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Health Service Seeking Behaviour of College Students in Rural Part of Murshidabad District of West Bengal (India)

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Abstract

'Need based Health Care Services' is the urge of the present century and to design 'Need based Health Care Services' for the nation understanding of 'Health Seeking Behaviour' (HSB) of population is essential. The policy makers must know the drivers of health seeking behaviour of the population for prevention, treatment, management of disease and promotion of health. At the community level, information regarding service utilization and preferences can be used to improve the appropriateness of the medical and health care services offered. In this context it had been realized that the students are the future of any nation. So, to maintain a healthy community an understanding of HSB of students is of paramount important. Secondly, Indian population mainly lies in rural areas. As the census report of 2011declare, 69% of Indian population are living in rural parts of India. These rural people have distinctive health problem, and they are mainly governed by their traditional beliefs, practices and ecological conditions. Some rural people still believe that a disease is always caused by hostile spirits or by the breach of some taboo. So, the health problems of rural need special attention. Taking these two things into consideration, in this study an attempt has been made to explore the perspective of rural student community towards the causes of various diseases prevalent and the health and HSB among the next generation of rural India. It was evident that rural students' health service seeking behaviour is a multi-dimensional construct which are affected by many variables. Healthcare quality affects their satisfaction, which in turn influences positive behaviours such as loyalty. Public health care facilities were preferred by due to low cost of services and HSB varies with the type of illness and income of the individuals.

Keywords: Health Seeking Behaviour, Need based Health Care Services, Rural Community, No Care Seeking Behaviour, Health Facility, Healthy Community.

1. Introduction

Health is well reflected and self-evident in the proverbial saying "Health is Wealth". Improved health status of individuals of any nation indicates greater human development which is an important parameter of economic development of the nation. So 'Health Care Seeking Behaviour' is directly a matter to the development of any nation.

As time passes on, the meaning of 'health' gradually has evolved. In earlier days 'health' was seen as a state characterized by anatomic, physiologic, and psychological integrity state of normal function that could be disrupted from time to time by disease. Health was seen as ability to perform personally valued

family, work, and community roles; ability to deal with physical, biological, psychological, and social status. Then in 1948, the World Health Organization (WHO) proposed a definition that linked health to well-being. WHO defined health in terms of physical, mental, and social well-being, and not merely as the "absence of disease and infirmity". But this definition was also criticized as being vague, excessively broad and was not construed as measurable. As the study by Chakraborty (1999) focused, the health of an individual or of a community is concerned not only with physical and mental status, but also with social and economic relationship. Mishra & Majhi (2004) mentioned that what is consider as being healthy in one society might not be considered healthy in another society. Ackernocht (1947) has pointed out that only in the abstract diseases and its treatment are purely biological processes. Actually, whether a person gets sick at all, the kind of disease he acquires and the kind of treatment he receives depend largely upon social factors. The common trust, customs and practices connected with health and disease have found to be intimately related with the treatment of disease (Majhi et. al, 2004). In order to bring holistic development of a society the cultural dimension of the health of a community should be given importance. Coming into the aspect of rural counterpart of a nation it can be said that the health problems of rural need special attention because the rural people have distinctive health problem, which are mainly governed by their traditional beliefs, practices and ecological conditions. Rural people in India, have their own beliefs and practices regarding health. Some groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo (Mishra & Majhi, 2004). They therefore seek remedies through magic & religious practices. On the other hand, some rural people have continued to follow rich, undocumented, traditional medicine systems, in addition to the recognized cultural systems of medicine such as ayurveda, Unani, siddha and naturopathy, to maintain positive health and to prevent disease. However, the socioeconomic, cultural and political ambushes, arising partly from the erratic exploitation of human and material resources, have endangered the naturally healthy environment, e.g. access to healthy and nutritious food, clean air and water, nutritious vegetation, healthy life styles, and advantageous value systems and community harmony. The basic nature of rural health problems is attributed also to lack of health literature and health consciousness, poor maternal and child health services and occupational hazards.

In rural societies, magico-religious means and treatment with different herbs and plants are the system of cure. Some rural societies have developed their own medicine system and some rudimentary knowledge base of medical techniques including the diagnosis of the disease at individual level. Both these techniques i.e. magico-religious and herbal medicine are used to cure the sick either together or separately. People have knowledge about the plants in their surroundings and also attribute cultural beliefs and practices to the plants.

Based on modern concept of health 'Health Care Seeking Behaviour' (HCSB) is defined as decision or an action taken by an individual to maintain, attain, or regain good health and to prevent illness. The decisions made encompasses all available health care options like visiting a public or private and modern or traditional health facility, self-medication and use of home remedies or not to utilize the available health services etc. Health care service seeking behaviour is basically an aspect of *help seeking behaviour*, either in advanced stages of ill health or as a precaution, of individual, who differ in their willingness for health care. HSB is defined as formal, when professional help was sought either from health care services or from health care providers i.e., physicians, psychologists etc. It is informal relational, when help was sought from members of the student's social network, i.e., parents, friends, teachers, trusted persons. HSB may be informal personal, when young people resorted to self-medication or browsed the Internet or read

self-help books. When an individual indicates both formal and informal behaviour equally regarding any problem, he or she is classified as engaging in formal behaviour. A category of "no care seeking behaviour" was subsequently created for those who reported health problems yet declared not taking any remediation steps.

Now understanding the main determinants of health care demand can be vital in furthering our knowledge of how changes in government policy will impact on individuals and their demand of heath care services. The policy makers must know the drivers of health seeking behaviour of the population for prevention, treatment, management of disease and promotion of health. The common beliefs, customs and practices connected with health and disease have found to be intimately related with the treatment of disease.

Socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of individual, economic and political factors may be the factors influencing the utilization of a health care system of a nation. In the context of developing countries poor roads, lack and high cost of transport may be the reasons behind not attending health care service facilities.

Census Reports of our country declare; Indian population mainly lies in rural areas. 2011 census report found 69% of Indian population as rural. And students are the future of any nation. So, to maintain a healthy community an understanding of health-seeking behaviour of students is paramount important. In this background the present study will try to assess the health-seeking behaviour of the college going students of rural areas towards public and private health care facilities in our country. In this study an attempt will be adopted to find the association between health seeking behaviour and selected variables. At the community level, information regarding service utilization and preferences can be used to improve the appropriateness of the medical and health care services offered.

2. Review of Literature

Study by Adhikari and Prasad[1] (2014) focused that the factors affecting health seeking behaviour were significantly associated with type of response of family members, source of income and economical status of the family, decision makers, severity of illness, cost of treatment, source of information, availability of health facilities, types of health facilities, distance of nearest health facility, ignorance of disease due to old age, poverty, poor attitudes of health worker, lengthy treatment process, trust on God for healing if ill, living alone and lack of someone to take them to hospitals and feelings of better treatment available elsewhere rather than formal health institutions. According to Chauhan[2] et al (2015) Health seeking behaviour of people depends on the perception of people regarding the quality of health care services in health centres. Manmeet[3] et al (2013) focused that gender differences in health care seeking behaviour should be kept in mind while selecting strategies for reducing delay in diagnosis and improving adherence to treatment of tuberculosis patient. Their study revealed the fact that the delay in diagnosis occurred more often among men than in women. The study by Dr. Atif[4] et al (2014) identified the socio-economic determinants affecting the health seeking behaviour of public residing in Karachi and Hyderabad. Rose Ann[5] et al (2013) pinpointed that Private health care facilities are preferable during the period of their illness. Using data from the India National Family and Health Survey-2 conducted in 1998-99 the study by Rani[6] (2003) explored significant differentials in care-seeking by age, caste, religion, education, household wealth, and women's autonomy.

Navaneetham[7] et al (2002) examined the patterns and determinants of maternal health care utilization across different social settings in south India (Andhra Pradesh, Karnataka, Kerala and Tamil Nadu). The

study pointed out that utilization of maternal health care services is not only associated with a range of reproductive, socio-economic, cultural and program factors but also with state and type of health service. *In international context,* a study of thesis by David Lawson[10] (2004) of University of Manchester in Uganda focused the fact that in poor countries like Uganda where large proportions of households are below the poverty line, understanding the determinants of health care demand provides a basis upon which governments can reform health policy particularly introducing user fees, and government objectives of recovering cost or increasing allocative efficiency. Study of David Musoke et al[11] (2014) highlighted that there is potential for stakeholders in health service provision to increase access to health care in communities with limited access to health facilities such as in rural areas by increasing the frequency of mobile clinic services and strengthening the community health worker strategy and by addressing the health systems challenges such as stock-out of drugs at health facilities by ministries of health which have for long affected health service delivery .

A research study by Laura Anselmi et al[12] (2015) resulted that where resources are limited, investing in service availability, in terms of number and type of Health Facility (HF) as well as resources in HFs will contribute to better quality of care and encourage populations to use health services. An investigation by M. O. Afolabi et al[13] (2013) explored the factors such as excessive waiting time at service delivery points and poor attitude of healthcare personnel that prevents the effective use of the university health centre. The factors include.

As far as both the national and international status is concerned, there is very little literature in the said field and very specifically no such study could be found which focuses on the rural college students. With this background the present study will try to examine self-rated health status of rural college students and their health seeking behaviour which is undoubtedly critical in health policy planning.

3. Objective of the Study

Health-seeking behaviour is viewed as the varied response of individuals to states of ill- health, depending on their knowledge and perceptions of health, socioeconomic constraints, and adequacy of available health services and attitude of healthcare providers (M. O. Afolabi et al, 2013). Examining consumers' healthcare behaviour can help in the design of ways to ensure better access to health and the quality of care.

The present study tried to examine self-rated health status of rural college students and their health seeking behaviour which is undoubtedly critical in health policy planning. The study tried to assess the health-seeking behaviour of the college going students of rural areas towards public and private health care facilities in Murshidabad district of West Bengal as because to maintain a healthy community an understanding of health-seeking behaviour of students is paramount important.

The specific objectives of this study are:

1. To gain information related to the activities of people that reported being ill in the past three months.
2. To explore the health service seeking behaviour of the students towards private and public health care facilities of rural colleges of Murshidabad district of the state West Bengal.
3. To find the association between health seeking behaviour and selected demographic and socio-economic variables.
4. To know whether the health needs of the students in the study area are being met or not.

4. A Brief Exposure to the Demography and Economy of the Sample

Both quantitative and qualitative aspects of targeted consumers are crucial factors for any study. Quanti-

tative aspects of target audience include composition, density, distribution, growth, movement and size. The knowledge of the quantitative phenomenon can help the marketing executives of the health service organization to decide upon the scale of operation that means the volume of production and qualitative aspects or the sociological factors such as educational quality, development, social class, income, motivational factors etc. helps to determine the degree of customization of the strategies related to either product quality, price range, availability or the promotion.

In this study out of 40782 villages in 19 districts of West Bengal 5 villages from Murshidabad districts of the state, has been selected to serve the purpose of the study. 100 students from each 5 villages in the district had been surveyed.

On the basis of the dataset obtained through survey of selected rural students of five colleges of West Bengal, the average view of the demographic structure of the respondents is such that the percentage of male members as a whole is 64 percent and that of the female members is 36 percent. 35% of total 500 students are Hindu and the rest as Muslim.

'Nuclear Family' concept has been accepted to a quite promising extent in the visited rural region as far as the average family size is concerned, it is 4.6 {(243+872+595+312+70+50+110+65)/500}. Considering the religion wise distribution of the respondents it is a quite promising picture that the small family size concept is also visible in the Muslim community nowadays.

As far as the occupational structure of the family members of the respondents is concerned, out of total 683 earning members of the surveyed villages 68 percent is engaged in agriculture, 24 percent is in manufacturing and 8 percent of the surveyed villagers are engaged in the service sector. It was evident that the population and worker ratio is quite impressive—3.4. Most of the respondents belong to the per capita annual income range of less than or equal to Rs.20,000.

5. Findings and Analysis

Coming into the main phase of the study it was evident that in last three months only 70 students out of 500 students had not been suffered from any kind of diseases. 70% of the students, i.e. total 347 reported their sufferings from fever. 1% reported their sufferings from jaundice, 2% reported skin disease, 1% pox, 2% typhoid, 1% allergy, 4% cough and so on. 2 students reported their sufferings from arthritis. 5 female students disclosed their irregularity of menstruation. 4% of the total surveyed students did not disclose their suffering. As it had been queried about the severity of their diseases it was evident that the severity of 19.1% of the suffered students (82) was high, severity of 51.2% (220) was moderate, and for the rest suffered students i.e. 29.8% (128) it was low.

Rural masses no more ignore their health. Out of 430 students who was suffering from any disease in last three months only 51 students went for treatment at the extreme stage of their sufferings. 210 students went to the doctor at intermediate stage and 169 students ger their treatment at early stage of their sufferings.

It was evident that 60% of the students who suffered from different diseases were depended on Health Services provided by the Govt. 30%, i.e. 127 students carried on their treatment in the Govt Hospital, 10%, i.e. 41 students in Hospital Outdoor and 20%, i.e. 87 students in Health Centre. But at the same time, it is a disheartening situation that the students are prone to take medicine directly from the retail shops without any consultation with the doctors. 17% of the students revealed the fact that they took medicine from the pharmacy without any expert consultation which is not at all expected. Another heartbreaking fact is that some students still go to the traditional healers in order to be cure. Though the figure is very small, only

17 out of 430, i.e., 4%, but it is indicating a backwardness of the rural areas of our country which is not at all expected.

Exhibit 1: Health Consciousness of the Students

Importance of Health for Human Being

Scale (S)	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	362	81	47	5	5
S*F	1810	324	141	10	5

Average Score= (1810+324+141+10+25)/500 = 2290/500 = 4.58

Self-Health Care

Scale (S)	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	305	119	38	28	10
S*F	1525	476	114	56	10

Average Score= (1525+476+114+56+10)/500 = 2881/500 = 4.36

Mental Upset for Illness in last 3 Months

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	91	76	167	90	76
S*F	455	304	501	180	76

Average Score= 455+304+501+180+76)/500 = 1516/500 = 3.03

Hesitation to share self-illness to friends

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	90	67	109	124	110
S*F	450	268	327	248	110

Average Score=(450+268+327+248+110)/500 = 1403/500 = 2.8

Worriedness of Symptom of Illness

S	Very Low (5)	Low (4)	Somewhat (3)	Much (2)	Very Much (1)
F	5	67	162	195	71
S*F	25	268	486	390	71

Average Score = (25+268+486+390+71)/500 = 1240/500 = 2.48

Illness Prevents to Daily Schedule

S	Very Low (5)	Low (4)	Somewhat (3)	Much (2)	Very Much (1)
F	71	24	176	124	105
S*F	355	96	528	248	105

Average Score = (355+96+528+248+105)/500 = 1332/500 = 2.66

How far hiding of disease expected

S	Very Low (5)	Low (4)	Somewhat (3)	Much (2)	Very Much (1)
F	467	-	10	5	18
S*F	2335	0	30	10	18

Worriedness of Disclosure of Disease

S	Very Low (5)	Low (4)	Somewhat (3)	Much (2)	Very Much (1)
F	38	52	233	129	48
S*F	190	208	699	258	48

Average Score = (190+208+699+258+48)/500 = 1403/500 = 2.81

Average Score = (2335+0+30+10+18)/500 = 2393/500 = 4.79	

But this is also a fact that most of the students go for treatment until and unless they are fully cured. Out of total 430 students 336 students i.e. 78% got treatment up to totally cured. 81 students bother to get the health care service just to get temporary relief and 13 students are totally ignorant in this matter.

And another noticeable matter is that though the surveyed entities are the college students but 25.1% of the students (108) are not able to take medicines as per prescription by their own.

The respondents disclosed the fact that still the rural people depend on Govt. Hospitals because of subsidised rate or no financial expenses in some cases.

Regarding the health consciousness it was a good experience and was evident that the students do consider that health of human beings is crucial for self-progress as well as for the family and for the society as expressed in Exhibit 1 and the students are much caring in this regard. They are not much mentally upset for their illness and they are not much hesitant to share their diseases with friends. They do not much bother to be worried to observe symptom of any sort of diseases and also their illness do not prevent them much from their daily schedule. The students do possess a strong positive mental set up that hiding disease is not at all expected. But a contradiction prevailed that they are somewhat worried that the information regarding the diseases may be disclosed from the service point.

Exhibit 2: Media Influence on the Health Care Service Seeking Behaviour of the Students

Influence of health service-related advertisement					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	52	195	129	81	43
S*F	260	780	387	162	43
Average Score=(260+780+387+162+43)/500 = 1632/500 = 3.26					

Habit of collecting information from different media					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	81	157	157	53	52
S*F	405	628	471	106	52
Average Score= (405+628+471+106+52)/500 = 1662/500 = 3.32					

Media Preference of the Students for Health Care Service Information					
Media	Newspaper	Radio & TV	Internet	Friends	others
F	71	124	114	167	24

Exhibit 2 is showing the media influence on the health service seeking behaviour of the students. Average scenario is telling that the students are not so much influenced by the advertisement of health care services. Somewhat they collect information from different media. And in this context, most of the students, i.e. 124, are placing the mass media, i.e., radio and television as the number one followed by internet.

It was the experience that distance of the health service points are no more a factor for the rural people. But they are financially incapable to a little extent to avail the health service and practically somewhat

they are not in a position to avail health service in need just because of the expenses as it is reflected in Exhibit 3.

Exhibit 3: Hurdles to Avail the Existing Health Care service

How far the distance prevents to take health service

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	43	86	200	104	67
S*F	215	344	600	208	67

Average Score=(215+344+600+208+67)/500 = 1434/500 = 2.87

How far the expenses prevent to take health service

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	52	62	157	124	105
S*F	52	62	157	124	105

Average Score= (52+62+157+124+105)/500 = 1332/500 = 2.66

Personal/Family capability to bear the cost of health service

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	82	176	152	38	52
S*F	410	704	456	76	52

Average Score=(410+704+456+76+52)/500 = 1698/500 = 3.4

Thinking much about the costs before going to take the service

S	Very Low (5)	Low (4)	Somewhat (3)	Much (2)	Very Much (1)
F	57	38	119	186	100
S*F	285	152	357	372	100

Average Score=(285+152+357+372+100)/500 = 12661/500 = 2.53

Exhibit 4: Normative Aspects of Health Service Evaluation

The role of doctor in evaluating the Health Care Service System

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	176	229	66	24	5
S*F	880	916	198	48	5

Average Score = (880+916+198+48+5)/500 = 2047/500 = 4.09

The role of physical environment of the health centre in evaluating the Health Care Service System

S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	143	181	110	38	29
S*F	715	724	330	76	29

Average Score = (715+724+330+76+29)/500 = 1874/500 = 3.75

The role of time spent in the health centre in evaluating the Health Care Service System					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	124	233	129	10	5
S*F	620	932	**387**	**20**	1
Average Score = (620+932+387+20+5)/500 = 1964/500 = 3.93					

The role of financial expenses in evaluating the Health Care Service System					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	138	186	119	38	138
S*F	690	744	357	76	690
Average Score = (690+744+357+76+690)/500 = 1886/500 = 3.					

The role of quality of health service in evaluating the Health Care Service System					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	133	229	81	48	5
S*F	665	916	243	96	1
Average Score = (620+932+387+20+5)/500 = 1930/500 = 3.86					

Exhibit 4 is depicting a picture of the normative aspects of health service evaluation to the present generation. And the result revealed that the role of doctor as much important and on an average, they assigned number 4 to it on a 5-point Likert scale ranging from 1 to 5. They assign same importance to the physical environment and time spent in the servicescape. Quality service is the ultimate term to the younger generation of rural India. Financial expense is not the criterion to the rural students to evaluate the quality of a service.

Exhibit 5: Attitude of Students towards the Existing Health Care service

The role of existing health care service system in health cure					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	252	133	95	10	10
S*F	1260	532	285	20	10
Average Score=(1260+532+285+20+10)/500 = 2107/500 = 4.21					

Satisfaction regarding the behaviour and responsibility of the Doctor					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	110	233	124	14	19
S*F	550	932	372	28	19
Average Score= (550+932+372+28+19)/500 = 1901/500 = 3.8					

respect and dignity at the time of receiving service					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)

Received service timely					
S	Very Much (5)	Much (4)	Somewhat (3)	Low (2)	Very Low (1)
F	143	95	157	76	29

F	157	171	90	67	14
S*F	785	684	270	134	14
Average Score = (785+684+270+134+14)/500 = 1887/500 = 3.74					

S*F	715	380	471	152	29
Average Score = (715+380+471+152+58)/500 = 1901/500 = 3.6					

Exhibit 5 is describing the students' attitude towards the existing health care service system on a five-point Likert Scale ranging from Very Much (5) to Very Low (1) for a positive statement. The average score is revealing that the students are much satisfied with the existing health care service system.

Now considering Exhibit 4 and Exhibit 5 together application of Fishbein Attitude model had resulted as follows:

According to Martin Fishbein:

$A_0=\sum_{i=1}^{N} B_i\alpha_i$, where A_0 denotes a respondent's overall attitude toward some object and

B_i => respondent's strength of belief that the object is associated

with some attribute X_i and

α_i denotes the respondents' evaluation of X_i

In the context of present study B_is and α_is are as follows:

Bi	The role of existing health care service system in health cure	Satisfaction regarding the behaviour and responsibility of the Doctor	Respect and dignity at the time of receiving service	Received service timely
α_i	The role of quality of health service in evaluating the Health Care Service System.	The role of doctor in evaluating the Health Care Service System.	The role of behaviour of assistants and others in evaluating the Health Care Service System.	The role of time spent in the health centre in evaluating the Health Care Service System

In our study 5-point scale of α had been applied ranging from low importance (1) to high importance (5). And we have got a positive result on this application (4.99+3.44+2.95+1.98) = 13.36). So, the students have a positive viewpoint about the existing health care service system in their areas. Further it had been examined that whether the attitude is related with any demographic factors or not. In order to do so I had quantified the qualitative factor 'gender'. At the time of survey while I was communicating with the students it was experienced that the society in the surveyed areas is still male dominating and female are still ignorant. So I had assigned '1' to female and '2' to male respondents. It was also an experience that the Hindus are comparatively liberal in different aspects of their daily life. So, the Hindu had been assigned '2' and the Muslim '1'. The application of correlation had resulted as follows (Exhibit 6).

Exhibit 6: Correlation between Demographic Factors and Attitude towards Health Care Service System

Gender	Age	Religion	Family Yearly Income
-0.08456545	-0.2	0.08805178	0.1363287

So, it was evident that the girl students possess positive attitude towards the existing health care service system. The higher-class students possess positive attitude towards the health care system. And the attitude goes positively with the family income of the respondents

It has been explored through survey that the respondents have considered the following criteria while they have selected the health service provider:

The respondents had been asked to rate the following mentioned 25 criteria on a 5-point semantic differential scale in order to determine the factors the students consider important while select their health service provider. The detail of the semantic scale is as follows on the data set obtained on 25 selected criteria or variables as mentioned in Exhibit 7.

V16 Quality of Existing Health Care System
V17 Behavior & Responsibility of Doctor
V18 Respect and Dignity at the Servicescape
V19 Timely Receiving of Service
V20 Role of Doctor in Cure of Patient
V21 Role of Physical Environment
V22 Role of Time Spent
V23 Financial Expenses
V24 Role of quality of service
V25 Importance of Health
V26 Self-Health Care
V27 Mental Displeaseness for Illness
V28 Hesitation to share illness to friends
V29 Worriedness by symptoms of illness
V30 Illness prevents to Daily Schedule
V31 How far Hiding disease expected
V32 Dependency on Family member
V33 Worriedness of Illness Information Disclosure
V34 Information collection before going for treatment
V35 Distance Prevent to take Health Service
V36 Expenses Prevent to take Health Service
V37 Family Capability to bear Cost of Health Service
V38 Thinking of Cost before going to Health Centre
V39 Role of Media Advertisement
V40 Collection of Information from Media

Exhibit 7

5 => Very Much	4 => Much	3=>Somewhat	2=>Low	1=> Very Low

The Kaiser-Meyer-Olkin measure that gives an indication towards the correlation aspects of the variables and detects the feasibility of factor analysis yields the value of KMO statistics as 0.611. Through the application of Principal Component Analysis (Exhibit 8) 8 factors has been explicitly identified which are most responsible for the variability in decision making.

It is evident from the rotated component matrix (Exhibit 9) that factor 1 has high coefficients for the variables – Role of Doctor in Cure of Patient (V20), Physical Environment (V21), Time Spent in Servicescape (V22), Financial Expenses (V23), Quality of service (V24) which may be summarized as *Service Provider's Image or Goodwill* or *Perception of Serviceability of Healthcare Servicescape.*

Exhibit 8: Total Variance Explained

Component	Initial Eigen values			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1.	3.824	15.295	15.295	3.824	15.295	15.295	2.406	9.624	9.624
2.	2.635	10.538	25.834	2.635	10.538	25.834	2.370	9.480	19.104
3.	2.416	9.662	35.496	2.416	9.662	35.496	2.319	9.277	28.381
4.	1.666	6.663	42.159	1.666	6.663	42.159	2.017	8.069	36.449
5.	1.532	6.130	48.289	1.532	6.130	48.289	1.895	7.579	44.029
6.	1.410	5.641	53.930	1.410	5.641	53.930	1.819	7.278	51.306
7.	1.300	5.200	59.130	1.300	5.200	59.130	1.565	6.261	57.567
8.	1.138	4.550	63.680	1.138	4.550	63.680	1.528	6.113	63.680
9.	0.995	3.981	67.661						
10.	0.942	3.769	71.430						
11.	0.794	3.175	74.605						
12.	0.741	2.963	77.568						
13.	0.714	2.856	80.424						
14.	0.639	2.556	82.980						
15.	0.594	2.377	85.357						

16.	0.580	2.321	87.678						
17.	0.507	2.030	89.708						
18.	0.465	1.859	91.567						
19.	0.416	1.663	93.230						
20.	0.388	1.553	94.783						
21.	0.322	1.288	96.071						
22.	0.300	1.200	97.271						
23.	0.263	1.052	98.323						
24.	0.240	0.961	99.285						
25.	0.179	0.715	100.000						
Extraction Method: Principal Component Analysis.									

On the other hand Family Capability to bear Cost of Health Service (V37), Media Advertisement (V39), Collection of Information from Media (V40) are highly attached with factor 2 and can be summarized as *Health Promotion*.

Behaviour & Responsibility of Doctor (V17), Respect and Dignity at the Servicescape (V18) and Timely Receiving of Service (V19) are highly attached with factor 3 and can be summarized as *Patient's Rights at Healthcare Servicescape.*

Worriedness by symptoms of illness (V29), Distance Prevent to take Health Service (V35), Thinking of Cost before going to Health Centre (V38)) are highly attached with factor 4 and can be summarized as *Behavioural Intention.*

Exhibit 9: Rotated Component Matrix *

	Component							
	1	2	3	4	5	6	7	8
V23	0.695	0.257	-0.106	-0.122	-0.210		0.218	
V24	0.676		0.311	0.107			-0.134	
V22	0.509	0.138	0.432	-0.375		0.171		0.174
V20	0.509		-0.104		-0.107	0.191	-0.410	-0.274
V37	0.130	0.753	0.159	0.225	-0.101			0.215
V40		0.681		-0.156				-0.140
V39	0.194	0.611		-0.252		-0.221		-0.247
V28	-0.118	-0.590	-0.102		-0.206		0.426	-0.226

V17	0.298		0.749	-0.103		0.206		
V18	-0.223		0.744					
V19	0.237	0.216	0.697	0.271	-0.120	-0.112	-0.172	-0.186
V29	-0.251			0.684		-0.184		0.165
V26		0.149		-0.641	-0.202		-0.116	
V35	0.201			0.591	0.190	0.207	0.223	-0.261
V38	0.297	-0.312	0.184	0.419	-0.117	0.332		0.338
V16	0.395	0.126	0.391		0.663		0.150	
V32	-0.161		-0.238	0.200	0.656	-0.136	0.199	-0.122
V30		-0.258			0.619	0.101	-0.368	0.133
V21	0.363			-0.183	-0.593	0.229	-0.110	
V34		0.332		-0.124		0.713		0.167
V36	0.212	-0.228			-0.144	0.677	0.121	-0.153
V33	0.272		0.123	0.217		-0.615	0.186	0.311
V27	0.171	-0.181	0.123	0.235			0.696	0.105
V25	0.174	-0.222	0.246	-0.109	-0.124		-0.534	
V31			-0.140					0.884
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.								
* Rotation converged in 23 iterations.								

Quality Dimensions of Existing Health Care System (V16), Illness prevent to Daily Schedule (V30) Dependency on Family member V32, *Home Health Care Quality.* Information collection before going for treatment (V34) Expenses Prevent to take Health Service V36 can be clubbed together as *Preventive Intent*. Mental Displeaseness for Illness V27 Hesitation to share illness to friends V28 together can be summarized as *Social Stigma or Genetic Mental Illness.* How far Hiding disease expected V31, Worriedness of Illness Information Disclosure V33 can be named as *Patients Illness Anxiety Disorder.*

6. Conclusion:

In summary it must be noted that health seeking behaviour of the rural students is a complex phenomenon. No one-single method can be used to explain or establish any behavioural pattern of the rural students in the context of health care services. The rural students seek help on health issues based on several reasons and the factors which influence the choice of treatment sources when symptoms occur include Service Provider's Image or Goodwill or Perception of Serviceability of Healthcare Servicescapes, Health Promotion, Student's Rights at Healthcare Servicescape, their Behavioural Intention, Home Health Care Quality, Social Stigma, Illness Anxiety Disorder, Preventive Intent and socio-cultural factors, social networks, gender and economic status etc. Health seeking behaviour is a reflection of the prevailing conditions, which interact synergistically to produce a pattern of care seeking but which remains flowing and therefore open to change. Prompt health-seeking is critical for appropriate management and for this reason; under-standing the determinant of health seeking behaviour becomes critical in the bid to provide client-oriented services.

Access to healthcare facilities in terms of cost of treatment and healthcare provider attitude are also determinants of health seeking behaviour. There are indications that cost of prescribed medicines, poor

access to facilities and patient delays affects the patronage and utilisation of public health services which increase the use of other treatment sources such as community pharmacies, drug peddlers, herbal medicine, religious or spiritual care organizations and students in health-related academic disciplines.

Customer satisfaction is defined as the pleasurable emotional state of customers' feelings based on their experience in an organisation. On this basis rural students' satisfaction is a multi-dimensional healthcare constructs which are affected by many variables. Healthcare quality affects their satisfaction, which in turn influences positive behaviours such as loyalty. Patient satisfaction and healthcare service quality, though difficult to measure, can be operationalized using a multi-disciplinary approach that combines patient inputs as well as expert judgement.

BIBLIOGRAPHY

1. Adhikari[1] Dewa & Rijal Dagendra Prasad 2014, 'Factors Affecting Health Seeking Behavior of Senior Citizens of Dharan', Journal of Nobel Medical College, Vol. 3, No.1 Issue 5, 2014, Nov-April, Pp-56.
2. Afolabi1[13] M. O, Daropale1 V. O., Irinoye A. I. & Adegoke A. A. 2013, 'Health-Seeking Behaviour and Student Perception of Health Care Services in A University Community in Nigeria', Health, Vol.5 (2013), No.5, 817-824, pp 822.
3. Anselmi[12] Mozambique Laura, Mylène Lagarde & Kara Hanson 2015, 'Health Service Availability and Health Seeking Behaviour in Resource Poor Settings', Health Economics Review, 2015, pp-11.
4. Arkernochet[8] E. H. 1947, Primitive Surgery, American Anthropology, Vol. 64, pp 25-45.
5. Chauhan[2] Ramesh Chand, Manikandan, Purty Anil J. & Samuel Abel Zile Singh 2015, 'Determinants of health care seeking behavior among rural population of a coastal area in South India', International Journal of Scientific Reports, Vol. 1, Issue 2, June 2015, pp-121.
6. Kaur[3] Manmeet, Sodhi Suninder K., Kaur Parampreet, Singh Jasmik & Kumar Rajesh 2013, 'Gender Differences In Health Care Seeking Behaviour of Tuberculosis Patients in Chandigarh', Indian Journal of Tuberculosis, 2013, pp-221.
7. Mahmood[4] Dr. Atif, Ali Dr. Mukkaram, Faisal Dr. Asima & Kumar Dr. Bheesham 2014, 'Public's Attitude Towards Seeking Healthcare and their Satisfaction with Health Services', Indian Journal of Medical Research and Pharmaceutical Sciences, November 2014; Vol. 1, Issue6, Pp-33.
8. Shashidhara[5] Y. N. & Malathi G. Nayak 2013, 'Health Seeking Behavior of Rural Adults', Rose Ann Dominic, Nitte University Journal of Health Science, Vol. 3, No.3, September 2013.
9. Rani[6] M & Bonu S 2003, 'Rural Indian Women's Care Seeking Behavior and Choice of Provider for Gynecological Symptoms', Stud Fam Plann, Vol 34, Issue 3, pp 173–185.
10. Navaneetham[7] K. & Dharmalingam, A. 2002, 'Utilization of maternal health care services in Southern India', Social Science & Medicine, Vol. 55, pp 1849–1869.
11. Majhi[9] J. and Sharma, B. V. 2004, 'Ethonomedical Practitioners and their Clients among the Kondhs', Man in India, Vol.84, Issue (1-2), pp 99-107.
12. Musoke[11] David, Boynton Petra, Butler Ceri & Musoke Miph Boses 2014, 'Health Seeking Behaviour and Challenges in Utilising Health Facilities in Wakiso District, Uganda, African Health Sciences, Vol 14, Issue 4, December 2014, pp-1052.