HEALTH LITERACY AND HEALTH PRACTICES IN WOMEN OF SABIA VILLAGE OF KUSHINAGAR DISTRICT: A QUALITATIVE ANALYSIS

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Abstract

The present investigation was carried out to understand the health literacy levels of rural women and how this literacy is influencing their health practices. The data was collected on 60 women. Amongst them 30 were Health workers (under Asha & Anganwadi scheme of Government of India) and 30 were housewives residing at Sabia village of Kushinagar district of eastern Utter Pradesh, India. In-depth interview responses had made it clear that the high health literacy group of participants i.e. Asha & Anganwadi health workers were doing health enhancing practices more than low health literacy group i.e. home makers as well as they were aware of benefits of maintaining general hygiene, causes of chronic and contagious diseases, knowledge about vaccination programs and the purpose of vaccination and how to prevent contagious diseases. The Asha & Anganwadi health workers also showed very few harmful health beliefs. The findings were discussed in the light of health literacy and advocacy among women.

Key words: Health literacy, health beliefs,

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Introduction

Over the last few years global health challenges like HIV/AIDS, cardiovascular diseases, diabetes etc. have expanded the attention of general population as well as those involved in health care professions (Kickbusch & Buse, 2000). In many countries literacy rates are lower among women than men, including India. There are clear indications that inadequate health literacy—as measured by reading fluency—also increases mortality rates. Health literacy plays a crucial role in chronic disease self-management as increasing rates of chronic diseases are estimated to account for almost half (47%) of the total burden of disease.

The health care facilities available in India are not so adequate to cater the needs of such a huge population. The additional costs of limited health literacy range from 3 to 5% of the total health care cost per year. Low levels of health literacy often mean that a person is unable to manage his own health effectively, access health services effectively, and understand the information available to him. Improving the health literacy of those with the worst health outcomes is an important tool in reducing health inequalities

Education and literacy are graded as key determinants of health, along with income and income distribution, employment, working conditions and the social environment. The countries ranked in the top 10 for 'women's well-being' have a female literacy rate of 90% and higher. The India Literacy Project (ILP, 2000) mentioned the data pointing out that India's literacy levels still hang around 60%, particularly due to a very low rate of female literacy. Developing countries that have attained a female literacy rate ranging from 70 to 83% have also achieved an infant mortality rate of 50 (per 100000) or lower (Save the Children, 2000).). Investment in women's education shows useful returns of positive health behaviors. Educated women are more likely to postpone marriage and childbirth, give better health care to their families, and send their children to school and contribute to overall economic growth (Filmer, 1999).

'Literacy' is now used not only to refer to reading, writing and comprehension ability, but also to describe a person's knowledge of a particular subject or field, such as nutritional literacy (Diamond, 2007), financial literacy (Vitt et al., 2000; Financial Literacy Foundation, 2007; Fear, 2008) and 'computer literacy, cultural literacy, media literacy, scientific literacy, and health literacy' (Keleher & Hagger, 2007).

The term 'health literacy' has been used for last three decades to reflect the intersection of the fields of literacy and health (Green, Lo Bianco & Wyn, 2007). The World Health Organization

(1998) has defined Health literacy as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health. It also recommends that health literacy implies the achievement of a level of knowledge, personal skills, and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions, and thus is critical to the empowerment of patients (Nutbeam, 1998, 2000). In a number of definitions health literacy was referred to as the individuals' ability to locate, understand and use information for health-related decisions and to make 'appropriate health decisions' (Ratzan, 2001; Green, Lo Bianco & Wyn, 2007). Health literacy also consists of a 'wide range of skills, and competencies that people develop to seek out, comprehend, evaluate and use health information and concepts to make informed choices, reduce health risks and increase quality of life' (Zarcadoolas et. al., 2005) as well as make sound health decisions in the context of everyday life at home, in the community, at the workplace, in the health care system, the market place and the political arena' enabling them to exert 'control over their health', 'seek out information' and assume responsibility (Kickbusch et. al., 2005); feel more empowered (Nutbeam, 2008); and, 'as a way to promote, maintain and improve health in a variety of settings across the life course' (Rootman & Gordon-El-Bihbety, 2008). However, these medical literacy definitions of health literacy say nothing about individuals who are neither patients nor part of a health-care setting; and they do not (except for arranging preventive screenings) consider the many health related decisions that people make in the context of 'keeping well' in everyday life (Peerson, 1998), rather than managing illnesses and conditions. Health literacy is directly linked to changed health behaviors and practices, engagement in social action for health and participation in altered social norms (Nutbeam, 2008).

The health literacy agenda for many countries across globe is aimed at 'improving health and reducing inequities by empowering both individuals and communities to make informed and ethical, decisions about their health'. Health literacy as a discrete form of literacy is becoming increasingly important for social, economic and health development. The positive and multiplier effects of education and general literacy on population health, particularly women's health, are well known and researched. Although overall literacy has improved in the post- independence period in India, the rate of increase has not been sufficient to reduce the number of illiterates over time. This is more so in female literacy. Illiteracy of females had a more detrimental impact

on rural than on urban areas. In the event of high female illiteracy, male literacy was beneficial for improving the use of services for reducing infant mortality rate (Gokhale, Rao, & Garole, 2002). Studies have shown that prenatal care is dependent on maternal education. Frost, Forste, & Haas, (2005) reported that socioeconomic factors are the most important pathways linking maternal education and child nutritional status, and that modern attitudes about health care also explain the impact of education, 60 percent of the effect of maternal education on child nutritional status. Moreover, literacy was the only factor independently associated with knowledge related to cervical cancer screening (Lindau et. al., 2002). Low literacy is associated with several adverse health outcomes. Scott and associates (2002) reported that patients with lower literacy were more likely to report not receiving influenza and pneumococcal immunizations compared to patients with higher literacy after adjustment for age, gender, race, education, and income (Scott et. al., 2002). Low literacy was associated with a decreased likelihood of using most preventive health measures under study for adults aged 65 and older, but not for adults of 2 younger age groups (White, Chen & Atchison, 2008).

Health behaviors have been defined in various ways. Conner and Norman (1996) defined them as any activity undertaken for the purpose of preventing or detecting disease or for proving health and wellbeing. In the Handbook of Health Behavior Research it was defined as behavior patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement (Gochman, 1997). Behaviors within this definition include medical service usage (e.g. physician visits, vaccination screening), compliance with medical regimens (e.g., dietary, diabetic, antihypertensive regimens), and self-directed health behaviors (e.g. diet, exercise, smoking, alcohol consumption).

In the light of above mentioned review, the present investigation is carried out with the objective to understand the health literacy of rural women regarding general hygiene, minor illness and major contagious as well as chronic disease and how this literacy is influencing their health practices.

Method

Sample: In the present investigation, the sample was restricted to the rural women only. This sample was selected from the Sabia village of Kushinagar district in eastern Uttar Pradesh. The sample of 60 women was further divided into two groups i.e. 30 women were working as Asha

and Anganwadi health workers who were educated at least upto to high school (high health literacy group)and they were also health literate by doing some in job trainings and 30 women were house wives, farm laborer and cooks at primary school mid day meal program with no school education (low health literacy group).

Measures: To explore health literacy level and health practices as in-depth interview was made with focus on the questions like- what are the sources of health related information? What do you do to maintain your general hygiene? What are the contagious diseases?" What do you know about vaccination? What do you do to remain healthy?

Procedure: The data was collected individually at the participant's homes. First of all, investigator had introduced herself and the purpose of study was discussed. Then all women were interviewed and their responses on health literacy and health practices were noted. Data were analyzed by content analysis method.

Results & Discussion

A number of themes had been emerged through the analysis of the interview. Educational attainment improves health directly but also indirectly through work, economic condition, social-psychological resources and healthy life style. Narratives revealed that education is positively related to women's health practices and health promotions behaviors. As the health literate ASHA and Anganwadi workers thoroughly discussed about hygiene, vaccination and doing and advocating of healthy behaviors. They were not only aware of health promoting information but also try to seek new information. It was found in previous studies that education is associated with good health. Education shapes two major psychological resources; personal control and social support. Literacy increases personal control (Mirowsky & Ross, 1989). Education develops sense of mastery and self-direction, the habits and skills of communications (inquiring, discussing, looking things up and figuring things out). Education inculcates the habit of meeting problems with attention, thought, action, and persistence. In contrast, people with low levels of educational and economic circumstances often learn that failure is built into their lives.

Sources of Health Related Information: The participants were asked "what are the sources of health related information." The responses were reflecting a variety of sources like television, pamphlets, health workers, friends, relatives, and husband and elder offspring. The high health literacy group had emphasized that because of their education, they could understand the causes

of many minor diseases, chronic diseases as well as contagious disease but the sources like media (both electronic and print media, especially television and newspaper), health camp and vaccination programs organized by health department. But the participants of low health literacy group stated that they had gained the health related information through the health related programs presented by television, Anganwadi workers, Asha and vaccination programs. And they were also aware due to conversation to other persons but don't try to implement this health information in their routine. They only use that information that may do well to their children and approved by the elders (i.e. mother-in-law and husband). They seek health information and discuss only those health relating things to significant others which were not socially stigmatized and taboo. Personal health issues and even gynecological issues were less frequently discussed by low health literate women as they feel ashamed on discussing such issues. In a study it was found that the women were most likely to discuss AIDS with their husbands as a general social issue, followed by friends and family members and least likely to talk to husbands about AIDS as a personal issue relating to their sexual relationship (Chatterjee, 1999).

Maintenance of General Hygiene: To understand the maintaining health behaviors of women, the participants were made a request, "what do you do to maintain general hygiene?". Asha and Aganwadi women responded that they follow daily routine like get up early in the morning, take rest after doing work, be active, avoid invalidated stale food and fruits, don't take medicine without prescription, see expiry date on medicine, maintain cleanliness during menstruation cycle, clean their homes and neighboring areas and change water of cooler daily. The uneducated women group did a very few health maintaining behaviors like- wash their hands before eating, use the net for safety from mosquito. They emphasized that they escaped themselves from bad eyes and jadu-tona (black magic) by puja (offering) to local deities. They did not go for doctor's consultation for minor illnesses.

Benefits of Maintaining General Hygiene: The women with low health literacy stated that if they would maintain their general hygiene, they will feel healthy and they will be able to earn bread. They would be able to care for their families. But the Asha and Aganwadi group of women had understood the benefits of maintaining general hygiene. They expressed that if they would maintain their general hygiene, they would be healthy and they could be successful in playing the important role of family's responsibilities. Due to cleanliness, the germs would not

develop and nobody would be infected by contagious diseases. Thus they were always ready to seek preventive and promotive health related information. The findings of present study showed that the high health literacy group of women reported that when they themselves or anyone else in the family became sick they preferably go to qualified medical practitioner and follow the proper treatment regimen, however, the low health literacy group of women stated that for minor illnesses they use the home remedies or go to traditional healer like ojha or priest or go for jhar-phunk or sometimes buy allopathic medicines from local pharmacy by the recommendation of a quack without knowing its side effects.

Harms of not maintaining General Hygiene: Both group of women stated that if they would not maintain their general hygiene, they would waste time, money and physical power and would be unable to carry their responsibilities.

Contagious Disease: The participants were asked "what are the contagious diseases?" Low health literacy group stated that there were some contagious diseases such as diarrhea, measles, fever, ringworm etc. And Asha and Aganwadi group stated that there were some contagious diseases like encephalitis, conjunctivitis, cholera, dengue, diarrhea, swinflue, measles etc.

Knowledge of Vaccination: The sample was asked "what do you know about vaccination?" Both groups of women had knowledge of vaccination about polio, measles, DPT etc. The uneducated women didn't have the detailed understanding about vaccination program but knew the importance of vaccination for their offspring. But Asha and Aganwadi workers were aware of every vaccination program which is helpful for their and their families' health even they knew about encephalitis vaccine.

Chronic Diseases: Both groups have a clear picture of chronic diseases like cancer, tuberculosis, AIDS, diabetes, asthma, leprosy, blood pressure, rheumatism, paralysis etc. but the difference emerges in understanding the management of such diseases like adherence to medication, precautions and preventive measures. The Asha and Aganwadi workers told that it could be develop through hereditary factors, biological causes, anemia, lack of food, due to drugs etc. But low health literacy group told that it could be develop due to poverty, *karm ka phal* (fruit of deeds in past birth) and jadu-tona (black magic). Limited literacy comes with many hardships related to health. Many qualitative researches revealed that women with limited literacy can experience difficulties when interacting with the health care system, and also on the coping

strategies they employ to circumvent these sufferings (Davis et al., 2006; Von Wagner et. al., 2009).

Prevention of Chronic Diseases: High health literacy group stated that it could be through cleanliness, timely treatment, be reliable with life partner, and give the vaccine in early childhood. Low health literacy group stated that the people could be married on proper time to avoid sex related diseases, to avoid bad eyes and evil spirit, and worship God for safety from chronic diseases. It was also found that low literate women performed religious rituals in case of illness because they assumed that illness was related with supernatural forces. Many studies found that these were performed by the tantric or sadhus who act as healers through devotion technique (Prasad, 2007). Women tend to perform *pujas* (offerings) when astrologer suggested if he finds some bad omen in the calculation of *zanam kundli* (sacred birth paper issued by *Pandit ji* containing details of zodiac sign of a person) or the occultist asked them to perform a rite to avoid bad consequences. They suggested doing so in order to protect them from the hurdles of life events or to live in a well-being state and to avoid diseases.

Health Practices: To understand the pattern of health practices in women they were asked 'what do you do to remain healthy?' High health literacy group had mentioned they were taking healthy diet, doing physical work/exercise, taking precautions, cleanliness at home and neighboring areas and maintaining regular routine more than low health literacy group. These findings suggested that health literacy in Asha and Aganwadi workers had penetrated into their collective psyche, therefore, these women became able to analyze the old rituals, traditional healing practices and health beliefs in move scientific manner. It was noticed that high literacy group was following healthy life style like doing exercise and maintaining diet plans however comparative group was dependent on religious rites. Previous findings revealed that Compared to the poorly educated, well educated people more frequently engage in positive health behaviors, like exercising, regular health checkups that may protect their health. High levels of educational attainment are positively associated with physical activity and other healthy behavior like likely to get preventive medical care, annual physical exams, immunizations, and screening (Ross & Wu, 1995), which positively affects many health outcomes.

Conclusion: It can be concluded that education is related to hygienic health practices and preventive behaviors. High health literacy group followed proper medical treatment for any disease but low literacy group preferably seeks religious way of healing due to lack of health

literacy. Being able to understand health information and make decisions from that information is vital to a person's well-being. Studies have shown a link between low literacy and poor health outcomes, like, people with lower health literacy skills had a higher incidence of diabetes-related problems (Schillinger et al., 2002), poor literacy was associated with a higher risk of hospital admission and low functional health literacy in women with diabetes was associated with factors that may negatively impact birth outcomes(Endres et. al., 2004), inadequate health literacy was associated with poorer physical and mental health in older adults (Wolf et. al., 2005).

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