# Health seeking behavior related to skin diseases in a periurban community

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## Introduction

Research into the health seeking behavior of people, indicate that there is a great deal of individual variation within the general population (1). Studies related to illness in the community also show, that the doctors see only a small fraction of the health problems experienced by the population at large and even though 80-90% adults experience symptoms, only about a quarter of them actually consult a physician[2].

What a person chooses to do when he or she is ill depends on many factors. Knowledge regarding the diseases, accessibly and availability of the medical services, the beliefs and practices of the community, the culture, the experiences of the society around him, limit of tolerance to symptoms and the advantages of assuming a sick role are few of these[1,2,3].

Skin diseases fall into a special category because the lesions are visible and lead to special psychosocial problems due to the mere presence of a lesion. However, the impact of a skin disease on an individual, very different societies and situations. Studies done in Sri Lankan rural communities show that, the health seeking behavior is influenced by the beliefs handed down from generation to generation[4,5,6]. The hot and cold concepts of folklore and the belief that expulsion of certain illnesses form the body, needs expression in the skin is known to be the major cause for the non treatment of skin lesions.

This study evaluates the findings from face to face interviews with people from the periurban villages of Sri Lanka who had skin problems.

## Method

A 23 item questionnaire was designed by the researchers to collect data on socio-demographic aspects, diagnosis, discomforts and the health seeking behavior of persons with skin problems.

5 villages from Kesbawa-Piliyandala area were selected to survey the prevalence of skin diseases in the community. The survey was conducted in 8 selected locations within this area, over a period of 3 months. A total of 418 households were surveyed using the W.H.O. guidelines. Eight clusters were identified for the survey. Five public health midwives and ten medical students who were trained by the researchers visited the selected households and directed those with skin lesions to a temporary clinic set up for the day. At this clinic, face to face interviews were conducted to collect data. The diagnosis of skin lesions were made after careful clinical examination by the dermatologists from the Department of Dermatology, National Hospital of Sri Lanka.

Two guidelines were used for recording data. A simple classification of skin diseases designed using ICD 10 as a reference was used to record the diagnoses. A guide to the health seeking behavior to identify the first line of treatment taken by the patients, the first preference for treatment and the beliefs about causation of diseases was also designed by the researchers and was used during the interviews.

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The socio-demographic data were recorded by the medical students, the diagnoses by the dermatologists and the health seeking behavior by the researchers from the Department of Community Medicine and Family Medicine. Where there were children under the age of 12 years the parent or guardian was interviewed.

The data were analysed using Epi-info and SPSS packages.

## Results

### 1. Participants

860 persons with different skin diseases were interviewed following a survey of 418 households in which 1807 people resided. The villages housed a predominantly Sinhala Buddhist community where 78.9% had at least a secondary education. There were more females with skin disease (62%) as compared to males (32%). The study population included a range of persons from infants to the elderly.

### 2. Prevalence of Skin Disease

In all 1446 diagnoses were made and 47.6% of the population surveyed had a skin disease. This included the persons with common skin problems such as Pityriasis versicolor and scalp dandruff which accounted for 22% of the diagnoses.

### 3. Responses to health seeking behavior

The overall responses to the first line of treatment undertaken and first preferences for treatment stated by the persons with skin disease are listed in tables 1 and 2. A large number (50%) had not sought any treatment for their disease, and out of those who had used some form of treatment, 20% had resorted to self care. Only 30% had contacted a physician. This was true even for fungal infections, parasitic infestations, and even for eczemas (Table 4). However, the majority (72%) admitted that they experienced some form of discomfort. Table 3 lists the different discomforts experienced by the people. Itching was the major discomfort experienced.

Western treatment was sought by 21% of the people. Eventhough 5% had only actually consulted a traditional physician, majority of those who practiced self care also had resorted to herbal remedies.

When preferences were considered, western treatment was preferred by the majority. But 22% of the people did not know where to seek treatment for their problem (Table 3).

**Table 1. Distribution of first line treatment**

| *First line treatment* | *Number* | *%* |
|---|---|---|
| Self care | 291 | 20.0 |
| Traditional | 69 | 4.8 |
| Western GP | 169 | 11.7 |
| General OPD | 91 | 6.3 |
| Skin clinic | 20 | 1.4 |
| Private specialists | 12 | 0.8 |
| Private dermatologists | 12 | 0.8 |
| Pharmacy | 58 | 4.0 |
| Not necessary | 724 | 50.1 |
| Total | 1446 | 100.0 |

**Table 2. Distribution of first preference for treatment**

| *First preference* | *Number* | *%* |
|---|---|---|
| Traditional | 99 | 6.8 |
| Western GP | 429 | 29.7 |
| General OPD | 436 | 30.2 |
| Skin clinic | 87 | 6.0 |
| Private specialists | 21 | 1.5 |
| Private dermatologists | 37 | 2.6 |
| Pharmacy | 16 | 1.1 |
| Do not know | 321 | 22.2 |
| Total | 1446 | 100.0 |

**Table 3. Discomforts experienced by the people**

| *Discomfort** | *No.* | *%* |
|---|---|---|
| Itching | 574 | 39.7 |
| Appearance | 344 | 23.8 |
| Scaling | 12 | 0.8 |
| Oozing | 23 | 1.6 |
| Fatigue | 01 | 0.1 |
| Attitude of others | 01 | 0.1 |
| Attitude towards other | 08 | 0.6 |
| Pain | 67 | 4.6 |
| No discomfort | 416 | 28.8 |
| Total | 1446 | 100.0 |

* Major discomfort experienced

## Discussion

The results show that 50% of those with skin disease had not sought any treatment even though most of them suffered some form of discomfort. This reinforces the known observations of other studies of the presence of an iceberg phenomenon of disease in the community which never reach a clinician[7,8]. The reasons for consultation seem to vary too and is not solely dependent on the presence of symptoms or discomforts experienced.

The 20% of the population that resorted to self care with home remedies (Table 1) reflects on the popularity of herbal medicines as well as the reliance of the people on the advice of the family and friends and the other lay people from the community. Most communities in Sri Lanka are known to have resources of this kind and the influence of the rest of the community in seeking treatment specially for chronic disease is considerable. Thus health education of the communities is an essential strategy in controlling disease.

Only 5% had actually consulted a traditional practitioner. This was probably because the popular herbal remedies are well known by the people and used in self care and majority do not want to adhere to the lifestyle and the dietary restrictions expected from the traditional methods.

4% who used the Pharmacy as the first line treatment mainly purchased western preparations for self medication. However, some of them had purchased herbal preparations. The Pharmacist is often a source of advice and most preparations can be brought over the counter. High rates of self medication has been reported from other studies eventhough no literature is available specially for skin preparations[9].

Among the 21% who had sought western treatment, the majority had gone to the general practitioner. The ready accessibility of care at all times, especially the evenings, privacy at the consultations and the better doctor patient relationships in family practice possibly outweigh the advantages of free services provided by the hospitals.

Specialised care as first line treatment was sought by only few and only for chronic recurring diseases. The low mortality associated with skin disease, lack of priority for cosmetic aspects and the dearth of specialists in this field possibly account for the low percentage seeking specialist care as a primary line of treatment.

A large number declared they would prefer western treatment given a choice. The reasons for this may be the speed with which the western drugs effect a remission, in addition to the fact that the western treatment does not demand dietary or life style restrictions as the traditional systems do. There may also be a bias in the peoples responses since the interviews were face to face and all the interviewers were western doctors.

## Conclusions

1. A large number of people do not consider it necessary to seek treatment for their skin problems.
2. Presence of symptoms or lesions does not always initiate the patient to seek medical care.
3. Of those who had sought treatment, majority had gone to the western GP.
4. In general the western medical services were preferred to traditional services.

**Table 4. First line treatment taken by the participants for selected skin diseases**

| Skin Disease / First Line Treatment | Dermatitis/ Eczema | | Seborrhoeic Dermatitis | | Fungal Infections | | Bacterial Infections | | Viral Infections | | Parasitic | | Psoriasis | | Acne | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| Self care | 28 | 16.2 | 90 | 41.3 | 44 | 17.0 | 3 | 11.5 | 2 | 5.6 | 3 | 42.9 | 0 | 0.0 | 25 | 23.1 |
| Chemist/ Pharmacy | 0 | 0.0 | 9 | 4.1 | 32 | 12.4 | 1 | 3.8 | 1 | 2.8 | 0 | 0.0 | 0 | 0.0 | 1 | 0.9 |
| Traditional | 24 | 13.9 | 5 | 2.3 | 9 | 3.5 | 2 | 7.7 | 0 | 0.0 | 0 | 0.0 | 2 | 25.0 | 3 | 2.8 |
| Western GP | 40 | 23.1 | 8 | 3.7 | 35 | 13.5 | 10 | 38.5 | 1 | 2.8 | 2 | 28.6 | 1 | 12.5 | 7 | 6.5 |
| General OPD | 21 | 12.1 | 4 | 1.8 | 15 | 5.8 | 2 | 7.7 | 5 | 13.9 | 0 | 0.0 | 1 | 12.5 | 2 | 1.9 |
| Specialist Dermatology | 16 | 9.2 | 3 | 1.4 | 4 | 1.5 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 37.5 | 1 | 0.9 |
| Not necessary | 44 | 25.4 | 99 | 45.4 | 120 | 46.3 | 8 | 30.8 | 27 | 75.0 | 2 | 28.6 | 1 | 12.5 | 69 | 63.9 |
| Total | 173 | 100 | 218 | 100 | 259 | 100 | 26 | 100 | 36 | 100 | 7 | 100 | 8 | 100 | 108 | 100 |

## Recommendations

1. The primary care physicians should have a good knowledge about recognition and management of common skin diseases.
2. The specialits should be available for consultations either at district hospitals or in the community at least on one day of the month.
3. The specialist training in dermatology should include exposure to community dermatological problems.
4. Health education at community level about the available modes of treatment would benefit the people in this community.

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