M-4

HEALTH SEEKING BEHAVIORS AMONG BHUTIA AND LEPCHA TRIBES IN SIKKIM

Mr. Rinchen Ongmu Bhutia

Tata Institute of Social Sciences, Mumbai

Abstract

Health-seeking behaviors are seen as that behavior that directly and indirectly contribute to health both at the time of illness and during its absence. There is a lot of literature that talks about health-seeking behaviors especially in the context of developing countries. However, very few literatures are focused on tribal health-seeking behavior in this regard. This paper presents an overview of the two prominent tribes in Sikkim i.e the Bhutia and Lepcha especially in the context of women's health and the factors that are responsible for shaping up health-seeking behavior and healthcare utilization. The factors determining the health behaviors may be observed in various contexts: physical, socio-economic, cultural and political. Therefore, the pattern of utilization of healthcare services both public or private depends on socio-demographic factors, social structures, levels of education, cultural beliefs and practices, status of women, economic and political system, social conditioning and the disease pattern and healthcare system itself. The policymakers need to realize the drivers of the health-seeking behavior of the population in a progressively pluralistic healthcare system. It must be understood that more collaborative efforts are required for scheming behavioral health promotion campaigns through inter-sectoral coordination with prior focus on disadvantaged and underserved segments of the population.

Keywords: health, health-seeking behavior, healthcare utilization, behavioral health promotion, Sikkim.

Introduction:

The policy formulation in healthcare should be based on information related to health-seeking, health promotion and healthcare utilization behaviors and the factors determining these behaviors. These healthcare behaviors mostly occur within institutional structures such as family, community or healthcare services. The factors determining the health behaviours may be observed in various contexts: physical, socio-economic, cultural and political (Kroeger, 1983). Hence, the pattern of utilization of healthcare services both public or private depends on socio-

demographic factors, social structures, levels of education, cultural beliefs and practices, status of women, economic and political system, social conditioning and the disease pattern and healthcare system itself (Fatimi & Avan, 2002; Katung, 2001; Navaneetham & Dharmalingam, 2002; Stephenson & Hennink , 2004; Uchudi, 2001).

The driving force for health-seeking behavior is the organization of the health care system. From time again the balance between the public and private health sector has always created tension in the delivery of healthcare services. It seems that the private health sector tends to serve the affluent; thus the resources for the public health sector must be freed for the poor. Inter-Sectoral coordination between these two sectors is a must while formulating any health policies or any health plans but what we can see is that the private sector is never taken into account while formulating health plans (Hanson & Berman, 1998; Giusti, Criel & De Bethune, 1997). Therefore, these two sectors may complement or substitute for each other. It is visible that the resources mixes with doctors working in the public domain also is seen as establishing their private clinic. Modern technology and their features along with the confidence of the healthcare providers play a significant role in decision making about the choice of the health facility (Newman et al, 1998; Sadiq & Muynck, 2002; Ndyomugyenyi, Neema & Magnussen, 1998).

This paper provides an overview of factors influencing health-seeking behavior and their use of healthcare services in the state of Sikkim encircling both public as well as private sectors. The healthcare system in Sikkim is described and the literature reviews from regional as well as international journals, using keywords (health, healthcare system, health-seeking behavior, health service utilization) and using the structure of the conceptual framework of Kroeger for assessing health-seeking behavior. The conclusion is drawn describing the scenario in Sikkim.

Healthcare delivery system in Sikkim:

Healthcare in Sikkim is provided primarily by the public sector. The State has established a well-functioning primary health care system through a network of two Community Health Centers, 24 Primary Healthcare Centres and 146 sub-centers. Healthcare is provided by 273 doctors and nine AYUSH practitioners. This gives an adequate ratio of approximately one doctor per 2,500 populations. Except for the Manipal Central Referral Hospital, which provides secondary and tertiary care, only a few private medical institutions are present. The State has four district hospitals and 1,560 hospital beds in 2012 or 2.6 beds for 1,000 people.

Sikkim has improved a lot in the last two decades due to the availability of the modern healthcare facilities in the state as well as improvement in the district-wise doctor-population

ratio. In Sikkim, all preventive, curative and promotive services related to health is granted but the people are not able to avail nor access those services or facilities due to rugged hilly terrain, lack of general awareness, ignorance, illiteracy, urban and rural disparity. It can be noted that lack of modern equipment in the hospitals and bed facilities compels the authority to refer such patients outside the state, which is not at all feasible for all categories of people in Sikkim, there are very few advance private medical institutions in the state and therefore the patients have to travel outside the state especially to West Bengal. Given the miscellaneous nature of the healthcare delivery system in Sikkim and the availability of limited resources, it's fundamental for the various sectors to plan and coordinate to improve the health of Sikkimese. Therefore, it is necessary to understand the health-seeking behavior of the population and the factors influencing this behavior.

Factors affecting health-seeking behavior:

Various factors establish for the leading causes of poor utilization of primary health care services: including poor socio-economic status, lack of physical accessibility, strong cultural beliefs and perceptions, the low literacy level of mothers. Several factors such as cultural beliefs, socio-demographic status, women's autonomy, physical and financial accessibility, and disease pattern and health service issues has a significant influence in accessing healthcare services. Access to healthcare services and health-seeking behavior are the dominant discourses of the research in a tribal population. It is believed that they are determined by their socio-cultural and magico-religious beliefs, customs and practices. Hence the choice of their health care system and its utilization has been shaped by socio-economic and cultural factors.

Cultural and socio-demographic factors:

Cultural beliefs and practices often pave the way to self-care, home remedies and consultation with traditional healers in rural communities. The advice and suggestion given by the elderly women in the house are also very important and cannot be ignored. This factor, in the end, results in a delay in treatment-seeking and is most commonly seen in women, not only for their health but especially when it is about their children's illnesses. Family size, educational status, and occupation of the head of the family are also linked with health-seeking behavior besides age, gender, and marital status. However, the cultural practices and beliefs have been prevalent irrespective of age, gender, level of education, socio-economic status among tribes, which in turn affect general awareness and recognition of the severity of illness, availability of services and acceptability of services. There are times when religious misinterpretations have ratified her

inferior status. For them, limited access to the outer world has been culturally rooted in the society, and for the unmarried, the scenario is even worst, even if it is a matter of consulting a physician in an emergency. Sikkim has a large number of powerful traditional faith healers Dhami, Jhankri, Phenolongba, Bonbo (Nepali community) Poor and Nejum (Bhutia community) Bumthing (Lepcha community) who depend on Jharphuk which is interestingly complicated expensive course of treatment using indigenous medicine. The Lepchas, Bhutia, and Sherpas are categorized as Scheduled Tribes in Sikkim. The Lepchas are the original inhabitants of the state compared to other ethnic groups; the Lepchas still maintain many of their traditional ways. The Bhutias comprise, the Sikkimese Bhutia and Bhutia from Bhutan and Tibet. Historically the Lepcha were animists who believed that every inanimate object has a soul of its own by the virtue of being a part of nature (Gurung& Swarup, 2013). Both Lepcha and Bhutia believe that the illness and misfortune are caused by an evil spirit, therefore to appease the spirit and overcome misfortune and cure oneself of illness, they offer animal sacrifices.

The diseases like Tuberculosis and skin infection is quite common among the Lepcha and Bhutia tribe in Sikkim. Though they are several healthcare facilities, the usage of traditional medicine and treatment is still popular because they believe that supernatural power is the causative factor for all kinds of diseases.

Women's autonomy:

Men have a predominant role in determining the health needs of a woman. Since they are the breadwinners and decision-makers, they decide when and where a woman should seek health care. It is seen that illnesses reported by women are comparatively less to the counterpart. The lower status of women impedes them from admitting and voicing their concerns about health needs. Women are generally advised to not visit the healthcare provider alone or to make the decision to spend money on health care. Thus, women generally cannot access health care in emergencies, which directly has severe repercussions on women health. Even though women are often termed as the primary caregivers in the family, but they have been deprived of the basic health information and holistic health services. In Sikkim, though women enjoy equal status in the family, the differences are vividly seen in the urban and rural settlements. The condition of women living in the East district is much better than other districts, the condition of North Sikkim is worst which has only 23 medical centers including hospitals, PHC, PHSC, etc. which is below the population requirement. The women and children need to seek the permission of the head of the household or the men in the family to go to the health services. Women in rural areas

are mostly socially dependent on men and lack of economic control adds to their dependency. The predominating system of values preserves the segregation of sexes and confinement of the women to her home. Therefore, educating women can bring social liberty, respect, and decision making authority in household chores.

Economic factors:

The economic polarization within the society and lack of social security system make the poor more vulnerable in terms of affordability and choice of a healthcare provider. People living in poverty cannot benefit from the healthcare system but it also restrains them from actively participating in the decision-making process that affects their health, which results in greater health inequalities. Materialistic possession of household items, cattle, agricultural land and type of residence implies not only their socio-economic status but also provides us with an idea of livelihood of a family. The economic ability to utilize health services has not been very different in Sikkim. For health expenditure in Sikkim, difficult terrain, which increases the unit cost of service delivery as well as resource constraints, has its impact in terms of unmet health targets in the state. The out of pocket expenditure undoubtedly has been a major barrier in seeking health care in Sikkim. Not only expenditure incurred on medicine's count but also the fare spent for treatment turns out to be burdensome resulting in limiting the choice and opportunity of health-seeking.

Physical accessibility:

Access to a primary health care facility is a basic human right. The discontentment with the primary care services in either sector forces people to health care shop or to move to higher-level hospitals for primary care, leading to considerable inefficiency and loss of control over efficacy and quality of services. In Sikkim, due to hilly terrain, the effect of distance on service use becomes stronger when added with the dearth of transportation and with poor road connectivity, which contributes towards increased costs of visits. The availability of Transport facilities, the physical distance of the facility and time taken to reach the facility undoubtedly influence the health-seeking behavior and their utilization pattern. It is noticed that the distance separating patients and clients from the nearest health facility has been marked as an imperative barrier to use, particularly in rural areas. The long-distance has been a disincentive to seek care especially in case of women who would need a companion to accompany. As a result, the factor of distance gets strongly adhered to other factors such as availabilities of transport facilities, the total cost of one round trip and women's restricted mobility.

Health services and disease pattern:

The issue of under-utilization of health services in the public sector has been almost a universal phenomenon, whereas, on the other hand, we can see that the private sector has expanded everywhere. The use of private-sector allopathic health facilities is higher compared to the public sector. The high usage is mostly due to issues curtailing to acceptability such as easy access, shorter waiting time, longer or flexible working hours, availability of better staff and drugs, friendly attitude and confidentiality in socially stigmatized diseases. However, the quality of services and responsiveness of the providers in the private health sector has been questionable. The client-perceived quality of services and confidence in health providers influence the utilization pattern. Also whether the medicine is provided from the health care facility or has to be purchased from the market affects. In Sikkim, the public sector, by and large, has been properly utilized but mainly by the rural people since it is the first point of contact and due to economic constraints. The type of symptoms experienced for the illness and the number of days of illness are major determinants of health-seeking behavior and choice of a care provider. In tribals in case of a mild single symptom such as fever, home remedies or prescriptions by friends or neighbors are used, whereas, with various symptoms and longer duration of illness, biomedical health provider is more likely to be consulted. Traditional beliefs tend to be associated with peculiarities of the illness itself and various circumstances and social factors. This complexity is seen in health-seeking behavior, including the use of home-prescriptions, delay in seeking biomedical treatment, non-compliance with treatment and referral advice. The healthcare providers' attitude and patients satisfaction with the treatment plays a pivotal role in health-seeking behavior.

Conclusion:

To formulate a policy that addresses the need of every individual and to meet the goal “Health for All by 2030” we need to understand the drivers of health-seeking behavior of the population in a progressively pluralistic health care system. It must be noted that access to healthcare services and health-seeking behavior are the dominant discourses of the research in a tribal population. It is believed that the socio-cultural and magico-religious beliefs, customs and practices have a strong influence on their health-seeking behavior. Hence, the choice of their health care system and its utilization has been shaped by socio-economic and cultural factors. This links with both to public and private sectors.

In addressing and acknowledging socio-economic status through inter-sectoral coordination and creating activities such as women's SHGs, providing life-skill training and non-formal education have shown to have a positive impact on health-seeking behavior besides the overall empowerment of women population. Programs and strategies focusing on gender issues, and gender sensitization needs to be developed. The healthcare providers need to be sensitized more towards the need of the clients with special focus to women to improve interpersonal communication. Furthermore, there is a strong need to further nurture critical, creative and reflective thinking to reorient our health system. There is an utter need for healthcare providers to be compassionate and caring to the needs of the people they serve. The healthcare providers should maintain integrity, creativity, and sensitivity and should set an example within the healthcare system and in the communities.

Public health awareness programs should be organized for mothers as components of public health efforts to help mothers understand the disease process and difference between favorable and unfavorable health practices, which in turn would help and enhance the mothers understanding of disease pattern, its process, its symptoms and the importance of preventive measures for a better family health. Financial incentives offered to public sector staff not only will help in retaining them but will also motivate them to deliver quality services. A comprehensive health care system needs to focus on the rural people who are generally the poorest and who become visible only when programs are signed with international donors. A coordinated effort is required in designing behavioral health campaigns for health promotion through multi-sectoral collaboration focusing more on the disadvantaged and the underserved segments of the population (i.e. women, children and elderly) would be a step towards improvement. With such convoluted and universal image of health system utilization and health-seeking behavior in Sikkim, it is very much needed to cut down the polarization in health system use by offering more client-centered approach, employing additional female workers, creating a supportive and conducive working environment and a pleasant and joyful ambiance at health services departments. It is seen that there is a near absence of data on the health situation of different tribal communities. In absence of a comprehensive picture of tribal health in the country, policy measures and government programs are often ad-hoc, therefore, there is a need to create state regulatory mechanisms and ongoing education and training for healthcare providers. The State needs to acknowledge that when it comes to improvement in social infrastructure and development the focus should primarily be given to the rural areas because it is here that the

maximal population resides. The State needs to endorse and conserve the much sought after but neglected traditional faith healers of the state by providing them with health education training for assisting and catering to the need of the health department, especially in the rural areas.

References:

Fatimi, Z. & Avan, I. (2002). Demographic, Socio-Economic and Environmental determinants of utilization of antenatal care in rural setting of Sindh, Pakistan, *Journal Pakistan Medical Association.* pp. 138-142.

Giusti, D., Criel, B., & De Bethune, X. (1997). View: Public vs. Private health care delivery:behind the slogans, *Health Policy Plan.* pp. 193-198.

Gurung, B.D. & Swarup, A. (2013). Two Waves of Transformation and Construction of Lepcha (Mon) Identity in Sikkim: An Assessment of Intra-Community Divide, *The International Academic Forum.*

Hanson, K. & Berman, P. (1998). Private health care provision in developing countries: a preliminary analysis of levels and composition, *Health Policy Plan.* pp. 195-211. https://doi.org/10.1093/pubmed/fdh207

https://www.academia.edu/36820908/STATUS_OF_HEALTH_IN_SIKKIM_ISSUES_AND_CHALLENGES

Katung, P.Y. (2001). Socio-economic factors responsible for poor utilization of PHC services in rural community in Nigeria, *Niger Journal of Medicine.* pp. 28-29.

Kroeger, A. (1983). Anthropological and socio-medical health care research in developing countries, *Social Science & Medicine.* pp. 147-161.

Navaneetham, K. & Dharmalingam, A. (2002). Utilization of maternal health care services in Southern India, *Social Science & Medicine.* pp. 1849-1869.

Ndyomugyenyi, R., Neema, S., & Magnussen, P. (1998). The use of formal and informal services for antenatal care and malaria treatment in rural Uganda, *Health Policy Plan.* pp. 94-102.

Newman, R. et al. (1998). Satisfaction with outpatient health care services in Manila Province, Mozambique, *Health Policy Plan.* pp. 174-180.

Sasiq, H. & Muynck, A.D (2002). Health care seeking behavior of pulmonary tuberculosis patients visiting Rawalpindi, *Journal Pakistan Medical Association.* pp. 10-16.

Shaikh, B. T. & Hatcher, J. (2005). Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers, *Journal of Public Health*, 27 (1), 49-54. Retrieved January 14, 2020, from

Stephenson, R. & Hennink, M. (2004). Barriers to family planning service use among the urban poor in Pakistan, *Asai Pacific Journal of tropical medicine.* pp. 5-26.

Tamang, K. L., Thapa, S. D., & Chhetri, B. (2016). Status of Health in Sikkim: Issues and Challenges, *International Research Journal of Management Sociology & Humanity*. 7 (6), 290-298. Retrieved January 13, 2020, from

Uchudi, J.M. (2001). Covariates of child mortality in Mail: does the health seeking behavior of the mother matter?, *Journal Biosocial Science.* pp. 33-54.