



ISSN: 2456-0057

IJPNPE 2021; 6(2): 36-38

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Received: 16-05-2021

Accepted: 24-06-2021

**Dr. Hoshiyar Singh**Associate Professor & Head,  
Department of Physical  
Education, J.S.P.G. College,  
Sikandrabad, Bulandshahar,  
Uttar Pradesh, India

## Investigating gender differences in health beliefs among rural population

**Dr. Hoshiyar Singh**

### Abstract

Hypertension is one of the non-communicable disease accounting for 10.8 percent of all deaths and 4.6 percent of all disability-adjusted life years in the country. There are several risk factors which contributes the hypertension. Health beliefs are important in preventing health risk behavior and give insight for individual to practice beneficial health behavior. By considering the increment of hypertension and utility of health beliefs, present study was undertaken to assess if there are any differences exists in health beliefs between males and females residing in rural areas. The present cross-sectional study conducted on a rural population of Mawana Tehsil in Meerut district of Uttar Pradesh, on individuals aged 18 years and above. A total of 263 participants were selected by multi-stage random sampling technique. The questionnaires for data collection comprised of a Demographic data sheet and Hypertension belief scale Robinson (2012). Descriptive statistics and one way Anova were used to analyze the findings. From the results it was observed that there was no significant difference found in the domain of perceived susceptibility, perceived severity, perceived barriers and self-efficacy. There was a significant difference found between males and females in the domain cues to action ( $p < 0.05$ ) and perceived benefits ( $p < 0.01$ ).

**Keywords:** health beliefs, hypertension, anova, males, females

### Introduction

Economic progress has empowered humankind successfully but the sedentary lifestyle has given way to non-communicable diseases. The number of deaths due to non-communicable diseases increased since 2000 in every region across the globe (WHO, 2014) [8]. World Health Organization (2011) [6] suggests that a total number of deaths due to non-communicable disease in male was 29, 67,600 and 22, 73,800 in females. While the percentage of deaths due to non-communicable disease occurring under the age of 70 is 61.8% in males and 55.0% in females, indicating that the younger population is at a higher risk than older people (WHO 2011) [6]. Cardiovascular diseases are the leading causes of death due to non-communicable diseases in 2012 i.e., 46.2% of non-communicable disease deaths (WHO, 2014) [8].

Hypertension is the leading factor contributing to most of the cardio vascular diseases. Hypertension is defined as a condition in which systolic blood pressure is equal to or greater than 140 mmHg and/ or diastolic blood pressure equal to or greater than 90 mmHg (WHO, 2013) [7]. According to WHO (2013) [7], 23.10% men and 22.60% of women over 25 years suffer from hypertension. Gupta (2016) [4] reported that prevalence of hypertension increased from about 1% in 1950's to 15% in 1990's in urban and from 0.5 to 7% in rural population; in the last twenty years prevalence of hypertension in urban locations has stabilized to about 25–30% but it has increased in rural population from 15 to 25%.

Health beliefs are important in preventing health risk behavior and give insight for individual to practice beneficial health behavior. The health belief model, developed by Becker & Maiman (1975) [3], is useful in analysing self-care activities related prevention of the diseases and focuses on behaviour related to the prevention of disease. Health beliefs are subjective evaluation of individual's susceptibility, severity, benefits and barriers towards healthy behavior and one's ability to successfully perform an action is self-efficacy.

According to the WHO (2013) [7] both men (23.10%) and women (22.60%) over 25 years suffer from hypertension, which indicates both men and women are equally effected by the hypertension. By considering the equal increment hypertension prevalence among male and

**Corresponding Author:****Dr. Hoshiyar Singh**Associate Professor & Head,  
Department of Physical  
Education, J.S.P.G. College,  
Sikandrabad, Bulandshahar,  
Uttar Pradesh, India

females and utility of health beliefs in prevention of diseases and practice of health promoting behaviors, present study is undertaken to assess if there are any differences exists in health beliefs between males and females residing in rural areas.

## Methods

### Research design

The present cross-sectional, quantitative study used a descriptive research design to assess the differences in health beliefs between males and females

### Study area

Study area for the present study was Mawana Tehsil in Meerut district of Uttar Pradesh, is one of the backward tehsil in Uttar Pradesh placed some backward position among other Tehsils of Uttar Pradesh on the basis of various socio-economic indicators, Based on 2011 Census data, total numbers of villages in Mawana Tehsil in Meerut district of Uttar Pradesh were 159 with the population of 2.96 lakhs people.

### Population, sampling technique, sample size and procedure

Population for the present study included all the individuals who were residing in Mawana Tehsil in Meerut district of Uttar Pradesh in the age group of 18 and above; multi-stage random sampling method was used to select the 263 participants from three villages of Mawana Tehsil namely (Manpur, Sujatpur and Askaripur). Following sampling procedure was followed to select the participants. Initially,

researcher had selected 3 villages randomly from Mawana Tehsil by lottery method, after selecting villages, unique number was given to each households in all the three villages and selected randomly by lottery method, finally, all the households having persons aged 18 year and above fulfilling the selection criteria were included in the study and selected randomly by lottery method.

### Survey instruments

The questionnaire for data collection comprised of a socio-demographic data sheet and hypertension belief scale (Robinson, 2012).

### Data collection procedure

Data collection was done at the household level by the researcher. All eligible members of the selected households were provided information on the study objectives and were enrolled with their consent. After selecting the participants through lottery method, rapport was established with the members and they were explained the purpose of the study. Before starting the interview the researcher had administered the screening tool to find out whether the participant met the criteria of the study. If the participant meet the inclusion criteria, questionnaires were administered to them. Questionnaires include the items related to sociodemographic information and hypertension knowledge.

### Statistical analysis

All the data collected were entered in to the SPSS-20. Analysis of the results was done by using of descriptive statistics and one way Anova.

**Table 1:** Distribution of socio demographic characteristics of study participants

	<b>Demographic Variables</b>	<b>Male (N = 123) n%</b>	<b>Female (N = 140) n%</b>	<b>Total N%</b>
Age Group	18-30	25 (20.3)	45 (32.1)	70(26.6)
	31-45	38 (30.9)	42 (30)	80 (30.4)
	>46	60 (48.9)	53 (37.8)	113 (43)
Education	No formal schooling	55 (44.7)	110 (78.6)	165 (62.7)
	Less than primary school	29 (23.6)	12 (8.6)	41 (15.6)
	Primary school completed	7 (5.7)	9 (6.4)	16 (6.1)
	Secondary school completed	2 (1.6)	0	2 (.8)
	High school completed	14 (11.4)	4 (2.9)	18 (6.8)
	College/Graduation completed	16 (13.0)	4 (2.9)	20 (7.6)
	Post-Graduation degree and above	0	1 (0.7)	1 (.4)
Occupation	Government employee	2 (1.6)	0	2 (.8)
	Non-government employment	5(4.1)	2 (1.4)	7 (2.7)
	Self-employed	44 (35.8)	13 (9.3)	57 (21.7)
	Non-paid	3 (2.4)	5 (3.6)	8 (3.0)
	Student	4 (3.3)	2 (1.4)	6 (2.3)
	Home maker	0	37 (26.4)	37 (14.1)
	Unemployed able to work	4 (3.3)	2 (1.4)	6 (2.3)
	Unemployed Unable to work	21 (17.1)	20 (14.3)	41 (15.6)
	Daily Wage Labourers	40 (32.5)	59 (42.1)	99 (37.6)
Marital Status	Never married	14 (11.8)	8 (5.7)	22 (8.4)
	Currently Married	105 (85.4)	113 (80.7)	218 (82.9)
	Separated	1 (.8)	1 (.7)	2 (.8)
	Widowed	3 (2.4)	18 (12.9)	21 (8.0)
Religion	Hindu	118 (95.9)	132 (94.3)	250 (95.1)
	Muslim	4 (3.3)	7 (5.0)	11 (4.2)
	Christian	1 (.8)	1 (.7)	2 (.8)

From the Table 1 it was observed that majority of the participants were above the age group of 46 i.e., 43% (Male 48.9% vs. female 37.8%), formal education i.e. 62.7% (Male 44.7% vs. Female 78.6%), daily wage labourers overall

37.6% (Male 32.5% vs. female 42.1%), Self-employed overall 21.7% (Male 35.8% and Female 9.3%), unemployed unable to work overall 15.6% (Male 32.5% vs. Female 42.1%). Majority of the participants were married overall 82.9%

(Male 85.4 vs. Female 80.7%), belonged to Hindu religion overall 95.1% (male 95.9% vs. female 94.3%)

**Table 2:** Shows Gender Differences in Health Belief Subscales

Hypertension Belief Sub Scale	Gender	M	SD	F	p
Perceived Susceptibility	Male	3.34	0.47	0.898	0.344
	Female	3.41	0.55		
Perceived Severity	Male	3.71	0.35	0.327	0.071
	Female	3.61	0.5		
Cues to action	Male	1.91	0.85	3.96	0.048
	Female	1.7	0.79		
Perceived benefits	Male	3.63	0.359	7	0.009
	Female	3.51	0.353		
Perceived Barriers	Male	2.6	0.57	0.086	0.77
	Female	2.62	0.53		
Self-efficacy	Male	3.14	0.47	0.942	0.333
	Female	3.2	0.43		

Table 2 shows Gender differences in health belief subscales among 263 participants (Males 123 and Female 140). Using analysis of variance (One Way ANOVA) it was revealed that there was no statistically significant difference between males and females in the domain perceived susceptibility (males M=3.34; SD=.47) (females M=3.41; SD.55). There was no statistically significant difference observed in the domain perceived severity between males and females (Males M=3.71; SD=.35) (females M=3.61; SD=0.5) There was a significant difference found between males and females in the domain cues to action ( $p<0.05$ ), males found to have high mean score (M= 1.91; SD= 0.85) than females (1.7= .0; SD=0.79). There was significant difference found in the domain perceived benefits ( $p<0.01$ ) between males (M=3.63; SD=.359) and females (M=3.51; SD=0.35). There was no significant difference found between males and females in the domain perceived barriers (males M= 2.6; SD= .57) (females M=2.62; SD =0.53). There was no significant difference found between males and females in the domain self-efficacy (males M= 3.14; SD= .47) (females M=3.2; SD =0.43).

## Discussion

The present study aimed at assessing the differences in the health beliefs between male and female participants residing in rural areas. From the results it was observed that there is no significant difference found in the domain of perceived susceptibility, perceived severity, perceived barriers and self-efficacy. There is a significant difference observed in the domain cues to action which male and females differed in receiving the information about the illness. These findings are in consistent with the study by Stefan (2015) [5], reported that women were more interested in receiving more informal health-related information from close family members, other kin and friends/workmates than men did. There is a significant difference found between males and females in the domain perceived benefits. This could be attributed to the reason that in the present study males were less active in receiving the information than females which further influenced perceiving the benefits from engaging health promoting behaviors.

## Conclusion

From the findings it was observed that males and female participants differed in the domain of cues to action and perceived benefits. So in future research providing health information and giving interventions should be much more emphasized to the gender gap in trouble shooting health

information behaviour.

## References

1. Das Anindita. Health Education, Prerna Prakashan, New Delhi 2012.
2. Mishra SC. Handbook of Health Education, Sports Publication, New Delhi 2001.
3. Becker MH, Maiman LA. Socio behavioural determinants of compliance with health and medical care recommendations. Medical care 1975, 10-24.
4. Gupta R. Convergence in urban-rural prevalence of hypertension in India. Journal of human hypertension 2016;30(2):79-82.
5. Stefan EK. Gender differences in health information behaviour: A Finnish population based survey. Health Promotion International 2015;30(3):736-745.
6. World Health Organization. Global status report on non-communicable diseases 2010. Geneva: World Health Organization 2011.
7. World Health Organization. A global brief on Hypertension: Silent killer, global public health crises (World Health Day 2013). Geneva: WHO 2013.
8. World Health Organization. Global health estimates: Deaths by cause, age, sex and country, 2000-2012. Geneva, WHO 2014, 9.