Journal of Agricultural Development and Policy, 2025
Volume 35, No. 1, 89-94
https://doi.org/10.63066/23220457.35.1.012

NAAS - 4.34
UGC CARE List Journal

Health Practices and the Influence of Socio-Cultural Beliefs in Rural Punjab

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Abstract

Health is a universal social objective that encompasses both physical well-being and overall quality of life. To represent Punjab as whole , this study was carried out in three distinct cultural regions: Majha, Malwa, and Doaba. To choose a representative sample, four districts from each of the three zones were chosen using a multistage sampling technique. Each district's two blocks and two villages yielded data, and each village had 20 respondents (10 SCs and 10 Non-SCs) constituting 320 respondents. The study explored factors such as home remedies, son preference, belief in stones and amulets, and gender-related hesitancy. SCs tend to depend more on home remedies due to their non-affordability. SCs have a higher belief in stones and amulets, reflecting cultural traditions and limited access to modern healthcare. Additionally, SCs show more hesitancy in consulting male doctors, particularly for gynecological concerns, underlining the importance of gender-sensitive healthcare. These findings highlight the need to address cultural and access-related barriers to enhance healthcare outcomes in rural areas.

Key words: Health, Cultural, Home remedies preference, Healthcare

JEL Classification: I15, Z10, I12, I11

Introduction

Health is a global social objective that goes beyond just physical well-being to encompass the overall quality of life, highlighting that it is not solely an individual matter. As defined by the World Health Organization (WHO) in 2006, health is not merely the absence of illness, but a state of complete physical, mental, and social well-being. To attain such a state of well-being, health should be viewed as more than just biomedical factors; it must also account for environmental, social, psychological, and cultural influences. These various factors are essential to consider when understanding, defining, and evaluating health (Park, 2007).

In many communities, especially in developing or low-income countries, women's social standing often limits their autonomy and ability to make decisions about various aspects of their lives. In these societies, gender roles are often rigidly defined, with traditional social, tribal, and religious norms deeply influencing the roles that men and women occupy. These established structures continue to shape the opportunities and freedoms available to women (Woldemicael and Tenkorang, 2010).

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Gender roles and patriarchal norms influence women's health in Punjab. In many rural regions, women face limited access to healthcare due to traditional beliefs that prioritize the health needs of men over those of women. Gupta and Mahajan (2013) highlighted how cultural norms in Punjab restrict women's autonomy, particularly when it comes to making decisions about their health. These societal expectations often result in delayed healthcare seeking, neglect of women's health issues, and ultimately, poor health outcomes for women.

Studies revealed that many women delayed seeking professional healthcare, especially for conditions related to reproductive health, due to fear of social stigma or shame (Kaur and Awasthi, 2019). Cultural taboos surrounding topics like menstruation, sexual health, and childbirth prevented open discussions about health issues. This led to women either avoiding medical consultation or seeking it too late, which exacerbated health conditions.

Using ingredients commonly found at home to treat minor health issues is referred to as home remedies (Santhosh and Amritha, 2020). Many of these treatments had a long history, often developed through trial and error and passed down through generations. Although numerous home remedies provided temporary relief in emergency situations, the practice generally involved taking medication without

understanding the underlying condition or the potential for harmful effects. In that period, it was considered more beneficial to possess knowledge of the scientific basis behind the medications being used, including their effectiveness for specific conditions, possible side effects, and mechanisms of action.

Patriarchal norms and economic dependency have a profoundly negative impact on women's health in Punjab and other regions with similar social and cultural frameworks. These factors hinder women's ability to make independent health decisions, cause delays in seeking medical treatment, and limit their access to vital healthcare services. Empowering women through economic independence, education, and challenging patriarchal norms can significantly improve their health outcomes. When women able to manage their health, seek timely care, and make informed decisions about their well-being, their overall health is greatly enhanced. Women's decision-making autonomy plays a crucial role in their ability to manage their health and effectively utilize healthcare resources (Chand and Raina, 2021).

Jaysawal and Saha, 2023 Empowerment was regarded as a way to create a social environment where important decisions could be made and choices exercised to bring about social transformation. It enhanced individuals' inherent abilities by helping them gain knowledge, power, and experience. The empowerment of women had emerged as one of the significant issues of the time. It was believed that women should be on an equal footing with men in areas such as education, employment, health, and other key aspects of life.

Data Sources and Methodology

The study was conducted in three cultural zones i.e Majha, Malwa and Doaba to make the study representative the whole Punjab. A multistage sampling approach was applied for the selection of representative samples. Four districts from three zones were selected from each cultural zone with ratio of 1:2:1 as one district from Majha i.e. Amritsar and one district from Doaba i.e. Nawanshahr were selected for the study. Malwa is the biggest zone of Punjab, so two districts namely Ludhiana and Sangrur were selected from this zone Therefore, the sample constitutes four districts from the whole Punjab. Further, two blocks from each district were taken. Also, from each block two villages were taken up for study. From each village rural females in the age group of 15-49 years (reproductive age) and having children up to 3 years were the respondents of the study. The total sample was 320 respondents. The primary data collected from the respondents pertained to the year 2022-23.

Results and Discussion

Socio-economic profile of the respondents

A socio-economic profile is a comprehensive description of the economic and social characteristics of individuals, groups, communities, or areas. It includes data on various factors affecting people's financial conditions, quality of life, and standard of living..The socio-economic profile of respondents in rural Punjab includes data such as age, caste, education, occupation, annual income, family size, marital status, and age at marriage. The findings are presented below.

Age, which signifies the duration of a person's life, influences various life aspects, including health, social roles, and responsibilities. It was observed that 41.88 per cent of Non-SCs and 38.76 per cent of SCs were in the 25-30 years age group. A notable 31.25 per cent of Non-SCs and 25.62 per cent of SCs were 30 years and above. A very small percentage (2.50%) of both SCs and Non-SCs were aged up to 20 years (Table 1).

Education plays a crucial role in improving the quality of life and health. In the Majha region, 40 per cent of SCs were matriculated, whereas 37.50 per cent of Non-SCs had attained senior secondary education. In Malwa, 36.25 per cent of Non-SCs were graduates, compared to just 6.25 per cent of SCs. In Doaba, 35 per cent of SCs and 42.50 per cent of Non-SCs were graduates. Additionally, a significant number of both SCs (42.50%) and Non-SCs (47.50%) had education up to the senior secondary level. Overall, a higher percentage of Non-SCs had completed their graduation compared to SCs. A small portion (1.88%) of SCs was illiterate, while none of the Non-SCs were illiterate. However, 8.12 per cent of SCs had only primary education.

Marriage age plays a vital role in shaping the health of women, particularly related to reproductive health. In the total sample, 75.63 per cent of SCs and 78.75 per cent of Non-SCs married between the age group of 21-26 years. A smaller percentage (19.37% of SCs and 9.37% of Non-SCs) married in the age group of 18-21 years. Only 5 per cent of SCs and 11.88 per cent of Non-SCs married between the age group of 26-30 years. This indicates a decreasing trend of early marriages in rural areas.

Household income is a key indicator of economic well-being and directly influences living standards. The findings showed that 35 per cent of SCs had an annual income in the range of Rs.1-2 lac, while 3.88 per cent fell into the Rs.2-3 lac range. In contrast, 45.63 per cent of Non-SCs had annual family incomes exceeding Rs.3 lac, with 27.50 per cent falling within the Rs.2-3 lac range. The data revealed a clear income disparity between SCs and Non-SCs, with Non-SCs having a higher percentage in higher income brackets, while SCs were more concentrated in lower-income groups.

Occupation plays a significant role in determining socio-economic status. A large proportion of SCs were employed in labor-intensive jobs, with 22.50 per cent in Majha, 18.75 per cent in Malwa, and 27.50 per cent in Doaba working as helpers, maids, or sweepers (Table 2). In contrast, Non-SCs were mostly engaged in non-labor-intensive occupations. A significant portion of Non-SC respondents' husbands

Table 1: Distribution of respondents according to their socio-economic profile

Socio-Economic Variables	Majha (n_1=80)		Malwa (n_2 =160)		Doaba (n_3=80)		Total (n=320)	
	SCs (40)	Non-SCs (40)	SCs (80)	Non-SCs (80)	SCs (40)	Non-SCs (40)	SCs (160)	Non-SCs (160)
Age (Years)								
Up to 20	2 (5.00)	1 (2.50)	7 (8.75)	3 (3.75)	1 (2.50)	1 (2.50)	10 (6.25)	5 (3.13)
20-25	13 (32.50)	11 (27.50)	26 (32.50)	22 (27.50)	8 (20.00)	5 (12.50)	47 (29.37)	38 (23.75)
25-30	19 (47.50)	19 (47.50)	28 (35.00)	26 (32.50)	15 (37.50)	22 (55.00)	62 (38.76)	67 (41.88)
30 & above	6 (15.00)	9 (22.50)	19 (23.75)	29 (36.25)	16 (40.00)	12 (30.00)	41 (25.62)	50 (31.25)
Education								
Cannot read and write	1 (2.50)	-	2 (3.00)	-	-	-	3 (1.88)	-
Primary	2 (2.50)	-	11 (13.75)	-	-	-	13 (8.12)	-
Middle	11 (27.50)	3 (2.50)	27 (33.75)	7 (8.75)	5 (6.25)	1 (2.50)	43 (26.88)	11 (6.87)
Matric	16 (40.00)	7 (17.50)	22 (27.50)	19 (23.75)	4 (10.00)	3 (7.50)	42 (26.25)	29 (18.12)
Senior secondary	7 (17.50)	15 (37.50)	13 (16.25)	25 (31.25)	17 (42.50)	19 (47.50)	37 (23.13)	59 (36.88)
Graduation and above	3 (7.50)	15 (37.50)	5 (6.25)	29 (36.25)	14 (35.00)	17 (42.50)	27 (13.75)	61 (38.13)
Age at marriage (Years)								
18-21	7 (17.5)	3 (7.50)	19 (23.75)	10 (12.50)	5 (12.5)	2 (5.00)	31 (19.37)	15 (9.37)
21-26	30 (75.00)	33 (82.50)	57 (71.25)	61 (76.25)	34 (85.00)	32 (80.00)	121 (75.63)	126 (78.75)
26-30	3 (7.50)	4 (10.00)	4 (5.00)	9 (11.25)	1 (2.50)	6 (15.00)	8 (5.00)	19 (11.88)
Household income (Rs./Annum)								
>1 Lac	9 (22.50)	2 (5.00)	11 (13.75)	8 (10.00)	6 (15.00)	1 (2.50)	26 (16.25)	11 (6.87)
1 -2 lac	10 (25.00)	7 (17.50)	29 (36.25)	19 (23.75)	12 (30.00)	6 (15.00)	51 (31.88)	32 (20.00)
2-3 Lac	16 (40.00)	12 (30.00)	26 (32.50)	22 (27.50)	14 (35.00)	10 (25.00)	56 (35.00)	44 (27.50)
3 Lac & above	5 (12.50)	19 (40.00)	14 (17.50)	31 (27.50)	8 (20.00)	23 (57.50)	27 (16.87)	73 (45.63)
Type of family								
Joint	19 (47.50)	25 (62.50)	34 (42.50)	55 (68.75)	13 (32.50)	23 (57.50)	66 (41.25)	103 (64.37)
Nuclear	21 (52.50)	15 (37.50)	46 (57.50)	25 (31.25)	27 (67.50)	17 (42.50)	94 (58.75)	57 (35.63)

Note: Figures in parentheses indicate per cent to respective total

Table 2: Distribution of respondents according to their occupation

Socio-Economic Variables	Majha (n_1=80)		Malwa (n_2 =160)		Doaba (n_3=80)		Total (n=320)	
	SCs (40)	Non-SCs (40)	SCs (80)	Non-SCs (80)	SCs (40)	Non-SCs (40)	SCs (160)	Non-SCs (160)
Occupation of respondents								
Skilled *	2 (5.00)	6 (15.00)	4 (5.00)	8 (10.00)	3 (7.50)	8 (20.00)	9 (5.62)	22 (13.75)
Semi-skilled **	3 (7.50)	4 (10.00)	10 (12.50)	8 (10.00)	6 (15.00)	5 (12.50)	19 (11.88)	17 (10.63)
Labour ***	9 (22.50)	1 (2.50)	15 (18.75)	3 (3.75)	11 (27.50)	-	35 (21.88)	4 (2.50)
Housewife	26 (65.00)	29 (72.50)	51 (63.75)	61 (76.25)	20 (50.00)	27 (67.50)	97 (60.62)	117 (73.12)
Occupation of husband								
Farming	2 (2.50)	10 (25.00)	9 (11.25)	23 (28.75)	3 (7.50)	9 (22.50)	14 (8.75)	42 (26.25)
Skilled *	7 (17.50)	16 (40.00)	20 (25.00)	32 (40.00)	9 (22.50)	13 (32.50)	36 (22.50)	61 (38.13)
Semi-skilled**	13 (32.50)	9 (22.50)	18 (22.50)	15 (18.75)	14 (35.00)	13 (32.50)	45 (28.13)	37 (23.12)
Labor***	6 (15.00)	2 (5.00)	11 (13.75)	4 (5.00)	6 (15.00)	1 (2.50)	23 (14.38)	7 (4.38)
Others****	12 (30.00)	3 (7.50)	22 (27.50)	6 (7.50)	8 (20.00)	4 (10.00)	42 (26.25)	13 (8.13)

Note: Figures in parentheses indicate per cent to respective total
**Skilled: Teacher, Community Health worker, Nurse, Carpenter, Driver, Plumber*
***Semi-skilled: Tailor, Factory Worker, Painter, Delivery Partner*
****Labour: Helper, Maid, Sweeper, Farm Labour*
*****Others: Scrap Vendor, Shopkeeper*

(38.13%) were employed in skilled work, compared to just 22.50 per cent of SCs. Additionally, a higher percentage of SC respondents' husbands (26.25%) were engaged in labor-intensive work, with 14.38 per cent working in other low-skilled occupations. This reflects a shift from traditional farming to non-farming occupations in rural areas.

The family structure in rural Punjab varies based on caste. Among Non-SCs, 64.37 per cent lived in joint families, whereas 58.75 per cent of SCs lived in nuclear families. The tendency for joint family systems was more prevalent among Non-SCs, with the highest percentage observed in the Malwa region (68.75%). Conversely, Doaba region had the highest percentage of nuclear families among SCs (67.50%). The data highlights that Non-SCs tend to have larger family units, while SCs are more likely to have smaller nuclear families.

Home remedies prior seeking medical assistance

Home remedies are conventional treatments or cures that people use with natural ingredients, many of which can be found in their own kitchen or garden, to address common health issues. Some people view these remedies as a natural substitute for prescription or over the counter drugs, and they have a long history of use in many cultures.

Home remedies, were crucial in rural areas before seeking medical attention. Home remedies were used by 91.25 per cent of SCs and 83.75 per cent of Non-SCs in the Malwa region and 67.50 per cent of SCs and 57.50 per cent of Non-SCs in Doaba (Table 3). Before going to medical facilities, various home remedies were reportedly used under the supervision and experience of family members and friends. Prior to visiting a medical facility, most respondents, or 78.12 per cent of SCs and 68.75 per cent of Non-SCs, used home remedies. The readily available, reasonably priced, safer, and side-effect-free ingredients were frequently used in home remedies. The home remedies were often used with ingredients that are readily available and cost effective, safer and did not cause side effects.

Table 3: Distribution of respondents according their use of home remedies prior to seeking medical assistance

Home remedies	Majha		Malwa		Doaba		Total	
	SCs	Non-SCs	SCs	Non-SCs	SCs	Non-SCs	SCs	Non-SCs
Yes	27 (67.50)	23 (57.50)	73 (91.25)	67 (83.75)	25 (62.50)	20 (50.00)	125 (78.12)	110 (68.75)
No	9 (22.50)	17 (42.50)	7 (8.75)	13 (16.25)	15 (37.50)	20 (50.00)	35 (21.88)	50 (31.25)

Note: Figures in parentheses indicate per cent to respective total

Belief in Stones and amulets

There are many cultures around the world that believe in stones and amulets as sources of good fortune, protection, or healing. Those who possess these items are said to benefit physically, emotionally, or spiritually from their mystical or supernatural abilities. The belief in the power of stones and amulets dates back to ancient customs, when it was believed that particular stones, gems, and symbols carried particular energies that could affect a person's fortune, health, or fate.

It was shown in Table 4 that majority of respondents i.e 81.25 per cent SCs and 93.12 per cent Non-SCs did not believe in stones and amulets. It was seen that 20.00 per cent SCs and 7.50 per cent Non-SCs believed in stones and amulets in Majha. It is also revealed that 18.75 per cent SCs in Malwa and 17.50 per cent SCs in Doaba believed in Stones. This suggests that belief in stones and amulets is more prevalent among SCs than Non-SCs, likely due to differences in cultural practices, access to modern healthcare, and societal factors.

Family support to avail health facility

Support from family members during medical problems is essential for the healing and general wellbeing of people dealing with physical or mental health issues. Family support can have a substantial impact on the affected person's emotional stability and healing process.

It was observed in Table 5, that family support had a significant impact on health-seeking behavior. It was found that only 15.63 per cent of SCs had consistent family support, compared to less than one-fourth, or 23.75 per cent, of Non-SCs. Sixty per cent of Non-SCs and sixty-one per cent of SCs reported intermittent family support. According to the overall data, 23.12 per cent of SCs and 16.25 per cent of Non-SCs lacked family support. Additionally, Doaba had more family support than the other three regions because its respondents were more economically independent and employed. Overall, the data showed that SCs encountered more obstacles when trying to access health services and had less family support.

Table 4: Distribution of respondents according to their belief in stones and amulets

Belief in Stones and amulets	Majha		Malwa		Doaba		Total	
	SCs	Non-SCs	SCs	Non-SCs	SCs	Non-SCs	SCs	Non-SCs
Yes	8 (20.00)	3 (7.50)	15 (18.75)	5 (6.25)	7 (17.50)	3 (7.50)	30 (18.75)	11 (6.88)
No	32 (80.00)	37 (92.50)	65 (81.25)	35 (43.75)	33 (82.50)	37 (92.50)	130 (81.25)	149 (93.12)

Note: Figures in parentheses indicate per cent to respective total

Table 5: Distribution of respondents according to family support to avail health facility

Family support	Majha		Malwa		Doaba		Total	
	SCs	Non-SCs	SCs	Non-SCs	SCs	Non-SCs	SCs	Non-SCs
Consistent	8 (20.00)	12 (30.00)	11 (13.75)	16 (40.00)	6 (15.00)	10 (25.00)	25 (15.63)	38 (23.75)
Intermittent	27 (67.50)	22 (55.00)	42 (52.50)	50 (62.50)	29 (72.50)	24 (60.00)	98 (61.25)	96 (60.00)
Absence of Support	5 (12.50)	6 (15.00)	27 (33.75)	14 (17.50)	5 (12.50)	6 (15.00)	37 (23.12)	26 (16.25)

Note: Figures in parentheses indicate per cent to respective total

Conclusions and Policy Implications

Under this study **e**mphasizes the key factors influencing healthcare among SCs and Non SCs, including home remedies, belief in stones and amulets, and gender-based hesitancy. SCs rely more on home remedies due to affordability. Belief in stones and amulets is higher among SCs, reflecting cultural practices and limited healthcare access. Hesitancy to consult male doctors, especially for gynecological issues, is more common among SCs, highlighting the need for gender-sensitive healthcare. These findings stress the need to address cultural and access barriers to improve rural healthcare outcomes.Gender-based hesitancy in accessing healthcare services also emerged as a significant barrier, particularly among SCs women. Many exhibit discomfort or reluctance to consult male doctors, especially for reproductive and gynecological health issues. This hesitancy often results in underreporting of symptoms, delayed diagnosis, and inadequate treatment. It highlights the urgent need for gender-sensitive healthcare services, including the availability of female healthcare providers and culturally competent health education.Overall, the study underscores the importance of addressing both cultural and systemic barriers to improve health outcomes in rural communities. Tailored interventions that consider caste, gender norms, economic disparities, and local belief systems are essential for building an inclusive and effective rural healthcare system. Bridging these gaps requires not only infrastructural improvements but also community-based health education, trust-building measures, and policy frameworks that prioritize equity and cultural sensitivity.

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Received: January 15, 2025 Accepted: March 25, 2025