



TO STUDY THE IMPACT OF HEALTH STATUS AND HEALTH CARE PRACTICES

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ABSTRACT

The majority of health systems have not been able to connect social and economic variables with the population's health with the determinants of health. To solve the complicated health concerns, systematic knowledge that transcends the health sector is required. A number of social science fields are collaborating with the medical field to create this information. For instance, the cost of medical treatment is a significant worry for the world's poor. As a result, health status is determined by poverty and livelihood vulnerability, and vice versa. Poverty has a lot to do with health. However, little rational information exists regarding how people's livelihoods are impacted when an earning member of a family experiences a significant health issue, or regarding how family, community, or other social networks assist that family in coping with the challenging times. Most people consider health to be a key indicator of development. Additionally, it is seen as a fundamental human right. There isn't, however, a thorough and widely agreed definition of health. It has a very individualized and culturally specific connotation that varies depending on the society. Even within the same society, it has various connotations. Health is typically understood to be the absence of disease, sickness, and disability. Such a limited conceptualization, however, is frequently deceptive since it leaves out the social values that are associated with it. The concept of health is typically explained using a collection of terms. They are specifically health, illness, and disease. In order to define health, it is therefore necessary to first define the notions mentioned above. Despite their overlap in everyday speech, they have distinct meanings.

KEY WORDS: Health Status, Health Care, Practices, Illness, and Disease.

INTRODUCTION

Since the 18th century, when public health was created to save humanity from the recurring scourge of epidemics, the concept has experienced a radical transformation. Public health has expanded from its original, limited definition after emerging from the sanitary movement. The topic has expanded, and public health is now seen as a comprehensive condition of wellbeing rather than just the absence of disease. More and more, social determinants are understood to be integral components of public health, just as much as biological, psychological, and environmental aspects. The development of social medicine has only emphasized how crucial socio-cultural aspects are when developing health policies. The neo-liberals' efficiency criterion of the market has replaced public health's providential, which was founded on the ideology of social justice. The introduction of the second generation of the health sector reform (HSR), which places more emphasis on the demand side than the supply side as it did in the first generation of economic reform, has caused a paradigm change in how people view health in general. The key players in the total realization of health have been identified as a number of actors, including communities. The multifaceted aspect of health has been acknowledged by the language of the New Public Health. A few commonly used phrases related to the idea of public health have been attempted to be defined in the part that follows.

CONCEPT OF HEALTH

"Illness brings to mind the symptoms and pains that are inherently human. It deals with how the sick individual, their family, and other people in their larger social network view, deal with, and react to their symptoms and impairment. It is regarded as a "lived experience," which includes, among other things, the monitoring of all bodily functions, the evaluation of those processes, and the prioritization of those processes as probable, serious, and requiring prompt treatment. Additionally, illness involves the patient's opinions on how to handle their suffering and the practical issues it brings up in their day-to-day lives. Therefore, the illness behavior consists of starting treatment (such as altering one's diet and activities, consuming special foods, resting, exercising, and taking over-the-counter or readily available prescription medications) and

determining when to seek help from professionals or complementary healers. The practitioner, on the other hand, "creates disease by recasting sickness in terms of ideas of disorder." It is what practitioners have been taught to observe using the theoretical frameworks specific to their field of practice. In other words, doctors reframe the sickness concerns of their patients and families as specific technological problems. Therefore, the physiology-culture interface produces the building of sickness.

APPROACHES TO HEALTH AND ILLNESS

Four main approaches to health have been identified in sociological literature. Marxist approach, Personian approach, Foucauldian approach, and feminist approach are the four main ones. According to the Marxist perspective, economic factors play a crucial role in both the development of sickness and how it is treated. Marx never provided a comprehensive analysis of health. His general epistemic positions can be used to infer a marxist approach to health. According to this viewpoint, a connection has been made between diseases and the overall socioeconomic system. Numerous chronic diseases are products of the profit-driven capitalism society. Under the guise of controlling disease, medicine serves as a tool of social control that oppresses the working class.

Talcott Parsons associates the institutional accoutrements of the medical profession with a non-capitalist framework, in contrast to the Marxist viewpoint, which sees medicine, health, or public health in the context of capitalism. According to him, the medical profession also plays a service and care function and is not always driven by financial gain. He has emphasized the value of medicine in controlling abnormal behavior in contemporary culture. Because medicine serves as a tool of social control in addition to being a benign institution founded on scientific care. He claims that illness is dysfunctional because it allows the typical response that people have to social pressure, which helps them to avoid their social obligations.

In a manner that is somewhat analogous, Michel Foucault demystifies the function of medicine. Foucault redefines medicine as an institution of social control rather than the institution of



healing. By delving deeply into the socialization process, the feminist approach to medicine tries to expand the Marxist and Foucauldian ideas on health. This strategy exemplifies how patriarchy creates gender-binary social positions that keep women out of the public sphere.

Therefore, the field of health is too complex to fit within biomedical stereotypes. In general, a number of elements are attributed to achieving wellbeing. These are additionally referred to as the health determinants. The health determinants will be covered in the following section.

CULTURE INFLUENCES HEALTH BELIEFS

In order to explain what causes illness, how it can be treated or cured, and who should be involved in the process, all societies have systems of health beliefs. The level of education patients have also has a significant impact on how well they will accept and apply the information given to them about health-related concerns. Western industrialized societies, such as the United States, promote medical treatment that fights microbes or uses cutting-edge technology to identify and treat disease because they view illness as a result of natural scientific processes. Some societies support prayer or other spiritual interventions to combat the alleged disfavor of strong forces because they think illness is the outcome of supernatural happenings. Cultural factors are a significant factor in patient compliance.

Health professionals should be aware of many significant cultural beliefs that are prevalent among Asians and Pacific Islanders. The older male in the family tends to make decisions and serve as the spokesperson, and the extended family has a great amount of influence. Individual family members' interests are not as significant as the family's interests or honor. Family elders are respected and their authority is frequently accepted without question. There is a great emphasis on avoiding conflict and direct confrontation because keeping peace is a valued trait in Asian cultures. Respect for authority prevents disagreement with medical professionals' suggestions. A patient's and their family's agreement with or willingness to adhere to treatment recommendations is not necessarily implied by the absence of opposition.

Since a person's behavior in China reflects on their family, mental illness or any behavior that suggests a lack of self-control may cause patients to feel ashamed and guilty. Chinese patients may be reticent to discuss signs of mental illness or despair as a result.

CULTURAL VIEWS OF HEALTH, ILLNESS, AND HEALERS



Health and illness are defined differently in each culture. In a population, an endemic condition can be accepted as normal and not be classified as a disease. Many cultures view ascariasis in young children as a common condition. Similar to how everyone has or has had malaria, it is accepted as normal in some regions of Africa. Blood in the urine was referred to be "male menstruation" and was accepted as normal in Egypt, where schistosomiasis was widespread and had an impact on the blood vessels around the bladder. Age and gender may also have an impact on these definitions. In most cultures, children's symptoms—like fever—are regarded as more dangerous than those in adults. In some societies, men may downplay symptoms more than women, but vice versa is also true. Adults' drive to keep working frequently causes them to deny their symptoms.

Parsons (1948) introduced the idea of the sick role, according to which a person must "accept" to be deemed ill and take steps to describe the status of his or her health, find a cure, and take the necessary measures to recover from the illness. People who play the ill card forgo their regular responsibilities, may engage in dependent behaviors, and seek medical attention in an effort to recover. By playing the sick person, they have "permission" to be excused from regular responsibilities, but they also owe it to themselves to make an effort to get better. The cultural justifications for disease causation need to be examined. It is based on literature, and an effort is made to be as inclusive of many cultures as is practical.



The idea of hot and cold is one of the most universal in the domain of bodily balances. It is especially significant in Mediterranean, Latin American, and Asian civilizations. Humoral medicine, which includes the concepts of hot and cold, is believed to have originated in pre-Christian Greek, Arabic, and East Indian traditions. Wet and dry, hot and cold, and other opposite concepts may have separately evolved in Chinese medical history, where heat is known as yin and cold as yang. A healthy body is viewed as being in balance between the two according to the hot and cold belief system. Violations of the delicate balance can lead to illness. For example, washing one's hair too soon after childbirth might cause cold air to enter the body, which is still heated from the birth, eating hot or heavy foods at night can make one sick, and breastfeeding can disturb a baby and make it sick. Hot does not necessarily refer to temperature, it should be emphasized. Fish may be seen as cold regardless of temperature, while meats like beef and pork are frequently classed as hot regardless of temperature. The system is used to try to regain balance after a diagnosis of disease. Thus, some childhood diarrheas in Central America are considered to be hot, and protein-rich "hot" meals like meats are avoided, increasing any malnutrition that may already exist or that the diarrheal disease itself may increase. There is a wealth of literature on the subject of hot and cold illness classifications and therapies for numerous civilizations throughout the world.

RESEARCH METHODOLOGY

The goal of this study is to examine how culture affects health and disease with particular reference to the Tamil Nadu area of Kancheepuram. With the use of this kind of analysis, planners can pinpoint the socioeconomic factors that influence people's health condition and health-seeking behaviors in the studied area. Analysis of rural households' knowledge of and usage of health care services is the goal of the study. The study could evaluate the health-related attitudes and behaviors of the rural families. This study specifically examines the home sanitation and hygiene techniques used in rural households in the study area. The study highlights the treatment preferences and practices of rural households. In the exploratory framework, the study primarily examines a few frequent diseases among rural households. The socio-economic features of the household are then linked to the health condition and medical

behavior of rural households. As a result, this study has an exploratory and analytical component to it.

SAMPLING

Acharapakkam and Chithamur are two of the 15 blocks in the Kancheepuram district that the researcher has chosen. There are 3 communities chosen from each block. Kalathur, Athur, and Annangal villages are chosen from the Acharapakkam block. Kalpattu, Mambakkam, and Nerkunam villages are chosen from the Chithamur block. Consequently, a total of 6 villages were chosen for the current investigation. 50 households are chosen as a sample from each community. As a result, 600 respondents in all were chosen at random from the six communities. In order to offer households with diverse occupational backgrounds relative weight, additional stratification is also used.

SAMPLING DESIGN

Village Name	Total number of eligible women in the reproductive age group	Sample Women	er cent of sample
Kalathur	112	100	49.01
Athur	116	100	47.16
Annangal	198	100	51.02
Kalpattu	212	100	44.64
Mambakkam	179	100	63.29
Nerkunam	185	100	58.82
Total	1002	600	51.54

In this study, a household is regarded as a sample unit. One should be aware that a home could contain five or six people. In this study, a sample of more than 40% of the homes from each hamlet was chosen.

DATA COLLECTION AND ANALYSIS

With the aid of a carefully planned interview schedule, the researcher has amassed the required primary data. By building a strong rapport with the respondents, the pertinent data are gathered from them. The respondents gave full cooperation in order for data collection to be successful. The responses are often accurate and good. The report of the rural health mission served as the source of the necessary secondary data for this investigation.

RESULTS AND DISCUSSION

HEALTH STATUS AND HEALTH CARE PRACTICES

It should be noted that out of the 600 total respondents, 13.67% earn less than Rs. 3000 per month, 23% earn between Rs. 3001 and 6000, 30% earn between Rs. 6001 and 9,000, and 18% earn between Rs. 9001 and 20,000. Furthermore, 15.33 percent of them make between Rs. 12,000 and more each year. Half of the respondents are expected to earn more than Rs. 6,000 per month, according to the debate.

Out of the 600 respondents, 34.33 percent are illiterate, 32.33 percent have only completed their primary education, 18.26 percent have completed their secondary education, and 15.08 percent have earned a degree. Nearly a third of the respondents are expected to have completed secondary school and earned a degree, according to the conversation. Illiterates are less significant in this study than literates. 600 people responded to the survey, and of those, 29.96% are farmers, 34% are laborers, 19.67% are employed in the private sector, and 16.66% are employed by the government.

PROFILE OF THE RESPONDENTS

TABLE -1: SOCIO-ECONOMIC CHARACTERISTICS OF SAMPLE RESPONDENTS

Income group	Number of respondents	Percentage
Below Rs.3000	82	13.67
Rs.3001-6000	138	23.00
Rs.6001-9000	180	30.00
Rs.9001-12000	108	18.00
Rs.12001 and above	92	15.33
Total	600	100.00
Occupation Group		
Labourers	204	34
Farmers	178	29.67
Private sector employees	118	19.67
Government employees	100	16.66
Total	600	100.00
Education group		
Illiterate	206	34.33
Primary	194	32.33
Secondary	112	18.26
Degree	88	15.08
Total	600	100.00

HEALTH STATUS

Based on selected indicators of physical, social, and mental health, health status is determined. On a scale of 1 to 5, 21 factors can be used to evaluate it. These include experiencing tension,

neck pain, difficulty sleeping, feeling depressed, having negative feelings, backache, neck pain, constipation, menstrual discomfort, colds and the flu, stiffness, fatigue, lack of spine flexibility, occurrence of skin allergies, dizziness, lightheadedness, negative feelings, occurrence of accidents, having negative feelings, interest in maintaining a healthy lifestyle, emotional wellbeing, nutritional status, and body mass.

TABLE 2 VILLAGE WISE RESPONDENTS' HEALTH STATUS

Villages	High level mean score 3.5-4.5	Moderate level mean score 2.5-3.5	Low level mean score below 2.5	Total
Kalathur	24 (24.00)	18 (18.00)	58 (58.00)	100
Athur	60 (40.00)	20 (20.00)	20 (40.00)	100
Annangal	34 (34.00)	50 (50.00)	16 (16.00)	100
Kalpattu	36 (36.00)	28 (28.00)	36 (36.00)	100
Mambakkam	52 (52.00)	18 (18.00)	30 (30.00)	100
Nerkunam	48 (48.00)	24 (24.00)	28 (28.00)	100
Total	254 (39.00)	158 (26.33)	188 (34.67)	600

Source: Computed from the Primary Data Figures in parentheses denote percentage

The health status of the respondents from the hamlet is shown in the data in table 2. It should be highlighted that 39% of the 600 respondents, or those with a secured mean score between 3.5 and

4.5 on a 5-point rating scale, have high health status. A majority of respondents in Nerkunam village (48%) and more than half of respondents in Mambakkam village (52%) have good levels of health status. It should be emphasized that respondents in the study area who have high levels of health status also tend to have high levels of income, occupation, and educational status. A mean score of 2.5 to 3.5 on a 5-point grading scale indicates that 26.33 percent of the 600 respondents overall have medium health status.

CHI-SQUARE SUMMARY RESULT

Chi-square Calculated value	Degrees of freedom	Chi-square table value at 5%
34.00	12	17.2

In the Annangal village survey, 50% of respondents reported having a medium level of health status. A secured mean score below 2.5 on a 5-point rating scale indicates low health condition for 34.67% of the study's total respondents. It should be emphasized that the majority of respondents from the villages of Kalathur (58%) and Athur (40%) had poor health.

For additional discussion, the Chi square test is utilized. At a 5% level of significance, the computed chi square value of 34 is higher than its tabular value. As a result, there is a big discrepancy between respondents' health and village status.

From the explanation above, it is evident that among the selected respondents in the study region, those with good health status rank first, those with low health status rank second, and those with medium health status rank last. The general health status of the respondents from Nerkunam and Mambakkam villages is at a reasonably high level, reflecting their physical, mental, and social well-being as a result of their favorable socioeconomic situation. Due to their low socioeconomic position, individuals from Kalathur and Athur villages frequently report having poor health.

CONCLUSION

It has been noted that rural households with the highest income levels typically have good health statuses as a result of adopting acceptable dietary and medical practices. Rural responders with low incomes typically have poor health condition. This results from poor dietary choices and subpar medical procedures. The low income rural respondents have a limited ability to use the health care services and facilities that are available to them in their rural communities, and they have a limited ability to pay for such services.

As can be observed from the study's findings, respondents who worked for rural governments held the top spot for having a good health status. Their level of education and financial situation are to blame for this. The respondents from rural labor groups typically have poor health conditions as a result of their low income and level of education. The respondents from the rural labor group are less conscious of their health and unable to take advantage of the government-funded health services and facilities that are offered.

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