CHAPTER V
SUMMARY AND CONCLUSION

Health care seeking behaviour refers to decision or action taken by an individual to maintain good health to prevent illness. The decisions depend on the available healthcare options like visiting a public or private and modern or traditional health facility, self-medication and use of home remedies or to utilize available health services etc.

In this chapter, summary and findings of the study are presented with verification of hypotheses, formulated for this study. The purpose of this research was to study the health care seeking behaviour of women belonging to rural area of Belgaum taluka of Belgaum district. The aim of the study is providing information and awareness that shall contribute to improve the status of health care provisions prevailing in rural areas of Belgaum District. It shall contribute in removal of obstacles in healthcare, understand the behaviour of rural women with regard to seeking health care, estimation of ignorance and approach to health care services, utilisation of services and benefits provided under various health schemes and programmes.

This study examines the behaviour of rural women regarding health. The data and findings of the study helps to understand how people engage with health care systems in the background of their socio-cultural economic and demographic circumstances, consequently focus on health care services, utilization from a behavioural perspective that may influence the choice of health care service in Belgaum taluka. The sample consists of 400 respondents of the age group of 21-60 rural married women. The empirical data was collected through demographic profile, characteristics, awareness, experience and perceptions towards health care. Data obtained was collected and analysed statistically by percentage, correlations and diagrams.

The results reveal that majority of the (39.25%) of women were of the age group of 21-30, (28.25%) were having primary level of education, (45.5%) women belongs to general caste, lives in joint family(59.5%) with annual income between 18,000 to 25,000/-Rs. Followed by minimum of (14.3%) of women between the age group of 31-40, (17.8%)having college level of education, (9.8%) belongs to scheduled caste, (40.5%) lives in nuclear family with annual income more than 26,000/-Rs.

Regarding the consumption of milk and fruits maximum of 45.5% (182) are consuming additional nutritious food once in a month followed by minimum of 16.0%, 27.8% and 10.8% of women consuming the nutritious food daily, weekly and rarely, in which the women belongs to the age of 21-60 maximum of 61.4% of women of the age group 51-60 and minimum of 38.2% of women of the age group of 21-30 are consuming nutritious food once in a month and followed maximum of 19.3% of the age group of 31-40 followed by minimum of 10.2% of the age group of 51-60 are consuming milk and fruits daily. Remained others are consuming nutritious food daily, weekly and rarely. The findings shows that consumption of milk and fruits is found more in the age group 51-60 compared to 21-30 age group, rather than consuming daily or weekly. Results conclude that consumption of milk and fruits are given less importance.

Education: out of 400 rural women in which maximum of 60.6% of women having secondary level of education and minimum of 27.0% of women consuming nutritious foods once in a month compared to daily consumption of 38.2% of the respondent having higher secondary level of education and minimum of 7.1% of primary level of education are consuming nutritious food daily.

Caste: out of 400 in which maximum of 68.3% of women who are belong to other backward caste and of minimum of 30.2% women belong to the general caste are women consuming nutritious foods once in a month compared to

maximum of 24.7% of general caste and minimum of 2.5% of scheduled caste women are consuming nutritious food daily.

Annual income: out of 400 in which maximum of 56.4% of women with annual income between 18,001/- to 25,000/-Rs. and minimum of 31.4% women with annual income more than 25,000/-Rs. consuming nutritious foods once a month compared to maximum of 23.8% with annual income more than 25,000/-Rs. and minimum of 11.7% with annual income between 18,001 to 25,000/-Rs are consuming nutritious food daily.

The result reveals that there is association between education, caste, and annual income and consumption of nutritious food.

Considering the habits of the respondent's maximum of 31.50% (126) women do not have any habit followed by minimum of 0.25% (1) of women have the habit of chewing Gutka and Betel leaf study reveals that due to the education and knowledge about the bad habit which affected their health, health consciousness about habits women belonging to the 21-30 age group 56.05% (88) are least addicted to the habit of chewing tobacco, Gutka and other such products.

Dealing with the medical treatment (acute disease) overall rural women between 21-60 maximum of 75.5% of women faced medical treatment (acute disease) followed by minimum of 24.5% (98) of women were away from treatment for acute disease from last 5 to 10 years, maximum of 91.2% (52) of women of the age group 31-40 and minimum of 48.9%(43) of women of the age group of 51-60 were free from medical treatment between the period of last 5 to 10 years.

Education: out of 400 rural women between maximum of 84.8% of secondary level of education and minimum of 60.6% of illiterate women were away from treatment for acute disease from 5 to 10 years compared to maximum of 39.4% illiterate and minimum of 7.9% of women having higher secondary level of education have undergone treatment for last 5-10 years.

Caste: out of 400 rural women between maximum of 84.6% of scheduled caste and minimum of 74.2% of general caste women were away from treatment for acute disease from last 5 to 10 years compared to maximum of 25.8 % genera caste and minimum of 15.4% of scheduled caste women have undergone treatment for last 5-10 years.

Annual income: out of 400 rural women between maximum of 81.9% of women having income more than 25,000/-Rs and minimum of 69.7% having annual income less than Rs.18,000/- were away from treatment for acute disease from last 5 to 10 years compared to maximum of 30.3 % with income less than Rs.18,000/- and minimum of 18.1% having income more than 25,000/-Rs have undergone treatment for acute disease for last 5-10 years.

The study reveals that due to the negligence towards their health and not undergoing treatment in proper time most of the women are facing medical or surgical treatment for last 5 to 10 years, it has been also found that after surgical treatment most of the women are away from proper follow ups, women are not taking rest suggested after such treatment by which these women are facing more related health issues for the same problem.

Regarding to the morbidity condition of rural women maximum (28.1%) of women of the age group of 21-30 and minimum (2.0%) of women of the age group of 31-40 facing are facing cold and fever. Musculoskeletal problem is high in 51-60 years, gastrointestinal problem is high in 41-50 age groups, Respiratory problems are high in 21-30 years, Diabetes high in 41-50 years, Hypertension is high in 41-50 years, Injuries/accidental and other problems are high in 21-30 years and other problems. The results reveal that most of the women are ignored about the first sign and symptoms of particular health issues and are neglecting unless it became severe.

In present study maximum of 50.0% women discuss their health problem with family members followed by minimum of 2.8% of women

discuss their health problems with friends. In the age group of 21-60 maximum of 55.1% of women in the group of 41-50 and minimum of 43.9% of women of the age group of 21-30 discuss their health problems with family members compared to maximum of 5.7% of the age group of 51-60 and minimum of 0.6% of the age group of 21-30 years discuss their health problems with friends.

Education: out of 400 married rural women maximum of 61.8% of women having higher secondary level of education and minimum of 44.7% illiterate women discuss their health problems with family members compared to maximum of 5.3% of illiterate women and minimum of 1.8% with the primary level of education discuss their health problem with friends.

Caste: out of 400 married rural women maximum of 61.5% of scheduled caste women and minimum of 27.5% of scheduled tribe do not discuss their health problems. Compared to maximum of 7.5% of scheduled tribe and minimum of 1.6% general caste women discuss their health problem with friends.

Annual income: out of 400 married rural women maximum of 61.9 % of women having income more than 25,000/- and minimum of 40.9% having annual income less than 18,000/-discuss their health problems with family members compared to maximum of 4.5% of women having annual income less than 18,000/- and minimum of 3.1% with the annual income 18,001-25,000/- discuss their health problem with friends.

The results reveal that there is association between the discussion of health problem with respect to age, education, caste and income.

In this study results reveals that health problems at the younger age are not discussed. This is common psychological reasons, where Indian women believe that health issues do not arise at the younger age. Most of the time the elder

women in the families overlook at the health issues of the younger women and keep comparing that how they are more fit then their youngster. This is also one of the reasons why some women do not like to discuss their health issues with their in-laws or grandparents.

Regarding the preference of treatment maximum 80.9% married women of the age group of 21-30 preferred to undergo treatment in private hospital and minimum of 70.5% of women in the age group of 51-60 prefer take treatment in private hospital compared to maximum of 28.1 of the age group of 31-40years and minimum of 13.4% of the age group of 21-30 preferred home remedies.

Education: out of 400 rural married women maximum of 90.1% of college level of education and minimum of 65.5% of women preferred to private compared to maximum to 23.9% of primary level and 2.2% of higher secondary level of education are preferred home remedies.

Caste: out of 400 rural married women maximum of 97.4% of scheduled caste and minimum of 69.2% of general caste preferred private hospital compared to maximum to 31.7% of other backward caste and minimum of 4,9% of general caste are preferred home remedies.

Annual income: out of 400 rural married women maximum of 90.5% of college level of education and minimum of 65.5% of women preferred to private compared to maximum to 23.9% of primary level and 2.2% of higher secondary level of education are preferred home remedies.

Most of the times these women are made to believe that home remedies are more reliable. The finding shows that most of the respondents prefer going to private hospital because they have their own reasons such as well-equipped staff, well maintained hygiene, proper diagnosis of the diseases, emergency services, proper caring, prompt action, proper follow up and patients records are maintained, maximum facilities are made available under one roof and most

important thing is satisfactory and hassle free investigation check-ups are carried out. Due to lack of co-operation or attention by the family members and fear about the treatment and follow-ups, even financial problem leads rural women to opt for home remedies. Few women moving towards government hospital due to low cost treatment and financial problems they also try to avail free services under government schemes. In some families senior or aged women are often neglected about their health so they too move to government hospital for free health services. Other social issues like education, caste, family income, treatment offered by the government hospital plays a vital role in above cases where women decide to move to private or government hospital or opt for home remedies.

Reasons to opt for health care provider's maximum of 41.5% of women preferred private hospital followed by minimum of 7.2% of women prefer government hospital in emergency. And others prefer differently. The study results indicate that preference also depends on the situation due to easy access, low cost and free services, and without specific reason. In this study it has been found that though government has implemented so many health programs and facilities some women are not interested to opt for government hospital is due to the treatment offered by the medical staff, most of them complain that they are treated better if they have influence or better financial background.

Considering the attention of the family members In this study out of 400 married women respondents maximum 98% of women of the age group are 41-50 and minimum of 68.4% of women of the age group of 31-40 are getting the attention from their family members compared to maximum of 31.6% of the age group of 31-40 and minimum of 2% in the age group of 41-50 are not getting attention from their family members in care of their illness.

Education: out of 400 married women respondents maximum 93,3% percent of women having higher secondary level of education and

minimum of 68.4 percent of women having college level of education are getting the attention from their family members compared to maximum of 35.2% of college level of education and minimum of 6.7% of higher secondary level of education are not getting attention from their family members in care of their illness.

Caste: out of 400 married women respondents maximum 95% percent scheduled caste women and minimum of 66.7 percent scheduled tribe women are getting the attention from their family members compared to maximum of 33.3% of scheduled caste women and minimum of 5% of scheduled tribe are not getting attention from their family members in care of their illness.

Annual income: out of 400 married women respondents maximum 91.7% percent of women with annual income less than 18,000/-Rs and minimum of 71.8% percent of women with the annual income between 18,001-25,000/-Rs are getting the attention from their family members compared to maximum of 28.2% with the annual income between 18,001-25,000/-Rs and minimum of 8.3% with annual income less than 18,000/-Rs are not getting attention from their family members in care of their illness.

Considering bout regular health check-ups the study results indicate that out of 400 rural women respondents in which maximum of 86.0% of women are not doing regular chechups followed by minimum of 14.0% of women are doing regular checkups.

Education: out of 400 majority of 93% women with college level of education and minimum of 81.4% women with primary level of education are neglecting regular check-ups compared to 14.6% and minimum of 7% of women with college level of education are doing regular check-ups.

Religion: out of 400 majority of 95.2% christian women and minimum of 83.9% Hindu women neglecting regular check-ups compared to 16.1% Hindu and minimum of 4.8% christian women are opt for regular check-ups. **Annual income**: out of 400 rural married women 90.2% having annual income less than 18,000/-Rs and minimum of 75.2% women having annual income more than Rs.18,001/-, are neglecting regular checkups. A noticeable (24.8%) of women with annual income more than Rs.25,000/- are opt for regular health check-ups.

The results show that maximum of 46.8% of women are go to hospital accompanied with their family members followed by minimum of 24.5%, 19.3 and 9.5 are accompanied with husband, children and by themselves. Among all the women belong to the age group of 21-60 in which maximum of 58.2% of women in the group of 41-50 and minimum of 38.9% of women of the age group of 21-30 are accompanied by other family members and women of the different age group are accompanied with husband, children and own. Study results show that there is a relationship between the family support and co-operation associated with health care seeking behavior of rural women.

Regarding the permanent contraceptives maximum of 67.5% of women of the age group of 21-30 and minimum of 37.7% of women of the age group of 31-40 used tubectomy over other measures as permanent contraceptive for birth control. According to Indian psychology women's are forced to undergo family planning measures than men because there are rumours that women are spending their time in home and men have to work hard outside. Men avoid vasectomy assuming it affects their health in general. In this study results reveal that majority of women go far family planning, laparoscopy was followed (17.4%) to get benefit from the government scheme, some couple due to the education and

personal understanding using condoms and only limited women said they followed calendar method as safe period calculator.

Considering physical ailments maximum of 62.5% of women are observed problem of arthritis, followed by minimum of 19.8%, 7.3%,5.8%,0.3% and 6.8% of women are facing Blood pressure,cancer, Diabetes, hearing problem and others. Among all the women in the age group of 51-60-maximum of 90.9% and minimum of 42.7% in the age group of 21-30 are facing arthritis problem whereas others are facing some other problem. Results shows that arthrities is common in the age agoup of 51-60.

Regarding the expenditure on health the study results indicate that out of 400 rural married women maximum of 71.4% of women of the age group of 41-50 and minimum of 42.1% women of the age group of 31-40 are spending more than Rs.10,000/- per year for health care compared to 3.2% in the group of 21-30 and minimum of 2.3% in th age group of 51-60 are spending upto Rs 500/- annually . Followed by others are spending less than Rs.10, 000/- per year.

Annual income: out of 400 rural married women maximum of 68.2% of women having annual income less than 18,000/-Rs and minimum of 41.1% women with the annual income between 18,000/- to 25,000/- are spending more than 10,000/- annually for health care compared to 3.8% having annual income less than 18,000/- and 1.2% having annual income between 18,000/- to25,000/- Rs spend upto Rs 500/- annually .

The study results reveal that expenditure on health care of the women depends upon the economic condition of their families and support of the family members.

According to the seriousness of the health problems maximum of 65.8% of women believe that taking treatment in the first stage of illness is necessary followed by minimum of 34.3% of women disagree with this statement.

According to the education point of view maximum of 84.5% of women who are having college level of education and minimum of 55.3% of illiterate women agree with this statement. It means there is a relationship between seriousness about health problem and decision making are closely related with the health care seeking behaviour of rural women.

Considering the attitude and perspectives of the respondents about health care maximum of 60.5% of women believe that taking care of own health is necessary followed by minimum of 39.5% of women believe others health is important than her own. According to educational point of view majority of 78.7% women of women having high school level of education and minimum of 43.6% of illiterate women agree that women must take care of own health. Result reveals that education of women affects the decision making the power of rural women. Due to backwardness in education and income rural women are not able to maintain good health. They give les importance to their health needs.

Verification of hypothesis

Hypothesis of the study are verified with the results obtained by the research.

The first hypothesis states that, Due to backwardness in education rural women are lagging behind in maintaining their health status is proved true.

As per the study of data majority of 61.4% of women of the age group of 51-60 are consuming milk and fruits once in a month. A noticeable of 30.6% of women of the age group of 21-30yr consume milk and fruits weekly. According to the education majority 60.6% the respondents having secondary level of education consuming milk and fruits only once in a month. A noticeable of respondents 38.2% of women having high school level of education consume milk and fruits daily. Village lie away from the market place, and due to busy schedule these women are unable to visit market frequently. Being ignorant about nutritional importance they give less importance to health needs and do not consume nutritious food.

Maximum of 31.50% (126) women don't have any ill habits followed by minimum of 0.25% (1) of women have the habit of chewing Gutka and Betel leaf. Younger generations are less addicted to bad habits but also they keep themselves away from nutritional diet. The awareness regarding regular health check-ups shows maximum of 86.0% of women do not take regular chechups followed by minimum of 14.0% of women are participate in regular health checkups. As a result women feel themselves fit and find it is waste of their time and money for going to health check-ups unless she faces any chronic illness. Hence avoid regular check-ups which are necessary. All these results show that due to the surrounding condition, women are lagging behind in maintaining their health status is proved true.

Second hypothesis of the study states that attitude and perceptions of the rural women regarding health depends upon the need for care, family support, awareness and accessibility to health care facilities is proved true.

According to the behavioural pattern of the respondents maximum of 65.8% of women believe that taking treatment in the first stage of illness is necessary followed by minimum of 34.3% negative response from the respondents. Though the acceptance of the statement is higher, these rural women are not serious about their own health. Maximum 80.9% married women of the age group of 21-30 preferred to undergo treatment in private hospital. And minimum of 70.5% of women of the age group of 51-60 preferred home remedies. Most of the times these women are made to believe that home remedies are more reliable. Though government has implemented many health programmes and facilities some women are not interested to opt for government hospital is due treatment and services offered by the medical staff, most of them complain that they are treated better if they have influence or better financial background.

Third hypothesis of the study states that Health care behaviour of rural women depends on the seriousness of illness, their financial resources and the cultural practices is proved true.

Expenditure on health care of women depends upon the economic condition of their families and support of the family members. Hence majority of 71.4% of women of the age group of 41-50 are spend more than 10,000/-Rs annually on health care compared to other age groups. According to the seriousness of the health problems maximum of 65.8% of women believe that taking treatment in the first stage of illness is necessary followed by minimum 34.3% of women disagree with this statement. 70.5% of women of the age group of 51-60 prefer home remedies. Most of the times these women are made to believe that home remedies are more reliable. Study results show that women themselves are not giving much importance to own health. Most of them believe in home remedies in their early stage of sickness which results in high expenditure when the disease turns severe.

The fourth hypotheses states that due to lack of awareness, women are deprived of utilization and facilities provided by the health care system is proved.

Regarding regular health check-ups shows maximum of 86.0% of women are not particapiting in regular health chechups followed by minimum of 14.0% of women are taking regular checkups, maximum of 41.5% of women preferred private hospital followed by minimum of 7.2% of women prefer government hospital in emergency. The study results shows that women are not interested to opt for government hospitals for treatment as services offered by the medical staff, most of the respondents complain that they are treated better if they have influence or better financial background. Village being a close community, the experience of a particular woman regarding health facilities are discussed with others. As a result maximum no. of women are diverted towards private hospitals

than government. The psychology behind this is treatment in private health care is hassle free , prompt and easy to access.

According to my observation the utilisation of government facilities is higher among educated women than less educated rural women. There is a need to change the psychology of rural people towards government facilities.

Fifth hypothesis of the study states that Health care seeking behavior of rural women is related with the ability to interact with the family and outside the family is proved true.

Pearson's correlation coefficient is statistical measure of the strength of the linear relationship between paired data. The sample of paired (x,y)data is a random sample of independent quantitative data. Here there are 400 observations (n=400) age (*x*) different members of the family (*y*). The present study explored relation between family support, cooperation and health care seeking behavior of rural women. Study results indicated that correlation of family support and health care seeking behavior r=86.952, p-value=0.0001.

The correlation coefficient value of 86.952 confirms positive correlation between variables. The study reject null hypothesis H_0=Health care seeking behavior of rural women is not related with the ability to interact with the family and outside the family. And accept alternative hypothesis H_1=Health care seeking behavior of rural women is related with the ability to interact with the family and outside the family. It means there is a relationship between the family support and co-operation associated with health care seeking behavior of rural women.

In this study results indicated that out of 400 rural women respondents in which maximum of 50.0% of women go to hospital accompanied with other family members some women i.e. 42.0% were not accompanied and minimum of 5.3% and 2.8% women were accompanied with neighbour or friend. There is a

relationship between the family support and co-operation associated with health care seeking behaviour of rural women.

Lower education levels keep rural women away from the use of emergency healthcare services as opposed to people with university education who were more likely to use government funded primary healthcare services for similar needs.

Findings of the study

Based on the analysis of the data following findings have been drawn.

- There is a close relation between the economic condition and support of the family members regarding health care behavior.
- Education of women affects the decision making power of rural women but majority of 28.25% the rural women in this study are found with primary level of education.
- Majority of 66.7% of rural women agree about the necessity of nutritional diet but are not aware about DHA and hence do not include such diet in a regular manner.
- As village Chandgad is low populated, underdeveloped and away from government PHC majority of rural women prefer private hospital for treatment as compared to government PHC.
- Irrespective of population density, rural women tend to avail govt. healthcare facilities if they are available within the vicinity. It is also observed that they use government PHC mostly for maternity purpose than compared to general illness as such facilities are costlier in private health care centres.
- Individuals income was significantly associated with the availability of services, low cost was reported as most common reason for preferring public health facility on other hand private

practitioners were preferred due to quality of care and available within the vicinity.

- Irrespective of age, caste or income rural women need to be accompanied by someone to approach govt., or private health care facilities.
- Rural women do not give much importance for regular pre-health check-ups even if they are financially sound.
- Rural women are found less interested to know about government health schemes but excited to know about the schemes which give financial benefit directly to them, for example Janani Shishu suraksha yojane, Prasuti Araike yojane etc. have gained popularity.
- Younger Generation of rural women are not discussing their health issues with elderly persons in their family.
- Maximum rural women of the age group of 41-60 are not aware about the sign and symptoms of menopause.
- Awareness regarding bad habit found better among the women in the age group of 21-30, women of this age group is least addicted to bad habits.
- Health is not given much importance and not treated in the initial stage of sickness.
- Health care behaviour depends upon support and co-operation from the family members.

CONCLUSION

On the basis of data analysis and major findings the following conclusions are drawn.

Health care seeking behaviour of rural women is dependent on the perception of people regarding the quality of health care services in health care centres. The perception of the people has to be changed to attract them more to

government hospitals and health centres. It can be concluded that by increasing number of health care facilities in public sectors and by improvement of the quality of services at taluka and village level. it can achieved by improving quality of care, proper maintenance of facilities and also by inculcating a caring attitude of health professionals while dealing with patients

Most of rural women feel themselves fit and find it is waste of their time and money for going to health check-ups unless she faces any chronic illness. Hence avoid regular check-ups which are necessary and as a result the family has to face a bad impact on health and economy. All these results show that women are lagging behind in maintaining her health status is proved true.

Women ignore the first signs and symptoms of particular health issue and do neglect unless it is become severe. Women are not interested to opt in going to government hospitals for treatment as services offered by the medical staff, most of the respondents complain that they are treated better if they have influence or better financial background and also the psychology behind this is treatment in private health care is that private hospitals are available at close vicinity with highly equipped machineries, prompt service and 24X7 attention.

Most of the rural women complained that they are attended by trainees in government PHC and resident doctors visit the PHC only once in a week. As a result trainees are unable to diagnose the disease in a right way which impacts the health of the patient and the disease may turn to a chronic illness. There is a need for presence of a qualified doctor on regular basis in the government PHC to avoid such kind of incidents in future.