

Demographic Profile and Health Consciousness of Rural Women of Reproductive Age Group in Khammam District of Telangana State

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ABSTRACT: People who are health-conscious have a greater grasp of their own health, pay attention to individual health problems, and then adopt healthy measures to ensure their personal health. Health consciousness is a part of individual consciousness. To study the demographic profile characteristics of rural women and health consciousness of rural women. The study was conducted in rural areas i.e., Wyrā and Enkoor mandals of Khammam district, Telangana state. The results of the study indicated that majority (52.50%) of the respondents belonged to young age followed by early middle age (32.50%) and 15.00 percent were in the late middle age category. Majority (22.50%) of the respondents were illiterates followed by high school education (20.63%), graduation & above (17.50%), college education (16.88%), middle school education (12.50%) and primary school education (10.00%). Majority (33.33%) of the respondents were agricultural labourers and 30.00 per cent were housewives, followed by other occupations. Majority (70.63%) of the respondents belonged to nuclear families followed by joint families (28.75%) and a meagre percentage belonged to extended families (0.62%). The respondents have an optimistic mindset towards their well-being and health, but they must be educated to take care of themselves regarding health consciousness. They have an optimistic mindset towards their well-being and health, but they must be educated to take care of themselves. Hence, there is a need to improve respondents' attitudes and practices towards health. Respondents should be aware of and take care of their entire family, as well as their neighbourhood and kin. Anyone who wants to attain achievement throughout their life must be in a healthy state. Everyone searching for fulfilment in life needs to stay in a good state of health. Raising consciousness and altering attitudes in order to encourage a healthier lifestyle certainly will have an influence on the future happiness and well-being of rural women.

Keywords: Health consciousness, Demographic, Rural, Women.

INTRODUCTION

Health consciousness is a part of individual consciousness. Consciousness is defined as "the state of understanding and realizing something," and it is closely associated with individual thoughts, memories, and feelings. It can not only convey information but also generate meaningful information and alter in response to individual requirements, allowing humans to behave independently. Becker *et al.* (2013) defined health consciousness as "the degree to which a person is

inclined to engage in health-related activities." It exhibits sensitivity to physical health, stress, and health threat factors. Gould classified health consciousness into four dimensions: health self-consciousness, health involvement, health attentiveness, and health self-monitoring. According to Hong (2011), believes that health consciousness includes three potential dimensions: Health Self-consciousness, Personal responsibility, and Health motivation. According to the theory of self-consciousness, Self-consciousness can predict the consistency of attitude and behaviour, which

includes health consciousness and health habits. Consistency exists between health consciousness and health behaviours. People who are health-conscious have a greater grasp of their own health, pay attention to individual health problems, and then adopt healthy measures to ensure their personal health. People truly recognized the importance of health to individuals during the COVID-19 pandemic, and their health consciousness would be considerably strengthened, thus they would adopt health habits to safeguard their health.

MATERIALS AND METHOD

The study was conducted in rural areas of Khammam district, Telangana state. Purposive random sampling was adopted for sample selection with criteria of women belonging to the reproductive age group (15-49 years), families having at least one smart phone with internet connection constituting to the sample of 160 rural women. A total 160 sample, 80 sample from Wyr mandal and 80 sample from Enkooor mandal of Khammam district. Two villages from each mandal i.e., total four villages, 40 women respondents from each village were selected. Data was collected with the help of developed schedule and Scale developed by Gould's

(1990) was used. The specific objectives for the study are as under following heads.

Objective 1: To study the demographic profile characteristics of rural women

Objective 2: To study the health consciousness of rural women

RESULTS AND DISCUSSION

Objective 1

To study the demographic profile characteristics of rural women

Profile of the respondents included age, education, occupation, and family type. The distribution of the respondents into the different categories based on their profile characteristics were presented in the tables by dividing the sample into groups by class interval method and discussed.

Age. The age of the respondents was measured as the number of completed years as reported by the women. Based on the age, they were grouped into three categories as follows. Based on chronological age, the respondents were classified into three categories namely young (< 30 years), early middle age (30-40 years) and late middle age (40 -50 years).

Table 1: Distribution of respondents according to their age n=160.

Sr. No.	Age (in years)	Gannavaram (n=40)		Rebbavaram (n=40)		TL Peta (n=40)		Moolapocharam (n=40)		Total (n=160)	
		F	%	F	%	F	%	F	%	F	%
1.	Young (< 30 years)	23	57.50	22	55.00	21	52.50	18	45.00	84	52.50
2.	Early middle age (30-40 years)	13	32.50	12	30.00	13	32.50	14	35.00	52	32.50
3.	Late middle age (40-50 years)	4	10.00	6	15.00	6	15.00	8	20.00	24	15.00
	Total	40	100.00	40	100.00	40	100.00	40	100.00	160	100.00

Table 1 indicated that in Gannavaram village, more than half (57.50%) of the respondents belonged to young age followed by early middle age (32.50%) and late middle age (10.00%). In Rebbavaram village, more than half (55.00%) of the respondents belonged to young age followed by early middle age (30.00%) and late middle age (15.00%). In TL Peta village, little more than half (52.50%) of the respondents belonged to young age followed by early middle age (32.50%) and late middle age (15.00%). In Moolapocharam village, less than half (45.00%) of the respondents belonged to young age followed by early middle age (35.00%) and late middle age (20.00%).

Overall, a little more than half (52.50%) of the respondents belonged to young age followed by early middle age (32.50%) and 15.00 percent were in the late middle age category. This might be due to the reason that the main criterion followed for selection of the respondents was that they should possess one smart phone connection in their family youngsters are more tend to have smart phones.

The results were in harmony with the study of Behera *et al.* (2022) stated that 13.8% respondents were in the age group of 15-19 years, 18.7% of the respondents were 20-29 years, 45.5% of the respondents 30-39 years, 21.9% of the respondents were 40 years and above.

Education. It refers to the educational level of the respondents, who were classified into six categories namely illiterate, primary school, middle school, high school, college education and graduation and above.

Table 2 indicated that in Gannavaram village, equal portions (30.00%) of the respondents completed their middle school and high school education and followed by college education (15.00%), graduation & above (10.00%), equal portions of primary school education (7.50%) and illiterates (7.50%). In Rebbavaram village, majority (37.50%) of the respondents were graduated followed by college education (22.50%), high school education (15.00%), primary school education (10.00%), equal portions of middle school education (7.50%) and illiterates (7.50%). In TL Peta village, majority (37.50%) of the respondents were illiterates followed by college education (22.50%), high school

education (17.50%), graduation & above (10.00%), primary school education (7.50%) and middle school education (5.00%). In Moolapocharam village, majority (37.50%) of the respondents were illiterates followed by high school education (20.00%), primary school education (15.00%), graduation & above (12.50%), equal portions college education (7.50%), and middle school education (7.50%).

Overall, majority (22.50%) of the respondents were illiterates followed by high school education (20.62%), graduation & above (17.50%), college education (16.88%), middle school education (12.50%) and primary school education (10.00%). The above table depicts that majority of the respondents were illiterates as well as completed their high school education may be due to the reason that schools were located very far from their villages. Safety and security aspects and financial problems which prevented women to take up higher education.

The results were in accordance with the results of Thahirabanu Ibrahim and Logaraj (2021) revealed that in their investigation of the effectiveness of a health education programme in encouraging cervical cancer screening among rural women in Tamilnadu's Chengalpattu district. Illiterate, primary education, secondary education, and graduated were the four categories used to describe the respondent's educational status. Majority of respondents (32.04 percent) finished elementary school, while 26.00 percent were illiterate, 22.07 percent finished high school, and 18.09 percent had a diploma.

Occupation. Based on occupation, the respondents were classified into seven categories namely agriculture, agricultural labour, small business, government job, housewife, private job, and student. The following table shows the data obtained and analyzed.

Table 2: Distribution of respondents according to their education n=160.

Sr. No.	Education	Gannavaram (n=40)		Rebbavaram (n=40)		TL Peta (n=40)		Moolapocharam (n=40)		Total (n=160)	
		F	%	F	%	F	%	F	%	F	%
1.	Illiterate	3	7.50	3	7.50	15	37.50	15	37.50	36	22.50
2.	Primary School	3	7.50	4	10.00	3	7.50	6	15.00	16	10.00
3.	Middle School	12	30.00	3	7.50	2	5.00	3	7.50	20	12.50
4.	High School	12	30.00	6	15.00	7	17.50	8	20.00	33	20.63
5.	College Education	6	15.00	9	22.50	9	22.50	3	7.50	27	16.88
6.	Graduation & above	4	10.00	15	37.50	4	10.00	5	12.50	28	17.50
	Total	40	100.00	40	100.00	40	100.00	40	100.00	160	100.00

Table 3: Distribution of respondents according to their occupation n=160.

Sr. No.	Occupation	Gannavaram (n=40)		Rebbavaram (n=40)		TL Peta (n=40)		Moolapocharam (n=40)		Total (n=160)	
		F	%	F	%	F	%	F	%	F	%
1.	Agriculture	8	20.00	4	10.00	3	7.50	10	25.00	25	15.63
2.	Agricultural labour	15	37.50	5	12.50	15	37.50	18	45.00	53	33.13
3.	Small business	4	10.00	3	7.50	5	12.50	0	0.00	12	7.50
4.	Government Job	2	5.00	6	15.00	4	10.00	4	10.00	16	10.00
5.	Housewife	10	25.00	19	47.50	11	27.50	8	20.00	48	30.00
6.	Private Job	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
7.	Student	1	2.50	3	7.50	2	5.00	0	0.00	6	3.75
	Total	40	100.00	40	100.00	40	100.00	40	100.00	160	100.00

*No respondent in private job category

Table 3 revealed that in Gannavaram village, majority (37.50%) of the respondents belonged to agricultural labour category followed by house wife (25.00%), agriculture (20.00%), small business (10.00%), government job (5.00%) and student (2.50%). In Rebbavaram village, majority (47.50%) of the respondents belonged to house wife followed by government job (15.00%), agricultural labour (12.50%), agriculture (10.00%), equal portions small business (7.50%) and student (7.50%). In TL Peta village, majority (37.50%) of the respondents belonged to agricultural labour category followed by house wife

(27.50%), small business (12.50%), government job (10.00%), agriculture (7.50%), and student (5.00%). In Moolapocharam village, majority (45.00%) of the respondents belonged to agricultural labour category followed by agriculture (25.00%), house wife (20.00%), government job (10.00%).

Overall, majority (33.13%) of the respondents belonged to agricultural labour category followed by housewife (30.00%), agriculture (15.62%), government job (10.00%) small business (7.50%), and student (3.75%). The above table depicts that majority of the respondents' belonged to agricultural labour category

and housewife may be due to the reason that respondents being rural sample were mostly dependent on agricultural activities and taking care of their families.

The results were in harmony with the study of Bathla *et al.* (2018) studied the Assessment of Food Habits and Dietary Intake of Rural Women. The main source of income among the families of selected respondents

were labour (61.7%) followed by farming (20.0%), service (10.0%), any other occupation (5.0%) and business (3.3%).

Family type. Based on the type of the family, the respondents were classified into three categories namely nuclear families, joint families, and extended families.

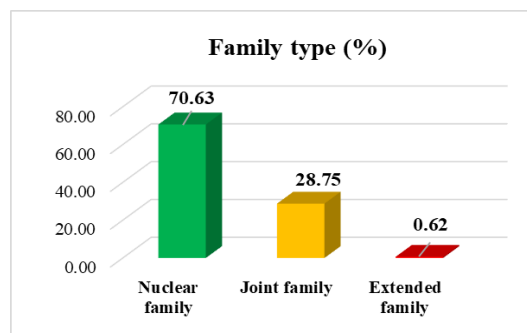
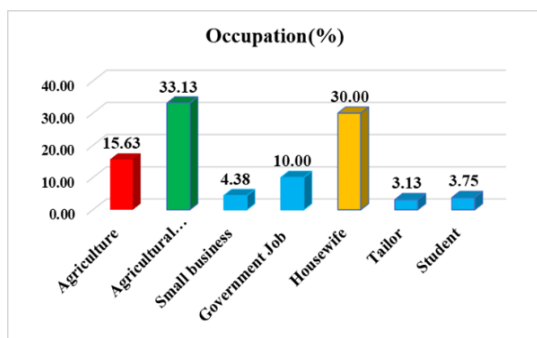
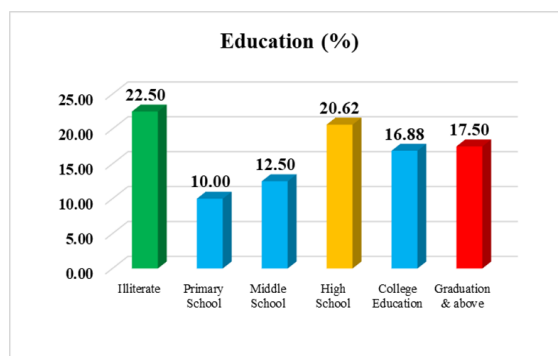
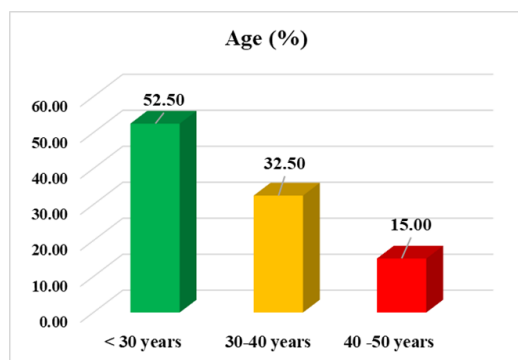
Table 4: Distribution of respondents according to their family type n=160.

Sr. No.	Family type	Gannavaram (n=40)		Rebbavaram (n=40)		TL Peta (n=40)		Moolapocharam (n=40)		Total (n=160)	
		F	%	F	%	F	%	F	%	F	%
1.	Nuclear family	30	75.00	30	75.00	29	72.50	24	60.00	113	70.63
2.	Joint family	10	25.00	9	22.50	11	27.50	16	40.00	46	28.75
3.	Extended family	0	0.00	1	2.50	0	0.00	0	0.00	1	0.63
	Total	40	100.00	40	100.00	40	100.00	40	100.00	160	100.00

It can be noted that in Gannavaram village, majority (75.00%) of the respondents were belonged to nuclear families followed by joint families (25.00%). In Rebbavaram village, majority (75.00%) of the respondents were belonged to nuclear families followed by joint families (22.50%) and extended families (2.50%). In TL Peta village, majority (72.50%) of the respondents were belonged to nuclear families followed by joint families (27.50%). In Moolapocharam village, majority (60.00%) of the respondents were belonged to nuclear families followed by joint families (40.00%). Overall, majority (70.63%) of the respondents belonged to nuclear families followed by joint families (28.75%)

and a meagre percentage belonged to extended families (0.62%). This might be due to the reason that joint family heritage has shifted from extended to nuclear families as a result of modern economic and social advancement in society. The tradition of having a combined family system became less common year by year. This is why women chose to live individually to meet their requirements.

The results were in harmony with the results of Singh and Tajsvita (2020) most respondents (60%) shared a joint family system, 32% shared a nuclear family system, and 8% shared an extended family system.



Objective 2

2. To study the health consciousness of rural women.

The health consciousness is the degree to which

respondents' concern or mindset about their self health and which is the basis for them to take health measures. The health consciousness was measured using the scale developed by Gould (1990).

According to Hong (2011), this re-conceptualization, health consciousness refers to an individual's comprehensive mental orientation towards her health, being comprised of self-health awareness, personal responsibility, and health motivation, as opposed to being related to a specific issue (e.g., smoking, exercise, healthy diet).

The scale consists of 11 items and were loaded with three factors. Four items heavily loaded on factor 1, measuring self-health awareness, or the tendency to focus attention on one's health. Another four items loaded on factor 2 pertained to personal responsibility. The remaining three items pertained to health motivation. Health consciousness, as consisting of three dimensions (e.g., self-health awareness, personal responsibility, and health motivation).

The three factors of health consciousness are self-health awareness, personal responsibility, and health motivation.

Table 5: Distribution of respondents according to their health consciousness n=160.

Sr. No.	Health consciousness	Gannavaram (n=40)		Rebbavaram (n=40)		TL Peta (n=40)		Moolapocharam (n=40)		Total (n=160)	
		F	%	F	%	F	%	F	%	F	%
1.	Self-conscious about health	37	92.50	29	72.50	21	52.50	11	27.50	98	61.25
2.	Attentive to their feelings about health	12	30.00	9	22.50	8	20.00	5	12.50	34	21.25
3.	Feeling of health reflection	12	30.00	12	30.00	7	17.50	7	17.50	38	23.75
4.	Concerned about health all the time	8	20.00	11	27.50	4	10.00	3	7.50	26	16.25
5.	Concern for physical well-being	11	27.50	11	27.50	7	17.50	5	12.50	34	21.25
6.	Taking self-responsibility for health	26	65.00	23	57.50	16	40.00	21	52.50	86	53.75
7.	Good health leads to active participation	11	27.50	11	27.50	11	27.50	6	15.00	39	24.38
8.	Worried about their health during sickness	18	45.00	23	57.50	34	85.00	30	75.00	105	65.63
9.	Leading life without illness is important	18	45.00	24	60.00	26	65.00	20	50.00	88	55.00
10.	Health depends on one's own care	9	22.50	13	32.50	5	12.50	4	10.00	31	19.38
11.	Living life in the best possible health is very important	11	27.50	10	25.00	4	10.00	4	10.00	29	18.13

The above table indicates that in Gannavaram village, in terms of factor 1 i.e., self-health awareness, majority (92.50%) of the respondents agreed that they were "self-conscious about health", equal portions (30.00%) of the respondents agreed that they were "attentive to their feelings about health", and "feeling of health reflection", only 20.00 percent "concerned about health all the time". In factor 2 i.e., personal responsibility, majority (65.00%) of the respondents stated that they would "taking self-responsibility for health" followed by less than half of the respondents "worried about their health during sickness" and equal portions (27.50%) of the respondents agreed that they would "concern for physical well-being" and "good health leads to active participation". In factor 3, health motivation, less than half of the respondents (45.00%) stated they were "leading life without illness is important", followed by (27.50%) agreed that "living life in the best possible health is important" and 22.50 percent agreed that "health depends on one's own care".

In Rebbavaram village, in terms of factor 1 i.e., self-health awareness, majority (72.50%) of the respondents agreed that they were "self-conscious about their health", followed by less than half (30.00%) of the respondents agreed that "feeling of health reflection", (27.50%) of the respondents agreed that they were "concerned about health all the time" and only 22.50 percent "attentive to their feelings about health". In factor 2 i.e., personal responsibility, equal portions (57.50%) of the respondents stated that they would

"taking self-responsibility for health" and "worried about their health during sickness" followed by equal portions (27.50%) of the respondents agreed that they would "concern for physical well-being" and "good health leads to active participation". In factor 3, health motivation, majority (60.00%) of the respondents stated they were "leading life without illness is important", followed by (32.50%) agreed that "health depends on one's own care" and 25.00 percent agreed that "living life in the best possible health is important".

In TL Peta village, in terms of factor 1 i.e., self-health awareness, majority (52.50%) of the respondents agreed that they were "self-conscious about their health", followed by 22.50 percent "attentive to their feelings about health", (17.50%) of the respondents agreed that "feeling of health reflection", and only 10.00% of the respondents agreed that they were "concerned about health all the time". In factor 2 i.e., personal responsibility, majority (85.00%) of the respondents "worried about their health during sickness", followed by (40.00%) stated that they would "taking self-responsibility for health", (27.50%) of the respondents agreed that "good health leads to active participation" and 17.50% agreed that they would "concern for physical well-being" In factor 3, health motivation, majority (65.00%) of the respondents stated they were "leading life without illness is important", followed by 12.50 percent agreed that "health depends on one's own care" and (10.00%) agreed that "living life in the best possible health is important".

In Moolapocharam village, in terms of factor 1 i.e., self-health awareness, majority (27.50%) of the respondents agreed that they were “self-conscious about their health”, followed by (17.50%) of the respondents agreed that “feeling of health reflection”, 12.50 percent “attentive to their feelings about health”, and only 7.50% of the respondents agreed that they were “concerned about health all the time”. In factor 2 i.e., personal responsibility, majority (75.00%) of the respondents “worried about their health during sickness”, followed by more than half (52.50%) stated that they would “taking self-responsibility for health”, (15.00%) of the respondents agreed that “good health leads to active participation” and 12.50% agreed that they would “concern for physical well-being”. In factor 3, health motivation, half (50.00%) of the respondents stated they were “leading life without illness is important”, followed by equal portions (10.00%) of the respondents agreed that “health depends on one’s own care” and agreed that “living life in the best possible health is important”.

Out of the total sample, Overall, in terms of factor 1 i.e., self-health awareness, majority (61.25%) of the respondents agreed that they are “self-conscious about their health”, followed by (23.75%) of the respondents agreed that “feeling of health reflection”, 21.25 percent “attentive to their feelings about health”, and only 16.25% of the respondents agreed that they were “concerned about health all the time”. In factor 2 i.e., personal responsibility, majority (65.63%) of the respondents “worried about their health during sickness”, followed by (53.75%) stated that they would “taking self-responsibility for health” (24.38%) of the respondents agreed that “good health leads to active participation” and 21.25% agreed that they would “concern for physical well-being”. In factor 3, health motivation, majority (55.00%) of the respondents stated they were “leading life without illness is important”, followed by 19.38 percent agreed that “health depends on one’s own care” and (18.13%) agreed that “living life in the best possible health is important”.

The results indicated that women’s self-health awareness has increased since the outbreak of COVID-19, as they were increasingly mindful about their state of health. Furthermore, they are more engaged in agricultural labour, and when confronted with difficult challenges in agriculture, they are concerned and worried about their health, i.e., personal responsibility increased. They have an optimistic mindset towards their well-being and health, but they must be educated to take care of themselves.

The results were in accordance with the results of Kumar *et al.* (2022) stated that most people were conscious of self-care and safety precautions, as well as Coronavirus signs and symptoms. The use of social media was the most rapid method for making people become more conscious regarding knowledge dissemination and preventing outbreaks of pandemics.

CONCLUSIONS

The study conclude that the respondents were conscious about their health regarding their self-health awareness.

The study emphasises the need for personal responsibility, and health motivation. After COVID -19 outbreak people become more conscious more health related issues, but they were not focussing on one’s own care towards health and concern for physical well-being. As a result, there is a need to improve respondents’ attitudes and practices towards health. Respondents should be aware of and take care of their entire family, as well as their neighbourhood and kin. Anyone who wants to attain achievement throughout their life must be in a healthy state. Everyone searching for fulfilment in life needs to stay in a good state of health. Raising consciousness and altering attitudes in order to encourage a healthier lifestyle certainly will have an influence on the future happiness and well-being of rural women.

FUTURE SCOPE

Respondents could be given a capacity-building programme on health and mental health issues. The significance of self-care and its associated components. This programme may help them improve their overall health and well-being.

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Conflict of Interest. None.

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