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Original Research Article

Influence of sociodemographic factors on parental awarness, attitude and practices in pediatric eye health – A questionaire based study

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Abstract

Background: Pediatric eye health is a crucial but often neglected aspect of child well-being, heavily influenced by parental awareness and practices. This study assessed these factors among parents in Chengalpattu district, exploring the impact of demographic and socioeconomic variables.

Materials and Methods: A cross-sectional descriptive study was conducted among 260 parents of children aged 1 month –12 years attending pediatric care at Chettinad Hospital and Research Institute. Data were collected using a structured questionnaire and analyzed using chi-square tests and logistic regression.

Results: Female parents showed better awareness than males (OR = 1.752, p = 0.028). Higher education was linked to greater awareness, while illiterate parents were least informed (OR = 9.79, p < 0.001). Low awareness was also noted among nuclear families (OR = 2.81), low-income groups (OR = 3.15), and parents of single children (OR = 2.59). Barriers included reliance on home remedies (33.6%) and societal stigma against glasses (59.3%). However, 63.8% valued early detection and intervention.

Conclusion: Parental awareness of pediatric eye care is shaped by education, income, and family structure. While support for professional care exists, misconceptions persist. Targeted educational programs are needed, especially for fathers and disadvantaged families, to improve pediatric eye health outcomes.

Keywords: Pediatric eye health, Parental awareness, Child vision care, Socio-economic factors, Public health education.

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1. Introduction

Global estimates suggest that there are around 19 million children with vision impairments globally. Among these children, 1.4 million are blind, and 17.5 million have impaired eyesight; the majority of these instances occur in impoverished nations.[1-3] Visual impairment resulting from uncorrected refractive errors (REs) impacts around 250 million people worldwide, with research indicating that uncorrected REs are the primary cause of visual handicap.[4-7] The World Health Organization (WHO) has revealed that uncorrected refractive errors (REs) are the primary cause of juvenile visual impairment globally, estimating that over 80% of vision loss might be averted via early diagnosis and intervention.[8] Research indicates that refractive errors, especially myopia, impact about one-third of the worldwide population.

Severe vision impairment and blindness in children may result from several sources, with corneal scarring due to vitamin A deficiency and measles identified as the primary cause, followed by cataract and retinopathy of prematurity.[9] The Vision 2020 initiative prioritizes the treatment of major refractive problems and the provision of low vision services, alongside the management of the aforementioned disorders.[10]

To implement this aim, early and consistent eye examinations in children are crucial for maintaining normal visual development and mitigating the risk of vision loss, enabling early identification and treatment, as well as consultation or referral to another eye care practitioner as

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required. The World Health Organization emphasizes the necessity of educating parents and guardians about the importance of regular eye examinations and appropriate treatments, particularly in developing countries where many individuals lack awareness of eye care, leading to the neglect of their children's ocular health.[11]

Recognizing the significance of routine eye examinations for children, beginning in infancy, is crucial for preventive eye care. Parents must have a proactive stance on eye care by prioritizing frequent examinations and swiftly seeking expert counsel if any issues emerge. Practical everyday routines, like restricting screen time, optimizing lighting, and encouraging outside play, foster a better visual environment for children. Fostering such an attitude is crucial for a child's comprehensive growth. When implanted early, these activities become essential elements of a child's routine, fostering long-term ocular health. Insufficient parental awareness of ophthalmological disorders may lead to vision impairment and ocular illness. Parents may actively participate in their children's ocular health by recognizing the significance of early intervention in situations of visual disorders. Prompt remedial actions may avert long-term repercussions and improve a child's quality of life. Consequently, investigating parental perceptions of pediatric ocular disorders is essential for promoting early identification and intervention.

2. Objectives

1. To investigate parental awareness, perspectives, and behaviours concerning paediatric eye health.
2. To evaluate the impact of educational status, demographics, cultural beliefs, and the number of children on parental awareness, attitudes, and behaviours toward paediatric eye care.

3. Materials and Methods

3.1. Study design

This study employed a cross-sectional descriptive design to investigate parental awareness, attitudes, and behaviors concerning pediatric eye health.

3.2. Study setting

The study was conducted at Chettinad Hospital and Research Institute, Chengalpattu district, Tamil Nadu, targeting parents seeking pediatric care for their children.

3.3. Study population

The study population included parents of children aged 1month –12 years attending pediatric care services at Chettinad Hospital.

3.4. Inclusion criteria

1. Parents with children aged 1 month –12 years.
2. Those willing to participate in the questionnaire-based study.
3. Individuals able to comprehend and respond to survey questions effectively.

3.5. Exclusion criteria

1. Parents with children outside the specified age range.
2. Parents unwilling to participate in the study.
3. Individuals with cognitive or communication impairments that hindered their ability to complete the questionnaire effectively.

3.6. Sample size and sampling method

A total of 250 parents using convenience sampling were included in the study.

3.7. Data collection

Data were collected using a structured, pretested questionnaire that focused on three domains: parental awareness, attitudes toward pediatric eye care, and practices related to seeking professional assistance for eye ailments. A pilot study was conducted to refine the questionnaire and establish a scoring structure to assess participants' responses.

The scoring system quantified:

1. The degree of knowledge about pediatric eye health.
2. The alignment of attitudes with recommended practices.
3. The consistency of practices in seeking professional eye care for their children.

The finalized questionnaire was administered systematically to eligible parents. Responses were statistically analyzed to identify patterns and relationships among awareness, attitudes, and practices and to evaluate the impact of demographic factors, educational status, cultural beliefs, and the number of children.

3.8. Ethical considerations

Ethical approval for the study was obtained from the Institutional Human Ethics Committee. Informed written consent was secured from all participants prior to their inclusion in the study. Confidentiality of the collected data was maintained throughout, with only relevant information disclosed in the study findings.

4. Results

Table 1 shows the demographic of the study participants (N=260). The sample of 260 individuals shows a higher percentage of females (56.5%) compared to males (43.5%). A majority are over 32 years old (58.8%), and most belong to nuclear families (59.6%). Parents' education levels are diverse, with the largest groups being graduates/diploma holders (26.2%) and secondary school (20.8%) or postgraduate (20.8%) educated. The parents' occupations

range from professionals (35%) to unskilled workers (26.5%), with a small percentage unemployed (13.5%). Family income is almost evenly split, with slightly more families earning above 40,000 per month (51.2%). Most families have more than one child (74.2%), and a significant majority have both parents working (66.9%).

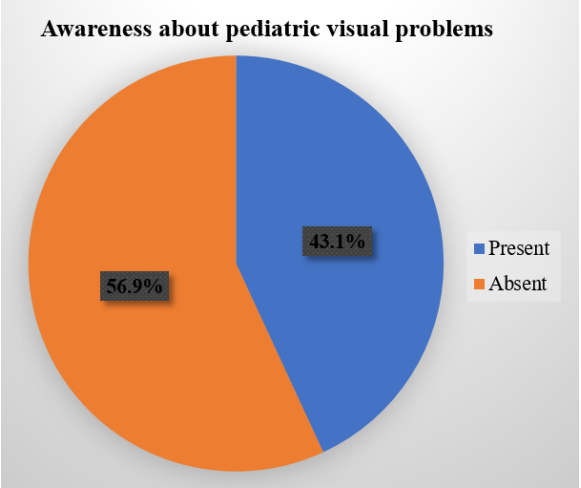

Figure 1: Parental awareness about paediatric visual problems (N=260)

Table 1: Socio-demographic variables of the study participants

S. No	Variable	Frequency (n=260)	Percentage %
1.	**Gender**		
	Male	113	43.5
	Female	147	56.5
2.	**Age**		
	<32 years	107	41.2
	>32 years	153	58.8
3.	**Type of family**		
	Joint	105	40.4
	Nuclear	155	59.6
4.	**Education of the parent**		
	Illiterate	33	12.7
	Primary school	51	19.6
	Secondary school	54	20.8
	Graduate/diploma	68	26.2
	Postgraduate	54	20.8
5.	**Occupation of the parent**		
	Unemployed	35	13.5
	Unskilled	69	26.5
	Skilled	65	25
	Professional	91	35
6.	**Monthly family income**		
	< 40000	127	48.8
	> 40000	133	51.2
	Number of children		
7.	Single child	67	25.8
	More than 1 child	193	74.2
8.	**Both working parents**		
	Yes	174	66.9
	No	86	33.1

Table 2: Association between demographic variables and Parental awareness about paediatric visual problems

Variable	Awareness		Total (N = 260)	Chi-square	Unadjusted odd's ratio (95% CI)	p-value
	No n (%) n = 148 (56.9%)	Yes n (%) n = 112 (43.1%)				
Age						
< 32 years	69	38	107	4.241	1.701 (1.024 – 2.825)	0.039*
> 32 years	79	74	153		1	
Gender						
Male	73	40	113	4.806	1.752 (1.059 – 2.898)	0.028*
Female	75	72	147		1	
Type of family						
Nuclear	75	30	105	15.113	2.808 (1.656 – 4.761)	< 0.001*
Joint	73	82	155		1	
Education of the parent						
Illiterate	27	6	33	38.285	9.794 (3.411-28.119)	<0.001*
Primary school	39	12	51		7.074 (2.978 – 16.801)	<0.001*
Scondary school	36	18	54		4.535 (1.944 – 9,748)	<0.001*
Graduate/diploma	29	39	68		1.61 (0.765 – 3.422)	0.208
Postgraduate	17	37	54		1	
Occupation of the parent						
Unemployed	31	4	35	37.327	12.40 (4.031-38.14)	< 0.001*
Unskilled	51	18	69		4.533 (2.289 – 8.979)	< 0.001*
Skilled	31	34	65		1.459 (0.766 – 2.779)	0.251
Professional	35	56	91		1	1
Monthly income						
< 40000	90	37	127	19.684	3.145 (1.882 – 5.258)	< 0.001*
> 40000	58	75	133		1	
Number of children						
Single	49	18	67	9.674	2.585 (1.405 – 4.755)	0.002*
Multiple	99	94	193		1	1

* P value < 0.05 - Statistically significant at 95% Confidence Interval, OR – Odd's Ratio, χ^2 – Chi-square

Table 3: Binomial logistic regression between demographic variables and Parental awareness about paediatric visual problems

S. No	Variable	p-value	Adjusted Odds Ratio	95% CI
1.	**Male**	0.006*	3.851	1.32 – 6.13
2.	**Parental illiteracy**	0.002*	3.022	1.81 - 8.14
3.	**Single child**	<0.001*	2.328	1.13 – 5.85

*Statistically significant at 95% Confidence Interval, OR – Odd's Ratio, AOR – Adjusted Odd's Ratio

The **Table 2** presents the association between awareness levels and various demographic variables among 260 study participants. Awareness is higher among those more than 32 years with younger individuals (<32 years) being 1.7 times more likely to be unaware (p=0.039). Females were more likely to be aware about paediatric visual problems compared to males odds =1.752 (p=0.028). Those from nuclear families are significantly more unaware compared to joint families, with an odds ratio of 2.81 (p<0.001). Parents' education shows that illiterate parents are the most unaware (OR=9.79, p<0.001), followed by primary (OR=7.07, p<0.001) and secondary school educated (OR=4.54, p<0.001) compared to postgraduates. Unemployment (OR=12.4, p<0.001) and unskilled occupations (OR=4.53, p<0.001) are associated with higher unawareness compared to professionals. Families with an income below 40,000 are more likely to be unaware (OR=3.15, p<0.001). Additionally, families with a single child are 2.59 times more likely to be unaware compared to those with multiple children (p=0.002). These results indicate significant associations between lower awareness and factors such as younger age, male gender, nuclear family type, lower education, unemployment, lower income, and having a single child.

Table 3 presents the results of binomial logistic regression analyzing the association between demographic variables and parental awareness about pediatric visual problems. The results indicate that male parents were significantly more likely to have lower awareness, with an adjusted odds ratio (AOR) of 3.851 (p = 0.006, 95% CI: 1.32–6.13). Parental illiteracy also showed a significant association with reduced awareness, with an AOR of 3.022 (p = 0.002, 95% CI: 1.81–8.14). Additionally, being a parent of a single child was associated with lower awareness, as indicated by an AOR of 2.328 (p < 0.001, 95% CI: 1.13–5.85). These findings suggest that gender, literacy level, and family size influence parental awareness of pediatric visual issues. (**Table 3**)

Table 4: Attitude about paediatric visual problems among the parents

Variable	Strongly Disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly Agree n (%)
Home remedies are better than eye care at hospital	17 (6.5)	69 (26.5)	76 (29.2)	62 (23.8)	36 (13.8)
Supplementary treatments (warm or cold compress, eye massage, protective glass, eye exercise) does not help in curing vision problems in children.	9 (3.5)	55 (21.2)	102 (39.2)	68 (26.2)	26 (10)
Early detection and intervention of vision problems can have substantial impact on a child's eyesight.	3 (1.2)	17 (6.5)	74 (28.5)	123 (47.3)	43 (16.5)
Surgical intervention should be pursued if recommended for children's eye disorders.	9 (3.5)	37 (14.2)	109 (41.9)	85 (32.7)	20 (7.7)
Ocular tumours can present in children and have poor prognosis if present.	2 (0.8)	36 (13.8)	115 (44.2)	93 (35.8)	14 (5.4)
Squint, ptosis and refractive error in children occur only due to genetic predisposition.	11 (4.2)	51 (19.6)	142 (54.6)	46 (17.7)	10 (3.8)
Children undergoing eye surgeries may not fully regain their eyesight, leading to a potential lifelong dependence on medications or glasses for vision support.	4 (1.5)	27 (10.4)	116 (44.6)	100 (38.5)	13 (5)
Societal judgments regarding corrective glasses affect children's compliance.	2 (0.8)	31 (11.9)	73 (28.1)	138 (53.1)	16 (6.2)
Cataract developing in children, can be left untreated until they come of age.	12 (4.6)	50 (19.2)	103 (39.6)	87 (33.5)	8 (3.1)
Technological advancements, like screen filters, blue light lenses help in mitigating the negative effects of screens on children's eye health?	0	32 (12.3)	107 (41.2)	100 (38.5)	21 (8.1)

Table 5: Practice towards paediatric visual problems among the parents

S. No.	Variable	Yes n (%)	No n (%)
1	I monitor the amount of time I let my child spend on electronic devices (e.g., smartphones, tablets, computers).	86 (33.1)	174 (66.9)
2	I include foods rich in vitamin A (e.g., carrots, green leafy vegetables) in my child's diet.	172 (66.1)	88 (33.9)
3	I take my child for routine eye check-ups.	102 (39.2)	158 (60.8)
4	I encourage my child to maintain a proper distance while watching TV or using electronic devices.	196 (75.4)	64 (24.6)
5	I ensure my child washes their hands before touching their eyes or face.	98 (37.7)	162 (62.3)
6	I encourage my child to take breaks while using electronic devices.	204 (78.5)	56 (21.5)

The **Table 4** presents parents' attitudes toward pediatric visual problems. A notable proportion of parents (33.6%) agree or strongly agree that home remedies are better than hospital eye care, while 29.2% remain neutral, indicating mixed views on professional versus traditional care. Regarding supplementary treatments, 36.2% agree they are ineffective, while 39.2% are neutral, suggesting uncertainty. A strong majority (63.8%) agree that early detection and intervention can positively impact children's eyesight, reflecting strong support for timely professional care. When it comes to surgical interventions for eye disorders, 41.9% are neutral, while 40.4% agree it should be pursued. Most parents (80%) acknowledge the serious prognosis of ocular tumors in children, with a similar neutral stance on genetic predisposition being the sole cause of conditions like squint and ptosis (54.6%). Concerns about post-surgical outcomes exist, as 43.5% of parents feel that children may not fully regain eyesight post-surgery. Societal judgments impact compliance with corrective glasses, with 59.3% agreeing. Parents hold varying opinions on whether cataracts in children should be treated early or left until later, with 39.6% neutral and 33.5% agreeing to delay treatment. Lastly, 46.6% believe technological advancements like blue light lenses mitigate screen-related eye issues, but many remain uncertain (41.2%). Overall, while parents are supportive of early detection and professional interventions, there is considerable neutrality or uncertainty on supplementary treatments, genetic causes, and modern technological aids.

Table 5 presents parents' practices regarding pediatric visual health. Only 33.1% of parents monitor the time their child spends on electronic devices, indicating that a majority (66.9%) do not regularly supervise screen time. A more positive trend is seen in dietary habits, with 66.1% of parents including foods rich in vitamin A in their child's diet, which supports eye health. However, only 39.2% take their child for routine eye check-ups, leaving a considerable 60.8% who do not prioritize this preventive measure. About 75.4% of parents' guide their child to maintain proper distance from screens, helping to reduce eye strain. Regarding hygiene, only 37.7% of parents ensure handwashing before their child touches their eyes or face, while a notable 62.3% do not follow this practice regularly. Around 78.5% of parents encourage regular screen breaks, indicating an awareness of the importance of rest during device use.

5. Discussion

The present study provides valuable insights into parental awareness, attitudes, and behaviors concerning pediatric eye health.

In the current study, female parents were significantly more aware of pediatric eye health compared to males (OR = 1.752, $p = 0.028$). This finding is consistent with studies like those by Sukati VN et al.[12] and Aldebasi Y,[13] where gender differences in awareness and knowledge were noted, with females generally demonstrating better understanding and engagement in child health care. Such gender disparities highlight the need for inclusive awareness campaigns that specifically engage fathers to improve overall family health literacy.

Parental education emerged as a critical determinant in this study, where illiterate parents were most unaware (OR = 9.79, $p < 0.001$), followed by those with primary (OR = 7.07, $p < 0.001$) and secondary education (OR = 4.54, $p < 0.001$) compared to postgraduates. These findings align with Aldebasi Y's report that higher educational levels correlate with greater knowledge of refractive errors and general pediatric eye health.[13] This consistent association emphasizes the need to prioritize educational interventions for less educated parents, addressing barriers to accessing accurate information about childhood visual health.

Family structure also played a significant role, with parents from nuclear families being more unaware than those from joint families (OR = 2.81, $p < 0.001$). While this variable was not explicitly discussed in studies such as Sukati VN et al.[12] or Alrasheed SH et al.,[14] it suggests the potential influence of support systems in joint families, which could

facilitate better health-seeking behaviors and knowledge sharing. This finding underscores the importance of community-based approaches to health education that leverage familial and social networks.

Economic factors significantly influenced awareness in this study, with families earning below ₹40,000 being 3.15 times more likely to be unaware ($p < 0.001$). Similar trends have been observed in studies conducted in Sudan and Nigeria,[8,11] where lower socioeconomic status was linked to reduced knowledge and health-seeking behaviors regarding pediatric eye care. These findings reinforce the need for affordable and accessible healthcare education programs targeting economically disadvantaged families.

Attitudinal barriers also surfaced in this study, with 33.6% of parents expressing a preference for home remedies over professional care, and 29.2% remaining neutral. These results are consistent with findings from studies in Nigeria and Sudan,[8,11] where significant proportions of parents believed that modern interventions like spectacles could harm children's vision or preferred traditional methods. Such attitudes call for culturally sensitive educational programs that address misconceptions and promote trust in evidence-based interventions.

Interestingly, 59.3% of parents in this study acknowledged societal judgments as a barrier to compliance with corrective glasses. This finding resonates with reports from Alrasheed SH et al.[8] and Sukati VN et al.,[12] where parents expressed concerns about the social stigma and psychological impact of children using glasses. Efforts to normalize corrective eyewear through public awareness campaigns and media representation are essential to overcoming these barriers.

On a positive note, 63.8% of parents in the present study agreed that early detection and intervention could positively impact children's eyesight. This aligns with findings from studies in India and southern California,[15,16] which emphasized strong parental support for timely professional care. However, concerns persisted regarding surgical outcomes, with 43.5% of parents doubting full recovery post-surgery. These doubts mirror those reported in Alrasheed SH et al., where parents expressed anxieties about the efficacy and long-term outcomes of surgical interventions.[3]

The present study's findings are consistent with prior literature, reinforcing the critical role of demographic, socioeconomic, and cultural factors in shaping parental awareness and attitudes toward pediatric eye care. While there is growing recognition of the importance of early detection and professional care, significant gaps persist in knowledge, trust, and acceptance of modern medical interventions. Addressing these challenges through targeted, community-specific educational initiatives, enhanced accessibility, and stigma reduction strategies will be essential to improving pediatric visual health outcomes.

6. Conclusion

This study highlights critical gaps in parental awareness, attitudes, and practices regarding pediatric eye health, particularly among less educated, economically disadvantaged, and male parents. Findings demonstrate that demographic and socioeconomic factors, such as education level, family income, and family structure, significantly influence awareness and behaviors. Although many parents acknowledged the importance of early detection and professional interventions, misconceptions and attitudinal barriers, such as reliance on home remedies and concerns over surgical outcomes, remain prevalent. These results underscore the need for targeted public health strategies to bridge these gaps and enhance pediatric eye care practices.

7. Limitations

The study has certain limitations that must be considered while interpreting the findings. First, the cross-sectional design provides a snapshot of parental perspectives at a single time point, limiting the ability to infer causation or changes over time. Second, as the study was conducted at a single hospital in Chengalpattu district, the findings may not be generalizable to other regions or populations with different socio-cultural contexts. Additionally, the reliance on self-reported data through a structured questionnaire may introduce response bias, as participants might have underreported or overestimated their awareness and behaviors.

8. Recommendations

To address the gaps identified, targeted health education campaigns should be implemented to improve awareness of pediatric eye health, focusing on less educated and economically disadvantaged families. Community-based initiatives that engage both parents, especially fathers, can help create a more inclusive approach to health education. Integrating pediatric eye care awareness into school health programs and leveraging mass media campaigns can further amplify these efforts. Additionally, future research should adopt longitudinal designs to explore changes in parental awareness and practices over time and extend the study to diverse populations for broader generalizability.

9. Source of Funding

None.

10. Conflict of Interest

None.

11. Ethical Approval

Ethical No.: IHEC-II/0514/24.

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