ISSN Print: 2394-7500
ISSN Online: 2394-5869
Impact Factor: 8.4
IJAR 2021; 7(8): 309-313
www.allresearchjournal.com
Received: 22-06-2021
Accepted: 26-07-2021

Kamalakanta Tripathy
P. G. Department of Population Studies, Fakir Mohan University, Balasore, India

Corresponding Author:
Kamalakanta Tripathy
P. G. Department of Population Studies, Fakir Mohan University, Balasore, India

Factors affecting women's health seeking behaviour in Odisha: Evidence from national family health survey

Kamalakanta Tripathy

Abstract
Sustainable Development Goal 3 ensures health and well-being for all. It aims to achieve universal access to healthcare and provide everybody the access to safe and effective medicines. Keeping this in view, objective of this study is to analyse the health seeking behaviour among women in Odisha. For the purpose, NFHS-3 (2005-06) data are used, and both bivariate and multivariate statistical techniques are applied. The results imply that around three-fourths of the women have economic constraint in accessing healthcare. Distance to healthcare is also a major constraint in accessing healthcare. Multivariate analysis shows that women's education, their exposure to mass media and wealth index have significant relationship with constraint in accessing healthcare by women. Further, social stigma and communication barriers also play their roles to sustain the unsuitable health seeking behaviour by women. Therefore, an integrated and structural approach is necessary to create awareness and correct the common constraints encountered in the process of health seeking among women.

Keywords: women, healthcare, health facility, constraints

Introduction
Women's health refers to the branch of medicine that focuses on the treatment and diagnosis of diseases and conditions that affect a woman's physical and emotional well-being. Currently, women in India face numerous health issues, which ultimately affect the economy's aggregate output. Addressing the gender, class or ethnic disparities that exist in healthcare and improving the health outcomes can contribute to economic gain through the creation of quality human capital and increased levels of savings and investment.

However, health related issues are often linked to the broad objectives of development. The pivot around which the new paradigm of development revolves is sustainable human development. Quantity of economic growth is only one, but distribution of income and provision of services like health, education, clean environment, basic human rights, etc., are other critical dimensions in the development process (Phillips, 1990) [9].

Therefore, it is now widely accepted that the real purpose of development is to enlarge people's choices in all fields – social, economic, political, cultural, etc. Seeking better health is one of the many choices people make, though it may not be the only one. Be it economic development, quality of life, human development, or general well-being, the health measures such as mortality rates are taken as a prime indicator. Therefore, health always remains high on the agenda of a welfare state (Madden *et al.*, 1997) [5]. However, in India in spite of its significant strides in eradicating epidemics and containing communicable diseases, the health status of the vast majority of population is far from satisfactory. The society is characterized by high rates of infant and child mortality, and loss of expectation of life at birth. One of the often-cited reasons for poor health status of the people is that the improvement in health delivery system could not keep pace with the changing needs of the people.

To begin with, resource allocation from the government for health is well below what was advocated by the Bhore Committee, which outlined a health policy that was formally adopted by the government (Berman and Khan, 1993: 23) [1]. Besides, there has been progressive reduction in the proportion of budgetary allocation to health sector in the successive Five-Year Plans. For instance, the proportion of health in total government spending was as high as 3.3 per cent in the first Five Year Plan, whereas in the Seventh Plan it was as low as 1.9 per cent. Not only the allocation of resources for health was low, but the distribution of these

meagre resources was also uneven. Moreover, major share of the expenditure was spent on curative health rather than on preventive or promotive aspects and not on the programmes which directly benefit the poor (Duggal, 1992) [2]. India, being a signatory to the 'Alma Ata Declaration', is committed to the principle of 'health for all'. Thus, health has been regarded as a fundamental right of the citizen and the government is to ensure its citizens the basic health services. The National Health Policy, declared by the government in 1983, enunciated a broad framework for attaining these goals. However, problems of the Indian Health Care System with respect to access and efficiency still remain in both public and private sectors.

Health seeking behaviour can be defined as any activity undertaken by individuals who themselves perceive to have a health problem or to be ill for the purpose of finding an appropriate remedy (Ward and Mertens, 1997) [11]. It is the perception of the individual that predominantly decides her/his health seeking behaviour. In any cultural context, a precondition of most health seeking behaviour is recognition of symptoms. Of key significance, therefore, is the way in which symptoms are interpreted, "the meaning the 'symptoms' have, the attribution of cause, and the beliefs held about appropriate and effective treatments", by the individuals affected and by those around them. Therefore, it has often been argued that factors such as beliefs, customs, knowledge and attitudes in regard to health practices could have a profound effect on health indicators (Hertz *et al.*, 1994) [4]. The information regarding health seeking behaviour of people in a particular area within their socio-economic and cultural matrix will go a long way in suitably planning health care delivery. Because, health care to be effective and acceptable must adapt appropriately to the changing circumstances of the population: its changing dynamics, household structures, patterns of work and economic dependency (Mechanic, 1995: 149l) [6]. Household and family disruption, poverty, substance abuse, violence and other destabilizing forces may often create new morbidities on the one hand and complicate the treatment and rehabilitation of those affected on the other. Therefore, a social analysis gets impetus to examine health issue broadly and in depth. Moreover, the importance of people's perception and its attributed meanings has a long tradition and important place in social analysis and is the centrepiece of symbolic interactionism (Mechanic, 1995: 1494) [6].

To project the health seeking behaviour of people insofar as their choice of system and source of treatment are concerned, it is necessary to study their perceptions. The assumption that the educated and economically well-off would always choose a more rational, expensive, and scientific system and source of treatment contrary to the illiterate and poor is not always true. The literate and rich are also found to be spending a large part of their health expenditure on faith healers, home remedies or rituals, etc. On the other hand, the illiterate and poor at times are found to be opting for a more scientific system of treatment and even a more expensive source of treatment as well. Studies have also shown that not all diseases or ill health are ever treated. There is also unevenness of treating different types of illness episodes. Thus, there emerges a three-way relationship between illness episodes, system of treatment and source of treatment. The issues involved in this relationship are to be explored on the basis of empirical data as well as on perceptual subjectivity. To cross-check findings and make comparisons possible, prevalence rate of illness episodes would be co-related with socioeconomic and demographic factors like age, occupation, gender, level of income and place of residence.

Furthermore, analysis of overall health spending of India shows that, although it ranks amongst the poorer countries in the world in terms of national income, both public and private health expenditures are relatively high. High private health spending, which refers to people's out-of-pocket expenses, gives a sordid picture of the public health care delivery system. Because, it directly implies that government's health expenditure has not catered to the people's needs, although the existing public health care system is founded on the notion of Universal Primary Health Care, i. e. the government is supposed to provide and finance a wide range of health care services for a large section of population. In spite of the economic reforms and the recent Structural Adjustment Programmes, the Indian government, however, cannot shy away from its responsibility to ensure minimum but adequate public health care facilities without the user's cost tag for the poor, downtrodden and vulnerable sections of the population. Or else, not only majority of Indians would have perennially decreasing health status but also India shall go back on its constitutional promise of social justice to the people of the Nation.

Whatever may be the reason for private health spending, it is likely to be dependent on the income level of the household, consumption expenditure on other necessities as well as savings. The spending on health care in general can also be related to decision and choice of health institutions. Private health spending does not necessarily mean that the source of treatment also pertains to the private sector. In other words, an individual may go to public health institutions for consultancy, diagnosis or treatment but during follow up actions (such as x-rays, pathological tests, buying drugs, etc.) one has to spend on his own. This private health spending mostly goes to the private sector. Government's spending through its health institutions like SC, PHC, CHC or other government hospitals perhaps caters to only limited health needs of the people. Therefore, the out-of-pocket expenses (or, private health spending) become necessary. However, often it can be seen that in spite of the availability of certain basic public facilities, the higher income group opts for the private sector, may be in search of better-quality care. On the other hand, the lower income group owing to mostly financial constraints opts for private facilities only in case of dire necessity. Thus, the private spending behaviour seems to largely depend upon the household income levels. Depending on the size of the income available for health spending, the people shall be choosing a particular type of facility or source of treatment.

Although quality of service may be a concern for the well-to-do, the affordability criterion will be more helpful for the poor to take a decision on the selection of service. Moreover, the proximity of the source of treatment or health facility at times influences individuals' choice. This is because, geographical location and as such distance of the health facilities imposes on one to consider time factor in making health care choices. In other words, opportunity cost of time and distance influences the health seeking behaviour of people. For purposes of empirical analysis, the State of Odisha is chosen. Because, the state has remained under-developed not only in terms of per capita income but also in terms of human development indicators like that of the

BIMARU (Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh) States. Amongst all, in most of the indicators for human development like life expectancy at birth, death rate, both male and female literacy rates, Odisha is far behind the national averages (Government of India, 1997: 185) [3]. It can be argued that an in-depth study of the health seeking behaviour of women of this underdeveloped state possibly would bring forth wide range of issues to be addressed which may be quite different from the findings of studies carried out in developed states like Kerala, Maharashtra, Gujarat or West Bengal. Thus, the study aims at bringing out the factors that determine the constraint in accessing healthcare on the part of women in Odisha.

Methodology

For the present study, data of National Family Health Survey-3 (NFHS-3) conducted in the state of Odisha during the year 2005-06 are used. To fulfil the objective, ever-married women who gave birth to at least a child three years preceding the survey are considered. Initially, women's perception about constraints in accessing health care for their own health problems are grouped into suitable categories, such as having constraints and not-having constraints. After looking at the frequency distribution, further classification is made into more categories. Later, linkage between perception of constraints of those ever-married women with respondent, husband and household characteristics is explored.

Results

Maternal and child health has remained an integral part of the Family Welfare Programme of India since the time of the first and second Five-Year Plans, when the Government of India took steps to strengthen maternal and child health services. As part of the Minimum Needs Programme initiated during the fifth Five-Year Plan (1974-79), maternal health, child health, and nutrition services were integrated with family planning services. In 1992-93, the Child Survival and Safe Motherhood Programme continued the process of integration by bringing together several key child survival interventions with safe motherhood and family planning activities (Ministry of Health and Family Welfare, 1992) [7]. In 1996, safe motherhood and child health services were incorporated into the Reproductive and Child Health Programme (RCH). The National Population Policy adopted by the Government of India in 2000 reiterates the government's commitment to safe motherhood programmes within the wider context of reproductive health (Ministry of Health and Family Welfare, 2000) [8]. Several of the national socio-demographic goals for 2010 specified by the policy pertain to safe motherhood such as 80 per cent of all deliveries should take place in institutions, 100 per cent of deliveries should be attended by trained personnel, and the maternal mortality ratio should be reduced to a level below 100 per 100,000 live births. But all these targets were not fulfilled due to poor quality programme intervention.

Most important part of the women health care include, antenatal, natal and post-natal care. The number of antenatal care visits and the timing of the first visit are important for the health of the mother and the outcome of the pregnancy. The World Health Organization recommends that all pregnant women should have at least four antenatal care (ANC) assessments by or under the supervision of a skilled attendant (World Health Organization, 2006) [12]. These assessments should be spaced at regular intervals throughout pregnancy, commencing as early as possible in the first trimester. Studies on the timing of the initial antenatal check-up, however, show that even when antenatal care is initiated as late as the third trimester, there is a substantial reduction in perinatal mortality (Ramachandran, 1992) [10]. Along with ANC, the institutional delivery and post-natal care should be provided at right time, so that the maternal and child mortality will decline significantly. Further, women are facing a lot of problem related to health care facilities. Many women are facing constraints, while they visit to the hospital or any health care provider.

The NFHS-3 asked women the perception of constraint in accessing health care. Table-1 represents the data related to different problems faced by women when they visit the health care facilities. Twenty-three per cent of women are facing problem for getting permission from the head of the household to go for health care. Forty-three per cent of women replied, they faced big problem for getting money for the treatment. Around 23% of women were facing problem for getting money for treatment but that is not a big problem. Thirty-seven per cent of women said, distance is not a problem, while rest of the women said distance is a problem for accessing health care facility. Around 39% of women said, they faced distance as a big problem to access health care. Sixty per cent of women have faced problem related to transport from home to health care centres. Eleven per cent of women are not getting any person to accompany them to hospital/ health care centres. Forty-one per cent of women have said, they are not getting female health care provider, which is a big constraint to access the health care. Around 52% of women are not being able to get health care provider at the hospital. Fifty-four per cent of women replied that, the unavailability of drugs in the health care centres is a major problem for the health care.

Table 1: Women's perception of constraint in accessing health care for themselves

Women's perception	No problem	Not a big problem	Big problem	Total
Getting permission to go	76.8(766)	14.6(146)	8.6(86)	998
Getting money for treatment	34.2(341)	22.7(227)	43.1(430)	998
Distance to the health facility	36.8(367)	23.8(238)	39.4(393)	998
Having to take transport	40.4(403)	24.8(248)	34.8(347)	998
Finding someone to go with her	63.2(631)	26.2(261)	10.6(106)	998
May not be a female health provider	58.7(586)	19.3(193)	21.9(219)	998
May not be any health provider	48.3(482)	16.6(166)	35.1(350)	998
May be no drugs available	46.0(459)	21.1(211)	32.9(328)	998

Table-2 represents the background characteristics of women and their perception of constraint in health care. The younger women faced a lot of problem to access health care facilities as compared to the elder women. With increasing age of the women, the problems to access service from the health centres are declining.

Table 2: Women's perception of constraint in accessing health care by respondent characteristics

Characteristics of the respondents	Women's perception of constraint		Total
	No problem	Have problems	
Age			
15-20	4.9(7)	95.1(136)	143
21-25	17.2(71)	82.8(342)	413
26-30	14.4(42)	85.6(249)	291
>30	19.2(29)	80.8(122)	151
Total	149	849	998
Education			
Illiterate	4.1(18)	95.9(426)	444
Up to class 7	11.3(30)	88.7(236)	266
>7	35.1(101)	64.9(187)	288
Total	149	849	998
Working status			
Working	18.1(130)	81.9(590)	720
Not-working	6.8(19)	93.2(259)	278
Total	149	849	998
Exposure to MM			
Not-exposed	7.4(21)	92.6(262)	283
Exposed to some extent	11.2(50)	88.8(397)	447
Exposed	29.1(78)	70.9(190)	268
Total	149	849	998

However, around 80% of elder women also faced significant problem to access health care. Education plays an important role for women's health care. With increasing education level of women, the problems/ constraints to access health care facility are declining. Working women have faced fewer constraints in access to health care as compared to 'not-working women'. Those women exposed to mass media, they face less constraints as compared to those women not exposed to mass media.

Table-3 shows the women's perception of constraint in health seeking by the household characteristics. By categories of religion, it was found that 86% of Hindu women faced problem, while only 63% of others category women had perceived problem. It was also evident by categories of caste that highest percentage of ST women (94.4) reported having problems, while lowest percentage of women (70.7) belonging to general category reported to have problems compared to women of other caste categories such as OBC and SC. Similarly, across categories of wealth index, a clear trend is observed that highest percentage of women (95) belonging to low standard of living have problems compared to lowest percentage of women (60) belonging to high standard of living. In case of household structure, it is also observed that highest percentage of women (89) living in nuclear family have reported problems in health seeking compared to their counterparts in non-nuclear families (82%).

Table 3: Women's perception of constraint in their health seeking behaviour by household characteristics

Household Characteristics	Women's perception of constraint		Total
	No problem	Have problems	
Religion			
Hindu	14.0(134)	86.0(824)	958
Others	37.5(15)	62.5(25)	40
Total	149	849	998
Caste			
Gen	29.3(80)	70.7(193)	273
OBC	12.8(31)	87.2(212)	243
SC	10.0(20)	90.0(180)	200
ST	5.6(15)	94.4(255)	270
Total	146	840	986
Standard of living			
Low	4.7(21)	95.3(422)	443
Medium	9.7(26)	90.3(242)	268
High	39.8(88)	60.2(133)	221
Total	135	797	932
Household structure			
Nuclear	11.3(54)	88.7(424)	478
Non-nuclear	18.3(95)	81.7(425)	520
Total	149	849	998

The net effect of background characteristics on women's perception of constrains to access health care facilities are analysed through logistic regression in Table-4. The result shows that education, occupation and standard of living are playing significant role for women's perception of constraints in accessing health care facility. With increasing education level of women, the constraints to access health care are declining.

Table 4: Women's perception of constraint in seeking health care by respondent, husband and household characteristics

Characteristics	B	Exp (B)	Significance
Women's Age (continuous)			
Education (continuous)	-.047	.954	.157
Working status	-.168	.845	.000
Not-working	--	--	--
Working	-.440	.644	.185
Exposure to mass media			
Not-exposed	--	--	--
Exposed	-.596	.551	.086
Husband's characteristics			
Age (continuous)	-.009	.991	.758
Education (continuous)	-.006	.994	.595
Occupation			
Agriculture	--	--	--
Manual worker	.773	2.167	.010
Others	-.102	.903	.727
HH characteristics(Religion)			
Hindu	--	--	--
Others	1.356	3.879	.001
Caste			
Upper caste	--	--	--
Lower caste	-.073	.929	.799
Standard of living			
Low	--	--	--
Medium	1.487	4.424	.000
High	1.247	3.480	.000
Type of family			
Nuclear	--	--	--
Non-nuclear	-.183	.833	.475
Constant	2.661	14.307	.007

Conclusion

From the above analysis, it is evident that more than three-fourths of the women face economic constraint in accessing healthcare and one-third of them need permission of family members to access health services. Distance to health care facility is also one of the major constraints in accessing healthcare. Moreover, there is a significant relationship between women's education, exposure to mass media and wealth index. Therefore, there is a need to create awareness on the schemes and facilities provided by the government about health care of women. On the other hand, if women face constraint in accessing the health care facilities, they may approach unqualified medical practitioners and seek home remedies as first consultancy source for their health problems. Thus, the study brings out a few factors that cause constraints for health seeking by women in Odisha such as socioeconomic conditions and distance. Moreover, ignorance of women about intricacies of health, social stigma, poor socioeconomic conditions, communication barriers in family and non-availability of necessary health care/ facilities determine the inappropriate health seeking behaviour, especially among the rural as well as urban poor women. Thus, an integrated and structural approach is necessary to create awareness and correct the common constraints encountered in the process of health seeking among women.

References

1. Berman P, Khan ME. Paying for India's Health Care, Sage Publications, New Delhi 1993.
2. Duggal R. Health Care Services and Financing in India, A Report for the Health Financing Review Mission of World Bank Foundation for Research in Community Health, Bombay 1992.
3. Government of India. Economic Survey 1996-97, Government of India Press, New Delhi 1997.
4. Hertz B *et al.* Social and Environmental Factors and Life Expectancy, Infant Mortality, and Maternal Mortality Rates: Results of a Cross-National Comparison, Social Science and Medicine 1994;39(1):105-114.
5. Madden IM *et al.* Undercover Care Seekers: Simulated Clients in the Study of Health Provider Behaviour in Developing Countries, Social Science and Medicine 1997;45(10):1465-1482.
6. Mechanic D. Emerging Trends in the Application of the Social Sciences to Health and Medicine, Social Science and Medicine 1995;40(11):1491-1496.
7. Ministry of Health and Family Welfare. Family Welfare Programme in India Year Book: 1990-91, Government of India, New Delhi 1992.
8. Ministry of Health and Family Welfare. National Population Policy 2000, Government of India, New Delhi 2000.
9. Phillips DR. Health and Health Care in the Third World, Longman Group, Harlow 1990.
10. Ramachandran, Prema. Need of organization of antenatal and intrapartum care in India, Demography India 1992;21(2):179-193.
11. Ward H, Mertens TE. Health Seeking Behaviour and the Control of Sexually Transmitted Disease, Health Policy and Planning 1997;12(1):19-28.
12. World Health Organization. Provision of effective antenatal care, In Standards for maternal and neonatal care, WHO Integrated Management of Pregnancy and Childbirth Care (IMPAC), Geneva 2006.