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Research Paper Rural India

Health Seeking Behavior and Health Related Resources in Amolapaam Village of Sonitpur District, Assam: A Participatory Research Approach

*Birinchi Choudhury

* Research Scholar, Dept. of Business Administration, School of Management Sciences, Tezpur University, Napaam, Dist. Sonitpur Assam

ABSTRACT

Health seeking behaviour is an important issue in health management, but unfortunately, it is not given proper importance by the policy makers for which the health care schemes are incapable to touch those people for whom the schemes have been introduced. This paper based on Participatory Rural Appraisal tried to fulfil the twin objectivise viz to study health seeking behaviour of the people living in Amolapaam village of Sonitpur district, Assam and to study the availability of health related resources in the village. The paper has indicated that the Amolapaam village is out of reach of different health related schemes.

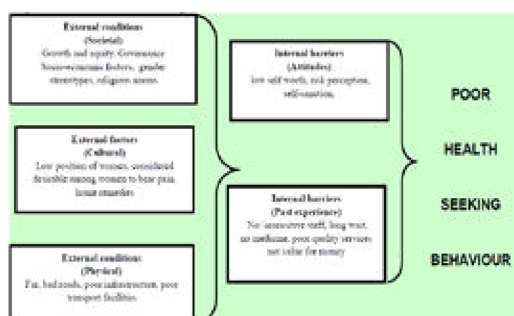
Keywords : rural, health, community

1. Introduction:

Health is an important indicator of development and quality of life. It is one of the determinants of happiness, ability to participate in the workforce and efficiency at work.

Health seeking behaviour is an important issue in health management, but unfortunately, it is not given proper importance by the policy makers for which the health care schemes are incapable to touch those people for whom the schemes have been introduced. Before beginning of any health related schemes for the rural people it is important to study the perception of the rural community. Uptake of preventive health services is low among rural and uneducated women. Low literacy and lack of awareness about service, schemes, and entitlements, low status of women, poverty and cultural factors are among the crucial factors that determine the health seeking behaviou (Prasad, 2009). Taking antenatal and postnatal care, institutional deliveries, use of iron an folic acid (IFC) anemia, child immunization and treatment of childhood diseases are key indicators to measure the overall health seeking behavour (USAID, 2009). Health service utilization has been associated with several socio-demographic factors such as age, gender and social position of the family. The illiteracy, lack of awareness about health series and schemes, low status of the women in the family and in the society, lack of family support to the women, poverty etc pushed health to a low priority in the rural area (Prasad, 2009). Several other factors such as bad road condition, unreliability of finding health provider, costs of transportation etc. forced the rural people to the local so called practitioners instead of accessing a government health facility (USAID, 2009).

Figure 1: Barriers of health-seeking behaviour



Source: USAID (2009)

Health is a very big issue for such developing countries like India. the Indian Government has started National Rural Health Mission, 2005 to facilitate health care to all rural people. But worrying thing is that the schemes have not touched the rural people for whom actually the schemes have been introduced. Many attempts have been made to document the health seeking behaviour of the rural people specially in India. Some of such studies are Sawain (1994), Basu (1994) and Singh (1994). But all these studies were undertaken without people's participation. Since health is an important issue, it is important to interact with the community by making them involve in Participatory Rural Appraisal. Only then the important issues will come to the focused. This study has considered this issue and therefore did a Participatory Rural Appraisal in Amolapaam Village of Sonitpur Village of Assam to understand the health seeking behaviour of the community living in the village.

2. Objectives of the study:

- To study health seeking behavior of the people living in Amolapaam village of Sonitpur district
- To study the availability of health related resources in Amolapaam village.

1. Study Area: Amolapaam Village

The geographical area where the study was done is Amolapaam Village (a revenue village) of Sonitpur District. The village is situated in the Northern side of Sonitpur District. It is nearly 12 km away from Tezpur Sub-division. The village has 313 households. The village comprises of different communities and tribes viz. Assamese, Nepali, Tea Tribe (Adivasi) and Bengali Muslims. The population of the village is approximately 1730 (Census Report of India, 2011).

2. Methodology:

For the present study Participatory Rural Appraisal were adopted. The author met different groups of the villagers. Those groups include female Self Help Groups (SHGs), youth clubs, Village Headman, teachers work in the village school and school students. Different groups conveyed their perceptions regarding health behavour of the villagers. The interaction with the rural community covered different health related issues like consumption behavior (food habits and intoxicant behavior), living and surrounding conditions, concerned about health, use of modern and traditional practices, availability of medical services etc. The community made a health related resource mapping available in the village. After collection of data from PRA, the author did triangulation so

that a consensus can be made regarding the data collected from different groups.

3. Findings and discussion:

I. Environment of the household:

Most of the villagers use thatch roofed katcha houses because their economic condition is not so sound. Of course, a few them have pacca houses. There is no ventilation system in the semi-pacca and thatch roofed katcha houses. It seemed difficult to move out the gases and smokes come from cooking, smoking etc. Most of the households have no electricity. Lack of proper defecation system showed unhygienic livelihood of the people. Only a few families have pacca latrine. Of course some households build latrine under scheme of Total Sanitation Campaign. There is no draining system in the village which results in water logged problems and dampness in the houses. This may be the cause of their illness throughout the year.

The environments of the households are not good for health issues. The unhealthy Cowshed, the unscientific store of cow dung and the store of pig foods have made the surrounding unhygienic. They also have no provision of safe drinking water facilities. Most of the villagers are educated only up to primary level.

II. Diet habits and Intoxicant behavior:

Every household seems of taking healthy diet. Because each family, with 5 member on an average, takes three times rice, 1 kg vegetables per day, 1.5 kg pulses per week, they also have eggs or fish or meat per week. Most of the farmers have sugar cane farm. So they have habit of consumption of enough sugar cane juice.

Most of the households' family heads consume at least one from paan, cigarettes, khaini, gutka etc. Most of female takes paan. A very few people have alcoholic behavior. They do not have any awareness regarding that the consumption of intoxicant can create cancer.

III. Diseases:

The people often have the problem of cough, cold and fever. They also suffered from malaria, typhoid, jaundice, dysentery and diarrhea. This is generally because lack of drainage system which creates water log problem results in the birth place of various virus and fungal diseases. Most of the families drink water from tube well, deep well or public well without filter or boiled. Lack of proper drinking water and sanitation facilities also results in above mentioned diseases.

IV. Availability of medical facilities:

The village has no medical facilities like Primary Health Center, sub Center and dispensary. They have only one small medicine stall in the village market from where they purchases medicines of different diseases without consulting with the doctors. For any medical treatment they have to go to Panch Mile, a nearby gateway village, which is three kilometer away from the village. There are two baiz in the village that provides local medicines to the villagers in time of crises. They also depend upon homemade medicines like kurtikalai for curing small pox, elameh for controlling bleeding due to cuts etc. There is one Anganwadi in the village under ICDS programme which provide some pre- natal and post-natal care to the village women and children. Though there are various government policy and measures that are provided under various plans but the irony is that the village folk are not benefitted because of unavailability. The adivasi (tea tribe) people because of their unawareness are not able to avail the vaccination and other facilities provided under ICDS scheme. Neither the women folk of adivasi are aware to intake iron and folic acid tables. The discouraging thing is that other than ICDS no any government medical schemes have covered the village.

4. Conclusion:

Since we found no problem with the food habits and other consumption behavior among the villagers we can conclude that all the health related issues is only because of unawareness of hygienic behavior, lack of proper drainage, sanitation and safe drinking water habits and lack of medical facilities. So a proper and systematic awareness program about hygiene, drainage, drinking water and sanitation is an urgent need. Also Government and other organizations may undertake this village under their plans and programs. A Primary Health Center was found to be the urgent need of the people.

The study has given an overall picture of the village community regarding the health issues they have. It is already mentioned that the study was based on participatory rural appraisal. This kind of studies provide give an overall and general picture rather a precise picture. Therefore, on the basis of the results got from this study, we cannot made a generalized conclusion regarding all villages of Sonitpur District of Assam.

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