CHAPTER - VII

SUMMARY AND CONCLUSIONS

The concepts of health and illness are relative and culture specific and assume different meanings sometimes even in the same society. Health according to WHO is "a state of complete physical, social and mental well-being and not merely the absence of disease and infirmity". On the other hand, illness is a subjective phenomenon in which individuals perceive themselves as not 'feeling well' and therefore tend to modify their normal behaviour. A distinction can be made between the illness conditions and the possible behavioural consequences of these conditions. The major concern of the medical sociologists is with the behavioural concomitants of illness conditions. Mechanic has labeled this concern as the study of 'illness behaviour'.

Illness is always stressful and can lead to many life difficulties but what is interesting to a behavioural scientist is
the tremendous variability in response to the same illness condition as Mechanic has pointed out "while one person will hardly acknowledge a condition and refuse to allow it to alter his life, another with a milder form of the same condition will display profound social and psychological disabilities". One part of the present research is concerned with exploring the influence of stress on illness behaviour. The objective is to find out how various individuals manage their stress. In the present study the term 'stress management' has been operationally defined to refer to the coping strategies adopted by individuals to overcome this stress.

The scenario of health care in India, presents a rather dismal picture. This is all the more glaring in case of women's health. Although women experience many health problems similar to those of men yet there are some problems which are peculiar to them because of the biological factor. Thus the health care needs of women are more complex and varied. However, in a large number of cases, these needs are overlooked and proper attention is not given to the health of women, due to a number of social and cultural factors in the Indian society.
Although a number of studies exist related to women's health in India, yet there seems to be lack of studies related to women illness-behaviour and management of stress due to illness. An attempt has been made in the present study to fill this research gap.

The objectives of the present study are as follows:

1. To find out differential pattern of rural and urban women's perception of illness.

2. To investigate the pattern of help seeking behaviour followed by the respondents at the time of illness.

3. To find out the awareness and utilization of various modes of treatment among rural and urban women.

4. To explore the determinants for seeking medical care and selecting sources of treatment and what influences their preferences for particular system of medicine.

5. To find out that whether the mode of treatment is changed and the type of change.

6. To explore the extent of stress due to illness among rural and urban women.
7. To analyse the role of relatives, friends and neighbours in coping with the stress of illness.

8. To investigate the coping strategies used for stress management.

The following hypotheses have been put to test in the present study:

(i) The rural women are likely to overlook minor ailments as illness as compared to urban women.

(ii) The perception of illness might be influenced by social-economic factors like age, education, occupation, income and psychological factors like beliefs and attitudes.

(iii) The awareness and utilization of modern medicine is likely to be lesser among rural residents as compared to urban residents.

(iv) The urban women might perceive higher extent of stress due to illness as compared to rural women.

(v) The relatives, friends and neighbours are liable to assist the ill persons in coping with the stress to a higher extent in the rural areas.
(vi) Folk notions about illness and the role of ethnomedicine might vary with place of residence, education and economic status.

(vii) The role of religion and faith healers is likely to be more pronounced in rural areas as compared to urban areas.

The present study was conducted in Patiala district of Punjab and the sample was drawn both from rural and urban areas. The sample from Patiala city was drawn from two types of localities that is those inhabited by people from upper strata and the other inhabited by people from lower strata. For the purpose of drawing rural sample, two villages were selected randomly, keeping in the mind their distance from a town or a city. One village was within 15 kilometers and the other was beyond 15 kilometers from a town or a city, were selected. A stratified random sample was drawn from the voter lists of Patiala city and the selected villages keeping in view the age categories of females. The selected respondents were interviewed with the help of an interview schedule. Moreover, observation and case histories were also utilized in order to probe deeper into the research problem.
The major findings of the present study have been summarized as follows:

The socio-economic profile of the respondents indicates that:

(i) The respondents were distributed in almost the same proportion in two age categories of 18-44 years and above 44 years. A higher proportion of the respondents from rural areas were illiterate, whereas a higher proportion of the urban respondents were better educated as compared to the rural respondents.

(ii) A majority of the respondents were housewives but their proportion was higher in rural as compared to urban area. All women engaged in middle/upper level occupations were from urban area only.

(iii) A majority of the respondents did not have an income of their own as they were housewives. All the respondents in the high income category were from urban areas. The respondents were therefore asked to mention their family income. A little more than two-third of the families were
placed in the low income category of less than rupees 10000 per month.

(iv) A majority of the respondents were the followers of the Sikh religion while a little over one-third of the respondents belong to the Hindu religion. A very few respondents were Muslims.

(v) A little more than half of the respondents were from lower caste groups and the remaining from upper & middle castes.

The major findings regarding socio-economic correlates of illness-behaviour have been summarised below:

(i) Almost half of the respondents were ill for a period of over one year. The diseases mentioned were: tuberculosis, diabetes, hypertension, asthma, muscular, migraine and multiple diseases.

(ii) A higher proportion of the respondents attributed their illness to carelessness on their part. About one-fourth of the respondents believed that their illness was due to bad deeds and wrath of god or goddesses.
(iii) About half of the respondents considered 'no disease' as an indicator of good health. A sizeable proportion of the respondents also mentioned 'no worries' and 'physical fitness' as indicators of good health. A higher proportion of the urban, better educated, younger and economically well-off respondents considered 'no worries' as the indicator of good health.

(iv) A majority of the respondents considered 'incapability of doing daily routine work' as a symptom of illness. A higher proportion of rural, economically weaker and respondents belonging to lower castes considered 'incapability of doing daily routine work' as the most important symptom of illness.

(v) A large majority of the respondents (more than three-fourth of them) were aware of all the three major systems of medicine. A higher proportion of urban, better educated, economically well-off and belonging to upper & middle castes were aware of all the systems of medicine.

(vi) A higher proportion of urban respondents availed of government hospital facilities as compared to the rural
respondents, most of whom depended upon home remedies. A higher proportion of illiterate and economically weaker respondents resorted to home remedies.

(vii) A majority of the respondents (about three-fourth) both from rural and urban areas preferred allopathy for their treatment. Most of the respondents mentioned easy availability of allopathic treatment as the reason for their preference.

(viii) The respondents were asked about their course of action in case the treatment proved ineffective. A higher proportion of the respondents mentioned that they tend to change the doctor. However, a considerable proportion of the rural respondents tended to resort to faith healing or prayers in such a situation.

(ix) For the purpose of taking treatment, the reason mentioned by a higher proportion of the respondents was the 'effectiveness' of the treatment. A higher proportion of the rural, less educated and economically, weaker
respondents mentioned that 'free treatment' is their major consideration while taking treatment.

(x) The pattern of consultation in case of illness indicates that a majority of the respondents consulted their husbands. A considerable proportion of the rural respondents consulted their mother-in-law, prior to treatment.

(xi) The respondents were asked to mention about the persons who were responsible for taking decisions in case of their illness. A majority of the respondents mentioned that their husbands were responsible for such decisions. A higher proportion of the rural respondents mentioned that their mother-in-law take decisions as compared to the urban respondents.

(xii) The respondents were asked to mention about the persons who look after them during illness. A majority of the respondents mentioned that they looked after themselves on their own. However, one-third of the urban respondents mentioned that their husbands looked after them. A higher proportion of rural respondents mentioned that their mother-in-law looked after them.
(xiii) The respondents were asked about the visit of relatives/friends during their illness. A majority of the respondents reported that their relatives visit them during their illness. However, three-fourth of them mentioned that the relatives/friends visited them only as a social obligation. A higher proportion of the rural respondents mentioned that relatives/friends looked after them during illness.

(xiv) A higher proportion of the respondents preferred to seek treatment after waiting and watching the symptoms. However, a higher proportion of rural, less educated, economically weaker and belonging to lower caste respondents tended to delay seeking treatment till the illness becomes acute.

The major findings regarding the socio-psychological correlates of illness behaviour have been summarised below:

(i) A majority of the respondents had traditional attitude regarding perception of illness. The proportion of the respondents having traditional attitude was higher among older, less-educated, economically weaker and respondents belonging to lower castes.
(ii) About two-third of the respondents were not sceptic about modern medicine. A higher proportion of older, less educated, economically weaker and those belonging to lower castes were sceptic about modern medicine.

(iii) A majority of the respondents were also not sceptic about the physicians. However, a higher proportion of older, less educated, economically weaker and belonging to lower castes were sceptic about the physician.

(iv) The respondents were asked to mention whether they perceived any relationship between body and mind in order to define illness. The data indicates that about two-third of the respondents perceived such relationship. However, a higher proportion of younger, better educated, economically well-off and those belonging to upper & middle castes perceived such relationship.

(v) A little more than half of the respondents had a feeling of dependency in illness. However, the attitude of dependency did not have a significant relationship with the independent variables like: age, education, occupation and income.
The data regarding the extent of stress indicates that a little more than half of the respondents had a high level of stress. The extent of stress was higher among urban, better educated, economically well off and those residing in nuclear families.

The main findings about stress management have been summarised in the following paragraphs.

The management of stress by the respondents has been analysed with reference to the six coping strategies adopted by them that is - seeking information; direct action/problem solving; denial/avoidance; reliance on religion; social support and fatalistic acceptance. The distribution of respondents in accordance with these coping strategies and their relationship with independent variables are as follows:

(i) A higher proportion of the urban, younger, better educated and economically well-off respondents gave more preference to seeking information strategy.

(ii) A higher proportion of urban, better educated and economically well-off and respondents from upper &
middle castes gave higher preference to 'direct action/problem solving' strategy.

(iii) A higher proportion of older, less educated and economically weaker respondents gave more preference to 'denial/avoidance' coping strategy.

(iv) A higher proportion of rural, less educated and economically weaker respondents gave more preference to 'reliance on religion' as a coping strategy.

(v) A higher proportion of less educated and economically weaker respondents gave higher preference to 'social support' as a coping strategy.

(vi) A higher proportion of rural, older, less educated and economically weaker respondents gave more preference to 'fatalistic acceptance' as a coping strategy.

An attempt has also been made in the present study to find out the folk notions about illness and the role of ethnomedicine. The major findings in this context have been summarized below:

(i) A majority of the respondents had a belief in evil spirits.

The proportion of the respondents holding such beliefs
was higher among the less educated, economically weaker and those belonging to lower castes.

(ii) A little more than one-third of the respondents mentioned that they visit faith-healers in case of illness. A higher proportion of rural, less educated, poorer and those belonging to lower castes visited the faith-healers.

(iii) Based on field observations and informal interviews, it was revealed that a considerable proportion of people both from rural and urban areas visit many sacred places and shrines for the treatment of their illness. A sizeable number of rural people also go to quacks for getting treatment.

(iv) In urban areas a considerable proportion of people visit the astrologers and ask them for some remedies to cure illness like wearing stones, or performing religious rituals. Many of them also resort to prayers and other religious activities like fasting, path of sukhmani sahib, jagrata and sukh sukhna. Moreover, the lower strata also believes in practices like tuna, wearing taviz and thread.
In the rural areas the visit to shrines and syanas is quite common. There is a widespread belief that such visits can cure them quite effectively. However, such beliefs are prevalent to a greater extent among the less educated and economically weaker strata of the rural population.

Based on the findings of the present study enumerated above the following conclusions can be drawn. The data clearly indicates a differential pattern of perception of illness among rural and urban women. The findings confirm the hypothesis that rural women overlook minor ailments as illness as compared to the urban women.

The analysis of data has revealed that the perception of illness and help seeking behaviour is significantly influenced by socio-economic factors like age, education, occupation and income. These aspects are also significantly related to psychological factors like beliefs and attitudes. Thus the hypothesis regarding the role of socio-economic and socio-psychological factors in illness-behaviour has been corroborated by the findings of the present study.
The findings about awareness and utilization of modern medicine have revealed that the urban, well educated, economically well-off and belonging to upper & middle castes are more aware of all systems of medicine and utilize modern systems of medicine to a greater extent. Thus the hypothesis in this context has been confirmed by the findings of the present study. These findings are inconformity with some other studies like Gould (1957), Bhatia et al (1975), Bhardwaj (1975).

The data regarding the extent of stress reveals that it is higher among urban women as compared to the rural women. The level of stress has also been found higher among better educated, economically well-off and those respondents residing in the nuclear families.

The hypothesis regarding the greater role of social support as a strategy for coping with stress in rural areas has not been substantiated by the findings of the present study. No significant difference has been found in rural and urban areas in this context.

The findings regarding folk notions about illness have shown that they vary according to place of residence, education
and economic status. They are prevalent to a greater extent in the rural areas and among less educated and economically weaker sections of the society. Thus the hypothesis in this context has been confirmed by the findings of the present study. Similar findings have been reported by a study conducted by Jaggi (1981). The findings of the present study have also indicated an important role of faith-healers in curing diseases both in rural and urban areas. However, the role of faith-healers is more pronounced in rural areas as compared to the urban areas. The hypothesis in this context, therefore, has been substantiated by the present study.