



"Comparative Insights Into Health Profile And Treatment-Seeking Behaviour Of Women In Rural And Urban Communities"

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ABSTRACT

Background: Women's health is a crucial component of public health and community development. Health profile and treatment-seeking behaviour are influenced by social, economic, and cultural factors, which often differ between rural and urban populations. **Objective:** The present study aimed to assess and compare the health profile and treatment-seeking behaviour among women residing in selected rural and urban communities. **Methodology:** A comparative cross-sectional study was conducted among 250 women (125 rural and 125 urban). Participants were selected using a convenience sampling technique. Data were collected using a self-structured questionnaire assessing socio-demographic variables, health profile, and treatment-seeking behaviour. Statistical analysis was performed using descriptive statistics and independent t-tests with SPSS version 16. **Results:** The study revealed a statistically significant difference in the health profile of women residing in urban and rural areas ($p < 0.05$). Urban women had higher mean health profile scores compared with rural women. However, no statistically significant difference was found in treatment-seeking behaviour between the two groups ($p > 0.05$). **Conclusion:** The findings suggest that urban women tend to have better health profiles than rural women, while treatment-seeking behaviour patterns were relatively similar in both groups.

The results highlight the importance of strengthening health awareness and accessibility of healthcare services in rural communities.

Keywords: Health profile, treatment seeking behaviour, urban, rural, women.

Introduction-

After 1961, India's population has risen to over twice its previous size. India has taken a leading position in establishing population and health regulations, yet poverty, gender discrimination, and illiteracy have posed significant challenges to effective implementation. (Buckshee, 1997)

A country population's approach to obtaining medical attention is influenced by its healthcare system. Government-funded Comprehensive health coverage is available to Residents of the Most developed countries. However, in Low- and middle-income countries like India, where the Most healthcare costs are financed by individuals out of pocket, universal health coverage remains a distant goal. A big Concern **despite this** exists In addition to easy access to healthcare, even with large government spending. Some impoverished individuals chose self-treatment or no therapy because of budgetary limitations. Although several studies have examined how populations in India and other countries seek health care, most of them have serious flaws.(Yadav, n.d.)

Indian women's health can be analyzed using a variety of metrics that differ depending on the country, socioeconomic and cultural factors. To effectively enhance the health of Indian women, it is necessary to examine many aspects of wellness Compared with both men and global health indicators. Various health challenges faced by Indian women presently confront Show influence on overall production of the economy.("Women in Punjab, India," 2025) Women's health issues in India have existed for Centuries. (Zodpey & Negandhi, 2020)

One of the most cherished world heritage monuments, Bibi Ka Maqbara, was built by Azam Shah, the son of Aurangzeb. Perhaps due to puerperal fever, his mother, Dilras Banu Begum, passed away on October 8, 1657, one month after giving birth to her fifth child.(Oxford University Press, 2025)

Self-reports showed that 3.9% of Indians between the ages of 15 and 49 had at least one of the four main NCDs: 0.8% had heart disease, 2% had diabetes, 1.4% had chronic respiratory illness, and 0.1% had cancer, 82-68 %, and 74 % had sought medical attention for their illnesses. Compared to men with diabetes or long-term respiratory disorders, women were more likely to seek disease-specific treatment. Compared to Hindus, married persons, and those without health insurance, Muslims, single people, and those with health insurance were more likely to receive cancer treatment.

To encourage as many people who are aware that they have major non-communicable diseases to seek treatment, a multimodal approach to healthcare policymaking is definitely necessary. Despite being aware of their condition, one-third (chronic respiratory disease) and one-fifth (cancer) of 15–49-year-

olds reporting a major NCD had never sought treatment. This highlights the need to enhance treatment uptake through accessible healthcare. (Netterström-Wedin & Dalal, 2023)

The health of women is one of the topics that Indian society ignores the most. Food inadequacies are the main cause of the rise in fatalities in rural regions, while ignorance and the spread of western culture in urban areas deteriorate people's health and make them more vulnerable to numerous diseases. The lack of medical resources and facilities, especially for pregnant mothers, is said to have contributed to the higher death rate in rural areas in 2023. (Punj et al., 2023)

P. Mani C. Reddy conducted a cross-sectional study in 2020 to learn how rural women in Telangana seek medical care. Participants in the study sought medical attention as soon as symptoms appeared and needed a family member's consent before beginning treatment. (Reddy et al., 2020)

The findings showed that 71% of people in rural areas and 69% of people in cities reported being sick in the preceding year. People from both regions said that they preferred private healthcare to public healthcare. (Yadav, 2022)

Positive health-seeking habits and awareness of health insurance coverage are more common in urban than rural settings. Raising knowledge of health insurance and encouraging health-seeking behavior is essential, especially in rural areas. (Sulthana et al., 2024)

Limited studies have compared the health profiles and healthcare-seeking behaviors of women living in rural and urban areas within the same geographic region, despite the increasing amount of research on women's health and treatment-seeking behavior. While metropolitan women may have better access to healthcare services and health information, rural women frequently encounter obstacles such as a lack of healthcare facilities, financial limitations, and societal restrictions. Designing successful community health initiatives and increasing healthcare accessibility require an understanding of these distinctions. As a result, it's critical to evaluate and contrast the health profiles and treatment-seeking behaviors of women in rural and urban settings.

In order to empower women and improve health outcomes for their families and communities, it is critical to evaluate the health profile and treatment-seeking behavior of women living in rural and urban areas.

Material and method-

The present study used a comparative cross-sectional research design. This comparative, two parallel group study include women (n=125) in one group of urban area and (n=125) women in rural area. To select the participant's convenience sampling was used and study was conducted in community area of district, Mohali, Punjab. This study was done between march, 2025 and may, 2025 at selected community area district. The study participants included women seeking treatment between the age of 20 or above 20 years both married and unmarried women.

Based on the pilot study the mean (20.3) and SD (5.38) of total scores of behavior of women seeking treatment was used to calculate sample size through chochrane formula (by power analysis) the

estimated sample size was 229. the study with this sample size had a power of 80% at 0.005% significance level. However total sample size was withdrawal 250 women, 125 in urban area group and 125 in rural area group.

$$n = \frac{Z^2 \sigma^2}{l^2}$$

$$n = \frac{(1.96)^2 (5.382)}{0.64}$$

In a convenience sampling of the total number of participants screened criteria and were assigned to either rural area women eligibility (n=125) in each group met the inclusion criteria and were assigned to either rural area women group (n=125) and urban area women group (n=125)

Recruitment commenced after ethical approval was granted by the research ethics committee of S.P.H.E college of Gharuan. Subsequently the researcher explained the objectives & procedure of the study to potential participants who met the inclusion criteria, who were then encouraged to ask any questions about the research before providing their informed consent. Written informed consent was obtained from those women who were willing to participate in study.

The socio-demographic questionnaire prepared through a literature review, consisted of data related to age, marital status, duration of marriage, level of education, type of residence, occupation, monthly family income & any health insurance coverage, BMI of participants.

The self- structured 3-point Likert scale questionnaires related to assess the behaviour of women seeking treatment consist of 11 items.

The total score of index ranges from 0 to 33. A score of zero to three indicates response to health problem or illness in order to restore their health to optimal level. Participants are instruct to mark as “never, sometimes & often” if they response sometimes and often then they have to specify in response of item mentioned.

The reliability of the self-structured questionnaire regarding behaviour of women seeking treatment was confirmed based on cronbach’s alpha coefficient test (α 0.80) however in the present study the cronbach’s alpha coefficient of self-structured questionnaire tool regarding behavior of women seeking treatment was as 0.71.

The reliability of self-structured questionnaire tool regarding behavior of women seeking treatment scale was assessed with 10 women in rural area group and 10 women in urban area group, whoever not included in the main study.

Participants met inclusion criteria if they were available at the time of data collection, who understand & read Hindi, English, Punjabi. Participants were excluded if they were not present at the time of data collection.

The self-structured questionnaire tool regarding behavior of women seeking treatment were completed through self-reporting, this tool typically required around 8-10 minutes while the socio-demographic variables tool took about 3-5 minutes to complete.

Descriptive statistics were used to interpret the sample characteristics. The chi-squares, frequency test were used to compare qualitative variables. In addition independent t-test were used to determine difference in quantitative data both within the group & between the group. The SPSS version 16 was used for all data analysis. At *P*- value of <0.05 was considered statically significant.

RESULT-

Table 1: Frequency and percentage distribution of respondents according to their Socio-demographic variables

N=250						
Variables	opts	Urban f (%)	Rural f (%)	Chi test	df	P value
Age(years)	20-35	24(19.2%)	20(16%)	14.9	3	0.03*
	31-45	34(27.2%)	32(25.6%)			
	41-55	26(20.8%)	30(24%)			
	>55	41(32.8%)	43(34.4%)			
Marital Status	Single	32(25.6%)	30(24%)	6.43	2	0.06 NS
	Married	77(61.6%)	70(56%)			
	widowed	07 (5.6%)	09(7.2%)			
	Divorced/Separated	09 (7.2%)	16(12.8%)			
Marital duration in years	0-5 years	46(36.8%)	40(32%)	8.3	2	0.04*
	6-10 years	27(21.6%)	27(21.6%)			
	>10 years	52(41.6%)	58(46.4%)			
Level of education	No formal education	28(21.8%)	17(13.6%)	17.8	3	0.001*
	Primary education	37(29.6%)	48(38.4%)			
	Secondary education	40(32%)	29(23.2%)			
	Higher education	20(16%)	31(24.8%)			
Type of residence	Rural	125(50%)	125(50%)	NA	--	--
	Urban	125(50%)	125(50%)			
Occupation	Government employee	04(3.2%)	02(1.6%)	20.4	3	0.001*
	Private employee	03(2.4%)	05(4%)			
	Student	39(31.2%)	41(32.8%)			
	Homemaker	79(63.2%)	77(61.6%)			
Monthly family income	5000-15000	50(40%)	50(40%)	4.82	3	0.79NS
	15001-25000	30(24%)	30(24%)			
	25001-40000	20(16%)	20(16%)			
	>40000	25(20%)	25(20%)			
Any health insurance coverage	Ayusman card	32(25.6%)	17(13.6%)	2.11	3	0.56NS
	Under employ state insurance	37(29.6%)	48(38.4%)			
	Private insurance	40(32%)	50(40%)			
	Other	16 (12.8%)	10(8%)			

Interpretation - The table shows that in both urban and rural areas, the majority of respondents (32.8%) are aged >55 years. Most respondents are married, with 61.6% in urban areas and 56% in rural areas. Regarding marital duration, 40.8% of urban and 49.6% of rural respondents have been married for over 10 years. In terms of education, 32% of urban respondents studied up to secondary level, whereas 38.4% of rural respondents studied only up to primary level. Equal numbers of respondents (125 each) are from urban and rural areas.

Occupation-wise, urban respondents include 3.2% government employees, 2.4% private employees, 31.2% students, and 63.2% homemakers; rural respondents include 1.6% government employees, 4% private employees, 32.8% students, and 61.6% homemakers. Monthly family income is similar across areas: 40% earn 5,000–15,000, 24% earn 15,001–25,000, 16% earn 25,001–40,000, and 20% earn >40,000.

Regarding health insurance, urban respondents have 22.4% Ayushman card, 29.6% employee state insurance, 32% private insurance, and 8% other insurance; rural respondents have 13.6% Ayushman card, 38.4% employee state insurance, 23.2% private insurance, and 8% other insurance.

Table 2: Item wise frequency and percentage distribution of assessment of health profile of women

N=250

VARIABLES	GROUPS			
	Urban(n=125)		Rural(N=125)	
Assessment of health profile among rural and urban areas based on selected questions	Yes f (%)	No f (%)	Yes f (%)	No f (%)
Any medical diagnosis	48(38.4%)	77(61.6%)	91(72.8%)	34(27.2%)
Any previous pregnancy associated complications	55(44%)	70(56%)	97(77.6%)	28(22.4%)
Do you take any iron and folic acid supplements	101(80.8%)	24(19.2%)	52(41.6%)	73(58.4%)
Do you take vitamin supplement	61(48.8%)	64(51.2%)	37(29.6%)	88(70.4%)
How often do you visit for general health checkup	55(44%)	70(56%)	97(77.6%)	28(22.4%)
Do you use sanitary products (pad, tampon menstrual cups) during menstruation	50(40%)	75(60%)	73(58.4%)	52(41.6%)
Have you ever had a routine screening	37(29.6%)	88(70.4%)	77(61.6%)	48(38.4%)

Interpretation - The table shows that among urban women, 61.6% had no medical diagnosis, whereas 72.8% of rural women had a medical diagnosis. Regarding previous pregnancy complications, 56% of urban women had none, while 77.6% of rural women had complications. Most urban women (80.8%) take iron and folic acid supplements, compared to 41.6% of rural women, while 51.2% of urban women take vitamins versus 29.6% of rural women. For general health checkups, 56% of urban women do not visit regularly, whereas 77.6% of rural women often visit. During menstruation, 60% of

urban women do not use sanitary products, while 58.4% of rural women use them. Routine screening shows that 70.4% of urban women never had screening, compared to 61.6% of rural women who had routine screening.

Table: 3 Comparison of health profile of women using unpaired t test

N=250

VARIABLES	comparison	Comparison of health profile of women residing in selected rural and urban areas of district Mohali (unpaired t test)			
		Group	Mean ±SD	df	Unpaired t test
Health Profile	Urban		22.98±5.1	98	21.13 <i>p</i> =0.003*
	Rural		15.84±2.4		

$p < 0.05$ = significant $p > 0.05$ = Non significant ** $p = \leq 0.001$ level of significance

Interpretation - The health profile of women in urban and rural areas differed statistically significantly ($p = 0.003$). Urban women had a mean health profile score mean and standard deviation was 22.98±5.1, which was substantially higher than that of rural women score mean and was 15.84±2.4. This suggests that women living in cities had better health profiles than those living in rural areas.

Table 4: frequency and percentage distribution of assessment of treatment seeking behaviour of women

N=250

Variables	Groups					
	Urban(n=125)			Rural(N=125)		
Assessment of treatment seeking b among rural and urban areas based on selected questions	Never f (%)	Sometimes f (%)	often f (%)	Never f (%)	Sometimes f (%)	often f (%)
Do you find it difficult to talk to family members about your health issue	17(13.6%)	49(39.2%)	59(47.2%)	20(16%)	49(39.2%)	56(44.8%)
Do you need anyone in your family's approval to enter medical facilities	10(8%)	54(43.2%)	61(48.8%)	38(30.4%)	41(32.8%)	46(36.8%)
Do you feel insecure/unconfident while discussing your healthcare provider	12(9.6%)	39(31.2%)	74(59.2%)	15(12%)	54(43.2%)	56(44.8%)
Do you hide a health problem from friends and relatives out of fear of judgement	20(16%)	69(55.2%)	36(28.8%)	18(14.4%)	47(37.6%)	60(48%)

Do you trust the advice given by doctors or health professionals	10(8%)	54(43.2%)	61(48.8%)	38(30.4%)	41(32.8%)	46(36.8%)
Have you ever been misdiagnosed or received incorrect treatment	12(9.6%)	39(31.2%)	74(59.2%)	15(12%)	54(43.2%)	56(44.8%)
Are you able to make your own health care decisions	17(13.6%)	49(39.2%)	59(47.2%)	20(16%)	49(39.2%)	56(44.8%)
Do you visit to the doctor as soon as you start having symptoms	14(11.2%)	52(41.6%)	59(47.2%)	19(15.2%)	50(40%)	56(44.8%)
Have you ever received vaccination as an adult	10(8%)	54(43.2%)	61(48.8%)	38(30.4%)	41(32.8%)	46(36.8%)
Do yo prefer self treatment over visiting to a hospital	20(16%)	69(55.2%)	36(28.8%)	18(14.4%)	47(37.6%)	60(48%)
Are you aware of functions nearby hospital/health centre	12(9.6%)	39(31.2%)	74 (59.2%)	15(12%)	54(43.2%)	56(44.8%)

Interpretation - The results show that women in urban and rural areas have quite different treatment-seeking behaviors. Urban women showed more positive health-seeking behaviors, such as self-assurance when talking about health issues, making their own health decisions, and seeking help as soon as symptoms arise. Rural women, on the other hand, demonstrated a larger reliance on family acceptance, a preference for self-treatment, and a propensity to conceal health difficulties out of fear of being judged, which reflects a lack of autonomy and more societal barriers. In general, metropolitan women behaved better than rural women when it came to obtaining therapy.

DISCUSSION

In total 250 of the participants completed this study (125 participants in each group) urban & rural. There was no statistically significant difference between the two groups in most socio-demographic data except age, marital duration in years, level of education & occupation as their (p -value is 0.003, 0.04, 0.00 & 0.00 respectively) indicating partial non-homogeneity. Similar study was conducted by **Pengpid Supa (2024)** in his study he also found that there were significant difference ($p < 0.001$) in terms of socio-economic status between rural & urban dwellers. In our study the independent sample t -test conducted on scores taken on same day of data collection reveal that overall mean of health profile of women scores rural group was lower than the mean of urban area, women group (15.84 ± 2.4 & 22.98 ± 5.1) (p -value was 0.003 significant at the level of (α 0.05) which show that there is difference between two groups urban and rural area women related to health profile. These disparities in health profile scores may be partly explained by difference in socioeconomic status. (Pengpid & Peltzer, 2024)

Out of the 250 women who was seeking treatment of both area of the district, Mohali (72.8%) 91 were previously diagnosed with some disease and often visit to physician for general checkup (77%) 97

women in rural area as compare to urban area. In contrast to present study another study done by **(Verma Vandana) 2021** he found that urban residents were more likely to seek treatment for their health problem than rural residents.(Verma et al., 2021)

While our study found a higher proportion of routine screening among rural women (61%). than urban women (29.6%). This finding is unusual when contrast with study by **(Garg Priyanka) 2025** show greater urban women (2.4%) reported screening uptake than rural women (1.8%). This discrepancy may reflect the impact of local outreach, health camps & mobile health services in urban areas.(Garg et al., 2025)

In present study (22.4%) 28 of rural women were classified as underweight (BMI 17 to 18.5) compared to urban only 8% of women. but it also concluded that most of urban women (44%) falling in overweight and obesity category as (30 BMI 25 to) or (BMI 30 to 35). Similar result found in study conducted by **Goouda Jitendra (2014)** show that overweight & obesity are more prevalent among urban women (23%) than rural women (7%) in India, with the burden highest among non-poor urban women. (Akbaribazm et al., 2021) Another study done by **AI Kibria (2019)** he also concluded that underweight was more common among young, poor, rural women (22.9%) while overweight & obesity were higher in older, Wealth, urban women (22.6% & 10.7%) showing clear disparities.(Al Kibria et al., 2019) Similar result shown in study done by **Pradeepa Rajendra(2013)** that the clinical and biochemical characteristics of the study subjects. In all the four regions, urban residents had significantly higher weight, BMI, waist circumference, diastolic BP and fasting and 2 h post glucose CBG compared to rural participants. Overall, in both urban and rural areas, women had higher mean BMI values than men.(Pradeepa et al., 2025)

As in the study majority of the participants in urban study areas were taking iron & folic acid supplement 80% in comparison to rural area women, very few only 41% women consuming these supplements. This finding is supported by another study done by **Chourasia Ankita (2017)** revealed that higher education, higher socioeconomic likely contribute to the observed urban –rural disparity in Iron folic acid supplementation with 80% of urban women versus 41% of rural women consuming the recommended doses.(Chourasia et al., 2017) another study done by **Yassin Mathewos Abatkun (2024)** found that urban residence, higher educational attainment, and better socio-economic conditions are strongly associated with improved IFA consumption. Conversely, rural women often face barriers such as distance from health services, inconsistent supply of IFA tablets, and misconceptions about side effects.(Yassin et al., 2024)

Also we found that most of study participants use the private health sector for treatment that is 32% and 40% in urban and rural area. Less than half of the subjective use government facilities (25.6%) (13.6%) in urban and rural area. Similar result revealed in study by **Yadav Rajaram (2022)** that about 63% individual prefers private health care, while only 37% use public facilities. Women prefer it for reason likely due to better quality care, shorter waiting time & greater accessibility.(Yadav et al., 2022)

In our study majority of rural area women (77%) had. Experienced complication in their previous pregnancies, compared to (44%) of urban women. This result align with the study by **kuppusamy (2023)** which highlighted greater prevalence across India, particularly in rural area it support notion that due to inadequate health. Care access & socioeconomic disparities. (Kuppusamy, n.d.) However there is contrast result shown by **Kumar et al. (2021)** reported that urban women had a slightly higher prevalence of maternal complications (53.8%) compared to rural women (56.2%) based on NFHS data from 2015-16. (Kumar et al., n.d.)

A key finding of our study was that there was no significant difference in treatment seeking behavior between urban women (mean = 27.6 ± 5.89) & rural women (mean = 2.52 ± 5.26) with a p-value of 0.57 indicating non-significant. This result is supported by study done by **Kaur Anoop (2018)** she also concluded that a higher proportion of urban women (62%) demonstrated good health seeking behavior compared to 48% in rural women, the difference was statistically non-significant ($p > 0.05$) this consistency suggests that despite socioeconomic difference rural & urban women may exhibit largely similar patterns of treatment seeking behavior. (Kaur et al., 2018) A comparable result was observed in a study conducted by **Apoorva M. Sheeba and Thomas Vimala (2018)** they found that **25.4% of rural women and 14.7% of urban women** did not seek any form of healthcare, indicating that although healthcare utilization was slightly higher among urban women, the difference was not substantial. (M. Sheeba Apoorva, n.d.) Similar study by **Patra Shraboni (2022)** reported that women over 35 years were significantly less likely to seek treatment compared to women under 30 ($p < 0.05$). Women with higher educational attainment were substantially more likely to utilize healthcare services ($p < 0.01$), and those with regular media exposure were also significantly more likely to seek treatment ($p < 0.05$), indicating a significant association between these factors and women's health-seeking behaviour. (Patra & Unisa, 2022)

In the present study, no significant difference was found in treatment-seeking behaviour between urban and rural women ($p = 0.576$). Nearly half of the urban participants reported difficulty discussing health issues with family members, and more than half felt insecure around medical professionals, sometimes concealing health problems due to fear of judgment. Although 59.2% reported misdiagnosis, 48.8% expressed trust in physicians, and 47% sought timely treatment. Self-treatment was preferred by 55.2%, and vaccination coverage was 48.8%. Most respondents were aware of nearby health facilities. A similar study by **Shiv Ratan, Seema Nigam, and Tanu Midha et al. (2022)** also found no significant association between treatment-seeking behaviour and residence ($p = 0.582$), with 39.8% of rural and 43.6% of urban women receiving therapy. Most participants sought care from government hospitals (36.5%), while long waiting times and financial constraints were major barriers. These findings indicate comparable health-seeking behaviour among rural and urban women despite socio-economic differences. (Shiv Ratan, n.d.)

Another important finding of our study was that (58.4%) of rural women reported using sanitary products such as pad, tampons during menstruation, compared to only (40%) of urban women. This

result partly supported by **Senapathi Pardeep (2018)** in his study menstrual hygiene management was found to be sub-optimal among both urban as well as rural adolescents. (Senapathi, n.d.) In contrast to these finding a study by **Chakrabarty Mahashweta (2023)** which show that the use of hygiene materials among adolescents girls is significantly higher in urban areas (68%) compared to rural areas (43%), highlighted a persistent rural –urban gap in menstrual hygiene practices in India. (Chakrabarty et al., 2023)

Conclusion

The study concludes that there is a significant difference in the health profile of women living in rural and urban communities, with urban women demonstrating comparatively better health indicators. However, treatment-seeking behaviour was found to be relatively similar between rural and urban women. Strengthening health education programs, improving accessibility to healthcare facilities, and increasing awareness about preventive health practices are essential to reduce rural-urban disparities in women's health.

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