Chapter VI

NRHM and Health Seeking Behaviour in Cachar

In last chapter I discussed contribution of national rural health mission in health care in Cachar district. This chapter deals with impact of national rural health mission on health behaviour of people in the district.

Health culture of contemporary India is characterised by multiple type of medicine. Modern medicine is known to be dominant in both rural and urban areas but traditional medicine like ayurveda, unani and folk medicine are still preferred by bulk of people[1].

Traditional concept of disease and illness as well as traditional health culture is not completely disappeared from Cachar. Despite of spread of modern medicine in villages still people of Cachar believe in folk medicine and magico-religious practice. Even for treatment of deadly diseases like jaundice, hepatitis and gallbladder rural people use to consult folk healers (Sen 2010)[2]. Folk medicines, used in villages of Cachar, are both natural folk medicine and magico-religious practice. Folk healers use herb, plant, mineral and animal substance to treat disease. Magico-religious practices are also used to some

[1]Madhu Nagla, Sociology of Medical Profession, Rawat Publications, Jaipur, 1997, Pp 1-58
[2]Jayeeta Sen, Health Culture and Care in North-East India with reference to Hepatitis and Goll bladder Stone, Mittal Publication, New Delhi, 2012, Pp 1-30

extent along with natural folk medicine in villages. People still hold their traditional view that there are certain diseases which cannot be treated without folk medicine (Das 2013)[3].

Jaundice, a symptom of liver disease, is perceived by village people as a disease caused by irregular life style. Another disease perceived by people is displacement of naval, symptom of which matches with diarrhea, dysentery or other abdominal diseases. For curing displacement of naval people prefer folk medicine. Rural people still believe that effect of black magic and evil spirit cause diseases. Some diseases caused by black magic and evil spirit are *thama ban, najar etc. Thama* is a magical activity which delays healing of external injury. *Ban* is also a magical activity causes massive destruction of heart and sudden death of person. *Najar* is evil eyes and it causes severe diarrhoea[4].

Majority of patients of traditional medicine men are from lower socio-economic strata, who get satisfaction by using folk medicines and magico-religious practices. Poor and illiterate people of Cachar also use modern

[3]Suranjan Das, Health Status of Patni Community in Cachar District of Assam: A Sociological Study, Unpublished Ph. D. Thesis submitted to Assam University Silchar, 2013, Pp 131-157

[4] Ibid, Pp 141-152

medicine but due to high cost of modern medicine, they like to use traditional medicine[5].

Folk medicine is practiced by people of six selected villages. While conducting field work in villages, it is observed that folk healers used to attend village market in weekly days. In market they use to draw attention of people by performing some activities like hiring singer for folk song, arranging magic show etc. One of the popular folk medicines sold in village market is *Mahmod Mia's lalpani* (red water of a renowned folk healer known as *Mahmod Mia*). *Mahmod Mia's lalpani or* red water is used by villagers to cure several diseases like gastric, indigestion, de-warming etc. It is taken as a tonic which helps for overall physical well-being. Other folk medicines sold in village markets are *Joubanchurna, Saribadi* liver tonic, ointments like *solaram* for skin disease etc.

Folk medicines are used by villagers for almost all diseases but for certain diseases like Jaundice, *najar*, green stool of babies, post-delivery complexities of women (*sutika*), erratic behaviour (*paglami*), piles (*orish*), asthmatic problem of children (*dememara*), sexual dysfunction of male (*dhatudurbal*), sprain and strain (*kachka*) and animal's bite, villagers consult village folk

[5]SujataKar, ArupendraMajumder and Subrata Kumar Roy, Age old Health Care System of Rural Bengalis and Meities of Cachar District in Assam: Beliefs and Practices, Man in India, Vol. 89, No. 1-2, 2009, Pp 59-172

healers. For orthopaedic problems people used to visit folk healers named *khandals* who treats orthopaedic injury mainly fractures by using herbal and non-herbal folk medicine.

There are renowned *khandals* available in Dalu and Baskandi villages in Cachar district. People of selected villages also visit *Khandal* of villages. One of the important reasons as described by respondents is unavailability orthopedic surgery in free of cost in nearby health centre. Cost of treatment given by *khandal* is lower as compared to orthopedic surgeons.

Rural people use folk medicines due to several reasons like tradition of family and community, easy availability of folk healer, minimum cost of therapy, faith in folk healer and efficacy of folk medicine for curing certain diseases.

Modern medicine started to penetrate in villages in Cachar district with gradual expansion of modern health care institutions through government initiatives. In fact modern health care became familiar to rural people after establishment of primary health centres in rural areas and their referral units either in rural town or in district headquarter of Cachar.

Health Care in Cachar during Pre-NRHM Period

People of six villages of study area are covered under three primary health centres viz. Bikrampur, Jalalpur and Borkhola primary health centres and sub centres. Though modern health institutions were established by government in rural areas, these institutions did not have adequate manpower and infrastructure to provide proper health care to people in the district.

Oral history of villages reveals just after establishment of Bikrampur, Jalalpur and Borkhola primary health centres, adequate medical staff, paramedical staff and infrastructure not existed earlier to ensure twenty four hour service, proper equipments' for emergency service, maternity and child health care etc. Primary health centre and sub-centre were not capable to provide complete treatment to villagers.

Quack practitioners and pharmacy owners played significant role in spread of modern medicine in remote villages of Cachar. In villages no pharmacy was run by qualified pharmacist or chemist. Quack practitioners and pharmacy owners were well accepted to village people. One of the reasons is people's easy access to quack practitioners and pharmacy owners.

Poor communication and transport was another reason for favouring quack in villages. Due to poor transportation and communication it was not possible on

part of villagers to come to health centres for any urgent need of medical care. In such situation quacks used to serve patients in remote villages. Quacks used to get success in many cases which helped to increase their popularity in villages.

High cost of treatment is another reason for favouring quacks and chemists by villages. Villagers can negotiate or request to quacks and pharmacy owners for adjustment of treatment cost with their financial capability. Villagers also get credit facility to the quacks and chemists known to them.

Importance of quack practitioners is gradually decreasing now in these villages due to availability of more numbers of medical practitioners in nearby health centres and private clinics in rural markets. But pharmacy owners are still of immense importance to villagers. For ailment of common health problems like cold, cough, body ache, head ache, nautia and vomiting, diarrhea and dysentery, fever etc village people under study first go to pharmacy and purchase medicine describing their symptoms.

Habit of self-medication is a serious problem among people of villages. This is patronised by drug sellers of rural markets who use to sell drugs without prescription of a registered medical practitioner. Most of the drug sellers in villages under study are found little learned who do not have proper

knowledge on action and reaction of drugs. A serious problem observed during fieldwork is mal use of drugs like antibiotics, non-steroidal anti-inflammatory drugs, drugs used for insomnia including schedule H drugs. Drugs taken by self or given by shop owners satisfy people's needs in most of the cases. But it is not known to villagers that only relief of symptoms may suppress a critical disease temporarily which may be relapsed in future.

Now a day's village people have multiple medicines for treatment. It is observed that financial starvation still compels village people to go to folk healers, quack practitioners, chemists or homeopathic doctors. Allopathic medicine is preferred by most villagers including poor but its systematic way of treatment including pathological test vis-a-vis cost for full therapeutic dose is still unaffordable to majority of villagers.

An attempt is made to understand socio-economic status of respondents and their preference to medicines like allopathic, homeopathic, ayurveda and folk medicine. Economic condition and educational qualification of respondent household and preference to folk medicine is given in following tables.

Table VI.1
Economy and Preference to system of Medicine

preference	Respondents			Total
	Poor	Lower Middle Class	Middle Class	
Folk	16	06	0	22
Allopath	44	30	19	93
Homeopath	10	7	2	19
Ayurveda	0	0	2	2
Homeo & Folk	8	4	0	12
Allopath & Folk	122	23	7	152
Total	200	70	30	300

It is observed from table that majority (50.66%) of respondent's prefer both allopathic and folk medicine. Only allopathic medicine is preferred by 31% of respondents. About 6.33% respondents prefer only homeopathic medicine and 7.33% respondents prefer only folk medicine. High percentage of people's preference to both allopathic and folk medicines indicates that folk healers still retain their popularity in village.

If we look into income wise distribution of respondent's preference to different system of medicine we observe that majority (66.66%) of respondents are poor and some (61%) prefer both allopathic and folk medicine followed by 22% prefer only allopathic medicine, 5% prefer only homeopathic medicine, only 8% prefer folk medicine and rest 4% prefers both homeopathy and folk medicine.

Respondents who belong to lower middle class group constitute 23.33% of total respondents. Majority 42.85% of lower middle class respondents prefer only allopathic medicine followed by 32.85% prefer both allopathic and folk medicine, 10% of respondents only homeopathic, 8.57% prefer only folk medicine and rest 5.72% prefer both homeopathy and folk. Middle class constitutes 10 % of total respondents out of which majority (63.33%) of them prefer only allopathic medicine followed by 6.66% prefers only homeopathy, 6.66% follows only ayurvedic medicine and 23.33% prefer both folk and allopathic medicine.

From above analysis it is observed that there is correlation between income and preference to medicine among people. Majority of respondents, who are poor prefer combination of allopathic and folk medicine. Trend is almost same in case of respondent belonging to lower middle class. But majority of the respondents, who are middle class prefer only allopathic medicine. Ayurvedic medicine is costly than other medicine, which is not at all preferred by poor and lower middle class but very few (0.66%) respondents within middle class prefer ayurvedic medicine.

Table VI.2
Education and Preference to system of Medicine

Preference	Respondents			Total
	Illiterate	Primary to below H.S.L.C	H.S.L.C & Above	
Folk	15	6	1	22
Allopathy	9	40	44	93
Ayurveda	0	0	2	2
Homeopathy	9	8	2	19
Homeo& Folk	6	4	2	12
Allopath & Folk	11	131	10	152
Total	50	189	61	300

NB: H.S.L.C. stands for High School Leaving Certificate

It is observed that educational attainment of respondents also matter for selection of medicine. But it should be mentioned that economy and education of a community correlate each other. Majority (93.44%) of respondents above high school leaving certificate examination are from middle class and lower middle class background. Again, quite some people (94%) are illiterate respondents and they come from poor family condition.

The table highlights that folk medicine is preferred by 22 respondents out of which majority (68.18%) are illiterate, 27.27% are less educated having educational attainment from primary school to below high school leaving examination and only few (4.54%) educated respondents prefer folk medicine

who have qualification equal to high school leaving certificate examination or above.

Allopathy is preferred by 93 respondents out of whom majority (47.31%) are educated having qualification equal to high school leaving certificate examination or above, 43.01% possess qualification from primary school to below high school leaving certificate examination and very few (9.68%) illiterate respondents prefer allopathic medicine.

Regarding preference of respondents to both allopathic and folk medicine, we find that total 152 respondents prefer such combination. It is observed that this combination is preferred by people, who are either illiterate or less educated having qualification from primary to below high school leaving certificate examination. Very few (16.39%) educated respondents prefer combination. It is also observed that homeopathy or combination of homeopathy and folk medicine is preferred by a portion of illiterate or less educated respondents.

In case of women and children in poor and illiterate group, it is also found that women and children are more likely to seek health care service in emergency and urgent need, they always ignore minor symptom and trouble, and their health care needs are given lower priority by their families and themselves.

National Rural Health Mission and Health Behaviour of People in Cachar

Village people do not get satisfactory health care in government health care institutions. Though some facilities like twenty four hour health service, regular out-patient department service, service for maternity and child health, family planning service, surgery for minor injury, wound and burn as well as availability of medical and paramedical staff are recently provided in concerned primary health centre and sub-centre of villages, but village people do not get treatment in government health centres.

Regular medical checkup is done in out-patient as well as in-patient departments of primary health centres of the villages at free of cost with five rupee registration fee for patients belonging to above poverty line. No fee is taken from patients belonging to below poverty line. Medical officers of primary health centres conduct outpatient departments regularly.

Recently national rural health mission has provided rural health practitioners (RHPs) in medical health sub-centres. People attend out-patient departments of their nearest medical sub centres. The villagers feel more free to discuss their problem with rural health practitioners of medical health sub centre than medical officers in their concerned primary health centre. In fact number of patients in out-patient department of medical sub centres is growing day by day due to presence of rural health practitioners.

Drugs and pathological tests are not properly available in primary health centre and medical health sub centre. Most drugs prescribed in out-patient department of concerned health centres are purchased by patients from market. Similar is the case with pathological tests. Most of the prescribed pathological tests are not done in primary health centres.

Few essential drugs in primary health centre and medical health sub-centre like ORS, de-worming drug, medicine for common diseases like cough, cold, fever, diarrhea, iron and folic acid etc. are sometime available. Supply of essential life-saving drug like antibiotic, anti-hypertensive drug etc. is not always available. Even needle is not always found available in hospitals. People have to purchase it. Full therapeutic dose of any drug is not given to patients. Rabies vaccines are supposed to be given at free of cost but these are not always available in health centres.

It is also observed that national rural health mission is still not able to establish adequate number of health centre and sub-centres to three block primary health centres in Cachar as per Indian Public Health (IPH) standard norms. Referral service is also not adequate for the patients of the villages under study. Patients of these villages are referred from their concerned primary health centres and sub-centres to first referral unit situated at Kalain or to second referral unit situated in Silchar town, headquarter of Cachar district. In

both the referral units' adequate number of specialist's doctors, pathologists and radiologists are not available till now.

One of the significant contributions of national rural health mission towards health care of rural people is provision of giving proper maternity and child health care. In selected villages Accredited social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) are performing very well in their respective field of rural health care. In every month they organise village health and nutrition day (VHND) in every villages under study. Anganwadi Workers of respective villages help ASHAs and ANMs to organise village health and nutrition day.

In village health and nutrition days of six selected villages it is found that newly pregnant women are registered, vaccines and essential drugs are given to registered pregnant women by ANMs. ASHAs and AWWs bring pregnant women to VHND programme for registration, immunisation other medical help. New born babies are also given vaccines and essential drugs if required. Vaccines like BCG (baciluscalmette-guerin), OPV (oral polio vaccine), DPT (diphtheria pertussis tetanus) Hepatitis-B vaccine and measles are given to infants of these villages as per schedule date.

At age of six weeks infants of villages are given three vaccines viz OPV-1, DPT-1 and Hep B-1. At the age of ten weeks children of these villages are given OPV-2, DPT-2 and Hep B-2 vaccines and at the age of fourteen weeks again OPV-3, DPT-3 and Hep B-3 are given. Vaccine of measles and vitamin A (1^{st} dose) is given to the children of these villages at the age of nine-twelve months. Two vaccines DPT Booster and OPV Booster along with vitamin A second dose are given to children at their age of 16-24 months in the VHND programmes of these villages.

Vitamin A 3^{rd}, 4^{th} and 5^{th} doses are given at age of twenty four months, thirty months and thirty six months respectively. At the age of five years DT booster and at the age of ten and sixteen years respectively TT boosters are given. But it is found that most of guardians of these selected villages are not always aware about the dose of vaccines after completion of one years of age of their children.

ASHAs and ANMs of these villages are regularly monitoring pregnant women of the villages. ASHA takes pregnant women in primary health centres and referral hospital if any complicacy arises. Majority of Pregnant women (around 89.87%) of these villages are receiving Mamoni kits and JSY. Two checks of an amount of Rs.500 (five hundred) each are distributed at least 90% of pregnant women of these villages for purchasing nutritious foods and

necessary things at pregnancy period and Rs 1400 for rural or Rs1000 for urban people just after institutional delivery at government hospital under Yanani Suraksha Yojana scheme.

Institutional delivery is directly supported by more than 50% of the guardians of pregnant women. ASHAs of these villages are helping to convince guardians of pregnant women to prefer delivery in government health centres. It is observed that more than 75% of the pregnant women in the year 2010-11 and 2011-12 are taken to government hospitals by ASHAs for institutional delivery. Home delivery is also preferred by around 15% of the guardians of pregnant women in these villages.

It is also observed that most of the middle class families (72%) in villages prefer private clinic for health check-up of pregnant women. Middle class people of villages under study prefer private nursing homes for delivery of pregnant women.

Family planning is also looked after by ASHAs and ANMs in the villages under study. ASHAs motivate married couple of these villages to opt for family planning after birth of two to three children. ANMs distribute condom

and emergency contraceptive pills to married couple who immediately want to avoid pregnancy. ANMs also distributes oral cycle contraceptive pill to women who are not interested for further pregnancy.

It is observed from the study that in two consecutive years 2010-11 and 2011-12 total number intra uterine devices are applied to 52 women who are not interested for further pregnancy. Total 47 medical termination of pregnancy was done safely with initiatives taken by ASHAs and ANMs of respective villages.

It is observed from the study that cultural factors which became hindrance on the way to family planning in villages is gradually getting reduced due to intervention of ANMs and ASHAs as well as spread of education in villages. Women in villages are showing more interest than men in family planning due to guidance given by ASHAs and ANMs. Now women are not afraid of taking pills and medical termination of pregnancy in villages under study.

Laparoscopic surgery of family planning for both male and female is known to village people now. Married couples in villages are not afraid of surgery required for family planning. As per record maintained by ANMs concerned

with selected villages under study, in two consecutive years 2010-11 and 2011-12 total 23 females of these villages have gone for laparoscopic surgery in government health centres for family planning. But no male opted for surgery of family still now.

The most significant contribution of national rural health mission for family planning is that more poor illiterate people are now approaching toward family planning ignoring cultural and religious bindings.

Sanitation and Health in village

Sanitation is a vital part of good health. Sanitation of villages is measured by studying how villagers prevent human contact with hazards of wastes particularly human and animal faeces, waste water, domestic waste etc. Housing condition and habit of cleanliness of villagers are also measured to know sanitation and health in selected villages.

Table VI.3

Housing Pattern of Respondent Households

Housing Pattern	No of Households	Percentage
Pucca	11	3.60%
Semi-Pucca	43	14.40%
Katcha	246	82%
Total	300	100%

It is observed from study that 3.6% households have pucca house made up of concrete walls and tiled floor. About 14.40% of households have semi-pucca houses made up of tin roof and brick walls or bamboo made cemented walls and katcha floor. But around 82% of respondent household have katcha houses made up of tin or chawl roof, bamboo or mud walls and katcha floor.

It is also observed from the study that respondents those who have pucca houses belong to income groups ranging from Rs. 8000-10000 and above. Households having semi-pucca houses belong to income group ranging from 4000-10000 and above. But some of the respondents who are below poverty line have got semi pucca houses under Indira AvasYojana scheme.

Table VI.4

Condition of Drinking Water

Source of drinking Water	Households	Percentage
Pond and river water	46	15.34%
Deep well and tube well	77	25.66%
Piped water supply	177	59%
Total	300	100%

It is observed from table that only 15.34% of total respondent households take drinking water directly from ponds and nearest river. About 25.66% of respondent households take drinking water from deep well and tube well. But 59% respondent households take drinking water from piped water supply. But supply of piped water is not regular. Water supply is provided for two to three

days in a week. Those who availed supply water have kept another source of safe drinking water. Poor people of the villages who are solely depended on supply water carry safe drinking water from far distant places due to irregularity of supply water.

Majority (98%) of villagers drink water without boiling. Majority (87%) of households belong to income group ranging from Rs. below 2000 to10,000 reported that due to high price of fuel they do not boil drinking water. Water filter is not used by 89% of the respondent household

Table VI.5
Condition of Latrine and Urinal

Condition of Latrine and Urinal	Households	Percentage
Sanitary Latrine and Urinal	69	23%
Insanitary but closed tank	153	51%
Insanitary and open tank	69	23%
No Latrine and urinal	9	3%
Total	300	100%

It is observed from table that only 23% of respondent households have sanitary latrines and urinals. Nearly 51% respondents have insanitary latrines but tank is closed with cover made of bamboo. Respondents reported that this kind of earthen tank lasts for two to three years. But 23% of respondents reported that they use insanitary latrine with open tank. Respondents who

reside by bank of river use pipe to through waste material to river. Only 3% of respondents do not have latrines who use open field or river bank. From above table it is observed that concept of sanitation for human waste material is very much prevalent in village but economic hardship is sole reason for using insanitary latrines and urinals. Respondents reported problems of using insanitary latrine due to flood during rainy season. 60% of BPL holder respondents have received sanitary latrine under total sanitation campaign scheme but the beneficiaries are of the view that after using it for one year the latrine has got damaged.

It is observed from study that only 1% respondents have drainage at their houses which is made up of concrete and bricks. Only 3% of respondents reported availability of *kaccha* drainage at their house. But 96% of respondents reported that they do not have any drainage at their house. Most of the respondents who live in village reported that they do not require drainage for waste water management or other purpose.

Personal hygiene is another parameter of health. People's habit of remaining clean is not always determined by economy but it is found from study that educated and economically better people in villages under study remain cleaner than poor and illiterate people. In rural areas people are not even conscious about their children's cleanliness.

Problem of communication

Communication and transportation in villages under study is very poor. Recently some initiatives are taken by government to improve condition of rural roads under scheme of Pradhan Mantri Gram Sadhak Yojana. Three villages under study are connected with roads constructed under Pradhan Mantri Gram Sadhak Yojana scheme but there is no public vehicle available for transportation. Rest of the villages are connected to motor able roads by *kaccha roads*. *Kaccha roads* during monsoon become muddy but in dry season some light vehicles move across these roads. Villagers used to reach nearest market and health sub centres on foot in monsoon.

Food Habit and Nutritional Health of Villagers

Food habit and daily dietary intake of respondent households are analysed to understand nutritional health status in selected villages. For knowing food habit of respondent households a survey of one week's food habit is conducted. It is observed from that survey that most of respondent households (78%) are not in a position to take complete food due to poor economic condition. Rice is the major food of all households to meet energy requirement of the day.

Majority of households cannot afford food items enriched with protein, fat, vitamins and minerals on daily basis. Protein rich food items like meat, fish,

egg, soya food etc. are taken in few (25%) households every day. Fish is preferably taken to meet protein requirement by all the households of selected villages. But due to unavailability of fish in natural sources as well as high price of fresh local fish in market, people use to take *chalani* fish imported from states outside Assam. Food value of *chalani* fish is inferior to local variety of fish. Only (24%) of respondents disagreed to take *chalani* fish. Many of them take dry fish.

Daily intake of fat rich food items like cheese, ghee, butter, nuts etc. is also poor in majority (87%) of respondent households. Fruits are also not consumed by most of the respondent households (97%) on daily basis.

Vegetable and green leaves are taken in all households but sufficient quantity of vegetables and green leaves are not taken by majority of respondents (77%) to meet daily requirement of minerals and vitamins. Milk is known as a source of complete food but very few respondent households (11%) afford pure milk on daily basis and rest cannot take due unavailability of milk in house and lack of affordability to purchase from market. Around 78% of respondent households are not able to consume nutritious food enriched with protein, fat, vitamins and minerals to children on daily basis.

To meet nutritional requirement of children successive governments takes number of initiatives in India. Integrated child development programme is one of the important programmes to improve nutrition and health of children throughout the country. Children below six years are enrolled in anganwadi centre to ensure overall development of children. Provision is there to provide nutritious foods to children on daily basis. But majority of respondents (89%) are of the view that SNP is rarely served in anganwadi centres on daily basis.

Mid-day meal is provided to all primary and middle school children to meet nutritional deficiency. But the benefit of mid day meal scheme is not properly reaching to the children studying in government schools. Majority (79%) of the respondents are of the view that mid-day meal is not served on daily basis. Respondents are also not satisfied with the quality of food served in schools and anganwadi centres.

Awareness about Health Care Policy

Village people under study are not fully aware of all government schemes for health care of rural people. There are certain schemes like Janani Suraksha Yojana, free immunisation of pregnant mother and infants, free family planning etc. are known to majority of (93.67%) respondents. Very less

(13.66%) people are aware of malaria eradication programme, leprosy eradication programme by DOTs, tuberculosis eradication programme.

Malaria eradication programme is reinforced by national rural health mission. Under this programme malaria prone area is selected by malaria department. DDT is sprayed out around houses of every malaria prone villages. The department also provides medicated mosquito net to people in malaria prone localities. It is observed from the study that such activities are not properly done in villages under study. In the year 2012 mosquito-net was distributed among Below Poverty line people of villages under study but all beneficiaries could not be covered under the scheme which led to hatred and quarrel among villagers.

108-Mrityunjay emergency risk management have 14 vehicles in Cachar district. The entire respondent under study knows 108 mrityunjay service provided by government in these villages too. 104 is a twenty four hours service known as *shurusha*, but people do not know about this scheme. Patients can complain for their grievance at any point of time to 104.

Provision is kept by government for decentralisation of health care through Panchayat Raj Institution. But no such attempts are seen to be made by health officials to implement it in selected villages under study. Even the respondents as well as members of Panchayat Raj Institutions of these selected villages are

not aware about existence of village health and sanitation committee, *Rogi Kalyan Samiti i*n these villages and their function. It is important to mention that concerned *Zila Parishad* members of these villages are aware of the scheme, who shows little interest to implement in village.

Problem of dependency on folk healer, quack and drug seller

It is observed from the study that still socio-economic circumstances of rural people under study compel them to consult folk healers, quack practitioners and drug sellers of their locality for primary health care. But the adverse effect such practices is suffered by many of them. The major problem of consulting these healers is delay of proper treatment in time for critical diseases. Symptomatic relief for time being makes critical diseases severe and in many cases patients consult modern medical practitioners when situation goes beyond control and ultimately patient dies.

Case study I

Name of Respondent: Laila Begam Barbhuiya

Husband's Name: Late Moinul Haque Barbhuiya

Name of Village: Buribail

Age of Respondent: 40

Educational Qualification: Illiterate

Mrs Laila Begam Barbhuiya resident of Buribail village under Bikrampur block primary health centre. Her husband late Moinul Haque Barbhuiya was a small farmer who died of cancer one year earlier during my field work in this village at his age of 48 years. Moinul Haque used to feel that something like thorn or fish-bone had attached to his throat causing pain and irritation. Since Moinul Haque himself was a folk healer of erratic behaviour therefore, both husband and wife decided to consult a local folk healer known as (*kantakhoauri*) who cures such cases by feeding a chanted ball of hot rice or a chanted piece of ripe banana. Moinul Haque took it continuously for few days but did not find satisfactory result.

Around after one month his problem became severe. He then consulted a homeopathic doctor of his locality and took homeopathic medicine for around two months which gave him symptomatic relief for couple of months. Around after six months the problem reoccurred vehemently with severe pain and irritation of throat. His family members, neighbours and kith and kin suggested both of them to consult a specialist doctor of Silchar medical college.

The poor couple somewhere heard mane of a popular homeopathy doctor who is mostly known to people as *Kinnarkhal's* doctor. Both husband and wife consulted the doctor immediately who assured them to cure his disease within

one year. Moinul Haque started to get relief of the problem after taking few doses of medicines.

Both Moinul Haque and his wife thought that they have got right doctor who would cure the disease permanently but despite of taking several doses of medicine his problem used to relapse time and again. Doctor used to suppress symptoms but finally could not do it. After treating the patient for one year doctor suggested them to go for pathological test. They did the same in a private pathological laboratory at Silchar town from where they came to know the disease was nothing but cancer. Physical condition of Moinul Haque got deteriorated by that time.

Their earlier doctor assured them to cure his disease but Mrs Laila Begam refused to keep her husband under his treatment. Immediately the patient was shifted to Cachar Cancer Hospital at Silchar. Doctors started treatment with chemotherapy but it was too costly for them to avail the treatment. The patient came back to his residence and started to take homeopathic medicine again. Finally Moinul Haque died on 6thseptember 2013 in the way to Silchar medical college hospital.

Case study II

Name of Respondent: Anjumanara Begam Laskar

Husband's Name: Late Anwar Hussain Laskar.

Name of Village: Bhairabnagar

Age of Respondent: 34

Educational Qualification: Illiterate

Mrs Anjumanara Begam Laskar resident of Bhairabnagar village under Borkhola block primary health centre. Her husband late Anwar Hussain Laskar was a small farmer and village leader who died of stroke two year earlier during my field work in this village at his age of 40 years. Her husband was only earner of the family and the sudden death of husband brought dark day of her life and she became poor to poorer. After her husband death Anjumanra Begam is residing with her Father in Law with her three son and only daughter (all are below 12 year). Her body shows that she is also a victim of malnutrition and anemia. In a hot day at evening her 6 years old daughter was suffering with diarrhea. Anjumanara is under control of her 65 years old mother in law. Her mother in law is of the view that the child was affected by *najar* (evil eye) called a folk healer of the same village. Folk healer gave enchanted water, salt after performing magical activity. They also brought some tablets of diarrhea from the nearby chemist shop. At night (about 7.30 pm) Anjumanara's mother in law told her that she should not be worried about her daughter, the child will get cure immediately and ordered Anjumanara to

engage her with daily work. Anjumanara failed to take decision for her or for her children. She spent whole night with tension at early morning she saw that the diarrhea was not controlled and the child condition became worse. Then her father-in-law went to nearby chemist shop and brought medicine and ORS but before he entered his house the child died.

Conclusion: National rural health mission initiated various plans, policies and programmes to improve health of rural people. But still benefit of programme has not reached to all sections of people in villages. Mission has accelerated various health services to health centre in villages like twenty four hour service, regular OPD service, service of minor surgery, maternity and child care, family planning and many other services to improve health of people. But all services except few are not properly provided to villagers. Modern medicine is still a dream for poor and uneducated people. Still majority of poor people opt for traditional health care. Villagers have deep rooted belief on folk medicine. They go back to folk healers, quacks and little learned drug sellers when they cannot opt for modern medicine. Government health policies are of no use for them. Only building of hospitals, more number of paramedical staff without equipment, free prescription of registered doctor without medicine cannot provide them complete and composite health care facility. Their life still remains in hand of quack, folk healer and money oriented drug seller in the society they live in.