

HEALTH SEEKING BEHAVIOR OF COMMUNITY IN RURAL AREAS OF UJJAIN, MADHYA PRADESH

**Dissertation
At
APRIAM Project, R.D. Gardi Medical College, Ujjain**

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**Under the guidance of
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2013–15**


**Institute of Health Management Research
Jaipur
2015**

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Devis Saha** student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at **APRIAM Project, R. D. Gardi Medical College, Ujjain** from **27th January 2015 to 7th May 2015**.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is mandatory for accomplishment of Degree.

I wish him all success in all his future endeavors.



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This certificate is awarded to **Devis Saha** in recognition of having successfully completed his internship in the department of Public Health, R.D. Gardi Medical College, Ujjain. He has successfully completed his Project on "**Health Seeking Behaviour of Rural Community of Central India**" from January 27, 2015 to May 7, 2015.

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning. We wish him all the best for future endeavours.

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Signature
Devis Saha

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Devis Saha,

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List of Abbreviations

ASHA -Accredited Social Health Activist

AW -Anganwadi Worker

BCC -Behavior Change Communication

CHC -Community Health Center

CHW -Community Health Workers

DH -District Hospital

HH -House Hold

HSB -Health Seeking Behavior

HW -Health Worker

MHW -Male Health Worker

NHM - National Health Mission

NVBDCP- National Vector Borne Diseases Control Programme

NLEP -National Leprosy Elimination Programme

FHW -Female Health Worker

UHC -Universal Health Coverage

OPE -Out of Pocket Expenditure

PHC -Primary Health Centers

IHCP- Informal Health Care Provider

RMP- Rural Health Care Practitioner

KMs- Kilometers

DISSERTATION

On the topic

**Health Seeking Behavior of Community in Rural Areas of Ujjain,
Madhya Pradesh**

1. Introduction

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” -WHO definition of Health (Official Records of the World Health Organization, no. 2, p. 100, entered into force on 7 April 1948) .

India is a country with rapid growth and development with its economy and infrastructure. But still 65 per cent of its population resides in rural area and are far away from the face of development. They value their tradition, culture and beliefs more than the development. In terms of Health, they have their own definition and perception about it.

Health seeking behavior can be defined as the response of an individual or a community towards any kind of diseases or ailment. According to ‘Health Belief Model’ there are several factors which motivate a person to (or not to) seek health care services. The 4Ps of health belief model which determine the health seeking behavior of a person are perceived susceptibility, perceived severity, perceived barriers and perceived benefits. Likewise Anderson's model of health care use demonstrates the factors that lead to use of health services. According to the model, usage of health services (including inpatient care, physician visits, dental care etc.) is determined by three dynamics: predisposing factors, enabling factors, and need. Predisposing factors can be characteristics such as race, age, and health beliefs. For instance, an individual who believes health services are an effective treatment for an ailment is more likely to seek care. Examples of enabling factors could be family support, access to health insurance, one's community etc. Need represents both perceived and actual need for health care service.

Further there are various other models namely social cognitive models, choice making model etc which define the behavior of health seeking of individuals and community.

Indian Health Care Scenario

India is a socialist country and provides many of the services to its public at either free of cost or at a subsidized price. Health services in India are provided by the government. Indian health System is a three tier system with primary, secondary and tertiary level. Along with it there are numerous horizontal and vertical programme like NRHM, NVBDCP, NLEP, RNTCP etc are being implemented to bring about good health to its citizen.

With a whopping budget of Rs 33000 crore in 2015 and new intervention in the field of insurance and infrastructure the ministry is all set towards the goal of Universal Health Coverage (UHC) as set by the Planning Commission in its 12th five year plan(2012-2017). It was aimed mainly for the financial protection of the citizen by reducing out of pocket expenditure in health. Still many of India's existing facilities do not have required Human Resources. The Existing number of facilities and manpower available in Madhya Pradesh against required is as mentioned in the table below:-

Table1.1: Health Infrastructure of Madhya Pradesh

Particulars	In position
Sub-centre	8764
Primary health Centre	1175
Community Health Centre	334
Mobile Medical units	108
Ambulance or patient carry vehicle	1544

(Source: RHS Bulletin-2014, March 2014, M/O Health & F.W., GOI, accessed from <http://pib.nic.in/newsite/PrintRelease.aspx?relid=118617> on dated 16th may 2015).

2. Review of literature

According to a study Babar T. Shaik, David Haran, Juantia Hatcher (2008) 'Studying health seeking behavior: collecting reliable data, conducting comprehensive analysis', *Journal of Biosocial Science*, volume 40(issue 01), pp. 55-66 comprehend that “The factors which determines these behavior are socio –demographic factors including education, social structure, cultural beliefs and practices, gender issues, economic and political system, environmental condition, the disease pattern and the health care system itself”- (kroeger, 1983; Andersen, 1995; Katung, 2001; Tridevi, 2000; Admson et al., 2003; Mumtaz and salway, 2005)

Again, Mackian in 2001 in 'A review of health seeking behavior: problems and prospects', *University of Manchester Health Systems Development Programme* said that an appropriate health-seeking behavior is not merely dependent on an individual's choice or circumstances; it depends largely upon the dynamics of communities that influence the well-being of the inhabitants.

Besides this Wilkinson in 2004 said that perception of people towards illness contributes a lot towards HSB.

There are few studies about Informal health care provider (IHCP) which says IHCP's are without state accredited medical qualification and are not legalized to practice allopathic medicine. Different types of informal health care providers identified in the community are: Community Health Worker (CHW), Village Health Worker (VHW), Rural Medical Practitioner (RMP), traditional healers, compounders, patent medicine vendors etc. Informal Health Care Provider's

(IHCP) are a heterogeneous group of providers with differences in type of training, regulatory frameworks, and services provided. (Deshpande K. et al., 2004)

Further, Informal health care providers are working because of the gaps in health care provision by qualified providers (Mahmood et al., 2010, Gidwani). In Madhya Pradesh three quarters of the qualified medical doctors were working in the private sector and 80% of them were in the urban areas serving only one quarter of the state population. While the unqualified health care providers working in rural areas constituted more than 90%. This percentage was more than 80% in some other parts of India (De Costa and Diwan., 2007).

Regulating the informal health care providers work under the situation of the inundated health system and the lack of the basic information about the private health sector in general in addition to enforce those regulations is a challenge (2002, De Costa et al., 2008b, Deshpande. et al., 2004, Cross. and MacGregor., 2009).

3. Statement of the problem

Health Seeking Behavior (HSB) depends on various external and internal factors, these factors changes from time to time with the changes in the market, because of intervention and also with the changing socio-economic condition of the people. Further various cognitive changes like awareness, experience and motivation etc determines the HSB. To understand the HSB deeply there is a need to study the community continuously at a stretch for a period of time with minimum gaps in the frequency of study. In spite of this, the changing disease pattern also may

defines the HSB, there is no account of this variability has been seen till now. It provides us a gap to study further to unveil the secret of HSB.

4. Rationale of the Study

In order to provide an effective health care service, it is very important to understand the intricacies of perception and behavior of the demand side (community) in response to an ailment. To reduce the out-of-pocket expenditure and to provide quality care to the patient with the vision of 'health for all' the government needs to reform many of its policy and regulation towards the drugs and health care services. This study will help the stake holders to understand the area and behavior more deeply which further will help them to make effective policy.

5. Research Questions

1. What is the treatment seeking behavior of rural community with special focus on infectious diseases?
2. What is the type of treatment the community use to take and at what cost?

6. Objectives

1. To determine the variation in Health Seeking Behavior with respect to gender and age group of people.
2. To determine the factors responsible for choosing a particular health care provider/facilities/ services.

3. To calculate the out- of-pocket expenditure on health of the selected household over the study period.
4. To calculate the quantity of antibiotic prescribed by the providers to the selected cohort over the study period.

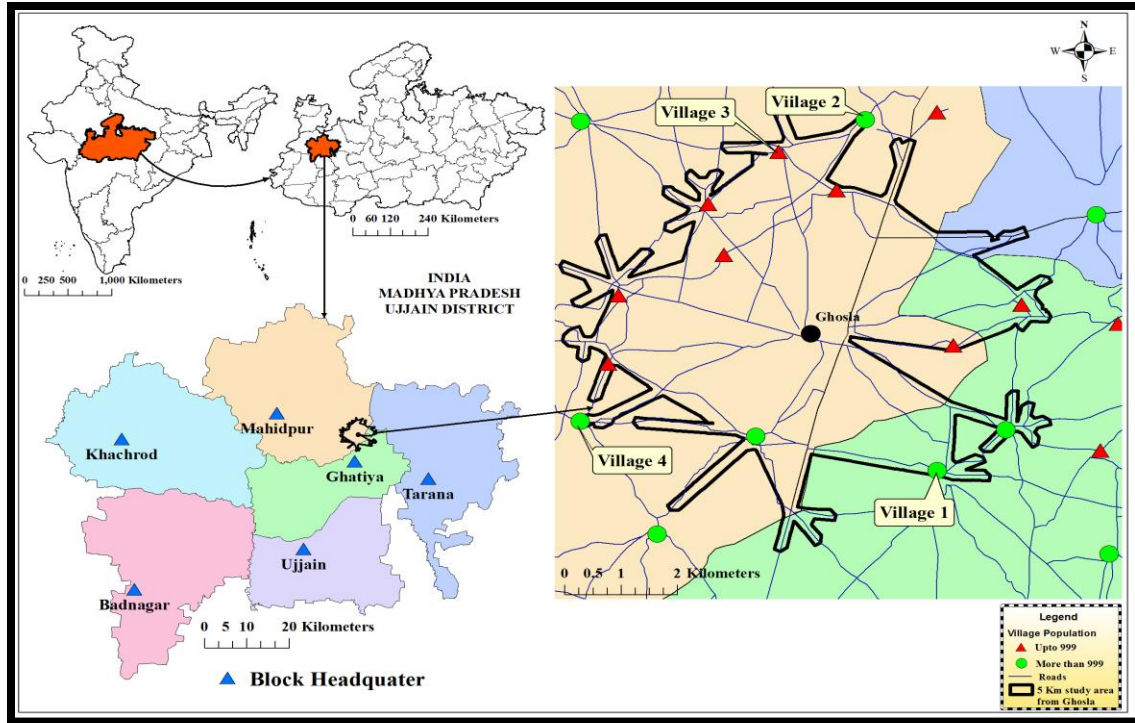
7. Methodology

7.1 Study Design

This was an exploratory and descriptive follow up study. It was nested under a larger study of Pollutant in Water and Resistance in Rural India- Intervention to Improve Antibiotics Resistance Management (APRIAM).

7.2 Study Location

The proposed study was carried out in the rural Demographic Surveillance Site (DSS) of R D Gardi Medical College (RDGMC), Ujjain which caters to 60 nearby villages in three development blocks. Four villages (out of 60) were purposefully selected within 5 km radius from the village having very highly concentrated population of health care providers. Whole study was carried out in & around the rural households of these 4 selected villages (2 in each of the 3 community development blocks) in the DSS of RDGMC.



Map 7.1-

Study Location (selected Villages)

A buffer of five kilometers by road taking Ghosla (nearest township) as the centre was created. All the villages inside the buffer was identified and categorized in to villages with population more than 999(large village) and less than 999(small village). In original study three small villages and three large villages were randomly selected from amongst the villages of buffer zone.

In this study of HSB, we have taken only four villages keeping in mind easy accessibility and reach and the time constrain.

7.3 Study Subjects

Study subjects were the members of all age group of the selected 86 household distributed across the four villages.

7.4 Sampling

A total of 125 household were selected as study samples. The households were already selected by the larger study under which this study is nested. Simple random technique was applied while selecting the study sample. For this study of HSB study, 87 households of four villages were taken out of the larger sample. The number of selected Households of the villages and its population is as mentioned in the table below:-

	Number of Selected House Hold	Total Population of selected villages
Village 1	24	135
Village 2	24	140
Village 3	13	69
Village 4	25	171
Total	86	515

Table: 7.2- Village wise distribution of selected household and population.

An inclusion criterion that was taken into consideration was presence of at least one child of age group 1-3 year of age.

7.5 Methods and Instruments of Data Collection

Data Collection was done by Trained Field Workers. Face- Face Interview technique was used to collect data. Pre planned field scheduled (Table 7.1) was followed for the process.

Both open ended and close ended questions were used for collecting data. The respondents were any member of the household, who should be more than 18year of age and should be permanently residing in that house. In case of children below 18 year of age, preferably mothers

were chooses as our first choice of respondent. If mother is absent, the grandparents were asked question and in case of adult above 18 year of age, we choose to interview the patient itself or its immediate caretaker.

Four health workers were trained on the data collection process. Two team were formed each consisting one MHW and one FHW. Each team was given two villages for data collection. The Field visits were designed in such a way that each village is covered alternatively with a gap of two days in between. The field schedule is as mentioned in the table give below:-

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Team 1- Village 1	Team 1- Village 2	Data correction/ Training/ Meeting	Team 1- Village 1	Team 1- Village 2	Data correction/ Training/ Meeting	
Team 2- Village 3	Team 2- Village 4	Data Correction/ Training/ Meetings	Team 2- Village 3	Team 2- Village 4	Data Correction/ Training/ Meetings	

Table 7.1- Field schedule (Data Collection)

The data collection process was monitored constantly by the research officers .Training on data collection and field preparedness were frequently given to keep the workers motivated and to minimize the bias and error. Two days in a week were reserved for training/ data correction and meetings as shown above

8. Statistical Treatment

Data collected was cross checked for any incomplete or partial filling. Using Microsoft Excel, the collected data was then entered, edited, coded, tabulated and organized into various frequency distributions.

9. Ethical Considerations

Informed consent was taken before starting the interview. If anyone disagreed to become part of the data collection process they were not forced by any means. Confidentiality was ensured to all participants.

Apart from this ethical permission was taken from ethical committee R. D. Gardi Medical College, Ujjain to go forward with the study. (Photo copy of ethical committee approval is attached as annexure-1).

10. Results

10.1 Socio Demographic Characteristics of Population

The Socio demographic Characteristic of the selected villages is as mentioned in the below table. Herein various characteristic chosen for socio-demographic are caste, type of toilet facility, Properties Owned, type of Ration Card, Type of house etc.

Characteristics		Percentage of respondents
Caste	Rajput	23%
	Sondhiya Rajput	15%
	Teli	4%
	Kumbhar	4%
	Balai	13%
	Banjara	6%
	Chamar	5%
	Gari	5%
	Others	25%
Toilet Facility	No facility/Bush/Field	78%
	Latrines	22%
Properties Owned	Agricultural Land	98%
	Television	52%

	Motor cycle	43%
	Car/jeep	1%
	Tractor	9%
	LPG	32%
	Mobile Phone	89%
Type of Ration Card	BPL	40%
	APL	51%
	No Ration Cards	9%
Type of House	Kuchcha	47%
	Semi Pucca	38%
	Pucca	15%

Table-10.1: Socio Demographic Characteristics of Study Villages (n=799 HHs)

The figures says that 37 Percent of the population belongs to Rajput Caste of different clan, Khumar, Bali, Banjara, Chamar, Gari etc falls under the Scheduled Castes and Tribes. Together they form 32 percent of the total population. The others caste found are Bairagi, muslims, jains etc.

Further, 78 percent of the population have no toilet facility and use open field or bushes for defecation. Only 22percent uses latrines for defecation.

Again 40 percent of the household have BPL ration Card, 51percent have APL cards and nine percent do not have any ration cards. 47 percent of household lives in ‘kuccha’ house, 15 percent in ‘Pucca’ house and 38percent of the population resides in ‘semi-pucca’ house. Apart from this 98percent of people have their owned agricultural land property. Likewise 32percent have television, 43Percent have owned motorcycle, only one percent have jeep or car and nine percent have tractors, 32 percent uses LPG gas and 89 percent of them owns mobile phones.

10.2: Reported cases with any kind of ailment

	Total episode of sickness	Male	Female	Below 15 year of age	Above 15 year of age
Village 1	145	92	53	90	54
Village 2	110	68	42	67	43
Village 3	85	41	44	46	39
Village 4	156	59	97	102	54
Total	496	260	236	305	190

Table-10.2: Reported cases of any kind of ailment.

The total number of episode of sickness reported during the study period is 496 out of which 260 (52 per cent) were males and 236(48 per cent) females. Although the distribution of male and female among the study population was almost similar but reporting of female observed during the study period was less. The trend is same in all the villages except in one village where the trend is contradictory by minor percentages.

Again the reported cases of age group below 15 year are more than that of age group above 15 year.

10.3 Any kind of treatment taken

The frequency of any treatment taken is as shown below:-

	Treatment taken	Male	Female	Below 15 year of age	Above 15 year of age
Village 1	100	60	40	56	43

Village 2	109	67	42	66	43
Village 3	79	39	40	41	38
Village 4	143	86	54	105	38
Total	431	252	176	268	161

Table-10.3: Any kind of treatment taken

The proportion of males taken treatment is higher than that of females and likewise the population taken treatment of age group below 15 year of age is comparatively more than that of population above 15 year of age. In total the percentage of male taken treatment is 96 % out of base population of 260 and 75% of female has taken treatment out of a base population of 236. Likewise a total of 89 % of population with a base of 309 people below 15year of age fallen ill did took treatment and 84% of population with base of 190 above 15 year of age has taken treatment.

10.4: Reason for not taking any kind of treatment.

Out of a total population of 179 who has not taken treatment, the reason given by them to not seek any kind of treatment is as shown below in the given figure.

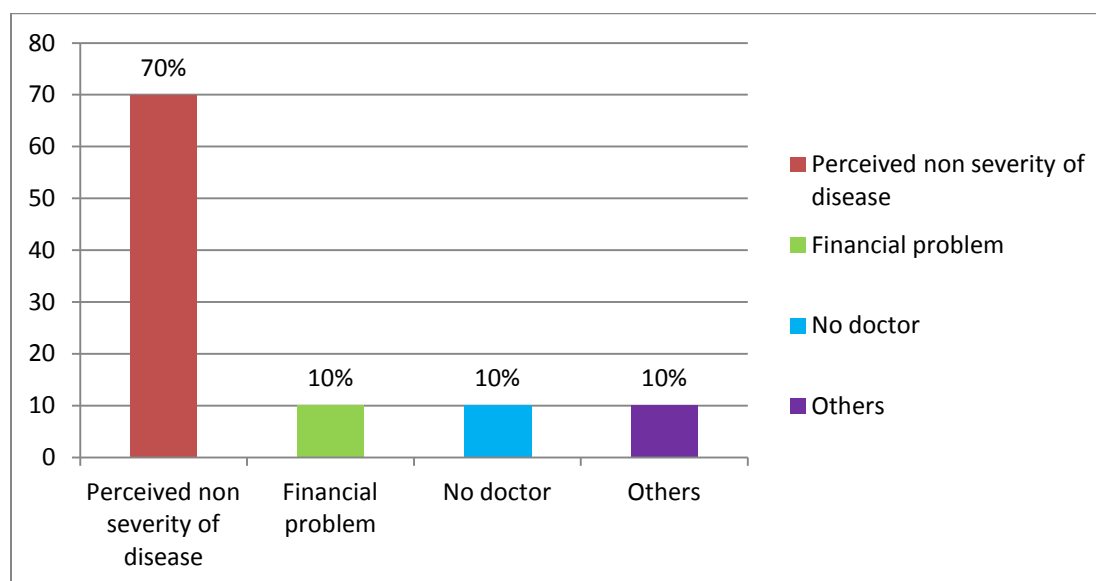


Figure 10.1– Reasons for not taking any kind of treatment (n=179)

10.5 Choice of treatment

Out of a total population of 431, those who have taken any kind of treatment, the choice of treatment is as shown below:-

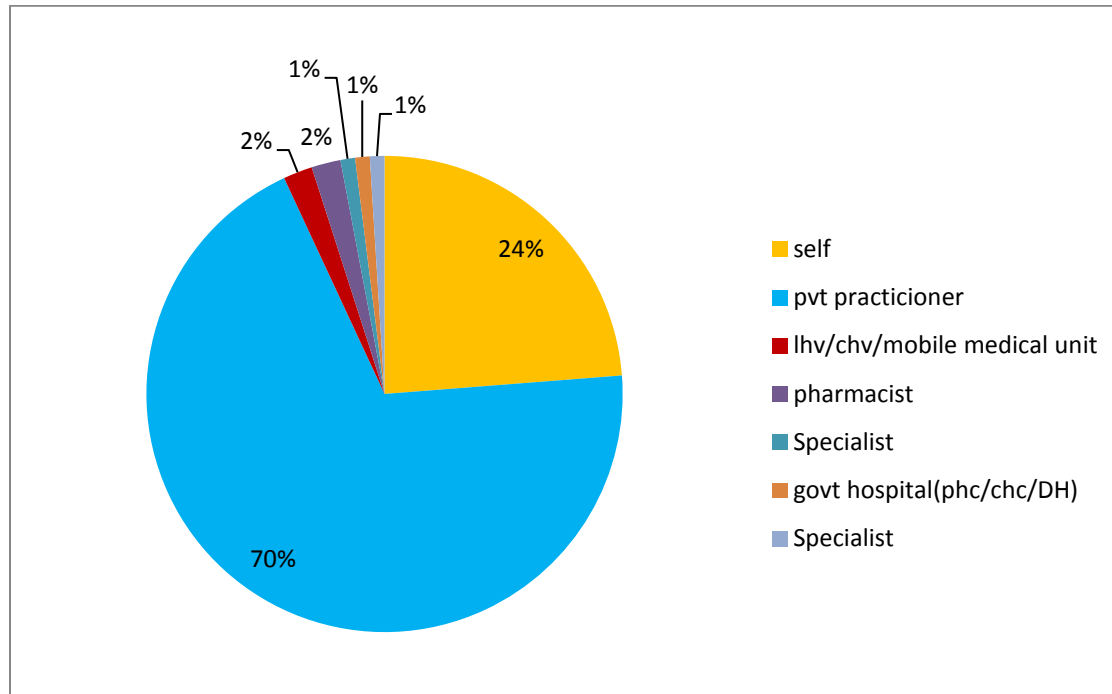


Figure 10.2 –Choice of treatment (n=431)

As seen in the pie chart above, a majority (70%) of rural folk has taken treatment from private practitioner. Still 24% of the population chooses self medication. People rarely (only 2%) went to any public service for treatment. Whereas, in two percent of cases people chooses to take treatment from a specialist. They did so, only when they feels that the disease is very severe. No case was found where people took treatment from traditional healers.

10.6 Reason for Choosing Self treatment

Out of a total of 103 cases who have taken self medication, the reason for taking self medication is as shown in the below mentioned figure.

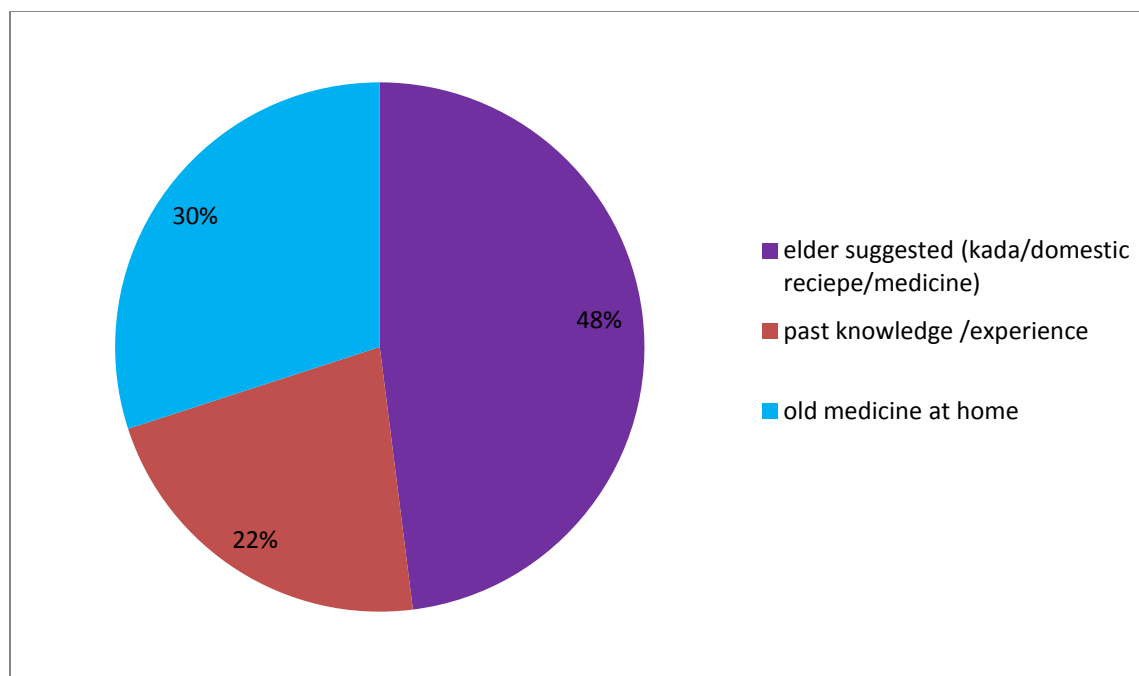


Figure 10.3 – Reason for choosing self-treatment (n=103)

Majority of people choose self medication because somebody has suggested them to take this medicine. The self treatment not only includes allopathic medicine but also domestic preparation like '*kada*', *raw egg*, *honey etc.* The allopathic medicines mostly used are OCT drugs like paracetamol, combiflam, citrizine, zhandu balm etc. They generally choose these drugs in case of mild fever, cold or body ache. They also take these medication in case of some sudden emergency (mostly at night time when doctor is not accessible). These drugs are mostly taken from village '*kirana*' store or nearby pharmacy. The habit of self medication was observed to be very common amongst the adult.

Cases of prescription sharing were also found where drugs one prescription is shared with other members of the household with common symptoms of illness. Mostly cough syrup were shared and the left over cough syrup is kept to be used in further cases of same illness.

10.7 Reason for choosing Private Practitioner

In a total of 307 cases the patient has taken treatment from private practitioner i.e. around 70 percent of total cases where the patient has treatment taken. Although there are a number of informal doctors doing practice in that area, the choice of doctor was found to vary from person to person and case to case. Various reasons given by the respondents for choosing a particular practitioner is as shown in the figure below:-

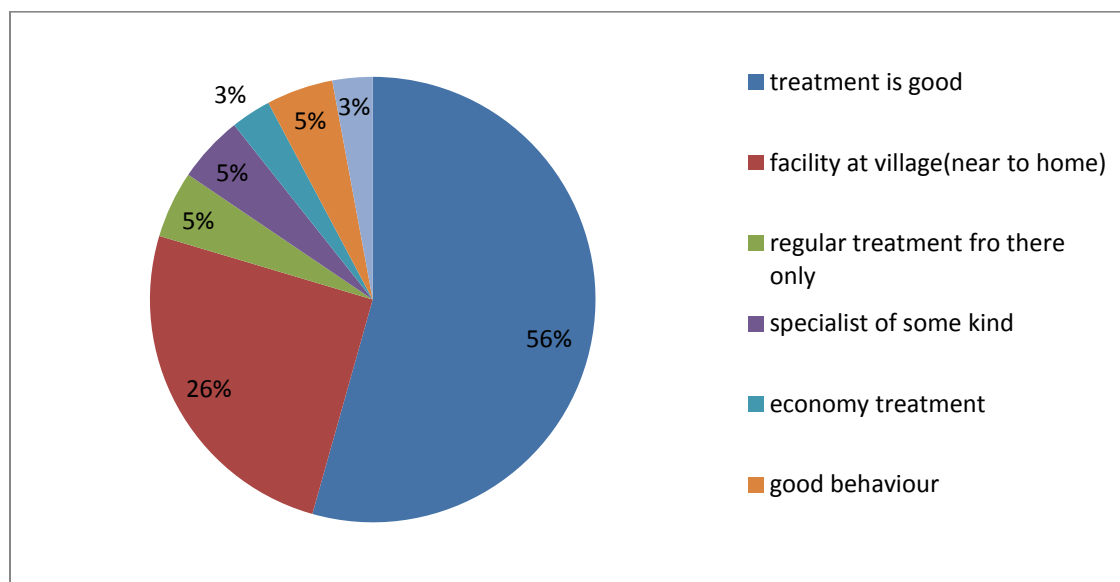


Figure 10.4 – Reason for choosing a particular private practitioner for treatment (n=307)

56 % percent of patient have chosen to take treatment from private practitioner because they feels that the treatment provided by that concerned doctor is good and it gets cured in short period of time. The second most reason given for choosing that particular facility or provider is accessibility. Most of the facilities (providers) were either at the villages or in nearby town or villages. Others reason mentioned are economy of treatment, good behaviour of the provider etc. some household have credit account near some provider and they pay once in a year after

agricultural harvesting. They either pay direct cash or wheat/ soya bean to the provider. Such house hold takes regular treatment from these providers only. But in case of emergency or some severity of disease people choose to take treatment from specialist in nearby city or from government facilities.

10.8 Out-of-pocket Expenditure

The details Out –of-Pocket expenditure(direct cost) of each villages for health of each villages for a period of 6 months is as shown in the table below-

	Village 1	Village 2	Village 3	Village 4
Total cost	21531	3781	14790	18190
Maximum cost	12000	480	4000	6000
Minimum cost	0	0	0	20
Average cost	414	118	235	234

Table-10.4 Out- of-pocket expenditure for a period of 6 months (Direct Cost)

In village one the total cost and average cost seems to be more if compare with other villages, it is because the maximum cost of treatment is higher than normal in one case adding to total cost and average cost.

Village two has some special feature as observed from the background study and field visits. This single village has more than five informal practitioner and most of the villagers who are agricultural farmers or labors have account opened with these practitioner which they pay once a year after the harvesting of crop. They pay money either in the form of crop (wheat/ soya bean) or cash. The accounts are maintained and recorded by the practitioner himself or by other members of the family. It has also been seen that the wives of these practitioner also contributing hands with their husband.

Likewise, travel cost (indirect cost) for seeking health facilities is as mentioned in the table given below-

	Village 1	Village 2	Village 3	Village 4
Total cost	4970	280	1660	2370
Maximum cost	4000	20	150	300
Minimum cost	0	0	0	0
Average cost	96	8	26	30

Table .10. 5- Cost of travel to reach to the facility/provider.(Indirect cost)

Most of the facilities (clinic) are located at a distance of 3-5 KMs from the selected villages. Patients either use motorcycle to visit to the practitioner or private auto rickshaw. Some patient though takes a walk to visit to the practitioner. They have spent 20-30 rupees for each visit.

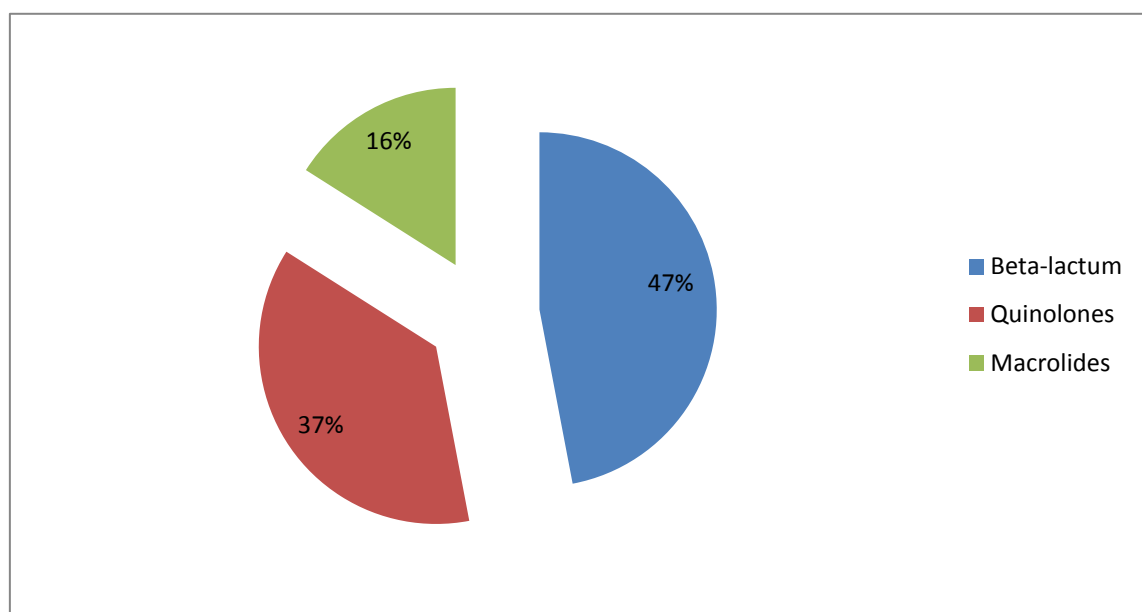
In village two the cost is less because of availability of sufficient clinics at the village itself.

10.9– Prescription of drugs and Anti-biotic

Out of all the treatment taken from either some facility or by self-medication, a majority were allopathic medicines. In few cases of self medication, traditional herbal preparation and household edibles was used. In case of self medication, the commonly used allopathic drugs were Paracetamol, Ibuprofen, Combiflam etc. No record of antibiotic use by self medication was found except few cases of Prescription sharing where the prescribed drug was shared among members of a household with common symptoms of illness.

Out of all the cases (307) prescribed by practitioner, maximum number of drug in a prescription was eight and minimum was one. The average number of drugs prescribed was four.

Out of all the prescription where Allopathic medicines were prescribed 31 percent of them contain either one or more anti-biotic. The Maximum number of antibiotic encountered in a prescription is two. Most of the antibiotics prescribed are given to patients with symptoms of Upper respiratory infection like cough, cold etc. The category of antibiotics prescribed is mentioned in the figure given below-



antibiotics (n=95)

Figure :10. 5- Percentage distribution of various type of

The most used antibiotics were Beta-lactum group of antibiotics and among beta-lactum's the most common were the cephalosporin. Ofloxacin and Cefixime are the most commonly used antibiotics.

Apart from this, injection were given in almost every alternative cases. Although we do not have the record of the drug given in those injections as they are injected in the clinic itself without any prescription. It is suspected that Antibiotics injections were given hugely by these practitioners.

11. Discussion

The study was done in four villages of Ujjain district. The villages have tribal community and most of them were dependant on agriculture for a livelihood. Socio-economic standards and level of education is poor. There were proper road connectivity to the villages from the nearby townships which has public medical facilities i.e. PHC, CHC etc and also has private clinics, most of them operated by informal providers.

During the field visits and data collection many aspects of HSB of rural community were revealed.

If we see the Health Belief Model, it defines the factors which motivate a person to (or not to) seek health care services. The 4Ps of health belief model which determine the health seeking behaviour of a person are perceived susceptibility, perceived severity, perceived barriers and perceived benefits.

As observed during the data collection and interaction with the community members various aspects of HSB were understood which comply with the Health Belief Model. Things became more clearer once the data was analysed.

Perceived severity

Out of all the cases of illness which were reported during the survey were common cold, cough, fever and headache. In 16 % of the cases where the patient has not taken any kind of treatment and among the various reasons given by them for not taking any treatment are moved around their perceived severity of the illness as shown in the figure-1, shown in result section.

Again 24 percent of them who have taken treatment prefer home remedies or self medication for common ailment. It is also related to the perceived severity about the illness. The choice of provider also changes with the perceived severity of the disease for instance it has been observed

that three percent of the patient have taken treatment from specialist from district hospital or private hospitals from nearby city.

Perceived Susceptibility

It was found that all the cases where treatment was taken, not a single case has gone for investigation. Even for persistent cough or high fever, investigation was neither suggested or nor preferred or done even if suggested. It is a common perception of people that they are not susceptible to more complex or severe disease.

Practice of irrational antibiotics was found. Patients do not take the complete dose of antibiotics prescribed to them which increases the chances of antibiotics resistance. It is still their ignorance and perception that they are not susceptible to resistance.

Perceived Barrier

Time has always been a barrier which reflects in the HSB of the community. All most all the cases in the villages preferred to take treatment from private informal provides rather than public facilities. There is an existing perception in the community that public health facilities have more waiting time as compared to the private providers. As most of the study population were agricultural farmers or labours it was also found that cost of daily wages which they lost is also a barrier in availing treatment from trained doctors of city or public facility. Other then this because of the cultural barrier the percentage of female reporting and availing treatment is comparably less than that of men.

Perceived Benefits

It was seen that 70 percent of the treatment were taken from private informal providers. The perceived benefits are easy accessibility, time saving, economic treatment, quick relief from the ailment (because of high use of antibiotics and injections) and other facilities provided by the

private providers like payment in instalment, credit facility which the farmers pays once a year and home visits on calls in case of emergency or night time etc are the factors or perceived benefits which compels the rural folk to prefer treatment from private practitioner.

Thus the study result complies with the Health Belief Model.

12. Conclusion

The study aims to understand the treatment seeking behavior of the rural community. As observed from the results and discussion the community has its own perception towards the severity and susceptibility of a disease. They have their own perception and choice of a provider. Factors which play an important role in describing the HSB are accessibility to good treatment, awareness about the benefits of public facilities or trained doctors, financial flexibility and the opportunity cost in the form of daily wages or time loss because of long waiting time. Besides this, people want quick relief as they want to engage themselves in earning (work) as early as possible.

The long prevailing gaps laid by the public health care providers by long waiting time, ill behaviour, unavailability of doctors, slow and casual response etc has caused an long lasting impact affecting the perception and attitude of common people towards government facilities and has offered opportunities to the informal provider's market .

This perception could be and need to be changed by consistent and affordable service by the public facilities. The community health workers are the face of public health services. There is a need to strengthen their skills to guide and motivate the community to avail the services from skilled medical practitioner in free of cost. The problem of accessibility can be solved by Mobile Medicals Units.

13. Limitations of the Study

- This study was nested under an ongoing larger study so there were many limitation in selecting sample and various other aspects of research objective.
- Time was insufficient to have an in-depth understanding of HSB. If the study could be done for a longer period of time better result can be expected.
- Quantitative study was not sufficient to understand HSB in real terms. There is a need to understand the background of the study and Qualitative study is needed to understand various perceptions more deeply.

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Annexure 1

Copy of Ethical Committee Approval, R. D. Gardi Medical College, Ujjain

INSTITUTIONAL ETHICS COMMITTEE
R D GARDI MEDICAL COLLEGE
Ujjain (MP) India

Name of the Ethics Committee: IEC-RDGMCC IEC Ref. No...311.....

Title of the Project Proposal: "Antibiotic Stewardship program including infection prevention and control and waste water treatment - implementation research in hospital and community in India"

Principal Investigator: Dr Megha Sharma Sponsor:

Telephone: 9827361961 Email: Fax:

Collaborators' Name, Address, Tel. No. Fax & Email:

FOR OFFICIAL USE

The following items [v] have been received and reviewed in connection with the above study to be conducted by the above investigator.

- ☐ Patient Information Sheet
- ☒ Study Protocol / Synopsis
- ☐ Summary of Change Document (in case of a revision)
- ☐ Patient Information Consent Form
- ☐ Investigators' CVs

And have been [v]

- ☒ Approved
- ☐ Conditionally approved (Identify item and specify modification below or in accompanying letter)
- ☐ Rejected (Identify item and specify reasons below or in accompanying letter)

Comments: Applicant is advised to communicate Ethics Committee about any amendment(s), if done, in the protocol & progress of work every 3 months or earlier as per the project duration.

Date of Approval: 17 July, 2013

Member Secretary
Member Secretary
Ethics Committee

Chairman
Chairman
Dr. L.N. Gurjar
Chairman
Institutional Ethics Committee
R D Gardi Medical College, Ujjain