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Filipino Women's Tuberculosis Care Seeking Experience in an Urban Poor Setting: A Socioecological Perspective

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Urban, poor Filipino women tend to delay seeking care for tuberculosis (TB), which increases their risk for morbidity and mortality. We interviewed 13 women and conducted three focus group discussions to characterize their TB care seeking pathways and identify the barriers and facilitators that influence care seeking at multiple levels. The quality of health services, shame associated with TB, financial insecurity, and familial responsibilities hindered care seeking, while support from community health volunteers and family members encouraged it. Strategies to improve TB control should create social support systems and improve the quality of health services to promote timely care seeking.

In 2010, the World Health Organization (WHO) urged for more concerted efforts in addressing health challenges, especially those that affect the urban poor such as tuberculosis (TB), which are exacerbated by the rapid unplanned growth of urban cities (WHO, 2010). *Health Care for Women International* also recognizes this health problem and issued a call for

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manuscripts on the ways TB impacts women around the world. The Philippines ranks ninth amongst twenty-two highest burden countries for TB (USAID, 2009). In 2007, TB was the sixth leading cause of morbidity and mortality, with an incidence rate of 290/100,000 (USAID, 2009). Tuberculosis is still one of the most important causes of morbidity and mortality for all Filipino women (WHO, 2008).

A comparison of TB prevalence between urban poor settlements and general urban populations, the latter based on the National Tuberculosis Prevalence Survey, revealed that the prevalence of active pulmonary TB amongst urban poor females was 49/1,000 in comparison with 29/1,000 for the general female urban population (Tupasi et al., 2000a). Also, Filipino women with lower levels of education and wealth have less knowledge of TB (symptoms, causes, transmission, and curability) compared with their wealthier and more educated counterparts (National Statistics Office (NSO) [Philippines] and ICF Macro., 2009), making them particularly vulnerable.

Delay in seeking diagnosis and treatment for tuberculosis leads to increased severity of illness, development of drug resistance, and continued transmission of disease (Tupasi et al., 2000b). Tuberculosis control programs therefore must work to improve the case detection rate or the proportion of estimated new sputum positive TB cases detected. Under the Philippine's National Tuberculosis Program's (NTP's) guidelines, health providers practice passive case finding, relying on the agency of individuals to seek treatment (Department of Health, Department of the Philippines, 2003). According to the National Demographic Health Study 2008 study, however, only approximately 42.6% of women who reported to have had TB symptoms sought consultation or treatment (NSO [Philippines] and ICF Macro., 2009). The proportion of female care seekers reduces with decreasing wealth and education. Specifically, the urban poor in Metro-Manila, the metropolis surrounding the nation's capital, are seven times more likely to not seek health services for TB and twice as likely to self-treat with local or traditional remedies than those of higher economic status (Tupasi et al., 2000b).

In order to explore ways to improve care seeking amongst women with symptoms of TB, we conducted a qualitative research study in the Barangay (or district) of Payatas, one of the largest urban poor communities in Metro-Manila. Focusing on women's access to care, we aimed to characterize TB care seeking in Payatas and identify facilitators and barriers at the individual, household, community, and health-system levels from the perspective of the community. Our ultimate goal was to improve TB control by developing programmatic recommendations that will inform collaborative efforts between nongovernmental organizations (NGOs) and the government health department focused on TB in the area.

METHODS

Population

Payatas has a population of 118,333 people, composed of three areas (Payatas A, Payatas B, and Lupang Pangako) and is built around a large open trash dump in Quezon City. Many households live in temporary housing made of salvageable materials, while few live in semipermanent or permanent structures. Individuals who scavenge trash for their livelihood usually live closer to the trash dump, while junk shop and store owners live farther away. Both men and women work to contribute to the financial security of their household.

Health System

Collaboration between the Quezon City Health Department (QCHD), NTP, and several tuberculosis-focused NGOs has been established in Payatas. In total, three local government units (LGUs) and four NGOs are active members in the collaboration. Together, the TB collaboration strives to meet the Millennium Development Goals 6 (MDG6) set for tuberculosis: 75% case detection rate and 85% cure rate by 2015. Through the NTP's Integrative and Comprehensive Policy for TB Control, a guideline for TB diagnostics and treatment is provided for both private and government health clinics (Department of Health, Philippines, 2003). Local government units (LGUs) provide free, or low-cost, clinic-based diagnostics and directly observed treatment short-course (DOTS) treatment for TB patients, requiring daily visits at a set hour. Additionally, Barangay Health Workers (BHWs), women from the community who are trained and paid by the government to deliver health services, can also act as DOTS treatment partners for certain cases. Instead of going to the clinic for daily treatment, patients can make an arrangement with a BHW to receive their daily TB medication elsewhere. Most NGOs in the area have implemented free DOTS program services in which patients receive treatment either at the clinic or from Community Health Volunteers (CHVs) who are neighbors trained to be DOTS treatment partners. Lastly, private clinics, which are generally not in compliance with the NTP protocol, also exist in the community and charge fees for consultation and treatment.

Research Focus

We recognized that the agency, or capacity, of women to seek care is not just dependent on individual-level factors, such as knowledge and attitudes, but is also influenced by her sociocultural and institutional environment. By drawing from a socioecological framework, we structured our investigation

around individual, interpersonal/household, community, and health system levels of influence, which, in turn, would allow us to develop strategies at all levels. Additionally, organizations' staff, who develop and deliver TB programs and services, are not all residents of Payatas and may not identify with the community. Therefore, an understanding of the sociocultural, environmental, and economic context also was necessary to develop programmatic recommendations. We used qualitative methodology to capture the rich context and shared community experiences that exist in the area. Last, we elicited strategies and suggestions from participants in order to foster community involvement and empowerment.

Methods and Sampling

We implemented the study in two phases, utilizing two types of qualitative methods: in-depth interviews (IDIs) and focus group discussions (FGDs). We hired and trained two local, female fieldworkers from the community to conduct the data collection in Tagalog. Our study was approved by the Johns Hopkins Bloomberg School of Public Health and University of the Philippines, Manila National Institute of Health Institutional Review Boards. Data collection took place from October 2010 until February 2011.

Phase 1. We conducted a total of 22 semistructured IDIs with 13 female patients to understand their care seeking experience and identify barriers and facilitators to obtaining TB treatment. In order to acquire a range of care seeking experiences, we recruited informants, through the help of BHWs and CHVs, who were receiving care for tuberculosis from LGUs and NGOs. Eligibility criteria included being female, 18 years or older, resident of Payatas, and referred to TB diagnostics or a DOTS patient. For the informants who recently were referred to TB diagnostics, we captured an ongoing care seeking experience by conducting three in-depth interviews 2 weeks apart. One to two IDIs were conducted with the informants who were already enrolled in TB treatment.

Phase 2. We facilitated three focus group discussions from different areas of Payatas (Area A, $N = 9$; Area B, $N = 6$; Lupang Pangako, $N = 14$), to build upon the emerging themes from in-depth interviews and to explore community norms concerning attitudes and perceptions toward tuberculosis, care seeking, and the health system. During the discussion, we used a problem ranking exercise to understand the participants' rationale and decisions about the relative weight of barriers to care in comparison to one another. Participants were also prompted to offer suggestions on how health services can address these barriers. Each FGD was 60–90 minutes and facilitated by a field worker in Tagalog. Focus group participants were recruited through one of the participating NGO's microfinance saving groups composed of mothers.

Analysis

We audio recorded all IDIs and FGDs, except for four interviews for which the informant did not give permission. Then, we transcribed and translated them into English. Local terms were retained in Tagalog to maintain the integrity of their meaning. A codebook was developed based on the research aims and from the themes that emerged from line-by-line coding of selected transcripts. We applied codes to all transcripts using Atlas.ti software and then created a matrix of themes and subthemes, along with quotes, to guide further analysis.

RESULTS

Of women who participated in our study, five received care from LGUs and eight from NGOs. The age of the women ranged from 23 to 73 years old. Four of the 13 women were older than 60. All were married or had a partner. The mothers had between one and seven children, while two women had no children of their own. Almost all participants worked in the informal sector ($N = 7$), for example, as scavengers and pillowmakers. Only two women worked in the formal sector prior to contracting TB, and the others had no defined work. In our sampling, we also included a range of patient types: symptomatics who were referred to TB diagnostics ($N = 2$), newly enrolled ($N = 6$), returning, defaulted, or both ($N = 5$) TB patients.

Tuberculosis Care Seeking Categories

During the analysis, we identified each woman's care seeking delay, or the length of time between onset of symptoms and seeking health care; the health system's delay, or the duration of time that the patient waited for services and diagnostic results until she was diagnosed and subsequently enrolled in DOTS; and the number and type of providers she sought before enrolling in DOTS treatment. Through this process, we observed different types of care seeking pathways. Through literature review, we concluded that Rintiswati and colleagues' (2009) four TB care seeking categories were applicable and could be used as a guide to categorize women in our study. We also added two categories to encompass women's experiences of health system delay. For the seven out of 13 women who did not experience health system delay, four were considered "ideal cases," who sought treatment from one provider within a month of onset of symptoms; two took longer than a month to seek care; and one woman was a "shopper" and sought treatment from two or more providers. Four out of 13 women reported that delays from the health system caused them to wait more than 1 month to enroll in DOTS. An equal number of those who shopped and did not shop for health providers experienced health system delays. Lastly, two women out

TABLE 1 Pathway to DOTS Treatment Categories for Women Living in Payatas, an Urban Poor Community

| Category | Description | Patients (<i>N</i> = 13) |
|--------------------------------|--|------------------------------|
| Ideal case | Sought treatment within 1 month of onset of symptoms | 4 |
| Slow but sure | >1 month of onset of symptoms | 2 |
| Health system delay | >1 month of onset of symptoms and experienced delay from health services | 2 |
| Shopper | >1 month of onset of symptoms, consulting and receiving care from multiple health providers | 1 |
| Shopping + Health system delay | >1 month of onset of symptoms, consulting and receiving care from multiple health providers and experienced delay from health services | 2 |
| Not enrolled | Symptomatics who did not complete TB diagnostics within course of study | 2 |

of the 13 were identified with symptoms of TB by a NGO and referred for consultation, but they never finished the TB diagnostic process by the end of the study. The women's care seeking categories are summarized in Table 1.

Barriers and Facilitators to Care Seeking: A Socioecological Approach

When reviewing and analyzing transcripts, we identified factors that influence women's care seeking behavior on multiple levels: individual, household/interpersonal, community, and health system. Factors were considered barriers if they discouraged and delayed women from seeking care. On the other hand, facilitators were factors that encouraged and prompted timely care seeking. As part of the study, we also invited women to offer their insights on how to improve access to care. We drew programmatic strategies from their suggestions and the influencing factors that were identified. A summary of these factors and strategies are found in Table 2.

Individual level influences on care seeking. In interviews, women recounted symptoms typical of tuberculosis: fever, recurring and prolonged cough, body aches, and weight loss. The majority of FGD participants also enumerated symptoms of TB. Women's understandings of the severity of their symptoms, however, influenced care seeking. Specifically, some patients and focus group members explained that hemoptysis, or coughing up blood, was a definite sign of TB. One woman recalled her thought process regarding her symptoms:

I thought I really wasn't sick, maybe in my lungs. Because, I felt okay. You would feel if there's something wrong in your lungs because you

TABLE 2 Barriers and Facilitators to Care Seeking: A Socioecological Model

| Level of influence | Barrier | Facilitator | Programmatic suggestion |
|-----------------------------|---|----------------------------|---|
| Individual | Nahihiya (Shame) Fear Knowledge | Fear | TB health education TB patient testimonials |
| Household/ Interpersonal | Economic Household responsibilities | Economic Family Support | Support programs for families with TB (economic, health education, transportation services, etc.) CHVs/BHWs as <i>kasamas</i> (companions) and social support Child care services at health centers |
| Community | Norms regarding TB Stigma Knowledge of health system and costs | | TB patient testimonials Communication campaigns to address stigma Promotion of free TB health services |
| Health system | Health system delay Interactions with providers | CHVs and BHWs | Improve quality and timeliness of services Increase coverage and utilization of CHVs/BHWs |

cough a lot and it doesn't take long for you to vomit blood, right? "My lungs are alright," I said.

Women illustrated the ways that fear of being diagnosed with TB was both a paralyzing and catalyzing factor for seeking health care. When asked what was preventing one mother, who has had symptoms of TB for 3 months, from following through on her referral, she distressfully responded, "I am afraid. I fear that I do have it. It's really fear that overwhelms me." Focus group participants also stated how *nabibiya*, or shame, came into play with fear: "The person would be scared that she would lose her job and that people and friends would avoid her." Fear about the consequences of TB, however, also pushed women toward care. One woman explained that her mother, a newly trained CHV, insisted that she ought to seek treatment, otherwise, her lungs would be "consumed" by TB.

Fear and symptom recognition did not necessarily convince women they needed to seek care. One woman, who was referred to treatment, urgently explained that her neighbor's severe symptoms impacted her: "I was shocked that she [her neighbor] was already coughing blood. Then it was already too late. I will really do it [the negative direct sputum smear microscopy] this Thursday to do something before it's too late." Two weeks after this was proclaimed, however, she had yet to submit her sputum. A local CHV

and her husband encouraged her to seek care; however, she told us, with frustration, that her household responsibilities inhibited her from following through. In her case, and many others, multiple barriers and facilitators were weighed in the treatment seeking process.

Household/interpersonal influences on care seeking. Filipino women expressed the importance of family, which includes their nuclear and extended family members, and how it was a source of influencing factors to their care seeking. Women stressed the importance of attending to their household responsibilities as a wage earner, wife, and mother. They also described how familial and social support contributed.

Women mentioned household financial restraints as the greatest barrier to seeking care. One woman at a FGD pithily stated, “If a person is sick, it also becomes a sickness of the pocket.” Women described that in seeking care they are imposing both an immediate and future financial burden on their family. First, when a woman goes to a clinic, her “time is spent filing in line for the checkup” instead of earning money for the day. Furthermore, women are afraid that initiating the process of diagnosis will incur more costs for their family: fare money for travel to clinics, time spent in seeking care instead of working, and cost of treatment. In the end, a woman may “regret how much she would spend to know her health.”

When “money is difficult to find, especially now that it is rainy season,” mothers have to prioritize their family first. One symptomatic mother reasoned: “Perhaps, I cannot commit to getting a check-up because, in doing so, I am thinking of myself while we don’t even have anything to eat.” Instead of seeking care, women endured their symptoms for as long as possible to provide for their family. One woman waited 3 months until she sought care and ignored her symptoms until she was “not able to walk, feeling cold, having a hard time coughing, and my chest was hurting” because her husband is a street vendor and money is not easy to come by.

Women already enrolled in DOTs treatment tended to speak anxiously about the impact of their illness on the financial status of the family. One woman, whose husband’s job is temporary and son has not found a job, shared the following:

I worry a lot because I couldn’t work and there’s no way to earn money to help [the family]; and I find it hard that my sickness keeps on coming back so I’m losing confidence. I thought, if there is a way for me to earn money, like selling things to survive. I can’t help but be sad because I got used to working and a boss that I work for.

When women thought that their health condition would interfere with work, however, poor household economics became a facilitator to getting a checkup. One focus group member explained that when a woman becomes sick “everything will get really affected because instead of fulfilling your responsibilities, you are not able to perform them.” Symptoms would worsen

and women would no longer be able to contribute to the household finances. In this context, women declared that it is an obligation to get treated so that they can “help with the expenses at home.”

Mothers prioritized their children above themselves, sometimes with detrimental consequences on their own health. For example, one mother described how she promptly brought her kids to the NGO to get treatment for the flu and worms, but she neglected to get a checkup for her TB symptoms. Even when women sought treatment for themselves, their role as caretaker continued. Some women explained with frustration that they would have to bring their younger children to the clinic, because they had no one else to look after them. As a result, their health seeking experience would be more inconvenient due to extra transportation fare, caring for kids while waiting for services, and, at times, being reprimanded by health personnel for bringing their children to the clinic. On the other hand, other mothers stated that they prioritized their children by promptly seeking care because they were afraid that would infect their children or so that they could quickly return to their responsibilities as a mother.

Support from family members and friends manifested itself in encouragement, being a *kasama* or companion, and taking on the mother's responsibilities. This did not just come from husbands, but also mothers, siblings, and adult children. One young woman, who lives with her in-laws, told of how her family members played a role in her care seeking:

My husband said my cough has been there for a while, so he said that I should already have a checkup because my cough might not be normal. So Mama, my husband's mom, accompanied me to have a checkup.

Women in FGDs also highlighted the importance of having a *kasama*, whether a family member or neighbor, by asserting that they would encourage and bring their neighbor to the clinic if she had TB. On the other hand, women who lacked a *kasama* to go along to a clinic expressed reluctance to follow through on referrals or get a checkup. Women voiced that unfamiliarity with the clinic's location and process made individuals fearful of accessing services. One woman jokingly stated, “I want someone to get lost with me.” So she waited a few weeks until her neighbor, a CHV, brought her and others with referrals to an NGO in a different part of Payatas.

Some women expressed that their husbands were supportive in the process, reminding their wives to find and finish treatment for the sake of the children. Often their husbands' encouragement also reflected their desire for their wives to contribute to the household finances. One woman was very grateful for her husband's support because he would “come home and cook because the children need to eat” instead of doing overtime at work. Another

woman shared a fond memory of how her husband's humor and concern helped her overcome her initial response to her TB diagnosis:

I went home [from the clinic] weak and pale then he got mad, "Why?" Then I said, "I have TB." Then I was crying and crying. "Crazy! You have TB!" So he made me laugh and I told him, "It's life threatening, right?" Then he said, "Crazy! Aren't you taking medicines?" I said, "Yes." "The reason why you're taking medicines is for that [TB] to stop!"

On the other hand, two women hid their symptoms from their husbands for different reasons. One woman feared being teased, while the other woman did not want to become a burden on her struggling family. Although, once the latter woman revealed her illness to her husband, he brought her to the clinic and told her fearfully, "If you had told me, I would have it treated earlier. So from now on, don't hide anything from me, whatever you feel. What if something happens to you?"

Community level influences on care seeking. Payatas is a squatter community in which "the houses are right next to each other, and there are times when someone would find out that someone has something." Neighbors often work together, share meals, and watch each others' children. Women illustrated that within the community, neighbors treated people who were associated TB or TB like symptoms differently. According to mothers in the FGDs, neighbors would "be disgusted with you," "tease you" or "avoid you," if you have TB. Therefore, acquiring a TB diagnosis was a matter of great shame.

These community norms toward those who have TB or TB-like symptoms influenced women's decisions to seek treatment. During an interview, one woman painfully recalled how her neighbors embarrassed her:

It's really shameful, especially when I'm outdoors, I cough a lot. They [her neighbors] would say, "That's already TB! Go to the Good Doctors (a NGO, pseudonym) now..." I am ashamed to say that I have TB, so I don't want to have a checkup.

For her, not getting a checkup left her symptoms undefined, allowing her to say, "I really don't know what is it, if I do have [TB] or I don't, just symptoms."

Focus group discussion (FGD) participants also confirmed this notion when they ranked *nabibiya*, or being ashamed, as an important barrier to seeking care because one "would think of what others would think [about them] before seeing a doctor."

Furthermore, once people acquire a diagnosis of TB, they feel they need to abide by a different set of rules for interacting with other people,

such as separating their food and utensils or avoiding social interactions. Women participating in focus groups and interviews alike expressed that these social norms can be ostracizing. Last, a few TB patients and FGD participants thought that TB is hereditary. Therefore, people did not want neighbors to associate their families with having TB. For example, when one woman revealed her sickness to her husband, he asked defensively, "Where did you get it? It's not from our family."

Women eagerly asserted that their community's response to TB needs to change to encourage others to seek care. One FGD participant pointed out to her peers that when "someone understands your [TB] condition, she shouldn't stay away from you [and] instead encourage you that there's a cure and to get treatment; and one more thing, all of us will get sick, it's just going to be different kinds." Women with TB also proclaimed that they wanted "to become a proof to people that one shouldn't be ashamed of this sickness because it can be cured."

Health system level influences on care seeking. Women reported that they can seek care for their TB symptoms from a range of health care services: government health centers, private and government hospitals, and private providers. Various hospitals and private providers are located outside of the area, while three LGUs and at least four NGOs, which are recognized by the NTP, are within Payatas. They stated that their choice was mainly influenced by the location and cost of the services as well as their perception of the quality of care.

Women described how the location of the clinic and her financial situation were linked factors in choosing health services. They told us that clinics within walking distance or that require less fare for transportation were more convenient. Even health personnel recognized the importance of location. One woman explained that the LGU doctor transferred them to an NGO clinic because "he said that we should go to wherever is near to our place." Residents who live farther from clinics, in areas that are typically more economically depressed, also suggested that "someone [health care professional] should go down here to give [them] a checkup."

As illustrated by a few women, information about the health system's location and cost influenced their decisions. One woman declared: "If the BHW had not told me where the center here is and told me it was free, I wouldn't have gone."

As exemplified by the previous woman's experience, the cost or perceived cost of health care services was a major factor in care seeking. Both LGUs and NGOs provide free TB medication; however, some women thought there were "no free check-ups here" and waited until they had more money to seek care. As a result, some women first sought services from a private doctor and then stopped treatment within a few months because of the financial burden of purchasing TB medications. One woman shared her experience regretfully:

At first, it [the treatment] was in the private one where I had my checkup. I would have to buy my medicines every day. I'm just a house helper, so my salary is not that big, so I stopped taking the medicines. But I had a checkup again immediately in the [government health] center, so I continued taking the medicines. . . . Perhaps, I wish that I would have gone to the center first so that I wouldn't have spent a lot on medicines at the private one.

The community's perception and experience of available health services also influenced their care seeking behavior. According to informants, seeking care at private clinics guarantees prompt and quality service, while LGUs and NGOs do not. One focus group participant irritably described the wait at a LGU like this:

You would wake up at four in the morning to get in line [at the government LGU]. And then, some staff would not be understanding and get mad at you if you do not answer the questions properly. That's one of the reasons why some [people] do not come back.

As a result, women said they either endured their symptoms until they could pay for private consultation or until their symptoms were unbearable. Therefore, almost all FGD and IDI informants emphasized that improving the efficiency and timeliness of health services was a definite way to improve TB care seeking in their community.

Once individuals sought care and began the diagnostic process, they reported that they still encountered health system delays. The time between the initial checkup and being enrolled in DOTS ranged from a few weeks to 4 months. Those who had negative direct sputum smear microscopy (DSSM) but abnormal chest x-ray (CXR) results experienced the longest health system delays. These findings have to be processed by the TB Diagnostic Committee (TBDC), a panel of specialists who meet twice a month to determine if a sputum negative patient should be treated for TB.

Health services personnel were considered either facilitators or barriers to seeking care. Echoing the description of the FGD participant, one woman, a scavenger, said that "sometimes I am hesitant to have a checkup there because I'm not really good in writing. So I go before the BHW and ask, 'Ate (Sister) Heather (pseudonym), can you please write this for me?' Then she gets snobbish, then angry." Even so, it was this particular BHW that noticed the patient's symptoms and followed up on the patient when she did not return for her DSSM results. Women in FGDs also echoed that they found clinic personnel, especially at LGUs, to be "snobbish" because they "shame you for not knowing something." When asked for suggestions for improvement, many women eagerly exclaimed that clinic staff ought

to improve their interactions so that community residents would be more willing to access care there.

On the other hand, seven out of 13 patients asserted that a local CHV or BHW encouraged them to seek care at the nearest clinic. CHVs and BHWs were seen by their neighbors as those who did things for the people and not for themselves, because they “didn’t say, ‘Uy, have a checkup for me to have money!’” Also, women who had less social support said their CHVs and BHWs became someone to “lean on.” Some FGD participants expressed that when CHVs refer individuals to care, however, they may come across as nosy and patients may respond in anger “because they do not want to know if they are sick with TB.”

DISCUSSION

Although other studies have investigated health seeking amongst the urban poor in the Philippines, ours is the first to explore it from the woman’s perspective. Through this qualitative study, we illuminated the ways that the TB care seeking pathway is a process, requiring a symptomatic person to first recognize the illness, consult health providers, follow through on diagnostics tests, and finally enroll in treatment. In that process, however, we also observed how urban poor Filipino women are also influenced by myriad factors that can encourage or impede care seeking. Drawing from a socioecological perspective, we were able not only to identify these factors but also discover the ways nested levels influenced one another.

Our study revealed barriers and facilitators in care seeking delay that are similar to others that have investigated TB care seeking in the Philippines. On a health system level, women’s perception that LGUs did not treat patients with respect and had slow services, which made private doctors more preferable, also was found in other studies from the Philippines (Auer et al., 2000; Tupasi et al., 2002b). Women’s suggestions to improve the quality of services at free LGUs and NGO, especially patient–provider interactions, aligned with conclusions from Auer and colleagues’ (2000) study in another Metro-Manila community. Also, women in our study described the ways neighbors reacted to those who have been diagnosed with TB, which caused shame, and, in turn dissuaded them from seeking care. This illustrates what Goffman (as cited in Nettleton, 2006, p. 95) described as stigmatization, or “the process by which the reaction of others spoils normal identity.” This phenomenon toward TB is well-known, not only in the Philippines but also in other countries (Auer et al., 2000; Nguyen, Johannson, Diwan, & Winkvist, 2001). On a household level, financial security and encouragement from family members also were found to be important in Auer and colleagues’ (2000) study. Similar to Chard’s study on Ugandan women, we discovered that TB care seeking is a “social process” in which neighbors, family

members, and health professionals play an important role (Chard, 2009). Last, at the individual level, women's understandings of the symptoms, progression, and treatment of TB influenced their care seeking, which supports prior research indicating that women with lower economic status and education are less knowledgeable about TB and may think that it cannot be cured (NSO [Philippines] and ICF Macro., 2009).

Our study's contribution is its exploration of women's care seeking, showing how factors at multiple levels can influence one another and also simultaneously be both facilitators and barriers. For example, recognition and knowledge of TB and the health system alone was not sufficient in prompting a woman to seek care; instead, her household economics and responsibilities also were contributing factors. And although health system level factors tended to delay care seeking, CHVs and BHWs leveraged a relational aspect that promoted care seeking and supplemented familial support. In this way, each level did not exist on its own, but within a greater context. Factors such as poor household economics, a woman's responsibility to her family, and fear of TB's effects functioned as both impediments and catalysts to care seeking. Thus, women's decision making was not straightforward, but rather it was a process of weighing immediate and future costs, especially to her family.

The importance of support from husbands, family members, and CHV/BHWs also was highlighted in our study. Specifically, the role of a *kasama*, or companion, to health care services showed that CHVs and BHWs can play a crucial role in ensuring follow through of referrals by acting as *kasamas*. Therefore, TB programs working in similar contexts should consider utilizing community health volunteers or other approaches that foster relationships between health personnel and community members. Other studies also showed that Filipino women thought that TB can be transmitted through sharing utensils and plates or talking (NSO [Philippines] and ICF Macro., 2009). We also observed, however, how this may contribute to social stigma because women feel that carrying the label of TB would no longer enable them to partake in community life. Therefore, education or health communication programs could address this understanding and, potentially, also the stigma of TB. Furthermore, patients desired to change social norms toward TB by being an example of successful treatment, suggesting that the use of testimonials may be effective in increasing knowledge but also alleviating fear and shame toward TB. Most importantly, our study shows that TB control programs must take into account this complex web of multilevel factors and involve various sectors, such as health communication and education, health services, social work, and economic development.

The main strength of the study is the use of rich narratives gathered from the women's stories about their experiences in seeking treatment for TB, thus highlighting the importance of each unique context. Furthermore, their experiences were triangulated with the perceptions of other women through

FGDs, assuring high validity of the results. We also elicited suggestions from women themselves on how to improve access to health care and timeliness in seeking care.

Our study also has several limitations. Due to the highly contextual and qualitative nature of the methodology, the results may not be generalizable to other communities, especially beyond the Filipino urban poor context. These findings are valuable, however, in that they can inform specific interventions that can reduce care seeking barriers and improve TB control amongst a growing urban poor population in the Philippines. Furthermore, since we did not compare care seeking experiences across gender, we cannot necessarily show that these factors are unique to women living in Payatas only. Nonetheless, several barriers specifically related to women's roles and familial relationships emerged from our study, suggesting that they warrant further exploration. Therefore, complimentary research is needed to explore the difference between men and women's care seeking for TB.

CONCLUSION

Delayed detection and enrollment in treatment is a critical issue for impoverished urban Filipino women with TB. Health care seeking must be addressed to successfully improve TB control and management amongst the urban poor in the Philippines. In Payatas, women with TB symptoms not only delayed their care seeking process, for various reasons, but also experienced health system delay, thus, increasing transmission and morbidity. Our study's socioecological approach elicited the influence of multilevel factors that work together to encourage and discourage women to seek treatment. Furthermore, we showed that patients and community resident' experiences and insights can be an asset to developing interventions to encourage care seeking.

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