Factors Influencing Choice of Health Care Providers Among Women in Tamil Nadu, India

P. Devi Priya
Associate Professor, Research Centre and Department of Economics
Lady Doak College, Madurai, Tamil Nadu, India
(Affiliated to Madurai Kamaraj University)
https://orcid.org/0000-0001-6201-5302

M. Helen Mary Jacqueline
Head &Associate Professor, Research Centre and Department of Economics
Lady Doak College, Madurai, Tamil Nadu, India
(Affiliated to Madurai Kamaraj University)
https://orcid.org/0009-0003-5115-7307

T. Nivista
Research Assistant, Minor Research Project Sponsored by ICSSR

OPEN ACCESS

Manuscript ID:
ECO-2025-13049277

Volume: 13

Issue: 4

Month: September

Year: 2025

P-ISSN: 2319-961X

E-ISSN: 2582-0192

Received: 15.04.2025

Accepted: 15.05.2025

Published Online: 01.09.2025

Citation:
Devi Priya, P., et al. "Factors Influencing Choice of Health Care Providers Among Women in Tamil Nadu, India." *Shanlax International Journal of Economics,* vol. 13, no. 4, 2025, pp. 1–9.

DOI:
https://doi.org/10.34293/economics.v13i4.9277

Abstract
Medical advancements have increased human life expectancy. Seeking healthcare at the right time of need is important. There are physical and financial barriers to access healthcare. The obstacles for women from seeking curative care are complex. Public healthcare is a means of achieving universal health coverage. The morbidity rate among women is on a rise, but seeking health care does not show a significant improvement (NFHS 4 and 5 rounds). For empirical substantiation, India and Tamil Nadu, a better-performing state in health indicators, were used for the analysis. The objectives of the study were to identify the factors influencing the preferences of women for curative care and reasons for the non-utilisation of public health care facilities. Secondary data from the National Family Health Survey 5 (2019 – 2020) were used. The binary Logistic model was applied to identify the factors influencing the probability of choice of healthcare providers by women. Spatial maps were used to represent differentials in public healthcare usage. Women in eleven states and union territories seek more public care (31%). Less than 30% of the public care is sought in Bihar, Telangana, and Andhra Pradesh. Compared to urban folks, rural people access public care more by 9%. Physical availability plays a vital role in access. Long waiting times, poor quality service, and lack of nearby facilities are the main reasons for pushing to access private care both at the national and state levels. Since increasing the number of public care units is a long-term goal, an immediate improvement can be made by extending their operating hours, allowing them to serve a larger population. Micro-studies probing obstacles to public care would increase their share of access through further directions.

Keywords: Choice of Care, Health Care Utilisation, Healthcare Accessibility, Morbidity, Non-Utilisation, Spatial Maps

Introduction

The life expectancy of humankind has increased tremendously owing to advancements in medical science. Sustainable Development Goal 3 on health is the objective of all nations. Public healthcare is an effective platform that helps achieve universal health coverage. The unique purpose of public health is to provide hygienic and preventive measures to people at risk of major infectious diseases. A large percentage of the population, especially those in older age groups, always lacked the resources to pay for necessary care and treatment.

This led to the introduction of the government's welfare branch in the physical sphere. A proportional rise in the younger age groups who required the care offered by the established treatment centres coincided with the decline in the infant death rate. On the other end of the spectrum, there was a significant increase in longevity, accompanied by crippling diseases. More financial accountability is required on the part of the state in both cases. When medical practices proved incapable of handling these issues, the state began to intervene in the therapeutic sector. However, the widespread adoption of this approach has increased the cost of the service and, in turn, complicated the issue of guaranteeing high-quality medical treatment to everyone, regardless of their financial situation. A medical insurance program that offers a service that is acceptable to both the donor and beneficiary at a reasonable cost is the suggested remedy (Phair, 1961).

As per the 2011census, females constituted 48.5% of the total population in India. The decadal growth rate of females was 18.12%, which was higher than that of males (17.19%). As a result, from 933 females per 1000 males in 2001 to 943 in 2011, the sex ratio improved. As far as sex ratio went, Kerala (1084), Tamil Nadu (996), and Andhra Pradesh (993), were the top three states.

According to reports, in India 2022, the work participation ratio of women aged 15-59 in rural and urban areas were 38.4 and 24.3, respectively (MOSPI 2023). Half the population that is not economically independent questions the status of women. The untapped potential can converge and be directed towards women-led development only when women are in the safety net of health. However, despite various health initiatives, disparities remain in how women access and utilise health services. Identifying the barriers and enablers within the existing healthcare landscape helps understand the crucial determinants for designing gender-responsive health policies.

Research Problem

Women are faced with unique health issues and conditions. According to estimates from the 71st round of the National Sample Survey 2014, the morbidity rate among women (110) is higher than that among men (87). Kerala, Punjab, West Bengal, Tamil Nadu and Andhra Pradesh are the five states recording a high morbidity rate above the national average. These states exhibit the same trend of higher illness prevalence among females than males (Devi Priya 2017). According to data from the National Family Health Survey (NFHS) 5 conducted in 2019-20, it is indicated that among the 38 states and union territories surveyed, 25 exhibited a prevalence of anaemia among women aged 19-49 that exceeds 50%, as highlighted in the National Health Profile of 2022. Assistant Director (Research), Institute of Public Health, has reported that in India there is a significant disparity in the access to healthcare that men and women have. Women's access to healthcare has not significantly improved between the fourth and fifth rounds of the NFHS (Ishwari, 2022). India has a widespread public-health system. Despite the availability of public healthcare, women have unmet health needs. As a result, this study attempts to investigate the variables influencing women's choice of healthcare providers and reasons for less inclination towards public care services.

Review of Literature

In rural Gujarat, married women's use of curative services is restricted due to the direct costs of health services. The travel time required to get there as well as the associated expenses such as transportation, purdah restrictions, and time expenditures also played a crucial role (Vissandjee et al. 1997). The influence of gender disparities in health and their utilisation from the NSSO 52nd round on health was examined and demonstrated that although women were less likely than men to be admitted in the hospital, they reported worse health. Despite the fact that income and education reduced gender disparities in health status, the statistically significant differences continued. Among men, 50% were financially independent compared to 12% of women (Kakoli and Anoshua 2008).

The utilisation of antenatal care in developing countries revealed that educated women were more likely to visit in the earlier stages than less-educated women. Women in urban areas utilised antenatal care more frequently than their counterparts. The study concluded that midwives and nurses should be aware

of possible hurdles to using healthcare in developing nations (Simkhada et al., 2007). Factors such as protracted hospital wait times, inadequate facilities, and uncooperative hospital staff were identified as primary causes of reduced use of healthcare services (Singh et al. 2020; Shrivastava 2023).

According to the patterns of illness and health-seeking behaviour among older Indian widows from the 60th NSSO round, older widows had a higher frequency of morbidity than older widowers. However, health seeking was lower among older widows (Agrawal and Keshri 2014). In rural West Bengal, lack of bed facilities, sharing beds with other women, lack of diagnostic test facilities, attention from doctors, and poor food quality at the tertiary care facility were the factors that influenced women's choice of healthcare provider. This suggests that in economically disadvantaged regions, such as North Bengal, the government should necessitate roadways, transportation, and electricity to facilitate access to health care (Bose 2019). According to statistics from the 2016 Ethiopia Demographic and Health Survey, wealthy women were 1.4 times more likely than poor women to use health facilities because they could afford to pay for their travel and prescription needs. Low-income women do not utilise preventative, promotional, and curative services as much (Demsash and Walle 2022). The findings of the 2019/20 Uganda National Health Survey showed that health insurance ownership, household welfare, proximity to medical facilities, patient gender, residential region, and household size consequently affected the selection of healthcare providers (Turyamureba et al. 2022).

Previous research has revealed that travel expenses and distance, medicine shortages, unpleasant staff and social, cultural, and economic challenges were the key impediments to accessing public health care facilities. Thus, the current study aimed to determine the factors influencing women's choice of healthcare provider in parallel with the nation and state. The differences and complexities found will aid in identifying the barriers preventing women from accessing healthcare. India and Tamil Nadu, a better-performing state in health indicators, were selected for the analysis.

Objectives

- To investigate the factors influencing the preferences of women for curative care in India and Tamil Nadu
- The preferences of Indian women regarding healthcare facilities
- To identify the reason behind the non-utilisation of public health care facilities by women

Methodology

Secondary data from the National Family Health Survey 5 (2019 – 2020) is used for the study. The nationally representative survey's women's questionnaire which includes 724,115 women in the age range of 15 to 49 is used to assess the type of health services utilised (last 3 months recall period) and the factors influencing them. The household questionnaire with a sample of 636,699 households has been used to analyse the reasons for non-utilisation of government facilities when sick. National-level and state-level weights are used in the tabulation. It is analysed for India and Tamil Nadu.

In identifying the factors influencing the probability of choice of healthcare providers by women, since two of the decision variables, public(=1) and private(=0)care is considered the Binary Logistic Model is applied. The functional form of the model is as follows:

$$ln\left(\frac{P_i}{1-P_i}\right) = \beta_1 + \beta_2 Age_i + \beta_3 Education_i + \beta_4 Residence_i + \beta_5 Caste_i + \beta_6 Wealth\ Index_i + \beta_7 Sex\ of\ the\ Head_i + \beta_8 Marital\ Status_i + \beta_9 Insurance_i + u_i$$

The independent variables are coded as

- MPCE taken as log
- Education: no education-0, primary-1, secondary -2, higher education-3
- Residence: rural-1, urban-2
- Caste: SC/ST-1, Others-2
- Wealth Index: poorest-1, poorer-2, middle-3, richer-4, richest-5
- Sex of the Head: male-1, female-2
- Marital Status: unmarried-0, married-1, divorced/widowed/seperated-3
- Insurance: uninsured-0, insured-1

Mapscreated with QGIS version 3.28.11are used to represent spatial differentials in seeking public health care services.

Utilisation of Health Care

The National Family Health Survey provides information on women's and children's health, population resources, and nutritional status to monitor the advancement of Sustainable Development Goal 3, which focuses on health and well-being for all at all ages. The data on the utilisation of curative care by women for themselves or for their children with reference to the last three months on the date of the survey were analysed.

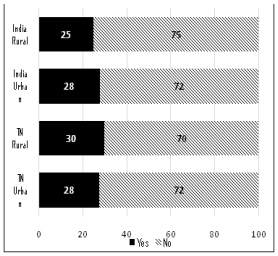

Figure 1 Utilisation of Health Care Facilities by Women, 2019-2020

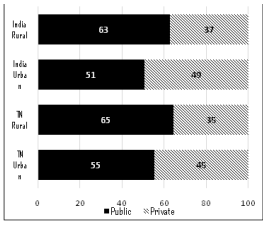

Figure 2 Type of Health Care Facility Utlised by Women, 2019-2020

Source: Computed from Unit Level data, NFHS-5

Figure 1 reveals the differentials in utilisation by women at the rural and urban levels, from the national to the regional level. One-fourth of rural women at the national level have access to health services. It was slightly higher (28%) in the urban areas. In Tamil Nadu, rural usage of health services is 30% slightly higher than the urban usage 28%. The insignificant regional variation confirms that there is no difference in the type of area (rural or urban) with respect to the utilisation of healthcare facilities. But the same trend of nearly three-fourths not seeking health care in the reference period of three months, poses three questions of whether women are physically fit or have unidentified illness or are hesitant to access curative care. Women residing in India and Tamil Nadu are susceptible to obstacles in accessing healthcare facilities, such as lack of services, superstitious beliefs, poor economic standing, and geographic location.

From Figure 2 it is obvious that among the curative care utilised by women, the same pattern of high proportion usage of public care is observed at the national, state and regional level, which includes urban and rural areas. But the usage of public care in rural areas is still higher in national (63%) and state (65%). Compared to metropolitan regions, public health facilities are used more frequently in rural areas. The reasons for this are that the availability of private hospitals in rural areas is very low, so public services have become the only source without alternatives. Primary care centres are the first point of contact to provide preventive, curative, and promotional care. They addressed family welfare services, simple common ailments, injuries, and health education. The sub-district hospitals providing secondary care, second in the tier of the health system, are available in at least one in each block. This encourages women, especially those in rural areas, to access public health care facilities more effectively.

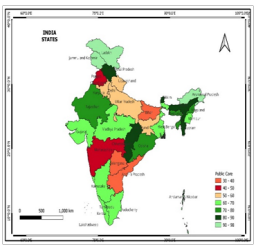

Figure 3 Public Care Sought in Indian States

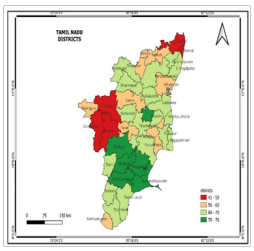

Figure 4 Public Care Sought in Tamil Nadu Districts

Source: Maps created by the authors using vector files from Geographical Information system and NFHS-5, women unit data

Figure 3 shows that women in 11 states and union territories seek more public care (31%). Whereas less than 30% public care is sought in Bihar, Telangana and Andhra Pradesh. Less variation is found in Tamil Nadu, where the number of public healthcare seekers ranges from 41 to 76%. Less than fifty percent are in five districts. Chennai, with more clusters of private healthcare, obviously has fewer public care seekers. Seven districts opted for more than 70% of the total. This reiterates the trust of people in public care and highlights that public care has been the best alternative and substitute for healthcare.

The health services availed of by the women are clustered in 12 categories along with others in the survey. For the study, it is combined and reclassified into four. They are

- Maternal Care & Family Planning – Family Planning, Antenatal care, Delivery care, Postnatal care,Medical termination of Pregnancy, Growth monitoring of child
- Immunisation & Disease Prevention – Immunization, Disease prevention
- Medical Treatment for Self &Others – Medical treatment for self & other person, Health check-up,others
- Treatment for Child

Table 1 Type of Health Care Sought by Women, 2019-2020

Health Services Availed for	India		Tamil Nadu	
	Public	Private	Public	Private
Maternal Care & Family Planning	8682(57)	6657(43)	236(64)	135(36)
Immunisation & Disease Prevention	7109(77)	2170(23)	211(75)	70(25)
Medical Treatment for Self & Others	57262(44)	74142(56)	2335(50)	2307(50)
Treatment for Child	16658(42)	23424(58)	881(49)	903(51)
Total	89711(46)	106393(54)	3663(52)	3415(48)

Source: Computed from Unit Level data, NFHS 5
Note: Figures in bracket indicate row percentages

From Table 1, it is evident that more than half of women at the national (57%) and state (64%) levels utilise public health care facilities for maternal care and family planning. The health of women at the time of pregnancy, childbirth, and lactation, depends on the antenatal care, delivery care and postnatal care taken by them. The women undergo a periodical checkup with respect to weight gain, examining the development of the foetus with the help of a scan, and consuming nutritional supplements that include iron, calcium, and vitamins. To lower the rate of maternal death, the Indian government launched Pradhan Mantri Surakshit Matritva Abhiyan in 2016. Three instalments, totalling Rs. 5,000, were paid as financial incentives. This encouraged all pregnant women in their second or third trimester to have at least one prenatal visit at government health institutions. The Tamil Nadu state-funded Muthulakshmi Reddy Maternity Benefit Scheme played a significant role in enhancing the utilisation of public healthcare for maternal deliveries. It was revised in 2011, that the financial assistance was boosted from Rs.6000 to Rs.12000. Since then, the state has registered a [1] four-fold increase in the number of deliveries from five percent in 2005 to 28 percent in 2011. PHCs contribute significantly to reducing infant mortality (Manonmoney, 1994).

Three-fourths of immunisation at the national and state levels were recorded to have been availed in public health care facilities. It implies that women understand the positive effects of vaccination as well as the benefits of the government-organised camps around the country and adhere to the illness-preventing strategies. This highlights citizens' confidence in the public healthcare system.

Curative care for women and others showed a high dominance of seeking private care (56%) at the national level. However, it was 50% in Tamil Nadu. For common ailments, people bypassing public care increase their curiosity to introspect theirits reasons. Private care services involve a huge out-of-pocket expenditure, which is in most cases catastrophic in nature.

The utilisation of public health facilities for the treatment of children is less than 50% at the national and state levels. The non-availability in the evenings and long wait may be important causes for this low usage. As children attend school and mothers wish that illness should not affect academics, women prefer to have their children receive care at private hospitals. Today, the child is a man or woman tomorrow. Even though they are impoverished, they borrow money to cure their children's illnesses.

Factors Influencing Choice of Health Care Providers

The predisposing and enabling aspects are described as determinants of healthcare utilisation (Aday and Anderson, 1974). The prominent socio-economic and demographic variables influencing the utilisation of public or private healthcare providers were analysed based on the logistic regression results. Table 2 shows that all the selected variables are significant at the national and state levels.

Table 2 Odds Ratio for Type of Health Care Sought by Women, 2019-2020

Variables		India			Tamil Nadu		
		Odds	SE	P>z	Odds	SE	P>z
Constant		0.77	0.02	0.0	0.60	0.06	0.0
Age		0.99	0.001	0.0	0.98	0.003	0.0
Place of Residence	Urban @						
	Rural	1.09	0.01	0.0	1.11	0.05	0.02
Caste	Others @						
	SC/ST	1.60	0.02	0.0	1.22	0.06	0.0
Wealth Index	Richest @						
	Poorest	2.38	0.04	0.0	3.57	0.29	0.0
	Poorer	2.12	0.03	0.0	2.81	0.21	0.0
	Middle	1.85	0.03	0.0	2.22	0.15	0.0
	Richer	1.55	0.02	0.0	1.72	0.11	0.0
Sex of the Head	Male @						
	Female	0.91	0.01	0.0	1.21	0.06	0.0
Education Status	Higher Education @						
	No education	0.93	0.02	0.0	1.46	0.14	0.0
	Primary	1.10	0.02	0.0	1.34	0.11	0.0
	Secondary	1.21	0.02	0.0	1.33	0.06	0.0
	Unmarried @						
Marital Status	Married	1.49	0.02	0.0	1.86	0.12	0.0
	Divorced/ Widowed/ Separated	1.37	0.04	0.0	1.62	0.18	0.0
Health Insurance	Yes @						
	No	0.85	0.01	0.0	1.13	0.05	0.0
Log likelihood		-154537.53			-7335.058		
Observations		247,364			11,763		
LR chi2(14)		11884.40			848.03		
Prob>chi2		0.0000			0.0000		
Pseudo R^2		0.0370			0.0546		

Source: The choice of private care is taken as the reference category

The relationship between age and care type was negligible. As age increases, health care seeking tends to increase, irrespective of the type of care. Rural people access public care by 9% more than urban people. Physical availability plays a vital role in access. With reference to the others category, the disadvantaged community accessing public care is up by 60%. Economic status has a negative relationship with the use of public health care. It is as expected that economic upliftment pulls people towards sophisticated multispeciality care services as a demonstration effect and status symbol. Social and economic downtroddens seek more public care. This highlights the efforts taken by the government to attain universal health coverage. The probability of access to public care is 9% lower in female-headed families than in male-headed families. But education shows a mixed pattern. Compared to women qualified with higher education, those with primary- and secondary-level qualifications accessing public care are likely to be 10 and 21% higher, respectively. Whereas women with no formal education availing of public care is less by seven percent. It is interesting that Indian literate women utilise public health care facilities more than women without formal education. This breaks the common stereotype that the educated population prefers private health centres. This arises from the general awareness of the advantages and benefits of public health centres among the literate. The likelihood of married and single women availing of public care is higher by 49 and 37%, respectively. This restates that public health care is the last resort for needy women. But the surprising fact at the national level is that, compared to insured, the uninsured using public care is down by 15%.

The probability of rural people accessing public care was 11% higher than that of urban people. The disadvantaged, in terms of caste are likely to avail public care 22% more than their counterparts. This is a vast difference compared to the national tendency. But wealth and education status show a clear inverse association with the use of public services. Female-headed families accessing public care is 21% greater than male-headed families. Compared with other unmarried women in the two groups, access to public care was high. As anticipated, the number of uninsured availing of public care is 13% higher than that of insured women. Studies have found that insurance coverage directly affects the choice of health services (Anderson & Bartkus, 1973).

Non-Utilisation of Government Facility

In the NFHS 5 household survey, details on bypassing public care were collected. Six reasons were listed and respondents have chosen from them. The 71st round of the National Sample Survey Organisation report 2014 detailed that among the reasons for non-availing medical care during illness, financial constraint played a significant role in both rural (57%) and urban (68%) areas. According to the estimations, Assam (84%), Odisha (76%), Rajasthan (44%), and Tamil Nadu (42%) had high rates of public care in rural areas. On the other hand, among urban regions, it was Kerala (31%), Assam (44%) and Odisha (54%). Additionally, six factors, such as the unavailability of particular services, distance between facilities, unsatisfactory quality, lengthy wait times, budgetary restraints, and others, were considered in the questionnaire to determine the reasons why people do not use public health care.

Irrespective of regional differences, quality not satisfactory and long waiting was listed for not seeking public care services.

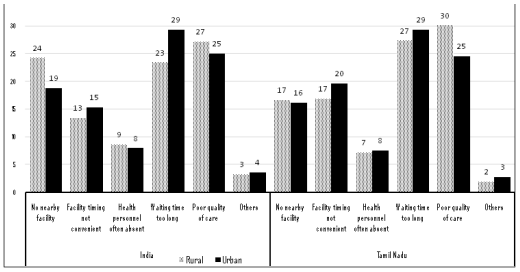

Figure 5 Reasons for Non-Utlilisation of Public Healthcare Facility by Households, 2019-2020 (Percentages)

Figure 5 depicts that long waiting times, poor quality service, and no nearby facilities are the main reasons for accessing private care both at the national and state levels. Tamil Nadu includes one more cause as public service with unfavourable timings.

One prominent feature appreciable is the fact that 'health personnel are often absent' scores a

minimum response at both the levels. This indicates the commitment and discipline of government staff towards their profession.

Primary care attends to illnesses on a pre-mentioned schedule daily. To get the required medicine or curative care, patients are required to wait until that particular day weekly. The services are not 24 x 7 either. The process takes too long to recover; therefore, people choose to travel to a private healthcare facility to recover from their ailments as quickly as possible. The lack of specialised personnel in primary care or infrastructure, such as testing facilities, leads to unsatisfactory services.

Recommendations

- Women should be insisted on undergoing a yearly health check-up regularly to identify illness in the initial stage. Primary care centres in both rural and urban areas must conduct camps on a regular basis and ensure the participation of the population within the jurisdiction.
- The success model in public immunisation has to be emulated in other curative care services as well
- As increasing the number of public care units is a long-term mission, the timing can be increased for immediate improvement. So that it could cater to a large number of people.

Conclusion

Women's trust in the public healthcare system continues to be reflected at both the national and regional levels. Although services such as maternal care and immunisation have gained traction, equal emphasis must now be placed on curative care, especially at the primary healthcare level. Strengthening early disease detection and treatment services is essential for ensuring that women—particularly those with longer life expectancy—can lead healthier, more productive lives. The study's findings highlight key barriers to accessing public health care and underscore the need to bridge the gap between availability and accessibility, especially across varied socioeconomic backgrounds. Enhancing the utilisation of public health facilities can significantly improve health-adjusted life years (HALYs) for women, which in turn may inspire greater confidence in government health services. As India moves toward universal health coverage, investing in accessible, quality public healthcare can help transform women's potential into a vital human resource for national development. However, a key limitation of the study is that the reasons for non-utilisation of public health care cannot be fully analysed using secondary data. Future research should incorporate primary data to explore these barriers in depth.

References

Aday, L. A., and R. Andersen. "A Framework for the Study of Access to Medical Care." *Health Services Research*, vol. 9, no. 3, 1974, pp. 208-220.

Andersen, J. G., and D. E. Bartkus. "Choice of Medical Care: A Behavioral Model of Health and Illness Behavior." *Journal of Health and Social Behavior*, vol. 14, no. 4, 1973, pp. 348-362, https://psycnet.apa.org/doi/10.2307/2136779.

Bose, M. "Determinants of Choice of Care Providers During Childbirth in Rural West Bengal, India." *Indian Journal of Human Development*, vol. 13, no. 1, 2019, pp. 1-24.

Central Bureau of Health Intelligence. National Health Profile 2022. Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, 2023.

Demsash, A., and A. Walle. "Women's Health Service Access and Associated Factors in Ethiopia: Application of Geographical Information System and Multilevel Analysis." *BMJ Health & Care Informatics*, vol. 30, no. 1, 2023, pp. 1-9.

Devi Priya, P. A Study on Utilisation and Expenditure of Health Care Services in Madurai District. 2017. Madurai Kamaraj University, PhD dissertation.

Government of India. Health and Family Welfare Department, Demand No.19, Policy Note 2012-2013. 2013.

Ishwari, P. "NFHS Data Shows 60% Women Face Trouble Accessing Healthcare." NewsClick, 28 May 2022, https://www.newsclick.in/NFHS-data-shows-6o-per-women-face-trouble-accessing-healthcare.

Kakoli, B., and C. Anoshua. "Influence of Socioeconomic Status, Wealth and Financial Empowerment on Gender Differences in Health and Healthcare Utilization in Later Life: Evidence from India." *Social Science & Medicine,* vol. 66, no. 9, 2008, pp. 1951-1962.

Manonmoney, N. "An Economic Analysis of Health Status in Tamil Nadu." Paper presented at the 76th Conference of Indian Economic Association, Bombay, 1994.

Ministry of Statistics and Programme Implementation. Women and Men in India 2022. 2023.

Phair, J. "Public Health and Medical Care." *Canadian Journal of Public Health,* vol. 52, no. 7, 1961, pp. 307-309, https://www.jstor.org/stable/41982655.

Shrivastava, S. R., et al. "Barriers and Opportunities in Utilizing Maternal Healthcare Services During the Antenatal Period in Urban Slum Settings in India: A Systematic Review." *Clinical Epidemiology and Global Health*, vol. 20, 2023, 101318.

Simkhada, P., et al. "Factors Affecting the Utilization of Antenatal Care in Developing Countries: Systematic Review of the Literature." *Journal of Advanced Nursing,* vol. 61, no. 3, 2008, pp. 244-260.

Singh, P., et al. "A Cross-Sectional Study to Determine the Reasons for Non-Utilization of Reproductive and Child Health Services in District Etawah." *International Journal of Community Medicine and Public Health,* vol. 7, no. 3, 2020, pp. 1178-1183.

Turyamureba, M., et al. "Factors Influencing the Choice of Private Health Care Providers in Uganda." *African Journal of Economic Review,* vol. 10, no. 4, 2022, pp. 1-18.

Vissandjee, B., et al. "Utilization of Health Services Among Rural Women in Gujarat, India." *Public Health*, vol. 111, no. 3, 1997, pp. 135-148.

Authors Details

P. Devi Priya, *Associate Professor, Research Centre and Department of Economics, Lady Doak College, Madurai, Tamil Nadu, India (Affiliated to Madurai Kamaraj University),* ***Email ID:*** *devipriya@ldc.edu.in*

M. Helen Mary Jacqueline, *Head &Associate Professor, Research Centre and Department of Economics, Lady Doak College, Madurai, Tamil Nadu, India (Affiliated to Madurai Kamaraj University),* ***Email ID:*** *helenmaryjacqueline@ldc.edu.in*

T. Nivista, *Research Assistant, Minor Research Project Sponsored by ICSSR*