

Health Consciousness among Illiterate and Literate Women in District Srinagar

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ABSTRACT The present research study titled, "Health Consciousness among Literate and Illiterate Women in Srinagar District" was conducted on a sample of fifty women among whom twenty-five were literate and twenty-five illiterate. The study focused on physical and mental health consciousness and was conducted to assess factors affecting the health consciousness among the literate and illiterate women, to assess the health status among the respondents and to compare consciousness among literate and illiterate women. Random sampling technique was used to select the sample. The tool used for the collection of data was health profoma, self-designed questionnaire and interview schedule. The study revealed the majority of both illiterate and literate women have the same food intake as other members in the family. Most of the respondents have not attended any lecture related to nutrition. Moreover, majority of illiterate and literate women sometimes had salads whereas, for most respondents fruits formed a regular part of their diet. Further, it was interpreted from the study that majority of women do not go for regular exercise to improve their health. They consult general physician during sickness and rely quite often on medicine. Women do not take iron rich foods during their menstrual periods. Food taboos were found to be common among them. Knowledge regarding nutritional needs was also found to be negligible.

INTRODUCTION

Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind, body and spirit, usually meaning to be free from illness, injury or pain (as in "good health" or "healthy"). The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO 1948, 2006). Although this definition has been subject to controversy, in particular as lacking operational value and because of the problem created by use of the word "complete", it remains the most enduring (Jadad 2008). Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Diseases (ICD), are commonly used to define and measure the components of health.

Women are central to development. They control most of the non-money economy through

bearing and raising children, and providing much of the labour for household maintenance and subsistence agriculture. Everywhere in the world women have two jobs- in the home and outside it. Their health suffers, their children suffer and their work suffers. Not only do women have special health needs because they bear and nurture children but they do most of the caring for their family's good health. So if women are ignorant, malnourished, over-worked and if they start having a large number of children at an early age, then the health of their families as well as their own health will continue to suffer. It is their health and their level of education that will to large extent determine the health and productivity of future generations of both the sexes. Women suffer a great deal of mental trauma and anguish as a consequence of discrimination in all spheres of life. Most women in India face the strain of domestic and occupational work which leaves them with little time for self awareness, and for looking into their own psychological needs. Women constitute half of the population of our society, women are also among the most under developed, illiterate and exploited segment of the society. Their role in the nation's economy is ignored not just in one society but in developing and even in developed and advanced countries and they remain backward educationally, economically and socially which affect their health status (Kumar 2006). When the world of health policy and public

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health considers the health of women, one tendency is first and foremost to link the well-being of women to that of children and the family, and, legitimately, to the health of society overall. Although this perspective is well-founded given that the health of women is well-documented to have a positive impact on the general health of all members of a society, too often a common focus among health policy decision-makers is to emphasize maternal and child health. Women's health within the policy domain is often defined as reproductive health and identified with women's children's health. Family planning efforts, inspired by the theory that overpopulation is a major impediment to development, have dispensed contraceptives in the interests of reducing fertility, but often ignored women's needs for information about, and control over, reproductive processes (Angell 2008).

Efforts to improve the health of women's children through programs that affect women's health are laudable. Yet, in the past decade, as women have begun to exercise greater influence over health policy formation, questions about such trends have been raised. Initially, women asked "Where is the 'M' in MCH programs?" (Rosenfield and Maine 2005). "What about programs designed to address women's needs as women as well as mothers?" Such questions challenge traditional health policies that focus primarily on MCH programs; the call for definitions of women's health which are broader than the reproductive and the maternal, incorporating mental and physical health across the life cycle, has been repeatedly expressed in recent years. As feminist theorists have recently argued, women's well-being is "not solely determined by biological factors and reproduction, but also by the effects of workload, nutrition, stress, war, migration" (der Kwaak et al. 2008). Mainstreaming a gender perspective into the health sector requires a broad-based definition of health for women as well as men that addresses well-being across the life cycle and in domains of both physical and mental health. Mainstreaming a gender perspective needs to be coupled with mainstreaming mental health issues as well, because women disproportionately suffer from mental health disorders and are more frequently subject to social causes that lead to mental illness and psychosocial distress. Ellen (2011) said that she completed a large study of treatments for depression, and although

there wasn't an emphasis on women's mental health, the study didn't show any differences in treatment responses for women and men in interpersonal psychotherapy and pharmacotherapy. Usually research focuses on differences between men and women. The study was officially published in the journal *Psychological Medicine* in early 2011. Galloway et al. (2002) explored factors influencing women's decisions to take iron supplements in 8 developing countries. The sample consisted of 1,40 + pregnant women, non-pregnant women of child bearing age, midwives, health care workers, healers, nurses, doctors, community leaders, elders, and husbands/partners residing in Guatemala, Honduras, Indonesia, India, Bolivia, Burkina faso, Malawi, and Pakistan. Questionnaire covering knowledge, attitude, and practices regarding maternal anemia, including its causes, consequences, symptoms, and treatments were completed by subjects. The majority of subjects recognized anemia by symptoms such as headache, dizziness, paleness, weight loss, and loss of appetite, rather than by specific clinical name. Anemia was attributed to a poor quality diet and lack of food due to poverty, hard work and working in the sun. Good diet, nutritious food, vitamins, and medication were considered as appropriate treatments by the subjects in all countries. The major barriers to effective iron supplementation programmes reported by the subjects were inadequate supply, poor distribution of iron tablets, inadequate counseling, lack of access to and poor usage of prenatal health care services, and beliefs against consuming medications during pregnancy.

METHODOLOGY

For the present study 50 women from district Srinagar were selected as the sample. Among them, 25 were illiterate and 25 literate. Purposive random sampling technique was used to select the sample and the tool used for the collection of data was health profoma and self designed closed ended questionnaire. A self designed questionnaire was prepared which consisted of following sections:

Section A- Comprised of questions related to the background information.

Section B- was designed to check the physical appearance of the respondents.

Section B (I)- Comprised of questions related to physical health.

Section B (II)- Questions related to the mental health and thus formed the last section.

After the required information was gathered, the data was carefully analyzed and tabulated. Analysis was done using a statistical software viz., Statistical package for Social Sciences by using column percentage, Chi-square analysis, and level of significance.

Objectives

1. To study the physical and mental health consciousness among literate and illiterate women.
2. To assess the factors affecting the health consciousness among literate and illiterate women.
3. To compare consciousness among these two groups.

RESULTS

In Table 1 it was found that 90% of illiterate and 72% literate have the same food intake as other members in the family. This shows insignificant relationship between the two ($p>0.05$). Further results also shows that 60% illiterate respondents don't know whether nutritional needs are same throughout life as they don't have any concept about it; whereas 76% of literate knew that nutritional needs vary throughout life. Chi-square analysis shows highly significant relationship between the two ($p\leq 0.01$). When asked whether they had attended any lecture related to nutrition, 84% illiterate and 52% lit-

erate revealed that they had not attended any lecture related to it. This depicts highly significant relationship between the two ($p\leq 0.01$). 56% of illiterate and literate women sometimes had salads which shows insignificant relationship ($p>0.05$). Furthermore, 36% of illiterate women sometimes included fruits in their diet, whereas, for 48% literate women fruits were a regular part of their diet. Such differences are statistically insignificant at level of 0.05. Among illiterate 84% and literate 92% revealed that they go for health check-ups when required which depicts insignificant relationship between the two ($p>0.05$) (Table 2).

Table 3 reveals that 40% illiterate and 52% literate respondents rely quite often on medicine. Chi-square analysis shows that the relationship between the two is highly significant ($p\leq 0.01$). While responding to the question of overcoming their health problems, 84% illiterate and 68% literate revealed that they consult general physician. Such differences are statistically insignificant ($p>0.05$). 92% of illiterate and 68% of literate revealed that they don't go for regular exercise to improve their health which shows significant relationship at a level of 0.05. Further, the results show that 44% illiterate and 64% literate had some knowledge of food and nutrition. Chi-square analysis shows that the relationship between the two is highly significant. Food taboo was common among 32% of illiterate and literate women. Common food taboos included not having fish and curd and fish and milk. This reveals insignificant relationship between the two ($p>0.05$). Further

Table 1: Educational status and factors affecting health consciousness

Factors	Indicators	Educational status				Total		χ^2 analysis
		Illiterate		Literate				
		F	%	F	%	F	%	
Food Intake of Family Members	Similar	17	68.00	18	72.00	35	70.00	0.09 ₁ *
	Dissimilar	8	32.00	7	28.00	15	30.00	
	Total	25	100.00	25	100.00	50	100.00	
Concept About Nutritional Needs	Some through life	4	16.00	5	50.00	9	18.00	19.12 ₂ ***
	Vary in life	6	24.00	19	76.00	25	50.00	
	Don't know	15	60.00	1	4.00	16	32.00	
	Total	25	100.00	25	100.00	50	100.00	
Attended Nutrition Education Lectures	Attended	4	16.00	12	48.00	16	32.00	5.88 ₁ ***
	Not attended	21	84.00	13	52.00	34	68.00	
	Total	25	100.00	25	100.00	50	100.00	

Degree of freedom (df) in sub-scripts of χ^2 -values column percentage

* Insignificant ($p> 0.05$)

** Significant ($p\leq 0.05$)

*** High significant ($p\leq 0.01$)

Table 2: Educational status and factors affecting health consciousness

Factors	Indicators	Educational status				Total		χ^2 analysis
		Illiterate		Literate		F	%	
		F	%	F	%			
Consumption of Salads	Yes	6	24.00	8	32.00	14	28.00	3.48 ₃ *
	No	3	12.00	-	-	3	6.00	
	Sometimes	14	56.00	14	56.00	28	56.00	
	Very often	2	8.00	3	12.00	5	10.00	
	Total	25	100.00	25	100.00	50	100.00	
Consumption of Fruits	Yes	7	28.00	12	48.00	19	38.00	6.24 ₃ *
	No	4	16.00	-	-	4	8.00	
	Sometimes	9	36.00	6	24.00	15	30.00	
	Very often	5	20.00	7	28.00	12	24.00	
	Total	25	100.00	25	100.00	50	100.00	
Health Check-up	Rarely	1	4.00	1	4.00	2	4.00	1.09 ₂ *
	When required	21	84.00	23	92.00	44	88.00	
	Regularly	3	12.00	1	4.00	4	8.00	
	Total	25	100.00	25	100.00	50	100.00	

Degree of freedom (df) in sub-scripts of χ^2 -values column percentage

* Insignificant ($p > 0.05$)

** Significant ($p \leq 0.05$)

*** High significant ($p \leq 0.01$)

table shows that 60% illiterate and 36% literate didn't as such consume iron rich foods during their periods depicting insignificant relationship between the two ($p > 0.05$).

DISCUSSION

From the present study it was found that both illiterate and literate have the same food intake as other members in the family. Also most of the illiterate sample doesn't know whether nu-

tritional needs are same throughout life whereas maximum literate women revealed that nutritional needs vary throughout life. A similar study (Beigh 2006) revealed that there is need for educating and creating awareness among women about nutrition.

Moreover, majority respondents had not attended any lectures related to nutrition. On the contrary, a study conducted in Mid-Western University employees (1983) indicated that the respondents have more knowledge about gen-

Table 3: Educational status and factors affecting health consciousness

Factors	Indicators	Educational status				Total		χ^2 analysis
		Illiterate		Literate				
		F	%	F	%	F	%	
Rely on Medicine	Rarely	6	24.00	12	48.00	18	36.00	11.39 ₂ ***
	Quite often	10	40.00	13	52.00	23	46.00	
	Very much	9	36.00	-	-	9	18.00	
	Total	25	100.00	25	100.00	50	100.00	
	Change in diet	4	16.00	4	16.00	8	16.00	
Measure to Overcome Health Problems	Exercise	-	-	4	16.00	4	8.00	4.42 ₂ *
	Consult physician	21	84.00	17	68.00	38	76.00	
	Total	25	100.00	25	100.00	50	100.00	
	Yes	-	-	-	-	-	-	
	No	23	92.00	17	68.00	40	80.00	
Perform Regular Exercise	Regularly	-	-	4	16.00	4	8.00	5.56 ₂ **
	Sometimes	2	8.00	4	16.00	6	12.00	
	Total	25	100.00	25	100.00	50	100.00	

Degree of freedom (df) in sub-scripts of χ^2 -values column percentage

* Insignificant ($p > 0.05$)

** Significant ($p \leq 0.05$)

*** High significant ($p \leq 0.01$)

Table 4: Educational status and health consciousness

Consciousness	Indicators	Educational status				Total		χ^2 analysis
		Working		Non-working				
		F	%	F	%	F	%	
Food Concept	Diet	4	16.00	8	32.00	12	24.00	9.62 ₂ ***
	Hunger satisfaction	10	40.00	1	4.00	11	22.00	
	Nutrition	11	44.00	16	64.00	27	54.00	
	Total	25	100.00	25	100.00	50	100.00	
Follow Food Taboos	Follow	2	8.00	3	12.00	5	10.00	1.53 ₄ *
	Don't follow	8	32.00	8	32.00	16	32.00	
	For fish and curd only	8	32.00	8	32.00	16	32.00	
	For fish and milk only	7	28.00	5	20.00	12	24.00	
	Others	-	-	1	4.00	1	2.00	
	Total	25	100.00	25	100.00	50	100.00	
Consumption of Iron Rich Foods	Consumed	2	8.00	8	32.00	10	20.00	5.10 ₂ *
	Don't consume	15	60.00	9	36.00	24	48.00	
	Sometimes consume	8	32.00	8	32.00	16	32.00	
	Total	25	100.00	25	100.00	50	100.00	

Degree of freedom (df) in sub-scripts of χ^2 -values column percentage

* Insignificant ($p > 0.05$)

** Significant ($p \leq 0.05$)

*** High significant ($p \leq 0.01$)

eral nutrition than about the resources and functions of specific nutrients. Their major source of information were newspaper or magazines and other family members where as the preferred source were various mass media. The study further reveals that majority of the respondents both illiterate and literate sometimes had salads whereas; for most respondents fruits form regular part of their diet.

The study further reveals that majority of the respondents both illiterate and literate sometimes had salads whereas; for most respondents fruits form regular part of their diet. Majority of the respondents revealed that they consult general physicians at the time of any health problem and rely quite often on medicine.

Majority of respondents didn't go for regular exercises to improve their health. Bruce (1993) found that adult women need to pay increased attention to their exercise level. A person of the age needs to engage in weight bearing exercise. A sedentary life style exacerbates bone loss. Walking for 30 minutes 4 times a week is a reasonable start but the intensity of exercise should be gradually increased.

Further, cent percent of the women consume both vegetarian and non- vegetarian type of food. Non-vegetarian food forms a major part of the diet in Kashmir, probably because of the climatic condition and event as part of the culture. Majority of literate and illiterate women did not

consume iron rich foods during their menstrual periods.

CONCLUSION

Most of the respondents were ignorant about different nutritional needs in various stages of life as they had not attended any lectures related to it. Fruits were taken regularly by majority of women while as, salads were hardly form a part of their diet. Further it was found that the majority of the women consulted general physician during ailments and rely quite often on medicine. Most of the women did not go for regular exercise to improve their health. Food taboos were common among the respondents. Majority of the women did not take iron rich foods during their menstrual periods.

RECOMMENDATIONS

After analyzing the results it can be recommended that awareness camps should be organized to make people especially women aware of the importance of good health, balanced diet, regular exercise, importance of iron rich foods during menstrual periods, changing nutritional needs during different stages of life etc. Both print and electronic media should be used to disseminate such information. *Anganwadis* should be given the more responsibility of creating awareness related to nutrition and good

health and they should be made more accountable. Awareness campaigns to be organized about the importance of visiting a counselor. Also awareness should be created about food taboos which do not have any scientific and religion base.

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