CHAPTER - I

INTRODUCTION

1.1 STATEMENT OF THE RESEARCH PROBLEM:

The period since the beginning of twentieth century and especially since 1960’s is known as the period of ‘health transition’. As a result of this health transition, global life expectancy at birth has increased and a change in morbidity has occurred. Acute infectious disease now account for less of morbidity burden, while chronic disease like cancer, heart problem, stroke account for more, in most of the countries. Although this health transition has occurred in all regions of the world, yet a wide gulf between the developed and developing world still exists, when a comparison is made regarding the standards of health and well being. The most common explanation for this disparity has been attributed to the availability and utilization of modern medical system in different countries.
In the developed countries, allopathy is the major system of medicine. Other systems are followed only by a few people (Stacey, 1988). An average westerner's view of health and illness is likely to be conditioned by the tenants of allopathy. But in developing countries the situation is entirely different. There is medical pluralism or existence of several distinct therapeutic systems in a single cultural setting (Leslie, 1978).

Cross-cultural data regarding illness behaviour from developing countries indicate that the perceived efficacy of biomedicine and the decision to use biomedical services are highly variable and are influenced by a number of intervening factors. Kloos et al (1987) in their study of illness behaviour in Ethiopia observed that the traditional medicine was considered to be as effective as modern medicine in curing various types of illnesses. In industrial East Asia, Locke (1980) found that traditional medicine was viewed as more effective than modern medicine for certain diseases, usually chronic disease. Ho et al (1984) in their research in Singapore observed that effectiveness was cited as major reason for choosing traditional treatment by majority of the patients.
Many other reasons also mediate while making a choice between traditional and modern medicine. Young (1981) in his study of a Mexican village found that there were three considerations regarding decision not to use a physician: (i) pre-existing preference for folk treatment (ii) access problems like lack of money or transportation and (iii) experience of failure to get cured with the help of modern medicine. The distance to reach a allopathic doctor in contrast to traditional healers also represents a constraint to use modern medicine (Kloos et al, 1986). The perceived cause of a disease determines the choice between traditional healers and modern medicine. For diseases having a natural cause, bio-medicine is preferred whereas, for diseases having a supernatural cause, traditional healers are preferred (Fosu, 1981). The choice of a healer also varies in relation to sex, age, education, occupation and residence (Rahaman et al, 1982; McCormack, 1988; Das Gupta, 1989).

In India too, different systems of health care co-exist in bitter competition with one another without producing any dent in the overall situation (ICSSR and ICMR, 1981). There is plethora of health traditions. Most of the curative and some
preventive services reach the community through home remedies, traditional healers and indigenous practitioners (Marwah et al, 1975).

There exists a wrong notion that standard of health and well being are low due to the lack of medical care or variations in health levels are due to the availability of medical care. India perhaps has adequate health care infrastructure available. The Government of India has initiated a number of programmes to control and eradicate communicable and epidemic diseases and to prevent health hazards to improve the standards of health of people. There are about 8 lakh hospital beds and 10 lakh qualified medical practitioners, that is 85 beds and 110 doctors per lakh population (Duggal et al, 1985). Numerous Primary Health Care Centres (PHCs) were made available in rural areas (Sinha, 1990; WHO, 1992). In addition to this formal sector, a large scale informal sector comprising caste based, hereditary and unqualified practitioners of various kinds are also available in India. Yet the health situation depicts a dismal picture.

Some people may not have access to health care when in need, yet others may not seek medical care because of various
socio-economic and cultural reasons. And further those who want to seek help, feel uncertain as to what type of treatment can cure their illness, leading them to consult both traditional and bio-medical practitioners.

An overview of the above discussion reveals that in medically pluralistic societies of developing world, like India, illness-behaviour is quite a complex phenomenon. It varies depending upon the norms, values, beliefs, attitudes and social taboos. The mechanisms evolved by the people to manage illness, the understanding of the causes for under-utilization of available health facilities are some of the questions to which little attention has been paid so far. The question of what influences a person for perceiving illness, taking any step for the cure of illness, is of great significance to the planners, implementers and organizers of health care delivery systems and also for developing certain models of health and illness-behaviour specifically relevant for developing countries. An understanding of illness behaviour can contribute both in terms of providing better medical care and making that care accessible to those who need it the most.
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.

The gross neglect starts with the definition of women’s health care needs and their low status in society. From the biological perspective woman is seen as the product and prisoner of her reproductive system. In the long history of health provisions in India, women's health has been perceived by planners primarily in the context of motherhood; little else is available to women to address their general and other gender specific health care needs.

A majority of women in India suffer from poor health but avail of less health care resources. Women in general and especially those living in rural areas, have never voiced their
concern over their health needs. They are often confronted with numerous socio-cultural factors which negatively encroach upon their physical well being and access to appropriate health care services.

In Indian context where the status of women is quite low, issues related to medical care are rather more sensitive. The process of illness experience among them is complex and multidimensional. Chatterjee (1988) identified four arenas which determine women's access to and utilization of health services: need, permission, ability and availability. Need is related to the extent of ill-health among women. Permission refers to the familial, communal and societal norms that dictate whether a woman can or cannot seek health services. Permission is very much a function of women's social status. Ability is the extent to which women can approach health services, depending mostly on their economic status. The availability refers to location, nature and quality of services and associated behaviour may not be consistent with existing health problems or need.
Although a number of studies exist related to women health in India, yet there seems to be lack of studies related to women illness behaviour and factors inhibiting utilization of the available modern health care. More studies like that of Chatterjee (ibid) are required to interpret the behaviour of women in illness and socio-economic and psychological factors related to illness behaviour. An attempt in this direction has been made in the present study.

1.2 Conceptual Framework:

The concept of health and illness which are relative and culture specific, assume different meanings sometimes even in the same society. So for a comprehensive understanding, both the concepts must be distinguished from one another. Health, according to WHO constitution is "a state of complete physical, social and mental well being and not merely the absence of disease and infirmity". According to Bisht (1985) "Health is perceived as a multidimensional process involving the well being of the whole person in the context of the environment. The perfect functioning approach to health conceptualizes health; biologically - as a state in which every cell and every organ is
functioning at optimum capacity and in perfect harmony with the rest of the body; psychologically - as a state in which the individual feels a sense of subjective well-being and of mastery over his environment; socially - as a state in which the individual's capacities for participation in the social system are optimal." In other words the maintenance of health encompasses treatment of physical diseases, coping mechanisms to deal with psychological stress, prevention through changes in the environment, promotion of healthy life styles and general well-being.

By disease, is meant an objective phenomenon characterized by altered functioning of the body as a biological organism; whereas by illness is meant a subjective phenomenon in which individuals perceive themselves as 'not feeling well' and therefore tend to modify their normal behaviour. To say that a person is ill implies that the consequences of such a state transcends not merely the biological and physical consequences of organic malfunction but also affect his social life in important ways (Field, 1976). Illness is a subjective feeling about health related problems (Fitzpatrick, 1986).
The concept of health may be regarded as a situational concept. One may be in health just now and then after a very short span of time, the same person may become ill. Health is reflected in the normal behaviour of an individual while illness suggests an abnormal state of being. Dingwall (1976) opines that in view of the unobtrusive nature of normality it is easy to identify 'abnormal' or in other words 'illness behaviour'.

Everyone can be expected to be ill sometimes in life, since no one is immune from all types of illness and disorders. Illness conditions are ever present facts of everyday life. However, a distinction can be made straightway between the illness conditions and the possible behavioural consequences of these conditions. The medical sociologists concern is with the behaviour concominants of illness conditions and with the relationship between the two (Robinson, 1971). Mechanic labeled this concern as the study of 'illness behaviour'. Mechanic and volcart (1961) described illness behaviour as "the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction".
According to Kasl and Cobb (1966) "Illness behaviour is the activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it." According to Rosenstock and Kirscht (1979) "the concept of illness behaviour includes three different behavioural components (i) preventive health behaviour; the activities undertaken by individuals who believe themselves to be healthy for the purpose of preventing disease, (ii) diagnosis seeking; activities undertaken by the individuals who feel ill for the purpose of defining their illness and discovering a suitable remedy and (iii) treatment seeking; the activities undertaken by those who consider themselves ill for the purpose of getting well". They have also noted that preventive health behaviour seems more common among younger than older, among women than men, and among people who are better educated and have higher incomes. Further, even if these preventive services like immunizations are free of charge, the poor still do not take advantage of these. Almost same set of variables is associated with diagnosis seeking behaviour. Financial resources, availability of health
care and degree of perceived stress are the main determining factors to seek medical care.

Mechanic (1976) and Rosenstock & Kirscht (1979) have identified eight variables which are important in the process of deciding to become ill. (i) characteristics of symptoms (ii) ability to recognize the symptoms (iii) severity of the symptoms (iv) extent of disability associated with the symptoms (v) degree of expected stoicism in the cultural background of the person (vi) extent of medical information available (vii) availability and accessibility of help (viii) acceptability of medical help in the cultural milieu.

It has been found that there are socio-cultural differences in attitude towards illness. Persons from upper social classes are more likely than persons from lower classes to perceive themselves as ill and to seek help (Koos, 1954). Zborowski (1969) and Zola (1966, 1972) found cultural differences in attitudes towards pain, towards readiness to acknowledge symptoms, towards interpreting symptoms as a sign of illness and toward seeking help. Berki and Kobashigawa (1976) found
that social class (income and education) has pervasive effects on illness behaviour.

Illness symptoms are differentially perceived, evaluated and acted upon by different kinds of people and in different social situations whether because of earlier experiences with illness, differential training in respect of symptoms or differential biological sensivities. Some people make light of symptoms and avoid seeking medical help, others respond to little pain and discomfort by seeking medical help and relieving themselves from work and other obligations and becoming dependent on others. The recognition of a symptom, while certainly a necessary condition to motivate help seeking behaviour is not itself sufficient for a definition of an illness. Some illnesses such as appendicitis may have obvious symptoms while other illness such as early stages of cancer may not. There are also cases who despite symptoms delay health care like cancer patients because of their anxiety about learning the truth and to confront what it means to have cancer (Becker and Maiman, 1975). Moreover, in societies where being
ill is considered stigmatizing, people hide their symptoms as long as possible.

The domain of health and illness is full of contrasts for each society has evolved its own mechanisms to cope with the problems of health and illness and the ways in which these have been defined. There is considerable evidence to prove that illness behaviour is determined by the culture which ranges from doing nothing to prompt and extensive use of health care. While the symptoms of a disease can affect everyone but its perception, interpretation and treatment differ with age, sex, class, ethnicity, place of residence and level of education.

Cockerham (1978) states that regardless of a society's level of medical knowledge and technology, the structure of medical science still functions within the context of values, attitudes and beliefs of the people comprising that society.

1.3 STRESS AND ILLNESS BEHAVIOUR:

The fact that illness is stressful and that it may further accentuate life difficulties requires no elaboration. But what is interesting to a behavioural scientist, is the tremendous variability in response to the same illness condition. 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 (Mechanic, 1978).

Mechanic and Volcart (1961) observed that there was a direct relationship between stress and illness in general. The concept of stress has not been adequately or precisely defined in the behavioural sciences. In general, it seems to signify a state of affairs characterised by anxiety, discomfort, emotional tension and difficulty in adjustment.

In the present research an attempt has been made to see the relative influence of stress on the illness behaviour. Stress was operationally defined as the subject's report of botheration by loneliness, insomnia, difficulty in relaxing, fear of financial burden, dependency and fear of hospitalization.

1.4 STRESS MANAGEMENT:
The literal meaning of stress management is 'specific programmes for those in need and in developing their coping skills'. In India there are hardly any programmes for helping ill people to manage their illness related stress. A few stress
management programmes might be available in big cities but they deal with general stress and not specifically with illness related stress. However, the present study is concerned with illness related stress only. Stress management in this country is mainly at the individual level, whereby individuals take recourse to certain activities which can help them in the management of their illness related stress. Accordingly, in the present study the term 'stress management' has been operationally defined to refer to the coping strategies adopted by the respondents to overcome their stress. Thus, the term 'stress coping' has been used throughout in the text of this thesis, as the term 'stress coping' has been used more oftenly in the literature on illness related stress.

Each individual develops skills of adaptation in dealing with the physical and social crisis so that he/she and can maintain a degree of equilibrium in the face of adversity. The forms of behaviour which reflect the kind of resistance to problematic situations are termed 'coping'. They are the things that people do to avoid being harmed by life strains (Pearlin and Schooler, 1978).
Freedman et al (1975) described coping as, "conscious and unconscious ways of dealing with stress without changing one's goal". According to Lazarus and Folkman (1984) "Coping is the process of managing demands (external or internal) that are appraised as taxing or exceeding the resources of the person". "Coping consists of efforts both action-oriented and intrapsychic to manage (i.e. master, tolerate, reduce, minimize) environmental and internal demands and conflicts among them". (Lazarus and Launcier, 1978).

1.5 REVIEW OF LITERATURE:

The review of literature has been categorized broadly into two sections:-

(i) Theoretical perspectives and models.

(ii) Empirical studies.

(i) Theoretical Perspectives and Models:

The present study falls within the field of medical sociology. It is socio-psychological in its approach because it is clear that in the study of response to illness or illness behaviour a socio-psychological orientation centered upon the articulation of the person and the socio-cultural system is required. As a
result of growing disillusionment with modern medicine a new trend has emerged accepting the fact that health is not just a medical but also a social-psychological concern. From this viewpoint, the emphasis is laid not on the medical reality of a disease but the subjective experience of an individual who considers himself ill.

Medical sociology as a sub-discipline is considered as of recent origin in the sociological curriculum. It is after the contribution of Parsons (1951) with an analysis of the role of motivation in illness and the sick role that medical sociology emerged as a specific sub-field. But inspite of the contribution of Parsons, medical sociology did not achieve any significant development until the 1960's. After that it was felt that sociology can make an important contribution to the medical understanding of the social causes of disease, can provide an insight into the patients' experience of illness and finally it can provide a new perspective on the role of bureaucracy in medical health-care system.

The first sociological perspective dealing with analysis of health and illness was that of functionalism. This approach was
concerned with the importance of health for the functioning of the social system as a whole. Functionalist viewpoint assumes that society usually operates in a smooth manner and illness is seen as a dysfunction which can disrupt the flow of this normal state of being. The prominent functionalist, Parsons developed the notion of the ‘sick role’ in order to describe the patterns of behaviour which the sick persons adopt in order to minimize the disruptive impact of illness. According to Parsons people learn the sick role through socialization and enact it - with the cooperation of others - when they fall ill. Parson's sick role model consists of two rights and two obligations; the right to be exempt from normal role obligations and the right not to be held responsible for one's condition; the obligation to get well and the obligation to seek competent technical help for one's condition.

During 1960-70 another perspective named conflict perspective emerged. This perspective emphasized that, despite the claim that capitalist society had a stake in recognizing and promoting positive health, a great deal of ill health remains unrecognized. Various studies (Wadsworth et al, 1971; Dunnell & Cartwright, 1972; Scambler et al, 1981) have demonstrated
that it is very common for individuals to experience symptoms and illnesses. However, only a very small proportion of such symptoms is presented to doctors and therefore officially unrecognised. Conflict was also seen in doctor-patient relationship. But due to lack of sufficient empirical evidence to support conflict perspective, an alternative approach based on interactionist perspective developed alongside conflict theory. Interactionist perspective emphasized the significance and meaning of behaviour rather than its causation (Burns, 1992). Many sociologists have applied this approach to understand how people experience being ill, how they react and adjust to news about a serious illness. Corbin and Strauss (1985), Jobling (1988), Kelly (1992) and Williams (1993) have investigated how chronically ill individuals manage their illnesses within the overall context of their lives.

Although the interactionist perspective is considered quite significant even today, two new perspectives 'feminism' and 'post modernism' have also been developed. Initially, much of feminist research in the health field was preoccupied with reproductive health, but recently it has tried to expand its scope
to cover various aspects of women’s health. Post modernism perspective is based on the nature of health risks including those produced by medicine itself, the importance of gender, age and ethnicity alongside social class and the impact of consumer culture on health. Thus, making sense of the illness or illness behaviour in a changing world is very much required as people (layman or professional) try to find pathways through the hazardous terrain of modern life.

From whatever sources and in whatever combinations, social, cultural and psychological factors all play some part in influencing the way sick people define their situation and hence their decision making process. For a better understanding of differences in patterns of illness behaviour, a brief review of the important existing models related to illness behaviour is necessary.

The sick role model developed by Parsons has been criticized on the ground that this model reveals only how the ill person is an integral part of a larger social context but it is unable to explain the experience of illness. Secondly, it cannot be applied universally. It fails to explain those illnesses which
do not lead to a suspension of normal activity such as
pregnancy, alcoholism, certain disabilities and some chronic
diseases. After Parson’s sick role model, another theoretical
framework was put forth by Becker (1963) which is known as
‘Labelling Theory’. It is based on the concept that what is
regarded as deviant behaviour by one person or social group
may not be regarded so by other persons or social groups. In
the process of seeking medical care two persons having same
symptoms may behave differently. However, this framework is
considered to have relevance for analysing only the medical care
seeking behaviour but does not provide a comprehensive
understanding of illness behaviour.

Rosenstock’s (1966) ‘Health belief model’ is another
important theoretical framework. This model presents decisions
to seek medical attention as an outcome of the interaction of
two variables - (i) sufferer’s psychological state of readiness to
take action, which is dependent upon his perception of his
condition and (ii) the extent to which the individual thinks that
any particular action is likely to be beneficial in reducing the
threat of illness which depends upon his views of the benefits of
any given service and possible barriers to its use. But usefulness of this framework is limited because it is applicable mostly to preventive health. Rosenstock’s model has been presented below.

Perceived susceptibility  
Readiness to act

Perceived seriousness of outcome

Perceived availability of action  
Assessment of benefit of action  
Action

Triggering factor

Source: Adapted from Dingwall, Robert (1976) Aspects of Illness

Mechanic (1962) in his model highlighted the influence of stress and inclination to adopt sick role. According to him stress explains why some action takes place and readiness to adopt sick role explains what action takes place. Individual variations to experience stress have been attributed to variations in the use of medical services. Perceived symptomatology is used to mention perception about seriousness of symptoms.
Mechanic’s model

Perceived stress → Coping responses → Action (reporting sick)

Perceived symptomatology → Inclination to adopt the sick role

Source: Adapted from Dingwall, Robert (1976) Aspects of Illness

Mechanic (1968) abdicated his earlier model and recommended ten heterogenous variables associated with illness behaviour. The variables are: the visibility and recognisability of deviant signs and symptoms, the perceived seriousness of the symptoms, the extent to which symptoms disrupt family, work and social activities, the frequency of occurrence, tolerance threshold of others, available information and cultural assumption, basic psychological needs leading to psychological processes, needs competing for attention with
response to illness, competing interpretations and availability of treatment resources.

According to Kosa and Robertson's (1969) model, illness episode is divided into four parts: (i) the assessment of a disturbance in, or of a threat to, the usual functioning of physiological-psychological health (ii) the arousal of anxiety by such an incident (iii) the application of one's general medical knowledge to the given disturbance (iv) the performance of manipulative actions for removing the anxiety and the disturbance based on the illness distribution. In this model, anxiety explains why some action takes place and application of general medical knowledge explains what action takes place.

Zola (1965, 1966) views that the decision to take action to seek help at any particular occasion, does not seem to be related in any systematic fashion to the severity of the symptoms. He identified five types of triggers which provoke patient's decision to seek medical aid. These are: (i) the occurrence of an interpersonal crisis (ii) perceived interference with social or personal relations (iii) the sanctioning of the sufferer's condition by others (iv) perceived interference with
vocational or physical activity (v) a sudden change in the normal symptomatology.

Suchman (1965) emphasized social, cultural as well as psychological factors for explaining differential reactions to illness. He identified a series of stages through which an individual passes in order to achieve recovery from illness. These stages are: (i) the symptom experience (ii) the assumption of the sick role (iii) medical care contact (iv) the dependent patient role (v) recovery and rehabilitation. Dingwal (1976) however, criticised Suchman's conceptualization on the ground that it is too rational of someone who is sick to consult doctor, receive treatment and recover. Moreover it deals with acute illness rather than chronic.

Fabrega (1973) made an attempt to extend the scope of Suchman's stages of illness behaviour and provided a greater precision for predicting behaviour. He extended the number of stages to nine and focused on decision making which takes into account judgements by the individual as to the degree of 'danger' implied by symptoms, weighing costs against
anticipated benefits and choice of behaviour based on previous experience of illness.

A general classification such as the stages of illness experience provides a useful framework for purposes of description but it does not explain nor takes into account all the variations that occur. We may also note that not every illness experience will involve all the stages and secondly, entry into and exist from each stage involves decision making on the part of the sick person and other people. The sociological significance of this decision making lies not in the behavioural consequences but also in observing the combinations of factors which influence the decisions.

Becker (1974) developed a conceptual model of human behaviour in response to illness which is not dependent upon stages in the form of 'health belief model'. This model has been expanded to include socio-cultural and environmental variables in predicting illness behaviour as well as health behaviour.
Health Belief Model

The elements of the health belief model show that the dependent variable - the probability that an individual would take appropriate action either to prevent illness or to recover health - depends upon individual perceptions of threat as these are influenced by a host of modifying factors. Considerable

Source: Adapted from Coe, R.M. (1978) Sociology of Medicine
empirical support for the health belief model has accumulated which indicates its ability to predict behaviour in response to illness better than descriptive 'stage' models or other decision - theory models.

Leventhal et al (1985) defined illness cognitions as patients’ own implicit commonsense beliefs about their illness. They proposed that these cognitions provide patients with a framework for (i) coping with and (ii) understanding their illness and tell them what to look out for if they are becoming ill. They identified five cognitive dimensions of these beliefs - identity i.e. the label given to the illness; the perceived cause of illness, timeline i.e. how long the illness will last, consequences, curability and controllability. Leventhal incorporated his model of illness cognitions into his self regulatory model of illness behaviour. This model is based upon problem solving models and suggests that illness is dealt with by individuals in the same manner as other problems.
The major theoretical perspectives on illness behaviour have been described in the preceding paragraphs. A critical appraisal of various models reveals that these models emphasize some aspects of illness behaviour while they ignore some others and moreover these models may be suitable for developed countries only.
For the purpose of present research work the researcher has concentrated on a model especially developed for developing countries by Crisman (1977).

**Illness Behaviour Model**

- Symptom definition
- Adherence/compliance
- Treatment Action
  - Self care
  - Lay referral
- Traditional care
- Biomedical care

*Illness behaviour encompasses many purposeful actions by people confronting illness. Most attention to date has been given to the study of the interaction of patients with bio-medical practitioners (solid line). However, such a focus is too narrow; many other aspects of illness behaviour are also relevant; especially in the developing world (dotted lines).*

**Source:** Adapted from Matcha, D.A. (2001) Readings in Medical Sociology.
As shown in the figure given on the previous page, help seeking begins with symptom definition or an evaluation of bodily problems. Then a treatment action plan is devised to respond to the symptoms. Treatment action may involve any combination of self care, family care, care from folk and professional healers. The degree to which this plan is carried out by the ill person and his/her family is as adherence or compliance. Adherence is influenced by an ongoing evaluation of outcome. Both symptom definition and treatment action are affected by lay consultation and referral and by the social networks in which the individual participates.

(ii) **Empirical Studies**

(a) **Perception of Illness**

The empirical studies have been reviewed in accordance with their contents and accordingly this section has been sub-divided into six sub-sections. Some of the studies which have empirically examined the notions of health and illness are those of Opler (1963), Hasan (1967), Dhillon & Srivastava (1972), Rizvi (1991), Jatinder (2001).
Opler (1963) maintains that the idea of harmony and balance finds a central position in the Hindu view of health and illness. He listed the following as the most commonly believed causes of various diseases: malfunctioning or imbalance of three humors - faulty diet, lack of harmony with the supernatural world and inappropriate behaviour in physical, social and economic matters.

Hasan (1967) revealed that illness primarily means 'not feeling well'. So a number of maladies were not recognized as illness because they were not accompanied by subjective feelings of discomfort. People usually do not care for minor ailments.

Dhillon and Srivastava (1972) in their study of Delhi found that people consider illness as an episode only if it is accompanied either with fever or pain or a person is unable to take care of himself. It was also reported that allopathic system was most popular in both the senses of preference as well as practically.

Rizvi (1991) in his study of Jaunsaris of Himalayan Region also found that for Jaunsaris illness means 'not feeling well' and
health means proper functioning of the body. The Jaunsarís believed that except for tuberculosis, syphilis and boils other diseases are due to supernatural causes and their cure was to appease the gods with prayers, vows, holy baths and sacrifices.

Jatinder (2001) in her doctoral dissertation noted that Jat Sikh peasantry in Punjab identify disease normally in form of ‘tap’ (fever) which may be a symptom of a disease or a disease in itself. In terms of causation the Jat Sikhs classified diseases into 3 categories - Bamari as naturally caused, Kasar - a supernaturally caused and Jhora - as profound grief caused by a social setback.

(b) Beliefs Regarding Etiology of Illness and Cure

Though it is difficult to separate studies focussed on notions of illness and health from studies focussed on causes of illness, yet some studies which have primarily focussed on beliefs about causation have been reviewed in this section.

Valunjkar and Chaturvedi (1967) have observed the religious aspects of concept of disease and its causation and stated that basic principles of Hinduism i.e. 'karma' and 're-
birth' play a vital role. Health and illness is perceived as reward and punishment for one's action in previous birth.

Kakar (1977) in his in-depth study of Punjabi society regarding beliefs concerning etiology of selected diseases i.e. smallpox, chickenpox and measles found that people attributed smallpox, to the 'wrath of greater goddess' or 'barri mai' and chickenpox and measles were ascribed to 'wrath of smaller goddess' or 'chhoti mai'.

Ojha (1986) also studied causal beliefs about five major common ailments namely typhoid, tuberculosis, epilepsy, smallpox and dysentery and found that generally 'Karma' was believed as responsible for ailments. Naidu (1986) also observed faith in 'Karma' as a causal explanation for suffering.

Pokarna (1991) in his study of rural Rajasthan reveals that people consider themselves sick only when they stop daily work and confined to bed. It is generally believed that people fall ill due to sins (papa) and faults (dosha) either in their present life or in their previous life.

Dalal (2000) undertook a comparative analysis of the causal attributions made by orthopedic, cancer, tuberculosis,
heart and surgical patients and observed that patients frequently blamed themselves and cosmic factors (fate, karma and God) for their health problems. These causal beliefs further affected the treatment related decisions made by the patients.

An overview of the above studies reveals that normally people perceive themselves ill when they had certain feelings of discomfort in form of pain or fever; otherwise they do not consider themselves as ill. Religious beliefs such as bad deeds in the past and some supernatural powers are considered as the major causative factors in illness.

(c) Patterns of Help Seeking

Khare (1963) on the basis of his study of a U.P. village revealed that duration of illness is an important criterion for moving towards supernatural treatment.

Zola (1965) while studying the illness behaviour of different ethnic groups explains that taking action or seeking medical aid is not related in any systematic manner, to the severity of symptoms. Instead, the decision to seek medical help, is to be explained at a particular point of time.
Dubey (1967) in his study of a village in Andhra Pradesh claimed that although indigenous herbs and magico religious practices are still continued in treatment of diseases, the efficiency and utility of allopathic drugs and injection have greatly changed the attitudes of people towards modern medicine.

Leslie (1968) mentions that the physician who does not try to understand the cultural and intellectual level of village folk and does not respect cultural differences proves to be less successful.

Ahluwalia (1974) in her article 'Sociology of Medicine in India' has highlighted the importance of traditional and modern systems of medicine in India. She maintains that there is immense heterogeneity in medical beliefs and practices all over the country.

Mehta (1982) in his paper "Some Considerations of Health and Medical Delivery System" claims that the indigenous medicine practitioners are better accepted in the villages than the physicians provided at PHCs due to social, cultural, psychological and situational reasons.
Kaushal (1986) in her study of 'Urban Chandigarh' showed varying patterns of seeking treatment. Although people do not attach supernatural causes to illness, yet they believe in propitiating gods and goddesses to ward off diseases.

Joshi (1988) in his study of central Himalayas found that for psychic and emotional problems people consult traditional faith healers and for clear physical symptoms people consulted medical doctor.

Kakar (1991) in his in-depth analysis of mystical, charismatic and divine images of the guru in Indian Society concluded that the guru - disciple relationship is more effective than the therapist - client relationship in alleviating illness.

Desjarlais (1994) in his study of Tibetan Buddhist found that villagers visit a hospital to take aspirin for headache and may consult a shaman (known as Bombo) to get cure of supernatural causes.

(d) **Differential Use of Medical Care**

Nathanson (1975) notes that women report symptoms of both physical and mental illness and utilize medical services for these conditions at higher rates than men.
Dutton (1978) found that affluent visit physicians for preventive care while the poor visit primarily for the treatment of overt symptoms of illness.

Yasudian (1979) in his study of Madras population found that various health services were utilized better by high middle classes as compared to lower classes. Moreover, private health services were utilized by high and middle class people whereas lower class people utilized public health centres.

Trakroo (1980) revealed that the respondents having clear perception of the health concept and a concern for their well being belong to the upper strata and they are more likely to take early and accurate decision in order to seek medical care, preferably the allopathic system of medicine.

Sumaraj (1991) in her study of Kerala women has described variations in the use of medical care on the basis of place of residence, income and education.

The above review of studies indicates that though many empirical studies have been carried out in India from time to time but there is dearth of studies focusing on women health and women illness behaviour and experience. Moreover, there is
a shift in nature of illnesses as a result of advancement in technology; therefore more studies are needed to seek knowledge regarding beliefs related to present day diseases like hypertension, asthma, anemia and other specific health problems of women.

(e) Illness Related Stress

In India there are not many studies which have focused on stress as frequent reaction to ill health. Further, most of these studies have been of a co-relational nature in which the causal linkages could be bidirectional. The stress-illness relationship envisages that stress affects illness - behaviour in the form of using more health services by people under stress than people who are not under stress (Gortmaker et al, 1982). Hospitalization itself adds to the stress of illness. Kuruvilla and Singh (1985), Dalal (1994) have studied stress as a result of hospitalization.

Only a few studies have focused on stress in terms of depression and anxiety as reaction to ill health. Further, these studies deal with stress in relation to chronic diseases like cancer, intractable pain and diabetes.

(f) **Stress Coping**

Kennedy (1973) has identified seven types of adaptive behaviour in which society engages in order to cope with illness and other health hazards. These behaviours are (i) escape behaviour (ii) precautionary behaviour (iii) emergency response (iv) curative (v) rehabilitative (vi) scientific research to deal with illness and (vii) acceptance behaviour.

Mandelbaum (1981) notes that in coping with illness, many people use secular means within the command of man and some means to power beyond man.

Dalal and Pande (1988) have found that cultural beliefs may not play an important role in cases of acute and life threatening diseases where the immediate goal is to survive. However, beliefs about disease play an important role in coping and recovery.
Kohli (1994) studied the role of beliefs in cervical cancer patients and observed that patients consistently held God's will, fate and ‘karamphala’ as responsible for their illness and God and proper treatment were viewed as contributing most to their recovery.

Agarwal, et al (1994) found positive life orientation as an important predictor of recovery from myocardial infarction. But the findings of these studies are constrained by the fact that the respondents were primarily hospital patients and with some life threatening illness. It is possible that the people staying at home and not having any specific health problem may have different beliefs and coping styles for recovery from stress related to their illness.

With the persuasive evidence that being ill and seeking medical help are stressful, research studies focusing on coping with illness-related stress are required so that some significant changes in certain aspects of medical care system can be made.
1.6 OBJECTIVES OF THE STUDY:

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 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.
1.7 HYPOTHESES:

The following hypotheses have been put to test in the 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 likely 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.
The role of religion and faith healers is likely to be more pronounced in rural areas as compared to urban areas.

1.8 METHODOLOGY:

For the present study Patiala District of Punjab was selected purposively. The reason for selecting this district was the convenience of the researcher. Moreover it was assumed that the illness behaviour of women will be the same all over the Malwa region of Punjab and thus it will not make much difference whether one district is selected for the study or the other.

Sampling Design:

For the purpose of the study, a stratified random sample based on age categories of females that is 18-44 years and above 44 years was selected from the voter lists of the selected villages and urban localities. This classification has been adopted, keeping in mind the actual reproductive span of a woman's life. It was decided to interview only those females who were currently ill or those who experienced illness during the last three months. Further, the females whose duration of illness was less than five days were also excluded from the
sample, in order to get authentic information regarding stress
due to illness and process of decision making for treatment
action. A preliminary survey was conducted among the
randomly selected females and they were asked about their
health status. Most of the selected females reported that they
were ill or had been ill during the last three months. However,
there were a few cases in both rural and urban areas who had
not fallen ill during the last three months. In order to replace
these females in the sample, the snow balling technique was
adopted and the women selected randomly were asked to give
names of some of their neighbour or acquaintance or other
female member in the family who was ill or had fallen ill during
last three months. Accordingly the ill person was replaced by
the earlier selected female. However, there were only a few such
cases.

(a) Rural Sample:

For selecting rural sample, one tehsil of Patiala district
was randomly selected and further two villages were also
selected randomly with reference to their distance from any
town/city. One village which was within 15 kilometers and the
other which was beyond 15 kilometers from a town/city was selected. The sample was drawn according to the sampling design mentioned above. Although it was decided to take a sample of 75 women from each village but the researcher could interview only 64 and 67 (total 131) women from each of the villages respectively, the reason being non-availability of eligible respondents.

(b) Urban Sample:

A list of localities in Patiala city was prepared keeping in view the socio-economic strata who reside in them. The assumption was that higher status families generally live in modern planned colonies and lower & middle class families live in old unplanned colonies. Accordingly, a random sample of 75 women from modern colonies comprising Model Town, Punjabi Bagh and Civil Lines was selected and a sample of 75 women was drawn from old colonies comprising Dhaka Colony, Arya Samaj, Sarhandi Bazar.

All the selected respondents were interviewed with the help of an interview schedule. Moreover, the life histories of some respondents were also collected in order to probe deeper
into the views and actions of some typical cases. The interview schedule comprises socio-economic background of the respondents, concepts of health and illness (respondents' perceptions), paramid health status of respondents, their illness, awareness of different medical systems, their pattern of help seeking, their beliefs and attitudes, social support, the extent of stress due to illness and modes of coping with stress. The collected data has been analysed with the help of statistical techniques.

Additional information wherever possible was collected through informal interviews. The researcher interviewed some other residents in addition to the selected respondents in order to get in-depth information and clarification on particular issues.

1.9 SIGNIFICANCE OF THE STUDY:

Generally people tend to view health problems from the perspective of their own particular societies and cultures. They usually respond to the threat of diseases in predictable ways. Thus knowledge about norms, values, beliefs and life styles or in other words understanding of human behaviour in illness is
of much interest to those responsible for delivery of medical care and health services. The image of the people about different systems - traditional and modern - of medical care and availability of facilities would influence the pattern of treatment sought. There is need to assess the physical environment (e.g. urban Vs rural) and patterns of human relationship (e.g. family, community) to examine the socio-cultural influences on the parameters of health and disease.

Although in the past, some attempts have been made to study people's perception of illness, not much authentic information is available about illness behaviour and stress coping among women in India. Thus the present study is an attempt to explore the role of socio-economic and socio-psychological factors in the perception of illness and the help seeking behaviour of women residing in rural and urban areas.