

Original Article

Socio-Economic Status and Health Seeking Behaviour Among the People of Rural Areas of Pangsha Upazila of Rajbari District, Bangladesh

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Abstract

Background: Health seeking behaviour is an important factor in health management. Socioeconomic status is having greater impact on health care utilization especially in developing countries. **Objective:** To identify the socioeconomic factors of rural community people and their health care seeking behaviour. **Methods:** The descriptive, cross-sectional study was conducted in Pangsha upazila of Rajbari district in Bangladesh, between January 2018 and February 2018. A total of 317 purposively selected people were interviewed face to face using a pre-tested semi-structured questionnaire. **Results:** In this study, majority 98 (30.91%) of the respondents were within the age group of below 31 years (41.47±15.12). More than two-thirds i.e. 218 (68.76%) of the respondent was male and majority 205 (64.50%) belonged to nuclear family. Most of the respondents were married 283 (89.00%) and 227 (71.40%) of the respondents were Muslim. Majority 149 (47.00%) of the respondents' monthly income was between 10000 and 20000 Bangladeshi Taka. Among all respondents, majority 60 (18.92%) people sought treatment for fever. 193 (60.89%) used to visit private health facility. 181 (56.9%) people took treatment by MBBS doctor and 205 (64.50%) of the respondents choose the specific health facility for the reason of better treatment. **Conclusion:** Health seeking behaviour of people in this study was appreciable. In this study, people received treatment from private health facility. The perception of the people has to be changed to attract them more to government hospitals. It can be done through improving the quality of care, proper maintenance of facilities. Awareness raising activities, and education for health behaviour change are also recommended.

Keywords: Health seeking behaviour, rural area, Bangladesh.

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Introduction

According to the WHO, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹ It is not a static condition, constant change and adaptation to stress result in homeostasis. When an individual makes a decision in relation to health, he/she weighs up the potential risks or benefits of a particular behavior. However, they do so in a way that is mediated by their immediate

practical environment, their social rootedness, socioeconomic status and their whole outlook on life more generally which may or may not apparently be relevant to an act of health seeking behaviour.²

Health seeking behavior is drawing out the factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviors or their use of medical care and treatment. Thus, health care seeking behavior is conceptualized as

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a 'sequence of remedial actions' taken to correct 'perceived ill-health'.³

Health seeking behavior is an important factor in health management, but this is often ignored while providing health facilities to people. As a result, facilities for providing health care do not get the desired acceptance of the community, and are therefore rendered unsuccessful⁴.

Health seeking behavior and practice are considered the primary and most vital step toward the medication of any health related complexity⁵. It is well explored that, healthcare seeking behaviors and local practicing knowledge requires considering in intervention to bring better health output in a variety of context⁶. By understanding the conceptualization of people of cause of their any disease and the perception on any particular health related problem helps to explore their health seeking behavior and practice⁷. It is widely acknowledged that, exploring the health seeking behavior in different socio-economic levels of any community is crucial for proper planning and implementing of effective health services, particularly for poor community⁸. Socioeconomic status is having greater impact on health care utilization especially in developing countries that is documented in many studies. For instance, wealthier families are about twice time take health care service from formal and informal practitioners⁹. Low socioeconomic status is a common barrier to get health services for people and those direct and indirect factors are- doctor fees, cost of transport, medicine etc.⁹. It is found from empirical studies from Bangladesh and few other countries that, socio-economic condition is considerable factors of health care seeking behavior for a community¹⁰. From this above-mentioned backdrops, it is necessary to understand the health seeking behavior and explore the socioeconomic determinants on this especially low economic community. Therefore, this study has been conducted in rural and urban area of Bangladesh to identify the socioeconomic factors of rural community and their health care seeking behavior. By doing this, it can open a new door for policy makers to make effective and timely health intervention model.

Methods

This descriptive, cross-sectional study was conducted in different villages of Pangsha Upazila of Rajbari district, Bangladesh from January 2018

to February 2018. A total of 317 purposively selected people were interviewed face to face using pretested semi-structured questionnaire. Data were checked and verified manually. Data analysis were done by using scientific calculator after entering in a master sheet. Quantitative variable were analyzed by mean & standard deviation while qualitative variable were summarized by percentage.

Results

Among 317 respondents, 172(54.25%) reside in urban and 145(45.74%) in rural area respectively (Figure 1). Out of 317 respondents, majority 98 (30.91%) of the respondents were within the age group of under 31 years (Mean±SD=41.47±15.12). Two-third 218 (68.76%) of the respondent was male and rest 99 (31.23%) was female. Majority 205(64.50%) of the respondents belonged to nuclear family while 112(33.33%) belonged to joint family. Most of the respondents was married 283 (89.00%). Three fourth 227 (71.40%) of the respondents was Muslim and few 2 (0.60%) was Christian. Most 281 (88.64%) of the respondents were literate. Among them 64(20.10%), 114(35.80%), 54(17.00%) & 49(15.00%) were educated up-to primary level, secondary level, higher-secondary level & above higher secondary level respectively. Only 36 (11.36%) of respondents were illiterate. Fifty percent 164 (51.74%) respondents were employed in this study. Majority 149 (47.00%) of the respondents monthly income had 10000 to 20000 Tk. (Table-I). Majority 289 (91.16%) people have ever been in hospital, 28(8.84%) people have not. Among the respondents, 60 (18.92%) people seek treatment for fever, 28(8.83%) people for diabetics, 30 (9.46%) people for hypertension, 28 (8.83%) people for maternal health, 44(13.88%) people for child health, 50 (15.77%) people for pain, 3 (0.95%) people for PUD, 74(23.34%) people for other sicknesses (Fig.1). About two third 193 (60.89%) people visit private health facility and 81 (25.56) visit public health facility. More than fifty percent 181 (56.9%) people took treatment by MBBS doctor, 76 (23.9%) people by village doctor, and 53 (16.7%) people by 'Kabiraj' (Traditional healers). 205 (64.50%) of the respondents choose the specific health facility for better treatment (as they perceived), 76(23.97%) people choose as health facility nearer to home (Table II).

Table-I: Socio-economic status of the respondents (n=317)

Variables	Category	Frequency	Percentage
Age group	<31 years	98	30.91
	31-40 years	75	23.65
	41-50 years	69	21.76
	>50 years	75	23.65
	Mean±SD =41.47±15.12		
Gender	Male	218	68.76
	Female	99	31.23
Family type	Nuclear	205	64.50
	Joint	112	35.33
Marital status	Unmarried	19	6.00
	Married	283	89.00
	Divorced	3	0.90
	Widow/Widower	12	3.79
Religion	Muslim	227	71.40
	Hindu	88	27.70
	Christian	2	0.60
Educational Status	Illiterate	36	11.36
	Primary	64	20.10
	Secondary	114	35.80
	Higher Secondary	54	17.00
	Above Higher Secondary	49	15.40
Employment	Unemployed	153	48.26
	Employed	164	51.74
Monthly family income	10000 to 20000 Tk.	149	47.00%
	20001 to 30000 Tk.	70	22.08
	30001 to 40000 Tk.	32	10.09
	>40000 Tk.	66	20.82
Total		317	100.00

Table-II: Health facility visit by respondents and reason for choosing the facility

Variables	Category	Frequency	Percentage
Health facility visited by the respondents	Public health facility	81	25.56
	Private health facility	193	60.89
	Others	43	13.57
Health personnel visited by the respondents	Village doctor	78	24.61
	Kabiraj (traditional healers)	53	16.70
	MBBS doctor	181	56.90
	others	5	1.60
Reason for choosing that specific health facility	Better treatment	205	64.50
	low cost	23	7.20
	near to home	76	23.90
	Referred by doctors	13	4.10
Total		317	100.00

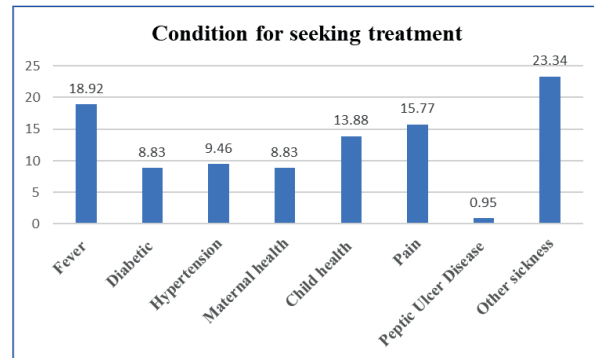


Figure 1. Bar diagram showing condition for seeking treatment

Discussion

Socioeconomic condition of the respondents of the present study showed quite similarity with the study conducted by Siddique et al.¹¹. Actually this study was conducted in rural area of Pangsha, urban and rural areas of Rajbari District of Bangladesh and most of the respondents represented from middle age (Mean±SD=41.47±15.12years). Gender distribution was greater in male 68.76% whereas female was 31.23% which results quite generalized picture in terms of gender. Though Siddique et al.¹¹ found one-fifth of the respondents were illiterate in the study but present study showed only 11.36% of the study subjects had no formal education. Therefore, we can say that illiteracy rate is high in this region.

Health seeking behavior depends on socioeconomic status as well as availability and accessibility of health facility. Majority 91.16% respondents visited health care facilities in lifetime and it was similar with other study ¹¹. In this present study, in case of illness, majority 60.89% of the study participants visited private health facility. Similar finding were observed in another study done in Bangladesh, where participants were accessing the private doctors for health care¹³. It indicates availability and easy accessibility of health facility as a preferred choice, particularly by those who don't have any financial constraints. But these finding differ to other study done in India where study participants visited public health facilities ¹².

In the present study, 25.56% of the study participants visited the public health facilities and another 13.57% visited other health facilities including pharmacies. Although, the quality of services provided by the public health facility is remarkable in our country but surprisingly in this study percentage was less who visited the public

health facilities. We found study subjects suffered from fever, maternal and child health condition, pain, diabetes, hypertension etc. that clearly indicates that all age group and gender are affected.

Most of the participants in present study reported to visit the health facilities for febrile illness 18.92% and pain 15.77%. This illness pattern was similar with the study conducted in rural population of Bangladesh¹⁴. Other common illness for health facility visits include: 8.83% for diabetics, 9.46% people for hypertension, 8.83% people for maternal health, 13.88% people for child health.

In this study, more than fifty percent 56.9% people took treatment from MBBS doctors, 23.9% people from village doctor, and it's depressing that still 16.7% people took treatment from 'Kabiraj' (traditional healers). But this finding is inconsistent with other study where in two-third respondents seek health care from village doctor (quack) and one-third visited with registered doctor/physiotherapist/dentist and very rare percentage went to homeopathic practitioner¹¹. Majority 64.50% of the respondents choose the specific health facility for the reason of better treatment, but in a study of South India, common reason for preferring to the health facility was easy accessibility of health services¹².

Conclusion

Health seeking behaviour of people in this study was quite appreciable. In this study, people received treatment from private health facility. The perception of the people has to be changed to attract them more to government hospitals and health centers. It can be done through improving the quality of care, proper maintenance of facilities and also by improving a caring and sympathetic attitude in health professionals while dealing the patients. Awareness raising activities, and education for health behavior change are also recommended.

Conflict of interest: The authors declare no conflict of interest.

Ethical approval issue: This research was approved by the Institutional Ethical Committee of National Institute of Preventive and Social Medicine (NIPSOM), Dhaka, Bangladesh.

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Authors' contribution: Conception and design of the study: SS; Data collection and compilation: SS, ZS, KMH; Data analysis: SS, ZS; Critical writing, revision and finalizing the manuscript: SS, ZS, KMH.

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