CHAPTER – II

REVIEW OF LITERATURE
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In the area of Sociology of Health now many studies have been carried out and enormous research literature is available. However, studies on illness/health behaviour and literature pertaining to health beliefs and behaviour are comparatively less. However the researcher has made sincere efforts to identity the available literature relating health beliefs and behaviour.

Health has always been a major concern for community development. “It is a basic requirement, not only for the fulfillment of human aspirations, but also for the enjoyment of all mankind of a better quality of life. It is also indispensable for a balanced development of the individual within the family and as part of the community and the nation”.

Hasan (1979)\(^1\) right point out that “The importance of social and cultural factors in health and disease and socio cultural implications of modern medicine and public health programmes can be understood only when both medical men and social scientists collaborate with one another”. He further observes that health and disease are related to sociological and cultural resources of a community in a specify environment.

Traditionally, women as mothers, wives and sisters were providers of health care within the home. The people’s concepts of preventive, promotive, curative, and destructive medicine are symbolically and meaningfully interwoven in their culture. Thus all actions, chants, gestures, utterances, songs, holy objects, words, rituals, and ceremonies associated with maternal and child health care is meaningful within their cultural frame of reference.

Perminder S. Sachdev (1990)\(^2\) estimated that a significant proportion of excess morbidity and mortality can be attributed to at least four behavioural factors: smoking, obesity, alcohol use and accidents. This paper examines the inter-cultural differences in these factors, both from a contemporary and an historical perspective. Some of the reasons for the continuation of these adverse patterns of behaviour are explored, in particular the role of psycho-cultural stress. Some possible mechanisms of effecting behavioural change in modern Maori society were also discussed.

Brit S. Schneider and Udo Schneider (2009)\(^3\) reported that several clinical trials give information about the importance of individual behaviour for the prevalence of these illnesses. Changes in health relevant behaviour may therefore lead to a decline of avoidable illnesses and related health care costs. In this context, the researchers use German micro data to identify determinants of smoking, drinking, and obesity. Our empirical approach allows for the simultaneity between adverse health behaviour and self-reported health as a measure of the individual health capital stock. They can show


\(^3\) Brit S. Schneider and Udo Schneider. Determinants and Consequences of Health Behaviour: New Evidence from German Micro Data, No 253, SOEP Papers on Multidisciplinary Panel Data Research from DIW Berlin, The German Socio-Economic Panel (SOEP) (2009),
that health behaviour is related to the socioeconomic status of an individual. Furthermore, they find gender-specific differences in behaviour as well as differences in the determinants of drinking, smoking and heavy body weight in particular.

Werner B.F. Brouwer and Job van Exel (2005) presented evidence on own expectations regarding length and quality of life, using data obtained from a Dutch convenience sample (n=600). Regression analysis is used to explain individual expectations. Age, current health status and the perception of current lifestyle are especially important explanatory variables of people's own expectations regarding length and quality of life. Average age of death of relatives moreover explains self-estimated life expectancy, whereas self-estimated life expectancy explains expectations regarding quality of life. Given the influence inaccurate expectations may have on actual behaviour, more research on own expectations and their relation with actual behaviour is needed.

B. Gail Frankel and Sandy Nuttall (1984) examined role of social support, structural-environmental and perceptual variables in explaining variation in illness behaviour in a sample of 240 adults with impaired hearing. The specific behaviour examined is physician visits over a 12 month period. We find that previous experience with illness and perceived health status are important variables with respect to illness behaviour and that the relevance of these variables and social support vary considerably.

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by level of psychological distress. The findings argue strongly for increased awareness of the role of social and psychological factors in illness behaviour, particularly among those who plan and deliver health care services.

B.V.L. Narayana (2012)\(^6\) shows that populations with poor formal literacy rates show equivalent or even better health indices. These target populations have better attitudes, better access and consequently better utilisation of health interventions. This utilisation was dependent upon, first people becoming aware of existence of health conditions and understanding their impact. On being confronted with a specific health condition, this general awareness would prime specific health seeking behaviours. The success of such behaviours was crucially dependent upon access to corresponding health interventions. Thus a sequential model of general awareness-specific awareness-attitudes-access-utilisation is developed.

Jannifer Brennnett (1999)\(^7\) investigated factors associated with child mortality in an area in Rawalpindi, one of the large cities of Pakistan. Using both demographic and anthropological methods, the research was conducted to examine specifically the processes and mechanisms whereby a link is established between child mortality and its covariates. Controlling for the socio-economic status as a determinant of child mortality, the study population was limited to a lower income stratum living in a homogeneous


environment where all households had equal access to health-related and other facilities. Results of the proportional hazards model analysis on 1301 index children suggest that non-economic factors like maternal health-seeking behaviour were related to high child mortality. The cultural norm of bearing a large number of children was the most significant correlate. In order of significance, this was followed by contraceptive use, current age of the mother, age at marriage and the hygienic conditions of the household.

E.K. Rousham (1994)\(^8\) conducted a survey on 131 mothers in rural Bangladesh to examine knowledge and perceptions of helminth infection in relation to use of health facilities and treatment-seeking behaviour. Almost all respondents considered worms to be a cause of bad health and a high percentage of mothers had obtained deworming treatment for their children. However, marked differences were found in mothers' descriptions of the causes and prevention of helminth infection in two adjacent areas; Pullakandi and Shekpara. The discrepancies in biomedical knowledge corresponded with differences in treatment-seeking behaviour in the two areas. All households in the area had access to free deforming treatment provided by a health clinic, but this facility was predominantly used by women living nearby in Pullakandi. Because of the cultural and social constraints on female activities, women living further from the clinic, in Shekpara, preferred to send their husbands to a pharmacy in the nearby town to buy deworming treatment. The study highlights the influences of social and cultural factors on treatment-seeking behaviour, which in turn affect women's exposure to health education and

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biomedical knowledge of helminths. Further questions are raised, however, on the ability of women to implement preventive measures and the impact of health education on rates of parasitic infection.

J.A.Kumaresan and E.T.Aganu (1994)\(^9\) determined some socio-cultural factors influencing knowledge and attitudes of the community toward leprosy was carried out in north-western Botswana, where cases of leprosy have been known to exist over the years. The study was largely qualitative, using ethnographic approaches. The research was tailored in a way to capture the ethnic diversity of the region, in particular two ethnic groups, namely Bayei and Bambukushu. The name or symptom complex associated with leprosy was 'ngara' or 'lepero' and this was associated with bad blood. Knowledge on disease causation was lacking, which in turn influenced health seeking behaviour of patients. Patients were well integrated and accepted into the social structure of communities.

Kathryn Dean (1989)\(^10\) reports on findings from an investigation of self-care practices in a population sample of persons over 45 years of age in an attempt to study self-care in a lifestyle framework. The findings show the importance of examining patterns of behaviour rather than exclusive focus on the magnitude of differences in discrete behaviours. Gender was the major independent influence on patterns of health


maintenance behaviour while social network variables assumed major importance for self-care responses to illness.

K. Nyamongo (2002)\textsuperscript{11} reveals how the patients in a rural region of Gusii, Kenya are likely to make beyond the homestead in their search for alternatives to combat malaria. Malaria is a very common health problem in the region resulting in enormous human and economic losses. Results show that patients are more likely to start with self-treatment at home as they wait for a time during which they observe their progress. This allows them to minimise expenditure incurred as a result of the sickness. They are more likely to choose treatments available outside the home during subsequent decisions. The decisions include visiting a private health care practitioner, a government health centre or going to a hospital when the situation gets desperate. Knowledge and duration of sickness, the anticipated cost of treatment, and a patient's judgement of the intensity of sickness determine their choice of treatment.

Alexander Segall and Jay Goldstein (1989)\textsuperscript{12} identified the range of self-care practices used at this time by Canadians and to explore some of the correlates of this behaviour. Data were obtained in 1983 through personal interviews with a randomly selected cross-sectional sample of 524 residents of Winnipeg, Canada. The dimensions of self-care investigated were: symptomatic self-treatment responses; recent self-medication activity; and the use of home remedies. Potential correlates considered include: socio demographics; perceived health status; understanding of medical knowledge; attitudes


toward medical care; and health maintenance/lifestyle beliefs and internal preventive control beliefs. A correlational analysis was performed to test the nature and strength of the association between all of the variables measured. The results suggest that selected social characteristics and sceptical attitudes toward doctors may be important correlates of self-care. However, in view of the diverse nature of self-care behaviour it seems unlikely that a single set of factors will be able to explain all forms of self-provided health care. The paper concludes with a discussion of personal and professional responsibility for health and implications for self-care research.

Ghulam Mustafa Zahid (1996)\(^\text{13}\) examined the Mother’s Health-seeking Behaviour and Childhood Mortality in Pakistan. This is based on the 1990-91 Pakistan Demographic and Health Survey (PDHS), a nationally representative survey covering all four provinces of the country. It was found that neonatal, infant, and child mortality rate is the highest among children of mothers aged less than 20 years. Infant and Child mortality rate is likewise higher among first and higher order births than among births of second or third order. It has further found that mortality declines as the length of the birth interval increases. The results reveal that the education of mother has significant effect on the neonatal, infant and child survival, as mother’s education increases the chances of survival of neonatal, infant and child also increases. Health care factors such as antenatal care, place of delivery, assistance at delivery and immunisation also influenced neonatal, infant and child mortality. The paper suggests that for the improvement of the health conditions of children in Pakistan, first, it is necessary that the educational status of the

population in general, and of mothers in particular, should be improved, and second, the health services should be accessible and available for the promotion of health care practices.

Abusaleh Shariff and Geeta Singh (2007)\textsuperscript{14} made an attempt to discuss the issues associated with the demand and supply of the five measures of maternity care—antenatal care, blood pressure check up, place of delivery, use of trained help at the time of delivery and postnatal care. Econometric analysis is undertaken to find out the determinants of the use of reproductive health care services among rural Indian households. The focus on the role of education, information and economic factors as determinants of health care accessibility and their utilisation is the specialty of this analysis. Analysis shows that education and information variables significantly influence health seeking behaviour and as well increase the utilisation rates for prenatal, child delivery and postnatal health care.

Christina R. And others (2011)\textsuperscript{15} examined access to health care by poorer residents in Chennai, India. It reveals constraining and enabling conditions for impoverished users seeking treatment. They explored patterns of health-seeking behaviour through the reasoning of residents themselves as well as stakeholders involved in providing care for these users. Particular attention is paid to the needy residents'


preference for private health care providers despite the costs involved and that free public facilities are available. The researchers address this issue by combining Sen's entitlement approach with Penchansky and Thomas' work on access to health care. Based on data gathered in a qualitative field-based research design including interviews with 14 residents and 58 stakeholders involved in caring for poor people, the authors argue that the availability of health care facilities within walking distance is a necessary but not sufficient precondition for satisfactory access. Rather, the study demonstrates the influence of 'entitlements to health care' which allow poor households that are endowed with resources such as income, knowledge and social networks to realise access.

Helmut Kloos, (1987)\textsuperscript{16} examined illness distribution and health behaviour among different socio-economic and cultural groups in urban and rural communities within the context of available health resources, national health policy and planning. Results show that in spite of the rapid expansion of health services since the Ethiopian revolution serious problems of allocation and access persist. Utilization rates varied with type and duration of illness, socio-economic level, age, sex and place of residence. The role of distance and other contact barriers, treatment outcome and availability of private clinics and alternative health resources in utilization is also evaluated. Coverage of the modern health services was associated with socio economic status and mobility of patients as well as availability of health services.

Suzanne C. Ho, et al. (1984) revealed that the survey of a quota sample of patients in institutional clinics providing Chinese traditional medical consultations. The survey aimed to look at the types of illness conditions presented in these clinics, the multi-usage of both modern and traditional health care by these patients, and the inter-relationship between illness behaviour and differential preferences of treatment methods for various disease conditions.

Lucia Knight and Pranitha Maharaj (2009) explored the patterns and determinants of health-seeking behaviour among Mangalam Africans. The results show that the majority of respondents consulted public health services. Despite this, it was possible to determine that income-based poverty and access to medical aid were the most significant predictors of healthcare choice. Poverty was related to other predicting factors such as employment, level of education and household size. Surprisingly, a sizable proportion of the poor without access to health insurance were using private health services. Although the reasons for this could not be determined, this presents opportunities for further research.

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Aurélien Franckel (2008)\textsuperscript{19} examined the descriptive results show significant variations in therapeutic practices, disease management and health care planning strategies from one Village to the next. At different levels, individual health-seeking behaviours appear to be conditioned by a set of collective norms developed by the Village community. The spatial analysis shows that these variations in behaviour describe two distinct geographic sets, distinguished by different levels of access to health facilities and different historical, social and cultural characteristics.

Steven Russell (2005)\textsuperscript{20} focussed on patient trust because of its effect on treatment-seeking behaviour and the treatment costs incurred by poor households. Drawing from other studies the paper distinguishes between trust based on the perceived technical competence of the provider, and on inter-personal dimensions of quality of care. Trust is also analysed at two inter-related levels: personal trust that is built through face-to-face encounters with providers; and more abstract institution-level trust. The paper applies these notions of trust to examine treatment-seeking behaviour in two poor urban communities in Colombo, Sri Lanka. Household survey data and qualitative data show that people from a range of income groups preferred to use public providers for more serious illnesses because public services were free and they trusted the technical competence of public providers at both a personal and institutional level.


Nanda P, and Rama V Baru’s (1993) study about the nursing homes and hospitals in Delhi provide an insight into the heterogeneity in provisioning of services and plurality in utilization patterns. The heterogeneity and haphazard growth of the private sector points to the need for registration and regulation. The utilization of medical services show that high percentage of people resort to the individual private practitioner for initial treatment. However, for minor and major ailments people use the government and municipal hospitals. Although more poor people use the government hospital, the middle and higher income groups also use them for minor ailments.

T.P. Kunhikannan, and K.P. Aravindan (2000) focused on the various aspects of health status of rural population of Kerala. Their study revealed that only around 28 percent of acute illness cases get reported to the government hospitals for treatment. Rest of the 58 percent seeks health care from the private institutions. Further the study shows that, a pronounced increase in per capita medical expenditure consulting a mediflation. This given financial strain to the poor sections of the society and they get pushed down to the level of poverty and increasingly indebted.


Papreen Nahar (2010) studied the health seeking behaviour of childless rural poor and urban middle class women in Bangladesh. Data for this study were collected from a northern district of Bangladesh named Mymensing, using various qualitative methods including life histories, in-depth interviews, and key-informant interviews. The study shows that social class and the geographical location of the childless women determine their health seeking behaviour.

Chirmule Deepti and Anuradha Gupte’s (1997) study conducted in the rural areas of five major states namely Gujarat, Maharashtra, Karnataka, Uttar Pradesh and Rajasthan revealed that, the utilization pattern of health services is determined by many factors such as cost, quality of services, health care availability, etc. However qualities of services play a dominant role in people’s decision about seeking medical help. The study shows that due the inefficiency of the public health centers people prefer seeking treatment from private practitioners. Economic factors such as poverty restricted the people from having modern scientific health care. Factors such as caste, class etc. are still dominant and important in determining the type of health care sought.

Duncan Pedersen and Carlos Coloma (1983) summarized the main findings of a four Village study, carried out during 1979 and 1980 in the highlands and lowlands of northwest Ecuador concerning Western and traditional medicine practices and their

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relationship with the health status of the people. The methodology used was based on a census and cross-sectional survey on morbidity, mortality and health-seeking behaviour; on structured and open-ended interviews with healers, traditional midwives and local medical personnel; and on case studies and follow-ups of individual cases of illness, as defined by the population. Morbidity and mortality data show that the health situation is similar or worse in those Villages with local medical services than in those with remote access to hospital facilities. The reported consultation and follow-up of actual cases revealed the existence of complex social networks for disease interpretation and management which combine Western and traditional medicine practices, religious and lay family healing procedures.

Peter Kinderman, et.al. (2006) examined the illness beliefs of people with psychosis, primarily using models developed in relation to physical illness. It is likely that modifications to these models will be necessary if they are to apply to mental disorders, and it is probable that some of the assumptions underlying the models will be inappropriate. In particular, different dimensions of understanding may be present in mental illness in comparison to those identified in physical illness. The present study examines the beliefs of 20 patients in the UK diagnosed with schizophrenia, including 10 currently psychotic inpatients and 10 outpatients in remission, about their experiences, using qualitative interviews and thematic analysis. Patients currently experiencing psychosis did not identify their experiences as separable 'illnesses' and did not have 'illness beliefs'. Patients currently in a period of remission appraised their experiences as

distinct from their own normal behaviour, but used conceptual frameworks of understanding that deviated significantly from conventional 'health belief' models. Patients' ways of understanding mental illness did not parallel those described in physical illnesses. Methods for assessing beliefs about mental illness should therefore not be transferred directly from studies of beliefs about physical illness, but should be tailored to the nature of patients' beliefs about mental illness.

Srinivasan K. and Sharan Raka (2005)\textsuperscript{27} focused their attention on the various aspects of religiosity and health. It is observed by various researches that the rural population of India, is very much influenced by religious beliefs. For example cultural formation of individuals closely inter linked with performance of individual's daily routine. The study aimed to examine the impact of religious practices and rituals as aspects of religiosity on health with specific reference to rural individuals of India.

Kirsi Lumme-Sandt, et.al. (2000)\textsuperscript{28} explored the views of the oldest-old on their medication. The data for the study came from narrative interviews with people aged 90 or over. Our aim was to look for different culturally shared interpretative repertoires used by the interviewees as they gave descriptions and accounts of their drug use and presented themselves as users of medical drugs. Three interpretative repertoires were identified. The moral repertoire stressed lay people's moral norms and presented them as morally acceptable and responsible users of drugs by explaining and minimizing.

\textsuperscript{27} Srinivasan K. and Sharan Raka, “Religiosity and Health”, MPRA Paper from University Library of Munich, Germany (2005).

Stuart Capstick (2009) examined the health conceptualisations across the cultures of the region which differ from the conceptualisations of biomedicine; the role of the relational self, traditional living and communalism in understanding health; the place of spirituality and religion in health and illness causation; and pluralism and pragmatism in health-seeking behaviour. Suggestions are made as to how awareness of key ideas might contribute to effective planning of health promotion and intervention activities.

A.V. Patil, K.V. Somasundaram and R.C Goyal (2002) argued that, despite of several growth-oriented policies adopted by the government, the economic, gender, disparities are posing challenges for the health sector. The growing ineffectiveness of the government sector is gradually driving poor people to seek help of the private sector, thus forcing them to spend huge sums of money on health care. Urban middle class people in India are accessing best health care in the world. Same time health facilities are not available to at least 135 million of rural and tribal people and the result study focused on the need of paradigm shift from the current biomedical model to a socio-cultural model to meet the needs of the needs of the rural population.

Social scientists who have studied the primitive communities have shown great concern is studying their social organization, kinship, marriage, family, religion, economic, etc., while their medical beliefs and practices have been neglected. Therefore, the earlier monographs of many of the primitive communities often contain little narration in connection


with disease and medicine. “It is true that all through the history of mankind attempts have been made to explain different aspects of medicines in terms of social variables. But it is only in the past fifty years or so that serious attempts have been made to study systematically the relation between the sub-culture of medicine and the wider society of which it is a part (Ahluwalia 1974)."31

With this background the researcher has intended to study the ways in which people choose to respond to their health issues. The researcher has approached the respondents with an open mind to study what factors really attribute for their health seeking process and attempted to find out the Health seeking behaviour of the people in the rural areas of Puducherry Union Territory.