%). 91.3% of the participants lived with parents who had some occupation(91.5%).

**Table 1. Demographic characteristics of the street adolescents (N =115)**

| Characteristics | N (%) |
|---|---|
| Age | |
| Early adolescent (12-13 years) | 24 (20.9) |
| Middle adolescent (14-16 years) | 69 (60.0) |
| Late adolescent (17-20 years) | 22 (19.1) |
| Sex | |
| Male | 73 (63.5) |
| Female | 42 (36.5) |
| Currently attending school | |
| Yes | 89 (77.4) |
| No | 26 (22.6) |
| Currently working | |
| Yes | 91 (79.1) |
| No | 24 (20.9) |
| Currently living | |
| At home with parents | 105 (91.3) |
| With peer, but not at home | 4 (3.5) |
| At a shelter | 6 (5.2) |
| Parents' working status | |
| Working | 105 (91.3) |
| Not working | 10 (87.0) |

The majority (88%) of the participants had ever utilised a healthcare service to treat their illness, but 112 out of 115 street adolescent reported they rarely sought the healthcare service because of the distance, monetary reason, and lack of information about the available healthcare service. Furthermore, most participants (67%) reported they had fairly pleasant experience with the healthcare service. 87 out of 115 participants stated they experienced unpleasant health care service, ranging from unfriendliness (32.2%) and discrimination (20.7%), to time rushing of the assessment (24.1%) and consultation (3.5%). Slightly half of the participants expected to have more available adolescent healthcare service.

**Table 2. Healthcare utilisation among street adolescents (N= 115)**

| Experience with healthcare utilisation | |
|---|---|
| **1. Ever utilized a healthcare service:** | 115 |
| a. Yes | 101 (88.0) |
| b. No | 14 (12.0) |
| 1a1. The last time utilizing a healthcare service: | 101 |
| Cannot remember | 43 (43.0) |
| One week ago | 16 (16.0) |
| One month ago | 14 (14.0) |
| Two months ago | 7 (7.0) |
| Three months ago | 9 (9.0) |
| One year ago | 9 (9.0) |
| More than one year ago | 3 (3.0) |
| 1a2. The reason for seeking a healthcare service: | 101 |
| Illness treatment | 99 (98.0) |
| Medical check-up | 2 (2.0) |
| 1ab. For those who are rarely or not utilizing the healthcare service, the reason for not seeking a healthcare service: | 112 |
| Long distance | 41 (35.7) |
| No fund | 29 (25.2) |
| Not knowing about healthcare service for adolescent | 42 (36.5) |
| **2. Experience with the healthcare service:** | 115 |
| Very pleasant | 14 (12.2) |
| Pleasant | 14 (12.2) |
| Fairly pleasant | 77 (67.0) |
| Poor | 10 (8.7) |
| **3. For those who have ever had unpleasant experience with the healthcare service, the kind of experience:** | 87 |
| Discrimination | 18 (20.7) |
| Lack of privacy | 11 (12.6) |
| Unfriendly providers | 28 (32.2) |
| Lack of explanation or advice from the providers | 6 (6.9) |
| Rushing assessment | 21 (24.1) |
| Rushing consultation | 3 (3.5) |
| **4. Expectation for the healthcare service:** | 115 |
| Building more adolescent health services | 58 (50.4) |
| Ensuring privacy | 5 (4.4) |
| Friendly healthcare providers | 40 (34.8) |
| Sufficient time for consultation | 2 (1.7) |
| Sufficient explanation or advice pertinent to the health problem | 3 (2.6) |
| Careful assessment | 2 (1.7) |
| Home visit/shelter visit | 1 (0.9) |
| Rehabilitation for street children in the shelters | 4 (3.5) |

The $\chi 2$ tests showed significant differences of family support and government support with the health-seeking behaviour of the street adolescents ($p < 0.001$) (table 3). There were more street adolescents with good family support (73.6%) and who perceived government support well (65.7%) reported good health-seeking behaviour.

**Table 3. Support received by the street adolescents according health-seeking behaviour(N =115)**

| | Health seeking behaviour | | | P value |
|---|---|---|---|---|
| | Poor n (%) | Good n (%) | Total f (%) | |
| Peer support | | | | 1.000 |
| Poor | 28 (50.9) | 27 (49.1) | 55 (100.0) | |
| Good | 30 (50.0) | 30 (50.0) | 60 (100.0) | |
| Family support | | | | 0.000* |
| Poor | 44 (71.0) | 18 (29.0) | 62 (100.0) | |
| Good | 14 (26.4) | 39 (73.6) | 53 (100.0) | |
| Community support | | | | 0.076 |
| Poor | 34 (59.6) | 23 (40.4) | 57 (100.0) | |
| Good | 24 (41.4) | 34 (58.6) | 58 (100.0) | |
| Government support | | | | 0.000* |
| Poor | 35 (72.9) | 13 (27.1) | 48 (100.0) | |
| Good | 23 (34.3) | 44 (65.7) | 67 (100.0) | |
| Mass media support | | | | 0.226 |
| Poor | 36 (56.3) | 28 (43.8) | 64 (100.0) | |
| Good | 22 (43.1) | 29 (56.9) | 51 (100.0) | |

***χ2 continuity correction, $p< 0.001$**

All variables (peer support, family support, community support, government support, and mass media support) were included in the multivariate modelling after having selected with bivariate analysis. Unlike the other potential predictors, peer support was found to have no significant difference ($p > 0.25$). However, we kept this variable for multivariate analysis since peer support was shown to be a strong predictor of adolescent behaviouraccording to Erikson (1963). In the logistic regression using simultaneous (enter) method, three variables (family support, government support, and community support) significantly influenced the street adolescents' health-seeking behaviour (table 4). The odd of health-seeking behaviour of the street adolescents with good family support is 5 times than those with poor family support.

**Table 4.Predictors of health-seeking behaviour of the street adolescents**

| Variable | B | P Wald (Sig.) | OR | 95% CI |
|---|---|---|---|---|
| Peer support | -0.305 | 0.573 | 0.737 | 0.256 – 2.127 |
| Family support | 1.595 | 0.001*** | 4.926 | 1.894 – 12.810 |
| Community support | 0.813 | 0.130* | 2.254 | 0.786 – 6.461 |
| Government support | 0.716 | 0.181 * | 2.046 | 0.717 – 5.842 |
| Mass media support | 0.130 | 0.808 | 1.139 | 0.399 – 3.255 |
| Constant | -8358 | 0.000 | 0.000 | |

***$p \leq 0.25$,**$p \leq 0.01$, ***$p \leq 0.001$**

## DISCUSSION

The main objective of this study was to investigate to what extent the social factors influence the health-seeking behaviour of the street children. Family support was found to be the strongest predictor of the health care utilisation of the children-on-the-street in this study (OR: 4.926). Consistent findings were shown in previous studies in the US [11] and Indonesia [12] that family has the strongest correlation with the health service utilisation of the street-involved children and youth. The majority of the street children in this study lived with their family, and while a small fraction of them lived in the shelter, they still had some connection with their family. Evidences show

that family connectedness is the most important protective factor of the adolescents' health, regardless of the ethnic origin, family structure, and income.[13] Having sufficient familial contact protects the street children from risky health behaviours such as substance abuse, sexual abuse, gun-carrying, and suicidal ideation and attempts.[14]

It is well established that family factor is an essential health determinant across the life course, including the adolescence during which children are undergoing transition from being dependent to partly independent as young adults.[4] Adolescents need loving and competent adult caregivers in the family context for their healthy development.[15] A qualitative study in Rwanda reveals that the street children are longing for 'a happy family' and that the family would be their fundamental reason to quit their risky health behaviours and to seek for healthcare service.[16] Despite spending a considerable amount of time in the street, street adolescents are strongly influenced by their family norms and attitudes related to health.[14] They also tend to engage in poor health behaviours to escape the harsh reality such as physical or psychological abuse they face at home and in the street.[14] A prior study in Indonesia shows that 63% of the parents have been maltreated by their own parents during childhood and 43% have maltreated their own children.[17] This intergenerational transmission of the behaviours in the family implies a greater necessity to improve parenting and family functioning.

Intertwined with the quality of relationship in the family, family's socioeconomic status plays a major role in adolescent health.[15] Adolescents of the families with low affluence have limited access and resources for maintaining health, as well as more stressors for their health and development.[18] The street adolescents in this study are of poor families. They have working parents whose income is insufficient to support their family hence the children work in the street. Parents' limited ability to earn adequate income along with poor parental knowledge might restrict the family functioning in health maintenance.[4] Yet, the subjective perception of wealth might have a stronger impact on the health-related behaviours than the objective socioeconomic position of the family. A study in seven European countries showed a significant effect of subjective perception of wealth on adolescent health after controlling the parents' educational levels, occupation, and family affluence, indicating the profound role of the psychosocial process of the socioeconomic status.[19] People who are feeling economically better off than the others in the same deprived areas are more likely to have more positive health-seeking behaviour.[20]. In our preliminary interviews, the street adolescents mentioned that they felt inferior to go to the health care service because of their social status. Many of our participants also had unpleasant experiences with the health care service including discrimination and unfriendliness of the providers, similar with prior study findings in Ghana [21] and Pakistan[22].

Furthermore, it is worth noting that the national socioeconomic and political contexts significantly shape the adolescents' access to healthcare and adoption of health behaviours.[23] For example, in some countries with universal healthcare system such as Japan which provide virtually free healthcare access to everyone, healthcare utilisation by the Japanese children is considerably higher than those with no universal coverage such as the United States.[24] Meanwhile, the national health insurance system in Indonesia is not well-established, so the economic factor is an important barrier for healthcare access.[25] Our pilot interviews with the shelter officers in this study revealed that many street adolescents had administrative issues to register for the national healthcare insurance scheme because their families were not settled into the local administrative (some of them migrated from different regions of Indonesia). Resultantly, they would avoid seeking for healthcare service. They would opt for self-treatment or any occasional community healthcare service that is usually carried out by local charitable bodies. Our study results also found that the government support is a strong predictor of the healthcare utilisation of the street adolescents (OR: 2.046).

## CONCLUSION

Our findings suggest that family support predominantly affects the health-seeking behaviour of the street adolescents in major urban areas in Indonesia. Family support is the strongest social factors compared to those of the community and the government. This present study results add to the body of literature that emphasising the central

role of the family in improving the health outcomes of the street-involved children and youth. This study also serve as the basis to develop a multilevel model of intervention. Interventions to address the health problems of the street adolescents should focus on strengthening the family connectedness with the adolescents and family functioning. Healthcare providers should also improve their attitude and service quality while caring for the street children. Effective community outreach for the street adolescents should be built on partnership principles with the family and the adolescents themselves.

This study has limited generalisability since we relied on sample drawn from the street children shelters in Indonesia's capital city and its surrounding urban areas. Our recruitment and data collection process was assisted by the shelter's officers whose power relation may lead to respondent bias. Other limitations are our cross-sectional data and self-reported measure for the healthcare utilisation and the social factors. Further studies with data triangulation and more representative sample of the street children are needed to better understand the health seeking behaviours of the street children and to inform practice and policy making

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**How to cite this article:** Reni Chairani, RatnaAryani, Tri Riana Lestari, Dinarti and HeniNurhaeni. Factors influencing the health-seeking behavior of the street children in Indonesia. Int J of Allied Med Sci and Clin Res 2021; 9(1): 51-58.
**Source of Support:** Nil.**Conflict of Interest:** None declared.