Section: Community Medicine

Original Research Article

# GENDERED BARRIERS TO HEALTH-SEEKING BEHAVIOUR: A COMMUNITY-BASED CROSS-SECTIONAL STUDY AMONG ADULTS IN CHENNAI

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***Received*** *: 03/04/2026*
***Received in revised form*** *: 19/05/2026*
***Accepted*** *: 02/06/2026*

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**DOI:** 10.70034/ijmedph.2026.2.478

**Source of Support:** Nil,
**Conflict of Interest:** None declared

**Int J Med Pub Health**
2026; 16 (2); 2892-2895

ABSTRACT

**Background:** Health-seeking behaviour (HSB) is a key determinant of health outcomes, particularly in low- and middle-income settings such as India. Gender shapes not only whether and how quickly people seek care, but potentially the kind of barriers they face. This study compared HSB and gender-based barriers to care between men and women in an urban Chennai population.

**Materials and Methods:** A community-based cross-sectional study was conducted in Chennai between July and September 2025. Adults aged ≥18 years were recruited by convenience sampling (N = 85; 44 men, 41 women) and completed a structured questionnaire following digital informed consent. The primary outcome was prompt health-seeking (seeking care "immediately" when unwell vs. any delay). Barriers to care were assessed as a secondary objective. Categorical comparisons used the Chi-square test, with Fisher's exact test for sparse cells; ordinal data used the Mann–Whitney U test; and multivariable binary logistic regression assessed independent predictors. $p < 0.05$ was significant.

**Results:** Men and women did not differ significantly in prompt health-seeking (38.6% vs. 51.2%; p = 0.24). However, barriers to care were strongly gendered in kind: men were more likely to cite cost as a barrier (63.6% vs. 29.3%; p = 0.002) and to report distrust of providers (15.9% vs. 0%; p = 0.012), whereas women were more likely to delay care because of gender-based stigma (17.5% vs. 0%; p = 0.005). Socioeconomic factors did not independently predict HSB on logistic regression.

**Conclusion:** While the overall promptness of health-seeking was similar across genders, the barriers preventing care were qualitatively different — structural and financial for men, relational and stigma-related for women. Gender-sensitive interventions should therefore be tailored to these distinct barrier profiles rather than applied uniformly.

**Keywords:** Health-seeking behaviour, Gender, Barriers to care, Stigma, Cost, Community medicine, Chennai.

## INTRODUCTION

Health-seeking behaviour — the set of actions individuals take to prevent, recognise and treat illness — is a central determinant of health outcomes, especially in low- and middle-income countries where access to care is uneven. Gender is a well-documented influence on HSB: social roles, financial autonomy, mobility and stigma all shape when and where men and women seek care.

In a community-based study among rural adults in Puducherry, Vijayalakshmi et al. reported that men used more medical services and demonstrated higher health awareness than women, with significant gender differences in the uptake of treatment.[1] In a different setting, Tenenbaum et al. found that women sought healthcare significantly later than men

following whiplash trauma, raising the possibility that delayed care-seeking among women may have downstream consequences.[2] Together these studies establish that gender differences in care-seeking are real but context-dependent.

Most existing work, however, treats barriers to care as a single aggregate, obscuring the possibility that men and women may face barriers that differ not merely in degree but in kind. Distinguishing structural barriers (such as cost and distance) from relational ones (such as stigma and fear of judgement) is essential for designing interventions that actually fit the population they target.

The present study was conducted under the Department of Community Medicine, Government Medical College, Omandurar Government Estate, Chennai. It compares health-seeking behaviour between men and women in an urban community and, as a pre-specified secondary objective, characterises the gender-specific barriers to care, with the aim of informing gender-sensitive public-health strategy.

## MATERIALS AND METHODS

**Study Design, Location and Timing:** This was a community-based cross-sectional study conducted in Chennai, Tamil Nadu, India, over a three-month period (July to September 2025), under the Department of Community Medicine, Government Medical College, Omandurar Government Estate.

**The Groups Compared:** Participants were adults aged ≥18 years residing in Chennai, recruited by non-probability convenience sampling. The two comparison groups were defined by gender — Group 1: men and Group 2: women. The sample size was planned to detect a difference in care-seeking between the two groups: assuming a conservative 30-percentage-point gap (smaller than the 37-point gap reported by Vijayalakshmi et al.[1]) at 5% significance and 80% power, approximately 36 participants per group were required. The achieved sample of 44 men and 41 women (N = 85) met this target.

**Data Collection and Survey Structure:** Data were collected using a structured, pre-designed questionnaire administered through a digital (Google) form. The instrument comprised four sections: (i) sociodemographic profile (age, marital status, education, employment, income, insurance, distance to facility, transport); (ii) health-seeking behaviour (promptness of seeking care, usual provider, recent utilisation); (iii) barriers to care, including a multi-select item and gender-specific barrier questions; and (iv) perceptions of equity and being heard. The questionnaire was distributed electronically through the Google Forms platform; participation was voluntary and responses were recorded anonymously.

**Handling Data and Fixing Discrepancies:** On closure of data collection, 85 responses were exported and audited for completeness and consistency. Minor data-entry inconsistencies were resolved reproducibly: free-text and formatting variants in categorical fields (e.g. spacing and dash differences in income and distance bands, and capitalisation in transport mode) were standardised to single categories; one age field containing a non-numeric entry was set to missing; and the multi-select barriers item was split into individual binary indicators. No respondents were excluded on the basis of age. The final analysed sample was N = 85.

**Statistical Analysis**

Data were analysed using SPSS version 16. Categorical variables were compared between genders using the Chi-square test; Fisher's exact test was used where expected cell counts were <5. Ordinal and Likert variables were compared using the Mann–Whitney U test. Associations are reported as proportions with odds ratios (OR) and 95% confidence intervals (CI). Independent predictors of the primary outcome were examined using binary logistic regression (predictors: gender, age, income, education). A two-sided $p < 0.05$ was considered statistically significant

## RESULTS

**Baseline Characteristics**

The sample comprised 44 men (51.8%) and 41 women (48.2%). The two groups were comparable in age, marital status, education, income, insurance and distance to the nearest facility (all $p > 0.05$); the only difference was in employment ($p = 0.028$), driven by homemakers being exclusively female. The sample was predominantly educated (82.4% with higher education) and employed — a profile to be borne in mind when interpreting generalizability. [Table 1]

**Table 1: Baseline demographic profile by gender (N = 85)**

| Variable | Men, n (%) (n = 44) | Women, n (%) (n = 41) | p |
|---|---|---|---|
| Age, mean ± SD (years) | 42.9 ± 12.3 | 40.0 ± 10.2 | 0.24 |
| Marital status | | | 0.54 |
| Married | 36 (81.8) | 34 (82.9) | |
| Single | 8 (18.2) | 6 (14.6) | |
| Widowed | 0 (0.0) | 1 (2.4) | |
| Education | | | 0.83 |
| Higher | 35 (79.5) | 35 (85.4) | |
| Secondary / Primary | 3 (6.8) | 3 (7.3) | |
| No formal education | 6 (13.6) | 3 (7.3) | |
| Employment | | | 0.03 |
| Employed | 36 (81.8) | 28 (68.3) | |

| | | | |
|---|---|---|---|
| Unemployed | 4 (9.1) | 6 (14.6) | |
| Homemaker | 0 (0.0) | 6 (14.6) | |
| Student | 4 (9.1) | 1 (2.4) | |
| Monthly household income | | | 0.78 |
| ≤ 25,000 | 14 (31.8) | 17 (41.5) | |
| > 25,000 | 30 (68.2) | 24 (58.5) | |
| Has health insurance | 23 (52.3) | 16 (39.0) | 0.14 |
| Nearest facility < 1 km | 17 (38.6) | 22 (53.7) | 0.55 |

**Primary Outcome: Promptness of Health-Seeking** There was no statistically significant difference between men and women in seeking care promptly when unwell. While a larger proportion of women reported seeking care immediately (51.2% vs. 38.6%), the difference did not reach significance ($\chi^2$ = 1.36, p = 0.24; Fisher p = 0.28; Mann–Whitney p = 0.12), and the confidence interval for the effect included no difference (OR for women vs. men 1.67, 95% CI 0.70–3.95). [Table 2, Figure 1]

**Table 2: Promptness of health-seeking when unwell, by gender**

| When unwell, seeks help… | Men, n (%) | Women, n (%) | p |
|---|---|---|---|
| Immediately (prompt) | 17 (38.6) | 21 (51.2) | 0.24 |
| After a few days | 12 (27.3) | 12 (29.3) | |
| Only when symptoms worsen | 12 (27.3) | 8 (19.5) | |
| Rarely / never | 3 (6.8) | 0 (0.0) | |

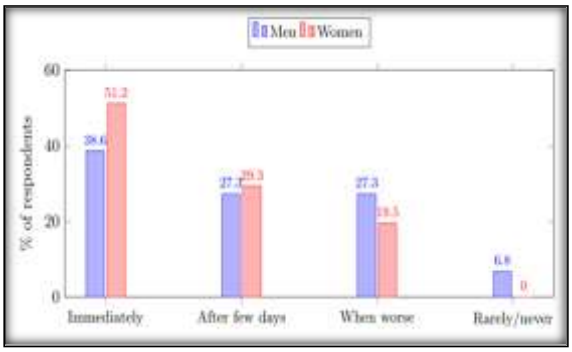


**Figure 1: Promptness of health-seeking when unwell, by gender (no significant difference, p = 0.24).**

**Secondary Outcome: Barriers to Care Are Gendered in Kind:** Although the amount of care-seeking did not differ by gender, the type of barrier did, markedly. [Table 3, Figure 2] Men were significantly more likely to report practical/structural barriers: cost was named as a barrier by 63.6% of men versus 29.3% of women (p = 0.002), and distrust of providers was reported only by men (15.9% vs. 0%, p = 0.012). Women, in contrast, reported relational barriers: delaying care because of gender-based stigma was reported by 17.5% of women and no men (p = 0.005; risk difference +17.5 percentage points, 95% CI +5.7 to +29.3); discrimination, fear of judgement and feeling that concerns are not taken seriously also trended higher among women, though not significantly. The cost and stigma findings both survived correction for multiple comparisons across the barrier items.

**Table 3: Barriers to care by gender (Fisher's exact test)**

| Barrier | Men, n (%) | Women, n (%) | p |
|---|---|---|---|
| **Practical / structural** | | | |
| Cost named as a barrier | 28 (63.6) | 12 (29.3) | 0.002 |
| Distrust of providers | 7 (15.9) | 0 (0.0) | 0.012 |
| Lack of time | 23 (52.3) | 24 (58.5) | 0.66 |
| Distance | 9 (20.5) | 6 (14.6) | 0.57 |
| Gender / relational | | | |
| Delayed due to gender stigma | 0 (0.0) | 7 (17.5) | 0.005 |
| Discrimination at facility | 2 (4.5) | 6 (14.6) | 0.15 |
| Fear of judgement (gender) | 4 (9.1) | 8 (19.5) | 0.22 |
| Concerns not taken seriously | 9 (20.5) | 11 (26.8) | 0.61 |
| Avoided care due to gender | 5 (11.4) | 5 (12.2) | 1.00 |

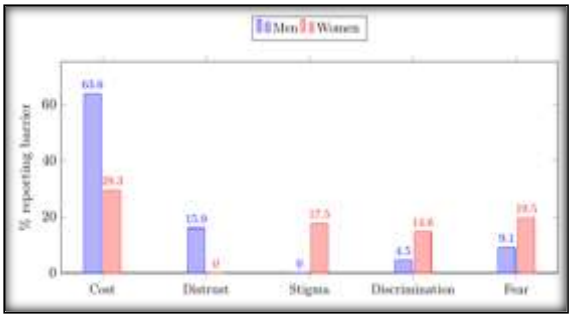


**Figure 2: Barriers to care by gender. Men report cost and distrust (structural); women report gender-based stigma (relational). Cost (p = 0.002) and stigma (p = 0.005) differences are statistically significant.**

**Independent Predictors (Logistic Regression):** On multivariable binary logistic regression, neither gender nor any socioeconomic variable (age, income, education) was an independent predictor of prompt health-seeking (adjusted OR for women 1.55, 95% CI 0.64–3.76; model explained little of the variance). Socioeconomic status did not significantly predict health-seeking promptness after adjustment.

## DISCUSSION

This community-based study yielded two findings of interest. First, contrary to the marked gender gaps in care-seeking reported in some earlier work — men using more services in rural Puducherry,[1] and women seeking care later after trauma,[2] — we found no significant gender difference in the promptness of health-seeking in this urban, educated Chennai sample. This may reflect the relatively high education and employment levels of our respondents, among whom traditional gendered constraints on care-seeking may be attenuated; it is also consistent with the study being powered only for large differences.

Second, and more importantly, the study shows that barriers to care are gendered in kind rather than in degree. Men predominantly reported structural and financial barriers — cost and distrust of providers — whereas women reported relational barriers, most notably delaying care because of gender-based stigma. This distinction is easily missed when barriers are pooled into a single index (indeed, our composite "any gender barrier" measure was not significant), and it has direct programmatic implications: a single, generic outreach strategy is unlikely to serve both groups. The gendered stigma reported by women echoes the relational and social influences on women's care-seeking noted in prior literature,[1,2] while the prominence of cost among men highlights a financial-access dimension that gender-focused programming sometimes overlooks.

Our finding of comparable promptness between men and women sits within a mixed international literature. A widely cited review by Galdas et al. described a consistent tendency for men to delay help-seeking, frequently attributed to traditional masculine norms,[3] and Thompson et al., in the multinational QUALICOPC study, likewise reported that gender shapes care-seeking behaviour.[4] That we observed no such promptness gap may reflect our urban, highly educated sample, in which conventional gendered constraints on care-seeking appear attenuated.

Our results align most closely with prior work in showing that barriers differ qualitatively by gender. In an urban slum of Kolkata, Das et al. described men engaging with healthcare as economic providers who prioritise rapid recovery and formal care, while women's choices were shaped by socio-cultural considerations and their family roles,[5] — a structural-versus-relational divide that closely mirrors our findings. Similarly, Finneran et al., in the large United States All of Us programme, found that the reasons for delaying care differed across gender groups, with cost and apprehension contributing to differing degrees,[6] reinforcing that gender shapes not only whether care is sought but why it is not.

The prominence of cost among men in our sample, alongside relational barriers such as stigma among women, also complements the broader Indian access literature: Pradhan and De report that women in India continue to face substantial household-, logistic- and facility-level barriers to care.[7] Collectively, these national and international findings support our central argument that gender-sensitive programming should address the distinct barrier profiles of men and women rather than a single, aggregated set of obstacles.

**Limitations**

Several limitations apply. The sample was recruited by convenience and skewed towards educated, employed, urban respondents, limiting generalisability. Data were self-reported, and the sensitive gender-barrier items (stigma, discrimination) are likely to be under-reported — a bias that, for the stigma finding, is conservative. The study was powered to detect only large differences, so the non-significant primary result is inconclusive rather than evidence of equivalence. Multiple comparisons were performed; the cost and stigma findings survive correction, but the weaker associations should be interpreted with the small numbers in mind. Finally, the cross-sectional design precludes causal inference.

## CONCLUSION

Among adults in this urban Chennai community, men and women sought care with similar promptness, but the barriers standing between them and care were qualitatively different: structural and financial for men, relational and stigma-related for women. Effective public-health interventions should therefore move beyond uniform messaging towards gender-tailored strategies — addressing cost and trust for men, and stigma and discomfort for women.

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