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HEALTH CARE SEEKING BEHAVIOUR AMONG THE RURAL ADULT WOMEN OF SRINAGAR UPAZILLA OF MUNSHIGONJ, BANGLADESH

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ABSTRACT

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There has been an increasing availability and accessibility of modern health services in rural Bangladesh over the past decades. However, previous studies on the health care seeking behaviour of the rural people of Bangladesh were based on limited number of factors (Variables) focusing mainly on the rural adult people both male and female. This cross sectional descriptive study was conducted to determine the health care seeking behavior among the rural adult women. Two hundred and seventy adult women from several villages of Srinagar Upazila under the district of Munshigonj were interviewed for the study. Data were collected by face to face interview form the respondents through a semi-structured questionnaire by purposive sampling method. From this study it was found that the mean age of the respondents was 26.94 years with standard deviation ±11.53 years. Majority of them were married (55.55%). Most of them were Muslims (93.33%). Among 270 respondents 30.00% were of H.S.C level and 15.55% were illiterate. Among the husbands of the married women proportion of illiteracy was 35.85%. About 22.22% respondents had family income below 5000 tk. per month and 67.78% of the respondents had nuclear family. The most common disease they suffered from was fever (16.22%). The other mentionable diseases were Joint pain 9.46%, Cough and Cold 8.11%, Peptic ulcer 6.76% and Hypertension 4.05%. Most of the respondents (26.66%) went to Thana Health Complex for seeking for health care. Another 16.67% women went to Private MBBS Doctor. Only 1.11% went to Community Clinic. Forty percent (40%) of the diseased women went to Local health center because of reliability and 21.11% went there as treatment cost is low. Almost all (98.89%) of the respondents replied that they should go to a qualified (MBBS) doctor. 54.44% rural adult

women of Srinagar were satisfied about the treatment facilities in Local Govt. Hospital/THC. Majority (43.33%) of the women were referred to specialized hospital in Dhaka after treatment failure in Primary site. During illness majority of the respondents (34.44%) took decision themselves for seeking health care. 20% women took decision combined with their husband. During the illness of their children 28.23% women went to Local Govt. Hospital/THC and 22.35% went to MBBS Doctor Privately. Majority of the respondents (30%) thought that they could get modern treatment from THC/Govt. Hospital and 25.55% thought that it could be found from Private MBBS Doctor. Among the 270 respondents 54.44% were willing to participate in local health awareness program. In my study I have found association between the economic status of the respondents and their satisfaction about the treatment facilities in Local Govt. Hospital. There was a significant relationship between the educational level of the respondents and their willingness to participate in local health awareness program. The respondents who were of HSC level of education were mostly (81.48%) willing to participate in such health program. In my study the findings could not be compared to similar type of findings of other studies, because there were limited references. The association between economic status of the respondents and satisfaction about the treatment facilities can be evaluated from further in-depth study.

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INTRODUCTION

Bangladesh is one of the developing countries of the South Asia. It is also the most densely populated large country in the world. It ranks 11th in population density. The current estimated population is 164.4 million. The density of population is 1099.3 per square kilometer. Most of the people living in rural areas depends mainly on agriculture and passing their days with poverty, illiteracy, superstition, false beliefs etc. They are also surrounded by health related problems. In a situation of high population density per square kilometer, acute poverty, low GDP growth, low gross literacy rate, persistent political instability, inadequate and discriminating morbidity and mortality are prevailing in Bangladesh.[1,2] Health Policy formulation should be based on information relating to determining these behaviors. All such behaviors occur within some institutional structure such as family, community or the health care services. The factors determining the health behaviors may be seen in various contexts; physical, socio-economic, cultural and political. Therefore, the utilization of health care system in public or private, formal or non-formal, may depend on socio-economic-demographic factors, socio cultural factors, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political system, environmental factors, disease pattern and health care delivery system.[3] A main driver of health seeking behaviour is the organization of health care system. In many health care systems, there is tension between the public and private health sector trends to serve the affluent. The public sector resources should be made free for the poor. A dynamic cooperation, either formal or informal, between the two sectors is-needed. But the private sector is rarely taken into account in health planning. The public and private sector

may complement to or substitute each other. There are very often resources mixed with doctors working in the public sector also establishing their own private practice. Features of the service outlet and confidence in the service provider also play a major role in decision making about the choice of health faculty.[4,5] A general perception on disease causation has been built based on the observations and interaction with interaction of the doctors with patients. The natural causes of illness include indigestible foods, sudden changes in the environment. Birth and falls resulting in injury are also categorized as natural sprains, fractures and dislocation of bones are thought of as naturally caused. Poor health and disease are outcomes of multiple factors involving not only individual's vulnerability, but also cultural contexts, social factors such as education, ecology, food production, beliefs, superstition etc. All of these factors shape the health seeking behaviour of rural women during illness in a particular community. Beyond the knowledge and scientific etiology of diseases, a person may be influenced by the attitudes, values, beliefs of his or her own which are prevalent in the society in which they live. Particular illness behaviour can be understood, explained and practiced on the basis of the factors responsible in eliciting and maintaining such behaviour.[6] For infectious disease particularly measles, tetanus, cough & cold people usually go to a Kabiraj, Fakir, rather than seeking allopathic treatment. With accidents and injuries such as snake bite, dog bite, burns and scalds, choking from swallowing small objects, kerosene, other chemicals and poisonous substances, they use traditional medicine rather than modern medicine. Lacking in understanding of the pattern of behaviour would create gaps in gaining insight of health and illness. There are several factors which favor the incidence of the disease among the rural adult woman of Bangladesh. We should take necessary measures to reduce spreading of disease. The knowledge of health care seeking of rural women can play a significant role on this aspect. But the rural women often refuse to take allopathic treatment or modern health facilities during their illness. In order to improve the health of the rural women of Bangladesh, it is necessary to have information regarding disease pattern and health seeking behaviour of the women. In my study, attempt will be made to find out the health care seeking behaviour of the rural adult women which may be helpful for further study on larger scale.[7] This may help to plan and implement more efficient health services that could have a positive impact on the health status of the rural adult women of Bangladesh.

METHODS AND MATERIALS

Type of study: This will be a cross sectional type of descriptive study.

Study period: The study will be conducted from the period of 1st December 2010 to 31st May 2011.

Place of study: The study will be conducted in some selected villages of Srinagar Upazila under the district of Munshigonj, Bangladesh.

Study Population: The study will be conducted among the adult women between 18 to 60 years of age of Srinagar Upazila under the district Munshigonj. On the basis of availability & time constraint the sample size was 270.

Sampling technique: Sample was collected by purposive sampling technique. Seven villages of Srinagar Upazila were selected. All the available adult rural women of the selected villages of Srinagar Upazila during the data collection willing to participate were interviewed as accidental sampling. Questions were asked in local language that would be easy to understand by the respondents.

Inclusion Criteria:

- All the women aged from 18 to 60 years and above.
- Those who were willing to participate.

Exclusion Criteria:

- All the women below 18 years of age.
- Who will not participate willingly.
- Very sick women.

Methods of data collection: Data will be collected from the selected adult women by face to face interview through an interviewer administered questionnaire with the respondents. After taking verbal consent from the respondents, they will be asked questions and questions were asked and the questionnaire was filled in by the researcher. One questionnaire was used for an individual respondent.

Date processing and analysis: After collection, data will be checked and verified for its consistency. Then data will be compiled, analyzed and tabulated according to the key variables. Data will be analyzed manually by using scientific calculator & computer according to the objectives. Result will be presented in tabular and graphical form. Statistical procedures will be applied in the analysis of data wherever necessary.

RESULTS

Table-1: Demographic characteristics of the respondents (N=270)

Age in years	**Number**	**Percentage (%)**
<20	96	35.55
21-30	87	32.22
31-40	57	21.11
41-50	12	4.44
>50	18	6.66
Marital status		
Married	150	55.55
Unmarried	111	41.11
Window	9	3.33
Religion		
Muslim	252	93.33
Hindu	18	6.66
Monthly family income.		
<5000	60	22.22
5000-10000	27	10.00
>10000	183	67.78
Respondents Educational Status		
Illiterate	42	15.55
Primary (1-5 Class)	57	21.11
Secondary level (6-10 class)	75	27.78
SSC/Equivalent	12	4.44
HSC/Equivalent	81	30.00
Degree/Graduation	3	1.11
Masters	0	0.0
Others	0	0.0
Occupation		

Housewife	150	55.6
Service Holder	6	2.22
Businessman	3	1.11
Farmer	0	0.0
Day labor	0	0.0
Cottage Industry workers	6	2.22
Student	93	34.44
Others	12	4.44

This study was a cross sectional type of descriptive study and attempt to find out the health care seeking behaviour of rural adult women of Srinagar Upazila. A total number of 270 respondents were interviewed for the study purpose. It was revealed that major proportion (35.55%) of the respondents were from <20 years of age group. The other age groups are 21-30 years 32.22%, 31-40 years 21.11%, 41-50 years 4.44% above 50 years 6.66%. The mean age of the respondents was 26.94 years with a SD±11.526 years. Shows that among 270 respondents 55.55% were married, 41.11% were unmarried and 3.33% were Widow. Among the 270 respondents 252 (93.33%) were Muslim and only 18 (6.67%) were Hindu. Out of 15.55% were illiterate, 21.11% were of primary level, 27.78% were of secondary level, 4.44% were of SSC/Equivalent level, 30.00% were of HSC/Equivalent level & 1.11% were of HSC/Equivalent level of education. Most of the respondents i.e. (55.60%) were housewives, 2.22% were service holder, 1.11% were businessmen, 2.22% Cottage Industry Workers, 34.44% were students and the remaining 4.44% were of other professions. 67.78% of the respondents have monthly family >10000 Tk., 22.22% have monthly family income <5000 Tk. and the remaining 10% have monthly family income between 5000-10000 Tk. Among 270 respondents 222 (82.22%) suffered from diseases during the last 6 (six) months. The remaining 48 (17.78%) did not suffer from any disease (Table-1).

Table-2: Distribution of the respondents by the type of diseases they suffered (N=270)

Disease	**Number**	**Percentage (%)**
Cough & Cold	18	8.11
Fever	36	16.22
Diabetes Mellitus	3	1.35
Hypertension	9	4.05
Peptic ulcer disease (PUD)	15	6.76
Joint pain	21	9.46
Asthma	6	2.70
Heart disease	3	1.35
Diarrhea/Dysentery	6	2.70
Urinary tract infection	6	2.70
Jaundice/Hepatitis	3	1.35
Skin diseases	3	1.35
Rheumatic Fever	3	1.35
Ear Infection (Otitis-media)	1	0.45

Eye disease	3	1.35
Headache	3	1.35
Dental problem/disease	6	2.70
Tonsillitis/Pharyngitis	9	7.05
Pregnancy/Delivery related problem	15	6.70
Physical assault	3	1.35
Road traffic accident	3	1.35
Weakness	5	2.23
Heat stroke	3	1.35
Fertility problem	3	1.35
Multiple diseases	36	16.22
Total	222	100

Table-2 shows the distribution of respondents by type of diseases they suffered from as follows: Cough and Cold 8.11%, Fever 16.22%, DM 1.35%, Hypertension 4.05%, PUD 6.76%, Joint Pain 9.46%, Asthma 2.70%, Heart Disease 1.35%, Diarrhea 2.70%, UTI 2.70%, Jaundice 1.35%, Skin Diseases 1.35%, Rheumatic Fever 1.35%, Otitis-media 0.45%, Eye diseases 1.35%, Headache 1.35%, Dental Diseases 2.70%, Tonsillitis 7.05%, Pregnancy/Delivery related problem 6.70%, Physical Assault 1.35%, RTA 1.35% Weakness 2.23%, Heat Stroke 1.35%, Fertility problem 1.35% and 16.22% respondents suffered from multiple diseases.

Table-3: Distribution of the respondents by the usual place of treatment during their illness (N=270)

Place of treatment	**Number**	**Percentage (%)**
Thana Health Complex	72	26.66
Union Health & Family Welfare Center	6	2.22
Community Clinic	3	1.11
Private MBBS Doctor	45	16.67
Homeopathic Doctor	0	0
Village Doctor	42	15.55
Unany/Ayurvedic Doctor	0	0
Kabiraj	0	0
Drug Seller of Pharmacy	36	13.33
Traditional Faith Healer	15	5.55
Thana Health Complex + MBBS Doctor	30	11.11
Thana Health Complex+Union Health and Family Welfare Center	3	1.11
Thana Health Complex+ Drug Seller of Pharmacy	3	1.11
MBBS Doctor+Village Doctor	3	1.11
Homeopathic Doctor + Drug Seller of Pharmacy	3	1.11
Multiple places of treatment (> 3 places)	39	14.44
Total	270	100

Table-3 shows that 26.66% respondents went to Thana Health Complex for seeking health care. UH & FWC was visited by 2.22%. The other proportion of treatment places were as follows: Community Clinic 1.11%, Private MBBS Doctor 16.67%, Village Doctor 15.55%, Drug Seller of Pharmacy 13.33%, Traditional Faith Healer 5.55%, THC and MBBS Doctor 11.11%, THC+UH & FWC 1.11%, THC + Pharmacy 1.11%, MBBS Doctor + Village Doctor 1.11%, Homeopathic Doctor + Pharmacy 11% and 14.44% respondents went to multiple places of treatment (>3 places).

Table-4: Distribution of the respondents by the reason for health care seeking from those health centers (N=270)

Causes of Preference	**Number**	**Percentage (%)**
Reliable	108	40
Nearer to house	24	8.89
Less cost/cheap	57	21.11
Co-operative or good behaviour of Doctor	6	2.22
Reliable + Nearer to house	30	11.11
Reliable + Less cost/Cheap	12	4.44
Reliable + Good behaviour of Doctor	6	2.22
For all above causes	9	3.33
Other causes	18	6.66
Total	270	100

Table-4 shows that among the 270 respondents 40% went to treatment place because of reliability, 8.88% went there because it was nearer to their houses. 21.11% said that the way there because of less cost. Other opinions behind choosing the treatment places are as follows: Co-operative or Good Behaviour of Doctor 2.22%, Reliable + Nearer to House 11.11%, Reliable + less cost 4.44%, Reliable + Good Behaviour of Doctor 2.22%, For above all causes 3.33% and Other causes 6.66%.

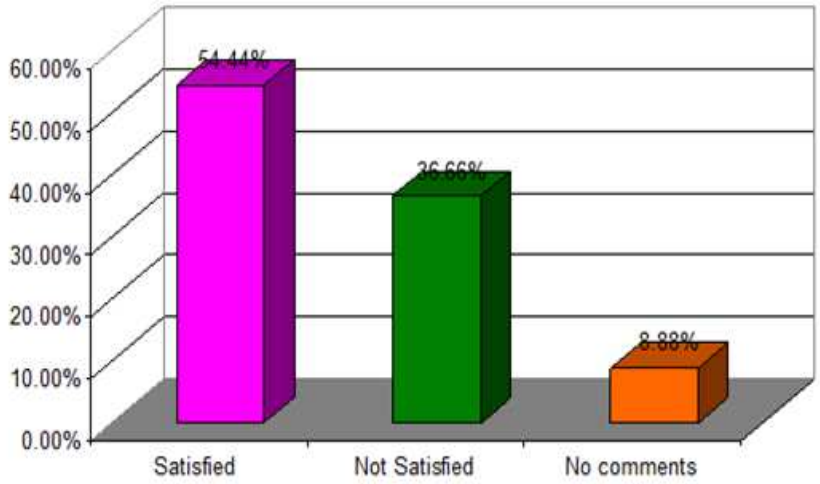

Figure-1: Distribution of the respondents by their satisfaction about the treatment facilities in Local Govt. Hospital/Thana Health Complex.

Figure-1 shows that among the 270 respondents 54.44% were satisfied, 36.66% were not satisfied about the treatment facilities in the Local Govt. Hospital/THC and 8.88% did not comment about it.

Table-5: Distribution of the respondents by decision makers for getting treatment (N=270)

Decision makers for getting treatment	Number	Percentage (%)
Self-decision	93	34.44
Husband	30	11.11
Son/Daughter	3	1.11
Parents	66	24.44
Father/Mother-in-law	9	3.33
Combined (Husband+wife)	54	20
Self+Husband+Son/Daughter	9	3.33
Self+Son/Daughter	3	1.11
Self+Father/Mother-in-law	3	1.11
Total	270	100

My study revealed that during illness 93 (34.44%) women took self decision for seeking health care. 11.11% on the basis of their husbands' decision, 1.11% by son/daughter. 24.44% were advised by their parents, 3.33% by father/mother in-law. 20% of the women took decision combinedly with their husbands. 3.33% take decision combinedly with husband and son/daughter, 1.11% self decision + son/daughters advice and 1.11% took decision combinedly with their father/mother in-law (Table-5).

Table-6: Distribution of the respondents on the basis of their opinion from where they can get modern treatment facilities (N=270)

Treatment site	Number	Percentage (%)
Govt. Hospital/Thana Health Complex	81	30
Union Health & Family Welfare Center	6	2.2
Community Clinic	0	0
Private Clinic/MBBS Doctor	69	25.55
Kabiraj	0	0
Homeopathic Doctor	3	1.11
Unany/Ayurvedi Doctor	0	0
Village Doctor	0	0
Traditional Faith Healer	0	0
Govt. Hos.+UH & FWC+MBBS Doctor	12	4.44
Govt. Hospital+MBBS Doctor	45	16.66
UH & FWC+MBBS Doctor	12	4.44
THC+Community Clinic	6	2.22
Multiple Sites	36	13.33
Total	270	100

The above table-6 shows that 30% of the respondents thought modern treatment could be found from Thana Health Complex. The other opinions were as follows: UH & FWC 2.20%, Private MBBS Doctor 25.55%, Homeopathic Doctor 1.11%, THC+UH & FWC+MBBS Doctor 4.44%, Govt. Hospital + MBBS Doctor 16.66%, UH & FWC +MBBS Doctor 4.44%, THC+Community Clinic 2.22% and 13.33% believed that modern treatment could be found from multiple size.

Table-7: Distribution of the respondents by place of treatment (referral) after failure of the primary one (N=270)

Place of referral	**Number**	**Percentage (%)**
Referred to Govt. Hospital of the District	69	25.56
Referred to Specialized Hospital In Dhaka	117	43.33
Referred to Private MBBS Doctor	15	5.56
Referred to Private Clinic	18	6.67
Goes to Private MBBS Doctor Willingly	27	10
Others (mainly go to faith healer)	24	8.89
Total	270	100

The table-7 shows that among the 270 respondents 43.33% were referred to specialized hospital in Dhaka after failure in the primary site (local health facility). 25.56% were referred to govt. hospital of the district (Munshigonj). 5.56% were referred to private MBBS doctors chamber. 10% women went to MBBS doctor willingly.

Table-8: Distribution of the respondents about their opinion on who take illegal money (N=270)

Health Care Providers who take illegal/extra money	**Number**	**Percentage (%)**
Doctor	6	20
Medical Assistant	15	50
Pharmacist	0	0
Nurse/Brother	2	6.66
Health Technician	3	10
M.L.S.S	0	0
Other Staffs	4	13.33
Total	30	100

The table-8 shows that 20% respondents said that extra money was taken from them during seeking health care Local Govt. Hospital, 50% of the women said that medical assistant took extra money from them. 6.66% respondents said that nurse/brother, 10% said that health technician and 13.33% said that other staffs took illegal money from them while seeking health care in Local Govt. Health facilities.

Table-9: Distribution of the respondents by their willingness to participate in local health awareness programme (N=270)

Willing to participate	**Number**	**Percentage (%)**
Yes	147	54.44
No	123	45.55
Total	270	100

The above table-9 shows that 54.44% rural adult women were willing to participate in local health awareness programme. 123 (45.55%) women did not will to participate in such programme.

Table-10: Association between economic status of the respondents and satisfaction about the treatment facilities in Govt. Hospital/Thana Health Complex (N=270)

Economic Status of the Respondents	**Satisfied**		**Not Satisfied**		**No comments**		**Total**	
Lower Class	18	30%	39	65%	3	5%	60	100%
Middle Class	9	33.33%	12	44.44%	6	22.22%	27	100%
Higher Class	120	65.57%	48	26.23%	15	8.20%	183	100%
Total	147 (54.44%)		99 (36.66%)		24 (8.88%)		270 (100%)	

Statistical analysis: X2 = 38.497, df = 4, p<0.0001, Contingency coefficient 0.353. So, the association is statistically significant.

The table-10 shows the association between monthly family income and satisfaction about treatment facilities in govt. hospital/THC. Those whose family income is >10000 Tk. are more satisfied 147 (54.44%) out of 183. In income group <5000 Tk. dissatisfaction is very high. 39 (65%) adult women out of 60 of this group are not satisfied. Mid income group 5001-10000 Tk. per monthl has no comments 22.2% out of 27 respondents.

Table-11: Relationship of the respondents' educational level with willingness to participate in local health awareness programme (N=270)

Educational Level	Yes		No		Total
Illiterate	9	21.43%	33	78.57%	42 100%
Primary Level (1-5)	24	42.11%	33	57.90%	57 100%
Secondary Level (6-10)	42	56%	33	44%	75 100%
S.S.C/Equivalent	6	50%	6	50%	12 100%
H.S.C/Equivalent	66	81.48%	15	18.52%	81 100%
Degree/Graduation	0	0%	3	100%	3 100%
Grand Total	147 (54.44%)		123 (45.55%)		

Statistical analysis: Chi-square (X^2) = 47.635, df = 5, p <0.0001, Contingency coefficient 0.384. So, the association is statistically significant. The table-11 shows 21.43% illiterate respondents wanted to participate in health awareness programme. Among the primary level 42.11%, among the secondary level 56%, among SSC level 50%, HSC level 81.48% wanted to participate in local health awareness programme.

DISCUSSION

The present descriptive cross sectional study was carried out among the rural adult women of Srinagar Upazila under the district of Munshigonj, Bangladesh. This study was conducted with a view to determining the pattern of health care seeking behaviour among the rural adult women. In this study the mean age of the respondents was 26.94 years with SD. ±11.53 years. Maximum proportion of the respondents belongs to the age group below 20 years. It is 35.55%. From this study it was found that most of the respondents were Muslims (93.33%). only 6.67% were Hindu. It indicates that Muslims make most of population of Bangladesh. It is similar to the report of Bangladesh Bureau of Statistics.[2] Majorities (55%) of the respondents of this study were married ad only 3.33% were

widow. This may be due to adult group of respondent. Education level of the respondents of this study reveals that most of the respondents (84.45%) were literate having different level of education, among the literate group a major part (30%) were belong to class H.S.C/Equivalent level of education. only 1.11% had graduation. It indicates the rate of female education is getting higher. It is not consistent with the BBS report.[2] Present study shows that among the respondents 55.60% were housewives in occupation. 34.44% were student only 2.22% were service holder reveals that the large populations of female in Bangladesh are economically dependent. Two third of the respondents were from nuclear family (67.78%). It indicates that the concept of joint family (non-nuclear) has been changed. The majority of the respondents have 4-5 members in their family. Monthly family income of 183 respondents was more than 10000 Tk. 10% of the respondents had monthly income 5000-10000 Tk. Most of the respondents (60 women) had family income >5000 Tk. I found 3 respondents whose monthly family income was 1,00,000 Tk. because their husbands were living abroad. In 1984 the Govt. of Bangladesh adopted a strategy for rural development which emphasized the critical aspects of the rural development process-agricultural development, improved physical infrastructure and income generation for the poor. Since then monthly family income of the rural people of Bangladesh has been increased day by day in my study area few people are living in abroad. They contribute to the economics development of the people. A great number of earning members of the families do business in Dhaka city. Moreover, being nearer to the Capital city, a significant number of the people are engaged in various types of job/works. This is why monthly family income is increasing. This is consistent with the national status of the country stated in ADB report on Bangladesh.[8] In my study I found that 90% of the respondents had tin-shed houses. Among the 270 respondents 82.22% suffered from various type of diseases during last 6 months. Most common disease is fever 16.22%. Equal 16.22% women suffered from multiple diseases. My study findings about the common diseases are not similar to the health and demographic report of NIPORT. Because Srinagar Upazilla of Munshigonj is very nearer to Dhaka. It is only 30 km. away from Dhaka. People are conscious about the health status. They can easily visit specialized hospital in Dhaka. Due to economic solvency they visit private MBBS Doctor too. So suffering from diseases has been decreased. A few people are being suffered from non-communicable diseases Hypertension (4.05%), DM (1.35%). Road traffic accident is a bit higher (1.35%). Because Srinagar Upazilla is along the side of the busy inter-district highway (Dhaka-Mawa Road) and nearer to Mawa Ferry Ghat. A significant number of people (16.22%) suffered from multiple diseases because they were old age women (age > 50 years).[9] In the present study it was found that most (26.66%) of the respondents go to Thana health complex for treatment. 16.66% go to M.B.B.S. doctor to seek health care. Only 5.55% of the respondent sought treatment from the faith healer. In this present study it was also found that higher income group i.e. respondents having monthly family income above Tk. 10000 are satisfied on the health facilities of THC. The lower income group (<5000 Tk.) are more unsatisfied (65%). The lower income group go to local Govt. hospital more than the higher income group. During illness of children women went to Local Govt. Hospital or Thana Health Complex for seeking Health Care. 7.77% women were dependent on Village Doctor. 21.11% women went to Private MBBS Doctor, because they were economically solvent. Nobody went to Community Clinic. 18.88% directly went to Specialized Hospital in Dhaka, because they were more conscious about the health of their children. It is the common scenario of Bangladesh.[9] Among 270 respondents 81% women thought that modern treatment could be found in Local

Govt. Hospital/THC. Only 2.2% went to Union Health & Family welfare center. 25.55% thought that modern treatment facilities were available in private clinic/MBBS Doctor. Still Homeopathic treatment was thought to be modern by 1.11% women. No woman said that Kabiraj, Unany Doctor, Village Doctor & Traditional Faith healer could provide modern treatment. Such type of study was not conducted before. So I could not compare my study findings. Bangladeshi women are more dependent on their husbands for economic purposes. Male partners are the main earning members in the families. In the rural area this dependence is more than that in urban area because urban women are more literate. They can go outside for earning purpose. Women are working in many sectors like garments, small industries and other. A great number of women are engaged in many types of profession like teaching, medical, engineering & corporate offices. So dependence of the urban women is not so high like rural women. But due to lack of job facilities, lack of education most of the rural women are dependent on their husbands. This is why my study findings are not similar to the report of Bennet Milton Rich which was on developed countries.[10] After treatment failure in primary size the most common referral site of the patients was specialized hospital in Dhaka (43.33%). Because Dhaka is nearer Srinagar Upazilla. 25.56% patients were referred to district hospital, 10% women to private MBBS Doctor. This is similar to P. Nahar Kabir and Jaman study on Dynamics of health care seeking behavior of elderly people in Rural Bangladesh.[11] The study shows that medical assistant was the main culprit who took extra/illegal money from the respondents (50%). Very few (only 20%. respondents said that Doctor's themselves took extra money from them during seeking health care in local health facilities. Only 10% women said that Health Technologists took illegal money from them. Nurses, Brothers were also involved in such illegal activity. This is common picture of the rural health centers of Bangladesh. But such type of statistics is not available in any previous similar studies. The study revealed that 54.44% of the respondents are willing to participate in local health awareness programme. Regarding relationship between the educational level of the respondents and willingness to participate in local health awareness programme a significant association was observed (X^2 = 47.635, df=5, p<0.0001). It was observed that the respondents who were of HSC level of education were mostly (81.48%) willing to participate in health awareness programme. Another 56% of secondary level education' respondents were also willing to participate in such programme. But 78.57% of the illiterate respondents were not willing to participate in health awareness programme. This relationship indicates that there is really an association of educational level with awareness to health. This finding are not in the line with the findings of Ahmed SM, Adams A.M study on Socio Economic Development and Health Seeking Behavior in Bangladesh.[12] When we search for the association between the monthly family income and satisfaction of the respondents about the treatment facilities in govt. hospital, it was found that higher class are more satisfied 65.57% and lower class are less satisfied and it is only 30%. But among the middle class people (Women) whose monthly family income was 5000 – 10000 Tk, 33.33% of them were satisfied about the treatment facilities in Local Govt. Hospital/Thana Health Complex. A strong significant association between economic status (by monthly family income) of the respondents and satisfaction about the treatment facilities in Govt. Hospital/THC (X^2=38.497, df=4, P<0.0001, contingency coefficient 0.353). This may be due to higher income level. Women whose family income is higher live in more peaceful condition. Their judgment about the health facilities usually will be positive. Middle class people have no alternative to choose treatment facilities except that in THC/Local Health Centre. So they had to say, "Yes, we are satisfied". Lower income group women are

open minded in expressing their opinions because they go to Local Health Centre more frequently than other income groups. Among them 65% said that they were not satisfied about the treatment facilities provided by Local Health Centre. This is the exact opinion of the most of the people of Bangladesh. This finding should be evaluated by further in-depth study.

LIMITATIONS

- The study was performed on only 270 rural adult women which was a very small fraction of large community and these small fractions do not reflect the picture of the whole community.
- Some variables like age of the respondent, monthly family income, educational level etc. were likely to be recalled biased.
- All the information in this study was accepted as stated by the respondents and could not be cross checked.
- There was no such literature regarding the pattern of health care seeking behaviour of the rural adult women, i.e. scarcity of the literature
- The study period was very short for conducting such a research work.
- Most of the women were very conservative. So, they did not want to talk to the investigator about their health problem.

CONCLUSION

From this study it can be concluded that:

- Respondents (16.67%) mainly go to private M.B.B.S. doctor for seeking health care.
- Respondents (26.66%) go to Government hospital or Thana Health Complex.
- Some of the respondents (13.33%) seek health care from village doctor.
- Very few respondents 1.11% go to community clinic for treatment.
- 40% of the rural adult sick women go to local health center because of reliability.
- 21.11% women go to health complex because they are very poor.
- 54.44% of the rural adult women are satisfied about the treatment facilities in the Thana health complex.
- 98.89% respondents said that they should go to qualified MBBS doctor.
- 20% of the sick women take decision combined with their husband for seeking health care.
- 54.44% respondents are willing to participate in the local health awareness programme.

In the perspective of present study findings, further in depth and large scale study is essential in our country to find out the pattern of health care seeking behaviour among the rural adult women.

RECOMMENDATION

Considering the findings of the present study following recommendations are made:

- In depth study should be carried out in our country to know the pattern of health care seeking behaviour.
- Health education programme should be arranged to aware the population about the health seeking behaviour of the women.
- Programs for socio-economic uplift of the poor people of the rural area may be undertaken by the govt., and other agencies in order to improve their economic condition to seek modern health care
- Non Govt. and voluntary organizations may encourage setting up modern health care services for the rural area.
- Doctors, Nurses/Brothers, Medical Assistant, Technician and all other stuffs of the health center should change their behaviour towards the patients. They should be more co-operative.
- Extra money taken mainly by the medical assistant in the emergency dept. of the Thana health complex. It should be strictly prohibited.
- Supply of medicine should be in the local health facility. Patients may be provided with essential drugs at lower price (it may be 25-50% of the market price).

- Family members should be co-operative to the adult female members of the family.

Conflict of Interest: None:

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