

Chapter II

FRAMEWORK OF STUDY

In previous chapter, I discussed concept and theory of society and health. This chapter deals with framework of study with background, review of literature and methodology of data collection.

BACKGROUND OF STUDY

My keen interest to study National Rural Health Mission has grown up with my involvement of sociology of health during my carrier. This particular branch of sociology deals with to investigate and analyse how society determines health of individual as well as community in a broader perspective. I develop my sociological imagination about rural community, who suffers from numerous problems owing to insufficient means to lead wealthy and healthy life since a long time and especially during modern-contemporary India.

Due to my born and brought up as well as socialisation in village, I have been closely observing problems of rural people and their problem of health from my childhood.

Since health is a vital aspect of one's life, its maintenance is necessary for all people and communities across societies. Maintenance of minimum good health is still dream for most rural people in India and elsewhere too. In village, people still depend on unscientific medical practices for ailment of health problems. Even for treatment of serious illness, most people in village life go to traditional healer, folk medicine giver, priest, *mullah* or *peer*. People mostly depended on folk and traditional ways of treatment till now.

Literature and empirical study of health among rural people indeed induced me to develop orientation to develop interest in health study. Various studies, conducted so far, show that successive government adopted various pro-people health measures, policies and programmes from time to time to develop health of rural people, but significant improvement in people's health has not yet occurred and if so only in some selected region of Indian sub-continent and everywhere.

National Rural Health Mission is introduced by government in 2005 with a view to provide health care facility to rural people. The programme is also introduced simultaneously in Cachar district of Assam. Therefore, necessity to study national rural health mission in Cachar district, in entirety, became inevitable to study its implementation and impact among rural people in Cachar district.

Review of Literature

Mckim Marriott (1955), in Kishen Garhi village study, intended to find out socio- cultural problem of western medicine in village. His study reveals that those villagers believe spiritual healers more than professional doctors. Spiritual healers gain faith of villagers easily by relating god and goddess with disease and illness. Thus technical skill of professional doctor is less valuable to villagers¹.

Carstairs, Morris G. (1955) studies '*Medicine and Faith in Rural Rajasthan*' and finds out influence of tradition on health behaviour of rural people of Rajasthan. His study reveals that there exists difference of opinion of medical professionals with villagers regarding disease and illness. Villagers are ignorant of real causes of disease and illness due to their strong hold on tradition. They are not aware of

¹Mckim Marriot, *Western Medicine in A Village of Northern India*, B.D.Paul (Ed), Health Culture and Community, Russel Sage Foundation, New York, 1955, Pp 239-260

scientific method of treatment of disease and illness. They cannot keep faith upon scientific tools and techniques used by physicians. Lack of knowledge of villagers regarding disease and modern medicine for treatment of disease creates misunderstanding between physicians and villagers. This misunderstanding creates lot of problem to introduce modern medicine in rural Rajasthan².

M. N. Srinivas (1979) in his monograph '*Management of Rural Health Care*' reviews efforts of government in delivery of health care services to rural population since beginning of planed era. He says people living in interior and remote rural areas do not have access to the primary health care. He highlights problem of health care service in rural areas due to certain peculiar reasons like their concept of health and disease is traditional, people's apathy towards allopathic medical practitioners, limited capacity to pay the cost of treatment, transport and communication difficulties, unqualified medical practitioners and health centers are under staffed. Doctors and paramedical workers do not want to work in rural areas because of professional, personal and social reasons. Therefore, to remove this problem enhancing the number of primary health centers and the sub-centers is not only the solution, rather to develop the

²MadhuNagla, Sociology of Medical Profession, Rawat Publications, Jaipur, Pp 103-114, 1997

philosophy of providing integrated health care system. For making health services more meaningful to the population of the country, it is necessary to bring about fundamental changes in focus and approach to entire health care delivery system in general and above rural health services in particular⁶⁷.

Matthews, C.M.E.(1979) studies health culture in a south Indian village and finds that belief of villagers regarding health is not simply a superstition but a part of system of medicine available and affordable to them. Indigenous system of medicine like Ayurveda, Siddha and Unani are familiar in village and people have very poor knowledge on allopathic medicines. Allopathic medicine is used by some villagers but they have stronger faith and respect on indigenous medicine and traditional healers⁶⁸.

Kakkar D.N. (1981) in '*Differential utilisation of Health Care Services in Rural Rajasthan*' studies social inequality and utilisation of health services in Rajasthan. He finds that members of lower classes and Scheduled Castes do not possess

⁶⁷Srinivas M.N., Management of Rural Health Care, Social Change, (1987)

⁶⁸Matthews C.M.E. Health and Culture in South Indian Village, Sterling Publisher Pvt. Ltd, New Delhi, 1979, Pp 63-109

adequate knowledge about disease etiology but also about seeking therapeutic help in time and they are more vulnerable as compared to higher castes⁶⁹.

Rao, Sujata K (1998) in her monograph '*Health Care Services in Tribal Areas of Andhra Pradesh: A Public Policy Perspective*' highlights health status of tribes in Andhra Pradesh. She finds poverty as prime cause of ill health, persistent morbidity and early death in tribes in Andhra Pradesh. Mortality rate of mothers and infants is more among tribes of Andhra Pradesh. According to her, among *Savara, Gadava* and *Jatapu* tribes, crude death rate and under-five mortality rate is higher than state average. Moreover, incidence of tuberculosis and malaria is more frequent in tribal area. Tribes do not get right food, iron, protein and micro-nutrients due to which incidence of nutritional deficiency disease, anemia, diarrhea, night blindness and goiter are widespread among them. Tribes of Andhra Pradesh have poor access to basic health care service responsible for adverse differential health status of tribal area with developed part of the state⁷⁰.

Nayar K. R. (1998) in '*Politics of Decentralisation: Lesson from Kerala*' finds positive impact of decentralisation of health care in Kerala. Health status of

⁶⁹MadhuNagla, *Sociology of Medical Profession*, Rawat Publications, Jaipur, Pp 104-113, 1997

⁷⁰ K. Sujata Rao, *Health Care Services in Tribal Areas of Andhra Pradesh, A Public Policy Perspective*, *Economic and Political Weekly*, February 28, 1998, Pp 481-486

people has improved due to decentralisation of health care. Need based programs make epidemiological shift in Kerala. But some more attention is required to find out new needs of people. Only problem of decentralisation is conflict between authority and political leaders in implementing need based programs⁷¹.

Roy, Babul and A.N.M. Irshad Ali(2001) in *Medical Pluralism and Pattern of Acceptance of the Different Medical Options Among the Dimasa Cacharis of North Cachar Hill in Assam*, highlights medical pluralism of Dimasas of North Cachar Hill district of Assam. Modern medicine is accepted to majority of Dimasas of North Cachar Hill but still they cannot leave their indigenous method of treatment. Due to lack of availability of professional doctors Dimasa people take allopathic medicine from pharmacy. Along with pharmacy medicine they continue their indigenous medicine⁷².

Patil, Ashok V. and others (2002) in 'Current Health Scenario in Rural India' find poor health scenario of rural India. To them, though health status of Indian

⁷¹Imrana Qudeer, Kasturi Sen and K.R. Nayar, *Public Health and The Poverty of Reform: The South Asian Predicament*, (Ed), Sage Publication, New Delhi, 2001, Pp363-378

⁷²Babul Roy and A.N.M. Irsad Ali, *Medical Pluralism and Pattern of Acceptance of the Different Medical Options Among Dimasa Cacharis of North Cachar Hill in Assam*, *Journal of Human Ecology*, 12 (1), 2001, Pp 25-32

population has improved with respect to some of the indices of health like mortality, morbidity, maternal mortality, infant and child mortality etc. but still health of rural population is not satisfactory. Rural people have poor health consciousness. Their traditional belief, socio-economic condition, political and environmental causes are responsible for poor health. They highlight certain diseases, which are very common to rural people occur due to socio-economic and environmental reasons only. They found the inadequate government health policy for rural people is also responsible for their poor health status. Therefore, they suggest for further revision of current health policies and to introduce new health policies which should be specifically formulated for rural people⁷³.

Dalal, Ajit K. (2005) in 'Integrating Traditional Services Within Primary Health Care' highlights drawbacks of dependence on western medicine in Indian socio-cultural context. Western medicine is still not affordable to majority of rural population. Moreover, government is not able to provide adequate number of professional doctors and health workers who are trained in western method of treatment. Shortage of free supply of western medicine and shortage of health workers trained in western medicine hamper primary health care in rural India. Therefore, he suggests to introduce integrating traditional services along with

⁷³Patil Ashok V., Somasundaram K. V. and Goyal R.C., Current Health Scenario in Rural India, Australian Journal Rural Health, 2002, Vol. 10, Pp 129-135

western medicine within primary health care so that rural people get at least one kind of health service readily available in primary health centers⁷⁴.

Majumder, Amlan (2006) makes an interdisciplinary study on health seeking pattern in North Bengal in terms of utilisation of health care. To him, pattern of utilisation of health care is affected by different socio-economic, demographic and other relevant factors in rural and urban areas of Cooch Behar, and Jalpaiguri district of North Bengal⁷⁵.

Gangadharan K. (2007) in *'Morbidity and Health Care in Kerala: A distributional profile and implication'* finds better health status in Kerala than any other Indian states. Despite of better health status morbidity is high in both rural and urban Kerala. According to him, increasing population, increase in use of fossil fuel, tobacco use, vehicle transport, increasing sedentary habit and aging are basic reason for increased respiratory infectious disease. Cardio-vascular disease, cancer, hypertension, diabetes etc. are emerging as severe chronic health

⁷⁴DalalAjit K., Integrating Traditional Services Within Primary Health Care, Journal of Health Management, 2005, Vol. 7(2), Pp 249-265

⁷⁵Majumdar Amlan (2006). "Utilisation of Health Care in North Bengal, A study of Health Seeking Patterns in an Inter disciplinary Fame work", Journal of Social Sciences, Vol. 13 (1), Delhi, Kamla-Ray Enterprises.

problem in the state. Government of Kerala is facing problem to provide health care to ever increasing people in Kerala⁷⁶.

Neelima A and Reddy Sudarshan A (2009) in their study '*People's Perspectives on Health Care Services in Rural Andhra Pradesh*' mention nature of access to health care system and utilisation of health care service in rural area of Andhra Pradesh. According to them, majority of people in rural Andhra Pradesh have access to health care. People prefer allopathic medicine because of availability of doctor, medicine and facility of medical tests. Quick response of allopathic medicine in curing diseases is another reason for its preference. Though villagers have no problem with allopathic medicine but in their own village there is no treatment facility due to lack of government hospital, unavailability of doctors, medical staffs and shortage of medicines. People are mostly depended on registered medical practitioners (RMP) and private hospitals. Private hospitals are far away from their house and cost of treatment is not affordable to them⁷⁷.

Mukherjee, Subrata and Levesque Jean-Frederic(2010) in '*Changing Inequalities in Utilisation of Patient Care in Rural India: Evidence from the NSS*'

⁷⁶K. Gagangadharan, Morbidity and Health Care in Kerala, A Distributional Profile and Implications, Indian Journal of Social Development. Vol. 7, No 2, December 2007, Pp 195-211

⁷⁷A. Neelima and A. Sudarshan Reddy, People's Perception of Health Care Services in Rural Andhra Pradesh, Social Change, June 2009, Vol. 39. No 2, Pp 257-269

studies inequality in health care in India from 1995-2004. By analysing health statistics of Bihar, Uttar Pradesh, Madhya Pradesh and Punjab, they show that there exists high level of poor rich gap in health care utilisation. There exists more Inequality in distribution of health care in the states which have little capacity to provide health care⁷⁸.

Baru Rama, Acharya Arnab and Others (2010) in '*Inequalities in Access to Health Services in India: Caste, Class and Region*' highlight inequalities in access to health service in India. After analysing data of National Family and Health Services, Central Bureau of Health Intelligence and other organizations they reveal that inequalities are found in public health services in rural and urban areas. There also exists state wise variation of health service .State wise variations are found in terms of infrastructure, human resources, supplies, bed-population ratio and spatial distribution of health institutions. According to them, inequalities are found in utilisation of preventive service such as childhood immunisation and anti natal care and affordability of health services in context of region, caste and class⁷⁹.

⁷⁸Subrata Mukherjee and J.F. Levesque, Changing Inequalities in Utilisation of Inpatient Care in Rural India: Evidence from NSS, Economic and political weekly, Vol. XLV No. 46, November 13, 2010, Pp 84-91

⁷⁹Rama Baru and Others, Inequalities in Access to Health Care India: Caste, Class and Region, Economic and Political Weekly, Vol. XLV No. 38, September 18, 2010, Pp 49-57

Hussain, Zakir (2011) in '*Health of National Rural Health Mission*' highlights progress of National Rural Health Mission in India. His study reveals that despite of measures taken by government of India for providing health care to rural people through national rural health mission there are many deficiencies for which people are not getting proper care. National rural health mission falls far short of its target. The program physically can meet the requirement of infrastructure, equipment, medicine, manpower in many states of India. Despite of deficiencies, he views that within limited period this programme has succeeded in putting back issue of public health at top of government agenda. According to him, national rural health mission has put pressure on state governments to divert resources to health sector, there by substantially strengthening public health system including its workforce⁸⁰.

D. Benerji (2005) in his study '*Politics of Rural Health in India*' highlights politics of national rural health mission programme initiated by government of India. According to him government has not considered the past experience for implementation of such an important programme throughout the nation. To him, successive government could not successfully implement various health

⁸⁰Jakir Hussain, Health of National Rural Health Mission, Economic and Political Weekly, Vol. XLVI, No. 4, January 22, 2011, Pp 53-60

programmes in past and causes of failure in past should have been considered before implementation of national rural health mission so that the promises given by government becomes fulfilled⁸¹.

Şankar Prinja, Arunkumar Aggarwal, Rajesh Kumar and Panas Kanavos (2010) in their study *User charges in health care: evidence of effect on service utilisation and equity from north India* find inequality in utilisation of health care service. They also find out gender inequality in utilisation of health care in north India⁸².

Yarlini Balarajan and others (2011), in their study '*health Care and Equity in India*' highlight inequalities in health care in India. Their study reveals that inequality persists in preventive and curative health care throughout India. They establish correlation between income and health inequality in India. They also suggest measures for minimising inequality in health care in India⁸³.

⁸¹D. Benerji, Politics of Rural Health in India, Indian Journal of Public Health, Vol. XXXXIX, No 3, July- September, 2005, Pp 113-122

⁸²Sankar Prinja, Arunkumar Aggarwal, Rajesh Kumar and Panas Kanavos, User charges in health care: evidence of effect on service utilisation and equity from north India, Indian Journal of Medical Research, 136, November 2012, Pp 868-876

⁸³Yarlini Balarajan, S. Selvaraj and S. Subramaniam, Health Care and Equity in India, Lancet, 5 February, 2011, 377 (9764), Pp 505-515

Chandan Medatwal(2011) in *Women's empowerment in NRHM: A Case Study of ASHA (accredited Social Health Activist)* highlights ASHAs employed under national rural health mission is very actively working in their respective field. They motivate rural women for getting proper maternity and child care. Despite of their hard work in respective field they receive very negligible remuneration for which they get demoralised⁸⁴.

Arun Kumar and Others(2011) in '*Gaps in facilities available in health sub centers as per Indian public health standards in a district of Haryana*' find significant gap in available infrastructure and manpower in selected sub centers of Haryana. Whatever service is available in these sub-centers is also provided to rural people⁸⁵.

Harish Nair and Rajmohan Panda (2011), in '*Quality of Maternal Health Care in India: Has the National Rural Health Mission Made A Difference*' focus upon quality of maternal health care in some selected parts of India. Their study reveals that maternal care is hampered due to some extraneous factors. Proper communication facility makes lot of difference in maternal care. Interpersonal

⁸⁴Chandan Medatwal, *Womens' Empowerment in NRHM: A Case Study of ASHA*, Shodh Samiksha Aur Mulyankan, Vol 3, Issue 32, September 2011, Pp 12-14

⁸⁵Arun Kumar, Manish K. Goel, Rambilas Jain and Pradip Kanna, *Gaps in facilities available in health sub centres as per Indian public health standards in a district of Haryana*, Asian Journal of Management Research, Vol. 2, Issue 1, 2011, Pp 651-657

relation with health workers also matters for quality maternity care. Government is yet to fulfill its target for quality maternity care. National rural health mission is a good starting which shows right ways of maternity care. Proper implementation of programme depends upon several factors⁸⁶.

Vikash Bajpai and Anup Saraya (2012), '*NRHM the Panacea for Rural Health in India: a critique*' highlight the reason for failure of government to fulfill objectives of national rural health mission. According to them government could not fulfill its objective of rural health care in last seven years of implementation of national rural health mission in India. Deficit in infrastructure and manpower in government health care sector is major cause of problem of health for them. Rather private health care institutions are growing in India. According to them, government should change its strategy to implement the programme properly⁸⁷.

Sujay R. Joshi and Mathew George (2012) in '*Healthcare through community Participation Role of ASHAs*' highlight how low incentive given to accredited Social Health Activist (ASHA) in Thane district in Maharashtra creates biased work activities. The study reveals that incentive, the major source of income of

⁸⁶ Harish Nair and Rajmohan Panda, Quality of Maternal Health Care in India: Has the National Rural Health Mission Made a difference, *Journal of Global Health*, 2011, June 1 (1), 79-86

⁸⁷ Vikash Bajpai and Anup Saraya, NRHM the panacea for rural health in India: a critique, *Global Journal of Medicine and Public Health*, Vol. 13, May-June 2012, Pp 24-30

ASHAs, becomes source of their motivation and willingness to work for the community. But low incentive demoralises most of ASHAs who come of poor socio-economic background which leads to biased activities of ASHAs in Maharashtra⁸⁸.

Patra,Suresh Kumar,L. Annam and M. Ramdas(2013) in *National Rural Health Mission and Health of Odisha: An Economic Analysis* highlight improvement of health status after implementation of national rural health mission in Odisha. Their study reveals that national rural health mission has significant contribution for development of health care in rural Odisha. Health infrastructure, manpower and essential equipments for health care delivery service have been increased in Odisha through proper implementation of national rural health mission⁸⁹.

Significance of Study

Since independence, government of India has been implementing several programmes to uplift condition of health care in rural area. But studies show that still health care practice is not in good shape vis-a-vis satisfactory in rural India.

⁸⁸Sujay R. Joshi and Mathew George, Health Care Through Community Participation Role of ASHAs, Economic and Political Weekly, Vol. XLVII No. 10, March 10, 2012, pp 70-76

⁸⁹Suresh Kumar Patra, L. Annam and M. Ramdas, National Rural Health Mission and Health of Odisha: An Economic Analysis, Language in India, Vol. 13: 4, April 2013, Pp 305-315

National Rural Health Mission is initiated by government to improve availability and accessibility of health care among rural dwellers. This programme aims to work jointly with health care department of every state and tries to improve health care by providing more financial assistance, improving men power strength in health care service, involving community people to various health programmes and all efforts will be made to deliver better health service to rural people. Cachar district of Assam is a backward district having huge number of rural people who are still suffering from poverty, illiteracy and backwardness. Access to modern health care is still dream for majority of rural people in Cachar district. In such a situation it is imperative to study **the Government of Assam's method and process of implementation of NRHM schemes is successful in achieving its goal in Cachar district of Assam?**

Major **objectives** of the study are as follows

- i) To Study health care in rural Cachar
- ii) To study role of National Rural Health Mission for health care in Cachar District of Assam
- iii) To study planning and process of National Rural Health mission (NRHM) for good health among people of rural Cachar.
- iv) To study implementation and impact of National Rural health Mission (NRHM) in Cachar district of Assam.

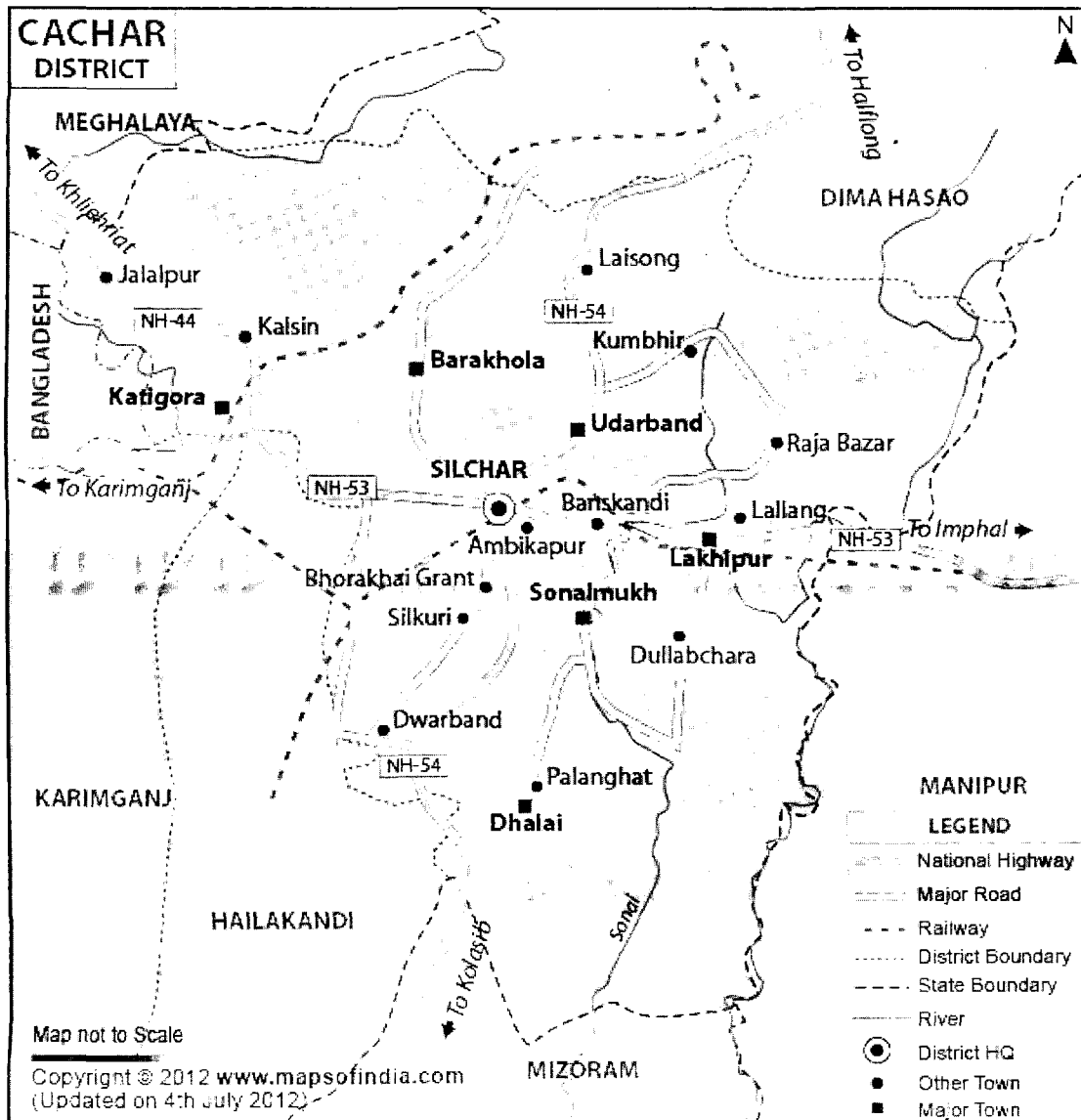
Hypotheses of the study are as follows

- (i) Health care practice in rural Cachar is undergoing change unlike earlier time.
- ii) National rural health mission is active vis-a-vis plays positive role to accelerate health care in rural Cachar.
- iii) Health care in rural Cachar besets with tradition and modernity.
- iv) Health situation is still worse in rural Cachar as compared to urban areas.

Universe of Study

Study is undertaken in **Cachar District**. Cachar District is one of the oldest districts of Assam. British created the district in 1830 when they annexed it from Cachari king. Cachar district is located in the southern part of Assam on longitude of $92^{\circ} 24$ second to $93^{\circ} 15$ second East and latitude of $24^{\circ} 22$ to $25^{\circ} 8$ second North. Barail and Jayantia hill ranges bound the district towards north. State of Mizoram is located towards south and south- west part of the district. West part of the district is bounded by two sister districts Karimganj and Hailakandi and neighbouring state of Bangladesh. State of Manipur is situated in east part of the district. Silchar is headquarter of Cachar district and the biggest town in Barak valley. River Barak is the largest river in the district. The river its tributaries

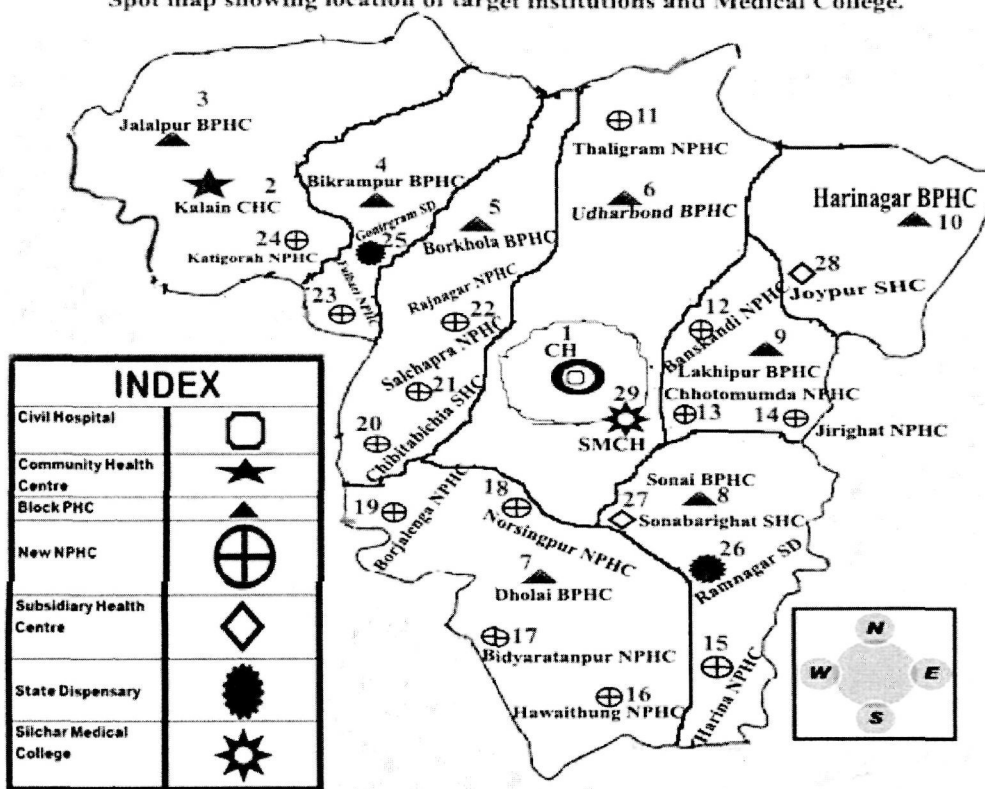
contribute a lot to create fertile land of this valley. The following map of Cachar district is given below for better understanding of geographical boundary and its important divisions



Bengali is the dominant language in the district since majority of the people speak Bengali (*Sylheti*, a Bengali-dialect). Apart from Bengali, other languages spoken are Meitei and *Bishnupriya* Manipuri. There are also very few Mizo, Kuki and Khasi people residing, speaking their own language in the district.

There are two sub-divisions in Cachar district viz. Silchar and Lakhipur. Head quarter of Silchar sub-division is Silchar town and office of Lakhipur sub-division is Lakhipur town. The district is further divided into fifteen development blocks like Silchar, Kalain, Barjalenga, Banskandi, Lakhipur, Sonai, Borkhola, Narshingpur, Udharbond, Rajabazar, Binnakandi, Tapang, Palonghat, Katigorah and Salchapra. The district has seven assembly constituencies. These are Silchar, Sonai, Dholai, Udharbond, Lakhipur, Borkhola and Katigorah. Dholai is designated for scheduled caste constituency. The seven constituencies make up the Silchar Lok Sabha constituency.

Spot map showing location of target institutions and Medical College.



Map shows health blocks in Cachar District

Cachar district is divided into eight health blocks. Each health block is known as block primary Health Center. Eight block primary health centres names are 1) Bikrampur block primary health centre, 2) Borkhola block primary health centre, 3) Dholai block primary health centre, 4) Harinagar block primary health centre, 5) Jalalpur block primary health centre, 6) Lakhipur block primary health centre, 7) Sonai block primary health centre and 8) Udarbond block primary health centre.

Table II.I

Population of Cachar District

Residence	Population	Male	Female
Rural	1,420,309	727,130	693,179
Urban	316,010	159,486	156,524
Total	1736319	886616	849703

Census of India, 2011

Above table shows total population of Cachar district is 1,736,319. Out of which urban population is 316, 010 (18.20%) and rural population is 1,420,309 (81.80%). Out of total rural population, male constitutes 727,130 (51.20%) and female represents 693,179 (48.20%). In urban area, total male population is 159,486 and female 156,524. Religious break-up of population is Hindu 886,761 (51%) Muslim 522,051 (36.13%) and Christian 31,306 (1.80%).

Table II.2

Profile of Rural Population of Cachar District

Description	Rural Population
Total population	1,420,309
Population (%)	81.80%
Male	727,130
female	693,179
Sex ratio	953
Child sex ratio (0-6 age)	956
Average literacy	78.14%
Male literacy	84.27%
Female literacy	71.77%

Source: Census of India, 2011

As per 2011 census, 81.80 % people of Cachar districts live in rural area. Sex ratio is 953 female per 1000 male. Child sex ratio is 956 girls per 1000 boys. Child population comprises 15.07 % of total rural population in the district. Literacy rate in of district is 78.14 % as per 2011. Male and female literacy rate is 84.27% and 71.71% respectively. Out of total 942,317 rural literate, male and female are 520,395 and 421,922 respectively.

SAMPLING

All rural population of Cachar district constitutes universe of study. Since the district is divided into eight health block, three health blocks viz Borkhola, Bikrampur and Jalalpur are randomly selected for the study.

Table II.3

Selection of sample

Name of Health Block	No. of Villages	Respondent Households
Borkhola	2	100
Bikrampur	2	100
Jalalpur	2	100
Total	6	300

The table represents three health blocks constituting of total 300 villages. Out of the three hundred villages of three blocks, six villages- two village from each health block- are randomly selected for study. Total sample size is 300 household, and from each block hundred household inclusive of fifty houses from each village is taken for the study.

Detail of sample household having social composition, economic profile, educational background and occupational profile is given below in following successive tables.

Table II.4

Economic Profile of respondent Household

Range of Income Per Month	No of Respondent Households	Percentage
Up to Rs 2000	100	33.33%
Rs 2001- 4000	55	18.33%
Rs4001-6000	45	15%
Rs 6001-8000	40	13.34%
Rs8001-10000	30	10%
Above Rs 10000	30	10%
Total	300	100%

Above table shows monthly income of respondent households. It is observed from table that monthly income of 33.33% of sample households is up to Rs. 2000 only and monthly income of 18.33% of sample households ranges from Rs. 2001 to 4000. Monthly income ranges from Rs. 4001 to 6000 for 15% of sample households followed by Rs. 6001 to 8000 for 13.34%, Rs 8001 to 10000 for 10% and above Rs 10000 for another 10% of the total sample households. It is observed that monthly income of more than 50% of sample households is below Rs 4000. Around twenty eight percent respondent households' income is more than Rs 4000 but less than Rs.8000. Total 20% of households have income above Rs. 8000 per month.

Table II.5

Educational Profile of Respondent household

Educational Attainment	No. of Persons	Percentage
Pre-school	197	11.12%
Illiterate	447	25.23%
Up to Primary	301	16.99%
Up to Middle School	307	17.32%
Up to High School	252	14.22%
High School Passed	140	7.90%
Higher Secondary Passed	88	4.97%
Graduate	33	1.86%
Above	7	0.39%
Total	1772	100%

The table highlights three hundred household has total 1772 people. Among of them 197 (11.12%) are in pre-school stage, 447 (25.23%) are illiterate, 301 (16.99%) have education up to primary school, 307 (17.32%) up to middle school and 252 (14.22%) gone up to high school. 140 people (7.90%) passed high school followed by 88 (4.97%) passed higher secondary school, 33 (1.86%) completed graduation and only 7 persons (0.39%) have qualification above graduation.

Table II.6
Occupational Profile of Respondent Households

Occupation		Number of Households	Percentage
Principal	Subsidiary		
Day Labourer	Nil	81	27%
Agriculture	Day Labourer	39	13%
Agriculture	Nil	73	24.33%
Agriculture	Business	29	9.67%
Business	Agriculture	18	6%
Service	Nil	24	8%
Others	Nil	36	12%
Total		300	100%

The table focuses 81 household (27%) are day labourer. 39 household (13%) belong to mixed occupation of agriculture and day labourer. In fact 73 (24.33%) household solely live on agriculture. 29 households' (9.67%) principal occupation is agriculture and business as subsidiary occupation. Only 18 household (6%) have business as principal occupation and agriculture as subsidiary occupation. 24 household (8%) depend on service and 36 household (12%) have other kinds of occupations.

DATA COLLECTION

The study is descriptive and qualitative in nature having some quantitative component. Both primary and secondary data are used in the study. Primary data are collected from six selected villages under three health blocks viz. Borkhola, Bikrampur and Jalalpur. The six villages are Buribail and Bhairabnagar under Borkhola block primary health centre, Dudpur and Bhangarpar under Bikrampur block primary health centre, and Baroitoli and Sharishakuri under Jalalpur block primary health centre. Primary data are also collected from health officials like medical officer, pharmacist, ANM, ASHA, who work in these villages. Moreover, primary data on health profile of Cachar district as well as all health block, community health centre, primary health centre and sub-centre under Cachar district are collected from concerned health official of the district. Since the study focuses on various aspects of health care starting from performance of National Rural Health Mission in Cachar district and its impact on rural people, therefore, data are collected from fieldwork by using tools like observation, interview schedule and case study method. Secondary data on population profile of Cachar district and National Rural Health Mission in India, Assam and Cachar district are collected from census along with book, journal, news paper and internet source.

Fieldwork

I started fieldwork on 10th May 2011. Since focus of my study is three health blocks viz. Bikrampur, Borkhola and Jalalpur of Cachar district, so I planned to put equal emphasis upon three health blocks. In first stage, I started fieldwork in Buribail village under Borkhola block primary health centre and finished part of data collection by 30th July 2011. For few days owing to heavy rainfall during that period, I could not visit Buribail in as its location is far off. So I continued to do my fieldwork in Bhairabnagar village under Borkhola block primary health centre up to 17th of August 2011 and further which continued up to 15th of November 2011

I also undertook fieldwork in Dudpur village under Bikrampur block primary health centre from 20th of November 2011 up to 10th March 2012. Second village under Bikrampur block primary health centre is Bhangarpar, which I started from 15th of March 2012 and I finished by 30th of June 2012.

I started fieldwork in Sarishakurhi village under Jalalpur block primary health centre on 6th July 2012 and finished by 25th October 2012. Next village is Baroitali under Jalalpur block primary health centre, I started fieldwork on 2nd November 2012 and I finished in February 2013.

In addition to collection of data from 300 respondent household selected health blocks under study, within this time period i.e. from May 2011 to February 2013, I visited and collected data from department of health and family welfare Cachar district, district hospital and community health centre of Cachar district, block primary health centres of Cachar district. I also visited all primary health centres of Cachar district and interviewed concerned authority of health centres. I visited some of sub centres and collected data from these sub centres.

During field work I came across with various problems. Initially I struggled to conduct fieldwork in the selected villages. The Villages selected for fieldwork are backward. I faced difficult to reach these villages during monsoon. Even in dry season vehicles are not frequently found to reach in these villages.

Initially village people hesitated to share their views and cooperate with my study. But I made frequent visit to the villages again and again and met some important personalities of these villages like teachers, post masters, panchayat leaders. They helped me to become familiar with the villagers in process of my data collection. Though I disclosed my objective of study and visit to their village, but it took some time to gain their faith. Gradually I got acclimatised with problem and created favourable atmosphere to conduct my fieldwork in these villages. Finally I completed fieldwork within stipulated time frame.

Conclusion: Study is made methodologically sound enough. Proper methodology is followed in every step of research starting from selection of appropriate design of the study, selection of universe and sample, selection of useful tools and techniques of data collection etc. to make study scientific.