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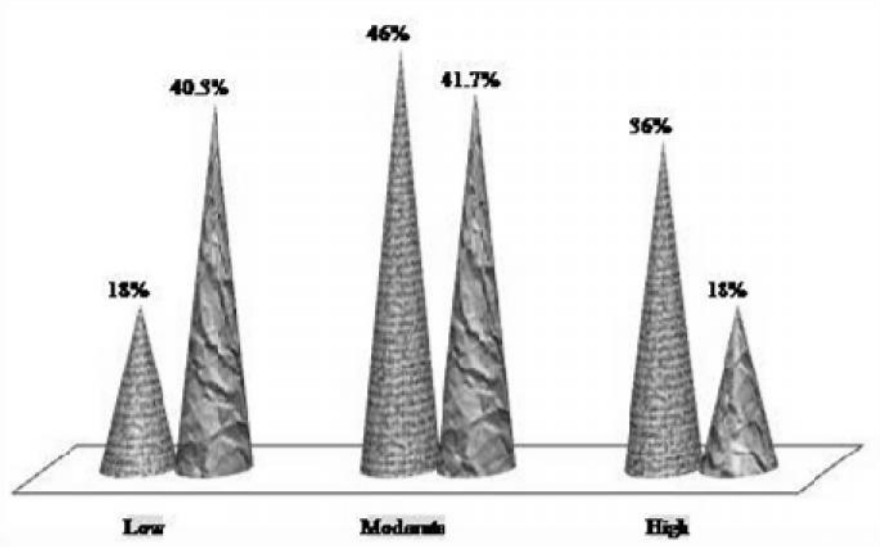

Neeru Sharma., Samridhi Arora and Ambika Sharma

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RESEARCH ARTICLE

HEALTH SEEKING BEHAVIOUR AMONG WOMEN: A STUDY OF RURAL, URBAN AND TRIBAL WOMEN OF JAMMU(J AND K)

Neeru Sharma., Samridhi Arora and Ambika Sharma

Department of Home Science, University of Jammu, Jammu(180006) Jammu and Kashmir

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ABSTRACT

India spends a huge amount on health sectors with a large number of preventive and curative schemes for women but women's health indicators still show a poor trend especially the menopausal transition and the post reproductive health. Hence the present study was undertaken with the objectives -To study the health seeking behaviour among women; To compare the health seeking behaviour of women both district wise and ethnicity wise; and To study the relationship of various dimensions of Women's Health Seeking Behaviour with her personal and socio-economic variables. The sample comprises of 600 women of Jammu, in the age range of 35-65 years, selected through multistage sampling technique from the rural, urban and tribal areas of Jammu province.Health Seeking Behaviour Checklist (HSBC) and SES Scale were used to collect the data which was subjected to statistical analysis. The analysis of Health Seeking Behaviour Checklist (HSBC) shows that most of the respondents from Jammu show moderate level of health seeking whereas respondents from Kathua show low level of health seeking behaviour. Most of the urban and tribal respondents show moderate level of health seeking behaviour but most of the rural respondents show low level of health seeking behaviour. Health Seeking Behaviour is significantly positively related with variables such as type of family, respondent's age at marriage and age at first pregnancy and their Self-Esteem whereas it is negatively related with SES and number of children the respondents has.

INTRODUCTION

Women's right to health has been strongly affirmed by the International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women in 1995. According to UN Population Aging Report (2013) the older population, in this world, is predominantly female. In 2013, globally, there were 85 men per 1000 women in the age group of 60 years and over. Notwithstanding universal declaration of human rights which aims to provide a common standard of living, women are by and large victims of poor health in almost every nook and corner of the world (Sen, 2012). A declining trend in both fertility and mortality rates has increased average life span and has created a new set of challenges in today's society (Biswas *et al*, 2003).Craft (1997)reported that all over the world women live longer than men, upto 12 years longer in the Russian Federation. However, while they may live longer, they are not necessarily living better or healthier lives. In developing countries communicable diseases and childbirth related illness account for most morbidity among women. In the developed world, too, women experiences of higher levels of physical and psychological morbidity (Craft, 1997).Women across the world face similar situations when it comes to healthcare. World Bank projects that by 2020 one in five women in the developing world will be 50 years or older, increasingly neglected and plagued with a host of chronic conditions. According to them cancer of cervix and breast claims 350,000 older women each year, osteoporosis afflicts 1/10 over 60 and osteoarthritis will be the increasing cause of disability in post-menopausal years. Health is one of the core components of National Common Minimum Programme and health care among the 7 thrust areas. Most of the health programs in India are aimed towards improving the reproductive health, but inadequate attention has been paid to the post reproductive health. Aged women have not been given much importance, but as the aged population in India is increasing and women are expected to outlive men much attention is required in the coming years to look after the health care needs of the aged women. With 77 million elderly in 2007 (Helpage India), the second largest in the world, out of which 40 million are women, the situation seems grave, especially when they avoid health seeking.80% elderly reside in rural areas, 40% live below the line of poverty and 35% marginally over it, 73% of them being illiterates out of which 42.08% are females. Out of 54% women who are 60+ 18.36 million are widows. There is a need to understand the women's health in relation to her attitudetowards health, ethnicity socio economic status, literacy status etc , as there is dearth of such data in India. Women are less likely to seek appropriate and early care for diseases yet the frequency with which such care is required and the quality of care required has not been well documented in South Asia (Fikree and Pasha, 2004). The study of beliefs

Corresponding author:* **Neeru Sharma
Department of Home Science, University of Jammu, Jammu(180006) Jammu and Kashmir

about health and disease has become important to understand why people seek or do not seek health care. Health care professionals have started studying these cultural aspects of health care in order to improve health care seeking among population. Hence to understand the health seeking behaviour of women in the menopausal transition, a study was conducted in the urban, rural and tribal areas of Jammu and Kathua districts of J&K state.

Objectives of the Study

1. To assess the health seeking behaviour of rural urban and tribal women of Jammu and Kathua District of Jammu province (Jammu and Kashmir state) during menopausal transition (35- 65 years).
2. Compare the health seeking behaviour of women both district as well as ethnicity wise.
3. To study the relationship of Women's Health Seeking Behaviour with their age at menarche, age at marriage, age at menopause, number of children and Socio-Economic Status.

METHODOLOGY

***Locale*:** The study was conducted in rural, urban and tribal areas of Jammu and Kathua District of the Jammu Province of the Jammu and Kashmir state of India.

***Sample*:** Six hundred women, in the age group of 35-65 years, were selected for the purpose of the study. The sample was equally selected from amongst the rural (N=200), urban (N=200) and tribal (N=200) areas of Jammu.

Criteria for sample selection

***Age*:** Only women above the age of 35 years and below of 65 years were included.

***Ethnicity*:** Rural, urban and tribal areas of Jammu and Kathua districts, falling in Jammu province were selected.

Health: Women having any apparent signs of physical or psychological disability were not included in sample group.

Marital Status: Only married women were selected.

***Sampling technique*:** Multistage sampling technique was used to systematically select the sample. **Rural**: Out of four tehsils of Jammu, three were selected randomly and a list of villages was obtained. From this list, randomly 10 villages from each district were selected. From each village, 10 women were selected through purposive sampling technique. In Kathua District also, there are four tehsils so similar technique was used for District Kathua.

Urban: Sample was selected from various wards of Kathua and Jammu City. There are 71 wards in Jammu and 17 in Kathua out of which 10 wards each were selected randomly from both the urban areas and from each ward 10 women were selected purposively.

Tribal: Areas having a concentration of Gujjar tribal population were identified from Jammu and Kathua tehsils. A representative sample was randomly selected from these areas.

Tools Used

Health Seeking Behaviour Checklist: A need was felt to construct a checklist which includes those items that can be used to classify the women as per the frequency of their health seeking behaviors exhibited. After initial brainstorming, a list of items was prepared and in the form of a checklist, these forms were given to experts to rate and give their views. Modification and changes as suggested by the experts were incorporated and the tool was pre tested on a small sample. After pre-testing, it was finalized after minor changes and used on the sample. This scale possess high reliability quotient of 0.51

Scoring: For positive scores a mark of +1, for negative -1 is assigned and then the total scores were calculated for a particular individual. The responses on all the items were put together and statistically treated.

Socio Economic Status Scale: This scale is devised by S.C. Tiwari, Aditya Kumar and Ambrish Kumar (Department of Geriatric Mental Health, King George's Medical University, Lucknow, India, 2004). The scale aims to assess the socio-economic status in rural and urban communities in India. The scale had seven profiles (House, material possession, educational, occupational, economic, possessed land / house cost, social profiles) which were rated on 10-point scale. The validity and reliability of the scale has been established through a defined Visual Analogue Scale (VAS) and test-retest methods. The **validity** of the scale was high demonstrating its sensitivity to discriminate families between middle and upper classes.

Data Collection

Home visits were conducted to collect the data. For introduction, the help of a local leader was sought.

Table 1 Background information of the respondents

Education	Frequency N = 600	Percentage (%age)
Illiterate	**230**	**38.3**
Primary	68	11.3
Secondary	**134**	**22.3**
Hr. Secondary	64	10.7
Graduation	57	9.5
Post Graduation	45	7.5
Technical	2	0.3
Occupation		
Service Holder	58	9.7
Business	11	1.8
Pension Holder	14	2.3
Daily Labourer	3	0.5
House Hold Work	12	2
Home Maker	**402**	**67**
Caste Occupation	100	16.7
Family Type		
Joint	288	48
Nuclear	**312**	**52**
Socio-Economic Status		
Upper	8	1.3
Upper Middle	157	26.2
Middle	**274**	**45.7**
Lower Middle	160	26.7
Lower	1	0.17

Firstly rapport was established through informal discussions, and then the respondents were told about the objectives of the study. The local language, *Dogri*, was used to ensure that the information received was accurate.

Data Analysis

Data was subjected to quantitative analysis. Mean, SD, ANOVA and Correlation were calculated. Statistical software SPSS version 15.0 was used. The data has been presented in the forms of tables and graph.

Background Information

Table.1 reveals that majority of respondents (38.3%) are illiterate, 22.3% have studied upto secondary class, 11.3% have studied upto primary and 10.7% have studied upto higher secondary. Majority of the respondents (67%) are home makers, 16.7% indulge in caste occupation and 9.7% respondents are service holders. Majority of respondents (52%) are living in nuclear families whereas 48% are residing in joint families. Results further indicates that majority of the respondents i.e. 45.7% belong to middle class, 26.7% belong to lower middle class and 26.1% belong to upper middle class.

Table 2 Mean age of the respondents during transitional phases of life

Variables	Mean	Std. Deviation
Age	49.59	9.3
Age at Menarche	14.08	1.4
Age at Marriage	19.42	4.2
Age at 1st Pregnancy	21.02	4.4
Age at last Pregnancy	28.20	6.08
Age at Menopause	48.6	4.47

Results presented in the Table 2 reveal that present mean age of the respondents is 49.6 ± 9.3years. Their average age at menarche is 14.08 ± 1.4, age at marriage is 19.42 ± 4.2, age at first pregnancy is 21.02 ± 4.4, age at last pregnancy is 28.2 ± 6.08 and average age at menopause is 48.6 ± 4.47 years respectively.

Health Seeking Behaviour of The Respondents

Health Seeking Behaviour Checklist was prepared on the basis of focused group discussion, carried out during the pretesting phase and observations of the rural, urban and tribal areas, to get the information regarding the levels of Health Seeking Behaviour of the respondents.

Table 3 Level of Health Seeking Behaviour of respondents

Health seeking behaviour	District wise		Ethnicity wise			
	Jammu N=300	Kathua N=300	Urban N= 200	Rural N=200	Tribal N=200	Total N= 600
Low	54 (18)	121 (40.3)	47 (23.5)	**96** (48)	32 (16)	175 (29.17)
Moderate	**138 (46)**	**126 (41.7)**	**91** (45.5)	70 (35)	**103** (51.5)	264 (44)
High	108 (36)	53 (17.3)	62 (31)	34 (17)	65 (32.5)	161 (26.83)
¡²	**44.98****			**55.64****		

Percentage in Parentheses; **significant at p≤0.01

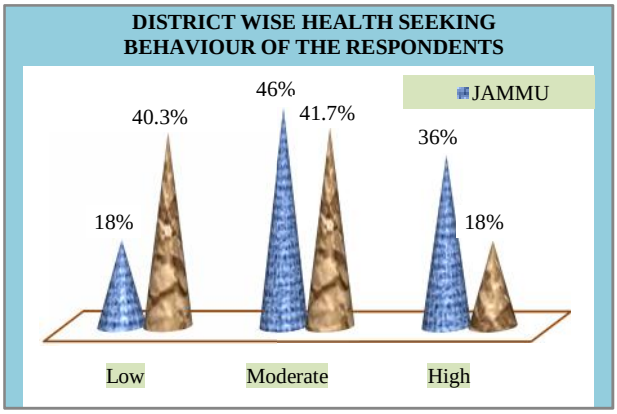

Fig. No. 1 a Figurative presentation of table 3

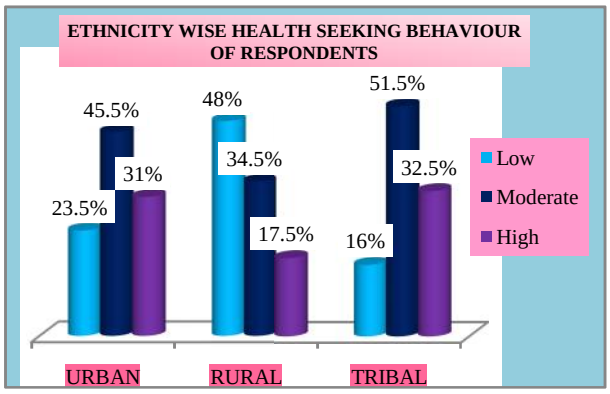

Fig. no. 2b Figurative presentation of table 3

Overall results in Table 3 show that 44% of the respondents have moderate level of health seeking behaviour followed by 29.17% of respondents who show low level of health seeking behaviourand 26.83% who have high level of health seeking behaviour. **District wise** results indicate that 46% respondents from the Jammu district are moderate health seekers and 36% show high level of health seeking behaviour. On the other side 41.7% respondents from the Kathua district are moderate health seeker and 40% show low level of health seeking behaviour. It can further be analysed that respondents from the Jammu district show moderate to high level of health seeking whereas respondents from the Kathua district show moderate to low level of health seeking.

Ethnicity wise results indicate that most of the respondents from urban (45.5%) and tribal (51.5%) areas are moderate health seekers whereas most of the respondents (48%) from rural areas show low level of health seeking. 32.5% tribal, 31% urban and only 17.5% rural respondents show high level of health seeking behaviour. Overall results reveal that most of the respondents (44%) show the moderate level of health seeking behaviour, followed by 29.17% who have low level of health seeking and 26.83% have high level of health seeking behaviour. **Chi-square** values reveal significant difference (p≤0.01) both district wise as well as Ethnicity wise It is clear from the results given in the table 4.2.2 that 17% of the respondents who are illiterate show moderate level of health seeking behaviour, 14 % of them who are illiterate show low health seeking behaviour and 11% who are educated upto higher secondary level show moderate level of health seeking behaviour.

Table 5 Education, socio-economic status, type of family and levels of health seeking behaviour of the respondents

Background variables	Levels of health seeking behaviour							
	Low		Moderate		High		Total	
EDUCATION	F	%age	F	%age	F	%age	F	**%age**
Illiterate	84	14	**102**	**17**	44	7.3	230	**38.3**
Upto Primary	17	2.83	34	5.7	17	2.83	68	**11.3**
Upto Secondary	33	5.5	66	11	35	5.83	134	**22.3**
Upto Higher Secondary	23	3.83	22	3.7	19	3.17	64	**10.7**
Upto Graduation	12	2	17	2.83	28	4.7	57	**9.5**
Upto Post Graduation	6	1	22	3.7	17	2.83	45	**7.5**
Technical	-	-	1	0.17	1	0.17	2	**0.33**
Socio economic status								
Upper	1	0.33	3	0.5	4	0.67	8	**1.33**
Upper Middle	39	6.5	63	10.5	55	9.17	157	**26.17**
Middle	86	14.3	**118**	**19.67**	70	11.67	274	**45.67**
Lower Middle	49	8.1	79	13.17	32	5.33	160	**26.6**
Lower	-	-	1	0.17	-	-	1	**0.17**
Type of family								
JOINT	98	16.3	118	19.67	72	12	288	**48**
NUCLEAR	77	12.83	**146**	**24.3**	89	14.83	312	**52**
TOTAL	**175**	**29.17**	**264**	**44**	**161**	**26.83**	**600**	**100**

19.67% respondents who belong to middle socio-economic strata are moderate health seeker, 14.3% show moderate level of health seeking behaviour and 11.67 % show high level of health seeking behaviour. 13.17% of respondents belong to lower middle SES show moderate level of health seeking behaviour. Results further indicate that majority of respondents (52%) reside in nuclear families and 48% reside in joint families. 24.3% respondents living in nuclear families show moderate level of health seeking behaviour, 14.83% show high and 12.83% show low level of health seeking behaviour. 19.67% respondents living joint families show moderate level of health seeking behaviour, 16.3% show low level and 12% show high level of health seeking behaviour.

Table 6 Mean Scores of respondents on Health Seeking Behaviour Checklist

VARIABLE	Mean N = 600	S. Dev.
Health Seeking Behaviour	10.20	3.698

Total score> Mean percent?

Table 6shows that that respondent's score 10.20, on an average on the Health Seeking Behaviour Checklist with a standard deviation of 3.698. The fig. 4.2.3 (a) given below shows that as age increases the mean scores on Health Seeking Behaviour decreases peaking around the age of 46-55 years, coinciding with the menopausal transition. The mean of the respondent's age at menopause, who have attained it, is 48.6± 4.47 years in the present study.

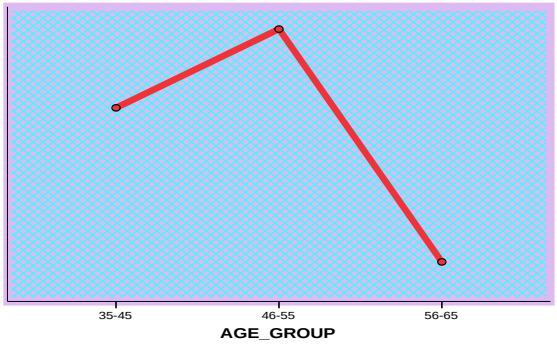

Fig. 4.2.3 a Age group wise figurative representation of HSBC.

Table 7 Association of Health Seeking Behaviour with Ethnicity.

Items of Health Seeking Behaviour Checklist	Urban	Rural	Tribal	F value
I regularly do physical exercise for half an hour.	0.41 ± 0.49	0.16 ± 0.36	0.39 ± 0.49	19.35**
I have sleep soundly for 7-8 hrs. daily	0.81 ± 0.39	0.78 ± 0.42	0.81 ± 0.39	.506
I examine myself for lump or swelling in body once in a month.	0.43 ± 0.50	0.41 ± 0.49	0.41 ± 0.49	.089
I regularly go for weight and B.P check up	0.53 ± 0.50	0.48 ± 0.50	0.56 ± 0.50	1.168
I go for dental check-up once in a year	0.32 ± 0.47	0.27 ± 0.44	0.40 ± 0.49	4.22**
I go for cancer screening test after every two years.	0.08 ± 0.27	0.10 ± 0.29	0.03 ± 0.16	4.41**
I go for complete health check-up once in a year.	0.30 ± 0.46	0.16 ± 0.37	0.19 ± 0.39	6.045**
I always consult doctor for continuous hair fall.	0.40 ± 0.49	0.27 ± 0.44	0.33 ± 0.47	3.87*
I always consult doctor before having any kind of medicines.	0.68 ± 0.47	0.57 ± 0.50	0.76 ± 0.43	8.812**
I always consult doctor in case of piles.	0.75 ± 0.43	0.55 ± 0.50	0.83 ± 0.38	21.63**
I regularly take my breakfast before 9:00 a.m.	0.64 ± 0.48	0.43 ± 0.50	0.83 ± 0.38	38.52**
I regularly take my lunch before 2:00 p.m.	0.31 ± 0.46	0.20 ± 0.40	0.39 ± 0.49	8.44**
I regularly take my dinner before 8:00 p.m.	0.23 ± 0.42	0.21 ± 0.41	0.59 ± 0.49	46.15**
I regularly take fruits and nuts.	0.54 ± 0.50	0.37 ± 0.51	0.72 ± 0.45	25.61**
I drink 7-8 glasses of water daily.	0.66 ± 0.47	0.77 ± 0.46	0.67 ± 0.47	3.06*
I take milk twice a day regularly.	0.43 ± 0.50	0.37 ± 0.48	0.62 ± 0.49	14.71**
I always wash my hands before touching any eatables.	0.93 ± 0.26	0.93 ± 0.31	0.91 ± 0.29	.505
I always use fresh water.	0.94 ± 0.25	0.84 ± 0.41	0.93 ± 0.26	5.88**
I always maintain my medical records with care.	0.73 ± 0.45	0.57 ± 0.53	0.74 ± 0.44	8.17**
I regularly watch/ hear health awareness programme on T.V/ radio	0.57 ± 0.50	0.37 ± 0.51	0.20 ± 0.40	30.76**

*significant at p≤0.05, **significant at p≤0.01

One way ANOVA (Table 7) was used to find the association of Health Seeking Behaviour of the respondents with ethnicity. Results reveal significant association of ethnicity with physical exercise, dental check-ups, cancer screening test, complete

health check-ups, hair fall, having medicine without consultation, consultation regarding piles, meals (Breakfast, Lunch and Dinner), eating fruits and nuts, water usage, keeping medical record and watching health awareness programmes on T.V. Results indicate that health seeking behaviour of the respondents of urban, rural and tribal respondents differ significantly on most of the items. Respondents from the tribal areas scored higher means on most of the items, followed by the respondents from urban areas and least by the respondents of rural areas. Respondents from the tribal areas scored higher means on the items such as dental check-up ($f = 4.22$, $p \leq .01$), having medicine with consultation ($f = 8.812$, $p \leq .01$), consultation regarding piles ($f = 21.63$, $p \leq .01$), meals: breakfast ($f = 38.52$, $p \leq .01$); lunch ($f = 8.44$, $p \leq .01$); dinner ($f = 46.15$, $p \leq .01$), fruits and nuts ($f = 25.61$, $p \leq .01$), milk usage ($f = 14.71$, $p \leq .01$), maintaining medical record ($f = 8.17$, $p \leq .01$). Respondents from the urban areas scored higher means on the items such as physical exercise ($f = 19.35$, $p \leq .01$), complete health check-up ($f = 6.045$, $p \leq .01$), consultation for hair fall ($f = 3.87$, $p \leq .05$), usage of fresh water ($f = 5.88$, $p \leq .01$) and watching health awareness programmes on T.V. ($f = 30.76$, $p \leq .01$) Respondents from the rural areas scored higher means on the items such cancer screening ($f = 4.41$, $p \leq .01$)and drinking of 7-8 glass of water ($f = 3.06$, $p \leq .0$)

Variables	Health Seeking Behaviour
Age	-.071
Education	.204(**)
Occupation	-.117(**)
Type of Family	.117(**)
SES	-.139(**)
Age at Menarche	-.037
Age at Marriage	.190(**)
Age at 1st Pregnancy	.147(**)
Age at Last Pregnancy	-.030
Age at Menopause#	.053
No. of Children	-.117(**)

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
# Data for only 271 women used who attained menopause.

Correlation analysis shows that **Health Seeking Behaviour** ispositively significantly correlated with Education, Type of family, Age at marriage and Age at first pregnancy($p \leq 0.01$) but negatively significantly correlated with Occupation, SES and number of Children ($p \leq 0.01$).

DISCUSSION

Health seeking behaviour refers to all those things humans do to prevent diseases and to detect diseases in asymptomatic stages (Mackain 2012). It means to take care of health or to lead a healthy life (Sen, 2012). This behaviour among different populations is a complex outcome of many factors operating at individual, family and community level including their bio-social profile, their past experiences with the health services, influences at the community level, availability of alternative health care providers including indigenous practitioners and last but not the least their perceptions regarding efficiency and quality of the services.

Most of the respondents were 49 years of age, most of them being illiterate, not employed outside home, residing in nuclear families and belonging to middle socio-economic status. Their average age at menarche was 14 years, age at marriage was 19 years, age at first pregnancy was 21 years, age at last pregnancy was 28 years and average age at menopause was 48 years (for those who have attained it).

Most of the respondents from Jammu show moderate to high level of Health Seeking Behaviours whereas respondents from Kathua show moderate to low level of Health Seeking Behaviours. Majority of the urban and tribal respondents show moderate to high level of Health Seeking Behaviours but most of the rural respondents show low to moderate level of Health Seeking Behaviours. Most of the respondents were illiterate; belong to middle socio economic status and living in nuclear families show the moderate level of health seeking behaviour. It was found that health seeking behaviour was peaking around the age of 46-55 years, coinciding with the menopausal transition. Significant association of ethnicity was found with Health Seeking Behaviours such as physical exercise, dental check-ups, cancer screening test, complete health check-ups, hair fall, having medicine without consultation, consultation regarding piles, meals (Breakfast, Lunch and Dinner), eating fruits and nuts, water usage, keeping medical record and watching health awareness programmes on T.V. Respondents of tribal areas scored higher means on most of the items, followed by the respondents of urban areas and least by the respondents of rural areas. Tribal respondents show high health seeking behaviour but observation reveals that these women were living in unhygienic conditions and still following traditional life style pattern and were not seeking health care as they were saying.

Health Seeking Behaviours are significantly positively related with Type of family, Age at Marriage and Age at first pregnancy and negatively significantly correlated with SES and number of children. It was expected that SES would be positively correlated with Health Seeking but on the results reveal the contrary. Dominic *et al* (2013) found a significant association between health seeking behaviour and demographic variables such as age education and family income. Health seeking behaviour is influenced by age, gender, education and income (Olasunbo and Ayo, 2013). Item analysis of present study shows that age of the respondents was positively significantly correlated with dinner timings and use of fresh water; whereas type of family was positively significantly correlated with physical exercise, self-examination for lump or swelling, consulting a doctor for hair fall, drinking 7-8 glasses of water regularly, maintaining medical records and watching health programmes on T.V / radio regularly. The food habits of elderly studied by Olasunbo and Ayo (2013), divulged the fact that 63% eat thrice daily and 35% had a habit of skipping meal. In the present study all the respondents have three meals but their timings varied. 70.7% respondents had their breakfast before 9:00am, 62.8% Lunch before 2:00 pm and 29.7% have their dinner before 8:00 pm. Current societal arrangements tend to make women less powerful than men, and less able to advocate for their own health (WHO, 2003). Women, who take primary responsibility for the care of others in home and community, are the last ones to demand for health care. Gender disparities in the sphere of health are the direct consequences of gender discrimination in other spheres of social well- being. Socio-economic status is a strong determinant of health-seeking behaviour (Khe *et al*. 2002, Ahmed *et al*. 2003), even

among the elderly (Ahmed *et al*. 2005). In the present study majority of the respondents from Jammu and Kathua district belong to middle socio-economic class families whereas most of the respondents from the tribal areas belong to lower middle class status. Socio- economic status was found negatively significantly correlated with Health Seeking Behaviour whereas positively significantly related with Women's Health Questionnaire. Though women's health is related to social class positively yet the actual behaviours bear negative relation to it. Contrary results have been found in the other studies. Zhang *et al* (2009) in their study of health seeking behaviour among Chinese women with genitourinary symptoms found significant relationship among income, education and treatment. Bourne (2009) concluded that it is not higher social class that determines health seeking behaviour but money. Those in upper class may have access to more financial resources, but rural residents have greater social network which avails them of extended economic resources. Uzochukwu, & Onwujekwe, (2004) and Kazembe *et al*. (2007) identified household resources as important determinants of health seeking behaviour. In a study conducted in Bangladesh, household wealth was found to have a positive relationship with the use of health services, where women from poor households had poorer health seeking behaviours. Michael *et al* (2007). Factors that were found to have significant influence on the health seeking behaviour were limited access to money, transport, decision making and nature of women's work (Hausman-Muela and Nyamongo, (2003).Baliga *et al* (2013) say that attribution of ill health to ageing, low economic status and negative attitude of health workers towards elderly are some of the factors associated with delay in seeking health care. They also stress on the need for health care among elderly. Dominic *et at* (2013) say that a proper understanding of health seeking behaviours could reduce delay in diagnosis, improve treatment compliance and health promotion strategies in a variety of contexts. Olasunbo and Ayo (2013) observed a significant relationship of health actions to demographic variables. Their study showed that men demonstrate better health seeking behaviours in regard to diet and empowered to bear cost of health care. They conclude that there are strong gender differences in relation to health.

CONCLUSION

Analysis and interpretation of the data reveals a need to devise intervention strategies to promote health seeking behaviours of the women during the menopausal transition. The results show a general low level of health seeking behaviour among all respondents especially the tribal women. The results also show that most of the respondents were illiterate and not employed outside their home. Hence the strategy would be to reach out to these women as they may have difficulty in understanding through formal approaches and written material will not be beneficial for them.

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