Qualitative Assessment of Health Seeking Behaviour and Perceptions Regarding Quality of Health Care Services among Rural Community of District Agra

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Abstract

Objectives: *To assess the health seeking behaviour and perceptions of rural community regarding the quality of available health care services.* ***Study Design:*** *Qualitative study through focus group discussions.* ***Study Area:*** *18 villages of 3 rural community development blocks of district Agra (Uttar Pradesh) selected on the basis of performance for achievement of RCH indicators.* ***Sampling Technique:*** *Multistage stratified random sampling.* ***Study Unit:*** *Men and women in reproductive age group.* ***Data Analysis:*** *The responses of community members were free listed and semi-quantified using standard qualifiers.* ***Results:*** *For health related problems community members first discuss with family members and other influential persons of their caste community and accordingly take decision regarding where to seek care and/or treatment. Majority of people first try some home treatment and only when they are not relieved they opt for approaching any provider. Choice of health provider is in fact dependant on decision makers which could be elder male family members or some other person from the community. Literacy status, socioeconomic status, past experience and perceived quality of health care services also play pivotal role in selection of provider. Quality of available health care services was poor in the opinion of respondents as a result of which rural community prefers to approach private providers ranging from indigenous medical practitioners, RMPs' and qualified doctors.*

Key words: Qualitative Assessment, Health Seeking Behaviour, Quality of Care.

Introduction

Health status in India is remarkable for its myriad contradictions and where the health situation in some states compares with the best of developing countries, the majority is bracketed with worst in the world[1]. Health system in our country is bogged down with a number of chronic maladies like inappropriate budgetary allocation and a 'top-down' hierarchy with multiple levels of operation which have led to compromise in effectiveness and quality of the services[1]. Although considerable progress has definitely been made in last few decades for expansion of the public health infrastructure but then mere existence or increasing the availability of services does not increase their utilization.

Health seeking behaviour in terms of illness behaviour refers to those activities undertaken by individuals in response to symptom experience[2]. Health seeking behaviour is influenced by a large number of factors apart from knowledge and awareness[3]? This behaviour among different populations, particularly in the rural communities, is a complex outcome of many factors operating at individual, family and community level including their bio-social profile, their past experiences with the health services, influences at the community level, availability of alternative health care providers including indigenous practitioners and last but not the least their perceptions regarding efficiency and quality of the services. Belief systems prevalent in the communities i.e. how people conceptualize the etiology of health problem and how symptoms are perceived is an important factor in deciding the first step of treatment seeking[2].

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Received : 30.12.04

With this perspective, present study was undertaken with an objective to assess the health seeking behaviour of community members; the factors that mostly affect this behaviour, and their knowledge and opinion regarding the content and quality of services that are being provided through primary health care facilities in the rural areas.

Material and Methods

The present study was undertaken between October to December, 2002, in district Agra, according to the principles of qualitative research with application of Focus Group Discussions for collection of information on the health seeking behaviour and other relevant issues from different homogenous, groups of the rural community.

Multistage Stratified Random Sampling Technique was adopted for selection of villages to be included in the study. In first stage, 3 rural blocks were selected from three strata formed out of 15 blocks of district Agra, on the basis of good, average and poor performance (following discussions with district health officials, as per achievement of RCH indicators during previous assessment year). In second stage, 3 subcenters (one each from different PHC areas of the identified blocks) were randomly selected from each block (likewise 9 subcenters were selected out of total 68 centers in the 3 blocks). In third stage from each of the 9 selected subcenter areas, one subcenter headquarter (HQ) village and one non-HQ village were also randomly selected (likewise 18 villages comprising of 9 HQ and 9 non-HQ were identified out of total 50 villages in the identified subcenter areas). Above sampling technique was adopted so as to obtain an overall picture of community's behaviour and perception, presuming a definite distribution existing within different blocks of the

district, with respect to the performance of public health sector, being better in some areas as compared to other relatively under served areas.

Two Focus Group Discussions (FGD) were conducted (one each among homogenous groups of 8-10 men and women belonging to reproductive age group i.e. 15-45 years and permanent residents of the respective villages) in selected villages according to a pre-tested checklist. The study team comprised of one male facilitator (Post Graduate MD student) and 2 male recorders (students of Post Graduate Diploma of Community Health), all from Department of Social and Preventive Medicine, S N Medical College, Agra. Total of 36 FGDs' were conducted at the village level, and all responses of the participants were noted down in verbatim by two recorders to avoid any loss of information.

Information revealed from and noted down during the FGDs' was analyzed manually according to the following steps: (1) Free Listing of responses on particular issues for obtaining the range of responses; (2) Identification of domains (major and minor) on the basis of responses that conveyed homogeneous perceptions from the free-listed responses; (3) Semi-quantification or coding of the responses in respective domains as per the proportion of respondents with specific answer or the emphasis laid on any issue. The qualifiers used for semi-quantification were - <1+ (very few or <10% respondents); l+ (some or 10-24% respondents); 2+ (approximately/nearly half or 25-49% respondents); 3+ (majority/over half or 50-74% respondents); 4+ (most or 75-89% respondents)and 5+ (almost all or >90% respondents)[4]. These qualifiers are depicted in parentheses after each response in the section on results and discussion.

Results and Discussion

Health seeking behaviour

a) Seeking advice regarding treatment of the health problem

It was revealed that for any health related problem majority of community members (3+) first seek advice from some or the other family member or in some cases as stated by approximately half of the respondents (2+) from close friends, relatives etc. Findings in this regard from men and women groups are described as follows:

i) Women (married and unmarried):

Most of the adolescent and young unmarried females (5+) first discuss their health problem with their mothers or elder sisters. Nearly half of them (2+) also discuss problems, (particularly those related to menstruation) with young married women in the neighborhood or their peers in the community.

On the contrary majority of married women (3+) were not found to discuss their health problems (until it is bearable), with anybody in the family or community, not even with their husbands. This was found more common (as stated by majority - 3+) with respect to the problems like white vaginal discharge etc., a very common problem in the rural community. Reasons given for this were: lack of concern of family members for their problems(2+), and considering it as a normal condition (2+).

Nearly half of the women (2+) stated that they prefer to discuss regarding their problem of white vaginal discharge with women of their age group in the neighbour or village, instead of family members, and initially go for herbal medication or home remedies tried or heard by other women. Some women (1+) also told that many a times they directly approach locally practicing Indigenous Medical Practitioners or RMP's known to cure these conditions.

Majority of women (3+) stated that when they have any health related problem then initially either they do not do anything or try some home remedy and only when the problem does not improve even after waiting for some days (or get worse), they tell about it to their mother in law or any known women in the neighborhood, and ask for their advice like, what should they do now? Where should they go? Which doctor is better with respect to location, fees etc? Even among these, very few women (<1+), specifically those who live in nuclear families or in case when costly medicines are required, disclose the problem to their husbands.

Very few women (<1+) stated that their husbands accompany them to doctor, otherwise, in most of the cases they either go with their mother in laws or with some other neighborhood women. Opposing statement was however given by most of the male respondents (4+) who told that their wives first tell all kind of their health problems to them and that they arrange for treatment, herbal or medical depending upon the problem. Some of the men (1+) told that sometimes because of their work as during harvesting season, they are unable to go with their wives and so they tell them to go to some doctor with other women or the neighborhood.

ii) Men (married and unmarried)

Almost all young unmarried males (5+) discussed their health problems with friends or peers in the village. Majority (3+) also told about their health problem to their mothers.

Most of the married males (4+) discussed their health problem only within their peer groups and with other community members. Only nearly half of the married males (2+) tell about their health problems to the family members and very few (<1+) to their wives, since they feel that there is no use of discussing with wives as they could neither treat, nor could give correct advice regarding treatment.

With respect to symptoms/signs related to Reproductive Tract Infections / Sexually Transmitted Diseases, most of the males (4+) were found to silently approach Indigenous

Medical Practitioner / Registered Medical Practitioners (RMP) practicing in some other village and some (1+) also approach providers in the city instead of discussing about them with anyone in the family.

b) Decision maker regarding seeking treatment

Almost all villagers (5+) before approaching to any health facility/provider for seeking treatment were found to discuss about it with experienced and elder members of the family (preferably) and community. In the community, advice is first sought mainly from the peer group or within their caste community by majority (3+) and not with other people of the village, unless the condition is considered serious enough to seek better advice.

It was almost universally revealed (5+) that elder male members of the family (like grand father or father) are the decision-makers most of the times, with regard to issues like, when and where to seek treatment for the disease, and specifically when the treatment involves some big expenditure. Only in some families (I+) elder female member (like grand mother or mother) also play the role of decision-maker. In some of the households (1+), along with the responsible or elderly family member other well-known community members were also found to participate in taking the decision about seeking treatment.

Even for the health problems of women and children, female family members were not found to be empowered to take decision as to when and where to seek treatment, and they have to depend and follow the decisions of their mother in laws, husbands or elder family members in majority of the families (3+).

Only some villagers (I+) also seek advice for the most appropriate alternative from shop keepers, village pradhan, school teachers and village level health functionaries (in decreasing order of preference).

c) Type and stage of disease when treatment is sought from some health provider

Trying home remedies or taking medicines on the basis of previous treatment was revealed as the most common practice (4+) in the villages in case of somebody getting sick in the family. During this period depending upon the severity of illness they wait for improvement and nearly half (2+) also seek advice from other people of their caste-community or peer groups.

When there is no improvement or if the problem aggravates then majority of the people (3+) approach some clinic based practitioner in the village or nearby area irrespective of provider's qualification. However when the health condition is severe or uncommon then mostly (4+) people approach directly to health provider either in the village itself or in the city.

Decision regarding the type of provider to be approached for seeking treatment largely depends on the socioeconomic status of the family as elicited by majority of the respondents (3+). Poor families generally approach local indigenous practitioners or registered medical practitioners of the area who provide cheaper treatment and also sometimes give medicines on credit. Some families approach government health facilities where treatment is provided at relatively lesser cost. However the families who can afford the expenditure prefer to go to private health facilities and doctors for seeking treatment.

Perceptions regarding the quality of available health care services

a) Knowledge regarding the available health care services to the rural community

Almost all the respondents (5+) felt that health care services for the rural community are concentrated mainly at PHCs', and that no appropriate health facilities are actually available at the village level. These PHCs' in the opinion of most of the respondents (4+) are located at distance and are unapproachable or difficult to approach for many of the village communities who are financially poor, those who are residing in remotely situated villages not connected by proper roads and where appropriate (cheap & readily available) means of transportation is not available.

Nandan D have also stated that the most important cause for not utilizing the services available at PHCs by the people residing in villages is the distance of these facilities from their villages (32%)[5]. Similar findings have also been mentioned in studies conducted on quality of care in other countries such as that of Elshabrawy et al (1992) in rural areas of Riyadh (Saudi Arabia) who found that 40% respondents were dissatisfied with the health care services due to various reasons e.g. long distance in one third cases, absence of specialty clinics (38.9%), unsuitable working hours of clinic (19.4%) and long waiting time (63.9%)[6].

Majority of female respondents (3+) considered PHCs as unapproachable as village women cannot go there on their own for seeking treatment for themselves or for their children, unless there is some male family member or elderly women to accompany them.

As for the subcenters, most of the respondents (4+) particularly from non-headquarter villages, were of the opinion that these are located at places where not all people from different villages could reach.

Responses of the community members makes it very clear that according to their perception about relative unavailability of government health facilities in spite of widespread primary health care infrastructure in the rural areas (as a result of inaccessibility, expensive treatment and poor quality services), village community is left with no resort but to

approach locally practicing indigenous medical practitioners (vaidhya / hakim / religious healers) and RMP's.

b) Perception regarding the quality of available health care services

Regarding the availability of services at government health facilities majority (3+) stated that doctors instead of dispensing prescribe costly medicines to be bought from the market. Some respondents (1+) opined that poor people who approach government facilities in hope of getting treatment free of cost as they could not afford costly medicines have to suffer most.

Nandan D following study in Lalitpur and Jhansi and Misra SK from a study in Mahoba also reported that the workers lack credibility in the community. The reason for dissatisfaction among community for PHC doctor was lack of caring and sympathetic behaviour. They found that community was charged fees and they do not get medicines from PHC, and most of the time they have to purchase them from market [7,8].

Very few respondents (<1+) also told about unavailability of any kind of service at PHCs' during night and on holidays and some respondents (1+) stated that no qualified health worker is present at the village level who can be approached in case of sudden health emergency.

Nearly half of the respondents (2+) also pointed that although facilities are available at PHCs' but there is nobody who can provide them, and some of them (I+) said that government health staff is not motivated and do not understand about their duty to provide services to the poor people, which has led to irregularity and irresponsibility for the villagers, who are unable to afford treatment from private doctors.

Nearly half respondents (2+) said that doctors and other PHC health staff never come to their villages for providing health services or for supervising village level functionaries. This has resulted in gradual deterioration of activities performed by ANMs in the villages. Majority (3+) said that ANMs at the subcenters do not provide necessary services and not even medicines for minor health problems to village people.

Ramanathan following a qualitative study have also suggested low levels of dissatisfaction in the face of indifferent quality of services[9]. Verma et al in a study conducted in four Indian states also found that client satisfaction of quality had a significant effect on their acceptance. Clients' rated quality as 'very good' when they found three elements viz. Doctors, facilities and workers to be of good quality[1].

c) Preference of the community for public and private health facilities/providers

Almost all villagers (5+), in spite of the cost involved, were found to prefer private facilities over government facilities. Panwar also found following MIRA study in district Agra that proportion of community preferring government health facilities was far less in both rural and urban areas as compared to private facilities (5.4% and 2.3% respectively), due to non-availability of drugs in the former and also because the people find private practitioners easily accessible and more concerned about their problems[11].

The reasons elicited in favour of private facilities during the present study were good behaviour with patients and their relatives (3+); surety of the best treatment for the patient (2+); availability at any time of day or night (2+); all services including investigations being available under one roof (2+); proper maintenance and availability of all basic physical facilities (2+); provision of transportation (1+); proper monitoring of serious patients (<1+) and availability of specialist doctors (<1+).

Opinion of villagers regarding good health providers was -should have good behaviour, polite, understanding and cooperative towards patients and relatives (4+); should understand the financial condition of patient, and give treatment and medicines accordingly (3+); should listen the problems patiently before giving treatment (3+); should be available always and provide treatment irrespective of time (1+).

Some of the respondents (1+), mostly women, stated that since they have no knowledge about the services that should be delivered and which are actually delivered to the village people and secondly they are nowhere involved in decisions regarding treatment seeking so they could not tell which type of services are better and should be preferred.

Conclusion

From the observations made it can be concluded that knowledge and past experiences of family members (in particular) and other influential persons in the community play a key role in health seeking behaviour of village people, which is further dependant on many factors such as literacy, socioeconomic conditions, family and community dynamics and availability of appropriate services. Female members of the rural community have minimal participation, rather they are neither empowered nor in position to have any decisive role in this regard. The opinions of community members reflect their harsh experiences with government health services, as they have been unable to fulfill their expectations. The gap so created and need of the community have led to preference and adoption of private health sector with wide spectrum from indigenous medical practitioners to unqualified providers and private hospitals.

Recommendations

For changing the age old health seeking behaviour as prevalent in the rural areas and for promoting utilization of services provided through public health infrastructure, it is vital that primarily the perceptions, attitudes and expectations

of the community, who is the actual consumer, be outlined and then accordingly further activities be planned and implemented. For creating informed clients IEC activities should be organized at community level with information on health services and their rights.

People who are better informed tend to expect and seek high-quality services and are in a better position to demand accountability from service providers. Before actually attempting to improve quality of services, it is important to determine the current level of quality and factors, which contribute to lower quality care. Community members/ groups/organizations and service providers should be brought together, and a system for developing service delivery guidelines, making decisions, setting priorities, planning activities and monitoring progress together should be developed.

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