Health Literacy among Rural Women with Special Reference to Community Health Centers of Madhya Pradesh: A Study

ABSTRACT OF THE THESIS

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ABSTRACT

Concept of Health Literacy

Our earliest scriptures define education as that which liberals, that provided the instruments for independence from lack of knowledge and domination. In the modern world, it could naturally include the capability to read and write, since that is the main instrument of learning. Hence the vital importance of women's education includes women's literacy.

The term ‘ health and literacy’, form an underlying concept that evolved from the 1970s to one that has captured the attention of a wide variety of disciplines, notably education and health care, but also library science, public health, and mental health. F. Butt encompasses the totality of the concept that is constructed in Health literacy. An evaluation of the concept of health literacy using the approach of concept/dimensional analysis, clear know-how of the concept is important, as health literacy has implications that are complete and affect each of man or woman and the whole society.

Historical background of Health Centers in India

The first detailed descriptions of health information system for compliant accurate and timely information on vital statistics, causes of deaths and morbidity data, nutrition, smoking utilization of alcohols and illicit drugs for the planning of health services in British India was given by Sir Joseph Bhore in his detailed reports of “Health Survey and Development Committee”, submitted to the government of India in 1946.

Health literacy could be defined as little more than an understanding of health information and instructions.In 1974, Simonds coined the term “health literacy”.

Madhya Pradesh is one of the Republic of India's largest states. The State is categorized by a complex social structure, a predominantly rural economy, a difficult and inaccessible terrain, and distribute settlements all over vast areas that together position severe challenging problems to delivery methods for health. Madhya Pradesh has a population of about 7.33 crores (approx.), which is around 6% of the country’s population. According to the form of the viewpoint of per capita income, literacy, urbanization, infrastructure, and other indicators of growth, Madhya Pradesh belongs to the country’s category of less developed regions. Infrastructure, and other indicators of growth, Madhya Pradesh belongs to the country's category of less developed regions.

Impact of Health Policies in Madhya Pradesh

In 2005, the National Rural Health Mission launched the Janani Suraksha Yojana, which emphasizes institutional deliveries, to reduce high levels of maternal and neonatal mortality. The program provides transport, financial support and incentives for Accredited Social Health Activists (ASHA) to encourage mothers to pursue institutional delivery. The scheme is fully sponsored by the central government and implemented in all states and territories of the Union (UTs), with a particular focus on low - performing states. Madhya Pradesh's performance until 2008 after JSY was introduced is summarized below with secondary source support.

It is observed that institutional deliveries have changed dramatically from 2005 - 06 onwards. The number of institutional deliveries in Madhya Pradesh is growing vastly. NRHM's evaluation study in 7 states, 2011, indicated the referral transport services viz in Madhya Pradesh. In all the first referral units (FRU), Janani Express Vehicles are functional. Although Janani Suraksha Yojana's progressive scheme was successful in bringing mothers to the institutions, the state still lacks the facilities required to ensure safe birth & medical care for children.

The trend in health and nutrition expenditure per capita shows that health expenditure in Madhya Pradesh and Bihar has always remained low compared to other EAG states. Various studies observe that various factors reduce government health spending. Also analyzed that, after the Fiscal Responsibility, Budget Management Act (FRBM) has been enacted in all states, states are left with very little scope to increase public sector allocations such as health and education. 'The FRBM Act enforces the government to reduce fiscal and revenue deficits by either raising revenue resources or restructuring/cutting overall public spending. To achieve MDG and other development goals, increased spending on health infrastructure and human resources is necessary for the state.

Defining health literacy

Health literacy has multiple definitions that are challenged among researchers and across disciplines. Considering ‘health literacy’ as a research field is considering an intersection of clinical, epidemiological, academic, health promotion, and psychological fields.

On the other hand, there has been a lack of research in the field of health information literacy that has applied a comparative perspective to explore the nature of ways in which people use knowledge to learn about health. Ultimately, there is a lack of understanding of the different

ways that people experience education in health information, or in other words, the different ways that data consumers consider having health information.

Access-evaluation, interpretation, and implementation of various parameters of health information related to health care, disease prevention, and dissemination of health information in the knowledge world.

Accessing: involves recognizing needs for health information, identifying likely sources of information, searching, finding, and obtaining information on health;

Evaluation: includes determining the value and applicability of the information. This requires the ability to interpret, sort, and analyze data on health;

Understanding: includes the study, understanding, and access to health information;

Some important definition of health literacy

Health literacy generally refers to individuals 'quality of gaining access to, understanding the use ofthe information in ways that promote and maintain good health'.

According to WHO (1998), health promotion glossary "health is 'psychological and social skills that verify human beings 'ability to access health information in ways that encourage and maintain good health."

According to the American Medical Association Foundation (1999). Defines Health Literacy as "the ability to acquire process and understand the basic health information and services necessary to make suitable health decisions and follow the standard of care instructions."

Nutbeam (2006), defines health literacy as " This has resulted in the development of 'outcomes' structures from health procedures that illustrate and explain the association between health promotion actions, health social factors and ensuing health outcomes health literacy."

Status of Women in MP

Even though it is well-known fact that the condition of women in the state is far from a satisfactory level, the state government is fully determined to improve their standard of life. The government is also taking steps to open up all the opportunities to women so that can realize their potential. To draw a comprehensive picture of the situation of women in MP an array of the temporal and spatial behaviour of social indicators is used to bring in the cultural, social, political, environmental, and developmental context of the region.

Need for Significant of the study

1. To identify the language barriers, literacy, and communication in health care.
2. To identify the role of Health Literacy in reducing health disparities.
3. To identity the Health literacy need of rural women.
4. To identity the Health literacy need of professionals.

Statement of the Problem

As researchers the factors for investigation that contribute to health disparities and unnecessary healthcare costs, one element receiving increased attention is health literacy. Health literacy is the ability to obtain, process, and appropriately act on health information (Nielsen-Bohlman, Panzer, and KindigLow health literacy has been found to contribute to poorer health outcomes (DeWalt et al.; Kalichman et al.; Lindau et al.) and increased costs to the healthcare system (Howard, Gazmararian, and Parker; Weiss and Palmer).

Hence the researcher has chosen the topic based Health Literacy among Rural Women with special reference to the Community Health Center (CHC) of MP. For the aforesaid purpose, the study is being conducted on the Community Health Center of Central India of Madhya Pradesh i.e. 42 Community Health Center out of 338 Community Health Center of Madhya Pradesh has been selected.

Objective of the study

1. To find out the key problems in accessing health-related information by the rural women of Madhya Pradesh.
2. To determine the effectiveness of data collation and analysis work done in health community centers of Madhya Pradesh.
3. To study the relationship between literacy and health status of the rural women of Madhya Pradesh.
4. To identify the awareness of health literacy of rural women in health care in Madhya Pradesh.
5. To study the quality of life of the rural women of Madhya Pradesh.
6. To know, how rural women use information.

Hypotheses are considered as an important instrument in research. The main purpose of hypotheses is to suggest a new experiment and observations. It can say hypotheses are the

tentative answer of the proposal made by the researcher at the beginning of the study M.R.Cohan and E. Nagge have described the function of hypotheses as follows:

1. The function of hypotheses is to direct our search for the order amongst facts.
2. It is of considerable advantage. It is a systematic inquiry that begins with a suggested explanation or solution of the difficulty, which are originated in it. Something in the subject matter and our previous knowledge suggest such a tentative explanation to us.

Based on the above points, the researcher has framed the following hypotheses for the present study:

1. The growth of health literacy in health information canter of Madhya Pradesh is not satisfactory.
2. There is a lack of trained, qualified professionals to provide the health care community and very less Community center.
3. There is no significant relationship between literacy and the quality of life of rural women.

Scope of the study

The scope of the study is limited to the Community Health Centers of Madhya Pradesh. They are divided into five Zones of Madhya Pradesh North Zone (Gwalior and Shivpuri), East Zone (Ujjain and Mandsaur), West Zone (Satna and Sagar), Central Zone (Bhopal only) and the South Zone (Indore and Dewas). The community health Centers located in selected cities of Madhya Pradesh is studied under this study.

The list is given below:

S.No	Zone	Blocks	Name of CHC
1.	Central Zone	Bhopal	Gandhinagar
2			Berasia
3	North Zone	Gwalior	Bhitarwar
4			Mohana
5		Shivpuri	Badarwas
6			Karera
7			Khaniadhana
8			Kolaras
9			Narwar
10			Pichhore
11			Pohari
12		Mandsaur	Malhargarh
13			Sitamau

14	East Zone		Shamgarh
15		Ujjain	Ghatia,
16			Tarana
17	West Zone	Sagar	Banda
18			Gadakota
19			Devari
20			Jaisinagar
21			Kesli
22			Kurai
23			Maalthona
24			Rahatgarh
25			Shahgarh
26			Surkhi
27		Satna	Amarpatan
28			Devrajnagar
29			Nagod
30			Majhgawan
31			Mukundpur
32			Rampur Baghelan
33			Uchehera
34	South Zone	Dewas	Bagli
35			Kannoad
36			Khategaon
37			Sonkachh
38			Toankkhurd
39		Indore	Depalpur
40			Sanwer
41			Manpur
42			Mhow

Methodology of the Study

Research is an inquiry or a deep and careful investigation especially searching for new facts in any branch of knowledge. The research design refers to a plan, blueprint, or guide for data collection and interpretation, sets of rules that enable the investigator to conceptualize and observe problems understudy". The appropriateness of the study mainly depends on the research design chosen for the study. It is a way for solving, the research problems in a well-organized and systematic manner. For conducting research, proper planning of research is most important, upon which the whole study depends.

Sampling and Size of the Sample

Community Health Center (CHC) is extending across India and also Madhya Pradesh. A total of 42 Community Health Center (CHC) dealing with various health disciplines are present in

Madhya Pradesh. The Community Health Center (CHC) is divided into 4Zones: Central, Northern, Southern, Eastern and Western Zone of Madhya Pradesh. 09 Community Health Center (CHC) are covered and taken as a sample from every Zone.

Some major finding based on the rural women questionnaire

- It has been found that 1230 questionnaires were distributed in overall 41 community centers out of which 1074 questionnaires have been received back. Most of the 24.16% questionnaires have been received from the Sagar district.
- It has been found that most of the rural women i.e 39.10 belong to OBC and 37.16 belong to SC category filled the questionnaires which are received back. While Sagar CHC and Satna district's questionnaire have been received from 24.30 OBC and 17.31 SC category candidates from the whole sample.
- 67.59% of the rural women had an average monthly family income from Rs. 2000-4000. While rural women of Ujjain district 83.01% and Gandhinagar district is 73.33% Bhopal have the lowest monthly income.
- Average monthly earnings of 25.41% of the rural women ranged from Rs. 5000-10000 and that of only0.37% ranged between Rs. 10000-more.
- 39.94% of rural women were found to be illiterate. While 56.25 are the most illiterate women found in Gwalior district.
- A large majority of rural women, almost 37.24% of rural women were educated at only at primary level. A very marginal proportion of the entire sample, less than 0.93% were graduates among rural women in whole sample.
- 49.33% of the rural women's husband were doing agriculture and 37.12% of rural women's husband are doing private work, whereas 56.18% of rural women husband's are doing agriculture work in Mandsour.
- It is found that the types of houses, Ownership of House, Number of Rooms, toilet facility, drinking water, electricity availability, Leisure time spent were highest in Sagar which is 1467 (24.49%), and lowest in Dewas which is 2.21%.
- It was found that 574 (i.e. 53.09%) women were unaware of health literacy, whereas 505 (i.e. 46.71%) women were aware of health literacy.
- It is found that the most of 73.37% of rural were unaware of health literacy in Shivpuri.
- The majority of rural women i.e. 45.16% were not aware of health literacy because of lack of health information, whereas 43.94% of rural women were unaware of health

literacy because of lack of health education, 9.03% are not have any interest in health information.

- It was found that the highest 56.06 of rural women are not accessing health information, resources, and services from the CHC and 43.94% were accessing the same.
- It was found that the highest percentage of Sagar district are aware of the knowledge about immunization, sources of information on immunization, and awareness about diseases prevention and the percentage is 24.63.The lowest percentage was found in the Ujjain zone which is 4.90%.
- It was found that the overall availability and accessibility is highest in Sagar, where rural women with (27.67%), lowest in Gwalior where it is only 3.94%.
- Women are satisfied with road network and percentage is 63.18 and the lowest is 36.82% women are satisfied with.
- The overall barriers for health treatments were faced by 63.67% rural women were because women were not able to afford doctor, medicine, and their social status.
- It was found that the highest 59.01% rural women were aware of the nutritious diet, whereas 40.98 percentage of rural women were not aware of about nutritious diet.
- Most of the 84.67 percentage of rural women were not aware of nutritious diet in the Sagar district.
- It found that the highest 73.02 percentage of rural women were not taking complete nutritious diet due to lack of monthly income and the lowest 26.97 percentage of rural women were not awere of the complete nutritious diet.
- It found that the highest 96.46 percentage of rural women chosen government hospitals, while 3.34 percentage of rural women chosen home for their child delivery.
- It is found that the overall 71.32 percentage of rural women were aware of contraception, while 28.68 were not aware of contraception.
- It is found that the most of 27.58 rural women of Sagar district was not aware about the use of contraception.
- It was found that 60.87 percentage of rural women were never using contraception. Whereas 39.13 percentages of rural women were using contraception.
- It is found that the reason for not using contraception by rural women was lack of information which is 41.21%, followed by 33.59% due to side effects, 25.21% percentage are not using because their husband are not agree.

- It was found that 59.14 percentage of rural women received to health information from CHC, Gwalior, followed by 21.66% received from district hospital, having 5.22%accesse it from sub-center, and whereas 1.59% accesses from television, women for getting health information.
- It was found that 87.32 percentage of rural women have taken treatment during pregnancy, while 12.68 percentage of rural women were not taken treatment during pregnancy.
- It is found that 89.09 % of rural women preferred CHC, 5.45 percentage of rural women preferred sub-center, 5.37 percentages of rural women were preferred private hospitals in case they were facing any health issue.
- It was found that the overall preferred hospital by rural women was maximum i.e 15.60% in Sagar and lowest 5.12% in Gwalior.
- It was found that the availability of nurse staff was maximum i.e 19.99%, doctors was 18.97%, lab technician 18.25, compounder 14.91% staff at CHC. While 26.44 health females worker, 26.11 health male worker, 22.31 health inspectors, 15.22 attendent staffs were not available in a regular mode.
- It is also found that the availability of staff was maximum in Sagar CHC 24.3 and least in Gandhinagar CHC with 2.46%.
- It is found that the availability of lab technician staff was maximum i.e. 28.55%, followed by a labour room with 28.43%, followed by a nurse with 20.22%, followed by a doctor with 20.22 percentage of medical staff available in CHC. While Radiographers & X-Ray Machines maintenance staffs are 41.05% are not available and the generator satff is also not available in CHC.
- It was also found that the availability of staff are maximum in Sagar CHC with 25% and the lowest staff was 4.7% available in Gwalior CHC.
- It was found that the aspect of immunization was maximum 15.14%, 12.84% Natal care (Pre and Postnatal), malaria with 11.90%, 11.77% body pain, 9.63% knee pain, followed by 9.33 cough, 8.65 blood pressure, 4.13 eye infection, followed by 3.23 menopause etcare some important reasons to visit CHC by rural women.
- It was also found that the availability of main aspect to visit CHC was maximum in Sagar district CHC 24.54, while a minimum of 4.79 in Ujjain CHC visited by rural women.
- It is clear that the poor activities like voicing against social justice are 14.02%, 13.91% Supporting widow remarriage, 13.36% Supporting equal status for women,

12.22% Decision about family Affairs, 12.72% Decision about health at home, 10.30 Family planning methods, 10.30 using the toilet, 9.52water facilities are poor condition.

- The overall social statuses of rural women are poor which is 68.82%, whereas 28.11 percentage women are having good social status.

Testing of Hypotheses

Hypotheses 01-The growth of health literacy in the health information center of Madhya Pradesh is not satisfactory.

H0= There growth of health literacy in the health center of Madhya Pradesh not satisfactory

H1= There is the growth of health literacy in the health center of Madhya Pradesh and it is satisfactory.

Level of significant =05 (from table 4.10.20)

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	56.000[a]	49	.229

a. 64 cells (100.0%) have expected count less than 5. The minimum expected count is .13.

b. Since p<.05, therefore p-value of chi-square indicates that the difference is statistically significant. Therefore, the null hypothesis (Ho) is rejected and the alternate hypothesis (H1) is accepted.

The table described that most rural women accessing to health information from CHC, Primary health center, and staff.

Hypotheses 02-There is a lack of trained, qualified professionals to provide the health care community and very less Community center.

H0= there is no lack of trained qualified professionals in CHC.

H1= there is a trained qualified professional in CHC.

Level of significance .05 (from table 5.2.25)

$\chi^{2=}$ 14.011 df= 12 p= .301

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.000[a]	12	.301

Since p<.05, therefore p-value of chi-square indicates that the difference is significant. Therefore, the null hypothesis (Ho) is rejected and the alternate hypothesis (H1) is accepted.

Form the availability of staff maximum in Sagar CHC with 25% and the lowest staff was 4.7% available in Gwalior CHC.

Hypotheses 3- There is no significant relationship between literacy and quality of life of rural women.

H0= There is a significant relationship between literacy and quality of life of rural women.

H1= There is no significant relationship between literacy and quality of life of rural women.

Significant value=.05 (form table 4.10.26)

ANOVA						
		Sum of Squares	df	Mean Square	F	Sig.
Poor	Between Groups	40495097.136	9	4499455.237	257.340	.048
	Within Groups	17484.500	1	17484.500		
	Total	40512581.636	10			
Good	Between Groups	6646687.500	9	738520.833	46.098	.114
	Within Groups	16020.500	1	16020.500		
	Total	6662708.000	10			
Very Good	Between Groups	36397.636	9	4044.182	126.381	.069
	Within Groups	32.000	1	32.000		
	Total	36429.636	10			

F=46.09

df=9

P=.0114

Since p<.05, therefore p-value of chi-square indicates that the difference is statistically significant. Therefore, the null hypothesis (Ho) is rejected and the alternate hypothesis (H1) is accepted.

Therefore, the above hypothesis is accepted and proved as the social status of rural women.

Conclusion

The research shows an intuitive awareness of the value of education for health information. The model is solely a function of the study's qualitative and quantitative results. The studies developed in this study by and broadly disclosed health literacy/health information literacy to be a new concept that needs to be substantiated in the Indian context to create a community of health literates. The study points out that the survey reflected on health literacy; by providing reliable health information/ sources, it was more important to build health determinants and organizations and opportunities for living a healthy life and making healthy choices. In general, it was also pointed out that various important factors such as culture, customs, education, social and economic status, marketing, and behaviors educated and collective decision-making on health. It would be beneficial to have a more systematic assessment of human health information literacy, health systems, and the usefulness and integrity of current deliberative methodology, including higher-level practices.

Suggestions based on rural women questionnaire

1. For the successful implementation of women welfare programs, the participation of women Stakeholders is essential. Widespread awareness about the programs among groups of beneficiaries and other stakeholders including voluntary agencies etc. would be desirable.

2. The top-down approach in Planning and Implementation has led to the formulation of schemes without assessment of the need of the people. Thus the interests of the people in these programs have declined. Stakeholders would, therefore, need to be actively involved in the formulation and planning of all schemes. This would facilitate not only better planning but also better monitoring of the programs.

3.Rationalization of objectives, specification of goals/sub-goals, their operationalization in terms of variables, preparation of a base-line/ preparedness profile, identification of target group, existing or new organization of people at the

local level, the process of intervention or service delivery, community participation, change over time in the socio-economic status of target groups(outcome/impact), conflicts are very important aspects to be looked upon.

4. Their resolution during the implementation of a scheme, bottlenecks and their correction, transparency of results and future leads, comparison of this data with those of other schemes in terms of opportunity, access, input, use, client satisfaction, social environment, and strains, cost-effectiveness, created assets infrastructure/equipment) and impact, etc. should deserve attention.

5. Government should take in confidence to the Panchayats for the successful implementation of the programs at the village/block level. Similarly, the Nagar Palikas in the towns should also be empowered to implement welfare programs in towns and cities.

6. Local participation in monitoring and evaluation is suggested to counter the traditional top-down approach to monitoring and evaluation. It has been seen that the traditional approach does not give a clear picture of the various schemes and projects being monitored. The conventional monitoring technique has proved costly and ineffective in terms of measuring and assessing program achievements. A bottom-up strategy that employs participatory methodologies should be encouraged.

RECOMMENDATIONS

1. **Adequacy of Health Facilities:** Dedicated cells/ units/autonomous bodies should be considered (within states) to monitor the pace of all public constructions, including hospitals, perhaps with penalty clauses. An annual report of this cell should be presented in the state assembly. To further the idea of bringing care closer to where people stay - and Health and Wellness centers- the establishment of new Sub-centers needs the continued priority.

2. **Utilization and Continuum of Care:** Dedicated initiatives/programmers on technology-driven CMEs for peripheral providers and tale-consultations of patients at CHCs should be considered to address the issues related to undue referrals.

3. **District Hospital Strengthening**: States must be incentivized to propose general ICUs and High dependency units for every 10-lac population region. This would ensure an emergency infrastructure- at first, shared by 2 or 3 districts within the government system. The use of district hospitals as training sites has been reported by

4 out of 15 Customer Relationship Management (CRM) states. Sourcing-in faculty from nearby government and credible private medical colleges should be considered to meet the demand of trainers. NHM should also be looking at possibilities of supporting credible not-for-profit missionary/trust hospitals for acting as training sites. Many such hospitals currently act as training sites and if provided sufficient autonomy, may agree to partner with the government.

4. **Procurement and availability of drugs: Disruptive solutions** –such as bulk procurement by center or prioritizing access to drugs as a special measure in broader agenda of NE. Other areas for continued focus are encouraging generic prescriptions, increasing general awareness on the use of antibiotics, and scaling up prescription audits.

5. **Free Diagnostics:** Strengthening Block PHCs/ Sector PHCs as hubs are required to ease the burden on higher facilities. The use of vaccine carriers as lab sample carriers could be proposed with additional incentives. The Madhya Pradesh States that have opted for private partnerships in the provision of lab services, now need to move towards assessing the outcomes of these partnerships, with support from NHSRC and other such institutions.

6. **Biomedical equipment maintenance:** Specific support will be needed by states to recruit biomedical engineers for the Programme to be implemented.

7. .**National Dialysis Program:** In States with models of Public-Private Partnership (PPP) and In-house schemes, the drugs and diagnostics related to dialysis, should be provided free of cost to all beneficiaries. The National Dialysis Programme should be linked to free diagnostics initiative and drugs should be enlisted in the EDL directory.

8. **Access to Blood:** Here the recommendation is to bring sanctioning and licensing under a single department of CHC and increasing demand for blood and linking it to non-surgical care. This would involve better identification and assured transfusions for cases of severe anemia. Also, forming guidelines on the use of Unbanked Direct Blood Transfers for states that have made minimal could be explored for improving access to blood.

9. **AYUSH:** Moving forward, inter-ministerial collaboration to ease out apprehensions related to bridge course for AYUSH and to promote AYUSH systems through NHM would be required.

10. **Ambulances**: There is a need for ensuring uniformity in training of providers, scaling up emergency response teams, and solving the last-mile concerns in hilly and difficult regions. Support would be needed by states to foster local experiments in inpatient transfer from remote regions. Systems-level thinking is perhaps required, to move beyond the innovative ideas of bike ambulances and similar suggestions.

. SUGGESTIONS FOR FURTHER RESEARCH

1. An exclusive research study' may be carried out by considering the variables like motivation, personality factors on the health awareness of neo-literates.
2. A study may be carried out on the health awareness of adult education.
3. A study on the problems of health personnel working in the government and non-government sectors may be carried out.
4. A study on the effectiveness of mass media in promoting health awareness may be undertaken.
5. In depth studies relating to health issues touching upon policy Implications, training, and administration may be attempted.
6. A study on the health literacy among Urban Women.