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Health seeking behaviour in India: A review of the existing literature

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Abstract:

This review was carried out to collate the work of researcher in health-seeking behaviour in India, to discuss the methods used and highlight emerging theme. The method used for collecting information was through review of existing literature. The review of the existing literature on health-seeking behaviour in India was collected through online scholarly databases namely Google Scholar, JSTOR, Medline and Academic Search. In total, 30 articles were reviewed with a range of different methodologies. Community-based survey was the most common and retrospective method was applied by most of the researcher in the study. A variety of illness/medical conditions have been covered in the reviewed literature. The emerging themes in the review included preference of private health care over public health care, self-medication, traditional and informal healers, decision making regarding seeking health care, and non-utilization of any form of health care.

Keywords: health-seeking behaviour; seeking health care; utilization of healthcare; private and public healthcare; self-medication; traditional and informal healers .

1. Introduction:

Health Seeking Behaviour refers to a decisions or an action taken by an individual to maintain, attain, or regain good health and to prevent illness. The decisions made encompasses all available health care options like visiting a public or private and modern or traditional health facility, self-medication and use of home remedies or not to utilize the available health services (Chauhan, et al., 2015). Health seeking behaviour was defined as any action taken by a person for seeking help from other person or agency in the community for relief of symptoms (Grover A, et al 2003).

India has a mixed health-care system, which can be broadly classified as public and private. Public health-care services are those which are provided by the Government owned and controlled entities whereas private healthcare services are the ones provided by privately owned or controlled entities. Almost twenty two percent of the population in India is believed to be below the poverty line (Planning Commission of India, 2013); therefore, the cost of treatment is a major factor in utilization of healthcare services. The healthcare expenses in India are paid out of pocket by patients and families, rather than through insurance. Since public healthcare services are lower in the cost aspect when compared to the private healthcare services, they play a very important role in providing affordable healthcare services to the Indian society. Patel et al., (2010) in a study done in Gujarat, India, found empirical evidence that free medical services was the primary reason for the choice and utilization of public healthcare

services. Considering the fact that public healthcare services are more affordable and have a wider reach in terms of their geographic coverage across the country, it is natural to expect a greater utilization of public healthcare services. However, national statistics reveal that the private sector accounts for the majority of healthcare services utilization in both rural & urban parts of India. According to the National Family Health Survey-3, the private sector remains the primary source of health care for 70% households in urban areas and 63% households in rural areas. Therefore, despite the fact that during the last two decades there has been a lot of emphasis on public healthcare services in the form of increased monetary outlay and multitude of programs by national and state governments (Annual Report, Ministry of Health and Family Welfare, 2010), there is an increase in the domination of private players in health care sector (NSSO, 2004).

2. Aim and objective of the review:

The aim of this review is to collate the work of all researchers and bring it to the attention of the readers. The specific objectives were: (i) to document the range of methodologies used to perform such studies; (ii) to list the health conditions for which health seeking behaviour have been studied (iii) to highlight the emerging themes that are prominent and repeatedly occur in the literature and (iv) to make recommendation for future work.

3. Locating the relevant literature:

The strategy for selection criteria is depending on an online data sources for recent reviews. As the topic is of medical as well as anthropological relevance, multiple databases were used namely Google Scholar, JSTOR, Medline and Academic Search. The process starts with a literature search using the search word "health seeking behaviour in India", "health seeking behaviour in urban and rural areas of India", "health care seeking behaviour", "illness behaviour in India" in electronic databases with limitation that the term should be found in the title of articles published during the year 2000-2017.

4. Methodological issues:

A range of different methodologies have been used to gather data on health seeking behaviour, as evident from Table 1. However, majority of the researchers have used cross-sectional study design. The study tools that have been adopted by majority of the researchers were semi-structured or structured interview, pre-tested interview scheduled. Such an approach provides freedom to the interviewer and an opportunity to discuss their experiences and perceptions in greater depth. Many authors argue that the best remedy for minimizing interview influences may not be a highly standardize questionnaire but an interview style which is adapted to normal every day communication (Kroeger, 1983). Interviews typically require participants to recall their past experiences, and these may be susceptible to errors in recalling and biasness. Difficulty in recalling past events may also contribute to biasness. In some of the study, recall periods range for a period of 15 days or 2 weeks have been adopted, whereas in some of the studies a one month period had been adopted and also a period of 6 months to 12 months and more had been adopted. A recall period of six-month would lead to under-reporting, especially of visits for trivial condition (Aljunid, 1995). Only

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one of the study (Ghosh N, et al., 2013), adopted a recall period of 15 days to avoid any biasness in recalling.

Table 1- Description of Studies included in the review

Study/Year	Type	Participants	Focus/Illness	Study Design/ Tools
Mahapatro, M and Kalla, A.K(2000)	Community based	621 Bhattara(tribe) Women	General	-----------------
Jain M et al., (2006)	Community based	Men and Women in reproductive age group	General	Qualitative Study through Focus Group Discussion
Agarwal P. et al. (2009)	Community based	960 respondents and 88 symptomatic of STD in the age group of 15-49	RTIs/ STIs and STD	Cross-sectional Descriptive Study
Willis, J.R et al., (2009)	Community based	255 (mothers of neonate)	Care-seeking for illness of newborn	Structured questionnaire
Patel PB et al., (2010)	Community based	448 households (men and women)	Health seeking Behaviour	Interviewed
Yadav, S.P (2010)	Community based	164 (mothers of sick children)	Malaria and its management	Pre-tested and pre-coded interview and FGD
Kshyatriya, G.K and Kumar, A (2011)	Community based	820 Kinnauras households	Perception of Health and Pattern of HSB	Semi-structured interview schedule, Informal Discussion, and Observation (Qualitative technique)
Balamurugan S.S and Bendigeri, N.D (2012)	Community based	656 women	RTIs	Cross-sectional Study, pre-tested profoma
Dominic, R. A et al., (2013)	Community based	260 adults (men and women)	HSB towards Government or Private Health Facilities	Cross-sectional, Descriptive Study
Mani G et al., (2013)	Community based	547 (women)	RTI/STI	Descriptive/ Cross Sectional Study
Shah et al., (2013)	Community based	500 household each from urban and rural areas (men and women)	Health Care seeking behaviour of Urban and Rural	Cross Sectional Study
Ghosh N et al., (2013)	Community based	256 mothers of sick children	Health Care Seeking Behaviour among Mothers of sick children	Cross sectional Study
Chakraborty K et al., (2013)	Hospital based	120	Psychiatric Disorders	Pre-tested questionnaire
Ravi, R.P and Kulasekaran, R.V (2014)	Community based	605 women	Sexual Health Problems	Cross sectional Study
Sharma, N and Sahu, D. (2014)	Hospital based	223 mothers of sick children	ARI in Children	Cross sectional Observational Study
Majumdar A et al., (2014)	Community based	270(mother, father, grandmother of children below 5 years)	ARI in Children	Cross Sectional Study

Prakash, LKP (2014)	-	-	ARI in Children and Health Seeking Behaviour in India	-
Nayak S et al., (2015)	Community based	774 (Caregivers of children below 15 years of age)	Prevalence and Health Seeking Behaviour of Chest symptomatic in children	Cross sectional study
Pavithran, S et al., (2015)	____________	400 adolescent girls between 14 to 18 years of age	Reproductive Health problems and health seeking behaviour	Cross sectional study
Patle, RA et al., (2015)	Community based	250 elderly men and women	Health seeking behaviour of elderly	Cross- sectional study
Chandwaani, H and Pandor, J (2015)	Community based	405 mothers	Health seeking behaviour of mothers regarding their children health	Cross sectional study
Chauhan, RC et al., (2015)	Community based	576 (both men and women)	Health seeking behaviour	Descriptive Study
Kumar D et al., (2015)	Community based	402 elderly male and female	Health status and health seeking behaviour of elderly	Cross sectional study
Velhal, VG and Durgawale, PM (2016)	Community based	400 families (men and women)	Health seeking behaviour	Descriptive/ Exploratory Survey Design
Patil, SP et al., (2016)	Hospital based	400 attendees of General OPD	Health seeking Behaviour	Cross-sectional study
Patil, RN et al., (2016)	Urban health centre	257 parents	Perception of children with psychiatric disorder	Cross sectional study
Paul R. V Arun et al. (2017)	Community based	270 married women	General/ Reproductive Symptom and health seeking behaviour	Cross sectional Descriptive study

5. Illness/ medical covered and participants in the study:

A wide variety of disease had been covered in the surveys of health-seeking behaviour in India. From the reviewed literature, diseases like reproductive tract infection, sexually tract infections and sexual health problems; acute respiratory tract infection in children to illness of newborns, from malaria in children to chest symptomatic, psychiatric disorders to sickness of the aged. A number of studies had been conducted in the area of RTI/STI of women and one study was conducted on RTI/STI of adolescent girls. Studies pertaining to childhood illness like respiratory tract infection, malaria in children, chest-symptomatic, and illness of newborns were gathered information mainly from mothers; but only one study by Majumdar et al.,(2014), information was gathered not only from mothers; but also fathers and grandmother. For psychiatric disorder in children, information was gathered from both the parents (Patil, et al., 2016).

Mahapatro and Kalla (2000) focus the health seeking behaviour of women in general which include morbidity like gynaecological complaints, tuberculosis, leprosy, old age complaints, goitre, anaemia, scabies, gastroenteritis, fever, cataract, respiratory infection, and whopping cough. Kshyatriya and Kumar (2011) focus on the common health problems like intestinal/ oral diseases; ARI/ URI/ ENT; UTI/STD/RTI;

arthritis/body pain/fracture; jaundice; and skin disease/leprosy. Dominic et al., (2013) in their studies on general health seeking behaviour include disease/ health problems like general health problems, chronic health problem, children's health problems, gynaecological problems, mental health problems and old age problems. Also, Kumar et al., (2015) in their study on the sickness of the elderly include musculoskeletal problems, hypertension, diabetes, diminished vision, cataract, hearing problems, stroke, gastrointestinal problems, pulmonary tuberculosis, filariasis, and cancer. A number of conditions had been covered in the studies and this clearly shows the quest of researchers to explore variants conditions and target different groups in the population.

6. Emerging themes

6.1. Preference of private health care facilities over public health care

Private healthcare facilities are growing in low and middle income countries. Health services in the public sector have always been under-utilized in developing countries. As evident from the reviewed literature, for chronic illness both rural and urban prefer private health care (Shah et al., 2013) whereas in the study by Dominic et al., (2013); Raza et al., (2016); for chronic health problems the private healthcare facilities was preferred. In the study of Balmurugan and Bendigeri (2012), male were treated by private practitioner more as compared to their female counterparts.

From the study of Jain M et al., (2006) it was found out that almost all villagers in spite of the cost involved, were found to prefer private facilities over Government facilities. Likewise in the study by Velhal (2015), the most preferred choice of health care during illness was private practitioner in 51.6% of the cases.

The study of Jain et al., (2006) found out the reason for opting private health care facilities were good behaviour with patients and relatives, surety of the best treatment for the patient, availability at any time day and night, all services including investigation are available under one roof, proper maintenance and available of all basic physical facilities, provision of transport, proper monitoring of serious patients and availability of specialist doctors. Patel et al., (2010) found out that 76.83% had faith in doctors, 69.81% quickness of service, and 47.56% good behaviour of clinic staff were the main reasons for opting private healthcare. Majumdar et al., (2014) found out that reasons for opting private were trust in 51.2% in urban slum areas. Nayak et al., (2015) found that in 84.4% were better treatment than government healthcare, 9.4% due to closeness to their house and 3.22% due to lack of trust in government doctors. Likewise in the study by Chauhan et al., (2015), the quality of care and availability were the main reason. Similar were the findings of Raza et al., (2016) where 50% of the cases considered private healthcare as the best provider and proximity of the healthcare centre.

Public health care services are an integral part of Indian Society. Females are most likely to use public healthcare services as compared to their male counterparts (Pal (Dey) and Mishra, 2012). Patel et al., (2010) found out that the reason for utilization of public healthcare facilities were free availability of services (73.3%) and close location of facilities (68.33%). Similar were the studies by Nayak et al., (2015) and Chauhan et al., (2015) in which free availability of services and satisfaction

with the healthcare services were the main reasons. Kshytriya (2011) stated that satisfaction with medical facilities was another reason for opting public healthcare. Majumdar et al., (2014) found out that for consultation, majority preferred government sector (63%) over private sector in rural areas.

The reasons for non utilization of public healthcare as reflected in the literature reviewed were long waiting period, distance from home, inadequate facilities, unclean premises, harsh behaviour of clinic staff, no faith in government doctor, harsh behaviour of doctor (Patel et al., 2010). Despite the above reasons, the public healthcare service had been utilized by the people and from the reviewed literature, for ante-natal and delivery service, 59.62% wanted to utilize Government healthcare facilities. Also for mental health problems and old age related problems, majority preferred Government hospitals (Dominic et al., 2013). In the study by Patil et al., (2016), majority availed Government health facilities. Also in the study by Raza et al., (2016), for acute illness, people visited the public healthcare facilities. The services of the Public healthcare facilities cannot be denied especially for those who cannot afford private healthcare facilities.

6.2. Self-medication

Self-medication has traditionally been defined as the taking of drugs, herbs or home remedies on one's own initiative, or on the advice of another person, without consulting a doctor (Hernandez et al, 2002). Self-medication is the selection and use of medicines by individuals to treat self recognized illness or symptoms, recurrent disease or minor health problems. This is the practice whereby individuals treat their ailments and conditions with medicines which are approved and available without prescription. Medicines for self medication are often called Over the Counter (OTC) drug which are available without a doctor's prescription through pharmacies, mostly in the less developed countries (Pwar et al., 2009 and Kamat and Nichter, 1998).

In most illness episodes, self-medication is the first option which makes it a common practice worldwide. Self medication was found to be a common practice in the literature reviewed. Home-based remedy was used by all parents at the onset of illness and majority of the people first try home remedy and only when they are not relieved they opt for approaching other health provider (Mahapatro and Kalla, 2000; Jain et al., 2006; and Yadav, 2010). About 49.3% and 12.7% of the participants reported using home remedies. The study of (Yadav, 2010), (Pal (Dey) and Mishra, 2012), (Patle and Khaske, 2015), Chauhan et al., 2015), (Velhal and Durgawale, 2016), (Raza et al., 2016) and (Paul et al., 2017) showed that about 9.1%, 14%, 11.6%, 45.7%, 11% and 12.7% of the participants surveyed reported using over the counter drugs or pharmacy for treating their ailments. In the study by Balamuragan and Bendigeri (2012), 3.4% took treatment from pharmacy as suggested by chemist. Also in the study by Dey (Pal) and Mishra, (2012), for 9.1% of children, parents purchased medicines from pharmacy by using previous prescription. The reason for using home-based remedies for treatment were the averse to the use of modern allopathic treatment, poverty, habit, tradition or personal belief and attitude, and ease of access (Mahapatro and Kalla, 2000; Patle et al., 2015). Self-medication is very common and a number of reasons could be enumerated for it (Solomon and

Abede, 2013); (Chang et al, 2003); (Worku and Miriam, 2003). Urge of self care, feeling sympathy towards family members in sickness, lack of health services, poverty, ignorance, misbelieves, extensive advertisement and availability of drugs in other than drug shops are responsible for growing trend of self-medication (Phalke et al., 2006). Although, self-medication are effective but their improper use due to lack of knowledge of correct dose, side effects and interactions could have serious implications, especially in extreme of ages.

6.3. Traditional and informal healers

In India, the informal healthcare sector not only includes the traditional healers but also homeopaths, spiritual and faith healers, traditional birth attendants and quacks. The Indian Government, through the Indian System of Medicines (ISM) categorizes seven traditional systems- Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa rigpa and Homeopathy (Davey, 2013). As is evident from some of the literature reviewed, in case of sickness the women utilized traditional measures of treatment in 49%, 50%, 8.2%, 4.5%, 9.6%, of the cases (Mahapatro and Kalla, 2000; Agarwal et al., 2009; Yadav, 2010; Kshytriya and Kumar, 2011; Balmuruguan and Bendigiri, 2012; and Mani, et al., 2013).

Shah et al., (2013) in their study found that the health seeking behaviour of respondent towards acute illness shows that more rural people took treatment from faith healers as compared to urban. Also in the study by Chakraborty et al., (2013), 15% in the case of psychiatric disorder used religious remedies. Agarwal et al., (2009) found that, 76.9% prefer their treatment on RTI/STI from quacks and 4.5% from traditional healers. In the study by Kumar et al., (2015), 6.1% utilized homeopathic medicines and 12.7% opted traditional and alternate medicines in the study by Paul et al., (2017). The reason for preference of traditional practices were due to the distances of the health facility, rugged hilly terrain, non-availability of providers and drugs, inflicting loss in terms of working time as reported in the study by Kshatriya (2011).

6.4. Decision making regarding seeking health care

Mahapatro and Kalla (2000) found that among the 32.7% women were more active and independent in making decision regarding treatment of their children below 6 years of age. The reason for high percentage of mother's participation in making decision about child's health care may be that they were important earning members of the family. In another study by Jain M et al.,(2006) the elder male members of the family like grandfather and father were the decision makers most of the time, with regards to issues like when and where to seek treatment for the disease, and when the treatment involves some big expenditure. In some families, elder female members like grandmother and mothers also play the role of decision maker. The findings from the study of Willis et al., (2009), found out that 55% of the final decisions to use a healthcare provider were made by a household member other than a mother, whereas the husband made the final decision in 31% of the cases and mother-in-law in 18% of the cases. Vehal and Durgawale (2016) in their study found out that the head of the family was the main decision maker regarding health seeking behaviour in 87.89%, followed by wife 9% and daughter in law 0.5% .

6.5. Non-utilization of any form of healthcare- Perception, myths and belief

For 7.5% of children, the episode of illness was not treated at all (Dey and Choudhuri, 2012). The reason was that parents thought the illness to be of mild nature and self-limiting. In the study (Mahapatro and Kalla, 2000), 11% women believed that the illness was God's wish and nobody could cure, whereas 7.6% aged women were of the opinion that old age health problem are natural and there was no point in wasting money on them. Also 21.2% of the women in the study perceived that their illness was not serious and that it was curable by home based remedy or by traditional therapy. The perception of symptoms as normal, shy, lack of female health worker, distance to health facilities and lack of treatment were the barriers in healthcare treatment in the study of Ravi and Kulasekaran (2014).

Ghosh et al., (2013) and Patle et al., (2015) stated that the reason for not seeking care were lack of awareness, fixed firm cultural belief, male-dominated society, more concern for the well being of the male child, and final word of the head of the family. The study also stated that dissatisfaction with the health care services, along with lack of accountability and humaneness of the healthcare providers, lack of accessibility, availability and affordability, inconvenient of transport facilities, religious misinterpretations, socio-economic constraints, and women's restricted movement were also the reason for non-utilization of healthcare services. The study by Raza et al., (2016) stated the reason for non-utilization of treatment was unawareness, no felt need and stigma attached to mental health.

7. Conclusion and Recommendation

To conclude, health-seeking behaviour in general and in the context of developing countries like India, is strongly affected by socio-economic and cultural influences. The review has found that a retrospective method had been adopted mostly by the researcher in the study in which the interviews required the participants to recall their past experiences. This method maybe susceptible to errors in recalling and difficulty in recalling past events may also contribute to biasness. Therefore, a prospective kind of approach should be adopted. Also, a wide variety of disease had been covered in the literature reviewed and more studies on chronic diseases like cancer should also be covered.

The important themes that have emerged in the review included preference of private health care facilities and public health care, self medication, traditional and informal healers, decision making regarding seeking healthcare, and non-utilization of any form of healthcare which are associated with perception, myths and belief. Distance of the public healthcare was one of the reasons for non-utilization of public healthcare facilities. Also inadequate of facilities, harsh behaviour of the health workers at the public healthcare were other issues for non-utilization of public healthcare. Therefore, there is a need to correct these issues and Government hospitals needs to be more sensitive towards the people coming for checkups at the hospitals. Also proper facilities, more staffs should be implemented to meet the needs of the people.

Self-medication is mostly the first option and a common practice by most of the people. This is due

to lack of health services, easy access to drugs, and ignorance. Though, self-medication is effective but their improper use may lead to side effects and serious complications. To check this, serious implementation of law for pharmacies to only dispense medicines with proper prescription may help check the problems of buying over the counter drugs.

In India, the traditional and informal healers also play a very important role. There is a need to recognize the different types of traditional and informal healers contributing to the healthcare system by giving them all sorts of training at the district, state and national level from time to time. Engaging them in the practices of healthcare will contribute to the healthcare system in those areas where there are no formal health care. Also, there is a need to increase the awareness level of the people to prevent them from replacing conventional treatment with the different types of informal systems.

In order for health policies to be more effective and acceptable, there is a strong need to understand the factors of health-seeking behaviour by expanding research into those areas which have been neglected. The health-seeking behaviour of the people differs from one area or from one state to the other. This is because of the availability of different healthcare facilities as well as the accessibility and affordability of the people as well as the perception of the available healthcare services. Also the status of women, education and awareness level plays an important role in health-seeking behaviour. Women who are working members or earning members are more active and independent in making decisions regarding health seeking treatment unlike non-working women. The status of women also plays a very important role. Women are mostly the care takers of the children and of everyone's health in the family, therefore increasing the awareness and education level is needed especially in the rural areas of India. Also empowering women to make important decisions and choices at home and in the community can help to eliminate the delay in seeking health care at the earliest.

Conflict of Interest: None declared

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