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RESEARCH PAPER

Exploring Health Seeking Behavior among Rural Men in Punjab, Pakistan: Insights from HealthCare Providers

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ABSTRACT

This study explores healthcare providers' perspectives to identify the socio-demographic, economic, cultural and health system factors shaping health-seeking behavior of rural male population. Pakistan is facing several challenges due to epidemiological transition. Although progress has been made, Pakistan's health status, especially of rural population is falling behind in the region. Exploring the factors of health seeking behavior of rural male population can yield critical roadmap for improving health outcomes in these communities. The data is collected through in-depth interviews of nine healthcare providers from various healthcare provision systems in the locale. Braun & Clarks approach of thematic analysis is used to analyze data. The analysis reveals key barriers such as financial constraints, educational deficits, cultural beliefs, and inadequate health infrastructure are identified by healthcare providers. The need for qualified medical personnel and essential medicines has inversely affected healthcare utilization. This study provides valuable insights for policymakers highlighting the need to develop and implement culturally sensitive health promotion strategies.

Keywords: Health Seeking Behavior, Healthcare Barriers, Healthcare Providers, Rural Health

Introduction

Health seeking behavior and utilization of health-care services are essential determinants to consider. They may influence the outcome measures, which may be compounded in rural settings where access to quality health services is often scarce (Butt & Islam 2022). Unique challenges, including the socio-demographic, economic, cultural, health system and geographical factors, are faced by the rural male population of Punjab, Pakistan, which influences their health-seeking behavior as health workers are closely linked to the delivery of care and have an opportunity to observe the behavior aspect directly (Shaikh et al., 2008; Peters et al., 2008; Ahmed et al., 2013). These challenges are further compounded in Pakistan by a public health system that is severely under-resourced, coupled with widening socio-economic inequities that disproportionately affect rural areas. (Khan et al., 2019).

The opinions of healthcare providers who are among the protagonists responsible for deploying rural men's healthcare services provide valuable information on what factors serve as barriers and facilitators to healthcare access from their standpoint. They articulate realities of structural and contextual causes that affect health behavior commitments (Ombok et al., 2022). Research to date has mainly focused on patients' experiences, and there is consequently a gap in knowledge about how health-care providers perceive them. HCP perspective can also give important insights into health system performance and the effects of cultural and social norms on health-care utilization (Shaikh et al., 2012; Rao et al., 2011).

Literature Review

Health seeking behaviors and utilization patterns of rural male population of Punjab are shaped by socio-demographic, economic, cultural, systemic and geographical factors (Olanrewaju et al., 2019). Understanding these communities is essential for designing effective interventions targeting health outcomes (Khan et al., 2020).

Health-seeking behavior is determined primarily by age and sex. Older people are more likely to use the health system due to a higher risk of illness. Throughout rural dwellings, men are the focal point of decision-making for family health-care use, therefore affecting overall utilization by household members (Naz et al., 2020). The priorities of girls are often seen as subordinating (health) to the boys, negatively impacting health welfare dynamics within households in rural areas due to gender norms. Education also has a strong impact, as people with more education tend to be better informed about health concerns and the services available. People with higher education prefer private health care (Mushtaq et al., 2011). Inversely, lower education levels can contribute to the use of traditional healers and delayed health care seeking, leading to worse physical health outcomes.

Health seeking behavior is also determined by marital status, which has implications on sex, family societal norms, etc. Given that married men were usually the breadwinners, they might be more likely to spend money on their health care so that they could work and provide for their families. The pressure of being well enough to survive economically influences their health-seeking behavior (Kumar & Bala, 2012). Another important determinant is the socioeconomic status (SES). Higher SES individuals have better availability of health services and are more likely to have access to private health care, while lower SES people face severe limitations, even struggling to meet the cost. This gap is seen in rural areas already dominated by poverty and rely on public health services with a lack of any other suitable alternative due to low income (Mushtaq et al., 2011; Hussain et al., 2019).

Health seeking behavior is also shaped by family structure and number of dependents. In the case of larger families, with more dependents to support, less potential income is available for health care. Thus, more common issues are deferred for management until they become serious (Singu & Kaur, 2017). In addition to supply chain and socio-demographic factors, economic determinants percolate downstream, affecting health-seeking behavior or utilizing available health care in rural Punjab. The individual's income level is one such factor, with higher incomes potentially allowing for private health-care facilities due to perceptions of superior quality services (Mushtaq et al., 2011; Hussain et al., 2019).

Health seeking behavior and health-care utilization are deeply rooted in cultural norms. As they are culturally accepted and accessible; traditional healers are regularly favored over formal health-care providers. Besides these expensive sources, traditional practices are part of the community, and at times, they consider them more authentic than modern medical services (Anwar et al., 2012). Health-seeking behavior According to tradition, gender roles and expectations concerning decision-making for health care in families lean on the man as the imperative to having more authority than women. Women of lower socio-economic strata are considered the most vulnerable group for health-care utilization due to a downtrodden state in social norms and being overburdened with family responsibilities (Winkvist & Akhtar, 1997). Negative societal perceptions and pressures often prevent people from receiving the care they require, as is true in tuberculosis (Anwar et al., 2023). Further, behaviors of family dynamics and community expectations also contribute to health-care decision-making as the main household drivers decide to timely utilize the services (Qureshi et al., 2016).

In conclusion, cultural factors, health system deficiencies and geographical/infrastructural barriers combine to affect the health seeking behavior of rural male population in Punjab for utilization of health-care services.

Theoretical Framework

The study utilizes a framework which elucidates the complex interplay of factors influencing health behaviors, incorporating elements from the Health Belief Model (HBM), Andersen's Behavioral Model of Health Services Use, Social Determinants of Health, and Cultural Competency Theory to provide a holistic understanding.

The Health Belief Model (HBM) assumes that health-related actions are influenced by perceived susceptibility, perceived severity, perceived benefit bars of the action, and cue to biological (Rosenstick, 1974). The perceived susceptibility to be ill, on the other hand, might remain underestimated by men in rural Punjab either because they have no health education or possess a fatalistic attitude towards a possible future illness. Perceived Severity - how serious a set of health symptoms or underlying condition is will also contribute to increased urgency in seeking medical treatment. The other reason is perceived benefits, which refers to the belief in the effectiveness of advised action to reduce the threat of illness (Anwar et al., 2012), as rural men may prefer traditional healers over formal medical services if they sovereign more significant benefit from that.

According to Andersen's Behavioral Model, health service utilization could be better understood by a comprehensive and multilevel model that distinguishes determinants in terms of predisposing factors (e.g., need awareness), enabling factors (ability to use services), and need factors . These include demographic features (age, education level, and marital status), social structure (ethnicity, social networks), and health beliefs focusing on attitudes towards health care. Among other factors, in rural Punjab, traditional male gender roles and lower education levels may lead to a delay in seeking health care among men (Naz et al., 2020). In rural settings, the lack of infrastructure and financial resources is crucial in determining access to health care (Sughra et al., 2018). Need factors include both perceived and actual need for medical care when perceived need depends on symptom recognition of individuals, while actual need rests upon severity and type of health conditions (Mushtaq et al., 2011). Strategies to improve healthcare utilization must consider the predisposing and enabling factors.

Above all, Cultural Competency theory is a conceptual framework for understanding and guiding an individual or group as they provide quality health care to others (Betancourt et al., 2002). This would require the acknowledgment and respect for health beliefs and cultural values of racial/ethnic minority populations as a point to start in addition to an understanding of their culture. It is also needed to address these factors (cultural) to be part of any dimension of care delivery (Winkvist & Akhtar, 1997). Promoting the importance of cultural competence for healthcare providers leads to better outcomes and higher levels of patient satisfaction. It is an essential theory for promoting culturally relevant healthcare systems to serve the rural population (Anwar et al., 2012). By integrating these, the present study attempts to comprehend the Health Seeking Behavior characteristics among the male rural communities in Punjab Province, Pakistan.

Material and Methods

This study employs qualitative research as part of a larger qualitative case study for a PhD dissertation. (Yin, 2018). The aim is to explore the Healthcare Provider's (HCP) perspective on factors affecting health seeking behavior and health care utilization. A qualitative approach is appropriate for this research as it allows for an in-depth understanding of the complex, context-specific factors that influence health behaviors in this rural setting (Creswell, 2013).

Study Setting

The study was conducted in a rural union council (UC) of Tehsil Arifwala, District Pakpattan in Punjab, Pakistan which is situated in the southern side of the province. This setting was chosen due to its representative nature of rural health care dynamics and the availability of a diverse range of health care providers within the community. The UC has variety of health care facilities, making it an ideal location to study the health care provider's perspective about health seeking behavior. The setting provides a comprehensive context to explore how socio- economic, environmental and cultural factors shape health care utilization patterns (Hussain et al., 2019).

Participants

Nine health care providers serving the rural community were selected for in-depth interviews. The demographic characteristics of these participants are detailed in Table 1. The participants included a senior medical officer, a homeopath, a dispenser, a quake, two hakeems (one of whom also practices faith healing), a faith healer, a lady health worker, and a bone setter. Their ages ranged from 33 to 68 years, and their professional experience varied from 5 to 40 years. The selection criteria for these participants were based on their direct involvement in providing health care services to the male population in the targeted community. This diverse group of participants ensures a broad perspective on the factors influencing health seeking behavior and health care utilization (Mushtaq et al., 2011).

Data Collection and Analysis

Data were collected through semi-structured in-depth interviews with the nine health care providers. An interview guide was developed based on the research objectives and relevant literature, ensuring that key topics were covered while allowing flexibility for participants to share their perspectives freely. The interviews were conducted in the local language (Punjabi or Urdu), depending on the preference of the participant, and lasted between 70 to 90 minutes. Each interview was audio-recorded with the consent of the participants, transcribed verbatim, and translated into English for analysis (Ritchie et al., 2013).

Thematic analysis was employed to analyze the interview data. This method involves identifying, analyzing, and reporting patterns (themes) within the data. The analysis followed a systematic process of coding and categorizing the data to identify key themes and sub-themes related to the factors influencing health seeking behavior and health care utilization (Braun & Clarke, 2006).

Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional review board. Participants were informed about the purpose of the study, the voluntary nature of their participation, and their right to withdraw at any time without any consequence. Informed consent was obtained from all participants before the interviews. Confidentiality and anonymity were assured by assigning codes to the participants instead of using their names in the transcripts and reports (Orb et al., 2001).

Thematic Analysis

The following table presents the diversity of health care systems in a rural union council as non-linear, complex, combining the formal, traditional with spiritual practices, through which rural men's engagements in healthcare may sometimes intersect. Such variety emphasizes the need to consider a number of different perspectives and approaches

in studying health seeking behavior, as well as utilization of services among rural populations.

Table 1
Distribution of Qualification, Age and Experience among Health Care Providers (HCP) in Rural Union Councils in Punjab-Pakistan

Sr. #	Type of HCP	Qualification	Age	Experience (years)
1	Senior Medical Officer (SMO)	*MBBS, **FCPS	52	25
2	Homeopath	***FA+ ****DHMS	44	22
3	Dispenser	FA+ Dispenser Diploma	33	5
4	Quake	Matric	52	20
5	Hakeem	Matric	46	20
6	Hakeem + faith healer	Primary	65	35
7	Faith healer	Primary	68	40
8	Lady Health Worker	Matric	50	20
9	Bone Settler (Jara'ah)	Illiterate	63	30

*Bachelor of Medicine, Bachelor of Surgery; **Fellow of College of Physicians and Surgeons
***Faculty of Arts (12 years education); ****Diploma in Homeopathic Medicine & Surgery

This table delineates various categories of healthcare professionals, detailing their qualifications, age, and experience, thereby offering insights into the diversity within the healthcare sector. The Senior Medical Officer (SMO), distinguished by an MBBS and FCPS, represents the highest level of formal medical education, being 52 years old with a substantial 25 years of professional experience. In contrast, the Homeopath, possessing an FA and a DHMS diploma, at 44 years old, has accumulated 22 years of experience in alternative medicine. The Dispenser, who holds an FA along with a Dispenser Diploma, is notably younger at 33 years old and brings 5 years of experience to the table.

The data also highlights non-conventional healthcare providers, including a Quack with a Matric education, aged 52 with 20 years of experience, and a Hakeem of similar educational background, aged 46, who also has 20 years of experience. Furthermore, a practitioner combining the roles of Hakeem and Faith Healer, despite having only primary education, demonstrates a long-standing practice with 35 years of experience at the age of 65. Similarly, a Faith Healer with primary education, aged 68, brings 40 years of experience to their practice. The Lady Health Worker, holding a Matric qualification, is 50 years old with 20 years of experience, providing crucial health services at the community level. Finally, the Bone Setter (Jara'ah), who is illiterate, has nonetheless amassed 30 years of experience at the age of 63, showcasing the persistence of traditional medical practices in certain regions. This table underscores the wide spectrum of healthcare providers, ranging from highly educated medical officers to traditional practitioners, each contributing uniquely to the healthcare landscape.

Results and Discussion

These thematic tables provide a structured summary of the key factors influencing health seeking behavior among the rural male population in Punjab, Pakistan, based on insights from health care providers. The thematic analysis thus reveals a complex interplay of age, economic constraints, education, employment status, and family structure affecting health seeking behavior among the rural male population.

Each table includes themes, descriptions, and illustrative quotes derived from the qualitative data collected during the in-depth interviews.

Table 2
Socio-Demographic and Economic Factors

Theme	Description	Illustrative Quotes

Age and Health Seeking Behavior	Younger rural men exhibit higher health seeking behavior if financial issues are not a hurdle.	"Younger men tend to seek health care more actively if they can afford it."
Economic Constraints	Financial constraints significantly limit the ability to seek formal health care services.	"Many avoid seeking care because they simply cannot afford it."
Education and Awareness	Lower levels of education and awareness contribute to delayed or avoided health care seeking.	"Most of them do not know enough about the importance of timely medical care."
Employment Status	Irregular or unstable employment affects the ability to afford health care services.	"Those without stable jobs often delay seeking treatment due to financial instability."
Family Structure	Larger family size and responsibilities can limit financial and time resources for seeking health care.	"With so many mouths to feed, spending on health takes a backseat."

The thematic analysis of socio-demographic and economic factors determining the health seeking behaviors among male rural population extracted detailed narratives from healthcare providers. The data shows that younger rural men have a greater potential to utilize healthcare, as long financial constraints are not strong disincentives. This is consistent with the expectation that young people might pay greater attention and be more willing to use health care, owing to their need for maintaining productivity or economic responsibilities and roles within families (Nicholls et al. 2010). This was reflected in the words of a health care provider who stated,

"They are not going to seek healthcare as actively as maybe younger males and the difference is those younger men probably have got better jobs or can afford healthcare".

Among these barriers, economic constraint are the major factor which prohibit them for access to more formal health care services. A number of these men will prioritize spending on bread and oil over health costs, which makes it difficult to see their way to seeking necessary help. A health care provider said, "What we see is that many wouldn't even touch a system because they just cannot afford it". This result is in line with previous study which showed that economic crises play important role as a barrier to access for health services when especially living rural area (Hussain et al., 2019). Financial barriers impact accessibility, not only in terms of the ability to pay for services themselves but also with regards to transportation and access issues surrounding healthcare facilities.

The reduced level of education and awareness adds to the delay or avoidance in seeking health care. Due to the abject lack of awareness among many rural men about need for medical care on time, most wait until a simple health issue escalates into something critical. However, one provider noted that "Most of them don't know enough about the value of getting medical care and how to get it done promptly". This highlights the key role of education in health-seeking idiosyncrasy (Mushtaq et al., 2011). There is also a correlation of better health literacy with higher level education, which enables more people become aware at an early stage and go for the right medical help. Interventions that target health awareness are important educational tools which can promote the prompt use of healthcare and have been shown to improve (not compromise) significantly on overall HSB.

Employment status plays a significant role in seeking health services. This is especially bad in rural locations where work can be spotty and seasonal. That has led to too many patients waiting for care because the lack of a steady job, which one health provider called to my attention. Economic insecurity caused by precarious employment was identified more than a decade ago as an enormous obstacle to health care. Secure employment with pathways for finances in place can help alleviate the issue (Mushtaq et al., 2011).

Furthermore, the studies demonstrated that family arrangement more specifically with larger families affect access to health care due to limited financial and time resources (Gomez 2011). Given competing numbers of dependents in families, there is usually little to

spend on health care over other pressing needs. Another provider said, "There are so many mouths to feed that health takes the backseat". This is symptomatic of the wider disadvantaged socio-economic position holding by family and its resource constraints, which must be addressed to cater for multiple needs in large rural households (Anwar et al., 2012; Winkvist & Akhtar, 1997). This suggests that health interventions need to be directed specifically at families, and support the large family in accessing healthcare.

Table 3
Cultural and Health system Factors affecting Health seeking Behavior

Theme	Description	Illustrative Quotes
Preference for Traditional Healers	Cultural beliefs lead to a preference for traditional healers over formal health care providers.	"People trust the traditional ways more; they believe in their local healers."
Gender Roles and Norms	Traditional gender roles impact health seeking behavior, often prioritizing men's health over women's.	"Men's health is often prioritized due to their role as breadwinners."
Social Stigma	Social stigma associated with certain health conditions deters individuals from seeking formal health care.	"There's a lot of shame around certain illnesses, so people avoid going to the doctor."
Familial Influence	Family members, especially elders, play a significant role in health care decisions.	"Decisions about seeking health care are often made by the head of the family."
Quality of Care	Perceptions of poor quality in public health facilities deter utilization.	"People think the care in public hospitals is not good enough."
Access to Medicines	Low availability of essential medicines in public health facilities affects health seeking behavior.	"Medicines are often out of stock, which discourages people from visiting."
Health System Reforms	Health system reforms aimed at improving services are necessary to enhance health care utilization.	"Reforms are needed to make health services more reliable and accessible."

This section presents a thematic analysis of cultural factors acting as barriers to health seeking behavior among the rural male population from perspective of healthcare providers. Cultural beliefs profoundly effects preference of traditional healers over the formal health care providers. This predilection is steeped in longstanding cultural habits and a reliance on local healers, as one HCP explained: "These are their own ways that they believe more; they have the belief of their traditional ways". People trust the traditional ways more; they believe in their local healer. In most cases, this preference for traditional healers results from their availability, perceived efficacy and cultural congruence with the medical health care systems (Anwar et al., 2012).

Consequently, the effects of traditional gender roles and norms on health seeking behavior are often reflected in widespread prioritization first for men's than women's health. Men are the main earners in many rural communities, and their health is often looked upon as critical to providing financial stably for a family (Qureshi et al. (2016). This societal expectation further contributes to prioritizing the health needs of men, which was expressed by a provider that "men's health is often prioritized because of their role as breadwinners". Such a gendered take on health-care can push the medical problems pertaining to women's bodies under carpet and get family members not seek care for their female associates (Ombok et al., 2022).

Individuals avoid formal health care as they are stigmatized for certain medical illness. For instance, illnesses like tuberculosis or mental health disorders that are associated with social shame can result in delayed treatment and lack of open dialogue (Winkvist & Akhtar, 1997). "There's so much stigma around certain illnesses, embarrassment about seeing your doctor," one health care provider said. This stigma is a social institution rooted in cultural norms and can slow early diagnosis because it makes people ashamed of seeking help.

In rural areas, health is a communal issue and decisions around it are usually shaped by senior family members. This hierarchy of decision-making may affect the utilization and timing of health care (Qureshi et al., 2016). One HCP said, "Most decisions related to seeking health care are made by the head of family". The respect for the opinion or suggestion of elderly could either promote health seeking behavior where these family members are well respected in a community, and/or inhibit it depending on how knowledgeable they were at that time (Bendtsen, 2002).

The interaction of these factors highlight a complex cultural milieu in which traditional beliefs, societal standards related to masculinity, social stigma (e.g. surrounding HIV status), and family fabric influence health seeking behavior among rural Punjabi men. These cultural barriers should be addressed through culturally sensitive interventions that honor and respect local traditions, practices and beliefs while offering awareness raising strategies on their right to health care services treated with confidentiality. (Betancourt et al., 2002; Basharat et al., 2019)

The quality of care provided in public health facilities is another primary concern. Healthcare providers noted that many rural residents perceive the quality of care in public hospitals as substandard. Inadequate infrastructure, insufficient medical supplies, and the perceived lack of competence or attentiveness among healthcare staff influence this perception. Poor quality of care can lead to adverse health outcomes and discourage individuals from seeking treatment in the first place. (Mushtaq et al., 2011). Addressing these issues requires a comprehensive approach that includes health system reforms and broader socio-economic development initiatives to improve living conditions and access to essential services in rural communities.

Conclusion

In conclusion, this study sheds light on the multifaceted factors influencing health seeking behavior and health care utilization among the rural male population in Punjab, Pakistan, from the perspective of health care providers. The findings underscore the significant impact of socio-demographic, economic, cultural, health system, and geographical barriers on the ability of rural men to access and utilize health care services effectively. Younger men showed a higher propensity for seeking health care if financial barriers were absent, while traditional gender roles and social stigma affected health behaviors. The lack of qualified medical personnel and essential medicines, coupled with poor transportation and long distances to health facilities, further deterred health care utilization.

Recommendations

From a policy perspective, the study highlights the need for targeted interventions to address the identified barriers to health-seeking behavior. Policies should focus on improving the availability and quality of healthcare services in rural areas, including increasing the number of qualified medical personnel and ensuring a consistent supply of essential medicines. Investment in health infrastructure, such as building and maintaining health facilities and improving transportation networks, is crucial to enhance physical access to health care. Furthermore, policies should support the training and integration of traditional healthcare providers into the formal healthcare system, recognizing their significant role in rural healthcare. Health insurance schemes and financial support programs should be developed to alleviate the economic barriers to accessing health care, particularly for low-income populations. Health education initiatives that are culturally sensitive and tailored to the specific needs of rural communities can also play a vital role in improving health literacy and encouraging timely health-seeking behavior.

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