

Healthcare Utilization among Urban and Rural Households in Esera District: Comparative Cross-sectional Study

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Abstract BACKGROUND: Health care seeking behaviour of households is influenced by individuals' characteristics, type of diseases and access of health services. This study conducted to assess the health care seeking behavior and associated factors of urban and rural households for perceived morbidity in Southwest Ethiopia. **METHODS:** A comparative community based cross-sectional study was conducted among urban and rural households living in the Esera district, southwest Ethiopia. 377 head of households (119 urban and 258 rural dwellers), selected via simple random sampling technique after census, were the respondents. Healthcare seeking behavior on perceived illnesses of households of the district was assessed using a pretested structured questionnaire. Descriptive statistics, and binary and multiple logistic regression analysis were applied to compare and identify independent predictors of health care seeking behavior. **RESULTS:** A total of 377 (119 urban and 258 rural) households were included in the analysis making a response rate of 95.7%. Health care seeking behavior was higher among urban households (80.7%) than rural households (48.1%). Being married and perceived severity of disease were significantly associated with health care seeking behavior of urban households. Health seeking behavior of rural households was statistically different with monthly income, perceived severity of disease, acute duration of disease and distance from health facilities. **CONCLUSIONS:** The overall health seeking behaviors of households for perceived illness was satisfactory, but urban households seek health care more than rural. Health seeking behavior of urban households differed in matrimonial status and severity of disease perception, whereas, of rural households differed in household monthly income, severity of disease perception, duration of disease and distance from health center. This cues to work on accessibility and promotion of health care on the majority of the population of the country.

Keywords: health care seeking, household, urban, rural, comparative, cross-sectional, Esera woreda, 'Ethiopia'

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1. Introduction

The issue of healthcare-seeking behaviour (HSB) is fundamental to all society, and consumption of health services is a multiple behavioral phenomenon [1]. Representative studies of preventive and curative service have often establish that the use of health services is related to availability, quality and price of services as well as to social group, health views, residences and personal features of the users [2,3,4,5,6,7]. Besides peoples' choice of health care differs in sociodemographic, socio-economic and cultural compositions which have an effect on their health care seeking behavior [8]. Urbans are generally believed to be open to new ideas and willing to try certain things on a trial and error basis [4]. To the contrary, rural are seen as prone to tradition, unchanging and unwelcoming to change, and willing to hang onto traditional values and practices [5,6,7,9,10,11,12,13].

Results from different continents of Europe, Asia and sub Saharan Africa showed that percentage of healthcare seeking behaviour for perceived morbidity in rural setup are still low. For example, in countries like Mongolia and Republic Congo it was reported as 44.1% and 54.6% respectively [5,8]. The main reasons include affordability, transportation, patient provider relationship and various medical examinations [4,5,6,7,9,10,12,15,16,17].

In Ethiopia, the prevalence of rural health seeking behavior was reported as 38.7% [10]. Cultural customs, residence, distance to functioning health centers and financial barriers were the major barriers for not seeking health services in health facilities [18]. In addition, health service delivery was inefficient and unfair, and quality of healthcare was usually poor between urban and rural [19]. The poor health seeking behavior and its major impediments has a direct consequence on the morbidity, mortality and quality of life of the people of the country [20]. Thus, this study assessed the magnitude of health care seeking behaviors and associated factors of health

care seeking behaviors among households for perceived morbidity living in urban and rural areas.

2. Methods

2.1. Study Design and Area

A community based comparative cross-sectional study was conducted in Esera woreda from February to March, 2015. Household heads who had perceived illnesses two months prior the data collection period were included. For the purpose of this study, census was conducted in the selected kebele (suburb) to estimate the approximate number of eligible households.

2.2. Study Population and Sampling

The sample size was calculated using a two population proportion formula; considering 52.3% proportion of urban households and 29.6% percentage of rural households seeking health care for perceived illnesses [21], a 5% significance level, power of 85%, 1:2 urban to rural ratio, design effect of 2 and 10% estimated non-response rate. From the 29 kebeles (4 urban and 25 rural) in the woreda, 10 (2 urban and 8 rural) kebeles were selected to get representative sample by simple random sampling (lottery method) from two strata. For each kebele sampling frame was developed by taking households with perceived illness for 2 months prior to this study. Census was done with HEW and data collectors during CHD on randomly selected kebeles. Then based on the population, sample size was allocated for each selected kebele proportionally. Ethical clearance was obtained from Research and Graduate Studies College of Health Sciences Ethical Review Board of Jimma University. Permission letter from all offices and consent from each study participants were also gotten. Finally household heads with perceived illness for 2 months prior to this study within the selected kebeles were selected randomly from the frame work and interviewed at their home.

2.3. Data collection Questionnaire

Healthcare seeking behavior was a dichotomized (seek or not seek) response variable in which households response for perceived illnesses after they recognized their illness and visiting health institutions. Data were collected via interviewing using a pre-tested and structured questionnaire. The questionnaire consists of socio-demographic and economic characteristics, type of diseases for healthcare visit, barriers and practice of health seeking behavior in urban and rural.

2.4. Data Analysis

Data were entered into EpiData version 3.1 and exported into SPSS version 21 software for analysis. Descriptive statistics like mean, frequency and proportions were explored. Binary and multiple logistic regression analysis were applied to identify independent predictors of health care seeking behavior. Independent variables having p-value <0.25 in the bivariate logistic regression analysis were entered into multivariable logistic regression analysis in order to control confounding effect. P-value of <5% was considered significant in the final model. Model

diagnostics and goodness of fit test were done and was found fit. Multicollinearity was checked to test correlation among predictor variables and none was collinear.

3. Results

A total of 377 households (119 urban and 258 rural) giving a response rate of 95.7% were interviewed. Among the study participants only 40(33.6%) urban and 13(5.1%) rural households were attended college education. The mean age (SD) of the urban and rural households was 37.5(±12.9) and 36.1(±12.4) years, respectively. Eighteen (18.4%) urban and 170(65.8%) rural households had a monthly income below poverty line (Table 1).

3.1. Health Care Seeking Behaviors

The overall health care seeking behavior of households for perceived illness was 220(58.4%) at the study area. About eighty one percent urban households and 48.1% rural households were seeking health care for perceived illness. Public health center was the most common place where households sought health care in which 45.3% of urban and 50.5% of rural dwellers sought care from. Hospital (25.6%) and private clinic (20.9 %) for urban, and health post (20.6%) and private clinic (12.1%) for rural households were other health care centers following health center.

3.2. Individual Related Factors and Reason for not Healthcare Sought among Households

In this study 157(41.6%) of households did not seek health care from anywhere in the whole at the study area. About 23(19.3%) urban and 134(51.9%) of rural did not seek care. The main reasons reported for not seeking health care were lack of money 46(29.3%), long distance 42(26.9%) and symptoms were not severe 41(26.4%).

Time of health seeking after onset of the illness were immediately as illness started 163(74%) and 57(26%) of households sought health care when it became worse (Table 2).

3.3. Practice of Health Seeking Behaviour

Self-treatment was widely practiced by 42(35.3%) urban and 119(46.12%) rural households for different reasons. The most prominent reasons were cost (31%) in urban and 47.5 % in rural), perceived knowing treatment (23.8% in urban and 20%) and long distance from health facilities for rural households. The sources of drugs for self-treatment in urban were buying from drug stores (73.8%) followed by sharing from kin or friends (16.7%). In rural, majority (40.8%) of them bought from local shops followed by drug stores (38.4%). Of the self-treatment done, 40.5% of urban and 58.8% of rural households reported as the treatment was unsuccessful. Factors associated with health care seeking behaviors between urban and rural Households.

This study had a model to assess healthcare seeking behavior on similar explanatory variables for urban and rural households at the study area. Marital status and perceived severity were independently associated factors with health seeking behavior in urban households. While

in rural households, monthly income, disease condition, distance from health center and perceived severity were the independent predictors of health seeking behavior.

Table 1. Socioeconomic and demographic factors versus healthcare seeking behaviour among urban and rural households, in Esera Woreda, Dawuro zone, April 2015

Characteristics	No (%) N= 377	Urban households		Rural households	
		Health care seeking behaviour Yes	No	Health care seeking behaviour Yes	No
Age in years(36 ± 12.4)					
18-30	161(42.7)	45(37.8)	16(13.4)	53(20.5)	47(18.2)
31-45	137(36.3)	42(35.3)	5(4.2)	48(18.6)	42(16.3)
46-59	57(15.1)	6(5)	1(0.8)	19(7.4)	31(12)
60+	22(5.8)	3(2.5)	1(0.8)	4(1.6)	14(5.4)
Sex					
Male	259(68.7)	71(59.7)	15(12.6)	78(30.2)	95(36.8)
Female	118(31.3)	25(21)	8(6.7)	46(17.8)	39(15.1)
Marital Status					
Single	67(17.8)	19(16)	9(7.6)	23(8.9)	16(6.2)
Married	258(68.4)	65(54.6)	7(5.9)	83(32.2)	103(39.9)
Widowed	25(6.6)	7(5.9)	1(.8)	12(4.7)	5(1.9)
Divorced	27(7.2)	5(4.2)	6(5)	6(2.3)	10(3.9)
Family structure among married					
Monogamy	193(74.5)	63(87.5)	5(6.9)	66(35.3)	59(31.6)
Polygamy	66(25.5)	2(2.8)	2(2.8)	17(9.1)	45(24.1)
Family Size					
Less than 4	154(40.8)	60(50.4)	13(10.9)	49(19)	32(12.4)
Greater than 4	223(59.2)	36(30.3)	10(8.4)	75(29.1)	102(39.5)
Occupation					
Housewife	71(18.8)	6(5)	7(5.9)	31(12)	27(10.5)
Farmer	157(41.6)	3(2.5)	0	69(26.7)	85(32.9)
Government employee	52(13.8)	37(31.1)	2(1.7)	9(3.5)	4(1.6)
Private Business	16(4.2)	14(11.8)	2(1.7)	0	0
Student	15(4)	3(2.5)	0	4(1.6)	8(3.1)
Merchant	63(16.7)	30(25.2)	12(10.1)	11(4.3)	10(3.9)
Others	3(0.8)	3(2.5)	0	0	0
Religion					
Orthodox	148(39.3)	47(39.5)	10(8.4)	39(15.1)	52(20.2)
Protestant	159(42.2)	39(32.8)	12(10.1)	53(20.5)	55(21.3)
Catholic	43(11.4)	4(3.4)	1(0.8)	24(9.3)	14(5.4)
Muslim	2(0.5)	1(0.8)	0	0	1(0.4)
Others	25(6.6)	5(4.2)	0	8(3.1)	12(4.7)
Educational Status					
Illiterate	123(32.6)	7(5.9)	3(2.5)	44(17.1)	69(26.7)
Primary education grade(1-8)	144(38.2)	18(15.1)	15(12.6)	57(22.1)	54(20.9)
Secondary education (grade 9-12)	57(15.1)	33(27.7)	3(2.5)	14(5.4)	7(2.7)
Graduated from college	53(14.1)	38(31.9)	2(1.7)	9(3.5)	4(1.6)
Ethnic Group					
Dawuro	199(52.8)	58(48.7)	10(8.4)	51(19.8)	80(31)
Hadya	66(17.5)	8(6.7)	4(3.4)	28(10.9)	26(10.1)
Wolayta	50(13.3)	3(2.5)	2(1.7)	22(8.5)	23(8.9)
Kambata	22(5.8)	0	2(0.5)	20(7.8)	2(0.8)
Amhara	31(8.2)	21(17.6)	6(5)	3(1.2)	1(0.4)
Others	9(2.4)	6(5)	1(1.6)	0	2(0.8)
Monthly Income					
Less than 1170 ETB	191(50.7)	11(9.2)	11(9.2)	69(26.7)	101(39.1)
Greater than 1170 ETB	186(49.3)	85(71.4)	13(10.9)	55(21.3)	33(12.8)
Source of money for health care during illness					
Cash	149(39.5)	89(74.8)	14(11.8)	31(12)	15(5.8)
Selling a kind	219(58.1)	6(5)	9(7.6)	87(33.7)	117(45.3)
Free health care service	9(2.4)	1(0.8)	0	6(2.3)	2(0.8)

In urban, being married was 11.3 times more likely to seek health care than being single (AOR=11.3, 95% CI: 1.2, 110.2). But marital status was not statistically associated with health seeking behaviour of rural households. Having serious illness was determinants factor of urban and rural household health seeking behavior. The odds of health seeking behavior among participants perceived serious illness was nearly seven

(AOR=6.6, 95% CI: 1.1, 10.9) and three (AOR=2.5, 95% CI: 1.1, 5.8) times higher than their comparator in urban and rural respectively Rural households with monthly income greater than 1170 Ethiopian Birr were 5.6 times more likely to seek health care as compared to their counterparts AOR=5.6, 95%CI: 2.04, 15.4). If households perceived acute illness, they were seeking health care than who didn't perceive (AOR=8.9, 95% CI: 2.4, 33.3) [Table 3].

Table 2. Individual related factors affecting healthcare seeking behaviour households, Esera Woreda, Dawuro zone, South west Ethiopia, 2015

Variables	Urban N (%)	Rural N (%)
Time of health seeking after onset of the illness		
Immediately as illness started	57(58.8)	55(44.1)
When it goes worse	39(41.2)	69(55.9)
Disease condition		
Acute	76(63.8)	153(59.3)
Chronic	43(36.2)	105(40.7)
Reasons for not seeking health care		
Thought sickness is incurable	3(10.5)	2(1.8)
Symptom is not severe	17(73.7)	26(18.9)
Assumed that getting well from symptom without treatment	1(5.3)	21(15.3)
Lack of time	0	2(1.8)
Lack of money	3(10.5)	42(31.5)
Long distance	0	41(30.6)

Table 3. Factors independently associated with outcome (Healthcare Seeking behaviour) variable between urban and rural residents of Esera woreda, south Ethiopia, 2015

Urban Households				
Variables	Healthcare seeking Behaviour		COR(95% CI)	AOR(95% CI)
	Yes	No		
Monthly income				
Less than 1170	9	9	1	1
More than 1170	87	14	6.2(2.105,18.349)*	1.6(0.197,13.824)
Educational level				
Illiterate	7	3	1	1
Primary education	18	15	0.5(0.113,2.342)	0.06(0.001,5.01)
Secondary education	33	3	4.7(0.782, 28.41)	0.78(0.013,46.209)
College graduate	38	2	8.1(1.144, 57.949)*	1.2(0.016,96.684)
Condition of the disease				
Acute	69	7	5.3(1.945, 14.388)*	1.8(0.23,14.781)
Chronic	28	15	1	1
Marital status				
Single	19	9	1	1
Married	65	7	4.4(1.446, 13.375)*	11.3(1.162,110.204)*
Widowed	7	1	3.3(0.353,31.158)	0
Divorced	5	6	0.4(0.095,1.645)	1(0.026,41.796)
Perceived severity				
Yes	79	9	7.2(2.692,19.412)**	6.6(1.051,10.951)*
No	17	14	1	1
Rural Households				
Variables	Healthcare seeking Behaviour		COR(95% CI)	AOR(95% CI)
	Yes	No		
Monthly income				
Less than 1170	57	84	1	1
More than 1170	50	27	2.7(1.534,4.857)*	5.6(2.044,15.409)*
Educational level				
Illiterate	39	62	1	1
Primary education	49	43	1.7(0.974,2.814)	1.5(0.591,3.883)
Secondary education	11	3	3.1(1.174,8.381)*	1.4(0.186,11.062)
College graduate	7	3	3.5(1.024,12.156)*	0.3(0.047,2.401)
Condition of the disease				
Acute	82	27	9.2(4.991,17.087)**	8.9(2.396,33.261)*
Chronic	26	83	1	1
Marital status				
Single	18	11	1	1
Married	73	89	0.49(0.217,1.101)	0.49(0.217,1.101)
Widowed	11	3	2.2(0.51,9.85)	2.2(0.51,9.85)
Divorced	6	7	0.5(0.139,1.968)	0.5(0.139,1.968)
Distance from health center				
≤10km	79	72	1.7(1.01,2.96)*	3(1.187,8.354)*
>10km	27	39	1	1
Perceived severity				
Yes	57	23	3.2(1.753,5.921)**	2.5(1.106,5.853)*
No	50	65	1	1
Health information				
Yes	98	88	2.8(1.25,6.479)*	2.3(0.762,5.329)
No	9	23	1	1

Note: *-significant results, 1-reference category **p-value<0.001, *p-value≤0.05.

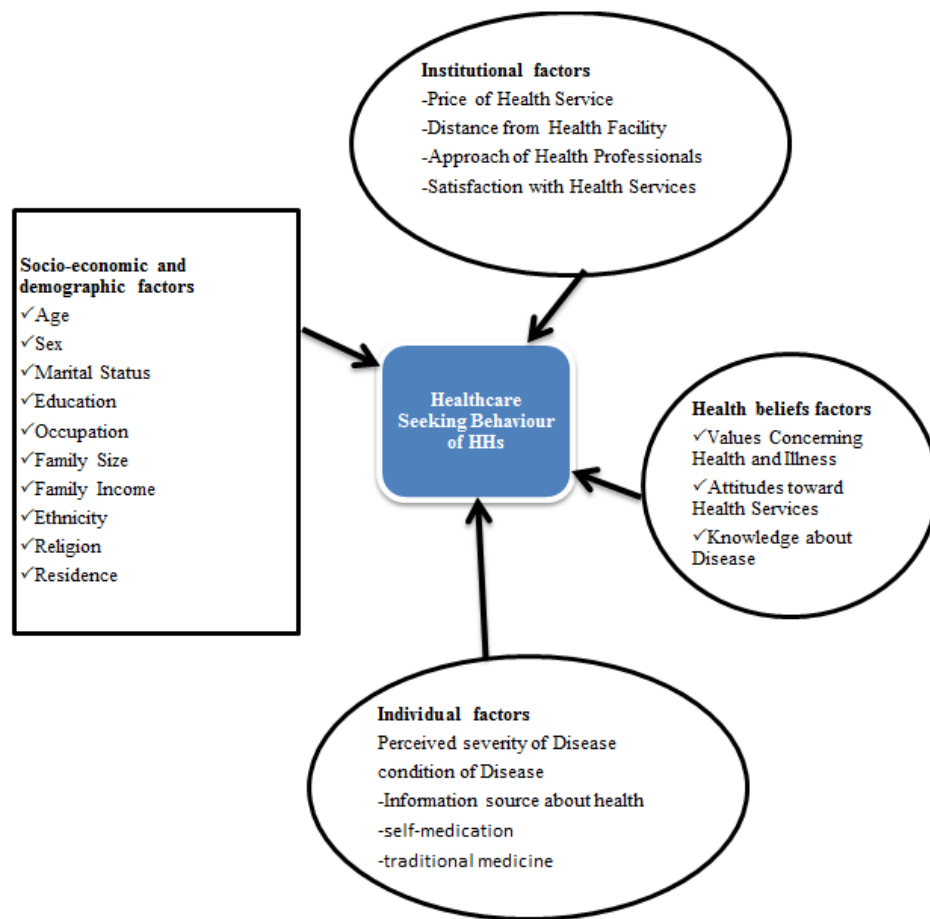


Figure 1. Conceptual framework of healthcare seeking behaviour adapted from literature reviews

4. Discussion

The current study revealed that the health care seeking behavior of households was 58.4%, with urban households sought nearly two times of rural dwellers. There is slight increment of health care sought in both residences compared to a study done in Amhara region, Ethiopia indicated that 52.3% in urban and 29.6% in rural households [21]. This might be due to improvement in accessibility of facilities and health information delivery by health extension program (HEP).

Regarding health seeking behavior practice, two out of five (42.7%) households practiced self-medication, a finding lower than Benin's report [22]. Amongst those who treated themselves, nearly half of them treated unsuccessfully and this was quite higher than experience of South Africans which reported 25% [23]. Some of the explanations could be due to related with less access of health institutions, widespread unlicensed drug sellers, illiteracy or others socio economic and demographic factors. The high unsuccessful self-treatment in both urban and rural household cues the need of awareness creation on modern medicine. Urban households were 4.5 times more likely to seek health care than rural households (OR=4.5, 95% CI= 2.7, 7.6) at p value < 0.001. This study is similar with the findings in Jamaica and Ethiopia that indicated healthcare seeking behaviour can be explained by area of residence in which urban households were more likely to have health seeking behaviour than rural households [1]. This might be due to better accessibility of the services urban residents.

This study showed that monthly income of households would affect their HSB. Consistent with studies from Georgia, Congo Republic, Mongolia and India [24]), this study showed that income affected rural households health care seeking behaviour [24]). But it was not a predictor for HSB of urban households and we hypothesized that it could be due to the high number of employee at urban residence than rural [25].

Marital status has significant effect on health care seeking behaviour in urban than rural households. Married urban residents sought healthcare 11 times more likely than bachelors. It is similar with findings from studies in Jamaica and Mongolia [1,17].

In distance was also a barrier for the rural households. This is relatively similar with the findings in Jimma which reported that 76.7% of the cases who were 10 kilometers or greater far from health institution did not utilize health service [26]. Is the explanation could be due to physical proximity of health facility affects the utilization of services.

Perceived severity was significantly associated with health care seeking behaviour in which households with severe illness were more likely to utilize healthcare than not serious in both residences. Those with acute disease condition also sought more likely than chronic illness at both urban and rural households This is not dissimilar with others findings from Jamaica and Ethiopia (1,16). This might be related to households/patients personal, psychological fear towards diseases conditions and its outcome [4].

Lastly, acute duration of illness was among the factors influenced for health seeking behaviour of rural households.

This is inconsistent with findings from study done in Congo Republic that reported patients with chronic illness had high probability of seeking a care than with acute illnesses [14]. This might be related with currently health information/education regarding communicable diseases was delivering for households following widely practiced health extension packages in Ethiopia [27].

5. Limitations

The limitation of this study is that social desirability bias. Especially, the modern health service utilization rate might be overemphasized, as many households might be afraid to admit that they visited traditional practitioners like *Kalichas*, (witchcrafts). In addition, cross sectional design of study, this measures the exposure and outcome simultaneously.

6. Conclusions and Recommendation

Residence has an effect on the households' health care seeking behaviors for perceived illness. Urban households seek health care more than rural households. Perceived severity of illness and being married showed a significant association for health seeking behavior of rural households for perceived illness. While monthly income, perceived severity, distance from health center and duration of illness showed a significant association for health care seeking behavior of rural households. Self-medication was widely practiced in the study area. It is; therefore, better to give priority in increasing accessibility of health care services. Because our study leads to such measurements.

Competing Interests

The authors declare that they have no competing interests.

Abbreviations

CHD- Community Health Day, HEWs-Health Extension Workers

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