International Journal of Community Medicine and Public Health
Joshi GS et al. Int J Community Med Public Health. 2024 Jun;11(6):2349-2353
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20241497

Original Research Article

Health care seeking behaviour and its socio-demographic determinants among women in rural area: a community based cross sectional study

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Received: 10 April 2024
Accepted: 13 May 2024

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ABSTRACT

Background: The health care delivery system of a country determines the health seeking behaviour of that country's population. Women's health care seeking behaviour is undocumented because women suffer the disease in silence, without seeking appropriate remedy for her illness. Hence the study was planned to assess the health care seeking behaviour and factors associated with it among rural women.
Methods: This cross-sectional study was conducted in the catchment area of Rural Health Training Centre located in Thane district in January 2024. Sample size of women aged 18 years and above was estimated. Subjects were interviewed after obtaining verbal consent. Data was recorded in pre-designed proforma and was analysed with the help of Microsoft excel. Descriptive and inferential statistics was applied. The statistical level of significance was fixed at $p<0.05$.
Results: Of the 400 women studied, 63.50% were illiterate. 52.75% visit private practitioners for treatment. 56.50% could make own decision regarding their health while 43.50% need permission from senior family members to visit health care facility. Only 42.50% visit to health care facility at the onset of symptoms. Due to time consuming nature, 35.75% were not using government health care facilities. Also, 22.50% women experienced unfriendly behaviour of the health care staff working there.
Conclusions: More than half of the women could not seek medical care immediately, two third were not aware of the various government health schemes, emphasizing the need to create awareness about it through grass root level health workers. There is an urgent need to rebuild community trust about public health care facilities.

Keywords: Health care seeking behaviour, Rural women

INTRODUCTION

The way people seek medical care when they are ill is known as their health seeking behaviour. Health care seeking behaviour means any action or inaction undertaken by individuals who perceive themselves to have health problem or to be ill for the purpose of finding an appropriate remedy.[1] For the purpose of providing basic health services it is essential to recognise and understand the behaviour of those who seek treatment. This will help to develop strategies for improving utilisation of health care services by women. The health of women and girls is of particular concern because, in many societies, they are disadvantaged by discrimination rooted in sociocultural factors.[2] The fact that women often live longer has significant impact on society in terms of health and finances. Gender inequality consistently impedes women's access to healthcare due to limited financial resources and mobility restriction, among other factors. The research on sociology states that a person's behaviour in seeking medical care will be impacted by their understanding of the illness, how they perceive it, their sociodemographic characteristics, and the accessibility and availability of health services. Health care seeking behaviour is a complicated result of numerous factors functioning at the individual, family,

and community level, depending on these determinants and their interaction.[3] Women seeks medical care and intervention when the problem they suffer becomes too much to tolerate and often when the problem reaches in the advanced stages or illness.

Also, due to their highly sensitive nature, they tend to hide problems related to their reproductive system and are hesitant to tell their family members about it. Women's health seeking behaviour are undocumented because women suffer from this disease in silence, without seeking appropriate institutional care for early diagnosis and treatment.[4] Although government initiatives aimed at improving public health services and thereby increasing their utilization, the private sector played a dominant role in most states of India.[5,6] Health seeking behaviour is one of key determinants of women's health and is influenced by personal knowledge, disease awareness, sociodemographic factors, and the availability and accessibility of health services.[7] The healthcare delivery system of a country determines the health-seeking behaviour of that country's population. People in most developed countries are covered by universal health coverage (UHC) which is funded by the government. However, in developing countries like India, universal health coverage remains a distant goal, with out-of-pocket spending accounting for most health expenditures. In developing countries like India, private health facilities are preferred due to their convenient and highly personalised infrastructure, whereas public facilities have long waited periods and are often located in remote areas.[8] In spite of significant government investment, convenient access to public health care remains a major problem.

Even after India's Independence, the country's population continues to suffer from a weakened health system. The country's population of almost 716 million people living in rural areas is still struggling to access basic health services in their area of residence. This situation has been exacerbated by the deteriorating living conditions of the people living in the rural areas. Almost 75% of health facilities and other health facilities are located in the urban areas.[9] By 2030, the United Nations Sustainable Development Goal-5(SDG-5) call for the achievement of gender equality and empowerment of women and girls. One of the key factors in influencing women's empowerment is their level of education. Women who have an education develop a sense of self-worth and are better able to make decisions and maintain health. Health care in most developing countries has been visualized as a basic right for the individual. This perception has over the years manifested itself through the emergence of extensive publicly supported health care systems with unlimited access at zero or little cost to the user. However, utilization of public health care facilities remains low over the years, even by the poorest of the community. This study was aimed to assess health care seeking behaviour among rural women and factors associated with health care practices during illness. Also, the objectives of this study were to identify barriers in seeking public health care and to help to improve utilization of public health care facilities.

METHODS

This was a community based cross-sectional study carried out in the catchment area of primary health centre, Wangani, in the month of January 2024 which is a Rural Health Training Centre of Rajiv Gandhi Medical college, Thane. Study participants were tribal women aged 18 years and above. Necessary permissions and approvals were obtained before conducting the study. Sample size was estimated using formula $n=4pq/L^2$. P value was taken from the study conducted by Reddy et al in Telangana, in which they observed 34.50% of the women seek medical care at the onset of symptoms.[10] So, P= 34.50%, q=65.50% L=5%. So, the sample size(n)=362. However, 400 participants were included in the study. Inclusion and exclusion criteria were defined. House to house visits were done in six villages under primary health centre to collect data from the 400 women. Informed verbal consent was obtained from the subjects before recording the data in the pre-designed, pre-tested and formatted proforma. The proforma comprises of socio-demographic factors, such as age, religion, marital status, education, and occupation etc. It also comprises questions regarding health care practices, health care seeking behaviour and reasons for not availing government health care facilities. Obtained data was analysed with the help of Microsoft excel. Descriptive and inferential statistics was applied. Results were represented in suitable tables. The statistical level of significance was fixed at $p<0.05$.

RESULTS

Total 400 subjects were included in the study. The mean age of participants was 37.54±13.4 years. Majority of the participants i.e. 66.25% were in the age group 18-40 years. All the participants were belonged to Hindu religion. 254 (63.50%) were illiterate. 390 (97.50%) were married. 340 (85.00%) were homemakers while 60(15.00%) were working. Majority of the subjects i.e. 89.00% had monthly income less than or equal to Rs.10,000. 260 (65.00%) study participants belonged to nuclear family and 140 (35.00%) to joint family (Table 1).

Majority of the women i.e. 398 (99.50%) were aware of the nearby health care facilities. 376 (94.00%) women select treating doctor on the basis of consultation charges. 216 (54.00%) subjects could make own decision in seeking health care. 174 (43.50%) participants said they need permission from the senior family members to visit doctor for seeking health care. Only 170 (42.50%) women visit health care facility immediately after onset of symptoms. 110 (27.50%) study participants face problem in discussing their illness among family members. 106 (26.50%) aware of various health care schemes (Table 2).

Table 1: Socio-demographic characteristics of the subjects (n=400).

Variables	Category	Frequency	Percentage
Age groups in years	18-40	265	66.25
	>40-60	107	26.75
	>60	28	07.00
Religion	Hindu	400	100.0
Occupation	Homemaker	340	85.00
	Working	60	15.00
Marital status	Married	390	97.50
	Single/widow	10	02.50
Literacy status	Literate	146	36.50
	Illiterate	254	63.50
Income	≤10000	356	89.00
	>10000	44	11.00
Type of family	Joint family	140	35.00
	Nuclear family	260	65.00

Table 2: Health care seeking behaviour of the subjects (n=400).

Characteristics	Frequency	Percentage
Aware of nearby health care facilities	398	99.50
Treating doctor is based on consulting charges	376	94.00
Can make own decision regarding seeking health care	216	54.00
Need permission from senior family members to visit to doctor	174	43.50
Visit health facility immediately after onset of symptoms	170	42.50
Problem in discussing health issue among family members	110	27.50
Aware of the various health schemes	106	26.50

Total 209 (52.75%) subjects said their first preference would be to visit qualified private medical practitioner for treatment. 104 (26.00%) first visit to government health care facilities for treatment during illness while 47 (11.75%) first practice home remedies for curing disease. 32 (08.00%) study participant first take advise of health care staff working in the area while 08 (04.00%) said first they visit to spiritual healer for the treatment (Table 3).

Table 3: Health care practices by the subjects during illness (n=400).

Variables	1st preference	Percentage
Visits qualified private medical practitioner	209	52.75
Visits government facility	104	26.00
Home remedy	47	11.75
Visits health worker	32	08.00
Visits spiritual healer	08	04.00

About 143 (35.75%) women said, visiting to government health care facilities is a time-consuming process so they opt for private practitioner's health care services. 117 (29.25%) subjects mentioned that they need money to spend on travelling as the public health care facility is far away from their residence. That is why they are not using government health care facilities. Other reasons for non-usage of public health care facilities are unfriendly behaviour of the staff (22.50%), distance too far (20.25%) and no faith in government health care facilities (13.50%) (Table 4).

Table 4: Difficulties in using government health care facilities (n=400).

Variables	Frequency	Percentage
Time consuming process	143	35.75
Need money for travel to public health facility	117	29.25
Unfriendly behaviour of public health care staff	90	22.50
Distance too far	81	20.25
No faith in government health care facility	54	13.50

About 216 (54.00%) women self-decide about their own health of which 136 (62.96%) were illiterate and 80 (37.04%) were literate. 214 (99.07%) married women take decision related to health care ($p<0.05$). 109 (62.64%) illiterate women and 65 (37.36%) literate women said they require permission from senior members in the family to visit health care facility. 167 (95.98%) married women and 07 (04.02%) single/widows said they need permission to visit health care facility from senior

family members. 103 (60.59%) illiterate and 67 (39.41%) literate visit health care facility immediately after onset of symptoms. 72 (52.55%) illiterate and 65 (47.45%) literate women said they have difficulty in discussing their health problems among family members ($p<0.05$) (Table 5).

Table 5: Socio-demographic factors and health care seeking behaviour of the subjects (n=400).

Variables and categories		Self-decision regarding health care			P value
		Yes (n=216)	**No (n=184)**	**Total (n=400)**	
		N (%)	**N (%)**		
Literacy status	Illiterate	136(62.96)	118(64.13)	254(63.50)	0.80
	Literate	80(37.04)	66(35.87)	146(36.50)	
Marital status	Married	214(99.07)	176(95.65)	390(97.50)	
	Single/widow	02(00.93)	08(04.35)	10(02.50)	
		Need permission to visit health care facility			
		Yes (n=174)	**No (n=226)**	**Total (n=400)**	
		N (%)	**N (%)**		
Literacy status	Illiterate	109(62.64)	145(64.16)	254(63.50)	0.75
	Literate	65(37.36)	81(35.84)	146(36.50)	
Marital status	Married	167(95.98)	223(98.67)	390(97.50)	
	Single/widow	07(04.02)	03(01.33)	10(02.50)	
		Visit health care facility at onset symptoms			
		Yes (n=170)	**No (n=230)**	**Total (n=400)**	
		N (%)	**N (%)**		
Literacy status	Illiterate	103(60.59)	15165.65)	254(63.50)	0.29
	Literate	67(39.41)	79(34.35)	146(36.50)	
Marital status	Married	170(43.58)	220(56.41)	390(97.50)	
	Single/widow	03(30.00)	07(70.00)	10((02.50)	
		Problem in discussing health issues among family			
		Yes (n=137)	**No (n=263)**	**Total (n=400)**	
		N (%)	**N (%)**		
Literacy status	Illiterate	72(52.55)	182(69.20)	254(63.50)	0.00
	Literate	65(47.45)	81(30.80)	146(36.50)	
Marital status	Married	103(26.41)	287(73.58)	390(97.50)	
	Single/widow	07(70.00)	03(30.00)	10(02.50)	

DISCUSSION

The present study was conducted in the tribal area of Thane district among 400 women aged 18 years and above. The mean age of the subjects was 37.51±13.4 years. This study observed, 27.50% women hesitate to discuss their health issues with their family members and 43.50% women need permission from the senior members in the family to visit health care facility to seek treatment. In a study conducted by Reddy et al, 35.00% women had problem in discussing about their health issue in the family and 42.00% women need permission to visit health facility.[10] In our study 26.00% of women visits government facility for seeking treatment, while study conducted by Hussain et al only 14.20% of subjects visit government facility to avail treatment.[11] In our study 52.75% of participants visits private practitioners for treatment which is consistent with the study conducted by Khannam et al in rural area of Wardha in 2012, where 50.13% participants gave their first preference to private practitioners for treatment of illness.[12] Our study revealed that 54.00% women took own decision about seeking treatment during their illness whereas study conducted by Milan et al in Bangladesh 34.44% women took own decision for seeking health care.[13] In our study, 42.50% study participant visit health facility as soon as symptoms appear whereas study conducted by Kakkar et al only 26.2% of participants visit health facility immediately.[14]

In our study out of 400 participants, 11.75% choose home remedy as the first preference for health seeking practice. While in the study conducted by Kakkar et al 23.6% choose home remedy as the first option. In our study, 99.5% participants were aware of the nearby health facilities.[14] Similar findings were observed by Upasona Sarmah et al in their study among antenatal women (94.00%) in Assam.[15] In the present study only 26.50% of women knew about various health schemes available for women. Similar findings were reported in the study by Upasana et al where 27% subjects knew about various heal care schemes available for women.[15] In our study, 20.25% women mentioned long distance and 22.25% said unfriendly behaviour of healthcare staff are the reasons for not using government health care facility which is consistent with the finding in a study conducted by Beena Thomas et al among tribal population in subjects with

presumptive TB symptoms where main reasons were long distance to health facility (29.9%) and indifferent behaviour of health staff (29.2%).[16]

In our study we observed that 53.00% of married women would be able to take own decision regarding health care seeking. Among illiterate women 27.25% women need permission from family member to visit health facility and only 25.75% of women visit health facility as soon as symptoms appear. In our study we observed significant association between education level and problem in discussing health issues among family members. In many communities, women are disadvantaged by discrimination rooted in socio-cultural factors. That is why health of the women is of particular concern. Women require to breach so many social barriers to empower and to get access for quality health care services. Health care seeking behaviour is one of the most important determinants of women health.

CONCLUSION

Most of the study participants preferred private doctors for treatment of illness, regardless of their social status and education level. Many women had mentioned various reasons for the same like visiting to government health care facilities is a time-consuming process, they need money to spend on travelling as the public health care facility is far away from their residence, unfriendly behaviour of the public health care staff. It is observed that nearly two-third of women could not seek medical care immediately after onset of the symptoms. This emphasizes the need to create awareness about importance of health care through ASHA and Anganwadi workers as well as public health care staff, rural politicians, social workers and NGOs working in the area. Health education of tribal women and providing health care services to them at local level will improve health seeking behaviour among them.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Joshi GS, Gurav RB, Samel DR. Health care seeking behaviour and its socio-demographic determinants among women in rural area: a community based cross sectional study. Int J Community Med Public Health 2024;11:2349-53.