International Research Journal of Medical Sciences _____ ISSN 2320 –7353
Vol. **1(10),** 17-21, November **(2013)** *Int. Res. J. Medical Sci.*

Health awareness among RHTC beneficiaries at Shivanagi

Veena S. Algur
Dept. of Community Medicine, BLDE University's Shri B M Patil Medical College, Hospital and Research center, Bijapur -586103, Karnataka, INDIA

Available online at: www.isca.in, www.isca.me
Received 16th October 2013, revised 5th November 2013, accepted 27th November 2013

Abstract

A developing country like India's, hurdles of development are various like burning social problems like poverty, illiteracy, ignorance, conservatism, un-employment, gender bias such social, political and cultural factors have led to a number of multifaceted and complex problems of vicious nature. Among all the developmental issues health for all is a mirage health care, health promotion has to be given a special priority .Mere existence of health services is not enough there is need to focus on utilization of available health care facility which is based on the awareness of general public and influencing socio economic and socio cultural factors like literacy ,economic condition cultural practices and gender, prevalent in community

Keywords: Health care, rural, awareness, health services.

Introduction

The goal **"Health for all "** is crippling due to various factors .Management of health care services specially in rural areas is challenging. It is known fact that India is a land of villages, Agriculture is back bone of our country 70% (2010)[1] of population are rural dwellers and all rural communities with typical Characteristics Among all the developmental issues health care, health promotion has to be given a special priority.

Social factors influencing health and health care service utilization are the important factors which reflect in health status of public. Health awareness play a vital role in health care seeking behavior whether a community is urban or rural its members are influenced by a unique socio cultural milieu of its own.

Health care is tough task to country like India due to the pangs of poverty, illiteracy, ignorance and conservatism. Public health care professionals are striving hard to focus more on prevention rather than on curative and rehabilitative services as preventive services are simple, affordable, easy and most suitable techniques of handling health care. Common practices like healthy life style, vaccination, sanitation and hygienic practices like use of handkerchief, balanced diet avoiding bare foot walking and washing hands have proved that these practices greatly contribute to the healthy life[2].

Significance of Study: The birds view of health scenario is alarming, health needs are more demanding, the goal which aims at "Health for all" by 2000 A.D, which was initiated during 1977 (30th May 1977) by World Health Assembly. WHA decided to launch social, global target "Health for all by 2000 A.D" defined as attainment by all the people of the world, a level of health, which will enable or permit every individual to lead socially and economically a productive life" is tough task which is striving very hard to achieve the goal. As the health of the Indians is in the pangs complex causes which are inter-related these factors make the task more difficult but not an impossible one. Unless we go for the scientifically effective and affordable strategies, it becomes a distant dream[3].

Management of rural health care services is a tough task as the components of rural life and Problem associated with it are multi dimensional and complex in nature. Rural health care demands not merely infrastructure, adequate trained staff or free drugs but more important than that is making people to utilize the available services and gain confidence in health care providers, which is not given prime importance A popular quote **"Health is Wealth"** and ancient[4]. Chinese quote which stands ever green.

"If the National plan is one year – Grow Rice
If it is for 25 years –Grow Trees
If it is for 100 years- Do Health Education"

To have the proper strategies community participation is a must. This can be achieved by creating awareness regarding health problems ways to alleviate them and channelize the efforts. In this contest the news papers play a major role[5]. Even a non formal health education for every one residing in a particular community can make miracle.

The present study makes an attempt to know the health awareness among RHTC patients which enables them to utilization of the available health care facility available at their locality among rural health training center OPD beneficiaries at Shivanagi village which is 30 km from BLDEA'S Shri B M Patil Medical college Bijapur and to know the respondents health awareness and its relationship between gender, socioeconomic status of patients and their health awareness regarding self health care and utilization of health care facility.

Objectives: i. To study health awareness among RHTC beneficiaries, ii. To know their relationship between gender , literacy socioeconomic status and health awareness.

Material and Methods

Following are information regarding particulars of study participants ,sample size and area in brief and which is included in study: Setting--------Rural Health Training Center, Shivanagi, Department of community medicine. Study period—1st Nov to30 November 2011. Study group----Adult patients attending OPD at RHTC Shivanagi. Sample size ----369 Adults. Study design---Cross sectional. Study tool----Interview technique using pretested pro forma, Statistical tests---X^2 and percentages.

Table-1
Age and sex wise distribution of respondents

Age in years	Male	Female	Total (%)
21-30	43	102	145(39)
31-40	29	41	70(19)
41-50	35	30	65(18)
51-60	29	24	53(14)
61 and above	23	13	36(10)
Total	159(43)	210(57)	369(100)

Table-2
Literacy status of respondents

Respondents	Literate (%)	Illiterate (%)	Total (%)
Male	99(66)	60(60)	159(43)
Female	68(32)	142(68)	210(57)
Total	167(45)	202(55)	369(100)

Table-3
Occupational status of responds

Gender	Agri/ labour (%)	Business (%)	Artisans (%)	Students /unemployed (%)	Total (%)
Male	96 (60)	25(16)	23(15)	15(9)	159
Female	184 (88)	9(4)	7(3)	10(5)	210
Total	280 (76)	34(9)	30(8)	25(7)	369 (100)

Table-4
Opinion regarding various causes of illness

Opinion	Male (%)	Female (%)	Total(%)
Rational	104(65)	130(62)	234(63)
Supernatural	7(5)	14(6)	21(6)
Fatalistic	35(22)	35(17)	70(19)
Don't know	13(8)	31(15)	44(12)
Total	159(100)	210(100)	369(100)

X^2test P >0.05

Table-5
Opinion regarding additional services required at RHTC

Additional services	Male (%)	Female (%)	Total (%)
I.P.D	33(57)	25(43)	58(15.7)
Free drugs	83(41)	118(59)	201(54.7)
Emergency services	42(44)	53(56)	95(25.7)
O.T	27(56)	21(44)	48(13)
Maternity Services (IPD)	26(29)	64(71)	90(24.3)
Don't know/ not answerd	22(33)	44(67)	66(17.8)

X^2 test P<0.01

Table-6
Knowledge about mode spread and outcome of the disease

Diseases	Cause		Total (%)	Outcome	
	Known (%)	Not Known (%)		Curable (%)	Not Curable (%)
Cholera	120(33)	249(67)	369(100)	241(65)	128(35)
Malaria	155(42)	214(58)	369369 (100)	268(73)	101(27)
TB	63(17)	306(83)	369(100)	199(54)	170(46)
Leprosy	17(5)	352(95)	369(100)	112(30)	257(70)
HIV/AIDS	156(42)	213(58)	369(100)	59(16)	310(84)

Table-7
Type of RHTC services utilized by respondents

Type of services	Male (%)	Female (%)	Total (%)
Immunization	27(40)	41(60)	68(18)
Only during sickness	94(41)	134(59)	228(62)
ANC/PNC/FP	34(36)	60(64)	94(25)
Injection Dressing/Investigation	63(53)	55(47)	118(32)

Table-8
Awareness about Family planning methods and Immunization programs

Programs	Aware (%)	Unaware (%)	Total (%)
Family Planning	338(92)	31(8)	369(100)
Immunization	325(88)	44(12)	369(100)

Table-9
Practices of personal hygiene according to gender and literacy status of respondents

Hand wash Before food	**Gender**	**Yes (%)**	**No (%)**	**Literacy status**	**Yes (%)**	**No (%)**
	Male	81(45)	78(41)	**Literate**	125(79)	42(20)
	Female	97(55)	113(59)	**Illiterate**	33(21)	169(80)
	Total	178	191	Total	158	211
Hand wash After toilet	**Male**	68(48)	91(40)	**Literate**	83(58)	84(37)
	Female	74(52)	136(60)	**Illiterate**	83(58)	84(37)
	Total	**142**	**227**	Total	**142**	**227**
Necessity of toilet	**Male**	32(44)	127(43)	**Literate**	83(58)	84(37)
	Female	40(56)	170(57)	**Illiterate**	59(42)	143(63)
	Total	**72**	**297**	Total	**72**	**297**
Bathing practices	**Male**	141(43)	18(47)	**Literate**	162(49)	5(13)
	Female	190(57)	20(53)	**Illiterate**	169(51)	33(87)
	Total	**331**	**38**	Total	**331**	**38**
Storage of Drinking Water	**Male**	00	00	**Literate**	11(57)	57(30)
	Female	21(11)	189(89)	**Illiterate**	10(48)	132(70)
	Total	**21**	**189**	Total	**21**	**189**

$P > 0.05$, $p < 0.01$

Results and Discussion

Age and sex wise distribution of respondents: A total of 369 OPD patients were interviewed for the study at Rural health training c enter. Majority of the respondents of both sex were 145(39 %) in the age group of 21-30 years. The total female respondents were more 210(57%) as compared to male respondents 159 (43%). There were only 36(10%) above the age of 60yrs.

Literacy status of respondents: Maximum 142(68%) were female illiterates as compared to 60(38%) Illiterate males. However Literacy percentage is more among males 99(62%)

Occupational status of responds: Out of total 369 respondents 280(76%) were engaged in Agriculture/Agricultural labors, 34(9%) were in business, 30(8%) were artisans and 25(7%) students/unemployed

Opinion regarding additional services required at RHTC: The opinion for free drugs supply to the community was from 83(41%) males and 118(59%) females. Requirement of 24 hours emergency services was of the opinion by 42(44%) males and 53(56%) females, Out of total 90 respondents who demanded MCH services 64(71%) were females.

Knowledge about mode spread and outcome of the disease: Communicable diseases like Cholera, Malaria TB, Leprosy and HIV/AIDS awareness regarding causes and outcome was elicited among the respondents. Maximum 155 (42%) knew the cause and transmission of Malaria and HIV/AIDS. where as only 17(5%) were aware that leprosy is caused infection Majority of respondents 268(73%) said that Malaria can be cured by drugs (treatment) and 241 (65%) knew that Cholera can be cured. Only 59(16%) were having wrong notion that HIV/AIDS can also be cured but at the same time 310 (84%) knew that HIV/AIDS is not curable. The above data is compared with gender and literacy status wise awareness among respondents, for the mode of spread and outcome of the above diseases. It is found that males have better knowledge than females so also about literates.

Type of RHTC services utilized by respondents: Majority of respondents i.e, 94 (41%) males and 134 (59%) females seek RHTC services only during sickness followed by 63 (53%) and 55 (47%) males and female respondents respectively seek services for First Aid and injections 27 (40%) males and 41 (60%) of females utilize immunization services, maximum beneficiaries 60(64%) women have utilized ANC/PNC/Family Planning services.

Socio economic classification and prescribed drug purchasing practice: Only 36 (10%) respondents were from class 1 (Upper class), ((44%) belonged to class 2 and 3 (Middle class) and (46%) belong to class 4 and 5 (lower class)It is observed that 82(50%) of the middle class and 86(42%) of the upper class and lower class could purchase all the prescribed drugs and completed the course. Only 53(31%) of lower class who would purchase the drugs in parts from the prescribed drugs and discontinued with out completing the full course.

A total of 67 (40%) of middle and lower class and 5(14%) of upper class respondents were dependent on free drugs. Statistically there is an association between socio economic status and purchasing practice of prescribed drugs.

Awareness about Family planning methods and Immunization programs: 338(92%) respondents are having knowledge about Family planning and 153(41%) have utilized services and adopted family planning methods 325(88%) were aware of immunization programme mainly Polio and BCG

254(69%) said that they have completely immunized their children.

Practices of personal hygiene according to gender and literacy status of respondents: The knowledge and practice of hand washing in the community appeared to be poor even today**[6].** Public health importance of hand washing was known since 19th century**[7]**. Even the Global hand washing day celebration on 15th October focuses on importance of hand washing. Earlier studies highlighted that simple act of hand washing could prevent Diarrhea, ARI and Skin infections[8-11]. It is one of the most cost effective method in public health interventions to prevent diseases.

Discussion: Socio demographic profile of age, sex and literacy status corresponds to state fig 2001 census, expect that in this study illiteracy status is higher by 15 to 25 % .Majority of respondents have related dieses to rational cause corresponding to poverty ,malnutrition and substandard living a very few believed in supernatural and fatalistic outlook .it is found only 1% in study of malhotra et al.[12]

Among the local health services R.H.T.C. is popular in the community because of better services provided. Existing government sub center and newly introduced P.H.C. having limited resource and are not popular. Present study reveals females have better knowledge about health care services compared to males since they have to bother for health of their family members. Majority of the respondents were aware of curability of the disease like Cholera, Malaria, TB, Leprosy and HIV/AIDS, then the cause and transmission. maximum subjects were reluctant to talk about leprosy due to social stigma. However 26% of respondents misconception was HIV/AIDS is curable, since the diseases are more common in rural set up many have the awareness due to wide publicity. Studies of Angadi[13], Goyal[14] and Seshbabu[15] et al have found that percentage of knowledge of curability is high then the cause and transmission of communicable diseases.

Purchasing drug is burden to 19.5% of respondents who are dependent on free drugs from RHTC to avoid unproductively due to illness which hampers the life. Whereas 50% respondents manage to buy all prescribed drugs. Due to low socio economic conditions, majority of subjects demanded for free drugs .One fourth of respondents demand was for 24 hours emergency services. the drug purchasing pattern which is influenced by economic factors, literacy level and individual habit will play an important role in non-compliance to complete compliance through various degrees of partial compliance [16]. Both partial and non-compliance lead to unsuccessful treatment, a significant problem faced by the health care professionals today. The non-compliance rates vary from 15% to as much as 90% [17]. The reasons for poor compliance are mainly discontinuation of treatment say when patient is unable to buy or unfortunately most patient declare themselves as cured once their symptoms decrease or lack of knowledge regarding completing prescribed regimen. Either of the reasons are based on deliberate action, misinterpretation or in adequate information[18].

Awareness and practices of MCH services like family planning and immunization is more encouraging when compared with NFHS reports[19]. Present study reveals that mere awareness is of no use. However being aware is necessary to make a well considered decisions but it is not sufficient, empowerment through awareness must be backed up by available, accessible and affordable choices in terms services, social support at family level and healthy public policies, for a successful enabling approach therefore health related activities must be in accordance with the needs of the community.

Conclusion

The literacy is the only tool which can help us to fight the battle "Health For All" there is utter need for health education for every one which is the Only key to break such vicious cycle, and which an developing nation like India can afford and adopt to reduce DALY (Disability Adjusted Life Years) is creating awareness among general public. There is need to focus more attention and give priority for this dimension of health care.

Now it is wake up time to India to fight against all odds and move towards health for all by reorienting existing priorities in health care services from curative to preventive on the basis of felt need services to the community. On the whole overnight we cannot change the rural health scenario, but slow and steady race will definitely lead us to "Health for all" by i. Poverty eradication, and compulsory education have to be taken up with participation of community members. ii. Instead of using Television use Tell a women to communicate health care message. iii. Priority should be to BCC and IEC on preventive measures to curb communicable and non communicable diseases. iv. Alternative and affordable new technique to tackle social aspect of health problems should be initiated, v. Medical social worker have to be liaison between policy makers ,health care providers and public to formulate need based health care activity.

Thus the multifaceted, powerful, economical handy weapon should include imparting health information and health education. Creating awareness can be utilized as a catalyst to create social action to fight the battle health for all leading to social welfare.

References

1. Censes report **(2010)**
2. Algur Veena S Yadavannavar MC Hand washing practices among patients attending RHTC *International journal of health science and Research*, **2(2),** 46 **(2012)**

3. Algur VeenaS et al, Coverage of health issues in News papers an Observational study, *International journal of current research and review,* **4(19),** 192 **(2012)**

4. Swasth Hind p 69 March April **(1998)**

5. Algur VeenaS et al Coverage of health issues in News papers an Observational study. *International journal of current research and review,* **4(19),** 193 **(2012)**

6. Ray S.K., Dobe M., Majhi S., Chakraborty D. Sinha, Roy A.K. and Basu S.S., A pilot survey on hand washing among some communities of West Bengal, *IJPH,* **50**, 227– 230 **(2006)**

7. Sandy Cairnoss, Editorial: Handwashing with soap – a new way to prevent ARIs? *Tropical Medicine and International Health*; **8,** 677-679 **(2003)**

8. V Curtis and S Cairncross. Effect of Washing Hands with Soap on Diarrhoea Risk in the Community : A Systematic Review *Lancet Infectious Diseases,* **3(5)**, 275 -81 (**2003)**

9. Stephen P Luby, Mubina Agboatwalla, Daniel R Feikin, John Painter, Ward Billhimer, Arshad Altaf, Robert M Hoekstra, Effect of Handwashing on child health: a randomized controlled trial, *The Lancet* 366 (9481) : 225 - 233 16 (**2005)**

10. Sircar BK,Sengupta PG, Mondal SK, Gupta DN, Saha NC, Ghosh S et al. Effect of Handwashing on the incidence of diarrhoea in a Calcutta Slum. *J Diarrhoeal Dis.Res.,* **5,** 112 -4 **(1987)**

11. Shahid N.S., Greenough lll W.B., Samadi AR, Huq IM and Rahaman N. Handwashing with soap reduces Diarrhoea and Spread of bacterial pathogen in a Bangladesh village, *J Diarrhoeal Dis. Res,* **14(2),** 85-89 (**1996)**

12. R Malhotra et al Awareness regarding TB in ruralpopulation of Delhi,Indian *journal of community Medicine* **vol 37no2** Apr-June **(2002)**

13. AngadiMM Masali KA K A P study on Malaria at village Shivanagi .Presented KACH 15 conference

14. Goyal R.C. et al, AIDS awareness among rural community *Swasth Hind,* **38(11-12)** (**1994**)

15. Seshu Babu VVR Kashiram, Awareness of leprosy in rural population of A.P., *Indian journal of public health,* **32(2)** (**1988)**

16. Jain L, Saxena S, Sen S. The fate of your prescription. *Indian Pediatrics,* **2,** 367-70 **(1985)**

17. Arya S. and Naidu A.N., Community awareness, attitudes and utilization of Primary Health Centre in rural Hyderabad, *Indian Journal of Community Medicine,* **VIII(2),** 13-21 (**1983)**

18. Moulding T., Onstad D., Starlarlo J.A., Supervision of outpatient drug therapy with the Medication Monitors. *Annals of Internal Medicine*; **73**, 559-64 (**1970)**

19. NFHS Karnataka fact sheet (**1999)**