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Curative Health-Seeking Behaviour and Service Utilization among Women in Rural Odisha: An Empirical Analysis

Sachita Nanda Sa[1*], Annapurna Mishra[2]

[1]Dr. Sachita Nanda Sa, Assistant Professor of Economics, Dept. of Social Science, Fakir Mohan University, Balasore

[2]Ms. Annapurna Mishra, Research Scholar, Dept. of Social Science, Fakir Mohan University, Balasore

Abstract

The health of women becomes an important factor in determining the growth of a country, while the ability to seek curative healthcare services may be hindered by various socio-cultural and structural factors. Curative health seeking behaviour refers to the actions taken in seeking cure from an already existing illness. This paper explores the therapeutic healthcare seeking behaviour of women in Balasore district, Odisha, India, using empirical research methods. The goal is to discover how women choose the various sources of medical treatment that they use. An empirical research approach was followed, whereby data was generated by means of a structured questionnaire administered to women in rural and urban blocks of the Balasore district in order to examine the impact of women's socio-demographic factors on healthcare utilization. The findings clearly show that they are the primary providers for therapeutic services among the survey respondents. A large number of women indicated that they delay seeking medical attention mainly because of financial reasons, lack of autonomy in decision making at home, and the distance between them and the healthcare facility. It was found that socio-demographic factors such as education, household income, and proximity to facilities largely impact the trend from non-formal healthcare to formal healthcare. This study underscores the importance of recognizing the fact that even though there is the existence of healthcare facilities in the district of Balasore, the uptake behaviour of women differs according to socio-economic levels. To encourage increased uptake of curative health care services, the government should intervene by lowering costs of services, enhancing the quality of health facilities, and sensitizing women.

Keywords: Curative Healthcare, Healthcare-Seeking Behaviour, Utilization Patterns, Women's Health, Odisha.

1. Introduction

Human capital consists of many different components; having access to good health is one of those components. Health is also one of the most critical determinants of both a country's economic development and social well-being. The government's investment in preventive

*Corresponding Author Email: sachitanandasa@gmail.com
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healthcare will have a long-term positive impact on health. Also, the efficiency of a healthcare delivery system can be measured by its ability to provide curative healthcare on time when an individual seeks it. Curative healthcare-seeking behaviour can be defined as the first action taken by any individual to treat an illness or body ache. This behaviour is very important for reducing the number of morbidity cases, which are defined as having had an asthma or pneumonia flare-up but not having received proper treatment, before developing into chronic illnesses or death. There are several pathways through which people access curative care, which include: gender, income strata, and geographic location.

According to the World Health Organization (1948), health is a complete mental, physical and social well-being and not just the absence of illness. Many believe that health cannot be described as a state but rather as a process that requires constant adaptation to changing circumstances and the means available for living. Health can be found among certain individuals; however, health does not exist among all people all the time, and there are typically no recipients of health observed within groups of people or among communities (Park & Park, 1995). A new outlook on health has developed in the past few years, which maintains that health is a basic human right, an essential component of development and an essential characteristic of quality of life.

The quality of health can be defined as an indicator of both growth in an individual's body and the economy. Developed countries have far greater levels of health than developing nations. The quality of life experienced by individuals and the access/availability of these types of services are very different across developed and developing countries. As a developing nation, India has limited access to adequate healthcare infrastructures in both the urban and rural settings.

There is a well-established correlation between poverty and poor health. For poor families, a small expense on healthcare, compared to most other families, is likely to lead to a significant financial burden. This is because most of their resources are spent on meeting daily necessities, therefore leaving them without sufficient means to address even the smallest expense when compared to other families. The provision of both preventive and curative services in a healthcare system will improve the health of individuals. Accessing healthcare services can lead to a significant percentage of an individual's income going towards those services, thus pushing many families further into poverty. The manner in which a healthcare system is financed is a significant factor in determining the health outcomes of families, particularly poor families, and will be a key factor in future healthcare systems. Overall, spending on health care continues to be a long-term goal of society.

Maternal and child care deals with the health needs of mothers and young children, who are considered the most vulnerable group of the community. If the mother and children of the household are having a good status of health care services, then it will indicate that the overall health status of the household is also good. Mothers need special care during pregnancy, and children need regular health check-ups and nutrition supplements to avoid illness, deficiency diseases and communicable diseases (Yesudian 1988). These special health problems of these two groups call for special health services. In many health service systems, the services related to maternal and child health problems are administered as a special category. But in the case of

a rural community, it was found that there is no separate hospital for maternal and child health care. Due to the lack of health service facilities, maternal and child health care has become one of the important components of the health programme. Certain health programmes, such as the special nutrition programme and school health programme, are exclusively carried out for these two groups. Utilization of health services means demand for health care. In the case of utilization of health services, the performance of mothers and children is worse in many developing countries. The above arguments become much stronger than ever in the case of the health status of women in India.

This paper examines the curative health-seeking behaviour and utilization pattern of women in Balasore district. Healthcare is always felt to be intimately related to the health and the very life itself of individuals. Healthcare means services provided by the physician or indirectly by others under the direction of the physician to individuals for maintenance and restoration of health and for prevention of disease (Bryan and Smith, 1979). The concept of disease usually refers to some deviation from normal functioning that has undesirable consequences because it produces personal discomfort or adversely affects the individual's future health status. In an era of scientific medicine, it is not surprising that many patients expect cures or at least relief to be available for many of their health problems (Many K. Beyrer 1977).

2. Review of Literature

Geographical accessibility continues to be a major bottleneck on the supply side, showing a sharp rural-urban divide, with urban prenatal care and trained delivery assistance significantly outpacing rural rates. However, econometric simulations show that merely increasing physical access to rural public facilities yields a significant but modest impact on actual service uptake (Hotchkiss, 2000). Deeply ingrained demand-side obstacles, such as prohibitive distances, exorbitant fees, and the conventional belief that maternal health care is intended for curative rather than preventative purposes, exacerbate this structural constraint. It's noted that a behavioural dichotomy appears when looking at rural-to-urban migration. Migrant women quickly adjust to urban infrastructure by using prenatal care at rates comparable to urban non-migrants, but their choice of delivery location is still closely tied to rural customs of home birth (Stephenson & Matthews, 2004). This phenomenon implies that while routine healthcare practices can be readily changed by structural availability, high-stakes decisions like childbirth are still heavily influenced by deeply rooted cultural norms and are further limited by urban isolation and a lack of social networks that support recent migrants. Formal education and domestic income are dual catalysts that directly increase a woman's healthcare autonomy and her chance of completing thorough clinical treatments, according to empirical findings from Moore et al. (2011) and Rejoice and Ravishankar (2011). On the other hand, Nteta et al. (2010) noted that the geographical friction of distance and travel time further exacerbates the situation of vulnerable women being trapped in inadequate care pathways due to economic hardship and systemic illiteracy. According to Jothy and Pugalenthi (2011), this financial and geographic isolation frequently necessitates a significant dependence on risky home care or unofficial therapies. Agarwal et al. (2011), however, present an important balancing dynamic, demonstrating that strong community-level healthcare services may effectively repair inequalities in baseline illiteracy.

Empirical research on the field of public health in the state of Odisha reveals the strong dependence of a female's propensity for seeking healthcare on the intersection between her socio-economic status, level of educational attainment, and family decision-making power. In a study by Bhue (2024) on the healthcare-seeking behaviour among mothers in the urban slums of Odisha, a clear class gap was found in the extent of maternal healthcare practices: mothers from General and Other Backwards Classes were much more consistent in pursuing complete healthcare programs than SC and ST groups. It became apparent that maternal illiteracy represents a major structural barrier, while secondary and tertiary education lead to timely hospital enrollment and adherence to prescribed therapies. The geographic location of the Odisha district areas presents a lot of friction in the pathways utilized by women to access curative care and maternal services. According to Dehury (2021), in an attempt to evaluate the infrastructure in the Balasore district, it was established that there is a serious shortage on the supply side even in relatively developed districts such as Balasore. It was pointed out that there are serious deficits in the form of inadequate medical personnel, availability of drugs, and poor follow-up after medical procedures, leading to a referral to the District Headquarter Hospital (DHH) Balasore for critically ill patients. This geographical constraint is further confirmed in a study done in Odisha by Siva (2023) and Mahapatro (2015), where it was observed that geographic isolation, difficult terrain, and the absence of a reliable public transport network make distance a great challenge. Natural disasters, such as monsoons, increase the challenge of accessing health facilities.

3. Data and Methodology

In order to understand the empirical dynamics of curative healthcare consumption and its financial implications, the current study will apply a multi-stage stratified sampling approach in the Balasore district of the state of Odisha. Household data collection was done through questionnaires in two different administrative regions. The rural Oupada block had two representative villages, while the semi-urban Notified Area Council (NAC) of Nilgiri block was selected. An equal sample size of 100 households, 50 for each respective block, was randomly selected for a mixed collection of health data that is qualitative as well as quantitative. The empirical test employs two different multiple linear regression models to understand the impact of household income, education, size, demographic composition, illness period, location, and having members in the reproductive age group on economic decision-making. While the first regression model analyzes the factors affecting total health care expenditure of households, the second model focuses on only the expenditure spent by households on the health care of females.

4. Data Analysis

Balasore district, situated in the Mahanadi Deltaic region, is divided into three sub-micro regions—the Balasore coastal plain, Lower Subarnarekha Basin, and Nilgiri upland—and lies between 86°20' to 87°29' East longitude and 21°03' to 21◦59' North latitude. Bounded by Mayurbhanj, Bhadrak, Keonjhar, and the Bay of Bengal, it spans 3,806 sq. km, covering 2.44 percent of Odisha's total area and ranking 20th in size. Administratively, the district comprises 2 subdivisions, 12 Tahasils, 12 blocks, 5 towns, and 2,952 villages, with a total population of 23.21 lakhs (51.09% males and 48.91% females) and a density of 532 people per sq. km. While

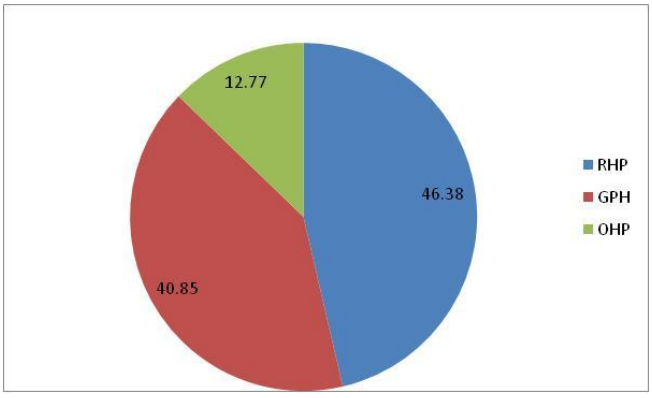
the overall sex ratio is 957 females per 1000 males, it drops to 943 in the 0–6 age group, with the population divided into 0–4 years (9.58%), 5–14 years (24.50%), 15–59 working age (57.90%), and the elderly (8.02%). Healthcare and drinking water facilities are critically poor in blocks like Nilagiri and Oupada; Nilagiri has a population of 1,47,450, with zero CHCs, zero private hospitals, and zero staff nurses, relying solely on 5 PHCs, 6 SCs, 7 doctors, 6 beds, and 154 ASHA workers, alongside 32 homoeopathic dispensaries. Similarly, the Oupada block has 82,617 people served by no CHC, just 4 PHCs, 4 SCs, 4 doctors, 6 beds, and 90 ASHA workers, with no staff nurses and minimal alternative medicine setups. Water scarcity is rampant, as Nilagiri has only 82 villages with water programs (967 tube wells, 47 piped projects), while Oupada has only 30 out of 150 villages covered (850 tube wells, 14 piped projects). Due to abysmal road connectivity and lack of local facilities, patients are forced to travel 25 km from Nilagiri and over 35 km from Oupada to reach the district hospital for serious cases like deliveries. This isolation worsens during the rainy season, forcing vulnerable villagers to rely on expensive local private practitioners. To pay for this costly treatment, families frequently borrow from money lenders at high interest rates, leading to the loss of livestock, land, and jewellery when they fail to repay, which drives up poverty, particularly among low-income SC and ST communities who suffer from poor health status. In this context, a research survey was conducted across rural and urban areas to study reproductive health problems, collecting self-reported data from 100 households encompassing 360 ailing cases divided into three broad categories.

Table 1: Types and prevalence of Health Problems in the study area

S. N.	Types of Health problem	Total Ailing cases
1	Reproductive Health Problem (RHP)	167(46.38)
2	General Health Problem (GHP)	147(40.85)
3	Other Health Problem (OHP)	46(12.77)
	Total	360(100)

Source: Primary Survey. Note- figures in parentheses are percentages.

Figure1: Percentage of Categories of Health Problems



Source: Authors estimation

In Reproductive Health Problems (RHPs), the researcher has included white or any type of discharge, menstruation related problems, DNC, infertility miscarriages. Pregnancy is also included in this category but is not viewed as a health problem. It has been done to analyze the availability and utilization of health facilities which are equally required in pregnancy as well as in other RHPs. General Health Problems (GHPs) include gastro intestinal problems, febrile illness or fever of any type, diarrhea, dysentery, cold, jaundice, accidents, injuries, fracture, skin disease, eye ailments, disease of urinary system and undiagnosed health problems. Whereas in the category of Other Health Problems (OHPs) those ailments are considered which are of long duration such as diseases of joints and bones, diabetes mellitus, blood pressure, psychiatric disorders, tuberculosis, cardiovascular diseases and respiratory diseases. Some cases are there, where they have more than one health problem. The above table and the figure show that 46.38% of the ailing cases suffer from Reproductive Health Problems. 40.85% ailing cases report General Health Problems and 12.77% report Other Health Problems. Maximum respondents are in the category of GHPs. Women are more suffers from RHPs (only 3 men).

Area and Health Problems

The following table shows three categories of health problems which people suffer from in rural and urban. It is evident from the responses of 360 ailing cases, that RHPs are highly prevalent in rural and urban areas. Whereas RHPs are dominant in rural areas as compared to urban areas, primary reason being poor and unhygienic living conditions in rural areas.

Table 2: Area Wise Differences in the prevalence of ailing cases

Types of Health problems	Area		Total Ailing case
	Rural	Urban	
RHP	68(40.71)	99(59.12)	167(64.38)
GHP	59(40.41)	88(59.86)	147(40.85)
OHP	19(41.30)	27(58.69)	46(12.77)
Total	146(40.55)	214(59.45)	360(100)

Source: Primary Survey, Note-Figure in parentheses is percentage

The above table reveals that the area wise differences in categories of health problems. There are two areas i.e. rural and urban and three types of health problems such as reproductive health problem, general health problem and other health problem. Total reproductive health problem is 167, out of that 68(40.71%) in urban area and 99(59.29%) in rural area. In rural area reproductive health problem is more, because they are not conscious about their health. Another health problem is general health problem 147(40.85%) ailing cases both in the rural and urban area. In case of urban area 59(40.41%) are found general health problem and in rural area it is also 88(41.12%). Lastly 46 (12.77%) have other health problems, out of that in urban it is only 19(41.30%) and rural 27(58.69%). Total 360 ailing cases in the study area, in urban area it is 146(40.55%) and in rural 214(59.44%).

Gender and Health Problems

It is a general perception that a woman is more prone to health problems and the following table confirms the same. From the below data it is evident that GHPs are highly prevalent in men as compared to women whereas RHPs are highly prevalent in women; lack of knowledge being the primary reason.

Table 3: Gender wise difference in the prevalence of ailing cases

Types of Health problems	Gender		Total Ailing cases
	Men	Women	
RHP	54(32.33)	113(67.66)	167(64.38)
GHP	74(50.30)	73(49.70)	147(40.85)
OHP	25(54.34)	21(45.65)	46(12.77)
Total	153(42.5)	207(57.5)	360(100)

Source: Primary Survey, Note-Figures are percentage

The table highlights that there are 360 ailing cases in the study area, out of them 153 male and 207 female .54(32.33%) male, 113(67.66%) female have reproductive health problems; out of 167 ailing cases. 147 have general health problem and only 75(50.30%) male and female 73(49.70%) only.46 have other health problems, out of that 25(54.34%) male and 21(45.65%) female in the study area. By combining both male and female health problems, there are 46.38% reproductive health problems, 40.85% general health problems and only 12.77% have other health problems.42.5% male are suffering reproductive, general and other health problems and female 57.5% are suffering from reproductive, general, and Other health problems.

Area wise Utilization/Non-Utilization of Health Facilities

The following table shows area wise utilization of health facilities. Table no. 4 shows the respondents' utilization/non utilization pattern in rural and urban areas. Out of the total 360 ailing cases 97% respondents utilize the heath facilities 11 while 3% do not use them. In the rural area 98% utilize the health facilities and only 2% do not utilize the health facilities .In urban areas 96% respondents utilize the health facilities and 4% people do not utilize health facilities. In the study area people are taking treatment because the public health center is near and low cost and a few number are not treatment because they are believe in "jhadafoonk" and domestic treatment.

Table 4: Area Wise Differences in Utilization/Non Utilization of Health Facilities for different ailing cases

Area	Treatment Taken		Total Ailing cases
	Yes	No	
Rural	210(98)	4(2)	214(59.44)

Urban	139(95)	7(5)	146(40.56)
Total	349(97)	11(3)	360(100)

Source: Primary Survey, Note-Figures in parentheses are percentages

Gender wise Utilization / Non-Utilization of Health Facilities

It is evident from many studies that gender and utilization pattern of health facilities are associated. Table 5. shows the utilization pattern of health facilities on the basis of gender. 26% women do not utilize any health facilities while only 14% men do the same. It is clear from the data that men are more receptive in availing medical facilities as compared to women.

Table 5: Gender Wise Differences in Utilization/Non-Utilization of Health Facilities

Gender	Treatment Taken		Total Ailing cases
	Yes	No	
Men	148	5	153(42.5)
Women	201	6	207(57.5)
Total	349(97)	11(3)	360(100)

Source: Primary Survey, Note- Figures in parentheses are percentages.

In the study area there are 153 male, out of them 96% have been taken treatment and only 4%not taken.207 total women ,out of them 97% receive treatment and 3% do not take any treatment. Because they believe in home treatment, “jhadafoonka”, need not felt etc. Merging men and women, 97% people in the study are taking proper treatment and only 3% not taking any treatment.

Utilization/Non-utilization of Health Facilities and Broadly Categorized Health Problems

Table 6 gives the breakdown of utilization/non utilization of health facilities by the ailing cases in broadly categorized health problems. It is seen that non utilization of health facilities in case of RHPs is significantly high among women, but they do not take it seriously till they disturb their routine life. In case of GHPs maximum cases are treated because these health problems severely affect the life of a person.

Table 6: Utilization/Non-Utilization of Health Facilities for Categories of Health Problems.

Types of Health problem	Treatment Taken		Total ailing cases
	Yes	No	
RHP	159	8	167(46.38)
GHP	144	3	147(40.83)
OHP	46	0	46(12.77)

Total	349(97)	11(3)	360(100)

Source: Primary Survey, Note-Figures in parentheses are percentage

In the above table shows that total ailing cases 360, out of them in reproductive health problems 95% people receive treatment and only 5% not receive treatment. In case of general health problem 97% taken treatment and 2% not taken. Other health problem all people are taking proper treatment. Other than those socio, economic and cultural factors discussed earlier, most important reasons are attitudes of ailing persons and their family. Severity of the health problem also determines the behavior of a person for utilization and non utilisation of health facilities. Lack of education, non exposure to media, shyness, lack of financial resources, lack of required health facilities, high preference to family care, low value in family, low self esteem and ignorance about the value of own health are few of the reasons due to which women fail to avail medical facilities.

Area and Utilization of Different Health Facilities

To study the utilisation pattern in accordance to different area the observed frequencies have been presented in table 7. The following table gives the breakup of utilisation of different health facilities.

Utilisation of health facilities includes public health facilities, private health facilities, untrained practitioners and chemists. Out of 214 rural ailing cases 4 ailing cases do not utilize any of the above given health facilities, 109 health problems give preference to public health facilities, 89 people go to private health facilities, and 7 go to untrained practitioners while 5 take treatment from chemists .In urban area out of 146 ailing cases those who utilize health care constitute 63 from public health facilities, 54 from private health facilities, 8 from untrained practitioners and 14 from chemists and 7 people are not utilize health care services . by taking both the rural and urban area 360 total ailing cases, out of that 11(3.05%) not utilize172(47.77%) of the ailing cases people go to public health facilities for treatment whereas only143 (39.72%) utilize private health facilities,21(5.83%) are taking treatment from chemists and 13(3.61%) are utilizing the untrained practitioners in the study area.

Table 7: Area Wise Differences in Utilization of Different Health Facilities

Utilization of health facilities	Area		Total ailing cases
	Urban	Rural	
Non utilization	7	4	11(3.05)
PHC	63	109	172(47.77)
Private health center	54	89	143(39.72)
Chemist	14	7	21(5.83)
Untrained practioners	8	5	13(3.61)
Total	146(40.55)	214(59.44)	360(100)

Source: Primary Survey, Note- Figures in parentheses are percentage

Utilization of Health Facilities for Broadly Categorized Health Problems

The people's choice of health service providers for different groups of health problems is given below. Their treatment-seeking behavior is influenced by some factors. The perceived quality of services is important determinant of the pattern of utilisation. Private practitioners are perceived to be providing better services because they include injections or drip as part of every treatment and are willing to make home visits which are convenient, especially where transportation is inadequate. The government health services are not popular because of the longer waiting period involved, the arrogant attitude and behaviour of all the staff, non-availability of medicines or service providers and examinations if required. The following table gives the breakup of utilisation of different health facilities for different health problems.

Out of 360 ailing cases 167 had RHPs. Out of them 4% ailing cases do not utilize any of the below given health facilities, 50% cases give preference to Public Health Facilities and 40% go to Private Health Facilities, 2% visit Untrained Practitioners and 4% take treatment from Chemists. Public Health Facilities are preferred over Private Health Facilities. Public and private health facilities are equally preferred for GHPs and OHPs.

Table 8: Utilisation of Different Health Facilities for Broadly Categorized Health problem

Types of Health problem	Treatment Taken					Total ailing cases
	Not taken	PHC	P.vtH.c	Chemist	Untrained practioners	
RHP	8	83	66	7	3	167(64.38)
GHP	3	71	56	10	7	147(40.85)
OHP	0	18	21	4	3	46(12.77)
Total	11(3)	172(48)	143(40)	21(5)	13(4)	360(100)

Source: Primary Survey, Note- Figures in parentheses are percentage

Area and Health Problems

In the previous table there is no association between area and health problems among broad categories. Febrile illness and undiagnosed ailments are more specific to urban area; while some other diseases such as gastro intestinal problems are more prevalent in rural areas. In all health problems such as febrile illness and gastro-intestinal problems are common in Balasore district.

Table 9: Area Wise Frequency of Different Health Problems

Types of Health Problem	Area		Total ailing caes
	Urban	Rural	
White discharge	4	8	12

Menstruation	8	9	17
under nutrition	5	2	7
Gastro	8	20	28
illness(fever)	20	15	35
joint and bones	7	10	17
Diarrhea	6	7	13
Jaundice	3	1	4
skin diseases	6	8	14
Diabetes mellitus	15	11	26
Accidents/injure/factures	7	13	20
Blood pressure	9	15	24
psychiatric problem	2	5	7
other undiagnosed problem	7	8	15
Pregnancy	5	12	17
Cold	10	25	35
urinary system	5	10	15
Tuberculosis	1	3	4
cardiovascular	5	8	13
Eye problem	6	13	19
Respiratory disease	6	7	13
Miscarriage	1	4	5
Total	146	214	360

Source: Primary Survey, Note-Figures in parentheses are percentages

In the study area there are 100 households both in rural and urban. There are 360 total ailing cases, out of them in rural area 214 health problems and in urban area 146 health problem are found.12 people have white discharge problem out of them 8 in rural area and 4 in urban area. Menstruation problem 17 women,9 in rural and 8 in urban. Under nutrition diseases are suffering only 7, 2 in rural and 5 in urban. Gastro diseases are very common maximum people are suffering these diseases. Total 28 people suffer these diseases, 20 in rural and 8 in urban, it is more seen in rural area because they are not aware on health. Another serious disease found on women that is illness.35 women are suffering from illness 15 in rural and 20 in urban.17 people are suffering from joint and bone diseases, out of them 10in rural and 7 urban area. A very rare disease is also seen on 4 people suffers, 1 in rural and 3 in urban.14 people have skin

diseases, among them 8 in rural and 6 in urban area. A very common diseases is diabetes which is affected to both men and women26, in rural 11 and urban 15.20 are in accidents ,13 in rural and 7 in urban .24 people have blood pressure 15 in rural and 9 in urban. Mentally disorder people are 7, 5 and 2 in rural and urban. Another diagnosed ailment is 15 suffering.8 and 7 in both areas. Pregnancy 17 women, 12 and 5 both in the area. Cardio diseases have 13 people 8 in rural and 5 in urban. Another common disease is cold 35 people affected on it.25 in rural and 10 in urban. Like these 214 diseases in rural and 146 in urban area.

Gender and Health Problems

RHPs such as white or any vaginal discharge, are more prevalent in women. While among men accidents, injuries, fractures and febrile illness are more prevalent. The major illnesses for women in general categories were fevers and digestive illnesses, general aches, pains and weakness followed by reproductive illnesses. Menstruation-related health problems, under-nutrition, white discharge, red discharge, pregnancy complications, maternal malnutrition, headache, joint pain, gastro intestinal, abdominal pain, and infections during pregnancy, anemia in general are common.

Table 10: Gender Wise Differences in Different Health Problem

Types of Health Problem	Gender		Total ailing cases
	Men	Women	
White or any discharge	3	9	12
Menstruation problem	0	17	17
under nutrition	5	2	7
Gastro	7	21	28
illness(fever)	8	27	35
joint and bones	7	10	17
Diarrhea	8	5	13
Jaundice	4	0	4
skin diseases	5	9	14
Diabetes	12	14	26
Accidents/facture	10	10	20
Blood pressure	15	9	24
psychiatric problem	4	3	7
other undiagnosed problem	10	5	15

Pregnancy	0	17	17
Cold	20	15	35
urinary system disease	5	10	15
Tuberculosis	3	1	4
Cardiovascular disease	6	7	13
Eye problem	5	14	19
Respiratory disease	8	5	13
Miscarriage	0	5	5
Total	153	207	360

Source: Primary Survey, Note-figure are parenthesis percentage

360 total ailing cases, out of them in 153 men have health problems and 214 women have health problem are found.12 people have white discharge problem out of them 3 men and 9 women. Women are more affected by these diseases. Menstruation problem 17 women. Under nutrition diseases are suffering only 7, 5 are men and 2 are women. Gastro diseases is very common maximum people are suffering these diseases. Total 28 people suffer these diseases, 7 are men and 21 are women, it is more seen on women because they are not taking food in proper time and not aware on health. Another serious disease found on women that is illness.25 .17women are suffering from illness and men 8.17 people are suffering from joint and bone diseases, out of them 7 men,10 women. A very rare disease jaundice is also seen on 4 men suffers, 14 people have skin diseases, among them 5 male and9 female. A very common diseases is diabetes which is affected to both men and women26, 15 male and female 9.20 are in accidents, 13 8 and 5 both male and female. 24 people have blood pressure 15 in rural and 9 in urban. Mentally disorder people 7, 5 and 2 in rural and urban areas. Other diagnosed ailment 15 suffering, 8 and 7 in both areas. Pregnancy 17 women. Cardio diseases have 13 people 6, 7 male and female. It can be said that most of diseases are suffered by women.

Utilization/Non-Utilization of Health Facilities for Different Health Problems

In the following table frequencies and percentage of non-utilization of health facilities are much higher in case of eye ailment, white or any other type of vaginal discharge, psychiatric disorder, menstrual problems, dizziness, weakness, low body immunity, disease of urinary system and undiagnosed ailments; whereas, in case of tuberculosis, jaundice, diabetes mellitus, accident, injuries, fractures diarrhea, dysentery and fever utilization of health facilities by the ailing persons is almost 100%. Health problems such as febrile illness, cold, cardio vascular diseases, DNC, infertility and miscarriages treatment have been utilized by 90% ailing cases.96% of people are taken treatment and only 4% people are not receive treatment.

Table 11: Utilization/Non - Utilization of Health Facilities for Different Health Problem by the households in the study area

Types of Health Problem	Treatment Taken	Total ailing cases

	Yes	No	
White discharge	11	1	12
menstruation	16	1	17
under nutrition	4	3	7
Gastro problem	23	5	28
illness(fever)	35	0	35
joint and bones	16	1	17
Diarrhea	13	0	13
Jaundice	4	0	4
skin diseases	14	0	14
Diabetes	26	0	26
Accidents	20	0	20
Blood pressure	24	0	24
psychiatric disorder	7	0	7
other undiagnosed problem	15	0	15
Pregnancy	17	0	17
Cold	35	0	35
urinary system disease	15	0	15
Tuberculosis	4	0	4
Cardiovascular disease	13	0	13
Eye problem	19	0	19
Respiratory disease	8	0	13
Miscarriage	5	0	5
Total	349	11	360

Source: Primary Survey, Note- Figures in parentheses are percentage

Sources of treatment for Different Health Problems

The below given table shows that Public Health Facilities are more utilized by the respondents in case of jaundice, diabetes mellitus, tuberculosis, pregnancy, diarrhea, dysentery, cardiovascular diseases; whereas, Private Health Facilities are frequently used by the ailing persons in case of DNC, infertility, miscarriages, accidents, injuries, fractures, blood pressure,

menstruation etc.In household survey, it is found that Oupada and Nilgiri blocks in Balasore district, most of women suffer from menstruation problem, gastro problem, accidents/factures/injure, white discharge diabetes and illness .Generally utilization of health facilities depends on the availability of proper treatment and cost. It is seen that for the treatment of all RHPs apart from pregnancy Private Health Facilities are preferred over Public Health Facilities.

Table 12: Sources of treatment for Different Health problem

Types of Health Problem	Treatment Taken					Total ailing cases
	Not taken	public health center	Private Health center	chemist	Untrained practionrs	
White discharge	1	7	4	0	0	12
Menstruation	1	12	4	0	0	17
under nutrition	3	1	1	0	2	7
Gastro	5	15	6	2	0	28
illness(fever)	0	15	19	1	0	35
joint and bones	1	10	6	0	0	17
Diarrhea	0	8	4	1	0	13
Jaundice	0	0	3	0	1	4
skin diseases	0	5	5	4	0	14
Diabetes	0	7	14	0	5	26
Accidents	0	13	7	0	0	20
Blood pressure	0	14	4	6	0	24
psychiatric problem	0	2	5	0	0	7
other undiagnosed problem	0	6	9	0	0	15
Pregnancy	0	10	7	0	2	17
Cold	0	15	11	7	0	35
urinary system	0	10	5	0	0	15
Tuberculosis	0	4	0	0	0	4
Cardiovascular	0	2	11	0	0	13
Eye problem	0	8	11	0	0	19

Respiratory disease	0	7	3	0	3	13
Miscarriage	0	1	4	0	0	5
Total	11	172	143	21	13	360

Source: Primary Survey, Note –figure are percentage

The above table reveals that treatment is taken by the people in the different way such as public health centre, private health care, chemist and untrained practitioners etc. 47.77% people in the study area prefer to take health care facilities from public health care, 39.72% people receive private health care, 6% take treatment from chemist and 3% from untrained practitioners .4% not take proper treatment.

Reasons for Utilization of Health Facilities area wise

Enlisted below are the reasons for utilization of health facilities in rural and urban areas for different health problems. From the survey, important reasons for utilization of any type of health facilities are proximity to the health facility, confidence on the health provider, reputation of the health centre, cost of the treatment (free/low) and immediate requirements (accident/emergencies).

Table13: Reasons behind Utilization of Health Facilities in Rural and Urban Area

Reason	Area		Total ailing cases
	Rural	Urban	
Near by	40(18.70)	37(25.37)	77(21.38)
Confidence	55(25.70)	27(18.49)	82(22.78)
Free of cost	46(21.49)	15(10.27)	61(16.94)
Emergencies	35(16.35)	32(21.12)	67(18.61)
Low cost	30(14)	25(17.12)	55(15.28)
Others	8(3.74)	10(6.84)	18(5)
Total	214(100)	146(100)	360(100)

Source: Primary Survey, Note-Figures in parentheses are percentage

The above table represents an analysis of the reason for the utilization of any type of health facilities by ailing persons in rural and urban areas. It is evident that recognized health facilities and confidence on health facilities are preferred by urban respondents; whereas, rural respondents consult health facilities mainly on the basis of confidence, recognized health facilities and low cost play an important role in choice of a health facility to cure the health problem. Cost of treatment and distance of health facilities from their residence are also important for rural and urban respondents.

Reasons for Utilization of Health Facilities (Gender wise)

Table 14 shows reasons behind utilization of any type of available health facilities by men and women. It is found that more or less the same reasons are responsible for the utilization of any health facility by men and women. Both the genders make decisions on the basis of confidence on health service providers because they give them psychological support. Medicine with psychological support provides complete cure from health problems. Sometimes people utilize those health facilities that are recognized as very good due to availability of required technical personals and equipments. It is also evident that mixed reasons which are not categorized, play an important role in the utilization of health facilities.

Table 14: Gender Wise Differences in Reasons behind Utilization of Health Facilities

Reason	Gender		Total ailing cases
	Men	Women	
Near by	38	49	87(24.17)
Confidence	58	65	123(34.17)
Recognized health facility	10	37	47(13.05)
Free of cost	13	30	43(11.95)
Emergencies	15	11	26(7.23)
Low cost	9	5	14(3.89)
Others	10	10	20(5.55)
Total	153(42.5)	207(57.5)	360(100)

Source: Primary Survey, Note-Figures in parentheses are percentages.

The table denotes that 87 ailing cases utilize health care facilities because of nearby 38 men prefer health care because nearby and 49 women are preferring it. For women the most important reason behind utilization of health facility is having faith on the service providers. 31.40% women and 37.90% man prefer those health care centers or health service providers where they believe they will get safe and correct treatment that will be fruitful for them. Third and the most important reason is the recognition of the health facility, which means that the general opinion about these facilities are good due to availability of specialist and modern technological facilities. Confidence on service providers is one major factor in choosing a particular health facility in rural area. On the other hand urban respondents are inclined towards recognized health facilities. It might be the result of better awareness and high level of literacy around urban ailing persons.

Reasons behind Non-Utilization of Health Facilities (Area wise)

It appears from the following data that in the study area some people are not utilize the health care due to financial reason, jhadafoonk, long waiting, (urban and rural area) and non-serious attitude in both urban and rural areas are the most important factors for the non-utilization of health facilities.

Table 15: Area Wise Differences in Reasons behind Non Utilization of Health Facilities

Reason	Area		Total ailing cases
	Rural	Urban	
Lack of faith	0	0	0
Long waiting	1	1	2
Financial reason	0	1	1
Not serious	1	0	1
Domestic treatment	0	0	0
Appropriate health facility not available	0	0	0
Jhada foonka	2	5	7
Need not felt	0	0	0
Others	0	0	0
Total	4	7	11

Source: Primary Survey, Note- Figures in parentheses are percentages.

This table shows that a very little people in the study area are not taking proper treatment. they are believing on domestic treatment, jhadefoonk, they have financial problem and don't feel serious. It is more in urban area in compare to rural area.

Reasons behind Non-Utilization of Health Facilities (Gender wise)

The following table presents gender wise differences for non-utilization of health facilities. In Balasore district deficient financial resources is the main reason for men as well women and non-serious attitude, domestic treatment towards health is also an important reason for the non-utilization of health facilities for women.

Table 16: Gender Wise Differences in Reasons behind Non-Utilization of Health Facilities

Reason	Gender		Total ailing cases
	Men	Women	

Lack of faith	0	0	0
Long waiting	1	0	1
Financial reason	0	0	0
Not serious	1	0	1
Domestic treatment	2	2	4
Appropriate facility not available	0	0	0
Jhada foonk		2	2
Need not felt	1	2	3
Others	0	0	0
Total	5	6	11

Source: Primary Survey, Note-Figures in parentheses are percentages.

5: Discussion

However, the empirical evidence reveals that the curative healthcare-seeking of women in Balasore is not a mere personal choice but a desperate survival practice under the constraints of structural neglect and geographical conflict. There is a serious deficit of CHC facilities and appointed staff nurses in Nilagiri as well as Oupada blocks, which means that almost 2.3 lakh people have no access to quality curative healthcare facilities. Instead, there are poor PHC units that are incapable of admitting any patient. As a result, pregnant women and critical patients have no option but to travel 25 to 35 kilometres for accessing district headquarters, which become an impossible feat during monsoon because of poor connectivity in rural roads. It is crucial to stress that the spatial marginality overlaps with environmental and demographic conditions. The serious lack of drinking water supply evidenced in that 80 percent of villages in Oupada have no piped water scheme has devastating consequences for reproductive age women, who collect drinking water for families. It leads to high levels of waterborne diseases and accounts for 360 self-declared sick members reported in the households being analyzed. When the state fails to offer any viable health care services through its public infrastructure, impoverished and rural people are left with no choice but to switch to local private service providers, whose fees for users are astronomical. In order to pay for such exorbitant and unaffordable medical costs, poor individuals and families have little option but to take money from local informal lenders, which they can never afford to return due to their interest rates. The only means available to settle debts is by selling off assets like livestock, land, and jewellery.

6: Conclusion

It is evident from the current study that the access to curative healthcare services among women

living in the Balasore district faces structural challenges in light of an urgent gap between the provision of public health facilities and needs within the community. As shown by the findings of this research in the Nilagiri and Oupada blocks, the shortage of secondary healthcare facilities – including the total lack of CHC centers and nursing care – serves to effectively bar rural women from seeking medical help. This deficiency is further exacerbated by the poor accessibility and chronic water scarcity in the studied communities.Ultimately, in situations where there is no such thing as an accessible and functional public healthcare system, families that are at risk end up paying exorbitant amounts of money out of pocket through private means. When this happens to poor individuals, especially SCs and STs, due to the informal borrowing of loans at extremely high interest rates, they are forced to sell their assets, thus pushing themselves deeper into poverty traps. In order to escape this vicious cycle of poverty, the government needs to employ fiscal measures as part of the solution towards developing human capital. These measures would include making primary health centers available and functional on a 24-hour basis, hiring enough health personnel for those places, creating affordable emergency transport lanes, and increasing water pipeline infrastructure in those areas.

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