



**DISCUSSION
BRIEF**

Health-seeking Behavior in Rural Uttar Pradesh:

Implications for HIV Prevention, Care, and Treatment

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According to the latest National Family Health Survey (NFHS) and District-Level Household Survey (DLHS) data, an average of 15 percent of the population that seeks healthcare services in Uttar Pradesh (UP) accesses government health facilities, while 85 percent opt for private providers. Although the reasons for this are multi-faceted, and include lack of confidence in the government health system, the practice has been formed over decades. The implications for HIV prevention, care, and treatment programs are great because, despite recent efforts to encourage private sector participation, the majority of services are largely located within the government health infrastructure.

Uptake of preventive health services is low in the state, especially among rural and uneducated women. Low literacy and lack of awareness about services, schemes, and entitlements, low status of women, poverty, and cultural factors are among the crucial factors that determine the health-seeking behavior in the state.¹ Lack of integration of HIV services into the private sector further limits access, especially for women and children whose attitudes and practices have been formed by negative past experiences in accessing general health services at government facilities.

In order to improve sustained uptake of HIV services, it is important to understand the patterns and determinants of general health-seeking behavior in UP. While the issues of healthcare access are broad, this paper uses data from the recent NFHS and DLHS surveys to analyze general health-seeking behavior and preventive health-seeking behavior in women in UP and draw inferences for recommendations to increase the uptake of HIV services. Potential actions that can be taken by the National AIDS Control Program (NACP) and UP

State AIDS Control Society (UPSACS) to improve HIV-related health seeking behavior within their current operational frameworks will be explored. Recommendations will be made that go beyond the current core strategy of raising awareness through large-scale communication campaigns.

Health-seeking Behavior

Taking antenatal and postnatal care, institutional deliveries, anemia, child immunization, and treatment of childhood diseases as key indicators to measure the overall health-seeking behavior, it is evident from the 2005/06 NFHS-3 data that the situation in UP is poor. In most cases, UP indicators are significantly lower than the national average (see Table 1).

Indicators for pregnant women—use of iron and folic acid (IFA) tablets, antenatal care (ANC) visits, institutional births, and postnatal care (PNC)—demonstrate very low uptake of healthcare services. However, when it comes to children with acute needs, data suggest that healthcare facilities are accessed more frequently for management of diarrhea, fever, and acute respiratory infection. Whereas only one out of five women had an institutional delivery and one out of four accessed ANC, one out of two children with diarrheal disease and more than three out of five children with respiratory infection or fever were taken to a health facility. Analysis of these data suggests that women and children are more likely to seek health services for emergent and urgent needs than for non-urgent/emergent or preventive ones, and potentially that women's needs are accorded lower priority by their families and themselves. Additionally, the tendency to seek healthcare is especially low for

Table I. Maternal and Child Health Indicators for UP and India							
Indicator	Geographic Area	NFHS-3 (2005/06)					NFHS 2 (1998/99)
		Total	Urban	Rural	Education None	Education 10 years or more	
Mothers who had 3 ANC visits for their last birth (%)	UP	26.3	40.9	22.6	17.1	64.1	14.6
	India	50.7	73.8	42.8	29.8	85.3	44.2
Mothers who consumed IFA tablets for 90 days or more when pregnant with their last child (%)	UP	8.7	16.4	6.7	3.8	26.6	n.a
	India	22.3	34.5	18.1	9.5	49.4	Na.
Institutional births (%)	UP	22.0	39.9	17.5	13.6	59.2	15.2
	India	40.7	69.4	31.1	19.8	80.6	33.6
Mothers who received PNC within 2 days of delivery for their last birth (%)	UP	14.2	31.1	9.9	7.0	46.2	n.a
	India	36.4	60.7	28.1	17.6	73.3	N.a
Children 12-23 months fully immunized (BCG, measles, 3 doses each of polio/DPT) (%)	UP	22.9	32.6	20.5	13.8	52.2	20.2
	India	43.5	57.5	38.6	26.1	71.0	42.0
Children with diarrhea in the last 2 weeks taken to a health facility (%)	UP	55.9	66.3	53.3	54.1	57.5	63.3
	India	58.0	65.3	55.6	51.3	69.1	65.3
Children with acute respiratory infection or fever in the last 2 weeks taken to a health facility (%)	UP	63.6	83.8	58.6	59.6	75.6	n.a
	India	64.2	78.1	59.9	57.5	75.8	n.a
Ever married women age 15-49 who are anemic (%)	UP	50.8	50.7	50.8	52.7	44.6	49.0
	India	56.2	51.5	58.2	60.2	46.6	51.8

Source: NFHS-3 state factsheet, Uttar Pradesh.

rural and uneducated women. This suggests an overall weak health-seeking behavior culture and low uptake of health services, which may be reflected in the under-utilization of HIV-related services as well.

For the purpose of this brief, full ANC, PNC, anemia, and use of IFA are being taken as proxy indicators for assessing preventive health-seeking behavior patterns in the state.

Determinants of Health-seeking Behavior

Health service utilization has been associated with several socio-demographic factors such as age, gender, and socioeconomic status. One of the main factors associated with health service utilization is that of “health services need,” as measured by individuals’ health status.²

In a study of 3,000 households in five Indian states (including UP) that assessed factors affecting health seeking and utilization of curative healthcare services, the key indicators of sickness were inability to move and work and loss of appetite or interest in the surroundings.³ This perception of “health”

influenced the people’s choice of provider and their treatment-seeking behavior. The study also found that perceived quality of services was an important determinant of the pattern of utilization. Private practitioners were perceived to be providing better services because they included injections as part of every treatment and were willing to make home visits which were convenient, especially where transportation was inadequate. The government health services were not popular because of the longer waiting period involved, the attitude and behavior of the staff, and lack of medicines.⁴

NFHS-3 data for UP substantiate these findings (see Table 2). Among those people who sought health services, client preference for private providers did not significantly differ by socioeconomic factors such as education, age, residence (urban/rural), marital status, or overall standard of living. This must be qualified with regard to the types of private sector service providers, which range from the local healer to specialized clinics. Socioeconomic factors and place of residence play a role in determining the category of private providers that are accessed by different groups. For example, nearly 23 percent of people in the lowest wealth index access

Table 2. Source of Healthcare that Household Members Generally Use When They Get Sick, UP, 2005/06											
Source	Residence			Meerut			Wealth Index				
	Urban	Rural	Total	Slum	Non slum	Total	Lowest	Second	Middle	Fourth	Highest
Public Medical sector	16.2	15	15.3	8.3	10.3	9.4	15	14.5	15.6	15.9	16.2
Govt/Municipal Hospital	10.6	2	4.2	7.8	8.8	8.4	1.5	2.3	3.5	7.1	11.1
Govt dispensary	0.3	0.2	0.2	0.5	1.3	0.9	0.1	0.3	0.3	0.3	0.3
UHC/UHP/UFWC	0.5	0.2	0.3	0	0	0	0.4	0.2	0.5	0.3	0.1
CHC/rural hospital/PHC	4.7	12.2	10.3	0	0	0	12.8	11.5	11.1	8.2	4.6
Subcenter	0	0.2	0.1	0	0	0	0.2	0.2	0.1	0	0
Anganwadi/ICDS center	0	0	0	0	0	0	0	0	0.1	0	0
Other Public medical sector	0.1	0.1	0.1	0	0.2	0.1	0.1	0.1	0.1	0.1	0.1
NGO/trust hospital or clinic	0.4	0.1	0.2	0.1	0.6	0.4	0.1	0.1	0.2	0.2	0.2
Private medical sector	83.2	84.6	84.2	91.4	88.1	89.6	84.7	85.2	83.8	83.3	83.2
Private hospital	5	2.2	2.9	4.7	5.4	5.1	1.2	1.5	2.2	4.3	8.7
Private doctor/clinic	74.9	63.9	66.7	83	80.3	81.4	59.2	67.7	68.3	72	72
Private paramedic	0.1	0.3	0.2	0.1	0.3	0.2	0.5	0.3	0.1	0.1	0
Vaidya/ hakim/ homeopath	0.7	0.2	0.3	0.8	0.8	0.8	0.1	0.3	0.2	0.4	0.9
Traditional healer	0	0.4	0.3	0	0	0	0.2	0.5	0.3	0.3	0
Pharmacy/drugstore	0.9	0.6	0.7	0.1	0.7	0.5	0.7	0.9	0.5	0.6	0.8
Other private medical sector	1.5	16.9	13	2.8	0.6	1.5	22.8	13.9	12.2	5.6	0.7
Other source	0.2	0.2	0.2	0	0.2	0.1	0.1	0.1	0.2	0.4	0.2
Shop	0.1	0.1	0.1	0	0	0	0.1	0	0.1	0.1	0
Home treatment	0.1	0.1	0.1	0	0.2	0.1	0	0.1	0.1	0.3	0.2
Other	0	0.2	0.1	0.1	0.5	0.3	0	0.1	0.2	0.1	0.2
Total	100	100	100	100	100						

Source: NFHS-3, Uttar Pradesh (2005-06), Table 67.

“other private medical sector” as compared to less than one percent among the highest wealth index. This category is outside of private clinics, private medical doctors, traditional healers, AYUSH (Ayurveda, Unani, Siddha, and Homeopathy) doctors, and private paramedical staff or pharmacies and includes untrained or unskilled health practitioners.

Poor literacy and lack of awareness about services, schemes and entitlements; low status of women and lack of family support for women reinforcing low self worth; abject poverty that pushes health to a low priority; and prevalence of culturally influenced practices that may in certain situations be detrimental to health are among the crucial factors that determine the health-seeking behavior in the state.⁵

Analysis of literature pertaining to uptake of reproductive and child health (RCH) services suggests that use of services is affected by the

broader contextual factors in which women live, such as poverty and limited educational opportunities, as well as individual attitudes which, in turn, are shaped by past experience, community perceptions, and practical aspects. Delays in seeking appropriate care, difficulties in physically accessing services, and facing serious breakdowns in services at the facility level have been noted as the three crucial barriers that inhibit access to healthcare.

Several other deterrents, such as bad roads, the unreliability of finding the health provider, costs for transport, and wages foregone, make it cheaper for a villager to get some treatment from the local practitioner or “quack,”⁶ who may have limited knowledge and skills in either modern or traditional medicine. This tendency to approach the local practitioner instead of accessing a government health facility likely has a direct bearing on the uptake of HIV-related services.

Uptake of HIV-related Services in the State

In 2008, UP achieved about 43 percent of the target for integrated counseling and testing (ICT). Among the five districts in UP in which the HIV prevalence rate is estimated to be >1 percent, two districts, Banda and Mau, achieved 26 and 25 percent respectively over a nine-month reporting period. The other three highest prevalence districts achieved 30-39 percent of their targets (see Table 3).

High HIV Prevalence Districts	Target 2008-09 (Nine months*)	Actual numbers tested for Mar. Dec. 2008 (Nine months)	Percent target achieved
Allahabad	32,855	12,923	39%
Banda	9503	2,485	26%
Deoria	18,046	5,474	30%
Etawah	8,646	3,117	36%
Mau	12,441	3,063	25%

Source: UPSACS Annual Action Plan 2009-10

*75% of the annual target was used in order to make a comparison with the nine-month reporting period data.

According to the UPSACS Annual Action Plan (2009-10), in districts with HIV counseling and testing gaps or heavy client burdens, special interpersonal communication (IPC) and targeted intervention (TI) strategies will be undertaken in order to increase the uptake of HIV services in these districts. Another key proposed strategy for improving uptake of services is convergence with NRHM. To increase access of the rural populations to services to treat sexually-transmitted infections (STIs), integrating STI services with NRHM and identifying gynecologic out-patient departments of medical colleges and female district hospitals as designated STI clinics are proposed.

Discussion and Recommendations

The HIV program, like several other vertical initiatives (e.g., pulse polio, tuberculosis [TB], universal immunization), places significant emphasis on the use of communication strategies to mobilize

communities and boost uptake of services. The UPSACS strategy states that urban and rural women will be reached through extensive mass media campaigns and IPC to promote prevention of parent-to-child transmission (PPTCT) services, awareness of the linkages between STIs and HIV, and consistent condom use. Undoubtedly, this is a proven strategy for raising awareness and, to some extent, generating demand for services. However, accessing services is not only a factor of better information, as is evident from the pulse polio program in the state where, despite widespread awareness about polio, there is resistance to or non-acceptance of the polio vaccine.⁷ Changes are required in the overall patterns of health-seeking behavior and the mindsets of the people, especially with regard to preventive health.

It must be remembered that the preference for private providers is a habit that has been formed over decades of unmet healthcare needs in terms of quality and accessibility of services at the public sector health facilities. It is unrealistic to expect that this would change sharply when it comes to accessing HIV services. For this to happen, it is important to address the internal and external barriers to health seeking, which requires the entire health machinery of the state to work in coordination.

The internal barriers relate to self worth and perception of the seriousness of the ailment as well as the extent of suffering and its economic repercussions (see Diagram 1). For example, if the disease causes loss of daily wages or if it afflicts the boy child, then chances of seeking healthcare are higher. On the contrary, if it does not impact day-to-day life and productivity or affects the woman, then there is less likelihood of accessing health services. Prevention and wellness are not common concepts, especially among the poor. In the case of HIV this assumes greater significance as the symptoms become evident only at an advanced stage. Thus, the majority of people are likely to seek health services only at a later stage.

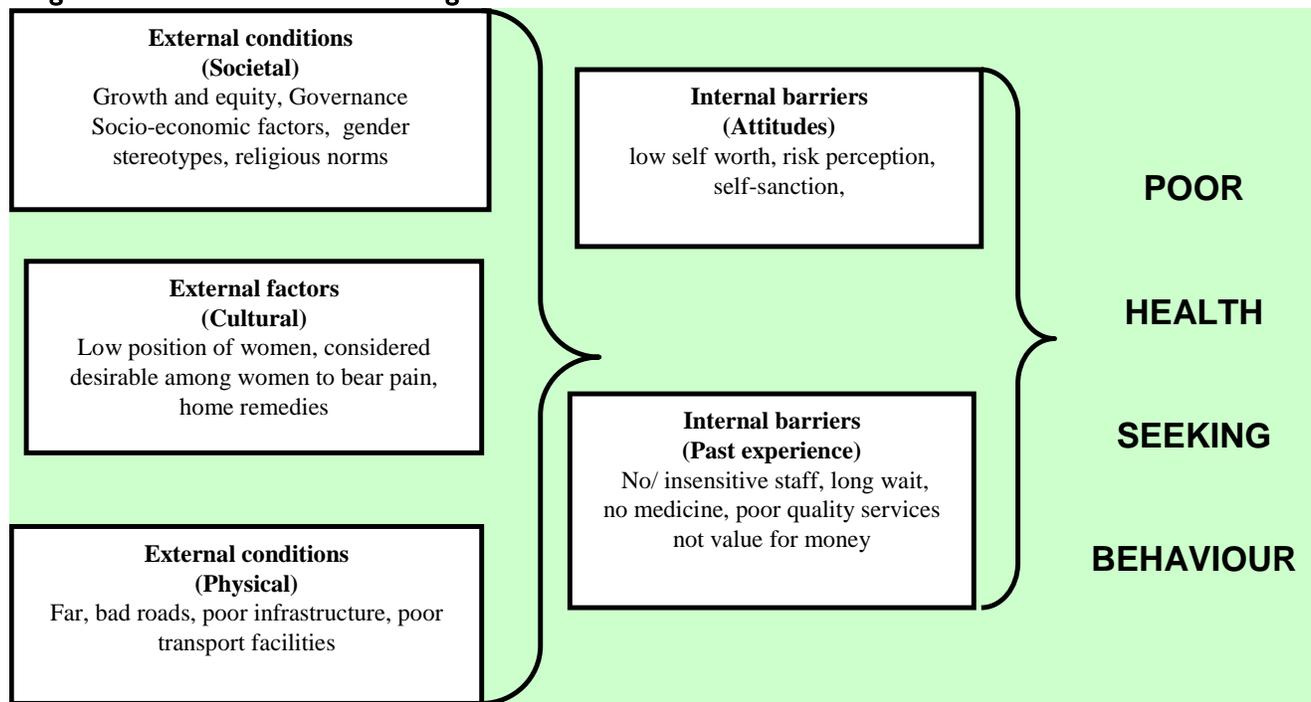
Internal resistance also results from negative past experience with the external environment, in this case, the public health system. Long waits, absent doctors/auxiliary nurse midwives (ANMs), and insensitive staff are factors that deter people from returning to the health facility. It must be noted that the state has a significant shortage in the number of healthcare units and staff needed with an estimated

shortfall of 5,823 subcenters, 730 primary health centers (PHCs) and 711 community health centers (CHCs). There are no First Referral Units at the block PHC and CHC level. Gaps in staffing (see Table 4) adversely affect the client-provider relationship, distancing the clients from the healthcare centers over the years.

External challenges are influenced by the overall approach of the government toward health in the state. It also depends on availability of trained doctors, nurses, and other health personnel. There is an acute shortage of doctors who are willing to serve in the rural areas. At another level, the external barriers relate to larger issues of human development, gender and caste stereotyping, economic growth and equity, poverty and systems of governance and corruption, which, in turn, reinforce certain internal barriers. Together these factors affect the health-seeking behavior of men and women. In the case of HIV, there are added dimensions of stigma, discrimination, and insensitive treatment in healthcare settings and denial at the personal level.

Healthcare professional	Required	In place	Shortfall
Multipurpose worker (MPW) (Female)/ANM at subcenters and PHCs	24,181	21,900	2,281
Health Worker/MPW (Male) at subcenters	20,521	5,732	14,789
Health Assistant (Female)/LHV at PHCs	3,660	2,128	1,532
Obstetricians and Gynecologists at CHCs	386	123	263
Total specialists at CHCs	1,544	413	1,131

Diagram I. Barriers to Health-seeking Behavior



Recommendations

From the above discussion, it is evident that increasing the uptake of HIV services will require a multi-faceted approach. This cannot be achieved by simply focusing on HIV messages and services. Hence, it is vital that UPSACS assume a broader role and undertake initiatives keeping in mind the immediate, medium, and long-term needs for HIV prevention and treatment in the state. Toward this end, the state HIV program could undertake some of the following:

- Expand and integrate within RCH/HIV and TB/HIV services, comprehensive HIV communication plans within the overall framework of NRHM. Some examples:
 - Whereas the first generation HIV messages focused on safety and prevention, the second generation messages could be broader based with an emphasis on health-seeking behavior targeting a broad spectrum of vulnerable groups. For example, acknowledging the linkage between a woman's age at marriage, condom negotiation skills, and her socioeconomic and biological vulnerabilities to HIV infection, the HIV program could ensure that its information, education, and communication (IEC) campaigns and other initiatives (e.g. Link Worker Scheme) advocate for marriage at a later age as part of HIV prevention messaging.
 - Similarly, high levels of malnutrition and anemia both in adolescence and during pregnancy are well established precursors of complications during pregnancy and childbirth as well as perinatal and neonatal mortality. In the HIV context, a person living with HIV who is also anemic is more likely to progress to AIDS and has a shorter life expectancy than someone without anemia.^{8,9} Additionally, anemia-related fatigue often affects the quality of life. Good nutrition should be promoted and supported as resources permit and regular communication with the person living with HIV by the healthcare worker should be facilitated.
- The state Health Department, through its wide range of programs, such as NRHM and Health Systems Development Project, has been involved in improving the health infrastructure and human resources in the state; however, the popular perception about healthcare providers is still negative. As the HIV services are located in these very same healthcare centers it is not possible to promote HIV services without attempting to alter the negative popular perceptions about the service providers. It is important that the image of PHC services in the minds of the community be improved.¹⁰ At one level, this requires improvement and standardization in the quality of services that could be done through a committed drive and systems for accreditation. In addition, it is important to build the confidence of the rural communities in the service providers such as ASHAs and ANMs. The IEC and behavior change communication (BCC) initiatives in the state could systematically work toward building the communities' confidence in the public health system in addition to spreading the word about HIV services.
- Engage Link Workers in promoting institutional deliveries and registration of all the pregnant women so that they come under the umbrella of the maternal and child healthcare package for ensuring safe motherhood and better survival of their children,¹¹ which in turn will improve access to PPTCT and pediatric care. A related strategy is to provide robust training to Link Workers so that they enter communities as agents of change and help transform the overall health-seeking behavior of communities.
- Initiate innovative public-private partnership models to capitalize on the preference for private sector services. Some efforts are underway, but need to be scaled up as the epidemic cannot wait for the public's perception to change toward the government-run facilities. Innovative models of social franchising, voucher systems, contracting in, and contracting out have successfully been tried in the RCH sector in UP. These could be reviewed and their lessons used for enhancing uptake of HIV services. UPSACS must also capitalize on the popularity of AYUSH doctors and build strong referral linkages with them.

- Maximize coverage by reaching out with HIV messages and/or services to all those currently accessing services. By way of example, UPSACS could review and adapt the Systematic Screening Instruments¹² toward addressing the unmet needs. This would require reviewing the existing instrument and lessons in implementation, as well as making necessary modifications to the tool including developing HIV-related screening questions, advocating with the health department, and providing necessary training and capacity building for introducing the instrument in the public healthcare system.
- Develop low-literacy tools and materials that help people retain essential messages. Patients with low literacy tend to be more responsive to information designed to promote patient action, motivation, and self-empowerment than detailed facts. Healthcare workers should be trained to

use low-literacy materials and tools and verify the patient's understanding through "teach backs."

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ENDNOTES

¹ Prasad. G. 2009. "Urban Health in Uttar Pradesh: Challenges and Opportunities." Available at http://uhrc.in/downloads/Presentations/Gajraj_Prasad.pdf accessed on [accessed July 8, 2009].

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³ Chirmulay D. 1997. *Factors Affecting Health Seeking and Utilization of Curative Health Care*. Pune: BAIF Development and Research Foundation. Available at: <http://www.cehat.org/publications/rhr4.html> [accessed June 12, 2009].

⁴ Ibid.

⁵ Prasad. G. 2009. "Urban Health in Uttar Pradesh: Challenges and Opportunities." Available at http://uhrc.in/downloads/Presentations/Gajraj_Prasad.pdf [accessed July 8, 2009].

⁶ Department of Planning, Government of Uttar Pradesh. 2005. "Note on Health Sector in Uttar Pradesh." Lucknow: Department of Planning, Government of Uttar Pradesh.

⁷ EPOS Health Consultants India Pvt. Ltd. 2002. "Understanding Barriers to Polio Eradication in Uttar Pradesh: Final Report." Available at <http://www.comminit.com/en/node/220372/303> [accessed on July 5, 2009].

⁸ Sullivan, P. J. 2002. *Infect. Dis.* 185 (suppl 2): S138–S142.

⁹ Volberding, P. 2000. *Clin. Ther.* 22: 1004–1020.

¹⁰ Chirmulay, D. 1997. "Factors Affecting Health Seeking and Utilization of Curative Health Care." Draft Report. Pune: BAIF Development Research Foundation. Available at <http://www.cehat.org/publications/rhr4.html#4> [accessed August 3, 2009].

¹¹ Aggarwal, O.P., Kumar, R., Gupta, A., et al. 1997. "Utilization of Antenatal Care Services in Periurban Area of East Delhi." *Indian Journal of Community Medicine* 22 (1): 29–32. Available at <http://www.cehat.org/publications/rhr4.html#1> [accessed August 3, 2009].

¹² Currently being used in the context of RCH in Gujarat under the USAID-funded project "Systematic Screening for Integrating Reproductive Health Services in India." For more, see: http://www.popcouncil.org/frontiers/projects/ane/India_SystematicScreening.htm.