ORIGINAL ARTICLE

Voices of Rural India: A qualitative study on ASHA workers' perspective on health-seeking behaviour of women

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Abstract
Introduction: Health-seeking behaviour is action or inaction to find appropriate cure when there is a health problem. Community health workers (CHW) can provide a comprehensive understanding of women's healthcare-seeking practices, to evaluate their level of care delivery to determine any barriers or enhancers on the health provider's side. The study aims to assess the CHW's perspective regarding health-seeking behaviour among rural women and determine the factors affecting it. **Materials and methods**: Qualitative, phenomenological, study using focus group discussions was conducted among ASHAs - the CHW, who provide healthcare in a rural village in India. The transcribed data was analysed further using thematic analysis. **Results**: From the ASHA's perspective, gender disparities, socio-cultural barriers, financial dependency on men, patriarchal decision-making norms in a family, overburden of household responsibilities, and lack of health awareness were found to hinder the health-seeking behaviour of a rural woman. Some short-term strategies that emerged to bridge this gap were home-based healthcare services, a multi-source group approach of awareness campaigns, promoting self-prioritisation of health among women and strengthening family planning awareness among both genders. **Conclusion**: Health-seeking behaviour patterns as observed by ASHA's was still filled with challenges

Keywords
Health-Seeking Behaviour, Community Health Workers, Qualitative, Women Health, ASHA Worker

Introduction
According to United Nations' World Population Prospects 2024, women constitute 49.7 % of the global population, while in India, they comprise 48.4%. (1) Representing half of the population, women are the torchbearers of societal wellness. Women are surrounded by responsibilities at home and workplace, prioritising the health of their family instead of their own. (2,3)
Despite the Sustainable Development Goals' clock ticking with only 5 years left (4) the focus on women's health has not gone beyond the concept of maternal and reproductive well-being. (5,6) At this juncture, the notion of health-seeking behaviour takes centre stage. Health-seeking behaviour of an individual is defined as "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy". (7,8)
A community health worker (CHW) is the one who connects the people who seek health care to the health system.(9) Selected from the village itself, an Accredited Social Health Activist (ASHA) has been trained to work as an interface between the community and the public health system in India.(10) A deeper knowledge regarding women's healthcare-seeking practices, including their boosters and barriers, can be obtained from ASHA workers. (11) Thus, the data obtained from this research can bring out changes needed to improve the current healthcare system and address any existing lacunae.(12)
The study thus aims to explore the ASHA's perspective regarding health-seeking behaviour among rural women and the factors affecting it.

Material & Methods
Study type, study design, study setting, study population: A qualitative, descriptive study using a phenomenological approach was conducted among ASHA workers, who are the grass-level community health workers from the government healthcare facilities providing healthcare in Ira village, the rural practice area of a tertiary medical college in Dakshina Kannada district, Karnataka. The facilities included a Primary Health Centre and a Sub centre, consisting of a total of 32 ASHA workers, covering a population of around 8515 people.
Study duration: 6 months (data collection , analysis and manuscript writing).Strategy for data collection: During 2023-24, the data was collected via two focus group discussions (FGDs) conducted by the researcher among 12 ASHA workers selected by purposive sampling, with 6 participants in each discussion, who consented to participate by signing a written informed consent before

the sessions. FGD's were conducted amongst the ASHA workers until data saturation was obtained which in our study was attained by the second FGD where no new information was showing up, owing to which the investigators stopped at two FGD's overall. Inclusion criteria : ASHA workers providing services in the selected village and who consented to participate. Exclusion criteria: The ASHA workers who were on duty providing health related services in the selected village for less than 6 months were excluded from the study. A pre-designed, semi-structured FGD guide was used to gather information from the participants which was face-validated by 2 external validators. The ethical clearance was obtained from the institutional ethical committee before the commencement of the study (INST.EC/EC/265/2023). With due consent from the participants the entire FGD was audio recorded using a recorder.

Data Analysis: All the recorded information was transcribed by the researchers within 24 – 48 hours. Each participant was assigned a specific code in the format of FGDxPy, where x denoted the FGD session and y denoted the participant number, thus ensuring confidentiality during transcription and data analysis. Once the audio recording was transcribed, a code book was generated for each of the FGD conducted by two reviewers independently which included aspects such as domains, codes in the form of phrases or sentences, subcodes under the main codes and the related verbatims. These were then further structured using thematic analysis where codes were categorized under distinct themes. Through inductive and deductive methods, identified patterns were interpreted to address the participants' perception of women's health-seeking behaviour and the factors influencing it.

RESULTS

In this study, the 12 participants were the female community health workers assigned in various parts of Ira village, who belonged to the age of 20 – 40 years with a work experience of minimum 2 years and a maximum of 15 years. The community health workers' perspectives on women's health-seeking behaviour and the factors influencing it were encompassed within eight key themes, highlighting both existing and newly emerging social outlooks. The deduced themes (Figure 1) from their reflections were mentioned as follows:

Holistic understanding of women's health among community health workers

The fundamental understanding of health is a vital prerequisite to make any remark on a person's health-seeking mentality. The concept of women's health conceived by each participant covered a spectrum of components, extending across many individual and social aspects, as shown in Fig.2.

Some of the quotes conveying their knowledge of such concepts about health were:

"Women's good health doesn't mean just physical health. It includes mental, economic, environmental as well as family health." (FGD2P5)

"For her, she shouldn't have any form of tension. Her husband, parents and kids, have to be well." (FGD2P4)

Around 41.7 % of the participants had mentioned the mental health component as an integral part of the overall well-being of a woman:

- *"Good health means… mentally, they have to be strong, free from any stressful thoughts." (FGD2P3)*

Surprisingly, it was crucial to find that the majority of the participants (58.3%) pointed out the very influence of the welfare of a woman's family and intrafamilial dynamics on her health in this society:

"Women feel healthy when they live in harmony with their husband and children." (FGD2P1)

"If everyone stays fit and happy at home, women will also be healthy." (FGD1P4)

Gender disparities in access to healthcare observed by community health workers

According to the perspective of the community health workers in the village, the disparities in health-seeking behaviour based on gender were still prevalent in the rural community. In the case of women, financial dependency, lack of education, less social interaction, lack of family/ husband's emotional support, hesitancy in sharing their health concerns openly etc., were explored to be a few among the factors affecting the rate of healthcare access.

The women in the village were perceived to be hesitant in seeking healthcare, for example,

"Women are reluctant to open up regarding sensitive or intimate health problems. In the case of joint families, the stigma over various health problems still exists and women find it more difficult to open up during our house visits due to lack of privacy. " (FGD1P4)

"women don't get time to take care of the health concerns. They wait until it gets worse. " (FGD2P3)

As depicted in Table 1, the need for a gender-specific approach was thus projected from the narratives such as:

"Women are having less knowledge about health…" (FGD1P1)

"more simple terms should be used when talking to women as they are less educated and don't go out much like men." (FGD2P2)

On the contrary, some participants commented based on their field experience that women's health-seeking rate had always been higher compared to men. Despite that, rather than proposing it as an indicator of women's freedom from discrimination pertaining to their right to health, it was found to be an evidence of overburdening of their responsibilities or considering females to be comparatively weaker when males played the role of sole breadwinners in a family:

"When women get sick, they feel too weak and they have to consult to get better. But usually, men get better by just taking one or two medicines from shops." (FGD1P3)

"Firstly, women should get better by seeking medical help so that they can take good care of the family." (FGD1P6)

"From my experience, men are comparatively less careful about their health since they have to earn for the family. " (FGD2P1)

Common health issues seen among women by community health workers

The majority of the health problems observed by the community health workers among women in this village

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were reproductive health concerns like menstrual or pregnancy-related complaints (41.7%) and non-communicable ailments like Diabetes Mellitus (58.3%), hypertension (50%), and thyroid dysfunction (33.3%) (Fig.3). The most prevailing health concern among this rural female population was anaemia (66.7%), particularly nutritional.

Health awareness observed among women

Nutritional awareness and knowledge among women were found to be adequate, but the practices were very limited, distinctly due to lack of self-prioritisation. One such example was mentioned by the participant as:

"Women don't consider their health. They will eat nutritious only when their husbands or kids also eat healthy." (FGD2P4)

The specific women-oriented health education initiatives provided in the village mainly included breast cancer awareness, mental health services via the *Sakhi* initiative adolescent health services like weekly Iron supplementation among school dropout adolescent girls via Anganwadi campaigns or *Kishori* meetings and finally, but certainly not the least, family planning awareness programmes.

The provision of services and awareness regarding family planning to women was observed to be still a hurdle among health workers. As per our findings, the stigma about openly discussing the concept of family planning among women had not been fully washed off from the rural outskirts of India, for instance:

"About family planning. They are not even ready to hear what we say. They don't ever talk about it" (FGD2P6)

Social and cultural factors affecting health health-seeking behaviour of women identified by the community health workers

As door-to-door service providers, ASHA workers had identified one of the major factors affecting women in seeking proper medical aid to be the distinguishable outcomes of the conventional 'patriarchal power play' in the family, like the overburden of household responsibilities, financial and social dependency on men, etc.

"… they don't have time to go for check-ups as they have to do the work at home, send children to school every day etc. And when they get time, there won't be anyone available at home during the daytime to accompany them to the centre." (FGD2P5)

"…if they have any sudden complaints, they won't have money to go to hospital suddenly." (FGD2P5)

The lower literacy level in comparison with men had also impacted the behaviour by reducing general health awareness:

"Usually, women in the village stop their education once they reach 7th standard and only men will continue their education. It affects their understanding and awareness about various health problems." (FGD2P6)

" to make them understand the health problems and benefits, it's a little difficult." (FGD2P5)

Challenges faced by the participants in providing healthcare for Women

Other than the occasional non-cooperation from the general public due to the community health workers' repeated visits, a participant commented that one of the challenges they face in providing health services to women was, mostly women could be easily manipulated towards or away from individual opinions:

"Women give a good response, but at home, husbands tell them later not to, like "don't go for that" "no need to do that test" "no need to take this injection" etc in many of the cases." (FGD2P5)

The religious barriers could not be ignored when it came to equitable health delivery in this community. The participants pressed upon the difficulties they faced in dealing with the Muslim community in convincing them of various healthy practices. For example,

" We have to be a little sensitive and flexible while dealing with Muslim women." (FGD1P1)

"Resistance to immunisation or other injections is the main issue we face when we go to Muslim areas." (FGD1P2)

Women's need for empowerment and decision-making capability advocated by the participants

As the frontline community health workforce, they unanimously pointed out the need for women's autonomy in health decisions by narrating multiple incidents they faced in the field:

"Women, even if they are interested in doing family planning surgeries, their husbands won't allow that." (FGD2P6)

"Many times, convincing the men in the family is important to convince their women" (FGD2P4)

The promotion of family planning among women had been a herculean task all the while when men tended to consider the topic to be outside their realm of responsibility, they mentioned.

"In case of family planning, even if we tell them, they won't do it. In our village, it is very difficult." (FGD2P5)

" We try to motivate a lot from our side. Still, there is not a single case of NSV exists in our village." (FGD2P6)

Healthcare services and interventions recommended for women by the community health workers

Though empowering women was the answer to many concerns, it seemed to be a slow-evolving process requiring a significant behavioural change in society. So, as a stopgap strategy, community health workers had put forth some notions that might facilitate effective health delivery among women *(Table 2)*.

One among such recommendations was the need for home-based health services for women:

"Home-based medical services are something that can be thought of. Most of the time, we face concerns from women at home regarding difficulty in going for regular check-ups or lab tests to hospitals or clinics." (FGD1P1)

"It's difficult, as many of the women live in houses far away from the main road. The health care should be reaching them, like testing blood at homes." (FGD2P3)

Another notion was the promotion of a group or family approach of awareness campaigns from more than one source, instead of educating the women individually, because family and community support played a key role in improving the health-seeking status of women:

" When women have any health problems, they should not be isolated, and the work should be shared by the family also. Motivation should come from many sources like healthcare professionals and community leaders, not just us" (FGD2P1)

" Men should understand the importance of checking whether the women in the family have any health issues. They should give the women freedom to open up to them." (FGD2P5)

A bigender approach to family planning by sensitizing men more intensively regarding family planning was another strategy they had suggested:

"Family planning awareness is given more focus on women, though we also try to promote among men. But it is still not sufficient. Keeping the focus of women's health in mind, men should be given strict counselling." (FGD1P4)

An expansion of beneficiaries of government health insurance schemes involving more of the female population had also been proposed based on their observation of the unavailability of financial aid during the time of need for many women. One participant thus quoted:

"Though we give information about various policies and schemes… like our Ayushman card. But they cannot always avail the benefits due to various factors. So, policies should try to include more services like OP fees and also minimal paperwork." (FGD1P5)

Lastly, a behavioural change among women to normalise self-prioritisation of their health and nutrition over the primary aim of the welfare of their family was quoted as the need of the era – *"They always eat less after feeding their husbands and children. They get physically weaker by not looking after their diet like they do for the family. Such awareness should be ensured." (FGD2P3)*

Table 1: Gender-based barriers among rural women from the perspective of community health workers

Gender-based barriers among women from the community health workers' perspective	*Number of participants*	*Frequency (%)*
Women		
Reluctant to open up about health problems	5	41.7
Shy to talk about family planning	4	33.3
Lack of health awareness compared to men	3	25
More time to explain due to lack of education	3	25
Men		
Unable to meet men during visits to counsel them regarding their spouse's health concerns	3	25
Men take medicines by themselves from the shop but consult only when symptoms worsen	4	33.3

Table 2: Recommended strategies by the community healthcare workers for effective healthcare delivery among women in India

Strategies	Number of participants recommended	Frequency (%)
Home-based healthcare services	3	25
Multisource group awareness approach	1	8.3
Behavioural change counselling for women to self-prioritise their health	2	16.7
Expanded coverage of government health insurance for women	1	8.3
Strengthening of family planning campaigns among men	2	16.7

Figure 1: Themes emerged from the study regarding health seeking behaviour among rural women through the lens of ASHA workers.

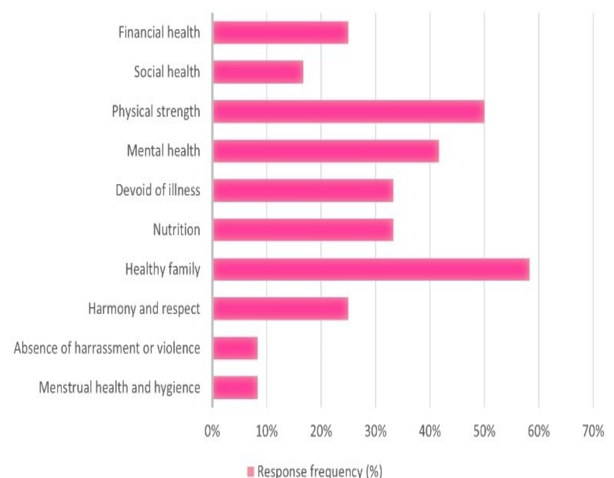

Figure 2: The factors contributing to women's health as stated by the participants.

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Figure 3: Word cloud depicting various diseases observed by the ASHA workers among the women

Discussion

The study began by exploring how community health workers (CHWs) perceive women's health holistically, encompassing physical, mental, economic, environmental, and familial dimensions. This perspective aligned with the World Health Organization's definition of health and the Dahlgren-Whitehead model. (13,14) Similarly, a Tanzanian research emphasized the importance of incorporating "cultural information" when defining health and designing interventions.(15) This approach influenced the study's recognition that CHWs' understanding of health is deeply rooted in local socio-cultural contexts.

A key finding of the study was the significant gender disparities in healthcare access identified by Accredited Social Health Activists (ASHAs), resulting from factors like financial dependence, lack of education, limited social interaction among rural women, and insufficient emotional support from family members or husbands, which ultimately led to hesitation in seeking healthcare. Similar Joshi et al, noted that many rural women required permission from senior family members to access healthcare and were reluctant to discuss their illnesses openly.(16) A rural Telangana study identified comparable challenges, including limited service accessibility and an initial reliance on home remedies.(17) Ohashi et al highlighted the critical role of husbands in encouraging women to seek medical care in rural Egypt, emphasizing how family dynamics influence women's healthcare access(18) A study in Indonesia also pointed out how family decision-making significantly shaped pregnant women's health-seeking behaviours.(19) These findings across Asia underscored the persistent influence of socio-cultural norms and patriarchal structures on women's autonomy in healthcare decisions.(20) Further research in Ethiopia and the USA revealed additional challenges posed by gender-based power dynamics and limited financial resources for women seeking healthcare.(21,22)

Although women demonstrated adequate awareness about health issues, particularly regarding nutrition, this knowledge often failed to translate into action due to a lack of self-prioritization. This reflected those societal norms where women prioritize their families' well-being over their own. Participants identified social and cultural factors as major influences on women's health-seeking behaviour, including household responsibilities, financial dependency, and lower literacy levels. The need to bridge the gap between knowledge and action highlighted the need of awareness about when and where to seek help.(17)

One significant challenge faced by CHWs was public non-cooperation, particularly within Muslim communities concerning practices like immunization. This issue mirrors findings from a study in Pakistan, which identified barriers such as lack of knowledge, limited empowerment, childcare responsibilities and threats of divorce by husbands that prevented women from seeking professional healthcare.(23) Similarly, a study on ASHAs in Uttar Pradesh noted that societal norms and broader contextual issues limited their effectiveness, contributing to such non-cooperation.(24,25)

Interestingly, in our study the CHWs observed that women tended to seek healthcare more frequently than men. This might be because women were perceived as more vulnerable when ill or feel weaker. However, this observation was in contradictory with the barriers women faced and might reflect societal expectations for women to maintain their caregiving roles through proper health management. In contrast, Yadav et al found that men—particularly those with higher socioeconomic status or older age—used formal healthcare services more frequently in Uttar Pradesh.(26) A Nigerian research showed that individuals with higher education and socioeconomic status were more likely to utilize formal healthcare services, suggesting education and economic status had always enhanced the awareness about health and healthcare options.(27)

The study also identified common health issues among women, including reproductive health concerns, non-communicable diseases, especially anaemia. These findings highlighted a global shift in disease trends, especially in low- and middle-income countries that faced a dual burden of communicable and non-communicable diseases. (4,28)

ASHAs unanimously stressed the importance of empowering women to enhance their decision-making capacity regarding health matters. They cited instances where men hindered women's access to desired healthcare services like contraception. This aligned with Goyal et al.'s study, which found that barriers such as stigma (29.63%), financial constraints (25.93%), family commitments, busy schedules, and poor accessibility limited a woman's ability to seek reproductive health services during antenatal and postnatal care.(29) A research from Bangladesh further reinforced the link between women's empowerment and improved healthcare access.(30) Conversely, a study in the Rural Mississippi Delta had identified many other barriers such as fear of serious diagnoses, poverty, rurality, gender socialization, medical distrust, and racism.(20) Additionally, poor attitudes among healthcare personnel and limited resources were challenges noted in resource-constrained settings like Peru.(31)

CHWs proposed several strategies for improving women's healthcare access. These included home-based care services, group awareness programs, behavioural

counselling for women, expanded health insurance coverage, and enhanced family planning campaigns targeting men. Such strategies coincided with findings by Ndambo et al that highlighted CHWs' potential to reduce stigma through home-based services and group initiatives.(32) The emphasis on involving men in family planning decisions was crucial, given India's patriarchal social norms. Studies had consistently highlighted barriers such as lack of awareness, cost constraints, and geographical challenges in accessing reproductive health services. (33,34) Likewise, these findings were synchronized with a 2018 study which emphasized the home-based care services' potential to improve access to quality healthcare for women in rural areas.(26)

Conclusion

According to the community health workers' perspective, we have found out that the health-seeking behaviour of a woman, especially in a rural community, had been hindered by various factors such as the prevailing gender disparities, socio-cultural barriers like religion, financial dependency on men, conventional patriarchal decision-making norms in a family, the overburden of household responsibilities, lack of health knowledge and awareness due to lower literacy, and minimal social interaction compared to men etc. It had also been noted that, from the healthcare providers' side, there were various contributing factors acting against effective healthcare services to women in outreaches, like inadequate laboratory services, which were intermittently discontinued due to a shortage of staff in primary healthcare centres and long-distance travel targets for ASHA workers. We had also noticed that the family planning concept still prevailed as a stigmatizing notion among the rural belts of our nation and in such cases, there is a long way to achieve the global population standards. **Strengths of the study**: As the grassroot level linkages between the health sector and the communities in India, ASHA workers' perspectives played a distinguished role. They had suggested multiple short-term stopgap strategies to bridge the health-seeking behaviour disparities. Few among such notions were home-based healthcare, multi-source group approach of awareness campaigns, promoting self-prioritisation of health among women, strengthening of family planning awareness among men and also extended inclusion of women population in health insurance schemes. Hence, health-seeking behaviour of an individual could be considered as a health indicator of an individual or a community, as it paved the foundation for a healthy lifestyle. Since gender inequality dominated the contemporary discourse, the achievement of the right to health among women will be highly crucial to establish universal health coverage globally.(35–37)

Recommendation

The study necessitates the need for further exploration as regards health seeking behaviour of women from women and men too to understand the ground realities and perspectives related to women's health seeking behaviour patterns.

Limitation of the Study

Since the FGD's were conducted among ASHA workers from one village, which could be a reason for data saturation with the second FGD, the findings can be extrapolated only to the village selected for the study.

Relevance of the Study

This study adds to the existing knowledge surrounding women's health wherein with many women centric programs are in place, the challenges that the field level workers face to provide the deliverables to the women of their community takes a centre stage.

Authors Contribution

Meera P Kumar – Contributed towards Conceptualization, study design, data collection, data analysis, manuscript write up

Anusha Rashmi- Contributed towards Conceptualization, study design, data collection, data analysis, manuscript write up

Farzanha B Ummer- Contributed towards data analysis

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Conflict of Interest

There was no conflict of interest.

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Declaration of Generative AI and AI Assisted Technologies in the Writing Process

During the preparation of this work, the authors have used WordArt for generating word cloud used in Figure 3. After using this tool/service, the author (s) reviewed and edited the content as needed and take (s) full responsibility for the content of the publication

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