CHAPTER – I

INTRODUCTION

Human health attributions influence health behaviours. Health attributions are partly shaped by culture. In turn, cultured health attributions affect beliefs about disease, treatment, and health practices. Likewise, culture influences health and healing practices. Certain cultures have culture-bound syndromes about which medical practitioners should be trained. Other socio-cultural factors such as immigration, acculturation, and social support play a significant role in health attributions and medical adherence.

Beliefs about health and diseases are passed from one generation to another. People, whether rural or urban, have their own beliefs and practices about causes and management of various diseases. Not all customs and beliefs are bad. Some are based on experience and have positive values, while others may be useless or harmful\(^1\). Public health communication is successful only if the interaction between the health professional and patient by exchanging the information rather than simply transmitting information\(^2\). If the doctor understands the patient’s health beliefs regarding their illness and treatment, they can incorporate this knowledge into their treatment and to improve health outcomes\(^3\).

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Majority of the rural people believe that wrath of gods and goddesses, evil eye, spirit or ghost intrusion is supposed to be the cause of diseases. Application of kajal (a black ink on the cheek) to ward off evil eye is still a practice, going on. In spite of the advancement of modern science, people still have faith in beliefs and custom. As information about these factors i.e. customs, habits, beliefs and superstitions is still lacking, the researcher has planned to study and understand the beliefs about causes and treatment of some diseases among the rural population Pondicherry union Territory.

Most sociological studies of lay health beliefs agree that public conceptions of health and illness vary according to the immediate material and social circumstances in which people find themselves. These circumstances can act to constrain the possibilities for action to change an 'unhealthy lifestyle'. Nevertheless, health promotion strategies have in the past assumed that persuading people to adopt healthy 'lifestyles' was largely about changing individual attitudes. However, Davison (1991) has shown that the possible ways to avoid illness through behaviour change. Further the study observed that ‘only very few informants whose belief in randomness led them to deny or ignore the possible benefits of lifestyle change. Rather, the recognition of a pervasive uncertainty in the field of illness and death existed side by side with a common-sense approach to taking appropriate care'.

HEALTH CARE SEEKING BEHAVIOUR: UTILIZATION OF THE SYSTEM

There is often a tendency for studies to focus specifically on the act of seeking health care from traditional healers and unofficial medical channels. However there are studies with the emphasis on encouraging people to opt first for the official channels (Ahmed, 2001)\(^5\).

Tipping and Segal, (1995)\(^6\), further these studies demonstrated that the decision to engage with particular medical channels is influenced by a variety of socio-economic variables: sex; age, the social status of women, the type of illness, access to services and perceived quality of service. There are also studies on the type of barriers or determinants, which lie between patient and services. They tend to fall under the division of geographical, social, economic, cultural and organization factors.

This categorization can be broken down to illustrate the type of measures frequently used. There are studies that identify the key junctions for the delay in seeking competent care, and of potential practical relevance for formulating strategies and appropriate policies. The view is often that desired health care seeking behaviour is for an individual to respond to an illness episode by seeking first and foremost help from a trained medical practitioner, in a formally recognized health care setting. Yet a consistent

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finding in many studies (Orubuloye, 1999)\(^7\) is that for some illness, people will choose traditional healer facilities. There are variations and apart from differences according to type of illness. According to Orubuloye et al. (1998)\(^8\), educated women may be able to negotiate with health provider for better health treatment not only for themselves but also for their children, than non-educated women. Also, rural women may respond differently from urban women on matters relating to their health treatment and health needs of their children.

**Health Seeking Behaviour**

Tipping and Segall et al. (1995)\(^9\) note that health seeking behaviour generally rely on the factors that enable or prevent people from making healthy choices in either their lifestyle behaviours or their use of medical care and treatment services. They pointed out that the underlying assumption is that behaviour is best understood in terms of an individual’s perception of their social environment. A number of model exists, and variations have been developed around them. One of the most applied models is the health belief model. Sheeram and Abraham (1996)\(^10\) categorized the range of behaviours

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that have been examined using health belief model into three broad areas: preventive health behaviours, sick role behaviours and clinical use. In this type of model, individual beliefs offer the link between socialization and behaviour. Another model is linked to the general assumption that those who believe they have control over their health care more likely to engage in health promoting behaviours (Normand and Bennett, 1996)\(^{11}\). The model is often utilized to assess the relationship between an individual’s actions and experience from previous outcomes.

Cornner and Norman (1996)\(^{12}\) refer these models and attempted to predict health behaviour on two assumptions central to classic health promotion: health is influenced behaviour; behaviour is modifiable. The downfall of these models is that most view the individual as rational decision makers, reviewing available information and forming behaviour intentions from this. They do not allow any understanding of how people make decisions or a description of the way in which people make decision.

Fazio (1990)\(^{13}\) proposes an alternative to this ‘deliberative processing model’ in the form of a ‘spontaneous processing model’ which takes greater account of the unpredictable nature of the actual process of decision making. However, the central problem remains that these models focus on the individual and the centrality of cognitive

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processes (‘I know, therefore I act’). This loses the sense that we are all rooted in social contexts that affect, in a far more complex manner, the way we process and act on information.

When individuals make decisions in relation to their health, they weigh up the potential risks or benefits of a particular behaviour. They do so in a way that is mediated by their immediate practical environment, their social origin and their whole outlook on life. Egbunjobi, (1983)\textsuperscript{14} noted that apart from the fact that most patients would choose the institution which they considered would give best services, rather than one nearest to them, yet other socio-cultural factors such as, relative living in hospitals as well as fee paid, ease of transport, religion and connections with hospital staff will all affect the health seeking behaviour. Aregbeyen (1992)\textsuperscript{15} noted that the nature of illness coupled with poverty, ignorance and lack of medical facilities are some of the reasons for health seeking behaviour of people while Adeagbo (1998)\textsuperscript{16} noted that, non-satisfaction with the cost and quality of health services, are the major factors of health seeking behaviour.

According to McCormick-Brown (1999)\textsuperscript{17} the perceptions of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties of a disease or the effects it would have on his or her life in general.

\begin{thebibliography}{9}
\bibitem{17} K. McCromical-Brown, “Health Belief Model Retrieved” September 27, (1999).
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For example, most of us view the flu as a relatively minor ailment. We get it, stay home a few days, and get better. However, if you have asthma, contracting the flu could land you in the hospital. In this case, your perception of the flu might be that it is a serious disease. Or, if you are self-employed, having the flu might mean a week or more of lost wages. Again, this would influence your perception of the seriousness of this illness.

Personal risk or susceptibility is one of the more powerful perceptions in prompting health behaviour of people. B de Wit and others (2005)\textsuperscript{18} opine that the greater the perceived risk, the greater the likelihood of engaging in health seeking behaviours to decrease the risk. This is what prompts men who have sex with men to be vaccinated against hepatitis and to use condoms in an effort to decrease susceptibility motivates people to be vaccinated for influenza to use sunscreen to prevent skin cancer, and to floss their teeth to prevent gum disease and tooth loss.

It is only logical that when people believe they are at risk for a disease, they will be more likely to do something to prevent it from happening. Unfortunately, the opposite also occurs. Maes and Louis (2003)\textsuperscript{19} observe that when people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviours tend to result. This is exactly what has been found with older adults and HIV prevention behaviour. Because older adults generally do not perceive themselves to be at risk for HIV infection, many do


not practice safer sex and unhealthy behaviours tend to result. This same scenario was found with Asian American college students. They tended to view the HIV/AIDS epidemic as a non-Asian problem; thus, their perception of susceptibility to HIV infection was low and not associated with practicing safer sex behaviours.

Courtenay (1998)\textsuperscript{20} viewed that the perception of increased susceptibility or risk is linked to healthier behaviours, and decreased susceptibility to unhealthy behaviours. However, this is not always the case. In college students, perception of susceptibility is rarely linked to the adoption of healthier behaviours even when the perception of risk is high. For example, although college students consider themselves at risk for HIV because of their unsafe sex behaviours, they still do not practice safer sex nor do they stop tanning even though they perceive themselves to be at increased risk for skin cancer. Perception of susceptibility explains behaviour in some situations, but not all.

**PERCEIVED BARRIERS**

Janz and Becker (1984)\textsuperscript{21} note that since change is not something that comes easily to most people, the last construct of the Health Belief Model addresses the issue of perceived barriers to change. This is an individual’s own evaluation of the obstacles in the way of him or her adopting a new behaviour. Of all the constructs, perceived barriers are the most significant in determining behaviour change.


In order for a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the consequences of continuing the old behaviour. This enables barriers to be overcome and the new behaviour to be adopted.

In trying to increase breast self-examination practices in women, it would seem obvious that the threat of breast cancer as a very serious disease, one for which women are at risk and for which the perception of threat is high. Byrd and others (2004)\textsuperscript{22} reported that barriers also stand in the way of women seeking Pap tests, even though they perceive cervical cancer as being serious and believe there are benefits to having a Pap test. The Barriers - fear that the test is painful and not knowing where to go for testing - are not outweighed by the benefits of the test or minimized by the seriousness of the disease. Burak and Meyer (1997)\textsuperscript{23} reported that among college women, fear of pain and embarrassment are the barriers to Pap tests. It is interesting that these barrier beliefs are greatest among women who have never had a Pap test.

**MODIFYING VARIABLES**

The four major constructs of perception of perceived seriousness, perceived susceptibility, perceived benefits, and perceived barriers are modified by other variables, such as culture, education level, past experiences, skill, and motivation. These are


individual characteristics that influence personal perceptions. For example, if someone is diagnosed with basal cell skin cancer and successfully treated, he or she may have a heightened perception of susceptibility because of this past experience and be more conscious of sun exposure because of past experience. Conversely, this past experience could diminish the person’s perception of seriousness because the cancer was easily treated and cured. In personal health classes on many campuses, students are required to complete a behaviour change project. They choose an unhealthy behaviour and develop a plan to change it and adopt a more healthy behaviour. The modifying variables behind this are motivation.

**CUES TO ACTION**

In addition to the four beliefs or perceptions and modifying variables, the HBM suggests that behaviour is also influenced by cues to action. Cues to action are events, people, or things that move people to change their behaviour. Examples include illness of a family member, media reports (Graham, 2002)\(^{24}\), mass media campaigns advice from others, reminder postcards from a health care provider or health warning labels on a product.

If the perception of threat is to a serious disease for which there is a risk, behaviour often changes. This is what happened in Germany in 2001 after an outbreak of Bovine Spongiform Encephalitis (BSE), better known as mad cow disease. Although mad

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cow disease does not occur in people, research suggests that eating cattle with the disease can result in a variant. Weitkunat and others (2003)\textsuperscript{25} reported that the perception of threat of contracting this disease through eating beef was one factor related to declining meat consumption in Germany. People changed their behaviour based on the perception of threat of a fatal disease.

Another example in which perception of threat is linked to behaviour change is found in colon cancer survivors. Mullens and others (2003)\textsuperscript{26} reported that colorectal cancer is a very serious disease with a high risk of recurrence that increases the likelihood of behaviour change in people previously treated for this disease. In particular, changes occur in their diets, exercise and weight. The same thing when the people perceive a threat of developing non-Insulin-dependent diabetes mellitus.

Among people whose parents had or have the disease, the perception of threat of developing it themselves is predicative of more health-enhancing, risk-reducing behaviours. Most important, they are more likely than others to engage in behaviours to control their weight given that obesity is a known risk factor of Non-Insulin-Dependent Diabetes Mellitus (NIDDM).

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PERCEIVED BENEFITS

The construct of perceived benefits is a person’s opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. People tend to adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a disease. Perceived benefits play an important role in the adaptation of secondary prevention behaviours, such as screenings.

The Health Belief Model

The Health Belief Model (HBM) was designed in the 1950’s and continues to be one of the most popular and widely used theories in intervention science. The focus of the HBM is to assess health behaviour of individuals through examination of perceptions and attitudes people have towards disease and negative outcomes of certain actions. The HBM assumes that behaviour change occurs with the existence of three ideas at the same time:

1. An individual recognizes that there is enough reason to make a health concern relevant in terms of perceived susceptibility and severity.
2. That person understands he or she may be vulnerable to a disease or negative health outcome in terms of perceived threat.
3. Lastly, the individual must realize that behaviour change can be beneficial and the benefits of that change will outweigh any costs of doing so in terms of perceived benefits and barrier.

The Diagram-1 shows the Health Belief Model with the key elements necessary for behaviour change.
FIGURE 1.1

The Health Belief Model

THEORETICAL PREPOSITIONS OF THE

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<th>Individual</th>
<th>Modifying</th>
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<td>• Perceived susceptibility of disease X</td>
<td>Demographic variables (Age, Sex, race, Ethnicity, etc) Socio-psychological variable (personality, Social class, peer and reference group pressure, etc.) Structural variables (Disease knowledge)</td>
<td>Perceived benefits of preventive action minus Perceived Barrier to preventive action</td>
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<tr>
<td>• Perceived seriousness (Severity) of disease X</td>
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<td>Perceived threat of disease X</td>
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<td></td>
<td>Cues to action Mass media campaigns Advice from other Reminder postcard from physician Illness of family member Newspaper or magazine article</td>
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Within this framework, human behaviour is seen as being dependent upon two primary variables: (1) the value placed by a person upon a particular outcome and (2) the person’s belief that a given action will result in that outcome. Accordingly, the health belief model, shown in Diagram, suggests that preventive action taken by an individual to avoid disease “X” is due to that particular individual’s perception that he or she is personally susceptible and that the occurrence of the disease would have at least some severe personal implications.

Although not directly indicated in Diagram, the assumption in this model is that by taking a particular action, susceptibility would be reduced, or if the disease occurred, severity would be reduced. The perception of the threat posed by disease “X”, however, is affected by modifying factors. As shown in Diagram, these factors are demographic, socio-psychological, and structural variables that can influence both perception and the corresponding cues necessary to instigate action. Action cues are required, says Rosenstock, because while an individual may perceive that a given action will be effective in reducing the threat of disease, that action may not be taken if it is further defined as too expensive, too unpleasant of painful, too inconvenient, or perhaps too traumatic.

Unfortunately, the usefulness of the health belief model is limited in that it has been applied mostly to preventive situations in which the behaviour studied is voluntary. Obviously, however, many people who seek health services are motivated to take action only by the appearance of clear and definite symptoms.
INDIVIDUAL PERCEPTIONS

Individual perceptions speak directly to the knowledge and beliefs that a person has about his behaviours and the outcomes they could have. In the context of the HBM, perceived susceptibility examines the individual’s opinion about how likely the behaviours they partake in are going to lead to a negative health outcome. For example, look at an individual who smokes. Smoking is known to have many complications such as lung cancer, bladder cancer, etc. If a smoker does not feel that he is at risk of developing any of these diseases, he has no reason in his mind to make a behaviour change. One of the goals of the HBM is to change perceptions of susceptibility in order to move towards behaviour change.

Prochaska JO, Velicer WF (1997) reported that the past 20 years of trans-theoretical model-based research has found some common principles of behaviour change which have applied to a wide range of health behaviours. These behaviours include: smoking cessation, exercise adoption, sun protection, dietary fat reduction, condom use, adherence to mammography screening, medication adherence, stress management, and substance abuse cessation, to name just a few.

These problem behaviours are important from both a clinical and a public health standpoint because they are strongly associated with increased morbidity, mortality, and with decreased quality of life.

Prochaska JO and DiClemente CC., (1985)\textsuperscript{28} noted that the Trans-theoretical Model (TTM) is a model of intentional behaviour change that has produced a large volume of research and service across a wide range of problem behaviours and populations.

It is also clear that in the rural areas that traditional beliefs and practices have its own influence on people to have specific response to illness and disease. In general in India, such superstitions, beliefs and practices are still prevalent in rural areas. For example, though people know that fever with small eruptions on skin is pox and treatment to the pox is necessary, many (including those live in urban areas) still believe that this is due to the anger of one female deity namely ‘Mariamman’. Such beliefs based on traditional myths influence people to have specific response in seeking medical/health care services. This affects the very approach of their help seeking behaviour.

**NEED OF THE STUDY**

One will be curious to know such traditional beliefs, myths and practices relating to disease and illness. So that it could be possible to understand that how people respond to disease and illness in general and in rural areas in particular. Practices like ear boring, putting black dot on the cheek of the child are based on myths that prevail in the area. Such practices help in driving away the bad spirits away and have a cheek in the evil/wicked eye of certain people. Such beliefs and practices were commonly found in the villages. Many people have such superstitious beliefs relating to pregnancy, child birth, menstruation, and related diseases.

The researcher is of interest to understand how the myths, beliefs and traditional practices influence the people to respond to their disease and illness. The researcher is also careful to see how apart from the traditional myths and beliefs contemporary socio-economic, environmental and situational factors influence their health seeking behaviour. It is with this basic understanding of health and illness behaviour, peoples’ culture and myths and beliefs, the researcher intended to carry out a study in the Rural Puducherry to understand how health related myths, beliefs and practices influence health seeking behaviour of the people.

CHAPTER SCHEME

The First Chapter deals with the importance of the present study.

The Second Chapter focuses on the review of literature relating to the present study.

The Third Chapter contains methodological aspects of the present study. It includes statement of the problem, objectives, hypothesis, profile of study area, concepts, selection of study area, research design, sampling, pilot study, pre-test, data collection, data analysis, significance of the study and limitations.

The Fourth Chapter presents results and discussion of the study.

The Chapter Five explains major findings of the study and offers conclusion.