

## ORIGINAL ARTICLE

# Health seeking behaviour among the farm house residents in Vijayapura district, Karnataka. A Cross sectional study

Sandeep Yankanchi, Rekha Udigiri

Department of Community Medicine, BLDE (DU) Shri.B.M.Patil Medical College, Vijayapura, Karnataka.

### CORRESPONDING AUTHOR

Dr. Sandeep Yankanchi, Assistant Professor, Dept of Community Medicine, BLDE (Deemed to be University) Shri B.M.Patil Medical College, Solapur Road, Vijayapura 586103, Karnataka - India  
Email: [sandeep.yankanchi@bldedu.ac.in](mailto:sandeep.yankanchi@bldedu.ac.in)

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### ARTICLE CYCLE

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### ABSTRACT

**Background:** Health seeking behaviour as defined by Kasl and Cobb is any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. More often than not, a country has a mixture of both public and private health care systems to ensure an equitable distribution of quality health care. **Objectives:** To identify the health seeking behavior and distance travelled to access the health care among the farm house residents. **Material & Methods:** A cross sectional study was conducted among the farm house residents in rural areas of Vijayapura district. A Sample of 450 farm house residents were interviewed by prestructured proforma containing information regarding socio demographic profile, health seeking behaviour and distance travelled to access the health care among the farm house residents. PSUs were selected with probability proportional to size sampling and 5 households in a selected PSU were selected by random sampling. All characteristics were summarized descriptively, Chi-square ( $\chi^2$ ) test was employed to determine the significance of differences. **Results:** Majority of the participants took treatment from government hospital followed by private practitioner when they are sick and majority of participants travelled between 1-5KM. (61.3%) and for the past illness it was (33.2%). **Conclusion:** The present study concludes that availability of government health facility constitute about (93.8%) compared to private (6.2%).

### KEYWORDS

Health Seeking Behaviour, Distance Travelled, Farm House, Agriculture

### INTRODUCTION

Health seeking behaviour as defined by Kasl and Cobb is any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. More often than not, a country has a mixture of both public and private health care systems to ensure an

equitable distribution of quality health care. Governments are using taxes, social security and donations to finance the public health care system. Public insurance schemes consist of the social security model, the publicly funded health care model and the social health insurance models.(1)

Under the Karnataka Land Revenue Law 2015: "Farm Buildings" or "Farm house" means a house attached to a farm and constructed in a portion of an agricultural land, used for the residence of the agriculturist or used for the purpose of keeping agricultural equipment's and tethering cattle. The home shall be used by the farmer for his own use and shall not be made available to any person or agency for commercial purposes. "Amendment of section 95.- Inside section 95 of the principal Act, - (a) after sub-section (1) State Farm building or farm house so erected shall not be more than ten percent of his holding subject to a maximum of such extent of land as may be prescribed. (2)

Farm workers are so scattered in rural areas that health care cannot reach them. Data on health seeking behaviour among farm owners is very sparse. Community studies can only reflect the true portrait of health care service in a particular community. Hence the present study was undertaken to explore the health-seeking behaviour among the farm house residents of Vijayapura district. To identify the health seeking behaviour and distance travelled to access the health care among the farm house residents.

## MATERIAL & METHODS

It was a cross-sectional descriptive study carried out among residents of the Vijayapura District Farm House. The study was done over a period of one year.

Following the approval of the Institutional Ethics Committee, the study was conducted in the Vijayapura District. Geographically, the district of Vijayapura was divided into five talukas: Vijayapura, Indi, Sindgi, Basavana Bagevadi and Muddebihal. Within each Taluka, household selection was carried out at different stages by considering villages as a primary sampling unit (PSU). (3) The villages, where the number of households was less than 5, were not included in the choice of samples and were removed from the list. The distribution of the total population of the sample of 384 (400) among agricultural households is carried out as a proportion of their population. Households have been selected in two stages. PSUs were selected

with probability proportional to size (PPS) sampling and 5 households in a selected PSU were selected by random sampling. The List of Households Staying in Farm was taken from the Govt Primary Health Centre and chits containing the head of the family were made. Total 5 chits from each village were selected randomly and included in the study. Four participants in each household were randomly questioned by using pre structured questionnaires about the health seeking behaviour and distance travelled to access the health care among the farm house residents.

If a selected household did not consist of four participants, was excluded and the new household was randomly selected. The Household members were reached with the help of ASHA / Health worker of PHC which helped to develop rapport with people staying in the household. The purpose and overview of the study was explained at the time of the interview and interviewers were informed that their participation was entirely voluntary, their anonymity would be assured and consent was taken. The sample size was determined using the formula.  $n = z^2pq/d^2$ . Due to a lack of information on morbidity among farm residents in the study area, the calculation was based on the assumption of prevalence of 50%. Assuming a 95% confidence level and 5% accuracy, the overall sample size was 384 farm residents. A sample of 384 (400) was sampled in this study, but the sample size was 450. The survey was conducted in the Vijayapura district, located in the northern part of Karnataka. Farming and agriculture related business is the main occupation for many people in the district. Persons living on farms for less than six months were excluded from the survey.

### Distribution of sample

Mean number of person per household (HH) = 4 (on the basis of pilot observation in a nearby village)

Hence, Total number of HH in farm houses =  $400/4 = 100$

Mean number of HH in farmhouses per village = 4.7 (~ 5) (on the basis of pilot observation in a nearby village)

Total number of PSU (Villages) =  $100/4.7 = 21$

All characteristics were summarized in a descriptive way. The data were analysed with SPSS v.23.0 software for frequency distribution and presented in tabular and figures.

**RESULTS**

A total of 450 were the study participants , Among the study participants , 50.9% were males and 49.1% were females , majority of male participants belonged to age group of 41-50 (21.4%) years and female participants belonged to age group of 11-20 (21.7%) years. The major proportion of males (97.8%) and female participants (96.8%) belonged to Hindu

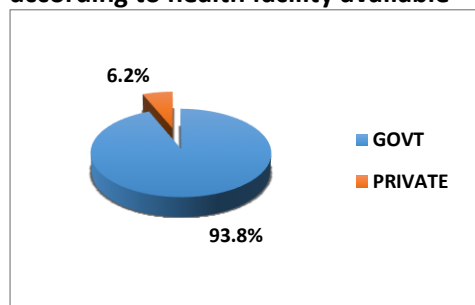
religion. 58.1% of male and 62.9% female participants belonged to nuclear family followed by 29.7% male and 25.8% female participants belonged to joint family. The majority of male (49.8%) and female (48.9%) participants were illiterates. More than 50% of the participants belonged to class V Socioeconomic status according to modified B.G.Prasad socio economic classification. [Table-1]

It is good to know from the present study that, Availability of government health facility constitute about (93.8%) compared to private (6.2%). [Figure-1]

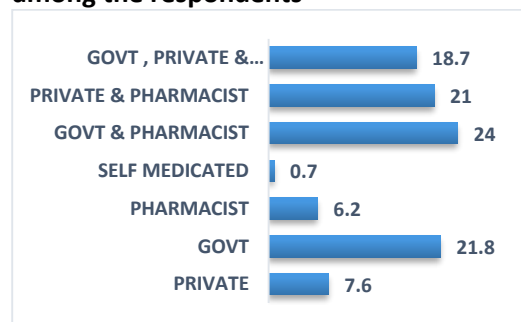
**Table 1: Distribution of respondents according to socio-demographic variables**

PARAMETERS		Male		Female		Total	
		N	%	N	%	N	%
<b>AGE</b>	≤10	19	8.3	31	14.0	50	11.1
	11-20	36	15.7	48	21.7	84	18.7
	21-30	41	17.9	31	14.0	72	16.0
	31-40	40	17.5	46	20.8	86	19.1
	41-50	49	21.4	39	17.6	88	19.6
	51-60	23	10.0	19	8.6	42	9.3
	61-70	9	3.9	7	3.2	16	3.6
	>70	12	5.2	0	0.0	12	2.7
<b>Religion</b>	Hindus	224	97.8	214	96.8	438	97.3
	Muslims	5	2.2	7	3.2	12	2.7
<b>Type of family</b>	Nuclear	133	58.1	139	62.9	272	60.4
	Joint	68	29.7	57	25.8	125	27.8
	Three Generation	28	12.2	25	11.3	53	11.8
<b>Educational Status</b>	Illiterate	114	49.8	108	48.9	222	49.3
	Primary	81	35.4	80	36.2	161	35.8
	Secondary	31	13.5	30	13.6	61	13.6
	PUC And Above	3	1.3	3	1.4	6	1.3
<b>Occupation</b>	Student	43	18.8	69	31.2	112	24.9
	Labour	10	4.4	9	4.1	19	4.2
	Household Activities	6	2.6	18	8.1	24	5.3
	Farmer	170	74.2	125	56.6	295	65.6
<b>SES</b>	Class IV	111	48.5	101	45.7	212	47.1
	Class V	118	51.5	120	54.3	238	52.9
<b>Total</b>		229	100.0	221	100.0	450	100.0

**Figure 1: Distributions of participants according to health facility available**

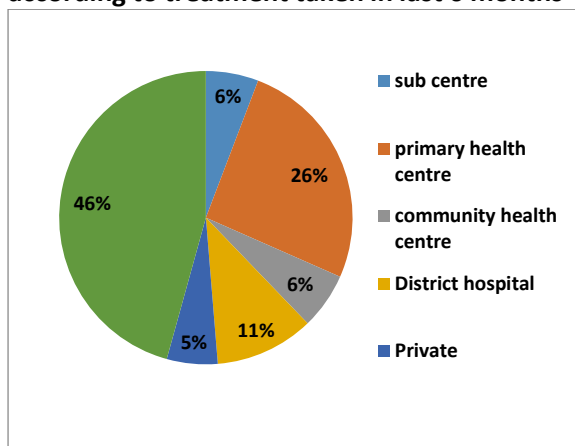


**Figure 2: Treatment seeking behaviour among the respondents**



In our study, according to the figure 2 (multiple options provided while asking questions), most commonly the respondents seek treatment for any health problems from government settings (PHC/SC/CHC) followed by pharmacist directly. Also, they seek treatment from private practitioners available locally (nearby places) and very few go for self-medication for treatment of health problems. [Figure-2] We observed that, According to the Figure 3, most commonly participants had taken the treatment for their health problems in last six

**Figure 3: Distribution of participants according to treatment taken in last 6 months**



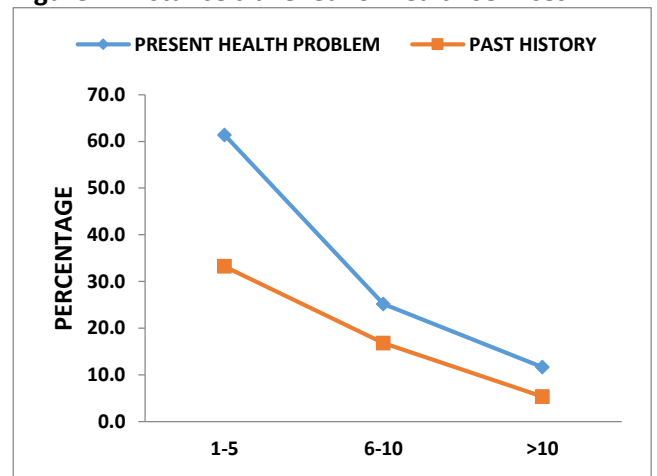
**DISCUSSION**

Health-seeking behaviour in terms of illness behaviour refers to those activities undertaken by individuals in response to symptom experience. This behaviour among different populations, particularly in the rural communities, is a complex outcome of many factors operating at individual, family, and community levels. (4)

In the present Study majority of respondents for both present and past health illness took treatment from government facility followed by private practitioner. Also, they seek treatment from private practitioners available locally (near by places) and very few go for self-medication for treatment of health problems. Most commonly participants had taken the treatment for their health problems in last six months from primary health centre (26%) followed by district hospital (11%). Other places preferred for taking treatment in last six months were sub-centres (6%), CHC (6%) and local private practitioners (5%)

months from primary health centre (26%) followed by district hospital (11%). Other places preferred for taking treatment in last six months were sub-centres (6%), CHC (6%) and local private practitioners (5%). [Figure-3] In our study, Majority of participants travelled between 1-5km (nearest health facility) for their present health related problems (61.3%) and for the past illness it was (33.2%). Very few (11.7%, 5.3%) travelled more >10kms for their both present and past health related problems. [Figure-4]

**Figure 4: Distance travelled for health services**



Similar findings were observed in a study by Kulkarni R et al., found that out of 400 agricultural workers, home remedies were sought by 67% and 33% visited a health care provider for the treatment. Overall, government doctors were opted by 48.75%, 28% opted private doctor, 12.25% anganwadi worker, 10% auxiliary nurse midwives, and 1% opted for pharmacist as the first priority health care provider for their illnesses. Among those cases where illness was not cured or the treatment given by the first health care provider was not satisfactory, 18.25% opted government doctor and 35.75% preferred private or Ayush practitioners.(4)

A study conducted by Chauhan RC et al., Among 559 study participants, majority (56.4%) visited public health care facilities for various illnesses. Almost one-third of the study participants visited the private health facilities and another 11.6 percent visited other health facilities including pharmacies.( 5) Ager et al., found that Majority of Agriculture workers had

treatment from governmental hospital (48%) and ANM (20%).(6)

Ahmed SM, et al, in rural areas of Bangladesh observed that among the household survey of 966 families, 1136 elderly (>60%) people reported illness in the past 15 days. Most of them treated themselves, while others went to drugstores (17%), allopathic practitioners (21%) and quacks (25%).(7) A study done by Bigogo G et al., in rural western Kenya found that 18–38% of participants visited health facilities. (8)

A study done by Gandhi S, et al, Gudalur block of Nilgiris district (Tamil Nadu) in observed that 46.9% of Bettukurumbas and 40.2% of the Paniya prefer hospitals run by NGO"s for hospitalization, whereas 40.5% of kattunayakans, sought care from traditional healers. (9)

Hoeven MVD et al., reported 75.6% of rural participants were of the opinion that, they had sufficient access to health care. Urban participants were more than 5 times more likely to prefer a medical doctor in private practice.(10)

Free availability of treatment may be the reason for utilizing Government health facility. The present study revealed that majority of participants travelled 1-5km (nearest health facility) for their present (61.3%) and past health related problems (33.2%). Similar findings were found in a study conducted by Noor AM et al., reported that the analysis of straight-line distances between communities and government health facilities revealed differences between districts with 99% of the population in Greater Kisii, 80% in Bondo, 65% in both Kwale and Makueni within 5 km of the nearest government health facility. The mean distance of access to health facilities was 2.4 km in Greater Kisii, 3.4 km in Bondo, 4.7 km in Kwale and 4.5 km in Makueni. (11 )Muller I et al., reported that the distance travelled for availing health services was less than 3.5km for health related problems . (12)

Availability of health centres (nearest health facility) within the 1- 5km range was the reason for travelling of most of the participants.

## CONCLUSION

The present study concludes that availability of government health facility constitute about (93.8%) compared to private (6.2%). Majority of participants travelled between 1-5km (nearest health facility) for their present health related problems (61.3%) and for the past illness it was (33.2%).

## RECOMMENDATION

Strengthening of the present public health infrastructure by providing resource like money, manpower, materials and provision of screening and diagnostic laboratory facilities at the sub center to reach the unreached population.

## LIMITATION OF THE STUDY

The study was conducted in the remote part of one of the district situated in Karnataka. Hence cannot be generalized to the entire community of farm house residents of remaining state of country.

## AUTHORS CONTRIBUTION

All Authors have Contributed equally

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Nil

## CONFLICT OF INTEREST

There are no conflict of interest

## DECLARATION OF GENERATIVE AI AND AI ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

The authors haven't used any generative AI/ AI Assisted technologies in the writing process.

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