Research Article
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Socioeconomic status & health seeking behavior of rural people: a cross sectional study in fatikchhari, Chittagong

Abstract

The objective of the study was to assess socioeconomic status & health seeking behavior of the selected rural community people. A cross-sectional study was conducted to collect data from 221 community people residing in 18 Unions of Fatikchhari Upazila. Interviewer assisted survey questionnaire was used. Uni-variate and bi-variate analysis were conducted using SPSS for windows version 20. Of 221 patients' majority were female (54%). The mean age of participant was 40±11 (SD); around 60% respondents seek health care from village doctors and nearby local health center. However, one-third number of population (35%) visited formal healthcare providers, such as registered Doctors, Physiotherapists, Dentists and Nurses having government approved professional degrees. The highest number of respondents seeks health care for fever (23%) followed by maternal and child related condition (22%) and pain, paralysis and arthritis related issues (22%). This study identified that number of factors affecting health seeking behavior including socio-demography, knowledge and perception towards healthcare etc. Awareness raising activities, education for health behavior change & pro-people healthcare delivery interventions may be instituted.

Keywords: socioeconomic status, health seeking behavior, rural people, semi-structured

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Kaoser Bin Siddique Md,[1] Shamim Khan,[2] Shahidul Haque Md,[3] Monaemul Islam Sizear,[4] Arafat ul Alam,[5] Monoarul Haque Md[6]

[1]Manager- Research, Evaluation & Development (RED) Department, Lion Mukhlesur Rahman Foundation (LMRF), Bangladesh
[2]Executive Director, Lion Mukhlesur Rahman Foundation (LMRF), Bangladesh
[3]Lecturer, Jagannath University, Bangladesh
[4]Project Coordinator, SAJIDA Foundation, Bangladesh
[5]Consultant, Institute of Epidemiology, Disease Control & Research (IEDCR), Bangladesh
[6]Report Reviewer, NIPORT, Bangladesh

Correspondence: Kaoser Bin Siddique Md, Lion Mukhlesur Rahman Foundation (LMRF), Bangladesh, Email munna371@yahoo.com

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Introduction

Health seeking behavior is considered the primary and most vital step toward the medication of any health related complexity.[1] It is well explored that, healthcare seeking behaviors and local practicing knowledge requires considering in intervention to bring better health output in a variety of context.[2] By understanding the conceptualization of people of cause of their any disease and the perception on any particular health related problem helps to explore their health seeking behavior.[3] It is widely acknowledged that, exploring the health seeking behavior in different socio-economic levels of any community is crucial for proper planning and implementing of effective health services, particularly for poor community.[4] Socioeconomic status is having greater impact on health care utilization especially in developing countries that is documented in many studies. For instance, wealthier families are about twice time take health care service from formal and informal practitioners.[5] Socioeconomic factors including educational level, economic conditions, cultural beliefs, residence location etc. play a significant role to determine health care behavior of a community overall.[6] Low socioeconomic status is a common barrier to get health services for people and those direct and indirect factors are- doctor fees, cost of transport, medicine etc.[5] It is found from empirical studies from Bangladesh and few other countries that, socio-economic condition is considerable factors of health care seeking behavior for a community.[7] From this mentioned backdrops, it is necessary to understand the health seeking behavior and explore the socioeconomic determinants on this especially low economic community. Therefore, this study has been conducted in rural area of Bangladesh to identify the socioeconomic factors and phenomenon of rural community on their health care seeking behavior. By doing this, any new socioeconomic factors might include that can open a new door for policy makers to make effective and timely health intervention model.

Material and methods

This was a descriptive cross-sectional study conducted at Fatikchhari, Chittagong, Bangladesh, where participants were selected from 18 unions of Fatikchhari. The study was carried out between the months of June 2015 and October 2015. The sample population was selected from 18 unions of Fatikchori: Doulatpur, Naraynhat & Baganbazar. Community peoples those who permanently residing in that area of study and interested to take part in this study were included. Non- probability purposive sampling was used to draw study sample. It was chosen because our sample populations were villagers and no register or sampling frame was found. Also, most of the patients were busy to their work. Sample participants were selected purposively visiting door to door from June 2015 and October 2015 from 18 unions of Fatikchhari Upazilla. Semi-structured survey questionnaire was used to collect data. Several literature and tools were reviewed before finalizing the study tools. Final questionnaire was comprised of 30 questions which divided into five parts:

a. Socio-demography (12),
b. Health seeking behavior (12),
c. Acceptance of proposed service (4)
d. Determining probable price of proposed service (1) and
e. Recommendation for the proposed service

In addition, final English version questionnaire was translated into Bangla and also back translation was done into English. Field test was done on July 07 just two days before starting final data collection to check the suitability of the tools. After, pretesting necessary modification and question rephrasing was done in the final questionnaire. Research Assistants were given proper training on ethical issues and administering questionnaires on July 04-07, 2015. Almost every house in the purposively selected villages was approached and offered to participate into this study, after describing the purpose of this study those who were willingly agreed to sign the consent form they were selected as study participant. Sitting face to face in a suitable location, interviews were conducted. Sufficient time around 20-30 minutes was given to minimize recall bias and assumption. After completing each interview questionnaire was manually checked for any missing data and different responses which were cross cheeked with repeating the question. Internal consistency was checked among the interviewer. Everyday collected data were manually checked and entered into Microsoft excel simultaneously. The data were entered into Microsoft Excel and then after cleaning all data, transposed into the Statistical Package for Social Sciences (SPSS) software version 20.0 (Armonk, New York, USA). Data had been displayed through using different tables and graphs. Study findings were verified through internal consistency checking. Verbal Informed consent was taken from the participants and also they were informed about the purpose of the study. The participation in this study was voluntary and confidentiality as a participant was maintained. The risk and benefit was explained to participant and they were not provided any sort of compensation. The patients were allowed to decline any question which they may find uncomfortable in replying or finding it sensitive. They had the right to withdraw and discontinue participation at any time.

Result

Table 1 shows mean age of respondents was 40±11 (SD); after categorization in four groups: the age groups 20-39 were 50%. The majority of patients, 85% were Muslim and others were Hindu. Similarly, this study recruited 88% married respondents and only 12% were single. The number of female was greater 54% whereas male 46%. This study classified level of education into four categories and found 21% patients who had no formal education. More than 27% patients completed college and above, followed by 22% and 29% enrolled in primary and secondary school. In this study, more than half of the total patients were homemaker, 44% and others profession were service (12%), business (19%), and labor (5%). Retired person contributed only Two percent. However, other professions contributed 12 percent which including students, driver and unemployment. Figure 1 reveals 94% respondents visited healthcare facility in lifetime. Figure 2 shows about 60% respondents seek health care from village doctors and there nearby local health centre which comprising of informal healthcare providers. However, one-third number of population (35%) visited formal healthcare providers, such as, registered Doctors, Physiotherapists, Dentists and Nurses having government approved professional degrees. Diabetic Hospital, Homeopathic and Ayurvedic health facilities were visited by 2% and 3% respectively. And the remaining respondents (1%) visited Huzur (Religious Leader), Kobiraj and others. Figure 3 indicates the highest number of respondents seeks health care for fever (23%) which followed by maternal and child related condition (22%) and pain, paralysis and arthritis related issues (22%). In addition to that 20% responded mentioned that they seek care for hypertension, however, less than half of them visited health care facility for diabetes which was 8%. Figure 4 shows approximately half of the total respondents reported that they visit a specific hospital for having better treatment facilities. Also, One-fourth number of respondents mentioned health care service close proximity to home followed by low cost 20%. Known doctors, referred by doctors and others scored very minimal which were 03%, 04% and 1% respectively. Table 2 states 51% and 43% respondents visited health facility 2-4 times in three months and six months respectively. Figure 5 shows more than One-third (37%) number of respondents indicated that they were not satisfied with the existing health care services whereas satisfied respondents were 62.9%. Figure 6 demonstrates more than half of the respondents recommended that visiting health care provider at home would be the very helpful followed by 36% depicted that setup clinic nearby home can be one of the potential solution.

Figure 1 Percentage of Healthcare Facility Visit in Lifetime.

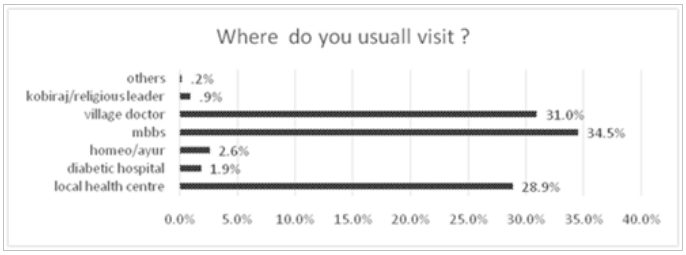

Figure 2 Types of Healthcare Facilities Visited by Respondents.

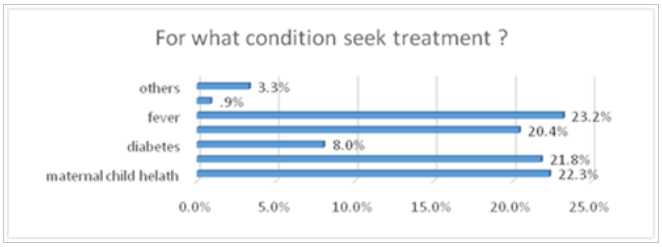

Figure 3 Respondents Seek Care for Types of Disease Conditions.

Figure 4 Preference to visit specific hospital.

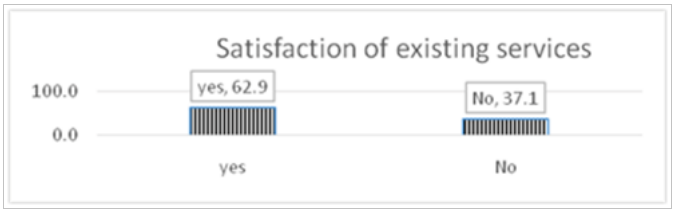

Figure 5 Satisfaction towards Existing Services.

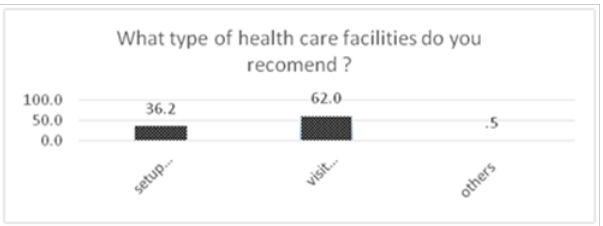

Figure 6 Recommendation for Prospective Healthcare Facilities.

Table 1 Socio-demographic Characteristics of the Respondents (n=221)

Variables	Category	Male (n=119) 46%	Female (n=102) 54%	Total (n=221) 100%	Percentage
Age Mean=40±11 (SD)	20-39	57 (51%)	54 (49%)	111	50
	40-59	52 (54%)	44 (46%)	96	43
	≥60	10 (71%)	04 (29%)	14	6
Marital status	Single	24 (92%)	02 (8%)	26	12
	Married	95 (49%)	100 (51%)	195	88
Religion	Islam	94 (76%)	93 (24%)	187	85
	Hindu	25 (74%)	09 (26%)	34	15
Education	No formal education	17(37%)	29 (63%)	46	21
	<Primary	18(37%)	31 (63%)	49	22
	<Secondary	37(57%)	28 (43%)	65	29
	College and above	47 (78%)	13 (22%)	60	27
Occupation	Service	24 (92%)	02 (8%)	26	12
	Business	42 (100%)	0	42	19
	Laborer	11 (92%)	01 (8%)	12	5
	Farming	10 (100%)	0	10	5
	Housewife	01 (1%)	96 (99%)	97	44
	Retired	04 (100%)	0	4	2
	Others	27 (90%)	03 (30%)	30	14
Household member	≤ 4	25 (44%)	32 (66%)	57	26
	>4	94 (58%)	69 (42%)	163	74
Monthly family Income (n=221) Mean=18,568 Median=15,000	<10,000	22 (41%)	32 (66%)	54	24
	10,000-29,999	70 (51%)	66 (49%)	136	62
	30,000-59,999	21(88%)	03 (12%)	24	11
	60,000-89,999	02 (100%)	0	2	1
	≥90,000	04 (80%)	01 (20%)	5	2
Monthly family expenditure Mean=14,407 Median=11,000	<10,000	30 (45%)	36 (55%)	66	30
	10,000-29,999	76 (54%)	64 (46%)	140	63
	30,000-59,999	10 (90%)	01 (10%)	11	5
	60,000-89,999	02 (100%)	0	2	1
	≥90,000	01 (50%)	01 (50%)	2	1
Residency of patients	Urban	01 (1005)	0	1	0.5
	Rural	107 (53%)	95 (47%)	202	91
	Peri Urban	08(57%)	06 (43%)	14	6

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Table 2 Frequency of health facility visit in 03 & 06months

Frequency of health facility visit	In three months (%) (Median: 02)	In six months (%) (Median: 05)
At least Once or None	58 (27)	16 (08)
2-4 Times	108 (51)	90 (43)
5-6 Times	23 (11)	44 (21)
>6 times	24 (11)	59 (28)
Total	213 (100%)	209 (100%)

Discussion

Bangladesh is the one of the developing countries in the world. The country has enormous potential for rapid development in the new world economy. The quality of life of the population in Bangladesh appears to have improved very significantly in recent years. But unfortunately in some sectors Bangladesh is far from the expected development, health sector is one of them. In recent years, the government and non-governmental organizations are working together to ensure basic health care services to all and to expand their health services in rural Bangladesh. Socioeconomic condition of the respondents of the present study showed quite similarity with the study conducted by Mahejabin & Praveen.[4] Actually this study was conducted in rural area of Southern-eastern part of Bangladesh and most of the respondents represented from middle age and gender distribution was nearly equal which results quite generalized picture in terms of gender. Though Mahejabin found more than half of their respondents were illiterate in their study but present study showed one-fifth of the study subjects had no formal education. So we can say that illiteracy rate is high in slum area than rural area. Health seeking behavior depends on socioeconomic status as well as availability and accessibility of health facility. We know in Bangladesh pharmacy both registered or nonregistered are available in here and there and in rural area still existence of traditional healer/kabiraj. In this study we see that two-third respondents seek health care from village doctor (quack) and one-third visited with registered doctor/physiotherapist/dentist and very rare percentage went to homeopathic practitioner. Ahmed, et al.,[8] showed the individuals from poor households would seek treatment from unqualified allopathic practitioners was 0.6 for self-care or self-treatment it was 1.8. Patients' level of education affected whether they avoided self-care/self-treatment and drugstore salespeople (who are usually unlicensed and untrained but who diagnose illnesses and sell medicine) and instead chose a formal allopathic practitioner. When a household's poverty status was controlled for, there were no differences in age or gender in terms of health-care expenditure.[8] We found study subjects suffered from fever, maternal and child related condition, pain, arthritis, paralysis etc that clearly indicates that all age group and gender are affected. A study conducted in Rural Ethiopia found that diarrhea and tetanus was common there. They also showed there is a systematic relationship between socioeconomic status and choice of providers mainly for adult-related conditions with households in higher consumption quintiles more likely to seek care in health centres, private/Non-Government Organization (NGO) clinics as opposed to health posts. Delays in care-seeking behaviour are apparent mainly for adult-related conditions and among poorer households.[9] Despite the wealth of studies on health and healthcare-seeking behaviour among the Bengali population in Bangladesh, relatively few studies have focused specifically on the tribal groups in the country. Traditional healers are still very popular among the tribal population in Bangladesh; Perceptions of the quality and manner of treatment and communication can override costs when it comes to provider-preference; Gender and age play a role in making decisions in households in relation to health matters and treatment-seeking; and Distinct differences exist among the tribal people concerning their knowledge on health, awareness, and treatment-seeking behaviour.[10]

Conclusion

This study concludes that a number of factors affecting health seeking behavior were identified. Some of them include socio-demography, knowledge and perception towards healthcare etc. Awareness raising activities, education for health behavior change & pro-people healthcare delivery interventions are recommended.

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Conflict of interest

The author declares no conflict of interest.

References

1. Price NL, Hawkins KA. Conceptual framework for the social analysis of reproductive health. *J Health Popul Nutr*. 2007;25(1):24–36.
2. Islam SMS, Biswas T, Bhuiyan FA, et al. Injecting Drug Users and Their Health Seeking Behavior: A Cross–Sectional Study in Dhaka, Bangladesh. *Journal of addiction*. 2015;2015:756579.
3. Patle RA, Khakse GM. Health–seeking behaviour of elderly individuals: A community–based cross–sectional study. *Natl Med J India*. 2015;28(4):181–184.
4. Mahejabin F, Parveen S, Begum R. Disease Pattern and Health Seeking Behaviour of Slum Dwellers in Dhaka City. *International Journal of Medical and Health Research*. 2015;1(2):4–8.
5. Kevany S, Murima O, Singh B, et al. Socio–economic status and health care utilization in rural Zimbabwe: findings from Project Accept (HPTN 043). *J Public Health Africa*. 2012;3(1):46.
6. Musoke D, Boynton P, Butler C, et al. Health seeking behaviour and challenges in utilising health facilities in Wakiso district, Uganda. *Afr Health Sci*. 2015;14(4):1046–1055.
7. Biswas P, Kabir ZN, Nilsson J, et al. Dynamics of health care seeking behaviour of elderly people in rural Bangladesh. *International Journal of ageing and later life*. 2006;1(1):69–89.
8. Ahmed SM, Tomson G, Petzold M, et al. Socioeconomic status overrides age and gender in determining health–seeking behaviour in rural Bangladesh. *Bull World Health Organ*. 2005;83(2):109–117.

9. Mebratie AD, Van de Poel E, Yilma Z, et al. Healthcare–seeking behaviour in rural Ethiopia: evidence from clinical vignettes. *BMJ Open*. 2014;4(2):004020.

10. Rahman SA, Kielmann T, McPake B, et al. Healthcare–seeking behaviour among the tribal people of Bangladesh: Can the current health system really meet their needs? *J Health Popul Nutr*. 2012;30(3):353–365.

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