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ORIGINAL RESEARCH ARTICLE

Barriers in health care access and health seeking behaviour among women in a rural area, Telangana – A Community based Cross Sectional study.

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Abstract

Background:
Health is influenced by an array of factors including social, environmental, genetic and a host of other factors. Health seeking behavior is a term which is used to explain the pattern of health care utilization among any population group and the sequence of remedial actions that individuals take in order to rectify perceived ill health. Health seeking behaviour of an individual is strongly influenced by socio-cultural beliefs and practices. Gender plays a very important role in influencing the health seeking behaviours. In rural areas of our country accessibility is a huge problem and a major determinant for care seeking.

Objectives:
1.To study the socio demographic profile of women in a selected rural area
2.To determine the association between health seeking behaviour and socio demographic factors
3.To identify various barriers in accessing health care services

Methods: A community based, cross sectional study was conducted among 360 adult population in rural field practice area of MallaReddy Medical College for Women. A pre-designed, pre-tested questionnaire used to assess the health seeking behaviour among study population after obtaining the consent. Data were analyzed using SPSS version 20.

Results: Among study population, 21% of subjects seek medical care as soon as symptoms appear. Only **22%** of participants were aware of existing government health schemes. . Nearly **45%** of women reported needing permission from senior family members before visiting a doctor. Factors like literacy status and socio economic status were associated with the health seeking behaviour of women in rural areas.

Conclusion: In Indian societies women are often characterized as special subgroup population and discriminated. This social discrimination is resulting in a narrow access to the health system. Availability is one of the major determinants of health seeking behaviour. Further a health care system must be accessible also.

Key words: Health seeking behaviour, Gender, Barriers

1 | INTRODUCTION

Health-seeking behaviour has been defined as a "sequence of remedial action that individuals undertake to rectify perceived ill health." (1) Health care seeking behaviour (HCSB) is a decision to choose from collectively available options stating from home remedies to public or private hospital settings. (2) Health-seeking behaviour is a multidimensional concept that includes various factors such as the Nature of the disease, extent of the disease, Environmental and cultural factors, gender, and financial status.

Health-seeking behaviors are broadly divided into

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preventive behaviors, illness behaviors, and sick role behaviors. (3, 4) Women face gender based inequality in health care treatment due to cultural practices that confine them to household activities, a lack of financial freedom, and poor knowledge. (5) A study done in Bangladesh depicts that many women do not prefer to consult male doctors to seek reproductive healthcare and they have to obey their in-laws and elderly women in health-related decision-making (6)

Certain factors such as caste and religion also play a role in HCSB, lower case face exclusion in the society which due to which they will be hesitant to go to hospital. Similarly, certain rituals, such as attending sermons, feasts, and festivals, as well as societal and social sacrifices, influence people's behaviour towards health. (4)

Despite government initiatives to improve public health services, the private sector remains dominant in most Indian states. Health-seeking behavior among women is influenced by factors like knowledge, awareness, socio-demographics, and accessibility of health services, playing a crucial role in determining their health outcomes. (5)

Health care services vary between rural and urban populations, hence it's important to consider political, social and cultural factors in HCSB. Hence, the study aims to explore the socio-demographic profile of women in a selected rural area and determine the association between health-seeking behaviour and socio-demographic factors. It tries to understand various challenges in accessing health care services-

Objectives:

[noitemsep,nolistsep,topsep=5pt]To study the socio demographic profile of women in a selected rural area To determine the association between health seeking behaviour and socio demographic factors To identify various barriers in accessing health care services

2 | METHODOLOGY

Study Design and Setting

This was a community-based cross-sectional study conducted in a area of Telangana.

Methods: A community based, cross sectional study was conducted in rural field practice area of Malla Reddy Medical College for Women, Hyderabad.

Inclusion criteria:

1) All adult women aged 18 years and above residing in the study area

2) Subjects who were willing to participate and has given written consent

Exclusion criteria:

1) Visitors, migrant population

2) Non cooperative

3) Severe illness, mental retardation

The sample size was determined using the formula n= Z2 p (1-p)÷E2 with a power of 80%, confidence limit of 95% and allowable error of 15% where p is the prevalence of a specific health-seeking behaviour (taken as 34.5% from previous related studies) . The calculation resulted in a required sample size of 360. The ethical clearance was obtained from Institutional Ethical Committee, Malla Reddy Medical College for Women, Hyderabad. (7)

The study was conducted in multistage sampling technique. In the first stage, out of twenty nine villages , sixteen villages were selected , out of which 4 from from each direction were selected randomly. In the second stage, households were selected by systematic random sampling. For this a list of all households was prepared from the family household register. Sampling interval (k) was calculated by using formula k=N/n (N-population size and n-sample size). On substitution in the formula (5085/360=14.1), sampling interval was rounded to 14. The first house is selected by last digit of a currency note randomly and it was found 5. Then subsequent houses were selected by adding sampling interval till the sample size of 360 is obtained.

In the third stage, if more than one eligible participant were present in the selected house, simple random sampling technique was used to select one eligible participant.

Data Collection

Data were collected by trained investigators using a pre-designed pre-tested semi-structured questionnaire. The questionnaire covered three main domains:

1. **Socio-demographic details:** Age, education, occupation, marital status, and socioeconomic status

2. **Patterns of health care utilization:** Self-reported actions taken during the most recent episode of illness, including the type of provider sought (government, private, traditional).

3. **Perceived barriers:** A checklist of common barriers to accessing care (e.g., cost, distance, waiting time, provider availability).

Statistical Analysis

Data were entered and analyzed using SPSS 26 version. **Descriptive statistics** were used to summarize socio-demographic characteristics and reported barriers. **Chi-square tests** were employed to determine the association between socio-demographic variables (such as education and socioeconomic status) and the type of health-seeking behaviour utilized. A p-value of less than 0.05 was considered statistically significant.

3 | RESULTS

Socio-demographic Profile

The study included 360 women. The mean age of the participants was **34.8 +/- 9.7 years** (Mean +/-SD). The distribution of participants by key demographic variables is presented in Table 1

Table 1. Socio-demographic Profile of Study Participants (N=360)

Demographic VARIABLE	FREQUENCY (%)
Age	
18-40 years	223 (62%)
41-60 years	79 (22%)
$\geq$ 60 years	58 (16%)
Marital status	
Married	230 (64%)
Unmarried /Single/Widow	130 (36%)
Education	
Illiterate	133 (37%)
Primary	102 (28%)
Secondary	58 (16%)
High	32 (9%)
Intermediate	24 (7%)
Graduate	11 (3%)
Religion	
Hindu	317 (88%)
Muslim	28 (8%)
Christian	15 (4%)
Occupation	
Unemployed/Homemaker	227 (63%)
Employed	133 (37%)
Socio economic status	
Upper&Upper middle	209 (58%)
Lower & Lower middle	151 (42%)
Type of family	
Nuclear	158 (44%)
Joint	202 (56%)

Majority of the study population were between 18-40 years that is 62%, among which married were 64% and 36% were either unmarried or single/widowed. Among the study population 37%were illiterate and 63% were literate. Majority belonged to Hindu religion which corresponds to 88% and the rest were Muslims and Christians. In the study population 63% were homemakers and 37% were employed. Around 58% belonged to upper socio-economic class according to modified BG Prasad classification. Nearly 44% belonged to nuclear type of family and 56% live in joint family. In the present study since 63% were married and majority of them were homemakers, they lack freedom in decision

making regarding health and finances

Health-Seeking Behaviour

In response to perceived illness, the majority of women primarily sought care from government facilities. The distribution of their health-seeking behaviour is shown in Table 2

Table 2. Health Care Seeking Behaviour among Study Participants (N=360)

Type of Provider Sought	Frequency (n)	Percentage (%)
Government Health Facility	223	62.0
Private Health Facility	101	28.0
Traditional Healer/Self-Medication	36	10.0
Total	360	**100.0**

While it is encouraging that most people used Government health services, nearly one-third still choose a private health facility because they perceive that it offers better quality or shorter waiting times. The 10% using traditional remedies reflect the ongoing influence of cultural beliefs and possible accessibility challenges.

Table 3. Health Care Seeking Behaviour among Study Participants

Health care seeking behaviour	Number (%)
Aware of various health schemes	22%
Need permission from senior family members to visit doctor	45%
Visits the health facility immediately after the onset of symptoms	21%
Hesitation in discussing health issues among family members	30.4%
Hesitation towards availing treatment from a male doctor	67%
Can make their own decision regarding seeking health care	34%

The present study revealed important insights into the health-care-seeking behaviour of rural women Table 3 . Only **22%** of participants were aware of existing government health schemes, indicating a significant gap in health literacy and programme outreach. Nearly **45%** of women reported needing permission from senior family members before visiting a doctor, highlighting persistent gender-based restrictions and limited autonomy in health-related decision-making. Timely care-seeking was also suboptimal, with just **21%** visiting a health facility immediately after the onset of symptoms, suggesting delays that could worsen health outcomes. Hesitation in discussing health issues with family members was reported by **30.4%**, reflecting cultural norms that discourage open communication about illness, particularly for women. A substantial **67%** expressed discomfort in availing treatment from a male doctor, demonstrating the strong influence of socio-cultural norms on provider preference. Despite these barriers, only **34%** of women reported being able to make their own decisions regarding health care, reinforcing the need for interventions that empower women and improve autonomy in health-seeking behaviour.

Table 4 presents the association of education status and socio-economic status (SES) with health-care seeking behaviour. A statistically significant association was observed between education status and the type of health facility utilised ($\chi^2 = 9.0693, P < 0.05$). Illiterate participants more frequently sought care from government health facilities (69/133) and traditional healers (17/133) compared to private facilities (47/133). In contrast, literate participants showed a higher preference for private health services (54/227) and government facilities (154/227), with relatively fewer relying on traditional care (19/227). This pattern suggests that increasing literacy is associated with a shift towards formal and especially private health-care services.

Table 4. Association between Socio-Economic Status and Education Status with Health Care Seeking Behaviour

Variable	Private	Government	Traditional	Total	Chi-square value	Level of significance
Illiterate	47	69	17	133	9.0693 P<0.05	Statistically significant
Literate	54	154	19	227		
Upper and Middle class	66	122	21	209	3.2319 P>0.05	Statistically not significant
Lower class	35	101	15	151		
Total	101	223	36	200		

However, the association between socio-economic status and health-care seeking behaviour was not statistically significant ($\chi^2 = 3.2319$, $P > 0.05$). Although individuals belonging to the upper and middle classes showed a somewhat greater inclination towards private facilities (66/209), and those in the lower class more often utilised government services (101/151), these differences did not reach statistical significance. This indicates that socio-economic status alone did not strongly influence the choice of health-care provider in this study population.

Table 5. Barriers toHCSB

Variable	Category	Distance to Health Facilities	Transportation to Health Facilities	Payment for Medical Service	Allocating Time to Go	Getting Permission to Go	Concern About Male Doctor
Age (Years)	18–40	24%	40%	36%	48%	52%	60%
	41–60	3%	7%	10%	18%	18%	10%
	>60	27%	77%	63%	38%	44%	65%
Education	Illiterate	36%	22%	24%	75%	22%	24%
	Literate	8%	8%	8%	12%	8%	5%
Marital Status	Married	8%	16%	23%	50%	38%	14%
	Unmarried / Single / Widow	32%	38%	53%	45%	46%	67%
Socio-economic Status	Upper & Upper Middle	19%	18%	27%	29%	10%	19%
	Lower & Lower Middle	3%	30%	54%	41%	29%	55%

Overall, the findings suggest that education plays a more decisive role than socio-economic status in shaping health-care seeking behaviour, with literate individuals demonstrating greater engagement with formal health services.Table **??** and Figure 1 shows that younger rural women face the greatest barriers to seeking health care. Among women aged 18–40 years, 40% reported transportation difficulties, 36% cited problems with paying for medical services, and almost half (48%) found it difficult to allocate time for health visits. Cultural barriers were also prominent in this group, with 52% needing permission to go and 60% expressing concern about being examined by a male doctor. In contrast, older women above 60 years reported much fewer obstacles (transportation 7%, payment 10%, male-doctor concern 10%).

Educational status revealed a clear gradient: illiterate women reported higher structural barriers such as distance (36%) and transportation (22%), and major financial barriers including time constraints (75%) and payment for medical services (24%). Cultural barriers also remained considerable among illiterate women, with 22% requiring permission and 24% concerned about male doctors. In comparison, literate women reported uniformly lower barriers across all domains (mostly 5–12%), indicating that educa-

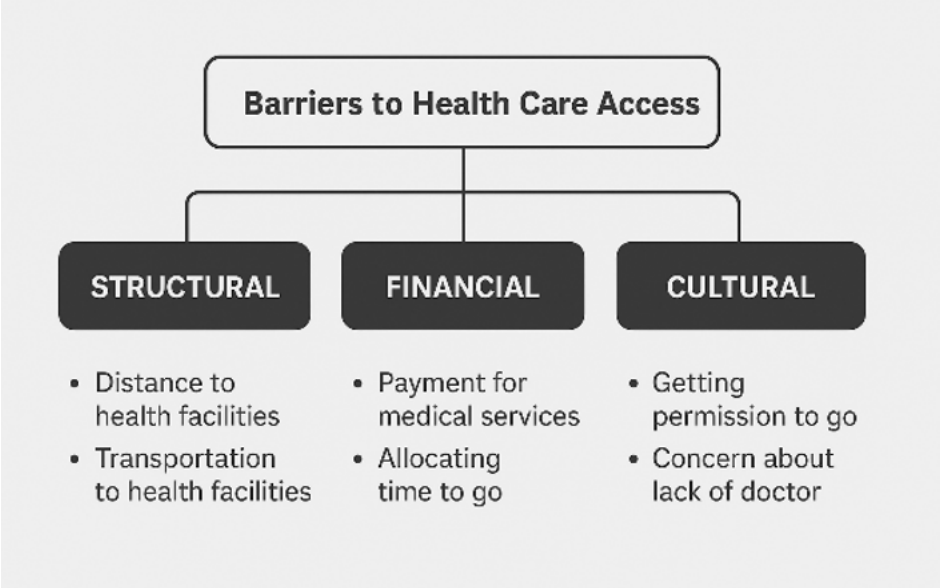

Fig. 1: Perceived Barriers for Health-seeking Behavior of Rural Women

tion reduces both structural and cultural constraints.

Marital status also influenced health-seeking behaviour. Unmarried, single, or widowed women showed markedly higher barriers, including transportation (38%), payment issues (53%), difficulty allocating time (45%), needing permission (46%), and concern about male providers (67%). Married women, in contrast, reported relatively fewer challenges (transportation 16%, payment 23%, time allocation 50%, permission 38%, male-doctor concern 14%).

Socio-economic status demonstrated a similar pattern. Women from lower and lower-middle SES groups reported high financial barriers (54% difficulty paying) and substantial cultural constraints (55% concern about male doctors), along with more transportation issues (30%). Women from upper and upper-middle SES groups reported comparatively lower barriers (payment 27%, male-doctor concern 19%).

Overall, the most significant barriers were concentrated among younger, illiterate, unmarried, and lower-SES women—especially cultural constraints such as concern about male doctors (up to 67%) and structural challenges like transportation (up to 38%) and time constraints (up to 75%). These findings highlight the combined influence of demographic and socio-economic factors on health-seeking behaviour among rural women.

4 | DISCUSSION

In the present study, majority of study participants belong to 18-40 years age group i.e., 62%. This similarity was noticed in the study done by Joshi GS, Gurav RB et al. (5) A large proportion of subjects belong to Hindu religion (88%), this is similar to a study conducted by Doley P et al. (8) In this study, illiterate women correspond to 47%, similar findings were noted in a study conducted by Reddy PM et al. (7) Among the study participants, 64 % were married which is similar to a study done by Rajaram yadav et al. (3) Among the study participants 63 % of women were housewives, this is similar to a study done by Neeru Sharma et al. (9) According to the modified BG Prasad classification, it was observed in this study that most of the participants were showing SES as Upper middle class 58%, which is similar to a study done by Fahmida Shammi et al. (10) In the present study, 57% belong to nuclear family which is in corresponding to a study done by Nishu Sharma et al. (11)

Among study participants it was found that women who need permission from senior family members to visit a doctor was 45% which is on par with a study done by Joshi GS et al. (5)

In the present study , 21% women visited health facility immediately following onset of symptoms which is in contrast to a study done by Reddy PM et al. (7) In this study women who can make their

own decision regarding seeking health care was 34% which is in contrast to a study done by Joshi GS et al. (5) It was found that 30.4% were hesitant in discussing health issues among family members which is similar to a study done by Reddy PM et al. (7) About 22% were aware of various health schemes which is similar to a study done by Joshi GS et al. (5)

Women in this study reported that 67% had hesitation towards male doctor which is similar to a study done by Nishu Sharma et al. (11) About 56% of study participants visit government facility during illness which is similar to study done by Chauhan RC et al. (2)

Even though 62% preferred government facilities, many reported dissatisfaction with service availability and doctor absenteeism, highlighting a gap between accessibility and acceptability. In the present study it was noticed that there significant association between literacy status and health seeking behaviour which is in contract to a study done in Ghana where there was no association with literacy status. (12)

In the current study, women above 40 years reported difficulty in accessing health care due to transportation and dependence upon family members for finances. 75% of the illiterate had difficulty in allotting time to go to a health care facility, probably due to household chores which is similar to a study done by Shovan Ghosh & Yasmin Khatun. This study also reported women above 40 years and unmarried felt greater financial burden than Illiterate and married women, as compared to a study done by Shovan Ghosh & Yasmin Khatun. (13)

The study's conclusions shed light on the intricate and multifaceted character of rural women's health-seeking behaviors. Beyond the descriptive numbers, the patterns show how deeply ingrained social, cultural, and economic factors affect women's autonomy, access to care, and ability to make decisions. The majority of women in the younger to middle-aged group (18–40 years old), many of whom were married and homemakers, place them in traditional family structures where obligations, expectations, and restricted mobility might significantly impede their capacity to seek care in a timely manner. This is consistent with previous research that emphasizes how gender norms influence women's access to healthcare, particularly in rural, patriarchal settings.

5 | CONCLUSION:

The study also emphasizes how important education is in influencing women's decisions to seek health care. Because education increases awareness, self-confidence, and perceived agency when interacting with health systems, literate women were more likely to seek private care. The educated population's increasing preference for private services could be a result of their belief that private providers are better or more accommodating. On the other hand, illiterate women were more dependent on the government and conventional medical methods, which highlighted the need for more accessible public services and focused health education initiatives. Government health facilities are available, however there is clear discontent with service availability, wait times, and uneven provider attendance. These structural issues erode public sector trust and encourage women to choose more expensive private services, which could further burden low-income families. Cultural standards remain a significant obstacle. Gender norms and social expectations are evident in the large percentage of women who said they needed permission to seek care and the significant discomfort associated with seeing male doctors.

This study shows that deeply ingrained cultural norms, socioeconomic limitations, and perceived quality discrepancies in healthcare facilities all have an impact on rural women's health-seeking behavior in addition to demographic characteristics. While socioeconomic position showed a weaker correlation, education emerged as a key driver of the type of healthcare accessed. The biggest obstacles are faced by younger women, women who lack literacy, and women from poorer socioeconomic origins, particularly when it comes to cultural limitations and mobility issues.

Recommendation:

The results highlight the necessity of multifaceted approaches that tackle social and institutional obstacles.

Strengthening public healthcare systems, improving quality and responsiveness, and increasing the number of female healthcare providers are all necessary interventions. Fostering supportive conditions for prompt care-seeking requires community-based

health education programs, empowerment initiatives aimed at women's autonomy, and the involvement of family decision-makers, particularly elders.

Access barriers could also be significantly lowered by better transportation infrastructure and increased knowledge of financial protection programs.

In addition to adding to the expanding body of knowledge about rural women's health-seeking behavior, the insights produced can help policymakers, healthcare professionals, and community leaders develop gender-sensitive, culturally aware, and system-strengthening strategies.

Conflicts of Interest: None

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