

GENDER DIFFERENCES IN HEALTH CARE SEEKING BEHAVIOUR OF TUBERCULOSIS PATIENTS IN CHANDIGARH

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(Received on 17.10.2012; Accepted after revision on 11.6.2013)

Summary

Background: Gender is a social determinant of health. In view of the substantial burden of tuberculosis (TB), it is important to look into the gender issues related to utilization of services.

Aims: To find out gender differences in health care seeking behaviour of tuberculosis patients.

Methods: A cross sectional study, using integrated mixed method, was conducted in Chandigarh (India). Systematic random sample was used to interview 109 TB patients (54 men and 55 women) from eight randomly selected health institutions.

Results: More women (40%) resorted to home remedies or medicines without prescription at the onset of symptoms compared to men (13%). More men (87%) consulted qualified medical practitioners compared to the women (60%). Consultations from private doctors were more common among men. Mean delay in diagnosis was more in men (60 days) than women (33 days). Main reasons for delay, in men and women respectively, were late referral by doctor (37% vs 26%), long distance to health institution (29% vs 28%), prolonged use of self-medication (30% vs 26%), and financial constraints (7% vs 17%). More women (20.8%) reported missing a prescribed dose of treatment as compared to men (11.1%). However, 10% men were on re-treatment compared to none of the women.

Conclusions: Delay in diagnosis was more in men than women. More delay occurred due to delayed referral by doctors among men and due to financial constraints among women. Hence, gender differences in health care seeking behaviour should be kept in mind while selecting programme strategies. [Indian J Tuberc 2013; 60: 217-222]

Key words: Adherence, Delay, Gender, Health Seeking Behaviour, Health Service Utilization, Tuberculosis

INTRODUCTION

Tuberculosis (TB) accounts for about 2.5% of global burden of disease¹ and 26% of preventable deaths². Each year, 8.74 million people develop tuberculosis and nearly two million die of TB. India accounts for one-third of the global TB burden with 1.8 million developing the disease each year and nearly 0.4 million dying of TB annually³.

Global estimates indicate that women account for about 3.6 million cases of TB. The situation is more complicated in countries like India where TB kills more women than any other infectious disease and more than all causes of maternal mortality combined. Moreover, about 100,000 women are rejected by their families each year

because of TB, strongly impacting their children and families⁴. In India alone, 30,000 children leave school annually, on account of their parents' TB⁵.

In view of the substantial burden of TB and specific health needs of women, it is important to look into the gender issues related to the utilization of health services under the Revised National Tuberculosis Control Programme (RNTCP). This study was conducted to find out gender difference in health care seeking behaviour of TB patients.

MATERIAL AND METHODS

The cross sectional study was conducted in Chandigarh Union Territory among TB patients selected from the clinics. In 2009, Chandigarh had

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two TB Units and 48 Peripheral Health Institutions (PHIs) where 2264 TB patients were registered (1366 men and 898 women).

Sample size was calculated taking into account estimated adherence to treatment of 80% among TB patients with a 10% absolute precision and design effect of 1.8. Multistage stratified systematic random sampling method was used for selection of 120 study participants (60 men and 60 women). Out of 48 PHIs, eight institutions were selected randomly. From the selected PHI, every 4th or 5th client was selected for interview, as during the duration of one interview three to four clients would consult the doctor and leave the clinic. Out of the 25-30 clients visiting the clinic on a single day, 8-10 clients were interviewed. Thus data were collected from 54 men and 55 women. Six men and five women did not consent for the interview. All ethical principals were followed.

Integrated mixed method approach was adopted to collect qualitative and quantitative data using a pre-tested interview schedule. The first part of interview schedule was open-ended for narratives and second part had semi-structured questions designed to seek information on demographic profile and socio-economic factors, patterns of health care seeking behaviour, access to health care services and treatment adherence.

Quantitative data (socio-demographic, delay in diagnosis, and adherence to treatment) was analyzed using SPSS 16 for Windows (SPSS Inc. Chicago, IL). The qualitative data were analysed to trace behaviour pattern from the onset of symptoms till approaching the clinic and reasons for delay in seeking care, if any. Statistical test of significance (chi square for categorical data and t test for quantitative data) were used to find differences in health care utilization among men and women.

RESULTS

The mean age of respondents was 32 years. Men were younger than women. More than 80% of respondents were married. More men than women were living in urban area. Most of the men and

women were working in the unorganised sector as street vendors, construction workers and household helpers/ maids (Table).

At the onset of symptoms, more women (40%) than men (13%) resorted to home remedies or medicines without prescription. More men (87%) directly consulted qualified medical practitioner as compared to women (60%) (Figure). The proportion of consultation with private doctors was higher among men than women. Multiple consultations before starting the DOTS were higher among men than women (on an average 1.4 and 1.1 respectively). There was a mean delay of 48 days from the onset of symptoms to diagnosis through sputum test. However, once sputum test was found positive, the DOTS treatment was started immediately. The mean delay was 60 days in men and 33 days in women. Though men are considered to be independent, resourceful and mobile, but had more delay in diagnosis than women.

Table: Demographic and Socio-Economic Profile of Respondents

Characteristics	Males N=54		Females N=55	
	No.	%	No.	%
Age (in Years)				
15-30	28	51.9	33	60.0
30-45	16	29.6	19	34.6
45-60	10	18.5	3	5.4
Area of Residence				
Urban	30	55.6	22	40.0
Rural	14	25.9	21	38.2
Slums	10	18.5	12	21.8
Marital Status				
Married	46	85.2	50	90.9
Unmarried	8	14.8	5	9.1
Literacy				
Illiterate	13	24.1	12	21.8
Up to level 10	36	66.7	39	70.9
Graduate and above	5	9.2	4	7.3

When asked to specify the main reasons for delay in the diagnosis of TB, 37% men and 26% women responded that the doctor from whom they were taking treatment did not refer them timely, 29% men and 28% women mentioned the long distance from home to health institution as the reason; 30% men and 26% women waited for relief in symptoms by the use of home remedies/over the counter medications, and 7% men and 17% women reported financial constraints.

Narratives provided insight into the reasons for delay in seeking care. Among women, main reason for the delay was the ‘customary practice’ of using home remedies or medication without prescription. A 25-year-old woman elaborated “I got fever; for two months I took home remedies and medicines from chemist shop but there was no improvement, so I went to a government hospital where after testing they told me that I have TB and sent me to a TB clinic near my place of residence”. Another 18-year-old woman mentioned “I had fever for about two months with cough, took medicines from chemist shop, but didn’t get relief, so came to dispensary to take medicines, they sent me to government hospital, where my sputum was tested

and X-ray was done and I was told that I am having TB”.

It is not only customary that women take home remedies or indulge in taking medicines without prescription but there are underlying social norms that push them to do so. As expressed by 30-year-old woman, “I started having fever about one year ago; I took medicines without consulting the doctor as my parents-in-law did not take me to a doctor. I came to my parents’ house who took me to the hospital. I was admitted for 15 days, was tested and learnt that I had TB”. Another 19-year-old female said “I lost appetite and had vomiting with fever, went to private doctor, didn’t get relief then I went to government hospital, then my father took me to a bigger hospital, they tested my sputum, blood and did X Ray etc. and told me that I have TB”. It shows that access to resources as well as the right to take decision for seeking treatment even in case of a married adult woman, is bound by social structure. Statements like “Parents-in-law never took me to doctor” or “father took me for treatment” by women respondents are indicative of ‘restricted mobility’ of women.

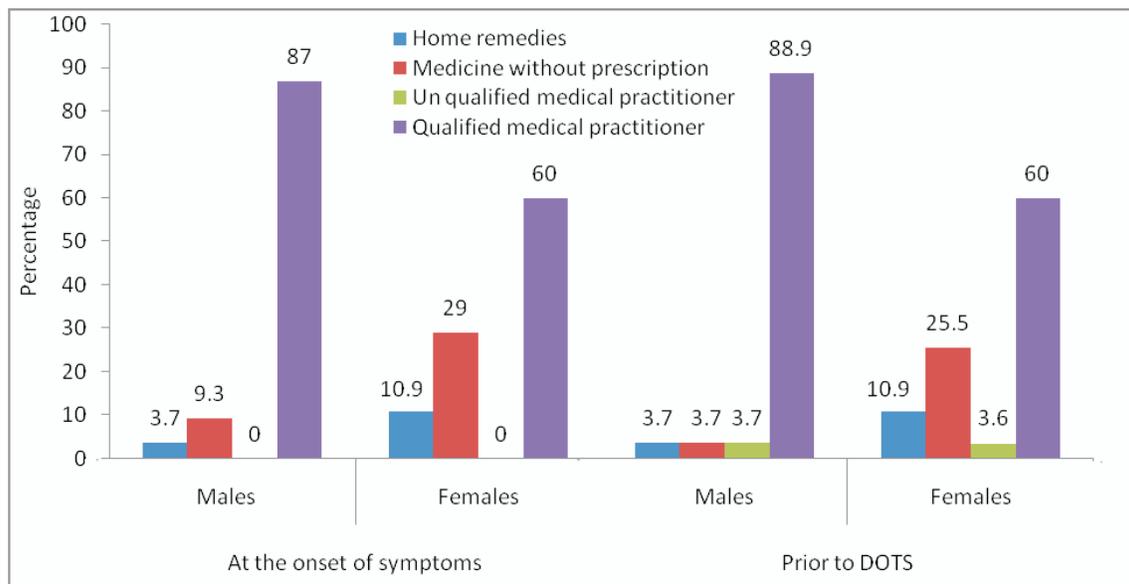


Figure: Source of Health Care in TB Patients

On the other hand, most of the men often did not share their health problems at home till the symptoms worsened leading to delay in diagnosis. A 33-year-old male respondent stated *“I was a habitual alcohol drinker, I got fever, cold and cough for which I took medicines from the chemist store but did not bother to tell this to my family; there was no improvement so I went to a government hospital and got sputum tested, where I was found to be positive for TB”*. Another 25-year-old man mentioned *“I got fever so took medicines from a pharmacist for about one and a half month but cough persisted and deteriorated..... my family came to know about my problem when blood started coming on coughing, they panicked and I went to a government hospital where I was diagnosed for TB.... referred to TB centre”*.

As far as treatment is concerned, more women (20.8%) reported missing a prescribed dose of treatment as compared to the men (11.1%). Among women, 87.3% reported that they would stop treatment at the advice of doctor; 9.1% could not say when they would stop treatment; and 3.6% would stop when the symptoms would disappear. In contrast, all men stated that they would stop treatment only at the advice of the doctor.

While all women were on anti-tuberculosis treatment for the first time, 9.5% men were on treatment for the second time as they had left the treatment for reasons like migration. A man in his late 20s narrated *“10 years ago when I was in my home town I had blood in sputum with cough and was on TB treatment for three months after which I left the treatment as family migrated to different town..... six months ago I started having cough with blood again so got sputum test done from a government hospital, referred to TB centre, near my residence”*.

DISCUSSION

Gender encompasses characteristics of men and women that are distinct from those that are biologically determined⁶. Present study revealed gender differentials in care seeking behaviour and reasons thereof using integrative mixed method

design⁷ while other studies had studied gender differentials using quantitative method only^{4,8}. The treatment seeking behaviour was different among men and women, although their demographic and socio-economic profile was similar.

More women than men had started with home remedies at the onset of symptoms. On the other hand, most men started the treatment from the qualified private service providers that has implications on timely diagnosis. Similar results have been found in another study as well⁹. Women autonomy has always been an issue of concern which has been reflected in other studies too^{4,8}. Women in our study were dependent on the family members for seeking care. More women than men had cited financial constraints. Women had no alternative but to resort to home remedies or medicines from a nearby shop without prescription. Under-reporting of TB in women has been attributed to barriers women face in accessing TB care by some¹⁰⁻¹², whereas others ascribe it to the natural epidemiology of the disease^{13,14}.

It was recognised that DOTS is a better health intervention over self-administered regimen as it led to better monitoring and follow-up of cases^{15,21}. However, despite the existence of DOTS centres within 1-3 kilometres in Chandigarh, distance was reported as one of the reasons for delay in seeking treatments in both men and women. It reflects that *emic* and *etic* perceptions for the ‘distance’ need to be considered while planning and implementing programmes¹⁶. Of course, the services should be acceptable and affordable¹⁵ but at the same time it is essential to determine the ‘extent’ to which observed gender differences in TB rates arise from distinctive ‘obstacles’ faced by men and women³. Poverty, one of the socio-economic factors being a major reason for not seeking proper treatment both by men and women is not a new finding¹⁷, however, decision to go for treatment outside home had been a limiting factor for women compared to men, similar trends have been seen in other studies as well^{15,18,19}. Domestic social responsibilities have been reported to hinder women’s access to the limited resources²⁰. However, present study found that ‘limited power to take decisions’ and ‘restricted mobility’ are the major reasons for not accessing care among women.

More delay in diagnosis occurred among men than in women in the present study. The reasons for delay also differed in men and women. Men often did not share their illness with the family until symptoms worsened when family members persuaded them to seek care from a government health facility. More men than women had approached private doctors at the onset of symptoms. Delay in referral by the doctor was cited by more men than women as one of the main reasons for delay. It is interesting to note that more men had contacted a doctor at the onset of symptoms than women and delay in diagnosis was also more among them. It seems that private doctors continue the treatment and do not get the sputum test done until symptoms worsen.

Another study using mixed method approach reported differential delay in seeking treatment, however, it reported more delay in women than in men but the reason for delay was reported to be only lack of awareness.²³ The delay in diagnosis and treatment among tuberculosis patients and reasons thereof have been reported in a multi-country study also where the mean delay between the onset of symptoms until treatment ranged from 1.5 to four months in different countries. Socio-demographic, economic, stigma, and time to reach the health facility, seeking care at non specialized individuals, and multiple consultations before diagnosis had been the main factors for delay²². Stigma, attached to TB, as shown by other studies¹⁹ seems to have taken a back seat as nobody reported about stigma in our study.

Women under treatment tended to miss prescribed dose of treatment more often than men. But on the other hand, some men abandon the treatment. More men were on re-treatment regimen than women in this study. A multi-centric study showed that more women dropped out during the course of diagnosis, while men diagnosed with TB did not adhere to the treatment⁹.

CONCLUSIONS

The delay in diagnosis occurred more often among men than in women. Most women

continue to be on home remedies because of their 'restricted mobility' and 'lack of decision making power' while more men continue to avail services from private doctors without 'sharing their illness to the family' until symptoms worsen. More women miss doses of treatment than men while some men abandon the treatment altogether leading to more re-treatments in them compared to women. Hence, gender differences in health care seeking behaviour should be kept in mind while selecting strategies for reducing delay in diagnosis and improving adherence to treatment.

ACKNOWLEDGEMENTS

We acknowledge the contribution of Dr Supreet Kaur, for her contribution in preparation of interview schedule and in initiation of data collection and Dr. P. K. Shridhar, State TB Officer, for his enormous support in conducting this study.

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