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THE HEALTH STATUS AND HEALTH-SEEKING BEHAVIOUR OF RURAL WOMEN IN COSTAL KARNATAKA

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Abstract

The health of women is a significant concern due to the discrimination they face due to socio-cultural factors in many societies. Women must overcome many social barriers to become empowered and receive quality health care services. Health-oriented behaviour is a major determinant of women's health. The aim is to portray the socio-economic conditions of rural women in the study area and determine how rural women in coastal Karnataka seek healthcare. Six villages were surveyed with a sample size of 300 in a cross-sectional study. Women at least 21 years of age were included in the survey. The data collected was predesigned and pretested using a semi-structured questionnaire. A Chi-square test was used to determine the association between variables after presenting the data in proportions with confidence intervals. The percentage of subjects who consult a doctor right away for symptoms is only 24.6%, and 79.3% of participants are aware of nearby functioning health centers. In case of disease, most subjects (43.5%) go to a qualified doctor. The present study found that there is still a need to create awareness about the importance of healthcare and available health centers as significant proportion of women population approached unqualified medical practitioners and seeking home remedies as first consultancy source for their health remedies.

Keywords: Behaviour, healthcare, medical practitioner, women

Introduction

Over the past decade, India's health policies have evolved from a reactive to a more proactive approach. The 2002 National Health Policy (NHP) focused on issues related to accessibility and availability. It tried to address the polarization of health care infrastructure, medical personnel and other health resources in urban areas, which had led to augmented regional disparities in access to health care. The widening economic, regional, and gender disparities require specific policies to be targeted at urban and rural audiences separately. The creation of the National Urban Health Mission (NUHM) and the National Rural Health Mission (NRHM) was a result of this. These policies proposed implementation strategies to address the differential needs of the various socio-economic groups residing respectively in the urban and rural areas of India.

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It is not surprising to find that individuals with greatest need for health care have the greatest difficulty in gaining access to health services and are least likely to have their health needs met. India faces several obstacles in providing "health for all" (Goal 3 of the Sustainable Development Goals decreed by the United Nations), most notable of which are inadequate physical access to high-quality health services and dearth of qualified personnel at existing facilities. Health care underinvestment is the cause of these problems. Only 4% of India's GDP was invested in total health expenditure between 2011 and 2015, of which only 1.3% was invested in the public health sector. Investments in developed countries such as the United States and Japan are substantially higher than these figures.

The NHP 1983 was aimed towards developing "*universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford*". Decentralisation and de-professionalisation of health services were the main objectives, but community participation fell short of expectations. Duggal R and Nundy M have outlined the following observations in order to highlight the gap in fulfilment of people's needs: (i) Setting up of rural health care facilities to facilitate curative care was slow, thereby leading to overcrowding at urban facilities. (ii) There were severe issues with respect to quality and breadth of services available at both outpatient and inpatient facilities in public health care centers, which compelled patients to seek private facilities. Health care providers reported that there was a lack of proper medical training.

To address the gaps and impacts of the 1983 NHP, the Indian government's Department of Health and Family Welfare (MoHFW) drafted the 2002 NHP. The importance of boosting the utilization of public health care facilities was stressed by this policy. To stimulate service delivery, the government has also fostered private investment in health care. The private health care delivery system has had unintended consequences such as rising costs, growing inequality and the exploitation of consumers. To enhance the health care sector and the country's economic and social development, the Government of India has initiated the NRHM and NUHM.

Researchers have also pointed out the decline in outpatient ratio at public health care centers over the past few decades, and further criticized that limited resources at these facilities are compelling patients to look for alternatives mostly in the form of private outlets and thereby incur catastrophic out-of-pocket (OOP) expenditures. Economic hardship can often be caused by excessive OOP expenditures, and it has been found that the poor are most affected in this regard. Berman P, Ahuja R and Bhandari L reported that the effect of OOP expenditure has significantly more impoverishing effect due to higher outpatient care needs in both urban and rural settings. In this context, it is also necessary to mention that price of the health care service, income of health care seekers and distance to the health care facility have been reported to be significant parameters in determining the choice of facility; however, the demand was reported to be price and income inelastic in rural India.

Health seeking behaviour is a term used to describe any action that has a significant impact on health. Ahmed, Adams, Chowdu, and Bhuiya (2003) defines health-seeking behaviour as any action an individual takes to improve their health condition. Poor nutritional status, low haemoglobin (anemia), unsanitary and primitive practices for parturition are the main causes of a high rate of maternal mortality. The recommended level is lower than the average calorie and protein consumption for pregnant and lactating women. There are certain diseases that can be prevented, such as tuberculosis, malaria, gastroenteritis, filariasis, measles, tetanus, pertussis, cutaneous diseases (scabies), and more. Women are among the weaker sections with high rates. There is a need to scientifically study the traditional medicine and healing system and combine them with the modern allopathic system so as to make it available and affordable for the poor rural population.

The primary issue in society is the lack of proper awareness and understanding among rural people. The government has taken advantage of many regimes, but the overall benefits have not been achieved properly. Most bankers hesitate to give loans to them because they don't have proper income and status in the society the aims of the study are to identify to what extent the concept of rural people in Udapi disrict. The study emphasizes the significance of both financial and non-financial assistance in the well-being and empowerment of rural people in rural areas in the study area.

Methodology

The nature of this study lies in its descriptive nature. For this micro level study, the unique feature of four tier area sampling design has been executed to get a random sample of 300 from the Udapi district of costal Karnataka. In the Udapi district, there are three blocks. Karkala and Udapi blocks were selected from the three blocks due to the high concentration of weaker section population. The sampling process involves selecting respondents from the 03 selected villages. By selecting 6 percent of the total population of the 3 villages, a total sample of 300 respondents was obtained for the present study. The researcher selected two primary sources of data collection for this study. There are primary data as well as secondary data. To identify a sample of 300 respondents in the Udapi District Karkala and Udapi blocks with secondary data, the 2011 census report was used. The primary data was collected through an interview method using an interview schedule. The data is analyzed using simple percentage analysis, chi-square test, and multiple regression models.

Result and discussion

The community's active participation in promoting their economic and educational position is determined by their age. Out of the 300 respondents, the majority of the respondents 31.4 percent were between 21-35 age group, 29.5 percent respondents were between 36-45 age-group, 21.2 percent respondents were among the 18-27 age-group and 15.9 percent respondents were Above-47 age-group. The study participants' average age was 41.7 years (SD±12.3). Majority of participants were of age group 21–35 years (30.5%), Hindu (67.9%), literates (57.3%), unemployed (61.7%), middle class (42.7%), and married women (61%).The study showed that 47% out of 300 participants required permission from any of the family members to access healthcare services. The percentage of subjects who consult a physician as soon as symptoms develop is only 29.1%, and 54.4% of participants are aware of nearby functioning health centers. Majority (53.7%) of the subjects visits qualified medical practitioner during illness followed by visiting RMP (21.6%) and following home remedies (19.1%).The present study found statistically significant association between marital Status (P = 0.04) and education status (P = 0.01) with health care seeking behaviour. The study participants' average age was 41.7 years (SD±12.3). Majority of participants were of age group 21–35 years (30.5%), Hindu (67.9%), literates (57.3%), unemployed (61.7%), middle class (42.7%), and married women (61%).The study showed that 47% out of 300 participants required permission from any of the family members to access healthcare services. Only 29.1% of subjects seek medical attention when symptoms appear and 54.4% of participants are aware of nearby functional health centres. Majority (53.7%) of the subjects visits qualified medical practitioner during illness followed by visiting RMP (21.6%) and following home remedies (19.1%).The present study found statistically significant association between marital Status (P = 0.04) and education status (P = 0.01) with health care seeking behaviour.

In the study area, morbidity rates were high amongst respondents. 32.1 percent of the respondents did not have any diseases, as revealed by the study. The percentage of respondents who have only one disease is 17.9 percent, followed by 37.1 percent who have two diseases, and 26.9 percent who have more than two diseases.

The study revealed that the respondents in the study had a mixture of acute and chronic diseases. The main health problems among acute diseases were cough, fever, headache, shoulder pain, and hand and leg pain. The percentage of women who had a fever problem was 37 percent. There were 31 percent of women respondents who had headache problems. The total percentage of females with shoulder pain problems was 23%. 28.7% of women said they experienced pain in their hands and legs. A problem with knee swelling was reported by 23% of women. Overall, there was a 11% increase in the number of women who had diarrhea. The percentage of women with eye disease was 7.1 percent. Minor accidents and injuries were reported by 11 percent of women respondents. Blood pressure, asthma, allergies, skin disease, and back pain were the primary health problems in the study area when it comes to chronic diseases. The percentage of women who had blood pressure problems was 21.1%. The total number of participants who had asthma was 16.7%. The total number of women with allergies and skin conditions was 19.3 per cent. 18.7 percent of women reported experiencing back pain problems. 16.4% of women reported having thyroid disease in total percent. The total number of women with diabetes was 13.7%. The percentage of women with kidney or urine disease was 8%. There was a 3.7 per cent increase in the percentage of women with leprosy overall. Among the women interviewed, 4.3 per cent experienced numbness. In the on-test of acute diseases, fever, headache, cough, shoulder pain, and hand and leg pain took the top five spots, as discovered by the study. The respondents of the study area believe that even with such diseases, they are unable to obtain medicine or treatment for them. When, as with chronic blood pressure conditions, asthma and back pain are the most common health issues among respondents. The district administration is expected to address these issues.

The study found that the disease quantum was distributed among the respondents in the study area. 39.1% of the respondents in the study area do not have any diseases, while 33.7 percent have acute diseases and 27.3 percent have chronic diseases. The survey reveals that the majority of people with chronic diseases come from poor socioeconomic backgrounds, which is an important factor. The field data from this micro study reveals that morbidity pattern of diseases is very high in women respondents It is revealed from the above discussion that 47.3 percent of the respondents are affected by either acute or by chronic diseases.

It is really touching that the respondents are saying with tears that they have a lot of problems in their family but they cannot reveal all these to everybody because nobody will help them in the form of cash or kind. They expressed a sense of sadness and anger that the government is always supporting the wealthy and not giving us any money for our benefit. Due to their illness, the respondents are faced with a variety of issues. The study examined the challenges that the respondents faced because of their ill health. The majority of the respondents 59.3 percent says that they have a financial problem in the family due to diseases, 32.3 percent of the respondents have their family problems due to the diseases and 17.4 percent point out that their children's study is affected badly by the diseases. The financial burden of providing education to their children, undisclosed family problems, and financial debt are the primary causes of mental stress experienced by the respondents. Here, it should be noted that whatever the problem, the woman has to take responsibility for resolving them.

After months or years of exposure, it is possible for the symptoms of many work-related or occupational diseases and disorders to develop. The severity of disease caused by the scheduled tribes is assessed using a 5-point scale, which includes most adverse, adverse, moderately, less affected, and not at all affected. In the study found that 59.1 percent of the respondents were most adversely affected by the illness, 26.1 percent of them were adversely affected, 2.4 percent was moderate, 13.7 less affected and 6.2 percent were affected.

Almost 74% of respondents were most negatively and negatively affected, regardless of their work, according to a careful review of the study.

The distance between the health centre and the respondent's residence within the study area was measured in the study. It reveals that majority of the respondents 53.3 percent were living above 10 Km of distance from the primary health centre, followed by 31.7 percent of them were living 6-10 Km from the primary health centre and only 15 percent were living below-5 Km of distance from the primary health care centre. Through there is a norms regarding the establishment of either Primary Health Centre or government hospital, as per the present population of the study area and the quantum of disease, more number of Primary Health Centre, availability of all sorts of medicine and other immediate facility like Ambulance are much needed. Nearly 85 percent of the respondents are required to travel to a Primary Health Centre or a Government Hospital for treatment. So, now what is wanted is according to population and their health needs Primary Health Centre and mini Government Hospital have to be established since the respondents are residing in the hilly areas and they seek assistance from the administration.

Nearly 37% of the respondents received treatment from both the primary health centre and the nearby government hospital, as per the study. Regrettably, 29% of individuals are opting for self-treatment. That's. It is not necessary to see a qualified doctor to buy pills in a medical clinic. Due to their ability to pay certain costs, only 57.4 per cent are receiving treatment from private hospitals. Treatment sources intelligently rank respondents in this study. It is revealed from the study that majority of the respondents 29.1 percent of the respondents get the treatment from the medical shop followed by 23.2 percent of the respondents get the treatment from Primary Health Centre's, 19.1 percent of the respondents get the treatment from Government Hospital, 13.7 percent of the respondents get the treatment from a Private doctor, 7.2 percent of the respondents get the treatment from Private Hospital, 7.1 percent of the respondents get the treatment from traditional heeler.

The study showed that respondents in the study area were looking for treatment based on their illness. There were 208 participants with health issues. Out of 193 respondents, 132 are experiencing acute diseases, while 61 are experiencing chronic diseases. Out of the 117 respondents, 23.7 percent respondents get their treatment from Primary Health Centre's, 19.1 percent get the treatment from Government hospitals, 14.7 percent get the treatment from private doctor or private hospital, 37 percent get their treatment from medical shop, 11 percent get the treatment from traditional heeler and 7.1 percent get their treatment from religious persons. While as in the case of chronic diseases, the total number of respondents was 69 of which, 71.4 percent get their treatment from Government hospitals and 24.1 percent get their treatment from a private doctor or private hospitals. Due to the fact that the Primary Health Centre and the government hospitals are only accessible to the respondents, there are no other facilities available to provide treatment at the lowest cost. While this is an acute illness, 39 respondents were accustomed to obtaining medication at the medical workshop because of poverty and ignorance about health, which is encouraging to note.

The study showed that women from the scheduled tribe in the study area had diverse health care practices and treatment sources. It was found that most of the women surveyed were receiving pregnancy care from primary health centres. The government hospital is where 53.4 percent of women respondents have their deliveries, as observed. The primary health center is where the majority of women, 68.9 percent, care for newborns, as noted by the survey. For the treatment of common diseases, private hospitals were visited by 16.8% of the women respondents. It is clear from the above that the respondents must rely on either the Primary Health Centre or government hospitals for all three practices. Their assertion is that they are not receiving the expected

treatment and are unable to afford private hospitals' treatments due to the exorbitant cost. The role of government and their interference make emergency care and life-saving medicines necessary.

Conclusion

Literacy and level of education are two basic indicators of the level of development achieved by a society as literacy results in more awareness besides contributing to the overall improvement of health, hygiene and other social conditions. The primary health centre is not located in the study region and people spend more money on private health sources, so the Government should provide new hospital and medical facilities in the study area. The Government of India should continuously take steps to strengthen preventive health care services, in addition to providing easy treatment for delivery and emergency services. The government should expand support for local herbal practitioners and provide health training for local quacks within the study area. This research clearly points to the need for public-private partnership projects in the healthcare sector. The dual obstacles of service availability (compared to public projects) and affordability (compared to private projects) should be overcome by these ventures. In the near future, integration of providers in terms of referral system sensitive to the socio-economic heterogeneity of the nation will be of paramount importance to ensure acceptance of the facilities, considering the pluralities of the health care system practiced in India.

References

Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. *Lancet*. 2011;377:505–15. doi: 10.1016/S0140-6736(10)61894-6.

Baru R, Acharya A, Acharya S, Kumar AKS, Nagaraj K. Inequities in access to health services in India: caste, class and region. *Econ Polit Wkly*. 2010;45:49–58.

Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Soc Sci Med. 2000;50:1385–401.

Ganatra B, Hirve S. Male bias in healthcare utilization for under-fives in a rural community in western India. Bulletin of the World Health Organization. 1994;72:101–4. PMCID: 2486511

Kurian NJ. Widening regional disparities in India: some indicators. *Econ Polit Wkly*. 2000;35:538–50.

Mberu BU, Haregu TN, Kyobutungi C, Ezeh AC. Health and health-related indicators in slum, rural, and urban communities: a comparative analysis. Glob Health Action. 2016;9:33163.

MoHFW . *National health policy 2015 draft*. New Delhi: Ministry of Health and Family Welfare, Government of India; 2014.

Pandey A, Sengupta PG, Mondal SK, Gupta DN, Manna B, Ghosh S, Sur D, Bhattacharya SK. Gender differences in health treatment-seeking during common illnesses in a rural community of West Bengal, India. J Health Popul Nutr. 2002;20:306–11. PMID:12659410

Patil AV, Somasundaram KV, Goyal RC. Current health scenario in rural India. *Aust J Rural Health.* 2002;10:129–35. doi: 10.1111/j.1440-1584.2002.tb00022.x.

Sundar R, Sharma A. Morbidity and utilisation of healthcare services: a survey of urban poor in Delhi and Chennai. Econ Polit Wkly. 2002;37:4729–40.

Vlassoff C. Gender inequalities in health in the third world: uncharted ground. Soc Sci Med. 1994;39:1249–59. PMID:7801162

World Development Indicators: Health expenditure (% of GDP).