8. CONCLUSIONS AND SUGGESTIONS
The present study relating to patients' attitudes towards diseases, was launched with the assumptions, that the attitudes of patients towards diseases differ from area to area, i.e. urban and rural patients have different attitudes towards diseases. In these two localities, the attitudes of patients also differed sexwise, educationwise, religionwise and economic conditions-wise. This proves the hypothesis on the basis of the following inferences, drawn from data collected and results calculated:

(1) That the patients of Aligarh District, belonging to two different social environments, differ in their attitudes to diseases. Differences have also been found in the attitudes of patients towards the stages of illness, classified in this study, into five categories, which were: symptom experience, assumption of the sick-role, dependant-patient role, medical-care contact stage, and lastly, the recovery and rehabilitation stage.

(2) That the patients of Aligarh District, have different attitudes towards diseases in the first stage of illness, i.e., the symptom experience stage. Of course patients in general also, though particularly those of Aligarh District were found to differ in their attitudes to the symptom experience stage of their illness. This was because the medical
care process begins with the individual perception that something is wrong. This perception includes awareness of physical change, such as pain, and evaluation of the change and its degree of severity, and sometimes, also the emotional response attached to it. It has also been very clearly shown here that the patients of the urban and rural areas of Aligarh District differ in their attitudes towards the symptom experience stage, because of differences in sex, education, religion, and economic position. Table No.1 reveals these facts. We can infer that the rural female and an urban female differ significantly, and so is the case with an urban and a rural male in the first stage of illness i.e., symptom experience (Table No.1). The role of education is important in the formation of attitudes towards the symptom experience. Respondents from both the universes, having different educational background differed significantly towards the symptom experience (Table No.1).

Religion, though not very significant in the formation of attitude towards symptom experience, does play an important role in the two different areas in the formation of attitudes towards this stage, and both Hindu, and Muslims differ in their attitudes (Table No.1).

And economic conditions of the respondents too did play a very important part in the formation of attitudes to
the symptom experience stage in the two different areas — urban and rural. Also, poor patients belonging to urban and rural areas had different attitudes while rich people had different attitudes towards the symptom experience, i.e., the rich immediately responded to the illness by contacting some experts, while the poor because of lack of money did not even contact a physician, thus prolonging the disease.

It has also been found that the patients belonging to urban and rural areas have different attitudes to the symptom experience stage. This has been shown in Table Nos. 1(i), 1(ii), 1(iii), 1(iv), 1(v), 1(vi), 1(vii) and 1(viii). The results easily inferred are that these patients do have different attitudes to the symptom experience stage. These differences in the attitudes of patients have also been noticed among the male, the female, the educated, and the un-educated, the Hindus, and the Muslims, and, the rich, and the poor respondents (refer Table Nos. 1(i), 1(ii), 1(iii), 1(iv), 1(v), 1(vi), 1(vii), and 1(viii).

(3) As soon as the patients become sure that they have some problem and feel the sickness, they start forming their different attitudes towards the disease concerned, and assuming the sick-role, behave differently, under different environmental conditions. And these attitudes depend not only on whether they come from an urban, or from a rural area, but
also on the fact that they belong to the one sex or the other, are educated or not, profess may be, different religions, and have different economic statuses. This has been shown in table no.2.

This study has shown that the urban female, and, the rural female has each a different attitude towards the assumption of the sick role, and that similarly, the urban male also differs in attitude from the rural male. But this difference is not so well marked merely because the female patients concerned differed in their religious professions (Refer Table Nos.2, 2(i) and 2 (ii).

Education, or lack of it, also, has been found to influence the attitudes of patients in their assumption of the sick-role (Table No.2). And thus in the sick-role stage the urban, and the rural educated patients form different attitudes, while urban and rural uneducated patients form different attitudes (Refer Table Nos.2(iii) and 2 (iv).

Religion may also, often mould the attitudes of patients. A Hindu may perceive and assume the sick role differently, in comparison to a Muslim patient (Refer Table Nos.2,2(v) and 2(vi).

Economic status too demonstrates its effect on the formation of attitudes towards the assumptions of the
sick role. Poor patients behave differently, and assume the sick-role differently from their rich counterparts (refer Table Nos. 2, 2(vii) and 2(viii).

And therefore we can say that it has been proved that the determining criteria for the assumption of attitudes towards the sick role depends largely on whether the patients are from rural or urban areas, are male or female, are educated or uneducated, and also on whether they are rich or poor, and even for that matter on whether they are Hindus or Muslims; and finally, that these attitudes differ significantly (refer Table Nos. 2, 2(i), 2(ii), 2(iii), 2(iv), 2(v), 2(vi), 2(vii), and 2(viii).

4. Now patients, after assuming the sick-role, contact an expert, to solve the problem they face. This stage has been discussed as the Medical-Care-Contact stage, in which patients come directly in touch with the physician. Here also it has been shown that the patients form different attitudes. These differences in attitudes of patients have been noticed, and it has been found that environmental conditions play a significant role. Urban and rural patients have too behaved differently. And what is more, here also, their attitudes differ on account of sex, education, religion and economic statuses. The attitudes of male and female patients belonging to urban and rural areas differ particularly in the Medical-Care-
Contact stage. But Hindu and Muslim female patients from urban and rural areas do not have their attitudes so sharply different as do their male counterparts in similar situations (refer Table Nos. 2 (i) and 3 (ii).

Further it appears that the attitudes of patients towards the medical-care-contact stage in urban and rural areas also differ on the basis of their educational background. Thus educated patients belonging to two different areas have different attitudes in comparison to uneducated patients from these two different localities (refer Table Nos. 3, 3(iii) and 3 (iv).

It has also been tested that Hindu and Muslim patients also differ in their attitudes to the medical-care-contact stage in these two different localities (refer Table Nos. 3, 3(v), and 3 (vi).

Economic factors also play an important role in the formation of attitudes of patients belonging to the two localities i.e., urban and rural. Rich patients differ in their attitudes towards the medical-care-contact stage from the poor patients of these two areas (refer Table Nos. 3, 3(vii) and 3 (viii).

5. Now after contacting the physician, patients become sure that they are ill, and thereafter they completely depend
on experts for the redressal of their problems. But here also it has been noticed that the patients have different attitudes. Infact attitudes in this dependent-patient-role stage have also been found to depend on environmental conditions (refer Table No.4). And so the two regional variations urban and rural, once again have been found to influence the attitudes of patients who differed too in these attitudes according to sex, education, religion and economic status (refer Table No.4).

It has been proved that urban females have different attitudes in comparison to rural female patients (refer Table No.4(i)).

Similarly, urban males and rural males also form different attitudes towards diseases in the stage of dependent-patient role (refer Table No.4(ii)).

Again it has also been found that educated and uneducated patients of urban and rural areas too have different attitudes towards diseases in the stage of dependent-patient role (refer Table Nos.4(iii) and 4(iv)).

Religionwise study has also provided the proof that the Hindu and Muslim patients of urban and rural areas form different attitudes towards diseases in the dependent-patient
role stage (refer Table Nos. 4(v) and 4(vi)).

The economic condition of patients were also found to tell upon their attitudes towards diseases and in both urban and rural areas, the attitudes of the upper economic class are different from the attitude of the lower economic class (refer Table Nos. 4(vii) and 4(viii)).

(6) Getting the physician's green signal that they have been cured, and could thereafter pursue normal lives, the patients reach what has here been called the stage of recovery and rehabilitation. This study has also shown that urban and rural patients differ in their attitudes towards recovery and rehabilitation, and here again, on the basis of sex, education, religion, and economic status (refer Table No. 5).

Thus an urban male and a rural male has been found to differ in these attitudes (refer Table No. 5(i)).

And urban females and rural females have also been found to differ in their attitudes to the recovery and rehabilitation stage (Table No. 5(ii)).

So also, do the educated, and uneducated, of urban and rural areas, differ in their attitudes towards the recovery and rehabilitation stage (refer Table Nos. 5(iii) and 5(iv)).
Similarly, Hindu and Muslim patients, from both localities, i.e., urban and rural, differ in their attitudes towards diseases in the recovery and rehabilitation stage (refer Table Nos. 5(v) and 5(vi)).

However, urban and rural patients were found to have no difference in attitudes towards diseases in the stage of recovery and rehabilitation. Therefore it has not been noticed (refer Table No. 5 (vii)).

Finally, the urban lower class, and the rural lower class also differ in their attitudes towards diseases in the stage of recovery-and-rehabilitation (refer Table No. 5 (viii)).

Thus we see that hypothesis No. 1, 1(a), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), and 1(h) have been tested, and it has been found that the patients belonging to the two communities, and of both sexes, and patients of urban and rural areas, both educated and un-educated, differ in their attitudes towards diseases in general. Whereas hypothesis 1 (i) shows that attitudes of the upper higher income classes, towards diseases, in the stage of recovery and rehabilitation in urban and rural areas may be very clear, yet, statistically it has been proved, that they do not differ in their attitudes
towards diseases in the stage of recovery and rehabilitation. Apart from this, urban poor (lower income classes) and rural poor, differ in their attitudes towards recovery and rehabilitation.

**Suggestions**

This study of the attitude of both urban and rural patients, to diseases, has therefore some suggestions to offer to the government, and physicians, and even to social welfare agencies.

The out-patients' department of hospitals are overcrowded and the rush of patients is often unmanageable for the small teams of doctors on duty. Most of the patients are illiterate and they misunderstand the doctor's instructions. If between 9.30 a.m. and 1.00 p.m. a team of doctors treats hundreds of patients, how much time does each patient get with his doctor? The time given could not ever be enough, and the operating principle would more often than not be — hurry! Now a patient waits for two and three hours, in different queues, before he comes face to face with his doctor just for a short while. And during this meeting the doctor has to examine him, make the diagnosis and even write out the prescription. Simple administrative reforms should be introduced to make the system work better. A social worker
or a para-medical guide should be appointed to guide the patients to the right doctor. A patient's fate must not hinge on something as trivial as a 'parchi', when the OPD Card itself specified all requirements. If a 'Parchi' is definitely needed, doctors should be instructed to make duplicate copies of prescriptions by the use of a carbon paper. This would save time and ensure that a patient, who has spent hours, waiting for a meeting with his doctor, is not sent back to the same doctor, say by a medicine dispenser, to get the 'parchi'.

The drugs prescribed by doctors are seldom given out at the OPD drug-counter. The department stores make only 25 per cent of the drugs available to the hospital as a whole. Very expensive drugs and drugs which need to be administered under supervision, as a rule, are not dispensed from the counter. Sometimes, even if a particular drug is available, it is not given out by the hospital chemist because he does not understand its brand name. The doctors, on the other hand, do not know that the chemist understands only generic names.

Every country aims to provide for its citizens the highest attainable standards of health. Good health reduces mortality and morbidity, and the consequent suffering, and also improves the overall productivity of society.
Health is a state of complete physical, mental, and social well-being. It is not merely an absence of disease, or, an infirmity. These are the concepts embodied in the WHO definition of health. But the above definition seems far from satisfactory. The WHO definition of health takes health to be a 'state'. Some argue that health can not be defined as a state at all, but must be seen as a process, which continuously adjusts us to the changing demands of living, and to the changing meanings we give to life itself. The ancient saying that 'nothing stands still' is just as valid in the case of health. There is no satisfactory definition of the term 'well-being'. Another drawback is that health, like happiness, can not be defined in measurable terms.

Ideal health will however, always remain a mirage, because everything in our life is subject to change. Health in this context has been described as a potentiality — the ability of an individual, or, a social group to modify himself or itself continually, and in the face of life's perpetual change. Now in working for positive health, the doctor and the community health expert, are in the same position, as the gardener, or, farmer, faced with insects, moulds and weeds; their work is never thought at any stage, to have reached completion.
The World Health Assembly, in its annual meeting, in 1977, resolved that the main social target of governments (and of WHO), in the coming years should be, the attainment by all citizens of the world, of a level of health, that will permit them to lead a productive life, socially and economically — a goal that is termed as 'Health for All', and that by the year 2000 A.D.

In order to achieve this goal, a number of intermediate goals, or milestones were planned. One of them is aimed at providing the right kind of food for all, and, another, essential drugs for all, by 1986.

But with malnutrition rampant amongst pre-school children in India, even today, and with UNICEF reporting that millions of children are still starving all over the world, it appears that the first intermediate goal was never achieved.

And, UNICEF also reports, that in the developing countries, 60-80% of the population, especially in the rural areas, does not have access to essential drugs. It is not uncommon to find even the emergency wards of medical colleges without essential drugs like antibiotics and intravenous fluids. If this is the state of affairs in the apex institutions, providing highly specialized medical care, the
The plight of rural areas can be well imagined.

These facts suggest that we have been nowhere near even reaching the intermediate milestones set as goals by the WHO. If we proceed in this fashion, we will hardly ever achieve the goal of 'Health for All', and in any case not by 2000 A.D. We should therefore think about the lacunae in our approach, and change our methodology accordingly.

The government should formulate a policy covering the provision of health facilities to the patients of the entire nation in general, and, the patients of the urban and rural localities of Aligarh District in particular. However, the government should specially concentrate attention on providing these health facilities to rural areas. Thus it should divert its resources to open more medical health centres in rural areas, in addition to those that exist already. Further, it should also educate the urban and rural masses about the advantages and disadvantages of good and bad health.

Physicians and social workers should also visit rural areas to educate the patients there, about the latter's health problems, and help them in their troubles. This becomes very important after what the current research has revealed about the attitudes of patients towards diseases, and therefore this study may pave the way for further research.
in this area, and provide necessary directions, for framing a policy for the general health of the people.

The need therefore is participation in health research, to obtain better information, and understand the needs, behaviour, attitudes, and beliefs of patients, particularly the young — a task, the results of which could be communicated to educators, health service providers, and administrators, and, to policy makers deciding on national programmes.¹

Nationwide health education programmes, backed by appropriate communication strategies, should be launched to provide health information in easily understandable form so as to motivate the development of an attitude for healthy living. The public health education programmes should be supplemented by health, nutrition, and population education programmes, in all educational institutions, at various levels. Simultaneously, efforts should be made to promote universal education, especially adult and family education, without which the various efforts to organise preventive and promotive health activities, family planning and improved maternal

and child health, cannot bear fruit.

The last few decades have witnessed an usual spurt in population which neutralizes the gains made in the various spheres. Every attempt should be made to secure the small family norm, through voluntary efforts, and bring the country to move towards the goal of population stabilization. A National Population Policy should be enumerated with the aim of making family planning a people's movement. This will secure a balanced growth in the population.

The effective delivery of health care services would depend very largely on education, training, and appropriate orientation towards community-health. This should include all categories of medical and health personnel, because all will depend on their capacity to function as an integrated team, each of its members performing given tasks, within a coordinated action programme. It is, therefore, of crucial importance that the entire basis and approach towards medical and health education, at all levels, is reviewed in terms of national needs and priorities, and the curricular and training programmes restructured to produce personnel of various grades of skill and competence, who are professionally equipped and socially motivated, to effectively deal with day-to-day problems, within the existing constraints.
Towards this end, it is necessary to formulate, separately, a National Medical and Health Education Policy which should -
(i) set out the changes required to be brought about in the curricular content, and training programme of medical and health personnel, at various levels, both up and down the hierarchy (ii) take into account the need for establishing the extremely essential inter-relations between functionaries of various grades (iii) provide guidelines for the production of health personnel on the basis of realistically assessed man-power requirements (iv) seek to resolve the existing sharp regional imbalances in their availability, and (v) ensure that personnel, at all levels, are socially motivated towards the rendering of the community health services.

The nutritional status of the children in India is also far from satisfactory. Malnutrition in the formative years of life not only retards physical development, but also mentally retards children. Thus, we have youths who are physically and mentally inferior when they could very well have been entirely fit in both mind and body, but for malnutrition. Malnutrition during pregnancy gets us low weight babies, and increases prenatal mortality significantly. The educational status of mothers is the single most important criteria which determines the nutritional health status.
of children. The Ministry of Education thus should make dedicated efforts to gear and speed up both primary and adult education. Organized school health services should be integrally linked with the general, preventive, and curative services. The Ministry of Food and Agriculture can go a long way in solving the problem of malnutrition. India is self sufficient in food grains. The problem is not of a shortage of food grains but the lack of apt and timely thinking in this direction, and also the absence of commitment to the goal. Low-cost ready-to-eat foods can be made easily available if only some sincere effort is made. The finances involved are not astronomical, and that too dwindle into insignificance when we think of the positive results.

The Ministry of Rural Development, and the Ministry of Industry, should work hand in hand for rural industrialization. Rural industrialization is a must for rural India. If youths from rural areas get jobs within those very areas then they will not migrate to cities; and thus the problem of unemployment too would be significantly checked. This will better the financial condition, and also the health status, indirectly.

There is an urgent need also for launching well considered schemes, to prevent and treat diseases, and injuries
arising from occupational hazards, not only in the various industries but also in the comparatively unorganized sections like agriculture. For this purpose, the coverage of the Employees State Insurance Act, 1948, may be suitably extended, ensuring adequate coordination of efforts, with the general health services. In their respective spheres of responsibility, the Centre and the State must introduce organized occupational health services to reduce morbidity, disability, and mortality and thus promote better health, and increased welfare, and productivity on all fronts. The Government should open larger number of rehabilitation centres to benefit lakhs of invalid patients. Social welfare agencies should also take up rehabilitative work.

Also, the handicapped and the disabled, could then get better attention. For, the handicapped often require specialized training, to enable them to acquire skills for their future employment. Many employers have found that those with disabilities, often make the most conscientious of employees. Social attitudes, based on human principles, can minimize the effect of disability, for the good of all.

The Conference on Primary Health Care in Alma-Ata (USSR), in 1978, concluded that the means of achieving 'Health for All' was only through primary health care. Primary
Health Care was defined as essential health care based on methods which were practical, scientifically sound, and socially acceptable, and based on technology made universally accessible, to individuals and families in the community, enabling their full participation, and at a cost, that the community and country can afford, all being achieved through community awareness which a healthy health condition so definitely requires.

India being a signatory to the Alma-Ata Declaration has committed itself to achieving the goal of 'Health for All', by 2000 A.D. But for this to reach any kind of fruitful materialization what is required is a large scale transfer of knowledge, simple skills and technologies, to Health Volunteers, who are selected by the community, and enjoy its confidence. Unfortunately the training of Village Health Guides and the Dai is far from satisfactory. That is why they are not able to carry out the services as affectively as they are supposed to. In fact the appointment of these volunteers is sometimes politically motivated, and they thus do not enjoy the confidence of the whole community.

The decentralisation of services would require the establishment of a well worked out referral system, to provide adequate expertise at various levels of organizations, set up nearest to the community. Unfortunately the referral
system too is far from satisfactory. And this is true for the whole country. The result is the provision of second rate medical care to most rural citizens.

Further, most of the national health programmes are delivered through these primary health centres. But due to various administrative bottlenecks, these programmes are not carried out effectively. The National Malaria Eradication Programme proved a failure due to administrative reasons only. For very much the same reasons the National Tuberculosis Control Programme has been known to fail. Thus some genuine thinking and action is necessary to make these programmes a success. Only then can we hope to improve the overall health status in India. The entire administrative set up places too much emphasis on paper work. Records become more important. This outstandingly hampers and harms action itself, so that ultimately very little progress is ever in evidence.

Apart from this the drug industry itself should be nationalized, and the drugs manufactured should be sold at no profit no loss basis. All the drugs should be taxfree, and essential drugs should be subsidised. A strict enforcement on the quality control of the drugs is very important. Instruments and equipments should not be taxed, so that they
can be available at cheaper prices. This will help in making all the health centres better equipped.

The multi-factorial causation of disease is well established. Cultural, social, environmental, and economic factors profoundly influence the causation of disease. And therefore, the health status of a society can not be improved by health measures alone, i.e. by the department of health alone. The entire hierarchy from top to bottom must play a very committed role.

The Ministry of Social Welfare should be actively involved in studying the social and cultural factors which could be deeply rooted in society. They should then actively work in removing the taboos and superstitions. Patients should gain social assistance to make themselves dependent. A simple service, like the provision of safe drinking water, can reduce the spread of water borne diseases drastically. Gastro-intestinal disorders increase mortality among children by almost 50%. Environmental appraisal procedures must therefore be developed, and strictly applied, while clearance is accorded to the various developmental projects.

The country has a large stock of health manpower comprising of private practitioners in various systems for example, Ayurveda, Unani, Sidha, Homeopathy, Yoga, Naturopathy
etc. This resource has not so far been adequately utilised. The practitioners of these various systems enjoy high local acceptance and respect, and consequently, exert considerable influence on health beliefs and practices. It is, therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously planned efforts should be made to dove-tail the functioning of the practitioners of these various systems and integrate their services, at the appropriate levels, within specified areas of responsibility and functioning, in the overall health care delivery system, specially in regard to the preventive, promotive and public health objectives. Well considered steps would also require to be launched to move towards a meaningful phased integration of the indigenous and the modern systems of medicine.

It is in this context that the importance of the present research becomes clear. For, the observations made, and the statistics collected, along with the calculations, should help start a process, whereby the data for one district in India, should very significantly emphasize the necessity of not only making the Government, and various social welfare agencies, help create more awareness among Indian patients,
but also, enhance the necessity of greater awareness of
different kinds, at levels, and in places, where opinions
and policies, in society and government, often originate.