

# Comparison of Health Seeking Behaviour among Antenatal Women Residing in Selected Rural and Urban Area

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## ABSTRACT

**Introduction:** There are many factors (physical factors, accessibility of facilities, socio-cultural factors, economical factors) prevalent in our Indian scenario related to health seeking behavior among antenatal women especially in rural area which hinders the provision of good health care seeking behavior. All the factors together produce a dilemmatic situation which makes them unable to utilize the antenatal services and ultimately affect their health seeking behavior of antenatal women.

**Methodology:** A descriptive (comparative) research design was used to conduct the present study using convenience sampling technique among 100 antenatal women, 50 from rural area, Pohir and 50 from urban area, Shimlapuri, Ludhiana were selected & their health seeking behavior was assessed using structured checklist. Analysis of the data was done by using descriptive and inferential statistics.

**Results:** Results of present study revealed that antenatal women of both rural and urban areas had mean age of  $25.5 \pm 1.65$  years,  $26.62 \pm 0.81$  years respectively. 62% antenatal women of urban area and 48% of rural area had good health seeking behavior. However, this difference was statistically non significant as ( $p > 0.05$ ). Association of health seeking behavior was statistically tested and found to be significant with duration of marriage, type of family, socio-economic status.

**Conclusion:** Thus, the study concluded that urban antenatal women had good health seeking behaviour as compared to antenatal women of rural area which remained statistically non significant ( $p > 0.05$ ).

**Key words:** Health seeking behaviour, Antenatal women.

## INTRODUCTION

Antenatal care begins from early stage of pregnancy. Women can access the antenatal care either by visiting the health center where such services are available or from health workers during their domiciliary visit. Antenatal visit may raise awareness among women and their family regarding the familiarity with the health facilities that enables them to seek help more efficiently during crisis or urgent delivery. <sup>[1]</sup>

The antenatal period is a time of physical and psychological preparation of

birth and parenthood. Becoming a parent is a time of intense learning both for parents and for those close to them. Antenatal care is monitoring a pregnancy for signs of complication detect and treat pre-existing and concurrent problems of pregnancy. It should also include various advices and counseling or preventive services, diet during pregnancy, delivery care, postnatal care and related issues. <sup>[2]</sup>

Furthermore, antenatal care is necessary for ensuring a healthy mother and baby at the end of gestation and it also helps to prepare the woman to understand the

warning signs during pregnancy and childbirth, to know the source for supplementation, treatment of hypertension to prevent eclampsia, immunization against tetanus, and diet during the course of pregnancy.<sup>[3]</sup> This supervision and care is designed to monitor the growth and development of fetus and identify the abnormalities that may interfere with normal process of labour, which is given by door to door visits and at health care centers also.<sup>[4]</sup>

As per the national population policy, 2000 & family welfare programme of government of India, promotion of maternal and child health has been one of the most important components which further lay emphasis on offering information and advice to women about pregnancy related complication and possible curative measures for their early detection and management. Antenatal care can also play a crucial role in preparing a woman and her family for birth by establishing confidence between the woman and her health care provider. It also analyzes the possible factors which ultimately help to contribute to its utilization.<sup>[5]</sup>

The influence of antenatal problems may alter the way a woman responds physiologically as well as psychologically and it limits the amount of participation in health seeking behaviour. Many health-seeking self-care behaviour are expected during the course of a normal pregnancy. When complications arise, women may be required to assume additional responsibilities to promote the health of the fetus and self. At the time of antenatal period, nurses have the opportunity to encourage the pregnant women about adoption of healthy and positive health seeking behaviour regarding antenatal care.<sup>[6]</sup>

Maternal mortality and morbidity continue to be higher despite the existence of national programs for improving maternal and child health in India. This could be related to several factors, an important one being non-utilization or

under-utilization of antenatal care, especially amongst the rural poor women as compared to urban women due to either lack of awareness or access to antenatal care.<sup>[7]</sup>

According to National Family Health Survey (NFHS- III, 2014-2015), only 51% women had 3 antenatal check-ups, 41% had institutional deliveries and 49% deliveries were assisted by health professional while Vaccination coverage was 44%. These figures state that in spite of various health schemes in our country the statistics still remains discouraging due to poor utilization of antenatal services.<sup>[8]</sup>

The Government of India has launched many community oriented programs like Safe Motherhood, Reproductive and Child health, National Rural Health Mission (NRHM), National Urban Health Mission (NUHM), Janani Suraksha Yojana (JSY) for reducing the maternal, neonatal mortality and morbidity rates. This renders quality antenatal care, prevention and treatment of anaemia, institutional/safe delivery services, post natal care, essential obstetric care services operationalizing the PHCs for round the clock services and training the SNs/LHVs/ANMs skilled birth attendants at birth.<sup>[9]</sup>

In view of the difficulty being faced by the pregnant women and parents of sick new-born along with high out of pocket expenses faced by them on delivery and treatment of sick new born, Ministry of health and family welfare has taken a major initiative to evolve a consensus on the part of all states to provide completely free and cashless service to pregnant women including normal deliveries and caesarean operations and sick new born in Government health institutions in both rural and urban areas,

## **MATERIALS AND METHODS**

Descriptive research design was used to assess the health seeking behavior among antenatal women residing in selected rural area of district Ludhiana, Punjab. The sample size was 100 antenatal women.

The sample was drawn using convenience sampling technique, a type of probability sampling technique; keeping in mind the set inclusion and exclusion criteria. Tool consists of two parts: Socio-demographic profile, Maternal profile, clinical profile and Checklist to assess the health seeking behaviour of antenatal women to assess the health seeking behavior among antenatal women. The content validity of research tool was determined by expert's opinion. The reliability of tool was estimated by test retest method. A pilot study was conducted to assess the feasibility of the study, on the sample of 10 participants in the same setting where the study is to be conducted as per the study objectives. The data was collected over a period of one month. The investigator first introduced her to the subjects and explained the purpose of gathering information. After obtaining the informed consent from the subjects about the confidentiality of information, the researcher assessed the health seeking behavior among antenatal women through self report (interview) method. Analysis of data was done in accordance with the objectives of the study. Data obtained was analyzed using descriptive and inferential statistics. Calculations were carried out manually using calculator, Microsoft excel, statistical package for social sciences (SPSS) 20 version.

## RESULTS

Antenatal women of rural and urban area as per socio-demographic variables as per age, duration of marriage, education, occupation, type of family, religion, socio-economic status, dietary habits. As per comparison of age more than half antenatal women 54% of urban area and 48% of rural area were between age group of 19-25 years. Regarding the duration of marriage, majority of antenatal women 72% of rural area and 54% of urban area had 1-5 years duration of marriage. Maximum numbers of antenatal women in rural area i.e. 48% and in urban area 44% had education up to

elementary. Majority of antenatal women 90% of rural area belonged to Sikh religion and 56% of urban area belonged to Hindu religion. Most of antenatal women 80% of rural and urban area belong to joint family. Furthermore, as per working status, maximum number of antenatal women 90% of rural area and 92% of urban area were non-working i.e. housewives. As per comparison of socioeconomic status, more than half of antenatal women 62% are from rural area and 66% from the urban area belongs to upper lower class. Maximum number of antenatal women 70% of rural area and 54% of urban area had vegetarian dietary habits. The groups were compared statistically and found to be homogenous except in case of religion.

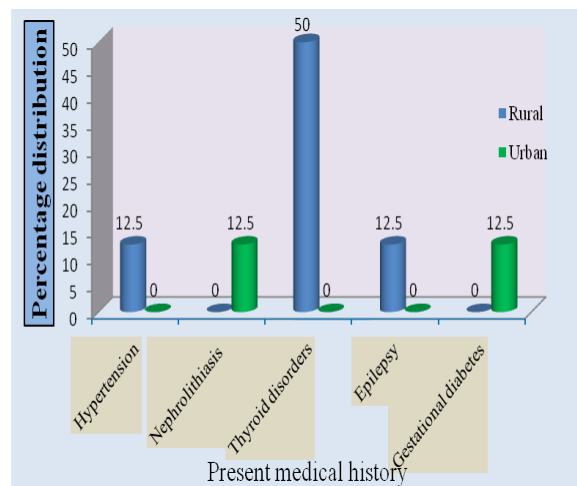


Fig. 1: Present medical illness of antenatal women of rural and urban area.

Fig. 1 depicts present medical illness of antenatal women. It shows that 50% antenatal women had history of present medical illness of thyroid disorders in, followed by 12.5% with hypertension, nephrolithiasis, epilepsy and gestational diabetes in rural area as compared to urban area 12.5% with history of nephrolithiasis, and gestational diabetes and there was no present medical illness of hypertension, thyroid disorder and epilepsy.

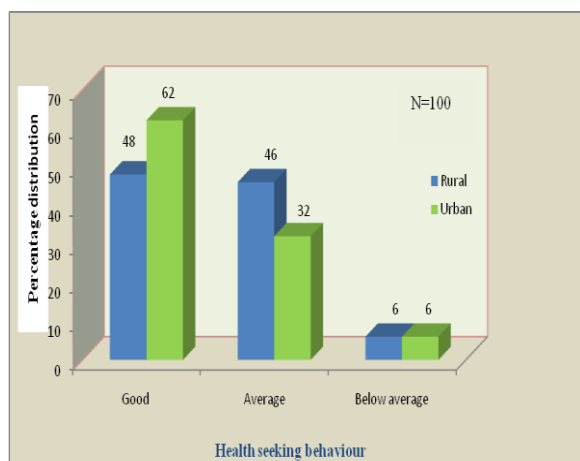


Fig. 2:-Comparison of health seeking behaviour among antenatal women of rural and urban area.

Fig. 2 depicts comparison of health seeking behaviour among antenatal women of rural and urban area. So, it can be concluded that antenatal women of urban area had good health seeking behavior as compared to rural women.

Table 1 represents the mean score of health seeking behaviour among antenatal women of rural and urban area according to components of checklist. It revealed that the first highest score of rural and urban antenatal women were in the component of socio-cultural factors.

Table 1: Mean score of health seeking behaviour among antenatal women of rural and urban area according to components of checklist.

Components	Max score	Rural women (n <sub>1</sub> =50)			Urban women (n <sub>2</sub> =50)			t/p value
		Mean ±SD	Mean %	Rank	Mean± SD	Mean%	Rank	
Physical factors	23	14.38±03.75	62.52	4	15.26±03.89	66.34	4	1.150 p=0.253 <sup>NS</sup>
Medications	06	04.82±01.48	80.33	2	04.58±01.65	76.33	3	0.764 p=0.447 <sup>NS</sup>
Accessibility of facilities	06	02.70±01.81	45	5	03.14±01.73	52.33	5	01.240 p=0.218 <sup>NS</sup>
Socio-cultural factors	03	02.80±00.63	90.3	1	02.74±00.69	91.33	1	0.450 p=0.654 <sup>NS</sup>
Economical factors	02	01.50±00.83	75	3	01.66±00.74	83	2	1.008 p=0.316 <sup>NS</sup>

Minimum score=40 NS: Non significant p>0.05

Maximum score=00 df(t-test)=98

# higher the score better is the health seeking behaviour.

Mean score of antenatal women of rural area=26.20 ± 6.247 (Mean%=65.5)

Mean score of antenatal women of urban area=27.34± 7.032(Mean%=68.35)

Table 2 Association of health seeking behavior among antenatal women of rural and urban area with selected socio-demographic variables. N= 100

Socio-demographic variables	Rural women n <sub>1</sub> =50			Urban women n <sub>2</sub> =50		
	n	Mean + SD	F/t value p value	n	Mean + SD	F/t value p value
<b>Age</b>						
19-25	24	27.92 ± 7.168	0.191 p =.826 <sup>NS</sup>	27	27.67±6.006	2.387 p =.103 <sup>NS</sup>
26-32	19	27.05± 7.168		21	27.90±7.842	
33-39	07	26.14± 7.034		02	17.00± 5.657	
<b>Duration of marriage(in years)</b>						
1-5	36	28.17±7.004	1.049 p=0.359 <sup>NS</sup>	27	29.04± 4.265	6.326 p=0.004*
6-10	13	24.92±7.088		18	27.39±7.014	
11-15	01	29.00±00.00		05	18.00±12.247	
<b>Education status</b>						
Illiterate	03	23.33± 8.505	1.411 p=0.252 <sup>NS</sup>	07	19.57±9.378	3.969 p=0.03*
Elementary	24	29.17± 5.387		22	28.86±4.144	
Secondary & senior secondary	13	24.92± 6.409		14	28.64±6.744	
Graduation	10	27.30±10.078		07	27.71±8.616	
<b>Occupation of women</b>						
Working	05	25.20±5.719	3.844 p=0.130 <sup>NS</sup>	04	26.50±10.247	2.196 p=0.145 <sup>NS</sup>
Non working	45	35.20±2.387		46	27.41±06.840	
<b>Type of family</b>						
Nuclear	10	29.50±5.083	1.184 p=0.282 <sup>NS</sup>	10	22.30±10.781	7.238 p=0.010*
Joint	40	26.80±7.394		40	28.60±05.212	
<b>Socio economic status (Kuppuswamy's scale 2014)</b>						
Upper class I	03	33.00±4.583	3.076 p =0.03*	01	33.00±00.00	0.916 p=0.441 <sup>NS</sup>
Upper middle class II	08	21.50±9.165		03	29.00±6.265	
Lower middle class III	08	29.25±5.970		13	29.38±6.265	
Upper lower class IV	31	27.81±6.161		33	26.21±7.330	

Minimum score=40 df(ANOVA)-29 df(t-test)-28

Maximum score=00

NS-Non significant (p>0.05)

\*=Significant (p<0.05)

The second highest score of antenatal women of rural area in the components of medication while in urban area it was in the component of economical factors. The least score of antenatal women of rural and urban area in the component of accessibility of facilities.

Table 2 depicts the association of health seeking behaviour among antenatal women of rural and urban area with selected socio demographic variables

In rural area all variables were found to be statistically non significant ( $p > 0.05$ ) except socio-economic status ( $p = 3.076$ ). In urban area all variables were found to be statistically non significant ( $p > 0.05$ ) except duration of marriage ( $p = 0.004$ ), educational status ( $p = 0.03$ ) and type of family ( $p = 0.010$ )

## DISCUSSION

The findings of the present study revealed that majority (62%) of the antenatal women of urban area had good health seeking behaviour with mean  $\pm$ SD (27.34  $\pm$  7.032) as compared to the near about half (48%) of antenatal women of rural area had good health seeking behaviour with mean  $\pm$ SD (26.20  $\pm$  6.247).

The findings of present study were supported by Kishk NA (2002) who compared the knowledge and practices towards ANC between rural ( $n_1 = 30$ ) and urban ( $n_2 = 30$ ) women in Alexandria, which revealed that the urban women had better practices during antenatal period, especially regarding utilization of earlier initiation and frequent visits of antenatal care. [10]

There was a significant association between the health seeking behaviour of antenatal women of rural area with socioeconomic status of family ( $p = 0.03$ ). There was a significant association between health seeking behaviour of antenatal women of urban area with duration of marriage ( $p = 0.004$ ), educational status ( $p = 0.03$ ) & type of family ( $p = 0.010$ ).

This is supported by another study conducted by Kumar S, Srivastava DK S, Jaiswal K, Jain PK, Singh CM, Rani (2011) to assess the health seeking behaviour of

antenatal women in Etawah, covering about 14 villages having a population of 15674. The results showed that there was a significant association of health seeking behaviour with educational status ( $p = 0.009$ ). [11]

A similar study was done by Ajonye AA (2013) to investigate the roles of some selected demographic variables (education, domicile and positions/order of pregnancy) on health-seeking behavior among 334 pregnant women using self-developed questionnaire in Benue state, Nigeria and revealed that education and domicile play significant roles in the health-seeking behaviour of pregnant women. [12]

## CONCLUSION

The antenatal women of urban area had good health seeking behaviour than antenatal women of rural area. There was a significant association between the health seeking behaviour of antenatal women of rural area with socioeconomic status of family. ( $p < 0.05$ ) and in urban area with duration of marriage, educational status & type of family. ( $p < 0.05$ ) i.e. these effect the health seeking behaviour of antenatal women of urban area.

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