

INTERFACE BETWEEN LEVEL OF EDUCATION AND HEALTH SEEKING BEHAVIOUR IN MIZORAM, INDIA

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Abstract: This paper is an attempt to examine the interface between educational level and health seeking behaviour of people in Mizoram, India. Special emphasis has been made to father's educational level and how it influences on the health seeking attitude of household members, particularly in time of illness.

Index Terms - level of education, correlation, health seeking behaviour, rural, urban, maternal

I. INTRODUCTION

Health and related issues has been considered under the domain of health personnel and medical practitioners. However, an inter-disciplinary world of today demand healthcare study from social scientist perspectives as health is not merely confined to biological rather it relates with social, economic, political and environment of people. Broadly speaking, health is a developmental issues linking policy matter at national and international level. Human behaviour and attitudes toward healthcare are directly or indirectly influence by level of development, which includes income, level of education, accessibility and transport communication, mass media exposure, age, sex, quality of healthcare system as well as availability of healthcare facility and health personnel.

Literatures reviewed shows that low literacy, lack of awareness, and low status of women affects health seeking behaviour in many part of the world. It may be due to lack of health education, non-availability of drugs and low literacy rate in rural areas. The communication factor also creates a barrier due to differences of language or cultural gaps and it can also affect the choice of a specific health provider or otherwise. The type of symptoms experienced for the illness and the number of days of illness are major determinants of health seeking behaviour and choice of care provider. In case of a mild single symptom such as fever, home remedies or folk prescriptions are used, whereas with multiple symptoms and longer period of illness, biomedical health provider is more likely to be consulted. Traditional beliefs tend to be intertwined with peculiarities of the illness itself and a variety of circumstantial and social factors. This complexity is reflected in the health seeking behaviour, including the use of home-prescriptions, delay in seeking bio-medical treatment and non-compliance with treatment and with referral advice. The attitude of the health provider and patient satisfaction with the treatment play a role in health seeking behaviour.

This paper is an attempt to examine the interface between educational level and health seeking behaviour of people in Mizoram, India. Special emphasis has been made to father's educational level and how it influences on the health seeking attitude of household members, particularly in time of illness.

II. RESEARCH METHODOLOGY

For present study, primary study has been carried out by using structure questionnaires. Multi-stage stratified sampling has been adopted to conduct primary survey.

-To collect information on people's health seeking behaviour all the eight districts of Mizoram are covered. From each district rural village, one Rural Development Block headquarters (village or town) and district capital/headquarter are surveyed base on number of household size, level of literacy and location. Therefore, the study covered at least one urban/town and two rural/villages from each district i.e 1(town) +2 (villages) =3 x 8 (districts) =24.

-From each district study covered large (L), medium (M) and small (S) number of household as well as high, medium and low level of literacy. To represent the whole district villages are selected spatially while literacy and number of household still keeping in mind.

-From each village or town at least 20% or more household are selected for conducting survey.

-Additional stratification is adopted for eight district headquarters as the towns are too big even after taking the sample size of 20 per cent household. It is also assumed that selection criteria such as household number and level of literacy might not be valid within district capitals as the capital has more or less uniform literacy or equal chances to access educational facilities and therefore selection has been made based mainly on geographical difficulty of the town that might contributes relatively more to the decision making of people's health seeking behaviour.

-Thus, selection of study sites is based on economic and altitudes of the town within itself, such as – one locality/ward from higher altitude, one locality from medium altitude, and one locality from low altitude to get better representation of spatial geographical variation within the city. While taking altitudes as selection criteria, location of localities will also be considered. For example-locality located in the main business centre or centre of the town and others from outskirts of the town, that might be far from healthcare infrastructure will be looked at.

-Structure household questionnaires, prepared in both English and Mizo collected information on the usual places where household members go for treatment when they get sick, distance of healthcare facilities from the village, education level, income, mass media exposure, BPL, APL status etc.

II.I Population and Sample

Present study covers the whole state of Mizoram. After adopting stratified sample methods, 10 towns and 14 villages were surveyed during 2016-2017. The total sample size is 3833(N) with 1280 (33.3%) rural and 2553 (66.6%) urban households.

II.II Data and Sources of Data

For present study, primary data has been utilized. Field survey has been carried out by using structure questionnaires. Multi-stage stratified sampling has been adopted to conduct primary survey in the all eight districts of Mizoram. Survey has been conducted during 2016-2017. All the analysis depend on primary data.

III. Theoretical framework

Variables of the study contains dependent and independent variable. Dependent variables parameters of includes health seeking behaviour such as whether patients went for check-up in time of illness, whether they visit healthcare facilities during last one year, whether they consult health personnel in times of illness and do they visited hospital for treatment before family member die. Independent variables are educational level of father, such as below class-10, up to class-12 and graduate or above including professional courses like MBBS, MBA etc. This paper is an attempt to examine the interface between educational level and health seeking behaviour of people in Mizoram, India.

Health is the topmost priority in every individual's life. Health is not only basic to lead a happy life for an individual, but also necessary for all productive activities in the society. Good health is a prerequisite to human productivity and development. Health is essential for economic, socio-cultural, political and technological development and vis-a-vis. Providing healthcare facilities and healthcare personnel is the basic rights of an individual. A healthy person and community is the infrastructure upon which to build an economically viable society. The progress of any nation and society greatly depends on the quality of its people. World Health Organization defines Health as "a state of complete physical, mental, social, and spiritual well-being and not merely the absence of disease or physical infirmity" (WHO, 2002).

Health service utilization has been associated with several developmental factors like, income, education, mass media exposure, age, gender and religion. One of the main factors associated with health service utilization is that of "health services need" as measured by individuals' health status (Prasad, 2007). Health seeking behaviour and healthcare services utilization pattern have been studied and the determinants have been classified into physical, socio-economic, cultural and political context. Number of studies show that trends in utilization of a health-care system, public or private, formal or non-formal, by and large, vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, education, economic status, income, mass media, accessible, employment, severity of illness, availability of physical infrastructure, type and cadre of health provider, accessibility of services at the public health sector facilities (Babar T Shaikh and Juanta Hatcher, 2004).

Designing healthcare policies and programme requires knowledge about healthcare seeking behaviour, so that possible difficulties with early diagnosis and effective treatment can be identified and so that appropriate interventions can be implemented. Early recognition of symptoms, presentation to healthcare families and compliance with effective treatment can reduce morbidity and thereby mortality. MacPhail and Campbell (2002) begin to explore this broader context of system and policy implications, as they suggest sexual health policy and practice for young South Africans is influenced by simplistic generalized views held by adults, thereby excluding the very groups they wish to target. It is these sorts of ideas that need to be teased out of work on health seeking behaviour more explicitly.

Health is essential for social and economic development; it is therefore seen as a resource for everyday living and sought after by all. The link between health and human behaviour is a major area of interest in public health. Studies on health seeking behaviour have shown the numerous influences on an individual's health behaviour. These influences include past experiences with health services, perception about quality and efficiency of health services and influences at the community level (Sule, et al, 2008). The decision to seek help is also influenced by an individual's educational and economic status, the extent to which he is worried about the symptom and duration of experiencing the symptom (Katung 2001). The choice of the health provider consulted for a symptom is also linked to the perceived cause of the symptom (Ahmed et al, 2001).

Therefore, health and health seeking behaviour is not just medical field rather it is developmental aspects broadly, which demand serious involvement of social scientist. That is why people used to say 'health is wealth' and in other way it can also be said level of development is reflected in level of health or infirmity and decision of people on healthcare utilization. Development is prerequisite to empower people to seek healthcare at the right time.

This paper mainly focuses on the interface between educational level and health seeking behaviour of people in Mizoram, India. Special emphasis has been made to father's educational level and how it influences on the health seeking attitude of household members, particularly in time of illness.

III.I Statistical tools

The collected data is tabulated using excel, put in a percentile table and work on any appropriate statistical tools. For statistical analysis bivariate correlation coefficient is used by using SPSS software.

IV. RESULTS AND DISCUSSION

Level of Education and Health Seeking Behaviour in Rural Mizoram

This section discusses two major important components. The first part is the general overview of father's educational level and performance of rural people on health seeking (table-1). The second part is the statistical test results of whether there is a correlation between father's educational level and health seeking behaviour of family members. Particularly influence of father's educational level on health check-up in time of illness, whether family members visit healthcare facilities during last one year, whether family members consult health personnel in times of illness and did patient visited hospital for treatment before he/she died, if death is reported among family members. We considered father, as head of the family, would have certain influences on the decision of the family members, even though he might consult spouse and other family members. His decision in turn, assumed, influenced by his level of education.

As shown in table-1, around 90% of fathers in rural areas are below class-10 passed while only 7.1 % are class- 12 passed and merely 3 % are graduates or above. Unfortunately, out of the 14 villages, 3 villages reported that all the household head/father are below class-10 while 4 villages reported that all the household head/father are only up to class-12 educated and 6 villages are not having family head or father who passed graduate & above including professional. This clearly shows a high drop-out rate in rural areas.

Village	Below CL-10	Up to CL-12	Graduate & above including Professional	Check-up in time of illness	Visit HC during last 1-year	Consult health personnel in times of illness	Visited hospital for treatment before family member die
Aibawk	66	34	0	90.5	41.3	81	92.3
Chapui	90.5	9.5	0	26.2	23.8	3.6	0
Chawilung	100	0	0	15.8	52.6	100	80
Chawngtlai	65.7	23.9	10.5	60.5	82.1	34.6	78.6
Cheural	100	0	0	25	37.5	33.3	0
E. Lungdar	79.1	15.2	6.3	52.2	30.8	89.8	80.6
Hortoki	94.9	1	4.1	16.3	53.1	68.8	23.1
Leng	98	2	0	16	12	33.3	0
Muallianpui	98	0	2	17.6	39.2	19	0
Sangau	96.1	2.2	1.6	42.6	42.6	97.7	77.1
Teirei	100	0	0	5	55	5	0
Thingdawl	87	7.5	5.5	88.4	24.7	76.5	51.9
Tuipang	87.5	2	9.2	59.2	59.2	85	50
W. Phaileng	94.9	2.8	2.3	20.3	64.9	66.1	19
Rural Average	89.8	7.1	3	38.3	44.6	56.7	39.5

Source: Field survey conducted during 2016-2017

It is evident from table-1 that there are only 38.3% of rural people reported of having check-up in times of illness of the family members. Out of these 14 villages Aibawk village and Thenzawl village are reported of having the highest number of family members who visit healthcare in time of illness with 90.5% and 88.4% respectively. Teirei and Chawilung villages are the least two that visit healthcare in time of illness with just 5% and 15.2% respectively.

As far as visiting healthcare during the last one year is concerned, Chawngtlai village distinguished itself by reporting as many as 82.1% people visiting healthcare, followed by West Phaileng (64.9%) and Tuipang (59.2%) whereas Leng village recorded

the least percentage visiting healthcare during the last one year (12%), followed by Chapui (23.8%) and Thingdawl (24.7%). The overall average of visiting healthcare facilities during the last one year in rural Mizoram is 44.6%.

Consultation of health personnel in time of illness is much more common compared with other dependent variables as 56.7 % do consulted health personnel in times of illness in rural area. Among the villages-Chawilung (100%), Sangau (97.7%), Tuipang (85%), East Lungdar (89.8%) and Aibawk (81%) are the top five villages whereas Chapui (3%), Teirei (5%), Muallianpui (19%), Leng (33.3%) and Cheural (33.3%) become the bottom most villages in consultation of health personnel in time of illness.

Unfortunately, five villages, such as Chapui, Cheural, Leng, Muallianpui and Teirei reported that patients in their families/villages are not visited hospital before he/she died. On the other hand Aibawk, East Lungdar, Chawilung and Chawngtlai reported that more than 78% visited hospital before family members died. However, it is very clear that health seeking behaviour is not common and highly dissatisfactory in rural Mizoram as merely 39.5% patient visited hospital before family member died.

Results of bivariate correlation between Father's Education and Health Seeking Behaviour in Rural Mizoram using SPSS

Statistical analysis proved that there is strong negative relationship between below class-10 level education of father and health check-up in time of illness in rural Mizoram ($r=-.786^{**}$) with 0.01 significant level. This indicates that family members whose father's education levels below class-10 are reluctant in seeking healthcare in time of illness. On the other hand, there exist strong positive correlations between class-12 passed and health check-up in rural Mizoram ($r=.721^{**}$) with 0.01 significant level. This means that family members whose fathers are class-12 passed are prompt to seek healthcare in times of illness. It is also important to mention here that those having graduate and above educated fathers are not significantly contributed to health seeking attitude in rural areas. This is mainly because graduate and above educated fathers are very few in numbers in rural Mizoram.

		VAR00001	VAR00002	VAR00003	VAR00004	VAR00005	VAR00006	VAR00007
VAR00001= Below CL-10	Pearson Correlation	1	-.951**	-.538*	-.786**	-.258	-.194	-.654**
	Sig. (2-tailed)		.000	.038	.001	.353	.490	.008
	N	15	15	15	15	15	15	15
VAR00002= Up to CL-12	Pearson Correlation	-.951**	1	.252	.721**	.117	.126	.604*
	Sig. (2-tailed)	.000		.364	.002	.677	.654	.017
	N	15	15	15	15	15	15	15
VAR00003=G raduate & above including Professional	Pearson Correlation	-.538*	.252	1	.477	.478	.253	.403
	Sig. (2-tailed)	.038	.364		.072	.072	.362	.136
	N	15	15	15	15	15	15	15
VAR00004= Check-up in time of illness	Pearson Correlation	-.786**	.721**	.477	1	-.018	.451	.675**
	Sig. (2-tailed)	.001	.002	.072		.949	.092	.006
	N	15	15	15	15	15	15	15
VAR00005= Visit HC during last 1- year	Pearson Correlation	-.258	.117	.478	-.018	1	.112	.283
	Sig. (2-tailed)	.353	.677	.072	.949		.692	.306
	N	15	15	15	15	15	15	15
VAR00006= Consult health personnel in times of illness	Pearson Correlation	-.194	.126	.253	.451	.112	1	.773**
	Sig. (2-tailed)	.490	.654	.362	.092	.692		.001
	N	15	15	15	15	15	15	15
VAR00007= Visited hospital for treatment before family member die	Pearson Correlation	-.654**	.604*	.403	.675**	.283	.773**	1
	Sig. (2-tailed)	.008	.017	.136	.006	.306	.001	
	N	15	15	15	15	15	15	15
**. Correlation is significant at the 0.01 level (2-tailed).								
*. Correlation is significant at the 0.05 level (2-tailed).								

It is also evident that, in rural area, there is a negative correlation between below primary level education and visiting hospital for treatment before family members die ($r=-.654^{**}$) with 0.05 significant level. This means those families whose father is below class-10 educated are reluctant in visiting hospital for treatment before family members die. In contrast, if father passed at least class-12, family members usually visited hospital for treatment before family members die. The relationship is positive ($r=.604^*$) with 0.05 significant level.

Therefore, we can concluded that in a highly literate state like Mizoram, merely class 10 level education does not have any positive impact on people's perception on healthcare rather at least class 12 standard education is necessary to influence people's health seeking attitude in rural Mizoram.

Urban Mizoram: Father's Education and Health Seeking Behaviour

Present segment discusses about father's educational level and health check-up in urban Mizoram. In line with previous discussion, father's education level has been divided into three categories such as, below class-10, class-12 passed and graduate-including professional. Among these three categories, maximum number of father (65.7%) belongs to below class-10 category, followed by class-12 level educated father and graduate and above with 16.7% each. It is interesting to observe from table-3 that almost 80% of urban residence areas are doing health check-up in times of illness. Aizawl city, Saiha town and Lunglei town records maximum number of health check-up in times of illness with 95.5%, 93.8% and 91.1% respectively. On the other hand, Hnahthial town, Serchhip town and Champhai town reported the least number of people having health check-up in times of illness with 58.4%, 65.3% and 70.5% respectively.

Table-3 revealed that the recent health seeking behaviour of people living in urban area is not that high as 62.2% do visit healthcare during the last one year. Out of 10 selected urban areas Saiha, Lunglei and Mamit recorded the highest number of people visiting healthcare within the last one year with 94.6%, 85.4% and 81.5% respectively. On the other hand most of urban residence are active and alert in consulting health personnel in times of illness. Out of 10 selected urban areas, 7 of them recorded that 90% of family members are consulting health personnel in time of illness and the remaining 3 towns are also recorded that more than 60% of them are doing the same.

Table-3. Mizoram: Urban area: Level of Education of Father and Health check-up

Name	Below CL-10	CL-12	Graduate & above including Professional	Check-up in time of illness	Visit HC during last 1-year	Consult health personnel in times of illness	Visited hospital for treatment before family member die
Aizawl	51.3	10.8	38	95.5	52.5	100	72.3
Champhai	53.5	14.5	23.5	70.5	75	95.7	66.7
Hnahthial	92.5	5.2	2.3	58.4	39.3	68.3	25.7
Khawzawl	71.2	23.3	4.7	74.6	42.1	61.3	21.3
Kolasib	70.7	8.2	21.2	75.5	28.4	95.7	76.9
Lawngtlai	59.2	33.5	7.3	88.1	80.8	96.5	32.4
Lunglei	68.7	13.1	18.2	91.1	85.4	95.1	90
Mamit	53.5	27.8	18.7	78.6	81.5	63.9	42.3
Saiha	55.4	14.3	30.4	93.8	94.6	100	77.1
Serchhip	80.7	16.1	3.2	65.3	42.7	91.4	66.7
Urban Average	65.7	16.7	16.7	79.1	62.2	86.8	57.1

Source: Field survey conducted during 2016-2017

Moreover, table also includes the performance of people visiting and taking treatment before family members died. Data shows that a little over 57% of them visited hospital for treatment before family members die in urban Mizoram. Saiha, Kolasib and Aizawl record maximum number of those who visited hospital for treatment before family members die with 77.1%, 76.9% and 72.3% respectively. Whereas Khawzawl (21.3%), Hnahthial (25.7%) and Lawngtlai (32.4%) reported of having minimum number of those who visited hospital for treatment before family members die.

Urban Mizoram: Correlations between Father's Education and Health Seeking Behaviour

Present section utilizes statistical tools to find out the relationship of educational level and health seeking behaviour in urban Mizoram.

It is evident from table-4 that, like rural Mizoram, there is a negative relationship between below primary level education and health check-up in time of illness. To make it simple-people who are under class-10 are hardly or never go for check-up in times of illness with a significant level of 0.05 ($r=-.714^*$).

Unlike the case of rural areas, father living in urban area who attained class-12 level education doesn't have any significant relationship with health check-up in time of illness. However, there is a strong positive relationship of graduate or above education and health check-up ($r=.683^*$) with 0.05 significant level.

Table- 4 revealed the negative relationship father whose education below class-10 and their visit of health care facilities during the last 1 year ($r=-.632^*$) with .05 significant level. Besides, there is also a negative relationship between below class-10 educated father and other variables like consultation of health personnel in times of illness and visiting a hospital for treatment before family members die without much significance. There is no significant relationship between class-12 level education of father and health seeking behaviour.

However, there is a positive correlation between graduate and above educated father and their visit to hospital for treatment before family members die ($r=.655^*$) at 0.05 significant level.

Thus, it is clearly uncovered that father's educational levels of below class-10 are stopping people to seek health care while class-12 level education doesn't make any sense in their health seeking attitude and those attaining graduate and above level are significantly related to their health seeking among urban residence.

		VAR00001	VAR00002	VAR00003	VAR00004	VAR00005	VAR00006	VAR00007
VAR00001= Below CL-X	Pearson Correlation	1	-.407	-.753**	-.714*	-.632*	-.374	-.300
	Sig. (2-tailed)		.215	.007	.013	.037	.257	.370
	N	11	11	11	11	11	11	11
VAR00002= Up to CL-XII	Pearson Correlation	-.407	1	-.265	.234	.436	-.227	-.462
	Sig. (2-tailed)	.215		.431	.489	.180	.503	.152
	N	11	11	11	11	11	11	11
VAR00003= Graduate & above including Professional	Pearson Correlation	-.753**	-.265	1	.683*	.350	.552	.655*
	Sig. (2-tailed)	.007	.431		.020	.292	.078	.029
	N	11	11	11	11	11	11	11
VAR00004= Check-up in time of illness	Pearson Correlation	-.714*	.234	.683*	1	.596	.525	.449
	Sig. (2-tailed)	.013	.489	.020		.053	.097	.166
	N	11	11	11	11	11	11	11
VAR00005= Visit HC during last 1-year	Pearson Correlation	-.632*	.436	.350	.596	1	.268	.235
	Sig. (2-tailed)	.037	.180	.292	.053		.426	.486
	N	11	11	11	11	11	11	11
VAR00006= Consult health personnel in times of illness	Pearson Correlation	-.374	-.227	.552	.525	.268	1	.765*
	Sig. (2-tailed)	.257	.503	.078	.097	.426		.006
	N	11	11	11	11	11	11	11
VAR00007= Visited hospital for treatment before family member die	Pearson Correlation	-.300	-.462	.655*	.449	.235	.765**	1
	Sig. (2-tailed)	.370	.152	.029	.166	.486	.006	
	N	11	11	11	11	11	11	11
**. Correlation is significant at the 0.01 level (2-tailed).								
*. Correlation is significant at the 0.05 level (2-tailed).								

Therefore, it is interesting to find some similarity and difference of rural and urban residence in their health seeking behaviour. Similarity is that in both cases there is a negative relationship of people attaining below class-10 education and their health seeking behaviour. Difference is that, in the case of rural area class-12 level education positively contributed for people perception on health seeking whereas in the context of urban area graduate and above education is significantly related with their health seeking behaviour.

Finding and Conclusion

- ✓ It is interesting to revealed that in rural areas, there is a negative correlation between below primary level education and health check-up in time of illness as well as visiting hospital for treatment before family members die with 0.01 and 0.05 significant level respectively. This means father below class-10 education is harmful for family members as it contributed negatively for healthcare seekers in rural Mizoram.
- ✓ In contrast to the above finding, father's education level of at least class-12 positively contributed for healthcare seekers in rural Mizoram. In other words, at least class-12 educated father is necessary for rural residence to seek healthcare.
- ✓ There is no relationship between graduate or above level education of father and their health seeking behaviour. This is mainly because the negligible number of graduate and above level educated father in rural Mizoram.
- ✓ Whereas father who attained at least class-12 education necessary to encourage healthcare seekers in rural area graduate and above education is required in the case or urban residence to encourage people to seek health care in time.
- ✓ Present research clearly uncovered that father's education levels play extremely important role for health seeker in both rural and urban residence in Mizoram

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