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Health Seeking Practices Of Patient Before Visiting Services Hospital Lahore

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Introduction

Health seeking practices are based on ones health belief model. H]ealth care utilization is determined by the organization of the health system. Health system does not merely represent the structures that provide health care but it encompasses various other elements which constitutes the system as a whole. These are economic conditions, family systems, social support network, culture forces, environmental conditions, political system and so on, which invariably affect the health care seeking patterns.Number of studies show that trends in utilization of a health care system, vary depending on factors such as age, gender,severityof disease, urban or rural habitat, economic status and availability of physical infrastructure type.

Objectives:

1. To assess different health seeking practices of patients

2. To identify association of the Severity of disease, socio cultural, economic and demographic factors related to health seeking practices of patients

Study design:

This was a cross-sectional study.

Study setting:

This study was conducted at medicine outpatient department and ward, Services hospital Lahore.

Study duraton:

The study was conducted during one month.

Results: Out of 150 patients, majority (56.7%) were nonworking including all housewives. Majority(78%) of respondents were

educated with most of them matric pass. While rest (22%) were illiterate. Out of 150 respondents, majority(58.7%) were females. Majority(76.7%) were married. Monthly income of most respondents resided between 15000 to 30000 rupees(36%). Most of the respondents had urban residence (80.7%). Majority of population(49.3%) had an insight of personal satisfaction and considered it equivalent to healthy followed with 45% respondents agreeing that they will seek health care services for both mental and physical stress. While 17.3% of respondents only considered pain equal to illness.

A considerable no. patients (49.3%) did seek medical service at an early stage of disease. While rest(50.7%) either presented late or have been seeking care for a longer duration. .i.e for more than one month.

Most of the respondents(88%) knew that disease has a scientific cause while rest(26%) also believed to have supernatural influences in disease. A large no. of female population 19 (12.6%) believes that evil eye, black magic, evil spirit can result in disease out of total of 29 respondents who believe in supernatural causes. About half of respondents (45.3%) preferred hospital for their illness with an almost equal percentage preferring local clinics (44.7%). However preference for self medication/ home remedies (28%) was also marked. And 25.3% preferred faith healers and traditional healers.

Majority(46%) of the respondents seek health care services when there is severity of disease. Financial issues(19.3%) and Transportation issues(17.3%) also are major determinants. With the type of disease(28.7%) decision of health services is also affected. Out of 150 respondents 117 (78%) were free to make their own decisions. While 33(22%) were dependent. Out of these who were not free to make their own decision during health seeking only 6 were male while rest 27(18%) were females. It was observed that majority of people(57 out of 150) had decision making power regarding the perusal of health seeking services within age range of 30 to 50 years. Out of 150 respondents 77.3% were influenced by the decisions of close friends and family members. home remedies/self medication were the 1st treatment of choice (39.3%) closely followed with hospital treatment (28.7%). Out of 150 respondents only 92(61.3%) preferred

medical treatment alone while rest 58(38.7%) preferred both medical and non medical treatment.

Out of 150, 34 (27%) respondents have visited spiritual healer for present or any past illnesses while 116(77.3%) never visited any spiritual healer 42(28%) respondents have visited hakeem and 30 respondents (20%) visited a homeopath for either present or past illnesses. out of 150 respondents,17 told that financial issues were a reason for visit to traditional healers.A large majority 114 (76%) did take self medication or home remedy.

It was found that a major no. of respondents (76%) were satisfied with their present medical treatment. The major reason of dissatisfaction was found to be non responsiveness to treatment (13.3%). Also lack of communication(2.7%) lack of attention by doctor (2.7%) and long waiting period (4%) were reasons for dissatisfaction.

Conclusion: According to our research "health seeking practices of patients before visiting services hospital Lahore" conduced in medicine department, the study shows that majority of our respondents preferred medical treatment for their illness but was also found to pursue other non conventional treatments like spiritual/ faith healers, homeopathics and hakeems along the lines. Also majority of the respondents were female who were house wives with many supernatural views of disease causation. Majority of married female were also not independent in decision making but depended on their husband or in laws for their treatment. Peer pressure is also a contributing factor along with severity of disease, type of disease, financial status, accessibility, availability in attaining and continuing a specific treatment. Education is also a major determinant in seek health practice/

Key words: health seeking practices, conventional interventions

INTRODUCTION

Health is the level of functional and metabolic efficiency of a living organism. In humans it is the ability of individuals or communities to adapt and self-manage when facing physical, mental or social changes.[i] The World Health Organization (WHO) defined health in its broader sense in its 1948 constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[ii][iii] This definition has been subject to controversy, in particular as lacking operational value, the ambiguity in developing cohesive health strategies, and because of the problem created by use of the word "complete".[iv][v][vi] Other definitions have been proposed, among which a recent definition that correlates health and personal satisfaction.[vii] [viii] Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Diseases (ICD), are commonly used to define and measure the components of health.

The health belief model (HBM) is a psychological health behavior change model developed to explain and predict health-related behaviors, particularly in regard to the uptake of health services.[ix][x] The health belief model was developed in the 1950s by social psychologists at the U.S. Public Health Service[x][xi] and remains one of the best known and most widely used theories in health behavior research.[xii][xiii] The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior.[x][xi] A stimulus, or cue to action, must also be present in order to trigger the health-promoting behavior.[x][xi]

Health seeking services is determined by the organization of the health system. Health system does not merely represent the structures that provide health care but it encompasses various other elements which constitutes the system as a whole. These are economic conditions, family systems, social support network, culture forces, environmental conditions, political system and so on, which invariably affect the health

care seeking patterns. As for health care system in almost all the developing countries, the public and private health sector co exist, complementing or conflicting with each other. [xiv]Yet, in health planning, least consideration is given to harmonize this co-existence in the larger benefit of the user. In developing countries, health seeking behaviors and health care services utilization patterns have been studied and the determinants have been classified in physical, socio-economic, cultural and political contexts[xv].

Number of studies show that trends in utilization of a health care system, public or private, formal or non-formal, by and large, vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, economic status, severity of illness, availability of physical infrastructure type and cadre of health provider.[xvi]

Maternal health services have a potentially critical role in improvement of reproductive health. The use of health services is related to availability, quality and cost of services as well as the social structures, health beliefs and personal characteristics of the users.[xvii] According to WHO, over half a million women die each year from complications of pregnancy or child birth. Most maternal deaths occur during child birth and presence of trained medical staff could greatly reduce this number.[xviii]

Understanding Maternal Health-Care Seeking Behavior In Low-Income Communities In Accra, Ghana by Patricia Anafi in 2012.

This study sought to examine health care decisions and choices that women make during pregnancy and childbirth in selected low-income and poor urban communities in Ghana.

The study found that three major forms of health care exist for pregnant women: biomedical care; herbal-traditional birth attendant care; and spiritual care. While some women use or prefer to use either solely medical care or herbal-traditional birth attendant care for their pregnancy and delivery, others combine two or all the three forms of health care. Pregnant women seek traditional birth attendants (TBAs) and spiritual care for spiritual protection against death, due to affection and cultural attachment to TBAs, fears about medical care and health facilities, and due to cost of seeking medical care. ^

Long waiting time and early reporting time at antenatal clinic were identified as partly limiting the use of medical care during pregnancy. [xix]

In Asia, most recent studies have identified allopathy as the first treatment sought by most people for different conditions including infertility. Some also follow religious practices with such treatment, either simultaneously or subsequently. [xx][xxi] Either before or when allopathic treatment does not work they seek other methods such as ayurveda, homeopathy and other such traditional methods or visit holy places and spiritual healers. [xx] Some others seek assistance from religious people or quacks.

In Africa, previously different diseases and their health seeking practices have largely been focused however a non-disease specific perspective that is the issue of ABIKU among Yoruba [xxii]. ABIKU refers to a belief that some children are from spirit world and will die at will. Consequently, some others recommend that the care for these children will be different from that of normal children. With no specific set of syndrome the diagnosis ABIKU is largely based on the child's no response to treatment (both bio medical and traditional) and upon confirmation from traditional healers[xxiii]. This belief in a spirit child may influence the treatment of children with different chronic illnesses.

All cultures have systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient education as having cultural relevance for them can have a profound effect on their reception to information provided and their willingness to use it.

Western industrialized societies such as the United States, which see disease as a result of natural scientific phenomena, advocate medical treatments that combat microorganisms or use sophisticated technology to diagnose and treat disease. Other societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed disfavor of powerful forces.Cultural issues play a major role in patient compliance. One study showed that a group of Cambodian adults with minimal formal

education made considerable efforts to comply with therapy but did so in a manner consistent with their underlying understanding of how medicines and the body work.

Asians/Pacific Islanders are a large ethnic group in the United States. There are several important cultural beliefs among Asians and Pacific Islanders that nurses should be aware of. The extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honor of the family are more important than those of individual family members. Older family members are respected, and their authority is often unquestioned. Among Asian cultures, maintaining harmony is an important value; therefore, there is a strong emphasis on avoiding conflict and direct confrontation. Due to respect for authority, disagreement with the recommendations of health care professionals is avoided. However, lack of disagreement does not indicate that the patient and family agree with or will follow treatment recommendations. Among Chinese patients, because the behavior of the individual reflects on the family, mental illness or any behavior that indicates lack of self-control may produce shame and guilt. As a result, Chinese patients may be reluctant to discuss symptoms of mental illness or depression.

Some sub-populations of cultures, such as those from India and Pakistan, are reluctant to accept a diagnosis of severe emotional illness or mental retardation because it severely reduces the chances of other members of the family getting married. In Vietnamese culture, mystical beliefs explain physical and mental illness. Health is viewed as the result of a harmonious balance between the poles of hot and cold that govern bodily functions. Vietnamese don't readily accept Western mental health counseling and interventions, particularly when self-disclosure is expected. However, it is possible to accept assistance if trust has been gained.

Russian immigrants frequently view U.S. medical care with a degree of mistrust. The Russian experience with medical practitioners has been an authoritarian relationship in which free exchange of information and open discussion was not usual. As a result, many Russian patients find it difficult to

question a physician and to talk openly about medical concerns. Patients expect a paternalistic approach-the competent health care professional does not ask patients what they want to do, but tells them what to do. This reliance on physician expertise undermines a patient's motivation to learn more about self-care and preventive health behaviors.

Although Hispanics share a strong heritage that includes family and religion, each subgroup of the Hispanic population has distinct cultural beliefs and customs. Older family members and other relatives are respected and are often consulted on important matters involving health and illness. Fatalistic views are shared by many Hispanic patients who view illness as God's will or divine punishment brought about by previous or current sinful behavior. Hispanic patients may prefer to use home remedies and may consult a folk healer, known as a curandero.

Many African-Americans participate in a culture that centers on the importance of family and church. There are extended kinship bonds with grandparents, aunts, uncles, cousins, or individuals who are not biologically related but who play an important role in the family system. Usually, a key family member is consulted for important health-related decisions. The church is an important support system for many African-Americans.

Cultural aspects common to Native Americans usually include being oriented in the present and valuing cooperation. Native Americans also place great value on family and spiritual beliefs. They believe that a state of health exists when a person lives in total harmony with nature. Illness is viewed not as an alteration in a person's physiological state, but as an imbalance between the ill person and natural or supernatural forces. Native Americans may use a medicine man or woman, known as a shaman.

As can be seen, each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices differ from those of the traditional American health care culture. Unfortunately, the expectation of many health care professionals has been that patients will conform to mainstream values. Such expectations have frequently created barriers to care that have been compounded by

differences in language and education between patients and providers from different backgrounds.

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making.[xiv

In Lahore, according to a research conducted on health seeking practices for children, the mothers from upper middle class took timely medical help, fed ample food and ORS to sick infants. The mothers from the village and the peri urban slum took their sick child mostly after second day of illness to a doctor but preferred home remedies. 14 % of mothers in the village and 6 % in the peri urban slum did not seek any medical help at all. [xxv]

In Pakistan, people mostly don't seek medical help until its too late as the disease has progressed and reached chronic stage, sometimes become malignant which poses a greater burden on the patient's expenditure and on country's economy. This research will help us assess the health seeking practices of patients i.e the pathway a patient adopts to reach appropriate treatment center. We will analyze health service use, identification of sources of delay in attending the right care and to find out possible remedies. This is an important issue and appropriate attention has to be given. We can even spread awareness among patients & suggest improvements to hospital administration to mobilize human resources, ward facilities & other tools to ensure patient care and delivery of empathetic health services.

LITERATURE REVIEW

In 2017, a cross sectional study was done by Abdul Qadir Bhutto and Nighat Nisan on Health seeking behaviour of people living with HIV/AIDS and their satisfaction with health services provided in Civil Hospital, Karachi, Pakistan. The population of interest consisted of both male and female people living with HIV/AIDS over the age of 18 years attending the HIV/AIDS health care centre of the hospital. Out of the total participants (182), 23.6% had positive health-seeking behaviour. Only 2.7% of the participants contacted health care professionals on noticing first symptoms of the disease. Almost a third of the participants (31.9%) reported the use of contaminated sharp equipment including razors and needles as a possible source of their infection. Only 8.8% of the participants reported that they were getting treatment on a regular basis. A majority (71.4%) reported that they were facing problems in getting antiretroviral medicines and only 14.3% received medicine on a regular basis from the health care centre. The vast majority had considered going elsewhere for treatment with 28.0% reporting that they had received treatment from faith healers while receiving antiretroviral therapy. Regarding sexual contact with their partners in last 6 months, 30 (16.5%) participants had had contact with only 2 of these reporting use of condoms. Most of the participants (91.2%) reported that their family members knew that they were getting treatment for HIV infection. The majority (84.1%) responded that people should first consult a doctor if they notice symptoms associated with HIV infection or AIDS.[xxvi]

In 2016, a study was done by Edgar Arnold Lungu, Regien Biesma, Maureen Chirwa,Catherine Darker on Health seeking practices and barriers to accessing under 5 child health services. In urban slums in Malawi. Home management was actively undertaken for childhood illnesses. Various health system barriers: lack of medicines and supplies; long waiting times; late facility opening times; negative attitude of health workers; suboptimal examination of the sick child; long distance to health facility; and cost of healthcare were cited in this qualitative inquiry as critical health system factors affecting healthcare-seeking for child health services.[xxvii]

In 2016, a qualitative study was done by Laili Rahayuwati,Kushan Ibrahim,Wiwi Marxian to analyze the pattern of behavior in choosing the health care services for breast cancer therapy, both from the point of view of patients and health care providers. This case study was conducted in several areas in Indonesia, especially in West Java province.Through the thematic analysis, there were five main themes obtained with respect to cancer patients' perceptions of the disease and the selection of therapy at the time of acquiring the disease symptoms: (1) the subjective concept of illness and legalized by socio-cultural factors; (2) the selection of the treatment received by the family; (3) the perception of recovery in any type of treatment; (4) the existence of positive meaning of the concept of illness in life; (5) the high expectation of recovery.[xxviii]

In 2015, a study on Health seeing behaviour and the use of traditional medicine among persons with type 2 diabetes in Uganda was done by Katarina Hjelm, Atwine, Albin and Hultsjo. A qualitative descriptive study design was used. Healthcare was sought from the professional health sector, mainly from the public hospitals before the patients switched to the traditional healers in the folk sector. Reasons for seeking help from traditional healers were mostly chronic conditions such as diabetes, high blood pressure and the perceived failure of western medicine to manage diabetes. The cost at the healers' facilities influenced healthcare seeking also because it was perceived to be affordable as it was negotiable and accessible because it was always available. TM therapies of patients with diabetes were herbal medicine, nutritional products and counselling. However, many patients whose conditions were difficult to manage were told to return to the public hospitals in the professional health sector.[xxix]

In 2013 a research was conducted by Abu Bakar, Van Baar, Fischer, Bomu, Gona on social cultural determinants of health seeking behaviour in Kenyan coast. Health-seeking behaviour, and the factors influencing this behaviour, were examined in a qualitative study in two traditional communities. In-depth interviews with 53 mothers, fathers and caregivers from two rural clinics at the Kenyan Coast were conducted.

Biomedical medicine (from health facilities and purchased over the counter) was found to be the most popular first point of treatment. However, traditional healing still plays a salient role in the health care within these two communities. Traditional healers were consulted for various reasons: a) attribution of causation of ill-health to supernatural sources, b) chronic illness (inability of modern medicine to cure the problem) and c) as prevention against possible ill-health. It was reported that fathers were the ultimate decision makers in relation to decisions concerning where the child would be taken for treatment.[xxx]

In 2013, a study was done by Kingsley Ukwaja, Isaac Alobu,Chibueze Newley regarding health care seeking behaviour, treatment delays and its determinants among pulmonary tuberculosis patients in rural Nigeria.Out of 450 patients (median age 30 years) enrolled, most were males (55%), subsistent farmers (49%), rural residents (78%); and 39% had no formal education. About 84% of patients reported first consulting a non-NTP provider. For such patients, the first facilities visited after onset of symptoms were drug shops (79%), traditional healers (10%), and private hospitals (10%). The median total delay was 11 weeks, patient delay 8 and health system(HS) delay 3 weeks. Factors associated with increased patient delay were older age (P <0.001) longer walking distance to a public facility (<0.001), and urban residence (P <0.001). Male gender (P = 0.001) and an initial visit to a non-NTP provider (P = 0.025) were independent determinants of prolonged HS delay.[xxxi]

In 2012, a cross sectional, qualitative study was done by Sunil K. Kapoor, A. Venkat Raman, Kuldeep Singh Sachdeva and Srinath Satyanarayana regarding Patient Treatment Seeking Behavior for availing TB treatment under the Revised National TB Control Programme from four tuberculosis diagnosis and treatment centers in Delhi.The study showed that informal providers and retail chemists were the first point of contact and source of clinical advice for two-third of the patients, while the rest sought medical care from qualified providers directly. Most patients sought medical care from more than two providers, before being diagnosed as TB. Female TB

patients and patients with extra-pulmonary TB had long mean duration between onset of symptoms to initiation of treatment (6.3 months and 8.4 months respectively).[xxxii]

In 2011 a research regarding the myths, beliefs and perceptions about mental disorders and health-seeking behavior in general population and medical professionals of India were determined In a cross sectional study in Delhi, India by Kishore, Jiloha and Bantman. A sample of 436 subjects was used. (360 subjects from urban and rural communities of Delhi and 76 medical professionals working in different organizations in Delhi). The mental disorders were thought to be because of loss of semen or vaginal secretion (33.9% rural, 8.6% urban, 1.3% professionals), less sexual desire (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's punishment for their past sins (39.6% rural, 20.7% urban, 5.2% professionals), and polluted air (51.5% rural, 11.5% urban, 5.2% professionals). More people (37.7%) living in joint families than in nuclear families (26.5%) believed that sadness and unhappiness cause mental disorders. 34.8% of the rural subjects and 18% of the urban subjects believed that children do not get mental disorders, which means they have conception of adult-oriented mental disorders. 40.2% in rural areas, 33.3% in urban areas, and 7.9% professionals believed that mental illnesses are untreatable. Many believed that psychiatrists are eccentric (46.1% rural, 8.4% urban, 7.9% professionals), tend to know nothing, and do nothing (21.5% rural, 13.7% urban, 3.9% professionals), while 74.4% of rural subjects, 37.1% of urban subjects, and 17.6% professionals did not know that psychiatry is a branch of medicine. More people in rural areas than in urban area thought that keeping fasting or a faith healer can cure them from mental illnesses, whereas 11.8% of medical professionals believed the same. Most of the people reported that they liked to go to someone close who could listen to their problems, when they were sad and anxious. Only 15.6% of urban and 34.4% of the rural population reported that they would like to go to a psychiatrist when they or their family members are suffering from mental illness.[xxxiii]

In 2011, a research regarding help-seeking behavior of patients with mental health problems

visiting a tertiary care center in north India was conducted by Nitin Mishra, Sajanjiv Singh Nagpal, [...], and Mamta SoodThe study was conducted in psychiatric outpatient setting at the All India Institute of Medical Sciences, New Delhi.Two hundred new patients visiting a psychiatric outpatient service at a tertiary care hospital were interviewed on a semi-structured questionnaire for various services contacted by them for their mental health problems.Psychiatrists were the first choice in 45% of the cases followed by non psychiatric physicians and religious faith healers. Important reasons to seek help from different sources included easy accessibility, belief in the system, or particular healer and good reputation. Mean duration of treatment varied from 2.35 months with the alternative system practitioners to 16.63 months with the psychiatrists. The mean expenditure per visit to a service was highest for the nonpsychiatric physician and lowest for alternative system practitioners.[xxxiv]

In 2010, a community based cross sectional survey in the Gilgel Gibe field research area in Ethopia by Abebe, Deribew, Apers, Woldemichael, Shiffa on health seeking behaviour and perceived stigma towards tuberculosis. Any person 15 years and above with cough for at least 2 weeks was considered a TB suspect and included in the study. Of the 476 pulmonary TB suspects, 395 (83.0%) had ever heard of TB; “evil eye” (50.4%) was the commonly mentioned cause of TB. Individuals who could read and write were more likely to be aware about TB [(crude OR=2.98, (95%CI: 1.25, 7.08)] and more likely to know that TB is caused by a microorganism [(adjusted OR=3.16, (95%CI: 1.77, 5.65)] than non-educated individuals. Males were more likely to know the cause of TB [(adjusted OR=1.92, (95%CI: 1.22, 3.03)] than females. 51.3% of TB suspects perceived that other people would consider them inferior if they had TB. High stigma towards TB was reported by 199(51.2%). 220 (46.2%) did not seek help for their illness. Individuals who had previous anti-TB treatment were more likely to have appropriate health seeking behavior [(adjusted OR=3.65, (95%CI: 1.89, 7.06)] than those who had not.[xxxv]

In 2010 a study was conducted to find the health-seeking behavior among migrant workers in Beijing, China by Peng Y, Chang, Zhou, Hu

and Liang. A sample of 2,478 migrant workers in Beijing was chosen by the multi-stage stratified cluster sampling method. The medical visitation rate of migrant workers within the past two weeks was 4.8%, which only accounted for 36.4% of those who were ill. Nearly one-third of the migrant workers chose self-medication (33.3%) or no measures (30.3%) while ill within the past two weeks. 19.7% of the sick migrants who should have been hospitalized failed to receive medical treatment within the past year. According to self-reported reasons, the high cost of health service was a significant obstacle to health-care access for 40.5% of the migrant workers who became sick. However, 94.0% of the migrant workers didn't have any insurance coverage in Beijing. The multilevel model analysis indicates that health-seeking behavior among migrants is significantly associated with their insurance coverage. Meanwhile, such factors as household monthly income per capita and working hours per day also affect the medical visitation rate of the migrant workers in Beijing.[xxxvi]

In 2006, a cross sectional study was conducted by Malik, Hanafi, Ali, Ahmed and Awad Mohamed in the west of the Sudan (Kordofan/Umadara Area to determine the health seeking behaviour of 96 mothers regarding the treatment of malaria in their children aged 5 years or less. Mothers usually start care at home and, within an average of three days, they shift to health workers if there was no response. The main health-seeking behaviour is to consult the nearest health facility or health personnel together with using traditional medicine or herbs. The majority of mothers with febrile children reported taking drugs before visiting a health facility. The choice between the available options determined by the availability of health facilities, user fees, satisfaction with services, difficulty to reach the facilities and believe in traditional medicine. For the the treatment of their febrile children, 81 mothers (84.4%) sought advice from health workers, 7 (7.3%) sought advice from grandmothers, grandfathers or neighbours, 0 (0%) sought advice from village volunteers and 4 (4.3%) sought advice from others.[xxxvii]

In 2005, a research was conducted on maternal health-seeking behavior in a rural community (Ologbo), Nigeria by Osubor, Fatusi and Chiwuzie by a Structured

questionnaire administered to 225 randomly selected mothers (age 15–49 years), and was analyzed using SPSS. Private maternity center was the most preferred place for childbirth (37.3%), followed by traditional birth attendants (TBAs) (25.5%). Government facility was preferred by only 15.7%: reasons for the low preference included irregularity of staff at work (31.4%), poor quality of services (24.3%), and high costs (19.2%). Education was found to be significantly associated with choice of place for delivery ($p < 0.05$), but no association was found with respect to age and marital status. Only 11.4% of mothers were practicing family planning.[xxxviii]

In 2004 a research was conducted regarding disease perceptions and health seeking behavior of household contacts in the Peruvian Amazon by Baldwin, Yori, Ford, Moore, Gilman and Vidal. Interviews with 73 patients finishing treatment and 79 of their adult household contacts. Contacts were knowledgeable about free screening and treatment, but contacts who noted weight loss, not cough, were more likely to be screened for TB ($P = 0.03$). Forty-two per cent reported that TB was prevented by nutrition, 28% by separating eating utensils, and only 19% by avoiding a coughing patient. Only one household contact reported being stigmatized. Stigma centered upon nutrition, and only 12% knew of the association between TB and HIV. Only 14% had a BMI <20, yet 30% reported regularly going to sleep hungry. Free food packages were reported to be the most important reason for treatment adherence by 33% of patients.[xxxix]

In 2001, a research was conducted in rural area of Nepal by Nakagawa Yamasaki, Ozasa, Yamada, Osuga on gender differences in delays to diagnosis & health care seeking behaviour. A cross sectional analysis of health seeking behaviour differences between men and women was done in rural Nepal. Women were found to have a significantly longer total delay before diagnosis of tuberculosis (median 2.3 months for men, 3.3 months for women). When they visited traditional healers first, women had a significantly longer delay than men from the first visit to health care providers to diagnosis (median 1.5 months for men, 3.0 months for women). More women (35%) visited traditional healers before diagnosis

than men (18%), and were more likely to receive more complicated charms from traditional healers. Men tended to visit the government medical establishment first if they knew that free TB treatment was available, but women did not.[xl]

In 2000, a study was done by Dr.A.Thorson on Health-seeking behaviour of individuals with a cough of more than 3 weeks. Sex inequalities can lead to poorer access to health care and delays to diagnosis of tuberculosis in women. In a population-based survey we assessed health-seeking behaviour in adults with long-term cough. The prevalence of cough was 1% (213) and 2% (279) in men and women, respectively. Women took more health-care actions than men, but chose less qualified providers and reported lower health expenditure per visit. Delay before seeking hospital treatment was longer for women (41 days) than men (19 days; p=0·04), and more men (27; 36%) than women (14; 14%; p=0·0006) reported giving a sputum sample at hospital. [xli]

In 1999, a cross sectional study was conducted by Singh, Devi and Gupta on awareness & health seeking behaviour of rural adolescent school girls on menstrual and reproductive health problems. It was conducted on 130 girl students aged 13-17 years in Haryana to assess their awareness and health seeking behaviour regarding menstrual and reproductive health. Mean age at menarche of the girls was 13.6 +/- 0.83 years. Awareness about the process of menstruation was poor. Commonest reported menstrual problem was dysmenorrhoea (40.7%) followed by irregular menses (2.3%) of which only 5.3% consulted a doctor and 22.4% took over the counter medications from the chemist shops. Knowledge about normal duration of pregnancy and need for extra food during pregnancy was poor. Most of the girls knew about importance, duration of child spacing and need for three medical examinations during pregnancy. Major sources of information were television (73.1%), radio (37.1%) and parents (36.1%). Girls preferred to consult parents (49.2%) and doctors (44.6%) for help at times of having reproductive health problems.[xlii]

In 1993 a Population-Based Study of Health Care Seeking Behaviour for Treatment of Urinary Symptoms was carried out in Olmsted County, Minnesota by Jacobsen, Guess, Panser and Chute. This cross

sectional study was carried out with men aged 40-79. Overall, 128 (6%) of the 2119 men had seen a physician in the last year for treatment of urinary symptoms. The proportion of men seeking medical attention increased dramatically with age from 3% among men aged 40 to 44 years to 18% for men aged 75 to 79 years (P for trend, <.001). The probability of having sought medical care was, however, inversely related to income, with 16% of men with incomes less than $15 000 per year having sought medical care compared with 4% of men with incomes of $45 000 per year or greater. This pattern was similar for educational status, with the proportion of men with less education having sought medical care for urinary symptoms being greater than that of their more highly educated counterparts. Men without insurance were more likely to have sought medical care in the last year for their urinary symptoms (12% of men) than men with insurance (6% of men). In addition, married men were less likely to have sought medical care for their urinary symptoms than their non-married counterparts (P<.01)[xliii]

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OBJECTIVES

The objectives of this study are:

1. To assess different health seeking practices of patients

2. To identify association of the Severity of disease, socio cultural, economic and demographic factors related to health seeking practices of patients.

METHODOLOGY

STUDY DESIGN:

This was a cross-sectional study.

STUDY SETTING:

This study was conducted at medicine outpatient department & ward, Services hospital Lahore, a public sector hospital in Lahore. The hospital is a tertiary care level government hospital with 1196 beds, 31departments, 27 major, 8 minor operation theatre and outpatient attendance of 700 patients on average per day.

STUDY DURATON:

The study was conducted during one month.

SAMPLE SIZE:

It was calculated by WHO statistical software's size. By using formula of estimating a population proportion with specific relative precision. At confidence interval of 95%, anticipated population proportion of 70% and relative precision (relative error) of 10% my sample size is 150.

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SAMPLING TECHNIQUE:

Probability convenience sampling was done.Patients were interviewed in 30-day data collection period.

INCLUSION CRITERIA:

Patients presenting in medicine OPD & ward were included.

EXCLUSION CRITERIA:

Patients presenting in emergency and non-willing patients were not included.

Operational Definition

Health Seeking Practice:

Health seeking practice has been defined as any action undertaken by individual who perceive themselves to have a health problem. It is governed by individual or household behavior, community norm and expectations and as well as provider related characteristics and behaviors.

Faith Healer / Spiritual Healers

People who treat patients by using magico-religious practices. They do no have any medical qualification.

Traditional Healers

Anyone who had qualified in any stream of medicine except allopathic medicine e.g homeopathic, hakeem, unani practitioner, ayurvedic practitioner etc.

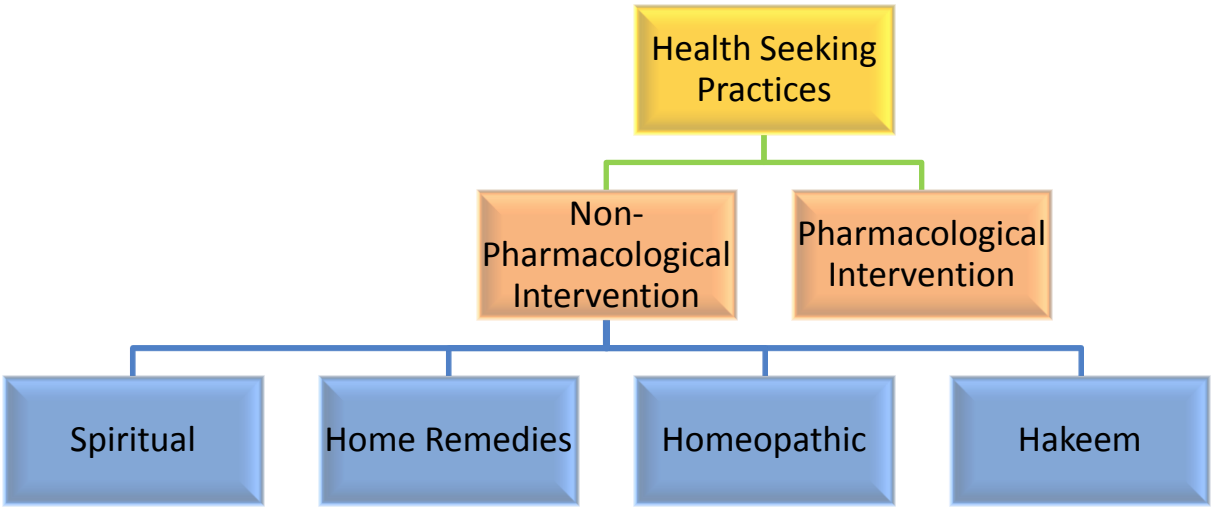
General Practitioner

Anybody who has at least completed his graduation in Medicine and received the degree from any medical college of Pakistan. However this person would not have specialized.

Hospital

A place where proper medical care is provided by medical practitioners and specialists.

Classification



DATA COLLECTION TOOLS:

Semi structured questionnaire was used containing closed and open ended questions. Closed ended questions had different options. Last option was the choice of the interviewee. Open ended questions had no options.

DATA COLLECTION PROCEDURE:

A detailed semi structured questionnaire (annexure-1) was used for data collection. Verbal informed consent was obtained from all the respondents and face to face interview was conducted and a close ended questionnaire with multiple choice/option was used. Questionnaire

was translated into local language. The questionnaire was presented in different settings. All the data was collected by the research group. Questionnaire was checked on daily basis by researchers for compilation and accuracy.

DATA ANALYSIS PLAN:

SPSS computer software version 23 was used for entry, compilation and analysis of data. For quantitative variables, frequency , mean and standard deviate was calculated. For qualitative variables , frequency and percentage distribution tables were generated. Data is presented using pie charts and bar graphs. For quantitative variables `t` test will be applied. P value of 0.05% will be taken as significant.

ETHICAL CONSIDERATION:

Formal approval was taken from ethical committee of services hospital. Written informed consent was taken from all the respondents.

RESULTS

Table 1(a) Demographic profile of the respondents

Demographic Profile	Variables	Frequency n= 150	Percentage
Occupation	Govt. Employer	16	10.7%
	Private Employer	13	8.7%
	Business	7	4.7%
	Laborer	9	6%
	Farmer	8	5.3%
	Shopkeeper	12	8%
	Non - working	85	56.7%
Education	Illiterate	33	22%
	Primary	24	16%
	Middle	25	16.7%
	Matriculate	40	26.7%
	FSc	6	4%
	Graduate	20	13.3%
	Post Graduate	2	1.3%

The table above shows frequency and percentage of occupation and education status of respondents. Out of 150 patients, majority (56.7%) were nonworking including all housewives and some other like students. While the rest(43.4%) was distributed as government employers, private employers, laborers, shopkeepers, farmers or having own business. Majority(78%) of respondents were educated with most of them matric pass. While rest (22%) were illiterate.

Table 1(b) Demographic profile of the respondents

	Variable	Frequency(n = 150)	Percentage
Gender	Male	62	41.3%
	Female	88	58.7%
Marital Status	Single	35	23.3%
	Married	115	76.7%
Monthly Family income	Lower than 15000	53	35.3%
	15000 to 30000	54	36%
	More than 30,000	43	28.7%
Location	Rural	29	19.3%
	Urban	121	80.7%

The table above shows that majority(58.7%) of respondents were females. Bulk(76.7%) were married. Monthly income of most respondents resided between 15000 to 30000 rupees(36%). Most of the respondents had urban residence (80.7%).

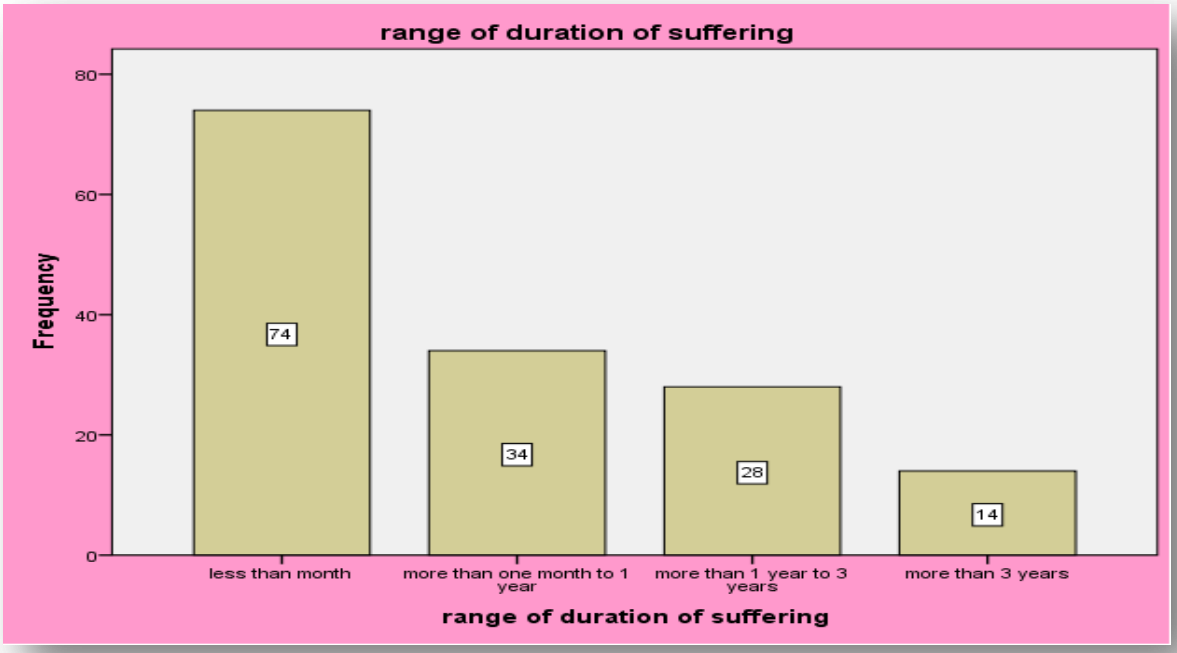
Table 2 Health Perception of the respondents

Variable	Frequency(n = 150)	Percentage
Without pain	26	17.3%
Without mental & physical stress	45	30%
Personal Satisfaction	74	49.3%
Something else	5	3.3%

Majority of population(49.3%) had an insight of personal satisfaction and considered it equivalent to healthy followed with 45% respondents agreeing that they will seek health care services for both mental and physical stress. While 17.3% of respondents only considered pain equal to illness.

Table 3 & Graph 1. Duration of illness of the respondents

Variable	Frequency(n = 150)	Percentage
≤ 1 month	74	49.3%
>1 Month to ≤ 1 year	34	22.7%
>1 Year to ≤ 3 years	28	18.7%
> 3 years	14	9.3%



A considerable no. patients (49.3%) did seek medical service at an early stage of disease. While rest(50.7%) either presented late or have been seeking care for a longer duration i.e for more than one month.

Table 4 Causation of disease according to respondents

Variable	Frequency(n = 150)	Percentage
Evil spirit	6	4%
Black magic	11	7.3%
Evil eye	12	8%
Scientific/medical cause	132	88%
Any other cause	10	6.7%

Most of the respondents(88%) knew that disease has a scientific cause while rest(26%) also believed to have some divine or supernatural influences in disease causation process.

Table 5 Causation of disease and gender differences

		DISEASE CAUSATION		**total**
GENDER		SCIENTIFIC/ MEDICAL CAUSE	SUPERNATURAL CAUSES*	
	MALE	58 (38.6%)	10 (6.6%)	68
	FEMALE	74 (49.3%)	19 (12.6%)	93
total		132	29	

*like evil eye, black magic, evil spirit

A large no. of female population 19 (12.6%) believes that evil eye, black magic, evil spirit can result in disease out of total of 29 respondents who believe in supernatural causes.

Table 6 Preference of Health seeking practices

Variable	Frequency(n = 150)	Percentage
Self Medication/ Home remedies	42	28%
Faith Healer	14	9.3%
Hakeem	15	10%
Homeopath	9	6%
General Practitioner/ Clinic	67	44.7%
Hospital	68	45.3%

About half of respondents (45.3%) preferred hospital for their illness with an almost equal percentage preferring local clinics (44.7%). However preference for self medication/ home remedies (28%) was also marked. And 25.3% preferred faith healers and traditional healers.

Table 7 Reasons for the Preference of Health seeking practices

Variable	Frequency(n = 150)	Percentage
Type of disease	43	28.7%
Severity of diseases	69	46%
On basis of fee	29	19.3%
Easy access/ transportation	26	17.3%
Availability	15	10%
Behaviour of treatment provider	11	7.3%

Majority(46%) of the respondents seek health care services when there is severity of disease. Financial issues(19.3%) and Transportation issues(17.3%) also are major determinants. With the type of disease(28.7%) decision of health services is also affected.

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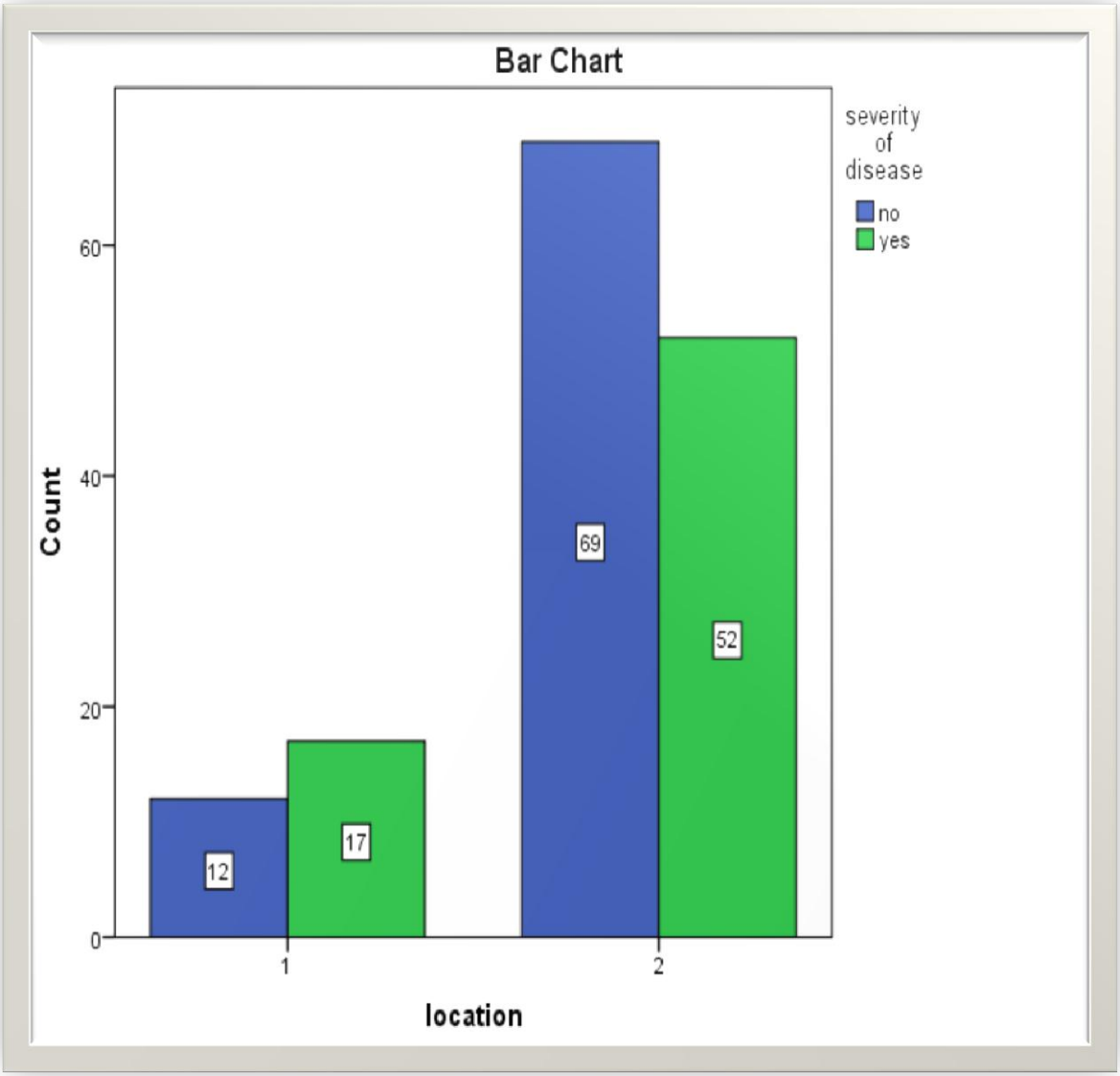
Graph 2 Comparison of severity of disease and location



*1 represents rural *2 represents urban

p-value= 0.129

It was observed that majority of respondents from urban area seek health care services with initiation of symptoms while rural population mostly seek health practices only when disease is severe.

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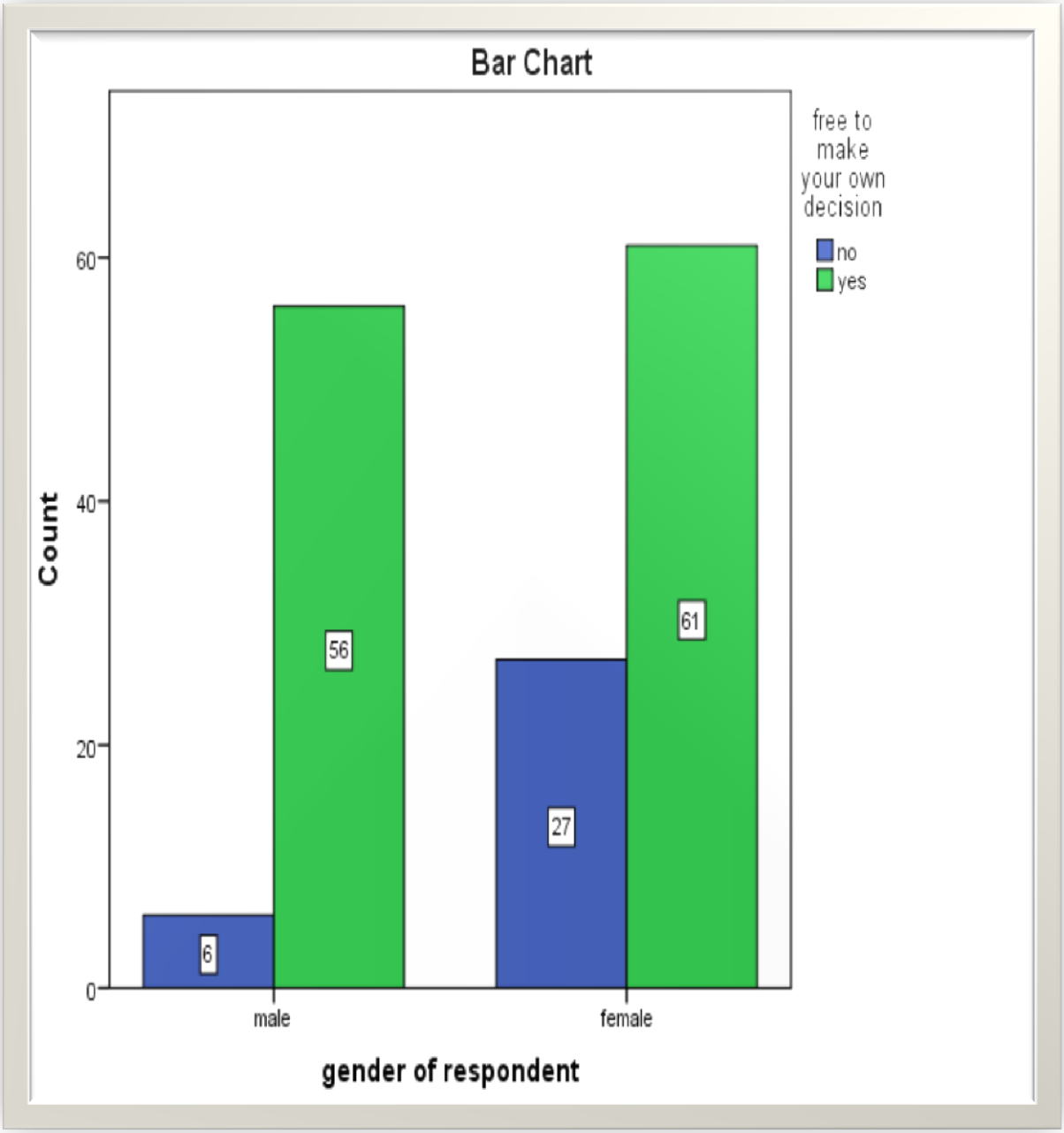
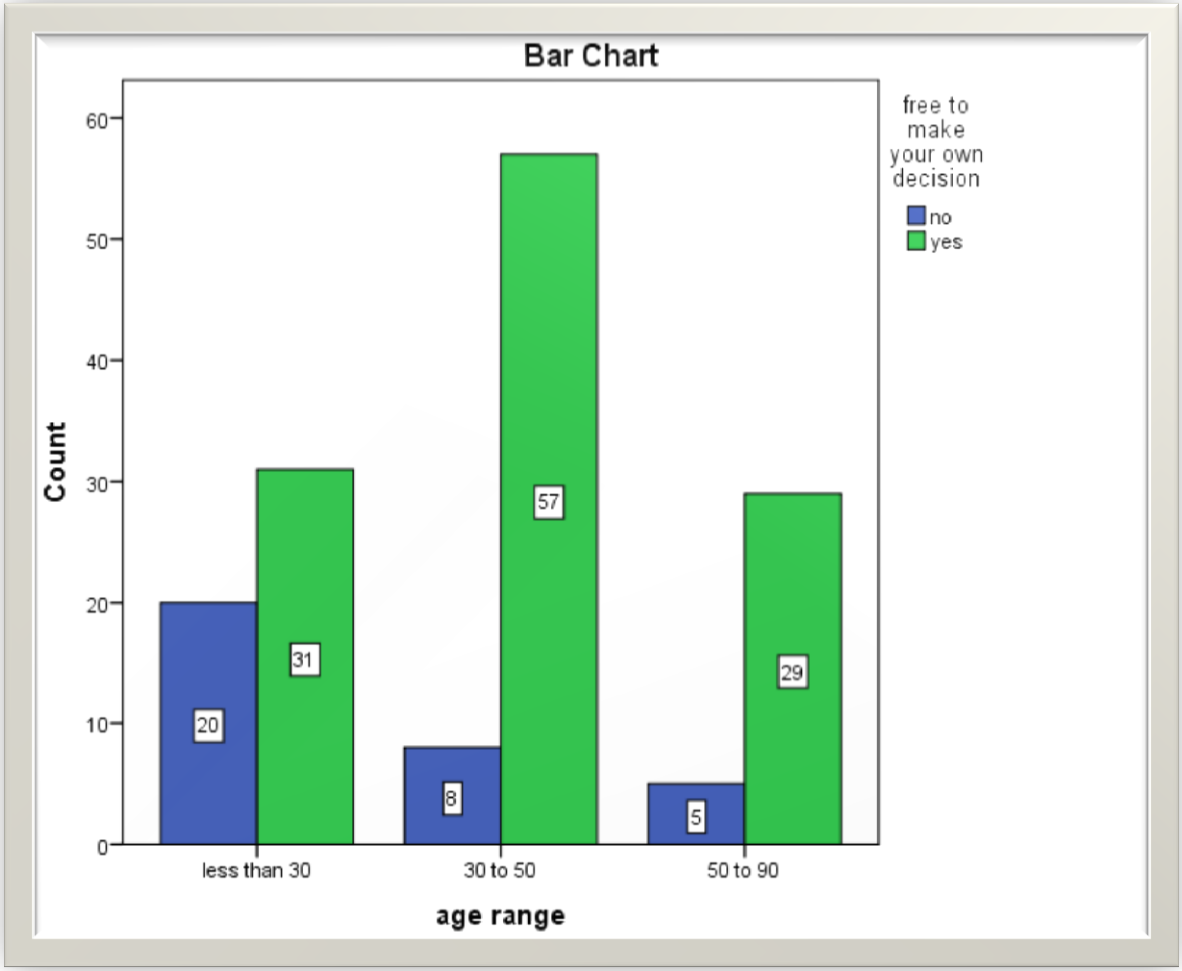
Graph 3 Free to Make Own Decisions



p-value= 0.002

Out of 150 respondents 117 (78%) were free to make their own decisions. While 33(22%) were dependent. Out of these who were not free to make their own decision during health seeking only 6 were male while rest 27(18%) were females.

Graph 4 Comparison of decision making and age differences



P-value=0.001

It was observed that majority of people(57 out of 150) had decision making power regarding the perusal of health seeking services within age range of 30 to 50 years(65 out of 150) while only 8 of them were dependent.

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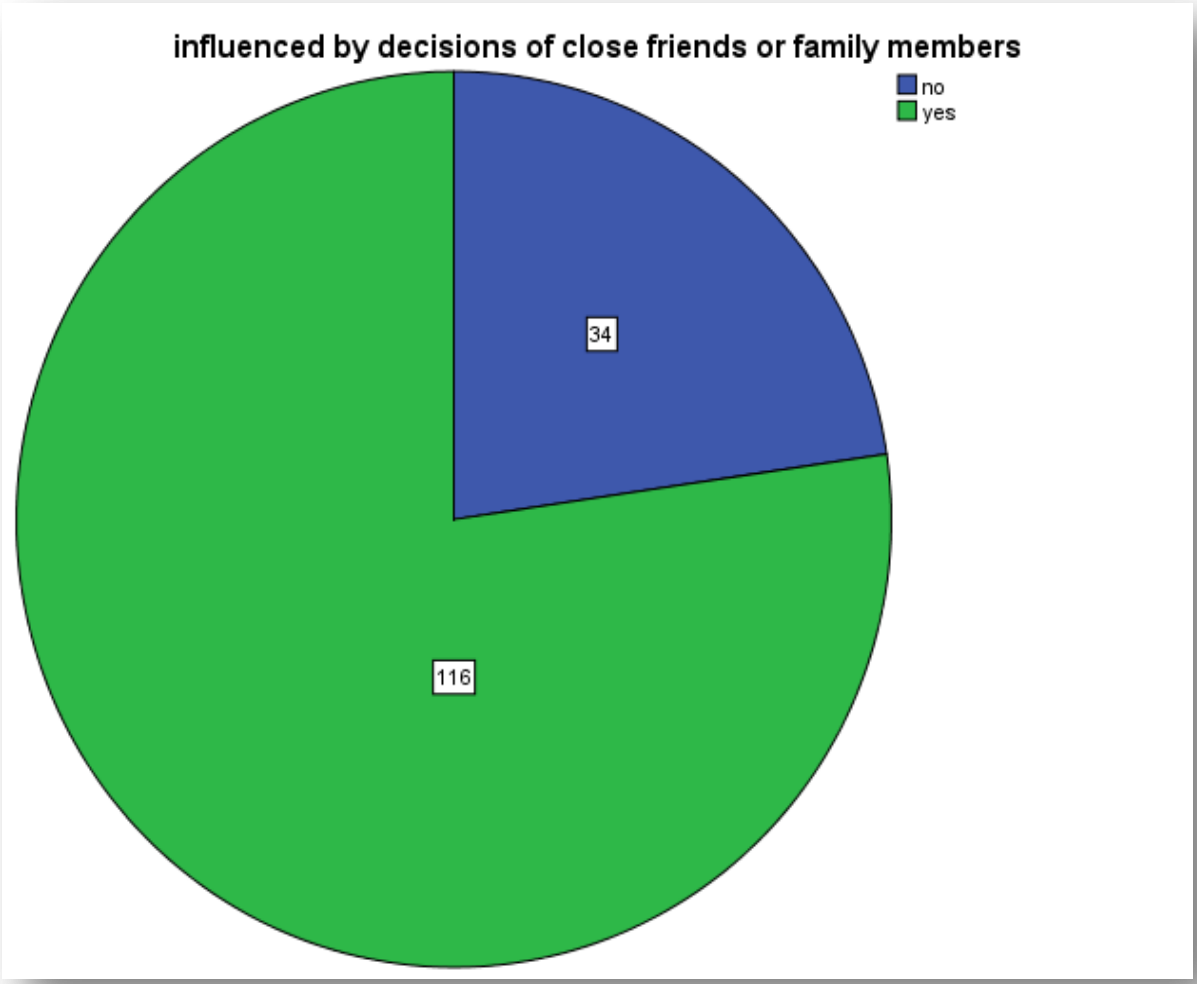
Table 8 Influence of Close Friends & Family Members



Out of 150 respondents 77.3% were influenced by the decisions of close friends and family members.

Table 9 Frequency of Distribution of Influence

Variable	Frequency(n = 116)	Percentage
Spouse	58	38.7%
Grand parents	3	2%
Parents	23	15.3%
Siblings	9	6%
Friend / Relative	13	8.7%
Neighbours	2	1.3%
Children	9	6%
In laws	3	2%

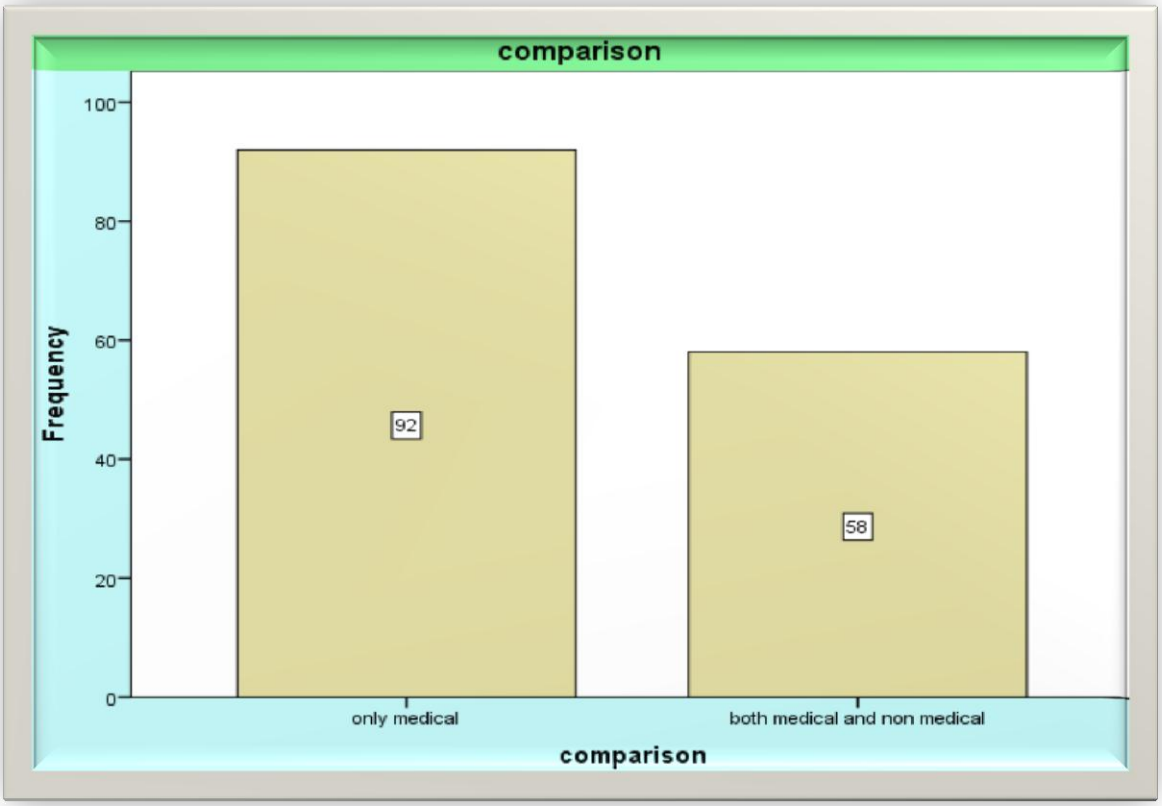
Most of them(38.7%) were influenced by their spouse. While considerable fraction (19.3%) were also influenced by parents , in laws or grand parents.

Table 10 1st Treatment for Current Illness

Variable	Frequency(n = 150)	Percentage
Faith Healer/Spiritual Healer	3	2%
Home Remedy/Self Medication	59	39.3%
Homeopathy	9	3.3%
Hakeem Medication	15	10%
Hospital	43	28.7%
General Practitioner/ Clinic	21	14%

home remedies/self medication were the 1st treatment of choice (39.3%) closely followed with hospital treatment (28.7%). 29.3%% of respondents either went to faith healers, hakeems, homeopaths or GPs for initial treatment.

Graph 5 Preference for Medical and other Treatments along with medical treatment



Out of 150 respondents only 92(61.3%) preferred medical treatment alone while rest 58(38.7%) preferred both medical and non medical treatment.

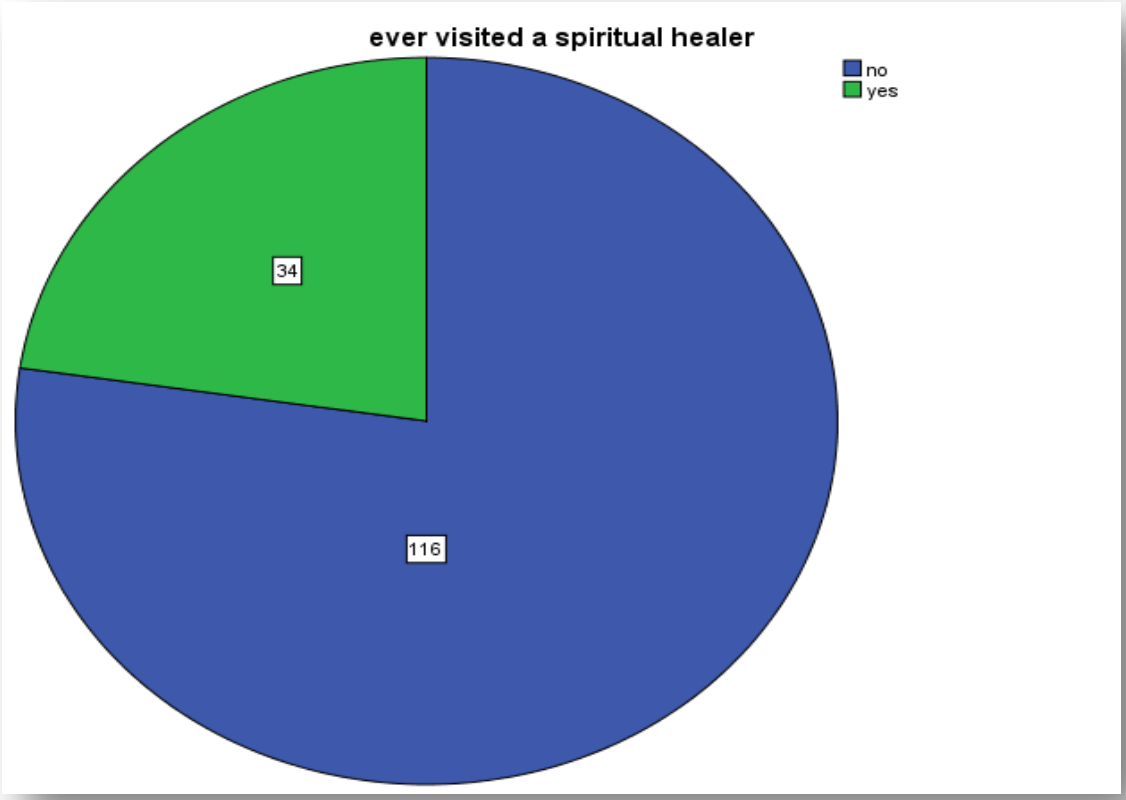
Table 11 Distribution of Frequency of Other Treatments

Variable	Frequency(n = 58)	Percentage
Faith Healer/Spiritual Healer	12	8%
Home Remedy/Self Medication	31	20.7%
Homeopathy	6	4%
Hakeem Medication	11	7.3%
Others	9	6%

the above figure shows distribution frequency for respondents visiting faith healers(8%) Traditional healers(17.3%) and some (8%) also took home remedy/ self medication for their present illness.

Table 12 & Graph 6. Respondents who ever visited a Spiritual Healer

Variable	Frequency(n = 150)	Percentage
YES	34	22.7%
NO	116	77.3%



Out of 150, 34 (27%) respondents have visited spiritual healer for present or any past illnesses while 116(77.3%) never visited any spiritual healer.

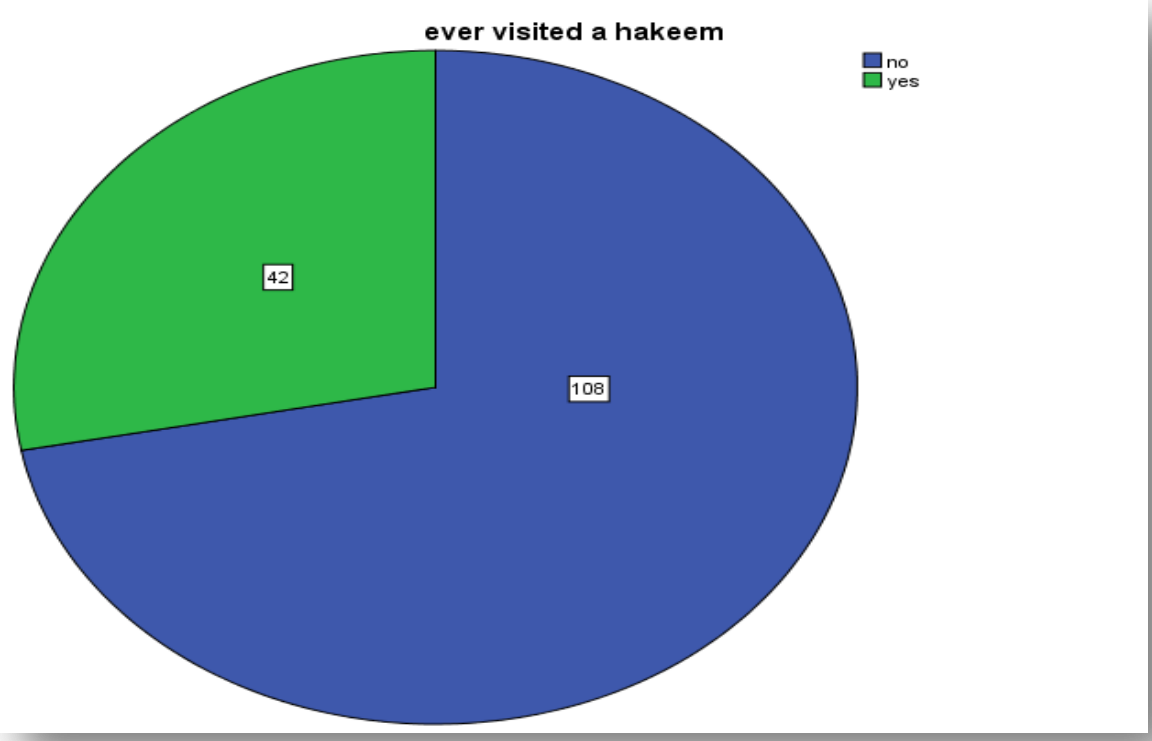
Table 13 Who gave idea to visit Spiritual Healer

Variable	Frequency(n = 34)	Percentage
Spouse	3	2%
Grand parents	5	3.3%
Parents/ In laws	7	4.7%
Siblings	3	2%
Friend/Relative	3	2%
Neighbours	1	0.7%
By one Self	12	8%

Most (8%) went on their own while an equal no (8%) went after getting idea from parents and grandparents.

Table 14 & Graph 7. Respondents who ever visited Hakeem

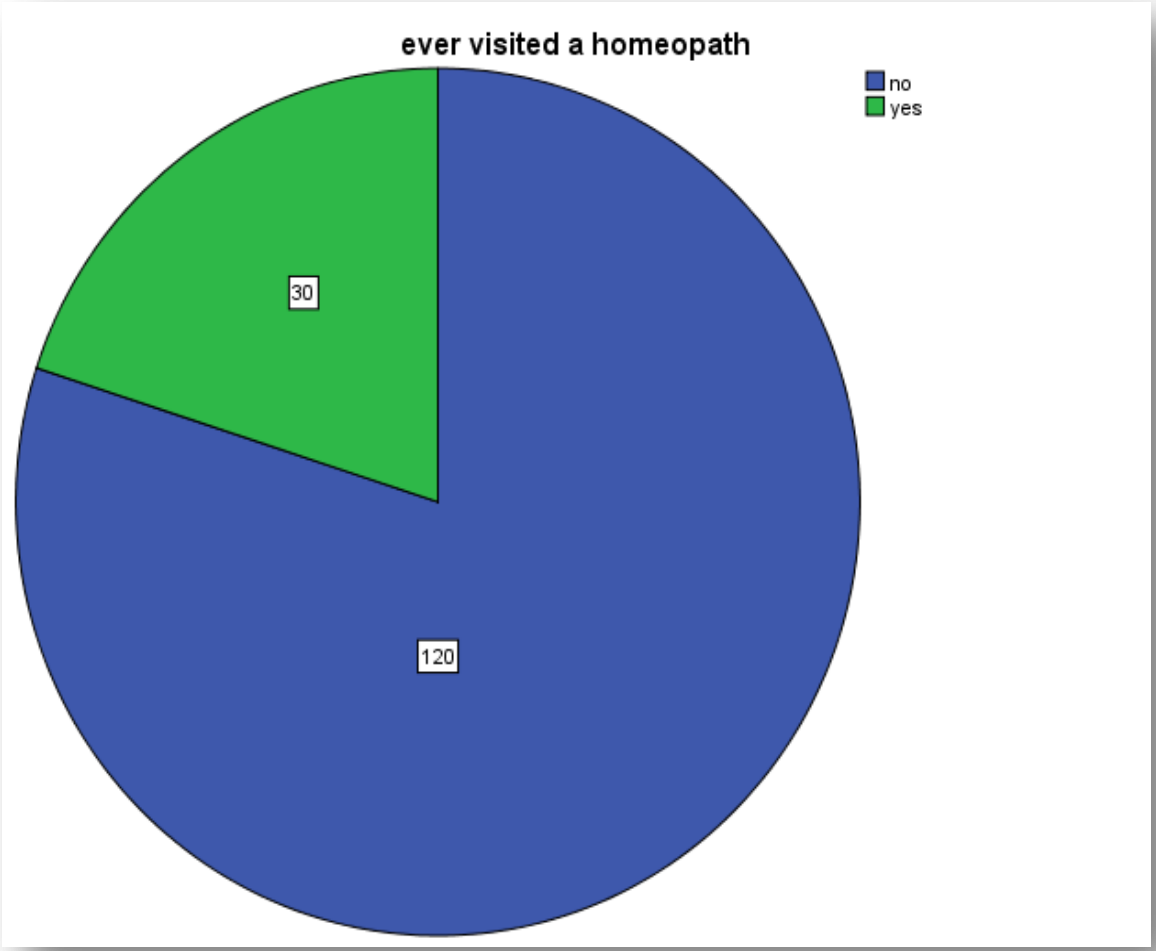
Variable	Frequency(n = 150)	Percentage
YES	42	28%
NO	108	72%



Out of 150 respondents, 42(28%) have visited hakeem for any present or past illnesses.

Table 15 & Graph 8. Respondents who ever visited Homeopath

Variable	Frequency(n = 150)	Percentage
YES	30	20%
NO	119	79.3%



Out of 150 respondents, 30 respondents (20%) visited a homeopath for either present or past illnesses.

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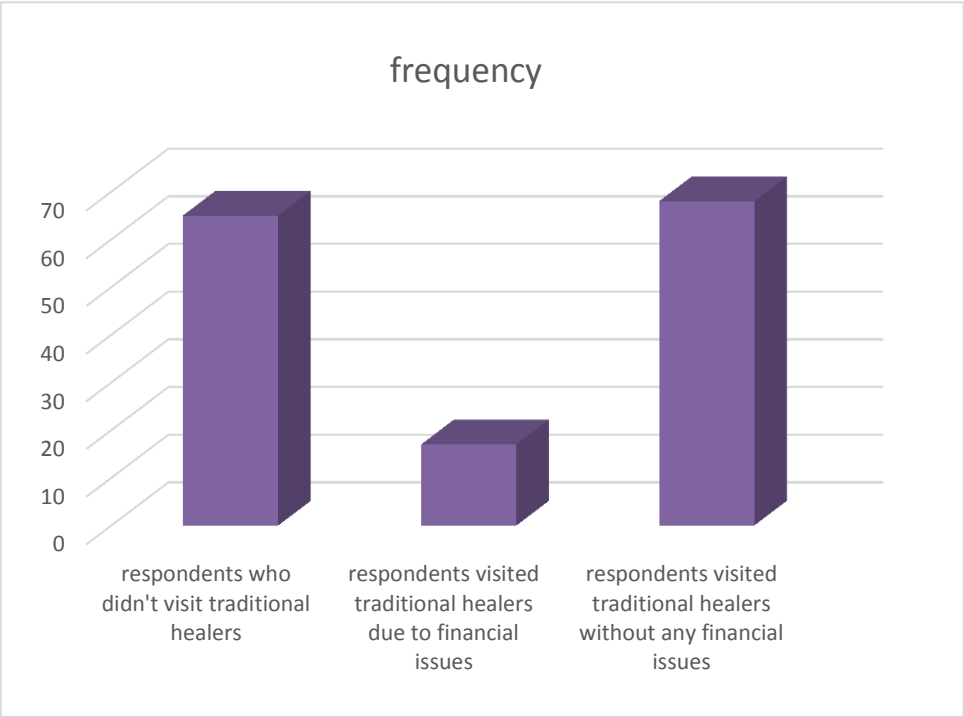
Table 16 & Graph 9. Financial Issues are Reason for Visit to Traditional Healers

Variable	Frequency(n = 85)	Percentage
YES	17	11.3%
NO	68	45.3%



out of 150 respondents, 65 respondents did not visit any traditional healer but 85 did visit traditional either for present or past illnesses. out of them 17 told that financial issues were a reason for visit to traditional healers.

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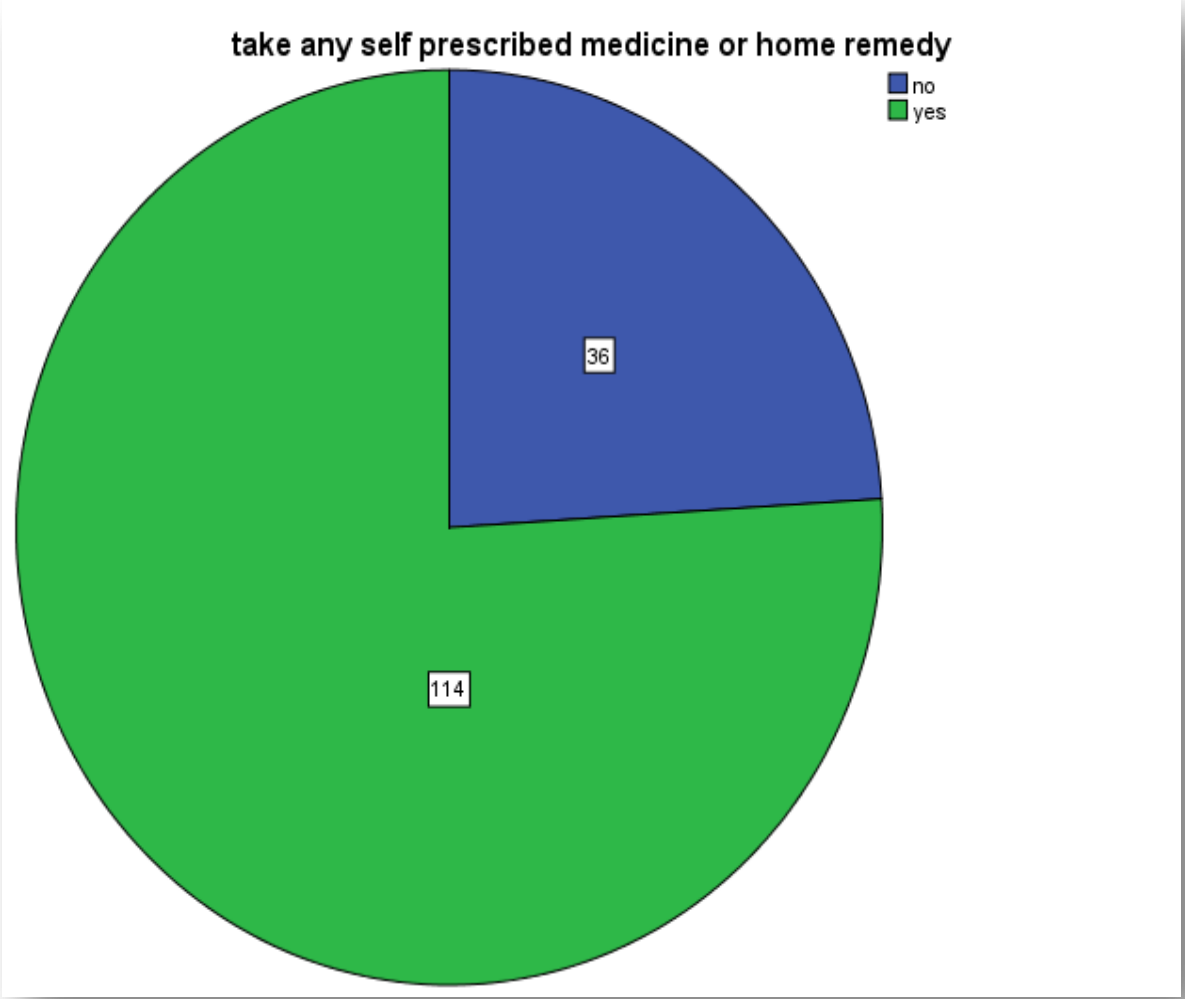
Table 17 & Graph 10. Respondents who ever took self prescribed medicine or Home Remedy

Variable	Frequency(n = 150)	Percentage
YES	114	76%
NO	36	24%



Out of 150 respondents, a large majority 114 (76%) did take self medication or home remedy for their present or any past illness.

Table 18 Respondents satisfied with Present Medical Treatment

Variable	Frequency(n = 150)	Percentage
YES	114	76%
NO	36	24%

It was found that a major no. of respondents (76%) were satisfied with their present medical treatment.

Table 19 Reasons for Dissatisfaction

Variable	Frequency(n = 36)	Percentage
Long Waiting Period	6	4%
Lack of Attention by Doctor	4	2.7%
Lack of Communication	4	2.7%
Non responsive to Treatment	20	13.3%
Any Other Reason	2	1.3%

The major reason of dissatisfaction was found to be non responsiveness to treatment (13.3%). Also lack of communication(2.7%) lack of attention by doctor (2.7%) and long waiting period (4%) were reasons for dissatisfaction.

DISCUSSION

We conducted a research "Health Seeking Practices of Patients Before Visiting Services Hospital, Lahore" during a period of one month. The sample population was 150. Our results show quite diversity considering a limited sample population from different backgrounds, socioeconomic status, age groups, literacy rates and both rural and urban settings.

Most of the respondents were of age group 30 – 50 with a range of 2 years to 86 years. Most of them were married (115, 76.7%). Majority of the respondents was female with a frequency of 88 or 58.7% while rest was male (62, 41.3 %). Females were mostly housewives and it was observed that females were more

likely to seek faith healers or traditional healers than male and hospital was their last resort. Therefore, a delay in diagnosis of disease was seen.

Majority of the population participating in our research came from urban setting (121 out of 150, 80.7%) so they had a fair knowledge of their health issues or related treatment. The rural population (29 out of 150, 19.3%) were mostly illiterate or had an education up to primary. They complained of difficulty in transport, financial issues and longer waiting period and majority of rural population (17 out of 29, 58%) told us that they only seek health services when there is severity of illness while it was opposite in urban settings where minority (52 out of 121, 42%) seek health services with respect to severity of disease. People from rural settings had also shown a slight higher frequency for hakeem medication as first treatment of choice,

A larger population presenting in hospital was non-working (85, 56.7%) while the rest of the respondents gave an image of working class (65) which were distributed among government employees, private employees, laborers, shopkeepers, farmers and business men. It was seen that farmers displayed a higher proportion of visit to Hakeem medication.

The literacy rate of the respondents was 78% (117). Out of them majority was matriculate (40, 26.7%) or primary (24, 16%) or middle passed (25, 16.7%). Frequency of illiterate respondents was 33 (22%). It was seen that most people preferred medical treatment for their illnesses but in case of illiterate population (19 out of 33), they were more inclined to take other non conventional treatments along with medical treatment but higher education status corresponded with only medical treatment as an only choice of treatment.

Monthly family income of the respondents was of range 3,000 to 2 lac with a mean of 27,000. Financial issues were found to be one of the main reasons for visit to traditional healers (17 out of 85, 11.3%). Also 29 respondents out of 150 (19.3%) agreed that they prefer health seeking practices on the basis of fee. It was also observed that people with less than 15, 000 income (53 out of 150, 35.3%) had a diversity in their choice of first health care service. Most of them took home remedies/ self medication. (15 out of 53, 28%).

Hakeem medication (8 out of 53), Homeopathic treatment (2), faith healers (1), GPs (9) or other treatments (4). Similarly respondents with an income range of 15,000 to 30,000 (54, 36%) also were more prone to take home remedy/self medication (26 out of 54, 48%). They had also shown willingness to take other non conventional medicines but lesser than that of less than 15,000 income group. But the respondents with more than 30,000 income (43 out of 150, 28.7%) displayed a higher proportion of visit to hospital as their first choice (14 out of 43, 32%).

According to the health perception of the respondents most considered their "personal satisfaction" as health (74 out of 150, 49.3%). Some equated health to a state "without mental and physical stress" (45 out of 150, 30%) while a little proportion only considered a "without pain state" to health (26, 17.3%).

Though a greater proportion of respondents presented within month in hospital (74 out of 150, 49.3%) but still a higher number of respondents (76 out of 150, 50%) presented after a month. Consequently, there is a delay n diagnosis and also the disease moves on to chronic stage so a non responsiveness to medicines can be seen.

According to most of the respondents scientific or medical cause is the major cause of disease causation (132 out of 150, 88%) but still there is a considerable percentage of respondents seen to believe in supernatural causes like evil spirit, black magic, evil eye (21%). When gender discrimination was done we observed that female respondents (19%) believed more in supernatural causes than male group (16%). Since Pakistan is a Muslim country, so majority of respondents were Muslim and had a firm belief that any disease is a trial from Allah and they should exercise patience along with treatment. Some also follow religious practices with allopathic treatments either simultaneously or subsequently.

It was observed that in our sample population, For their current illnesses most people preferred GPs (67 out of 150, 44.7%) and hospitals (68 out of 150, 45.3%) but still a considerable percentage were enthusiastic about self medication/home remedies (42 out of 150, 28%) , faith healers(14, 9.3%), hakeem medication (15, 10%), homeopath (9, 6%). The higher application of self medication is a proof

that distance is a major health seeking barrier and living in proximity of a health care facility increases the probability of seeking care.

Severity of disease (69 out of 150,46%) is a major reason for preference of health seeking practices. Financial issues (19.3%) also play a major role along with transportation issues (26 out of 150, 17.3%). Availability (15, 10%) and behavior of treatment provider (11, 7.3%) also contribute to preference of health seeking practices. Type of disease or illness (43, 28.7%) is found to be a major demarcating factor for health seeking practices. For example; for subjective problems like anxiety people were found to seek spiritual healers. For GIT problems a large proportion was found to visit hakeem. Also chronic diseases or those diseases which are not yet treated by allopathic medication respondents show an inclination towards other non conventional health seeking practices. Most females had a history of visit to spiritual healers, hakeem or homeopath for infertility.

Majority of respondents were free to make their own decisions (117 out of 150, 78%) while 33 were dependent in their treatment choices (22%). Out of 62 males only 6 (9.6%) were dependent while out of 88 females 27 (30.6%) were dependent. This kind of result is also seen in other developing countries and it shows that women are still not considered socially equal to men and they depend on their male members for their major life choices.

116 out of 150 (77.3%) respondents were influenced by their close friends or family members while seeking health care practices. This is because of our cultural norms and also most families are joint where parents (23 out of 116, 15.3%) and grandparents (3, 2%) have a major say while making decisions. In case of married females their husband (58 out of 116, 38.7%) is often the decision maker or spokesperson. In our research distribution among siblings (9 out of 116, 6%), neighbours (2, 1.3%), children (9, 6%), friends or relatives (13, 8.7%) was also seen. It is because in our culture families are close knit and friends or relatives are respected and often consulted. Also bread earner of a family is often a decision maker.

1st treatment of choice of most respondents was home remedy / self medication (59 out of 150, 39.3%) closely followed by hospital service (43

out of 150, 28.7 %). A lesser proportion was also seen to seek general practitioner (21 out of 150, 14 %), hakeem medication (15 , 10%), homeopathy (9, 3.3%), faith healer (3, 2%). Majority of the respondents (83 out of 150, 55.3 %) are not continuing with their first treatment of choice because of non responsiveness to treatment (52 out of 83) or either change of mind (6.7%), understanding of disease (10%), dissatisfaction with quality (0.7%) or any other reason like side effects (2.7%).

When we asked our sample population for their preferences of treatment most replied "medical treatment" i.e. 143 out of 150(95.3%) however when they were asked about their preferences for other treatments along with medical treatment 58 out of 150 (38.7%) replied in "YES". Again majority was seen to have an inclination for home remedies or self medication(20.7%) closely followed by faith healer services (8%), hakeem medication (7.3%), homeopathy (4%).

When we asked our respondents if they have ever visited a spiritual healer 34 out of 150 (22.7%) replied in "YES". In Pakistan, people consider visiting a spiritual healer as a fulfillment of their religious obligations. This is mainly due to peer pressure and social norms. Education is considered to be a strong determinant of these behaviours. Beliefs in the evil forces and spiritual powers as a cause of disease are still prevalent among women of lower level of education. Similar results were confirmed by a study conducted during 2012 in Ghana, their at the time of treatment there were three types of approaches which also included spiritual care.

When we asked these people who gave them idea to visit a spiritual healer most of them replied grandparents and parents or in laws (8%). But a majority went to them on their own or ideas rooting from other sources (8%%). For example; TV ads or miracle stories. Some of them were also convinced by their spouse (2%), siblings (2%), friends or relatives (2%) and neighbours (0.7%).

When we asked our respondents have they ever visited a hakeem or homeopath 42 out of 150 (28%) were positive for hakeem while 30 out of 150 (20%) where positive for homeopath. They were mostly consulted because of misconceptions about side effects of allopathy medicine, cost, easy access to them,

lack of proper consultation and peer pressure.

When the respondents were asked about their satisfaction level with present medical treatment majority (114 out of 150, 76%) were satisfied while rest (36, 24%) were not satisfied, mainly because of non responsiveness to treatment, long waiting period in outdoor patient department. Lack of attention by doctor, lack of communication and strikes by doctors etc.

When they were asked whether they will continue with their medical treatment only 8 out of 150 were non compliant while rest will continue medical treatment.

CONCLUSIONS

According to our research "health seeking practices of patients before visiting services hospital Lahore" conduced in medicine department, the study shows that majority of our respondents preferred medical treatment for their illness but was also found to pursue other non conventional treatments like spiritual/ faith healers, homeopathics and hakeems along the lines. Also majority of the respondents were female who were house wives with many supernatural views of disease causation. Majority of married female were also not independent in decision making but depended on their husband or in laws for their treatment. Peer pressure is also a contributing factor along with severity of disease, type of disease, financial status, accessibility, availability in attaining and continuing a specific treatment. Education is also a major determinant in seeking health practices.

RECOMMENDATIONS

- People have many misconceptions and lack awareness about disease causation. Behavioral health promotion campaigns through inter-sectoral collaboration focusing more on disadvantaged segments of the population are required.
- In Pakistan, the concept of family physician is also lacking and no counselling services are available so detailed history of any person is not known to physician which may result in false diagnosis non responsiveness to treatment and people are then eager to go for other traditional treatments.

- Most people have no idea where the treatment for their problem is available including educated group and they resort to all kinds of conventional and non conventional treatments with little improvement. So directories on diseases, their treatment and where those treatments are available should be attainable in printed forms at the local facilities. Information regarding this area can also be published in some weekly magazine or in newspaper.
- Primary health care system should be improved and made accessible to people to reduce burden on tertiary care facilities. Also proper referral services should be available at these facilities.
- The diagnostic tests are mostly very expensive and recommended without first considering income of the patient so mostly in case of sole bread earners of a family, they like to believe more in other hearsay advices of friends or family members rather than pursuing that medical treatment so government should take measurements to make these tests economical and doctors should advise them keeping in view income status.
- There is a major barrier in health seeking services of lack of communication between health care provider and patient which is mostly not found in case of quacks. Most people in Pakistan do not like a paternalistic attitude. This can be overcome with awareness campaigns through media, internet , TV, newspaper, radio
- There are limitations in our study settings, but still students in teaching hospitals can be given projects to list up all the available services in that specific health care facility.
- Health care facilities should be available within one hour walking distance.
- Greater availability of staff and equipment increases probability of seeking care when ill.

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