

Awareness and Perception of Health Issues Among Rural Women

V. Selvam, D. Ashok, P. Pratheepkanth,

Abstract: According to a United Nations report on healthcare, about 75% of the healthcare infrastructure, including medical experts and doctors are concentrated in urban areas in India even though only 27% of the population lives in urban parts. India meets the global average in the number of doctors, but 74% of its doctors cater to a third of the urban population, or no more than 442 million people, according to a KPMG report released in 2017. The country is 81% short of doctors at rural community health centres and the private segment accounts for 63% of hospital beds, according to government health and family welfare statistics. Even though the government is putting in active efforts to enhance the current fitness care systems by opening primary health centres and helping the rural poor women and children via free medical amenities, qualitative and quantitative accessibility of primary healthcare services is very less in remote village areas. The reason budget in India estimates for health at an appreciable growth of more than 27%. From Rs.37,061.55 crore in 2016-17, the budget estimate for 2017-18 has been increased to net Rs.47,352.51 crore. This will help to appear tertiary care, human resources for health and medical education and to support national health mission. For the rural population, health care necessities are different than the urban due to various social economic reasons. Rural population particularly women is mainly engaged in agriculture labour movement and they are many challenges like issues in agriculture, health issues, no appropriate primary education and less awareness on various government schemes and benefits. Based on the above various issues, the present study aims to find out the awareness and perception of health issues among women in rural area in Vellore district, Tamil Nadu in India. The findings of the study found that, the respondents have full awareness and perception about health issues and also they were aware of the various schemes and initiatives taken by the government to uplift the rural women and children to live healthy and better life in rural area.

Keywords: Awareness, Perception, Health issues, government initiative and Development of rural women

I. INTRODUCTION

India is the country of huge population, as per Census 2011, the total population of India is 121 crore, out of which the rural population is 83.3 crore (68.84%) and urban population is 37.7 crore (31.16%). It is obvious that majority of population lives in rural area. Since independence, in view of the population delivery and social organisation of the society, the government of India select to have maximum attention and network of public health care system in order to have precautionary, promote, healing and specialized services

Manuscript published on 30 January 2019.

*Correspondence Author(s)

Dr. V. Selvam, Professor, Department of Commerce, SSL, Vellore Institute of Technology, Vellore (Tamil Nadu), India.

Dr. D. Ashok, Professor and Dean, VIT Business School, Vellore Institute of Technology, Vellore (Tamil Nadu) India.

Dr. P. Pratheepkanth, Senior Lecturer in Accounting, Department of Accounting, University of Jaffna, Sri Lanka.

© The Authors. Published by Blue Eyes Intelligence Engineering and Sciences Publication (BEIESP). This is an [open access](http://creativecommons.org/licenses/by-nc-nd/4.0/) article under the CC-BY-NC-ND license <http://creativecommons.org/licenses/by-nc-nd/4.0/>

India opted for three tier health care system through preparation of Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) founded on certain population norms to cater rural population. The drive to create a network for Primary Health Care was to look at the social determinates of health and to offer therange of healthcare services to rural population (Shashi Rani 20117).

A. Information Technology -A Way Forward in Rural Healthcare

The only way to take a ray of hope between rural women and children in India is by implementing redefined policy with a set of proper strategies, which will safeguard sustainability of rural healthcare plans. Health authorities say this idea is also going to invite the private sectors, wherein stockholders would be interested in making an asset in rural healthcare sections like isolated diagnostics, telemedicine services and process of other rural health connected amenities. Information technology can play a big role with software application being used for social sector systems on a large scale to advance access to healthcare in rural parts. Hospitals empanelled under the government insurance scheme and medical technology facilitated and connected to servers in districts. Beneficiaries can use a smart card that permits them to access health services in any empanelled hospital. For this, more private top hospitals are wanted in the rural areas. The central budget 2017-18 has given a lot of incentive to rural health with allocation for the sector enlarged by around 27% but the undertaking can bring huge change only if the private sector provides a similar asset to boost rural health among women and children in India.

B. Ayushman Bharat – Rural Healthcare Redefined

Under the Rashtriya Swasthya Suraksha Yojana (RSSY), though all poor families are covered, but they are not getting actual benefit as healthcare facilities in rural areas are not up to the spot, forcing them to travel to urban areas. This year, however, the government has improved the annual limit per family increased from Rs.30,000 to Rs.1,00,000, with an extra top-up of Rs.30,000 for senior citizens. Administrators approximations that enrolling all below poverty line families in the country in health-insurance programmes would cost anyplace from Rs.2,460 crore to Rs.3,350 crore. In South Indian states like Tamil Nadu, Karnataka and Andhra Pradesh governments have run cashless health insurances schemes for all helping rural population to a large extent. This year the central government is presented universal health protection scheme called Ayushman Bharat. The scheme will of Fer complete health coverage upto

Rs.5,00,000 per family per year to about 50 crore people around 1,50,000 sub centres and primary health centres being transformed as health and wellness centres (HWCs) to provide healthcare services for secondary and tertiary care hospitalization (Chetan Chauhan 2018).

C. Review of Literature

The researchers reviewed the following literature for the study and presented below. Smith (2015) studied that stunting is commonly referred to as an indicator of "malnutrition," evidence is accumulation for a vital role of the disease environment in shaping nutritional outcomes. Coffey (2014) stated that according to joint UNICEF and WHO (2012) estimates for 2010, 15% of the world population and 19% of people in developing countries defecate in the open without using any toilet or latrine. Of these 1.1 billion people, nearly 60% live in India, which means they make up more than half of the population of India. People in India are much more likely to defecate in the open than even people in much poorer sub-saharan African countries, on average, and open defecation in India has declined little despite rapid economic growth. LewandoHundt et al., (2012) found in their study that there are issues of accessibility in terms of distance, and of acceptability in relation to the lack of local and female staff, lack of cultural competencies and poor communication. Also, they found that provision of accessible acceptable health care in rural areas poses a challenge to health care providers and these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area. MeenakshiGautham et al., (2011) in their study found that most rural persons seek first level of curative healthcare close to home, and pay for a composite convenient service of consulting-cum-dispensing of medicines. Non-Degree allopathic practitioners (NDAPs) fill a huge demand for primary curative care which the public system does not satisfy and are defector first level access in most cases. Ray et al., (2011) analysed in their study that large number of patients did not avail any services when they fall sick especially in the tribal district where distance, poor knowledge about the availability of the services and non-availability of the medicine in addition to the cost of treatment and transport. Utilization of government health facilities was around 38% followed by unqualified practitioners and private practitioners. Referral was mostly by self or by close relatives/ families.

According to Jennings et al., (2010) demonstrated in their study that the messages provided to pregnant women significantly improved in birth preparedness, danger sign recognition and newborn care and authors concluded that a job aids-focused intervention can be integrated into routine antenatal care with positive outcomes on provider communication and maternal knowledge. Efforts are needed to address time constraints and other communication barriers, including introduction of on-going quality assessment for long-term sustainability. Kaveri Gill (2009) concluded in their study that the National Rural Health Mission is on the right track of addressing the rural health care with the institutional changes it has brought within the health system. But there are problems in implementation, so that delivery is far from what it ought to be with respect to physical infrastructure, medicines and funding. Whereas with respect to human resources and to the extent these impacts actual availability of services, structural issues of some complexity need careful

resolving with a definite long-term investment in the training and education of paramedical and medical staff. Srivastava et al., (2009) study revealed that the utilization of RCH services in the government facilities was higher among the backward classes than the general category, and higher the level of education the lower was the utilization of the government services. World Bank (2008) examines the health benefits of having latrines for women and children. Access to sanitation reduces the risk of being exposed to the pathogens in human waste that spread waterborne diseases. GuhaMazumdar et al., (2007) in their study shows that, for the majority of women's health problems biomedicine is regarded as the first choice, failure of which leads clients to seek treatment from Indian system of medicine (ISM) as a final resort. Nevertheless, women showed a preference for ISM treatment for certain specific health problems, strongly backed by a belief in their efficacy. Shefali Chopra (2018) expressed that the key aim is to contribute to improving health and equity in India. It differentiates and address both the challenges to releasing India's potential globally and the challenges like malaria, TB, water borne diseases, inadequate nutrition, high infant and child mortality rates, sanitation, clean drinking water and iodine related deficiencies to solving long-standing health and health services distribution problems internally. In this above literature review, it is very clear that in general all the previous reviews related to specific rural health issues like malnutrition, sanitation, hygiene, malaria and dengue were discussed in some northern parts of India. But in particular, so far no research were conducted on awareness and perception of health issues among rural women in Vellore district, Tamil Nadu in India. In this background, the present study aims to study the awareness and perception of health issues among rural women in Vellore.

D. Statement of Problem

After literature review, the researchers identified and presented the research problems for the study. In the situation of rural health services, the challenge of government health care scheme is that there are numerous gaps in primary health services and the health care facilities are mainly urban centric. The alterations in health status in urban and rural areas are created on various factors such as availability, accessibility and affordability of health amenities, literacy and educational status, poverty, employment and source of livelihood, income and family size, food intake and nutritional status, gender inequality, housing, access to fresh water and sanitation facilities, material and knowledge for health programmes. These factors have direct impact on health status of the rural population. In addition to this, health is an important component for safeguarding better quality of life. Large crowds of the Indian poor continue to fight and continually losing the battle for survival and health. The problems begins even before birth, as the malnourishment of the mother decreases life chances of the foetus. Even with world-wide progress, an increasing proportion of child deaths occur in Africa and Southern Asia.

Globally, the occurrence of major infectious diseases has declined since 2000, with malaria and TB, but the challenge of these and new diseases remains in many regions of the world, one of them being India. In general the main health issues related in rural India are: lack of primary health care services, proximity of health facilities, sanitation and hygiene, water borne sicknesses and in specific key problems related to women and children in rural areas like reproductive health, inadequate nutrition, HIV, high infant and child death rate, malnutrition, sanitation and fresh drinking water, protein energy malnutrition and iodine related deficiencies. Based on the above specific issues on women and children health, the researchers wants to study the awareness and also their perception on health related issues among women and children in rural area. In this direction, an attempt is made to fill the above research gap and intends to study in Vellore district.

E. Research objectives

1. To study the demographic profile of the respondents.
2. To identify the awareness on key health issues related to women and general health issues relating to women and children in rural area.
3. To find out the perception of women about the various government schemes and initiatives for tackling health issues in rural area.

F. Testing of Hypothesis

Ho: There is no significant association between educational qualification and general health issues relating to women and children in rural area.

Ho1: There is significant association between educational qualification and general health issues relating to women and children in rural area.

II. RESEARCH METHODOLOGY

A. Nature of the Study

Descriptive

B. Area of the Study:

Maniyampattu village in Vellore district of Tamil Nadu having total population of the state is 24,68,965 as per 2011 censuses, with seven Taluks and 75% of the district people are educated living in rural area. The important source of work are cultivation of paddy and sugar cane.

C. Sampling Method:

Convenient sampling method was applied for the study.

D. Questionnaire Design and Survey:

A structured questionnaire was used to collect the sample contained both open and closed ended questions and also Likert's scale from 5 strongly agree to 1 strongly disagree was applied for the study. The first part of the questionnaire deals with demographic profile of the respondents and the second part of the deals with awareness and perception of key and general health issues among rural women and children. Survey method is used to collect the data from the respondents.

E. Data Collection

Both primary and secondary data used for the study.

F. Sample Size

The researchers issued 143 questionnaires and collected only 109 and taken for analysis only 100 questionnaires for the study and the remaining 9 questionnaires were not taken due to incompleteness.

G. Statistical Tools Used

Statistical tools like percentage analysis, frequency distribution, mean score with rank correlation and one way ANOVA was applied by using SPSS software for the study.

H. Period of the Study

The study was done during January 2018 to April 2018 timeline.

I. Limitations of the Study

The study was restricted to Vellore district in Tamil Nadu only. The sample size is restricted to 100 that to from rural women only. The results of the study may not be similar if it is conducted in any other district of Tamil Nadu.

J. Reliability Test

In order to measure the internal consistency among the research variables, the researchers applied Cronbach Alpha Test. The output value of Cronbach Alpha from SPSS was 0.792. This results a good and unbiased degree of internal reliability amongst the items and this leads to further analysis of the data. As per Hair et al (1998), the generally agreed upon lower limit is 0.70.

K. Data Analysis and Interpretation

The data pertaining to demographic profile of the respondents were presented in table 1.

Table 1. Demographic profile

Demographic variables	Category	Frequency	Percentage
Educational Qualification	Illiterate	62	62
	10 th Std	16	16
	12 th Std	12	12
	Degree	8	8
	PG	2	2
	Total	100	100
Age	15 to 20	13	13
	21 to 25	18	18
	26 to 30	22	22
	31 to 40	31	31
	Above 41	16	16
	Total	100	100
Occupation	Student	8	8
	Business	19	19
	Government service	10	10



Awareness And Perception of Health Issues Among Rural Women

Self-employment	23	23
Daily wager	14	14
Private	21	21
Farmer	5	5
Total	100	

Source: Primary data

L. Inference

From the above table it is inferred that with regard to educational qualification 62% of the respondents belongs to illiterate, 16% of the respondents belongs to the 10th standard, 12% of the respondents belongs to 12th standard, 8% of respondents belongs to degree and 2% of respondents belongs to PG only. Similarly, 13% of the respondents belongs to the age group of 15 to 20, 8% of the respondents belongs to the age group of 21 to 25, 22% of the respondents belongs to the age group of 26 to 30, 31% of the respondents belongs to the age group of 31 to 40 and only 16% of the respondents belongs to the age group of above 41. Based on the respondent's occupation, 8% of the respondents belongs to student, 19% of the respondents belongs to business, 10% of the respondents belongs to government service, 23% of the respondents belongs to self-employment, 14% of the respondents belongs to daily wager, 21% of the respondents belongs to private and only 5% of the respondents belongs to farmer. It is inferred from the above analysis that majority (62%) of the respondents were illiterate, majority (31%) of the respondents belongs to the age group between 31 to 40 and majority (23%) working as self-employment.

L. Awareness on Key Health Issues among Rural Women

The data pertaining to key health issues of the respondents were presented in table 2.

Table 2 Mean score with rank correlation

Variables	5	4	3	2	1	Total	Mean score	Rank
Lack of primary health care facilities	52	15	3	18	12	100	3.77	1
Proximity of health facilities	45	21	5	20	9	100	3.73	4
Sanitation and hygiene	30	42	10	12	6	100	3.74	3
Water borne diseases	53	37	8	2	0	100	3.75	2

Source: Primary data

N. Findings

The findings of the study revealed that, lack of primary health care facilities is the first and foremost important awareness on key health issues among rural women with mean score value 3.77 was ranked 1, water borne diseases, like cholera, malaria and dengue were thesecond big awareness key issues with mean score value 3.75 was ranked

2, sanitation and hygiene with mean score value 3.74 was ranked 3 and proximity of health facilities is the forth key issues among rural women with mean score value 3.73 was ranked 4.

O. Awareness on General Health Issues among Women and Children in Rural Area

The data pertaining to general health issues among the respondents were presented in table 3.

Table 3 Mean score with rank correlation and one way

ANOVA

Variables	5	4	3	2	1	Mean score	Rank correlation	Sig.
Reproductive health	10	22	0	55	13	2.61	6	0.003
Inadequate nutrition	30	44	4	15	7	3.75	1	0.021
HIV	0	0	0	29	71	1.37	8	0.000
High infant and child mortality rate	4	10	20	40	26	2.26	7	0.017
Malnutrition	25	40	6	20	9	3.52	2	0.005
Sanitation and clean drinking water	16	19	1	40	23	2.62	5	0.031
Iodine related deficiencies	12	30	11	33	14	2.93	4	0.042
Protein energy malnutrition (PEM)	17	28	45	7	3	3.49	3	0.010

Source: Primary data, at 5% level of significant

The findings of the study reveals that, the first and foremost important variable on awareness on general health issues among women and children in rural area is inadequate nutrition with mean score value 3.75 was ranked 1, malnutrition with mean score value 3.52 was ranked 2, protein energy malnutrition with mean score value 3.49 was ranked 3, iodine related deficiencies with mean score value 2.93 was ranked 4, sanitation and clean drinking water with mean score value 2.62 was ranked 5, reproductive health with mean score value 2.61 was ranked 6, high infant and child mortality rate with mean score value 2.26 was ranked 7 and HIV with mean score value 1.37 was ranked 8. In addition to mean score with rank correlation, the researchers also applied one way anova. The results exhibits in table 3, that the calculated value on one way anova for all the eight variables at 5% level of significant is less than the hypothetical value at 0.05. Hence, there is significant association between educational qualification and general health issues relating to women and children in rural area.

P. Women Perception about the Various Government Schemes and Initiatives for Tackling Health Issues

The data pertaining to women perception were presented in table 4.

Table 4 Mean score with rank correlation

Variables	5	4	3	2	1	Total	Mean score	Rank
(ICDS)	35	36	0	19	10	100	3.67	4
(SBM)	40	60	0	0	0	100	4.40	1
(KAS)	7	15	23	31	24	100	2.50	11
(NBA)	16	39	12	20	13	100	3.25	7
(NRHM)	20	35	15	19	11	100	3.34	6
(INAP)	40	37	14	7	2	100	4.06	2
(RMNCAH)	23	35	7	27	8	100	3.38	5
(JSSK)	10	28	19	23	20	100	2.85	8
(RBSK)	12	24	16	30	18	100	2.82	9
(RKSK)	4	28	28	18	22	100	2.74	10
(NDCP'S)	28	32	26	8	6	100	3.68	3

Source: Primary data

III. FINDINGS

The findings of the study reveals that, 60% of the respondents agree that, they were aware of swatch bharatmission scheme and also the initiatives taken by government for the welfare of rural people with mean score value 4.40 was ranked 1,40% of the respondents strongly agree that they were aware of the India new-born action plan with mean score value 4.06 was ranked 2,38% of the respondents agree that they were aware of national disease control programs with mean score value 3.68 was ranked 3,36% of the respondents agree that integrated child development scheme with mean score value 3.67 was ranked 4 and 35% of the respondents agree that they were aware of reproductive, maternal, new-born, child and adolescent health scheme and initiates by the government with mean score value 3.38 was ranked 5.

IV. CONCLUSION

The analysis and findings concludes that the healthcare delivery is rural India is now uniquely poised to undergo a change at all its stages like prevention, diagnosis and treatment, as the government focus on the sector has increased a lot in the recent past. The real change will come when public and private sectors come together to fill in the gaps and ensure that medical personnel are deployed in adequate numbers in rural India so that the rural women get complete benefits and full aware about government schemes and initiates. In addition to this, the study also conclude that, to improve the prevailing situation, the problem of rural health is to be addressed both at the macro (national and state) and micro level (district and regional), in a holistic way, with genuine efforts to bring the poorest of the population to the centre of the fiscal policies. A paradigm shift from the current 'biomedical model' to a 'sociocultural model' is required, to meet the needs of the rural population. A comprehensive revised national health policy addressing the existing inequalities and work towards promoting a long-term perspective plan exclusively for rural health is the current need. The policy makers should focus more on quality provision of rural women health care for all rather than quantitative coverage of all. Above all, in order to provide

just and fair health care to rural women, the government needs to do more budgetary allocation and development of infrastructure as per need and demand.

REFERENCE

- Cleland JG, Van Ginneken JK, (1988) Maternal education and child survival in developing countries, *The search for pathways of influence*, Vol.27, No.12, pp.1357-1368.
- Census (2011), *Government of India*.
- Coffey, D, R Khera and D Spears (2014) "Women's Status and Children's Height in India, Evidence from Joint Rural Household," *Working Paper*, Rice Initiative for the Stay of Economics, Houston.
- ChetanChauhan (2018), Rural health: Emerging challenges, *Kurukshetra: A Journal on Rural Development*, Vol.66, No.10, pp.35-38.
- Frank Transer, (2006) Methodology for optimizing location of new primary health care facilities in rural communities: A case study in Kwazulunatal, South Africa, *Journal of Epidemiology Community Health*, Vol.60, pp.846-850.
- GuhaMazumdar p, Gupta K. (2007) Indian system of medicine and women's health: a client's perspective, *Journal of Biosocial Science*, Vol.39, No.6, pp.819- 841.
- Hair, J.F, Anderson, R.E, Tatham, F.L, and Black, W.C, (1998), *Multivariate analysis*, Englewood, CO; *Prentice Hall International*.
- Jennings L, Yebadokpo AS, Affo J, Agbodbe M,(2010), Antenatal counselling in maternal and new-born care: Use of on aids to improve health worker performance and maternal understanding in Benin, *BMC Pregnancy and Child birth*, Vol.10, pp.75.
- Kaveri Gill, (2009), A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM) Findings from a study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan, *Working Paper PEO*, Planning Commission of India.
- LewandoHundt G, Alzaroo S, Hasna F, Alsmirian M, (2012), The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouin in the North East region of Jordan, *Social Science and Medicine*, Vol.74, No.1, pp.36-43.
- MeenashiGautham, Erika Binnendik, RukKoren, David M. Dror, (2011), First we go to the small doctor, First contact for curative health care sought by rural communities in Andhra Pradesh & Orissa, *India Journal Medical Research*, pp.134, No.5, pp.627- 638.
- Ray SK, Basu SS, Basu AK (2011), Assessment of rural health care delivery system in some areas of west Bengal- An overview, *India Journal of Public Health*, pp.55, No.2, pp.70-80.
- Smith, L. C., and L. Haddad (2015), Reducing Child Under nutrition: Past Drivers and Priorities for the Post-MDG Era, *World Development*, Vol.68, pp.180-204.
- Srivastava RK, Kansan S, Tiwari VK, Piang L, Chand R, Nandan D, (2009), Assessment of utilization of RCH services and client satisfaction at different levels of health facilities in Varanasi District, *Indian Journal of Public Health*, Vol.53, No.3, pp.183-189.
- Shashi Rani (2017), Rural health: Health infrastructure, equity and quality, *Kurukshetra: A Journal on Rural Development*, Vol.65, No.9, pp.29-33.
- Shefali Chopra (2017), Tackling health hazards in rural India, *Kurukshetra: A Journal on Rural Development*, Vol.65, No.9, pp.22-25. Health care for all: The national health policy 2017
- Srinivas, V (2017), Health care for all: The national health policy 2017, *Kurukshetra: A Journal on Rural Development*, Vol.65, No.9, pp.8-11.
- World Bank (2008), Environmental health and child survival: epidemiology, economics, experience. Washington, DC, *World Bank*, 135.

Awareness And Perception of Health Issues Among Rural Women

AUTHORS PROFILE

Dr.V.Selvam, Professor, Department of Commerce, SSL, Vellore Institute of Technology, Vellore 632 014, Tamil Nadu, India.

Dr. D. Ashok, Professor and Dean, VIT Business School, Vellore Institute of Technology, Vellore 632 014, Tamil Nadu, India.

Dr. P. Pratheepkanth, Senior Lecturer in Accounting, Department of Accounting, University of Jaffna, Sri Lanka.