Scholars Journal of Applied Medical Sciences
Abbreviated Key Title: Sch J App Med Sci
ISSN 2347-954X (Print) | ISSN 2320-6691 (Online)
Journal homepage: https://saspublishers.com

OPEN ACCESS

Medicine

Healthcare-Seeking Behavior of Coastal Women in Bangladesh

Dr. Fahmida Shammi[1*], Dr. S M Mohammed Ullah Mizan[2]

[1]Assistant Professor, Community Medicine, Chattagram International Medical College, Chattogram, Bangladesh
[2]Junior Consultant, Paediatrics, Upazilla Health Complex, Sandwip, Bangladesh

DOI: https://doi.org/10.36347/sjams.2024.v12i08.009 | **Received:** 01.07.2024 | **Accepted:** 08.08.2024 | **Published:** 16.08.2024

***Corresponding author:** Dr. Fahmida Shammi
Assistant Professor, Community Medicine, Chattagram International Medical College, Chattogram, Bangladesh

Abstract **Original Research Article**

Background: Healthcare seeking behavior encompasses actions taken by individuals who perceive themselves to be ill in an attempt to find appropriate remedies. For women, particularly in regions like coastal Bangladesh, socio-cultural and economic barriers often impede their ability to access and utilize healthcare services effectively. Understanding these behaviors is crucial for developing strategies to improve healthcare access and utilization. ***Objective:*** To assess the healthcare-seeking behavior of coastal women in Bangladesh, evaluating the quality of services provided and identifying barriers to effective healthcare utilization. ***Method:*** This descriptive, community-based cross-sectional study was conducted from June 1, 2019, to August 31, 2019, in three randomly selected villages in coastal Bangladesh. A sample of 200 women aged 20 years and above was surveyed using a pre-designed, semi-structured questionnaire. The study analyzed sociodemographic data and healthcare-seeking behavior, including preferences for healthcare practices and decision-making autonomy. ***Results:*** The study revealed that 35% of participants had inhibitions about discussing health issues with family members, and 42% required family permission to access healthcare services. Conversely, 65.5% were able to make their own healthcare decisions. Regarding first-choice healthcare practices, 60.5% preferred visiting qualified medical practitioners, while 19.5% consulted Registered Medical Practitioners (RMPs), and 15.5% relied on home remedies. Notably, married women (71.6%) were more likely to make their own healthcare decisions compared to unmarried (53.2%) and widowed (68.2%) women. Literate women showed greater awareness of available health centers (80.6%) compared to illiterate women (56.7%). ***Conclusion:*** The findings underscore significant barriers in healthcare access among coastal women, including the need for family permission and reliance on non-qualified practitioners. Socioeconomic and educational factors notably influence healthcare-seeking behavior, with married and literate women demonstrating better healthcare decision-making and awareness. There is a pressing need for integrated strategies to enhance healthcare awareness and access, address socioeconomic and educational disparities, and improve healthcare-seeking behaviors among rural women.

Keywords: Healthcare seeking behavior, coastal women, Bangladesh, sociodemographic factors, health services, literacy, marital status.

INTRODUCTION

Healthcare seeking behavior is defined as "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill, for the purpose of finding an appropriate remedy." Identifying and understanding health-seeking behavior is essential to providing basic healthcare services and developing strategies to improve the utilization of health services, especially among women [1-2]. The health of women is a particular concern because many societies disadvantage them through discrimination rooted in sociocultural factors. These factors include unequal power relationships between men and women, social norms that reduce education and paid employment opportunities for women, a focus on women's reproductive roles, and experiences of physical, sexual, and emotional violence [3-4].

In Bangladesh, the health of coastal women has gained importance due to their unique vulnerabilities and the challenges they face. Empowering these women and improving their access to quality healthcare involves educating them about common health issues and enhancing their access to healthcare services by establishing health centers and raising awareness of health-related needs. Health-seeking behavior is a significant determinant of women's health and is influenced by individual knowledge, disease perception, sociodemographic factors, and the availability and accessibility of health services. It is a complex outcome

influenced by factors at the individual, family, and community levels [5-9].

Under the primary healthcare approach, promotive, preventive, and curative services are provided by health teams, including field-level health workers like community health workers, midwives, and health volunteers, to coastal women during different life phases, with a focus on improving health-seeking behavior. This study aims to assess the health-seeking behavior of coastal women to evaluate the quality of services provided by healthcare teams at the ground level and to address the barriers to and take necessary measures for improving the health-seeking behavior of these women. There is limited literature on this aspect, which is why this study was undertaken to assess healthcare-seeking behavior among coastal women in Bangladesh.

Objective

To Asses Health care seeking behavior of coastal women in Bangladesh.

METHODOLOGY

The study was a descriptive, community-based cross-sectional study conducted from June 1, 2019, to August 31, 2019, in three randomly selected villages out of 11 villages associated with a medical college in the coastal regions of Bangladesh. Study participants were women aged 20 years and above. Ill and moribund patients, participants of the pilot study, and women who were not willing to participate were excluded.

The sample size was estimated using the formula $n = \frac{4pq}{d^2}$, where $P = 72.6\%$ (taken from the findings of a previous study), $q = 27.4$, and precision (d) = 7.26 (10% of P). The calculated (n) was 150.9. Considering a 10% non-response rate, the total was 165.9, which was rounded off to 200, making the final sample size 200. Based on the proportionate sampling method, it was decided to collect data from 89 subjects in Village A, 60 subjects in Village B, and 51 subjects in Village C. Houses were selected using a systematic random sampling method. In each selected house, the youngest eligible subject was included in the study.

A pre-designed and pretested semi-structured questionnaire was used as the study tool. A pilot study was initially conducted on 50 coastal women, and the questionnaire was translated into the local language as part of the standardization process. The questionnaire included sociodemographic variables such as age, religion, education, occupation, socioeconomic status, and marital status, along with questions regarding healthcare seeking behavior and preferences for healthcare centers. Data was collected through face-to-face interviews.

Study participants were briefed about the purpose and nature of the study, and informed consent was obtained before data collection. The study was approved by the Institutional Ethics Committee on April 25, 2019.

Data were analyzed using IBM SPSS Statistics for Windows Version 23.0. Data were expressed in proportions with confidence intervals (95% CI) and means with standard deviations (SD). Pearson's Chi-square test was applied to assess the association between marital status and education status with healthcare seeking behavior. A P value of less than 0.05 was considered statistically significant.

RESULTS

The study included 200 coastal women in Bangladesh, with the majority aged 20-30 (30.5%), followed by 30-40 (24.5%), 40-50 (22.5%), 50-60 (17.5%), and 60-70 (5%). Regarding religion, 69% were Hindu, 22.5% Muslim, and 8.5% Christian. Educationally, 48.5% were illiterate and 51.5% literate. In terms of occupation, 35.5% were working, while 64.5% were not. Socioeconomic status was diverse, with 6.5% in the upper class, 17.5% in the upper middle class, 38.5% in the middle class, 29.5% in the lower middle class, and 8% in the lower class. Marital status showed 58% were married, 31% unmarried, and 11% widowed.

Table 1: Demographic profile of study participants (*n*=200)

Age Group	**Frequency (%)**
20-30	61 (30.5)
30-40	49 (24.5)
40-50	45 (22.5)
50-60	35 (17.5)
60-70	10 (5)
Religion	**Frequency (%)**
Hindu	138 (69)
Muslim	45 (22.5)
Christian	17 (8.5)
Education	**Frequency (%)**
Illiterate	97 (48.5)
Literate	103 (51.5)
Occupation	**Frequency (%)**
Working	71 (35.5)
Not working	129 (64.5)
Socioeconomic status	**Frequency (%)**
Upper class	13 (6.5)
Upper middle class	35 (17.5)
Middle class	77 (38.5)
Lower middle class	59 (29.5)
Lower class	16 (8)
Marital status	**Frequency (%)**

Married	116 (58)
Unmarried	62 (31)
Widow	22 (11)

The study examined healthcare-seeking behavior among 200 coastal women in Bangladesh. It was found that 35% of the women (95% CI: 28.4, 42) had inhibitions about discussing their health issues with family members. Additionally, 42% (95% CI: 35.1, 49.2) required permission from a family member to access healthcare services. On a more positive note, 65.5% (95% CI: 58.5, 72.1) of the women reported being able to make their own decisions regarding healthcare.

Table 2: Health care seeking behavior among study subjects (*n*=200)

Health care seeking behaviour	No. of subjects answered Yes (%)	95% CI
Do you have inhibitions in discussing your health issues with family members	70 (35)	28.4, 42
Do you require permission from any of the family members to access health care services	84 (42)	35.1, 49.2
Can you make own decisions regarding health care	131 (65.5)	58.5, 72.1

In the study, 60.5% of the 200 coastal women in Bangladesh preferred to visit a qualified medical practitioner as their first choice for healthcare during illness. Additionally, 19.5% opted to visit a Registered Medical Practitioner (RMP), 15.5% relied on home remedies, 3.5% consulted spiritual healers, and 1% used over-the-counter medication.

Table 3: Distribution of study subjects according to first preferred health care practices during illness (n=200)

Health care practice during illness	Frequency (%)
Visits qualified medical practioner	121 (60.5)
Visits RMP	39 (19.5)
Home remedies	31 (15.5)
Spiritual healers	7 (3.5)
Over the counter medication	2 (1)

The table shows that married women were more likely to make their own healthcare decisions (71.6%) compared to unmarried women (53.2%) and widows (68.2%), with a statistically significant association (p=0.04). Regarding knowledge about available health centers, literate women were significantly more informed (80.6%) compared to illiterate women (56.7%), with a p-value of 0.01 indicating statistical significance.

Table 4: Association between marital Status and education status with health care seeking behavior (*n*=200)

Marital status	Own decision making		Total (%)	Chi square *P*
	Yes (%)	No (%)		
Married	83 (71.6)	33 (28.4)	0.04	
Unmarried	33 (53.2)	29 (46.8)	62 (100)	
Widow	15 (68.2)	7 (31.8)	22 (100)	
Total	131 (65.5)	69 (34.5)	200 (100)	
Education status	**Knowledge about available health centres**		**Total (%)**	**Chi square *P***
	Yes (%)	**No (%)**		
Literate	83 (80.6)	20 (19.4)	103 (100	
Illiterate	55 (56.7)	42 (43.3)	97 (100)	
Total	138 (69)	62 (31)	200 (100)	

DISCUSSION

In the present study, 200 coastal women in Bangladesh were included, with a mean age of 39.2 ± 12.3 years. The study found that 35% of the women had inhibitions about discussing their health issues with family members, and 42% required permission from a family member to access healthcare services. These findings reflect the barriers women face in seeking healthcare services. In a study conducted by one study, 29% of women did not want to discuss tuberculosis with their husbands [10]. Our study observed that 65.5% of coastal women could make their own decisions regarding healthcare. In contrast, a study in Tamil Nadu found that only 3.3% of antenatal and postnatal rural women could decide on their place of delivery, highlighting the low status of women in society [11]. A systematic review by study observed that decision-making power is often not with women but with their partners and mothers-in-law [12]. Another study. found that over one-third of rural

Bangladeshi women identified their husbands as the main healthcare decision-makers [13]. Other study reported that only 12% of rural Bangladeshi women were empowered to decide on seeking healthcare for themselves, and 8.5% for their children. These barriers often lead women to delay seeking help, hoping their health issues will resolve independently. This underscores the need for targeted strategies to empower women in their healthcare-seeking behavior [14].

In the present study, 34.5% of the subjects sought medical care as soon as symptoms appeared. Other study found that only 13.5% of study subjects in Iran visited health centers for mild symptoms [14]. According to one study older females were 0.41 times more likely to seek treatment than males [15]. This emphasizes the need to sensitize women about their health and provide essential health education.

Utilization of health services is crucial for achieving sustainable development goals, alongside the availability of these services. The study found that 60.5% of participants preferred qualified medical practitioners during illness, while 3.5% approached spiritual healers. Similar results were observed in a study by Awasthi S *et al.*, among the urban poor in Lucknow, where 48% sought care from qualified health personnel, and in a study. in rural Bangladesh, where 42% sought qualified care [11]. Studies in South Africa found that 83.6% and 71.8% of subjects visited hospitals for treatment, respectively [15]. Other study found that 82.05% of pregnant women in Karachi preferred hospital or clinic care, while 13.67% opted for self-medication [16].

The study found that most married women could make their own health decisions compared to unmarried and widowed women, a statistically significant association (P = 0.04). Additionally, 80.6% of literate participants were aware of available health centers compared to illiterates, another statistically significant association (P = 0.01). A study in Tamil Nadu found a positive relationship between women's education and treatment-seeking behavior. Barman B *et al.*, in India observed that women's education was positively and significantly associated with utilizing maternal and child health services [11].

The health of women at all life stages is crucial as it impacts children's and family health. However, it is often neglected due to social factors. Despite government schemes and programs, many women still do not utilize these services. Reducing maternal mortality, neonatal mortality, under-5 mortality rates, and ensuring universal access to sexual and reproductive healthcare services are targets of the Sustainable Development Goals (SDGs). These can be achieved through primary healthcare systems and improving women's healthcare-seeking behavior. Primary care physicians play a key role in sensitizing and improving healthcare-seeking behavior. This study highlights healthcare practices and the extent of healthcare-seeking behavior among women. It may also help identify determinants of healthcare-seeking behavior and plan appropriate interventions to overcome barriers and promote women's health in the community.

CONCLUSION

Nearly half of the women require family members' permission to access health services, and only one-third seek medical care as soon as symptoms appear and are aware of nearby health centers. The present study highlights the need to raise awareness about the importance of healthcare and available health centers, as a significant proportion of women first consult unqualified medical practitioners or rely on home remedies. This study strongly emphasizes that the healthcare-seeking behavior of rural women is influenced by socioeconomic conditions and geographical factors, as their choice of doctor often depends on consultation fees and the location of healthcare services rather than the qualification of healthcare professionals and the quality of service provided. Ignorance about health issues, social stigma, socioeconomic conditions, communication barriers within the family, and the availability of necessary healthcare significantly contribute to inappropriate healthcare-seeking behavior among rural women. An integrated and structured approach is strongly suggested to create awareness about common health issues and improve health-seeking behavior among rural women.

REFERENCE

1. Latunji, O. O., & Akinyemi, O. O. (2018). Factors influencing health-seeking behaviour among civil servants in Ibadan, Nigeria. *Annals of Ibadan postgraduate medicine*, *16*(1), 52-60.
2. World Health Organisation. Health topics: Women's health. Available from: https://www.who.int/topics/womens_ health/en/. [Last accessed on 2019 Aug 12].
3. Daisy, S. (2016). A study on health status and health seeking behaviour of rural women in Coimbatore. *Int J Educ Res*, *2*, 1-2.
4. Habtu, Y., Yohannes, S., & Laelago, T. (2018). Health seeking behavior and its determinants for cervical cancer among women of childbearing age in Hossana Town, Hadiya zone, Southern Ethiopia: community based cross sectional study. *BMC cancer*, *18*, 1-9.
5. Paul, R. A. V., Kalidas, P., Sujatha, K., Senthilkumar, S. K., & Sreesupria, A. (2017). A study on health seeking behaviour among married reproductive age group women in a rural area. *IOSR JDMS*, *16*, 811.
6. Khan, A., Shaikh, B. T., & Baig, M. A. (2020).

Knowledge, Awareness, and Health-Seeking Behaviour regarding Tuberculosis in a Rural District of Khyber Pakhtunkhwa, Pakistan. *BioMed research international*, *2020*(1), 1850541.

7. Gopalakrishnan, S., Eashwar, V. A., & Muthulakshmi, M. (2019). Health-seeking behaviour among antenatal and postnatal rural women in Kancheepuram District of Tamil Nadu: A cross-sectional Study. *Journal of family medicine and primary care*, *8*(3), 1035-1042.
8. Lassi, Z. S., Middleton, P., Bhutta, Z. A., & Crowther, C. (2019). Health care seeking for maternal and newborn illnesses in low-and middle-income countries: a systematic review of observational and qualitative studies. *F1000Research*, *8*.
9. Sikder, S. S., Labrique, A. B., Ullah, B., Ali, H., Rashid, M., Mehra, S., ... & Christian, P. (2011). Accounts of severe acute obstetric complications in rural Bangladesh. *BMC pregnancy and childbirth*, *11*, 1-13.
10. Mainuddin, A. K. M., Begum, H. A., Rawal, L. B., Islam, A., & Islam, S. S. (2015). Women empowerment and its relation with health seeking behavior in Bangladesh. *Journal of family & reproductive health*, *9*(2), 65.
11. Khajeh, A., Vardanjani, H. M., Salehi, A., Rahmani, N., & Delavari, S. (2019). Healthcare-seeking behavior and its relating factors in South of Iran. *Journal of education and health promotion*, *8*(1), 183.
12. Srivastava, S., & Gill, A. (2020). Untreated morbidity and treatment-seeking behaviour among the elderly in India: Analysis based on National Sample Survey 2004 and 2014. *SSM-population health*, *10*, 100557.
13. Omotoso, D. J. A. R. R. (2010). Health seeking behaviour among the rural dwellers in Ekiti State, Nigeria. *African Research Review*, *4*(2).
14. Chauhan, R. C., Manikandan, P. A., Samuel, A., & Singh, Z. (2015). Determinants of health care seeking behavior among rural population of a coastal area in South India. *Int J Sci Rep*, *1*(2), 118-22.
15. Chandana, K. R., & Kumar, R. (2020). Health status of tribal women of Bhadradri Kothagudem district in Telangana state. *Int J Health Sci Res*, *10*(1), 53-62.
16. Nakovics, M. I., Brenner, S., Bongololo, G., Chinkhumba, J., Kalmus, O., Leppert, G., & De Allegri, M. (2020). Determinants of healthcare seeking and out-of-pocket expenditures in a "free" healthcare system: evidence from rural Malawi. *Health economics review*, *10*, 1-12.