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# Understanding Health-seeking Behaviour among Women in India: An Exploratory Online Study

**Ratna Mulay**
MBBS, DCh, MSc, PhD, Bhopal
And
**Jaya Phookan**
Faculty, Department of Women's Studies,
Barkatullah University, Bhopal

**Abstract**

*Health-seeking behaviour among women in India is shaped by a complex matrix of socio-cultural norms, patriarchal structures, economic constraints, access to education, and healthcare services. Existing literature highlights that despite policy advancements and increased awareness, women continue to face significant barriers to timely and appropriate healthcare access. The present study explores health-seeking behaviour among 292 women aged between 18–75+ years across India. Data was collected through a structured digital questionnaire. A non-probability sampling approach was adopted, combining convenience and purposive techniques to ensure regional and age-wise representation. The findings suggest that while literacy, affordability, awareness, and accessibility to health care have improved health-seeking behaviour overall, younger women (below 35 years) remain less proactive in seeking medical care unless faced with acute health issues. This survey is indicative that women below 35 need to pay more attention to their health, as this seems to be the age at which non-communicable diseases (NCDs) start gripping women. Although patriarchal norms continue to influence decision-making, there is a perceptible shift in male family members' attitudes, with increased support for early treatment. The study underscores the need for targeted interventions and age-sensitive health education strategies to promote preventive care and early diagnosis among younger women.*

**Keywords-** Women, Health-seeking, behaviour, NCDs in women, Treatment, Preferences.

## Introduction

Health-seeking behaviour refers to the range of actions individuals undertake in response to perceived ill health, encompassing decisions such as visiting a healthcare facility, opting for home remedies, engaging in self-medication, or choosing not to seek any form of care at all. These choices span across public and private sectors, and include both traditional and modern systems of medicine. The decision-making process is influenced by a constellation of factors—such as the nature and severity of the illness, gender norms, socio-cultural environment, perceived quality of care, cost and accessibility of services, and the individual's educational and economic background. Social beliefs regarding the origin of illness and the acceptability

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of certain treatments also play a critical role in shaping health-seeking patterns, particularly among women in patriarchal and resource-constrained settings.

Historically, women's health in India has remained a peripheral concern, often overshadowed by reproductive health priorities and socio-cultural expectations of self-sacrifice. While recent decades have witnessed a surge in targeted interventions—such as the distribution of Iron and Folic Acid (IFA) supplements to pregnant women and adolescent girls—these efforts have largely focused on maternal and child health. A significant gap persists in addressing women's health beyond the reproductive spectrum, particularly in areas such as preventive care, non-communicable diseases (NCDs), and mental health.

The concept of health-seeking behaviour (HSB) refers to the sequence of actions individuals undertake to recognize, interpret, and respond to symptoms of ill health. It encompasses decisions about when, where, and how to seek care, and is shaped by a range of factors including socio-economic status, cultural norms, gender roles, and access to healthcare services. In public health research, HSB serves as a critical lens for evaluating the effectiveness of health programs, identifying barriers to service utilization, and informing policy design.

In the Indian context, women's health-seeking behaviour is deeply influenced by patriarchal conditioning, economic dependency, and internalized norms of caregiving. From a young age, many women are socialized to prioritize the needs of their families—particularly male members—over their own well-being. This often results in delayed or deferred treatment, even among educated women. Illiteracy, financial constraints, and limited autonomy further compound the issue, leading to underutilization of available health services.

However, recent shifts in literacy rates, employment patterns, and digital access have begun to reshape this landscape. Increasing numbers of women—including semi-literate domestic workers and home-based entrepreneurs—are engaging with health systems in new ways. These transitions offer a timely opportunity to examine evolving patterns of health-seeking behaviour across age groups and socio-economic strata.

Against this backdrop, the present study investigates the health-seeking behaviour of Indian women aged 18 to 75+, drawing on responses from a sample of 292 participants. The aim is to identify age-wise trends, socio-cultural determinants, and emerging challenges in women's engagement with healthcare systems, with a view to informing inclusive and responsive health policy.

**Literature Review-**

Existing studies on the health-seeking behaviour of women in India consistently highlight the influence of socio-cultural norms, patriarchal structures, and economic constraints on healthcare utilization. Women's roles as primary caregivers within households often result in the deprioritization of their own health needs, particularly among those from lower socio-economic backgrounds. Limited education, restricted mobility, and inadequate awareness of

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available health services further compound these challenges, leading to delays in seeking timely medical care.

Despite the proliferation of government-sponsored health schemes aimed at improving access—such as maternal health programs, nutritional support, and subsidized treatment—many women remain unaware of these initiatives or lack the confidence to engage with public health systems. Consequently, there is a marked preference for private healthcare providers, perceived to offer better quality and responsiveness, even when cost becomes a barrier.

Chakraborty's (2004) study on the health-seeking behavior of the elderly found that several socioeconomic and personal factors led to irregular treatment. The study was based on a rural block in West Bengal and highlighted that vulnerable elderly populations, specifically those with low income and limited support, had worse health outcomes due to treatment inconsistencies. The study identified several characteristics associated with higher rates of irregular treatment among the elderly. Absence of individual income, no assets, illiteracy, full economic dependency, low socio-economic status, having no accompanying persons, less spending on treatment, and a negative attitude towards ageing showed differences in treatment characteristics. The incidence of irregular treatment was significantly higher (87.8%) among elderly people whose physical activity was affected by a disease, compared to those with no such limitations. The findings from Chakraborty's study underscore the need for health policies that address the specific needs of vulnerable elderly populations. The study is particularly relevant to the challenges faced by older adults in developing countries, where formal health insurance and social safety nets are often limited.

As per Das and Das (2017), factors that Influence Health-Seeking Behavior in the Indian community are-

- Socio-cultural Factors:

  The traditional and fixed roles of gender and Patriarchy impact women's health-seeking behaviour significantly. Generally, limiting their access and approach to the Governmental facilities providing healthcare services.

- Socio-economic Status:

  In view of restricted access to resources, women usually are not able to get timely medical care.

- Lack of Awareness regarding Health-care Schemes:

  Under education and access to resources, socio-cultural restrictions limit awareness regarding HSB. Though Ayushman insurance has increased awareness towards HSB.

- Perception of Quality of Healthcare and disregard for health providing systems:

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Studies have shown a preference for private facilities over government institutions, because of deep deep-rooted perception that better treatment is available in private facilities

- Negative Experiences at health care facilities:

  At times, women experience an unfriendly attitude from healthcare staff. This is the main factor of discouragement for them from using public facilities.

- Health care systems- Availability, accessibility & acceptability – These are the most important points of HSB amongst women. Especially for economically poor, lower literacy, rural and tribal women.

Because of these factors, there was a predominant consequence of delayed HSB, the worsening of the disease, and the excessive cost of the treatments.

Kanbarkar & Chandrika (2021), in their paper "Health Care Seeking Behaviour – A Theoretical Perspective", explore the multidimensional nature of health-seeking behaviour, emphasizing how gender, age, education, and socio-economic status intersect to shape women's decisions regarding healthcare. The authors argue that women's health choices are often constrained by cultural expectations, financial dependency, and limited autonomy, particularly in rural and semi-urban settings. They advocate for a more inclusive understanding of health-seeking behaviour that accounts for both structural barriers and individual agency, and call for policy frameworks that address these layered determinants through community-based interventions and health literacy programs.

Malik, Yadav and Yadav(2024), in a descriptive, community-based cross-sectional study design, found that the private clinic/hospital was the most nearby healthcare facility, and a majority of women 50% preferred this as a first option. The government facility stood second with 30% visitors. Most were escorted by spouses or fathers. The reason for the recent visit was minor problems like dental visits, respiratory infections, etc.

Priya & Karne (2021) in their study on "Health Seeking Behaviour of Women: Findings from Primary Data" highlighted that Urban women, especially those in informal employment, face barriers such as time constraints, lack of accompaniment, and low health insurance coverage.

Despite proximity to healthcare facilities, many women delay check-ups due to household responsibilities and financial dependence. Only 16.1% of surveyed women had health insurance, and the majority relied on husbands' savings for hospitalization costs. Chronic illnesses were common, yet affordability and lack of awareness hindered timely care.

McKian( 2003) pointed out that pointed out that the health-seeking behaviour is a somewhat overutilized and under-theorized tool. Although it remains a valid tool for rapid appraisal of a particular issue at a particular time, it is of little use as it stands to explore the wider relationship between populations and health systems development. If we wish to move the debate into new and more fruitful arenas, we need to develop a tool for understanding how populations engage

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with health systems, rather than using health-seeking behaviour as a tool for describing how individuals engage with services.

Rani and Bonu (2003), in their seminal study "Rural Indian Women's Care-Seeking Behavior and Choice of Provider for Gynecological Symptoms," offer a comprehensive analysis of gender disparities in healthcare utilization across India. Drawing on data from the National Family Health Survey (NFHS), the authors found that women often delay or avoid seeking treatment for gynecological symptoms due to a combination of socio-cultural taboos, limited autonomy, and economic dependency. The study highlights that even when services are available, women's decision-making is frequently mediated by male family members, and their mobility is restricted by household responsibilities and social norms. Notably, the authors observed a preference for private healthcare providers, despite the availability of public services, largely due to perceptions of better quality and confidentiality. This research underscores the need for gender-sensitive health policies that address not only access but also agency, awareness, and trust in public health systems.

Thangaraj and Loganathan (2021), based on their study, pointed out that health problems amongst women of rural India need special attention as rural people have distinctive health problems, which are influenced and regulated by their traditional beliefs, practices, ecological, and economic conditions. A few of the tribal areas amongst various groups still believe, even now, that diseases are caused by negative and hostile spirits or by some tabooed violations. This study examines the presence and predominance of traditional treatments, herbs, magic, etc. The decision maker is the head of the family, who is a male.

Siva et.al (2025), in a meta-analysis, find that there exist significant barriers in considering ways of healthcare access among tribal communities. Barriers and factors include - poverty, illiteracy, cultural practices, geographic isolation, distance to healthcare centres, availability of transportation, and the fear of mistreatment in government services. In past years, some tribes have started showing more interest in adopting modern healthcare services. Still, many prefer to continue to rely on traditional medicine and indigenous practices. Patriarchal dominance is a major factor, and religious mindsets strongly influence healthcare-seeking behaviour. Government initiatives like the National Rural Health Mission and the Integrated Child Development Services have had some success in improving healthcare utilisation among tribal populations.

The literature underscores an urgent need for targeted interventions that build community trust in public healthcare, enhance health literacy among women, and address structural barriers to access—especially in rural and underserved regions. Strengthening gender-sensitive outreach, improving service delivery, and fostering participatory health governance are critical steps toward equitable health-seeking behaviour among Indian women.

**Objectives of the Study-**

- To understand the current health-seeking behaviour of women in India, in the age groups of 18- 75+ years.

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- Explore age-wise variations in health awareness, treatment-seeking tendencies, and socio-cultural influences across diverse geographic and socio-economic backgrounds.

**Research Methodology**

This exploratory study employed a descriptive cross-sectional design to examine health-seeking behaviour among Indian women. Data was collected through an online survey using a structured questionnaire developed by the researchers. The questionnaire link was disseminated via WhatsApp and other digital platforms, allowing voluntary participation from women across India. Thus, a non-probability sampling approach was adopted, combining convenience and purposive techniques. This method facilitated rapid outreach but may limit generalizability due to digital access and self-selection biases.

The study included women from varied age groups (18–75+), occupations (working, non-working, homemakers), and educational backgrounds. Participants were encouraged to include responses from domestic workers, support staff, and other women with limited digital access by assisting them in filling out the questionnaire. A total of 292 responses were received, representing a wide geographic spread across India, with five responses from Indian women currently residing abroad. The sample included urban, semi-urban, and rural respondents, with notable representation from Bhopal, Delhi, Mumbai, Nagpur, Pune, Kanpur, Indore, Hyderabad, and other cities and towns.

Data Collection Tool:

The questionnaire was administered via Google Forms, designed to capture demographic details, health-seeking patterns, and attitudinal responses. The form was circulated digitally through personal and professional networks.

Data Analysis:

Responses were compiled and analysed using Microsoft Excel, employing basic descriptive statistics and thematic categorization to identify trends and patterns.

Ethical Considerations:

Participation was entirely voluntary, and informed consent was implied through form submission. No personally identifiable information was collected, ensuring anonymity and confidentiality. The study adhered to ethical norms for independent research, with sensitivity toward vulnerable respondents.

**Results-**

The study received responses from 292 Indian women across a wide geographic spread, including metropolitan cities (e.g., Delhi, Mumbai, Hyderabad), tier-2 cities (e.g., Bhopal, Nagpur, Indore), and smaller towns and semi-urban areas across more than 60 districts in India. A majority of responses were from Bhopal, followed by Delhi, Mumbai, Pune, Kanpur, and Hyderabad. Additionally, five responses were received from Indian women currently residing

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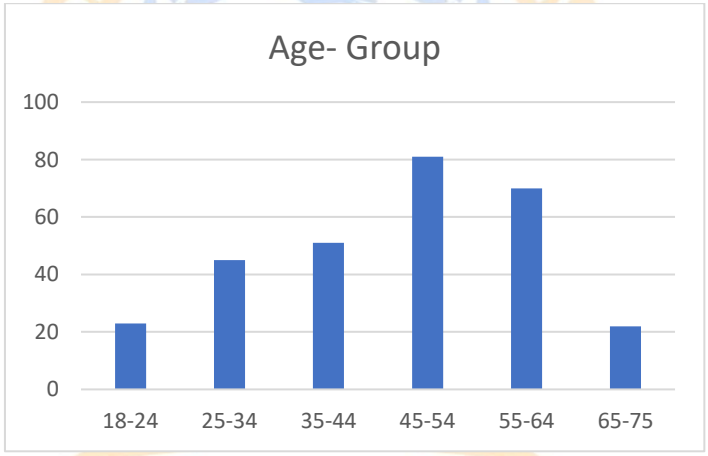
abroad. This distribution reflects a diverse socio-cultural and regional representation, enhancing the generalizability of the findings.

Responses were as follows:

**Table 1: Age-Wise Distribution of Women Respondents (N = 292)**

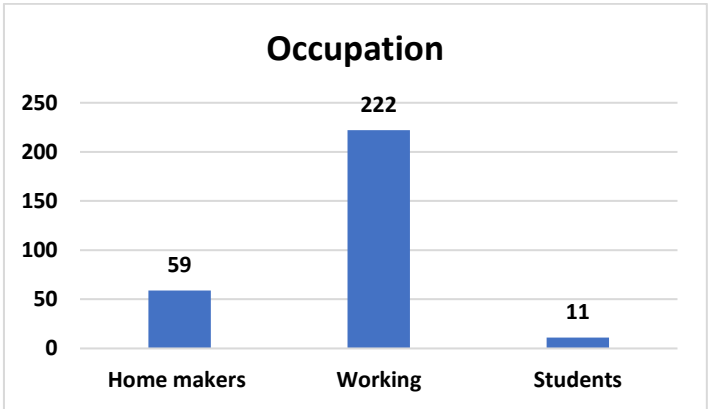
| Age | Number of Respondents |
|---|---|
| 18-24 | 23 |
| 25-34 | 45 |
| 35-44 | 51 |
| 45-54 | 81 |
| 55-64 | 70 |
| 65 | 22 |
| **Total** | **292** |

**Fig. 1: Age-Wise Distribution of Women Respondents (N = 292)**




This figure illustrates the number of participants across six age categories, ranging from 18 to above 65 years, highlighting the highest representation in the 45–54 and 55–64 age groups.

**Fig. 2: Occupational Profile of Women Respondents**



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The sample consisted of 222 working women, 59 homemakers, and 11 students. Many homemakers are working part-time from home to earn and contribute.

**Table 2: Distribution of Physical Health Conditions Among Women Respondents (N = 292)**

**Physical Health Conditions**

| | | | | | |
|---|---|---|---|---|---|
| **PCOS** | 24 | **Hypo thyroid** | 18 | **DM,HT, heart dis** | 1 |
| **Asthma** | 14 | **Malignancy** | 1 | **DM, asthma** | 1 |
| **Arthritis** | 13 | **Migraine** | 6 | **DM, arthritis** | 4 |
| **Acidity** | 2 | **Liver** | 1 | **HT, asthma** | 1 |
| **Allergies** | 1 | **Back pain/spinal** | 3 | **HT, arthritis** | 4 |
| **Autoimmune** | 3 | **Depression** | 1 | **urine inf** | 1 |
| **Hypertension (HT/BP)** | 36 | **DM & HT** | 9 | **multiple** | 8 |
| **Diabetes mellitus (DM)** | 41 | **DM, HT, Asthma** | 2 | **Malignancy** | 1 |
| **Heart disease** | 1 | **DM, HT, Arthritis** | 5 | **Arthritis , asthma** | 2 |
| **Hyper-thyroid** | 1 | | | | |

Note: The total number of respondents in the study is N = 292. Out of the total 292 respondents, 113 women (38.7%) reported no physical health problems. The remaining 179 participants presented with one or more health conditions. The frequencies listed above may vary with the total number of respondents, as several women reported more than one physical health condition besides the grouped ones. Each condition has been counted separately to reflect the full spectrum of health issues experienced, without merging comorbidities into single categories.

**Analysis of Physical Health Conditions and Treatment Preferences Among Women Respondents (N = 292)**

Out of the total 292 women surveyed, 113 respondents (38.7%) reported no physical ailments so far. The other 179 (61.30%) respondents presented with one or more health conditions, ranging from minor complaints to major non-communicable diseases (NCDs) such as hypertension (HT), diabetes mellitus (DM), arthritis, and asthma. 36 respondents were suffering from hypertension, and 41 from DM only, independent of other diseases. A total of 63 respondents were suffering from diabetes, and 58 had hypertension with or without other associated disease or disorder. These two conditions—diabetes and hypertension—emerged as the most prevalent health concerns among the study population. Age-wise, the majority of women experiencing NCDs were above 40 years, while those below this age group were largely

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disease-free or reported minimal health concerns. It is important to note that the figures are overlapping, as many women reported multiple concurrent health issues. Therefore, the cumulative count of conditions exceeds the actual number of participants.

**Treatment Preferences of the Respondents**

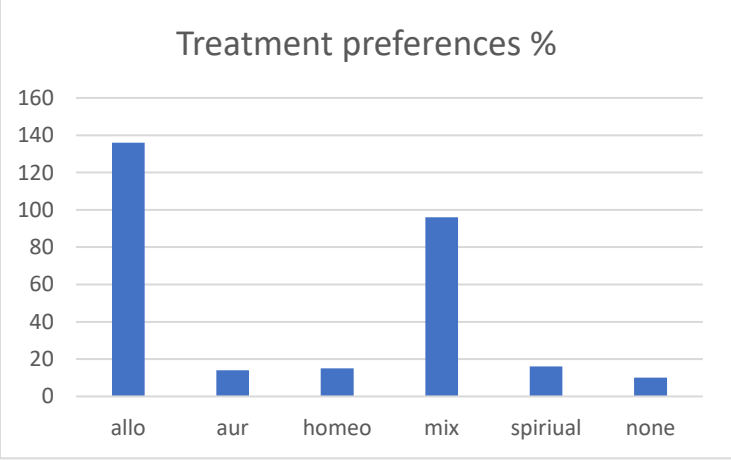
**Table 3: Treatment Preferences Among Women Respondents (N = 292)**

| Treatment preferences | | % |
|---|---|---|
| allopathy | 137 | 46.91 |
| ayurvedic | 16 | 5.47 |
| homeopathy | 15 | 5.1 |
| mix | 98 | 33.56 |
| spiritual | 16 | 5.47 |
| none | 10 | 3.42 |

Respondents expressed diverse preferences for managing their health conditions:

- Allopathy was the most preferred mode of treatment, chosen by 137 women (46.9%).
- Ayurvedic treatment was preferred by 16 respondents, and homeopathy by 15.
- A significant number—98 women (33.6%)—opted for mixed treatment approaches, combining conventional and alternative therapies.
- Spiritual healing was endorsed by 16 participants, while 10 women (3.4%) reported no belief in medicinal interventions.

**Fig 3: Treatment Preferences of the Respondents**




**Health-Seeking Behavior and Treatment Practices Among Women Respondents**

Among the 292 women surveyed, 160 respondents (54.97%) reported seeking immediate medical consultation when experiencing health issues, while 93 women (31.84%) sought consultation occasionally or only when necessary. A smaller segment—29 respondents

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(9.93%)—did not seek medical consultation at all, and 10 women (3.42%) did not respond to this question. Among those who delayed or avoided consultation, reasons varied: 11 respondents (3.76%) cited financial constraints, while 28 women (9.58%) felt no need for spending on consultation due to being medical professionals themselves, having family members in healthcare, working in hospitals, or possessing insurance coverage. Additionally, 10 respondents (3.42%) expressed a lack of trust in medical systems, 4 practiced self-medication, 7 consulted only occasionally, and 2 did not specify any reason.

Regarding medicine intake, 199 respondents (68.15%) reported taking medications regularly, 64 women (21.91%) took them occasionally, and 21 (7.19%) did not take any medication. Eight respondents did not answer. It is noteworthy that although 113 participants had earlier reported no ailments, they responded to this section—possibly reflecting preventive or occasional medicine use—resulting in a total that exceeds the number of those with reported health conditions. When asked specifically about prescribed medication usage, 210 respondents (71.91%) confirmed regular intake, 46 (15.75%) took prescribed medicines occasionally, and 9 women (3.08%) did not follow prescribed regimens. The remaining participants did not respond.

In terms of doctor visits, 88 respondents (30.13%) visited doctors regularly, 94 women (32.19%) did so occasionally or when required, and 103 (35.27%) did not visit doctors regularly. A significant majority—250 respondents (85.61%)—preferred private healthcare facilities, citing cleanliness, time efficiency, and safety as their primary reasons. When it came to payment responsibility, 181 women (61.98%) paid their own medical bills, while 113 respondents (38.69%) had bills covered through other means. These included 55 women (18.83%) whose spouses paid the bills, 19 (6.5%) who had medical insurance, and 8 (2.7%) whose parents paid, particularly in the case of student respondents. Others received free treatment due to professional affiliations or had bills paid by children or extended family members.

As for preferences regarding annual health check-ups, 113 respondents (38.69%) endorsed regular yearly check-ups, while an equal number—113 (38.69%)—did not opt for them. Another 58 women (19.86%) underwent check-ups only when required or upon medical advice. It is important to note that in several sections, the total number of responses may vary from a Total of 292 responses due to overlapping answers or participation by respondents who had earlier indicated no ailments. Only actual responses to each question have been considered in this analysis.

**Health Check-Up Practices**

Among the respondents who did not opt for regular medical check-ups, the reasons cited were as follows:

- 74 women (25.34%) stated that they did not feel the need for routine check-ups.
- 11 respondents (3.76%) cited financial constraints as a barrier.
- 6 women (2.05%) reported non-availability of doctors in their vicinity.

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- 7 respondents did not specify any reason.
- 1 woman mentioned, “I am a doctor myself.”
- 6 respondents felt that regular check-ups were a waste of time.
- 3 women acknowledged ignorance as the reason for not seeking preventive care.

**Discussion-**

From the results, it is quite clear that women are paying more attention to health nowadays, especially those above 40. Below 40, only a few had any regular NCD besides acidity, migraine, thyroid-like complaints. PCOS was more prevalent in the <40 years age group. The highest number of complaints was stated after 55 years of age. Where multiple NCDs were reported by the participants. These are the women who prefer to visit doctors regularly. Women preferring self-medication were mostly doctors.

As in normal course, NCD development begins years before it actually shows physically. In these women, disease progression might have begun way before it showed up. Unfortunately, awareness is poor, and preventive measures are often delayed until symptoms become pronounced. This underscores a critical gap in early health education and screening, especially for women in their twenties and early thirties.

A noteworthy observation was that women who practiced self-medication were predominantly medical professionals, such as doctors, who felt confident managing their own health. However, this raises questions about the broader implications of self-care versus professional oversight, especially in chronic disease management.

One of the limitations of the study lies in its digital mode of data collection. The survey was conducted via Google Forms and circulated through WhatsApp, which inherently restricted participation to women with internet access and smartphones. As a result, the sample was skewed toward educated, urban, and semi-urban women, with only four illiterate respondents, all working as domestic help. Furthermore, a significant proportion of participants were working professionals, particularly teachers and doctors, who are generally more health-conscious and financially secure. This demographic bias may have influenced the overall findings, particularly in terms of health awareness, treatment preferences, and access to private healthcare.

The data also revealed that regular doctor visits were more common among women aged 40 and above, but these visits were often problem-driven rather than preventive. As age increased, routine consultations became more frequent, especially among women with stable incomes or supportive family structures. Financial constraints were rarely cited as a barrier, suggesting that the majority of respondents belonged to middle- or upper-income groups.

In summary, while the study highlights encouraging trends in health-seeking behaviour among educated and urban women, it also points to the need for inclusive outreach, early intervention, and preventive health education—particularly for younger women and those from digitally or economically marginalized backgrounds.

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## Conclusion

The findings of this study indicate a positive shift in health-seeking behaviour among women, particularly those who are working, financially independent, or belong to well-to-do families. Even among household help, the urgency to seek medical consultation is often driven by the need to avoid wage loss or absenteeism. Women suffering from non-communicable diseases (NCDs) such as diabetes, hypertension, thyroid disorders, and arthritis are more likely to engage in regular medical consultations. These conditions, however, often stem from prolonged neglect or delayed awareness, especially in the pre-40 age group.

Health awareness notably increases after the age of 40, regardless of socio-economic status. Women begin to pay closer attention to their health, adopt regular treatment routines, and prefer private healthcare facilities for reasons of cleanliness, efficiency, and time management. This trend challenges earlier studies that suggested women delay treatment or lack access to timely care. While this study reflects the experiences of relatively affluent and self-sufficient women, clinical observations still point to persistent neglect—particularly among elderly women who are financially dependent.

Importantly, the study highlights a generational shift: two decades ago, nearly all women aged 60+ were economically dependent. Today, it seems, a significant proportion of urban elderly women are financially self-reliant, which has improved their access to healthcare and autonomy in decision-making.

Despite the enduring influence of patriarchal norms, there is growing male awareness and support for women's health needs. This has contributed to improved affordability and accessibility of healthcare for women, especially in urban settings. Strengthening government health infrastructure, enhancing the outreach of existing programs, and fostering male sensitization towards timely treatment for women—irrespective of the severity of illness—remain critical. Moreover, promoting a holistic understanding of health among young adults, beyond the mere absence of disease, is imperative. While the present study offers valuable insights into women's health-seeking behaviour, its online format presents inherent limitations—particularly in reaching populations with limited digital access, lower literacy levels, or restricted autonomy in health decision-making. These constraints underscore the need for expansive, field-based research that encompasses diverse socio-economic and educational strata. A large-scale, multi-modal study—grounded in both fieldwork and inclusive methodologies—is essential to shape responsive health policies and ensure that all women, regardless of background or circumstance, have equitable access to healthcare and the right to informed decision-making.

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