

HEALTH CULTURE AND HEALTH SEEKING BEHAVIOUR IN BARAK VALLEY WITH REFERENCE TO HEPATITIS AND GALL BLADDER STONE.

INTRODUCTION

Health is one of the many social institutions that have been persisting in each and every society since its genesis. In ordinary parlance health is often conceived as any thing that is associated with human survival. Broadly speaking, health is understood as a way of maintaining physical system safe from the threat of disease as well as ability to perform the normal function assigned to an individual. The greatest threat encountered by human health is due to disease and illness that pose functional disorder in the physical system of all living beings. In other words a disease free constitution of body that can perform all normal function is considered as health. To facilitate a fuller participation of its member society adopts a set of unspoken rules to overcome disease and illness: as sound health is considered as backbone for sustenance and survival of a society. It is the most precious wealth possessed by man. It is a source of happiness, key to determining all the activities and shaping man's destiny.

In ancient Greece and in India, the prime objectives of administrators were to present a disease free society to citizens. In ancient India under the patronage of king medical aid was available to the poor. Ashoka the great was proud of providing medical aid to the down trodden (quoted in Barua, 1997:1-4). In India, primitive stages of medical psychological lore were provided in Vedas. "Charaka Samhita" and "Susruta Samhita" the two books of first century A.D throw an insight on fully evolved system of medicine that resembles those of Hippocrates and Galen in some respect.

The term health and disease are interwoven in cultural complex of a society, they are mirrored from particular socio-cultural milieus. The interfaces between social factors and growth of disease in the milieu of health have been a major thrust of mankind. Strictly speaking, social construction of disease and illness are not monolithic. Since the global world is variegated with diverse culture, health and disease are perceived and taken for granted from the perspective of socio-cultural context with in which they occur. Every individual in the society have cognitive knowledge related to health and disease. The individual's cognitive map covers the symptoms of disease as well causes and remedies of the disease. People's cognitive knowledge succeeded in to health related behaviours which are interwoven with the cultural complex of the society. Members of a society are accepted to act in accordance with norms, values, beliefs and lifestyles of that particular society which are encapsulated through the process of socialisation. Thus, the significance of intricate relationship between social factors and disease that involve specifically amongst specific group has immensely contributed for the development of medical sociology as a substantial area in the field of sociology.

Before moving further it might be worthwhile to conceptualise health, disease, illness as well as medicine in clear terms as these are often used synonymously and inseparable to each other. Good health is a cherished goal of every society because health is the key to human survival and a society exists through the existence of its members. Health is also conceptualised as complex and interrelated whole of body, mind and spirit. Genetic inheritance, body chemistry, gender, age, nutrition, physical conditions are all physical aspects of body composition. People's cognitive aspects such as perception, thoughts,

memories, knowledge of emotional feelings, defenses and self esteems are all facets of mind. The spiritual facets includes positive and negative learned spiritual practices, symbols as well as metaphysical forces. The spiritual forces are in constant flux and flows in different contexts. The contextual change of an individual includes individual's family, culture, work, community, history, and environment. Health is also controlled by environmental factors, biological variations, social organisations. Thus, it is not that only culturally deviated people are prone to disease and illness but marginal isolation, geographical or social mobility to fulfill role expectations are also important etiologies for out breaking of disease. Besides, changing or ambiguous role structure, inadequate social structure of an individual, inadequate social support, status inconsistency, blocked aspirations, lack of consistency or uncertainty in outcome of important events, and rapid social changes are also considered as important forces that can cause diseases (Srivastava and Saxena, 1991;73-80).

Health of an individual indicates both sound body and mind as it is explicit in the definitions of health provided by WHO as a "State of completely physical, mental and social well being and not merely the absence of disease" (Crockerham, 1994:2). Murray and Zentner perceive health as the stability, balance and comfort in the body system. In the language of Murray and Zentner health is "purposeful, adaptive response, physically, mentally, emotionally and socially, to internal and external stimuli in order to maintain stability and comfort" (1975: 6). Concept of health is also visualised as to experience a sense of well being as two Canadian scholars Robert Evans and Gregory Stoddart have pointed out, "Health not only means an absence of disease or injury, but also an absence of distress or an impaired capacity to carry out ones daily activities."

(Quoted by Crockerham 1994:2). Functional aspects of health is provided by Rene Dubos who views, "Health can be defined as the ability to function" (Quoted by Crockerham 1994:2). This definition throws light that healthy people are not only free from any physical disorder but they can also perform all expected function. From the behavioural point of view, good health is perceived a gesture of good behaviour. The concept of health is also associated with supernatural spirit and perceived as analogous to day and light by many people (Spector, 2006). However, the term health entails both physicals, mental as well as social well being that permits an individual to be physically, mentally and socially fit. Thus, an individual who is both physically and mentally fit to perform functions are considered as healthy.

An interruption in the function of physical structure can be referred to as disease. Disease is a universal phenomenon. It is usually referred as a kind of deviation from normal functioning of the body that produces discomfort and adversity in the individual's health status. The concept of disease is applied in many ways. In simple sense a set of abstract ideas are associated with the term disease that implies deviation from normal condition which is to be matched with specific clinical syndrome underlie with specific kind of a disease. Often, the concept of disease is used to refer as physical or behavioural deviation that poses social problems for individual or the community. Social definition of disease states that it requires further investigations whether these abnormalities are fit into the culturally identifiable symptoms.

Disease is attributed to constellation of signs and symptoms put forward by individual. It is an object of observation and an understanding of that depends upon the knowledge about the disease and function of human organism. Hence

disease can be accounted as a pattern, a product of natural history and their appearance can be related to other. For instance, until the symptoms of malarial fever and typhoid fever were earmarked, people used to relate two symptoms with one another; and it was the task of doctor to negate the particular symptom of one from other and specify the symptom of new event.

Disease was considered as a product of mind and bodily relation till 17th century. It was Rene Decarts who reoriented the mind -bodily approach and put an insight on the machinery aspects of body, and says that the scope of that are within the previews of human knowledge (Crockerham, 1994:3) Disease is the condition that breaks into the homeostatic balance of body and is generally perceived as failure of physiological activities and a departure from a state of health. The medical scientists often make distinction between disease and illness. A medical scientist refers disease as a set of objectives, clinically identifiable symptoms, while illness refers to an individual's perception of those symptoms. Disease is perceived as a situation when normal functioning of the body is paralysed and one feels discomfort or threat to individual's future of health status. It can also be explained in terms of an assemblage of germs, bacteria or other pathogenic agents over an organism that disturbs the balance in the system of body and results in some form of malfunctioning. A set of signs and symptoms are associated with disease. In Klemplerer's view disease is "Life under altered conditions disease is the experiment of nature; we see only the results, and we are ignorant of the conditions under which the experiment has been performed" (Klemplerer, 1961:18). However, disease is a malfunction of physical and social environment. Physically, differences in environment exert differences in the scope

of disease. Socially, incidences of disease may vary on the basis of people's physical and behavioural conditions of living.

As illness is common to every society so every society has developed a system to cope with disease according to its beliefs and values. In contrast to disease, illness is conceptualised as a behavioral aspect of disease. Illness is a type of action deviated from normal behaviour expected by society, cause of that is pointed out toward disease. Implicit in culture every human society has systems of values regarding health and disease as well as methods for coping with disease and illness to get relieve from the problems created by disease and illness. In other words every society has created a "Pharmacopia and a therapeutic system. be it magico --religious, secular or scientific" (Castiglioni, 1947: 26).

Illness is a stimulus response to social pressure. It is associated with behavioural aspects. It is defined as deviant behaviour and hence dysfunctional for the efficient functioning of the social system. It is a way of avoiding social responsibilities. Illness has some expected role also. An ill person moves in to the sick role. Concept of sick role is associated with set of institutionalised expectations and the corresponding sentiments and sanctions (Parsons, 1951). Status of illness is expected to remain free from all types of roles of social responsibilities. An ill person can not be expected to take care of himself. It is presumed that some one must help the person. The state of sick person is undesirable and he should want to get well and obliged to seek competent medical advice as well as help from the medical experts to get himself out of sickness. He is also expected to be co-operative with medical personal.

Medicine plays a key role in restoring the disordered health in to an orderly form. The term medicine is inseparable with the concept of health because

the term medicine is referred as social institution that deals with health aspects of the society. An institution is defined by the encyclopedia of Social Sciences as cluster of usages. It connotes a way of thought or action of some prevalence and permanence, which is embedded in the habits of a group or the custom of people. Our culture is a synthesis or at least an aggregation of social institution, each of which has its own domain and its distinctive office. The function of each is to set a pattern of behavior and to fix zone of tolerance for an activity or a complement of activities (Anonymous: 84). The term medicine is assumed as a set of social practices which act as an apparatus and to control some natural phenomena which may other wise affecting man, himself which so influence his behavior as to unfit him for normal accomplishment of his physical and social functions. The phenomena may also cause to lower his vitality and tend towards death (River,1924).

As sound health and illness are conceived as the function of good and bad behaviour respectively, hence physical stability and homeostatic balance of an individual is a function of physical as well as behavioural aspect of an individual. Culture plays a key role in shaping the behavioural pattern of an individual. Thus, health practices are by and large an embedded part of culture. To quote Tylor, "culture is the complex whole which includes knowledge, beliefs, art, morals, laws, customs and other capabilities acquire by man as a member of society" (1898. 1:1). Culture is viewed as crystallized phenomena of man's life activities (Bose, 1953). Individuals in society have knowledge about physical and social world and also have the capacity to adopt a mechanism to conquer the physical as well as social odds. Whatever human society is acquiring is transmitted from one generation to other generation.

Illness and disease are not assumed as purely bio- physical phenomena because they cannot be isolated from the socio-cultural milieu. Culture plays a major role in determining the patterns of disease because it determines the behaviours that predispose individuals to acquire certain diseases. Diseases act as agents of natural selection in the evolution of both human biology and culture. Cultural practices, however, can also be maladaptive when they exacerbate health problems. Moreover, through culture, people actively change the nature. In sociological context, disease is associated with way of life. Beliefs and practices of an individual are determined by culture. Culturally defined mechanism to overcome disease is evolutionary in nature, and is defined as cultural adaptation. Cultural adaptation to disease includes behaviours and beliefs that function to limit morbidity and mortality in two ways. First, there are behaviours and beliefs that yield as preventive functions, by reducing exposure to diseased organisms for certain segments of society. Second, there are beliefs and behaviours about appropriate remedy and therapy for disease. Culturally set up behaviour and belief of social organization may possibly be give rise to prophylaxis even though their conscious purpose may not be related to health. In this regard Talcott Parsons (1951) in an analysis of health values views that health values are associated with and follow cultural values such as activism and mastery over the environment, worldliness (emphasis on practical and secular pursuits) and instrumentalism (an indefinite progress perspective).

These values contribute to elaborate health sciences. The development of sciences promote an opportunities to live in accordance with health values including the maintenance of good health that enhances mastery and progress. Perception of diseases and its cure assumes different dimensions in different

societies. In this regard Srivastava and Saxena state: “cultural patterns and typical ways of life give substance to the manner in which illness is perceived expressed and reached to. To some extent the cultural context defines what conditions are recognised to assess and define the illness conditions.” (1991:73-82).

However, cultural pattern not only determines the symptoms, preventions and curative aspects of disease it develops the coping pattern of disease too. The ways an individual perceives and defines illness and cope with their problems and difficulties depend on cultural background, personal characteristics as well as economic factors. Besides these, social and physical permissibility of the doctor also play a catalytic role in accepting him for treatment. Individual experiences some changes from expected behaviour that can be regarded as undesirable and unfavourable to normal behaviour. Thus, the recognition of deviation from personal standard of functioning or experiences of change in one’s life situation alerts the person to the problem. Individual has some implicit ideas regarding the abnormality that may be mentally, physically and socially unusual. These ideas are based on personal experience, part culture, condition and knowledge about health and diseases. These are acquired in course of life that varies from group to group or culture to culture. The cultural context plays a key role in identification of both the symptom and remedial measures. It also creates a condition to deal with the problems and provides appropriate remedial measures.

Culture acts as the guiding force of the world and teaches the way of living. Every individual acquires culture from the society it belongs. Rajpramukh terms this process of enculturation and socialisation is as cultural “lens”. A society exists through cultural lens. In his view cultural lens provides social categorisation such as man or woman, child or adult, young or old, kinsfolk or

strangers; or in terms of class, able or disable, normal or abnormal, healthy or ill. Each category or status is accompanied by culturally prescribe role. Rajpramukh further suggests subdivision of culture with the complex whole that exists in various professional sub-cultures. Each subculture is a complex whole of larger culture and shares many of its perspectives and values including its own distinctive feature which some time interfere larger culture. Therefore, cultural background plays an important role on every aspect of human life including health and illness also.

Helman put forward the view that Individual's health and health related behaviour are not only an off-shoot of cultural factors they are subject to socio-economic and environmental factors too (Helman, 2001:3). Regarding sub-culture Leach proposes cultural pluralism within a society which is inherited by the individual as the basis of its caste, class, rank, economic and political status and to some extent on the basis of their sex also (Leach, 1982 : 41-43). Hall earmarks three different levels of culture in every human group. They are primary level, secondary level and tertiary level. Primary level culture is latent and exists outside the consciousness of individual. Secondary culture under lies in role assumption shared within the society but not with outsiders. Tertiary culture are all visible rules and rituals, traditional dresses and all other visible cultural symbols (Hall, 1984:230-231).

Beliefs and practices related to health as well as disease are culture bound. In many cultures disease is seen to be a misfortune or a deed of supernatural force, or divine retribution or malevolence behaviour of one self in past life. The values and custom associated with culture are wider part of it and therefore the important task of medical sociology or anthropology is to study the

organisation of health and illness. It also studies the way of presenting illness to other people by self; it also studies the attributes of illness and the traditions of dealing with illness.

Human beings have been making an ongoing effort to stay healthy since ancient times. Studies in the history of medicine have shown prevalence of three types of medical systems. On the one hand is “primitive medicine” that is the medicine of primitive people which is based on magical and religious practices. On the other hand is “folk medicine” in which natural causes are determined along with supernatural causes of disease and is evolved in the folk culture. At the extreme end, it is the scientific medicine of modern technology based on logical and rational thought that diseases are benevolent function of natural forces (Ackerknecht, 1941,b).

Efforts of human beings to overcome disease and illness, as DuBos (1969) observes is instinctual. The primitive humans who over came disease and illness were more or less closer to animal had the instinct to fit healthy. In primitive society functioning of body was yet to known and attributed by beliefs in magic. Disease and illness was considered to be a function of magic and evil spirit. It was conceived that medicine made from vegetables and animal that were invariably used to take after doing some ritual activities would eradicate the evil spirit. Even it is reported that during Neolithic age in Mediterranean and North America of present era people used to engage in surgical operation called “trepanation or triphining” that involve a hole or a number of hole made on the skull keeping intact the bone tissues in order to relieve the evil spirit from the body of that particular person (Crockerham,1994). In Ancient times, the disease and illness were considered to be a wrath of god and goddess or supernatural beings. The

cause of disease or illness was considered as the will of supernatural being but not the function of an individual's bio-physical condition.

In India disease has been regarded as extra-biological-entity. It is considered as owing to disobedience of natural and religious laws. It has been regarded as the outcome of sins and crimes committed by a person in the present life or in previous lives. Even at this vintage some diseases are attributed to the wrath of God and Goddesses. Some beliefs pronounced three humours (*tridosha*) in the human body, that is, wind, bile and phlegm as etiology of internal disorders. Every society has certain norms, values and ideals in regard to health and disease, a deviation from which is treated as an aberration or a disease. The notion about supernatural and magical belief about disease influences in the acceptance of many irrational practices. For example, the patient seeks the services of magicians or goes to a saint or guru to find out how best he can make atone for his past system of medicine. Appeasement of deities, who are believed to be associated with a particular disease with prayers, invocations offering of milk, flowers and rice; fasts sacrifices and giving alms are another common practice. Visits to sacred places such as temples, rivers and mountains are undertaken. Approach towards disease and its curative aspects have been inextricably linked to religious and cultural norms and practices in India. Predominance of supernatural beliefs and practices prevails in each and every society. Even today the method in maintaining homeostatic balance and harmony is different from the prevailing modern scientific health philosophy. Traditional health related beliefs and practices exist among people who know and live by their traditional ethno-religious and cultural heritage. Cultural heritage of health has the system of maintaining health, protection of health and the method of restoring health.

Traditional ways of maintaining health are the active everyday ways that people used to do for living and attempting to stay well. It includes the system of clothing, cooking and food items, games as well as arts and crafts for pleasure. Prayer and celebration either at familial level or at community level are ways of maintaining spiritual health. With a view to protect health individual belonging to particular society inherits the ways to avoid the harmful persons, circumstances and elements for. For health restoration remedial measures are taken in the form of seeking help of traditional healer, using decoctions and massages, seeking family or community support, healing rituals, exorcisms, special prayer and uses of herbal trees.

In this context it is said that Hepatitis and gallbladder stones are glaring example of two diseases which are caused by food habits and other cultural factors. The present research is about studying the health culture and health seeking behavior of people in Barak valley with special reference to hepatitis and gallbladder stones that are endemic in this area. On an enquiry with four local physicians in Silchar town in Assam, it is understood that at least one patient on every alternative day has been diagnosed with hepatitis and or gallbladder stone formation.

STATEMENT OF THE PROBLEM:

The hepatitis is a disease caused by inflammation of liver due to infection or viruses. Generally, hepatitis is of two types: hepatitis A and hepatitis B. Hepatitis C, D, E and other derivative forms are subsequent arrivals.

The Acute Viral Hepatitis (AVH):

Hepatitis A is known as Acute Viral Hepatitis (AVH) commonly called as jaundice has been known since antiquity. Hippocrates first described the disease in the fourth century BC. AVH is a systematic infection predominantly affecting the liver. The endemic prevalence is more in Africa, North and South America and in Asia including India with poor sanitation facilities. Countries of Eastern Europe and other parts of America have less endemicity, where children are exposed to infection in early childhood. Lowest prevalence rates occur among the young and adolescents of USA, Canada and Australia. Day care centre and residential institutions are identified as risk prone places in these developed countries. The only difference between viral hepatitis and chronically virus hepatitis is based on the duration of the disease; in case of chronic hepatitis the duration is six months or more. The disease associates with the symptoms of anorexia, nausea, vomiting, malaise and fever with chill. AVH virus lies in contaminated water and food, fecal matter, drugs in the industry etc. Non-sterile needles and blood-borne disease are rare sources of infection. Hence, from these sources the viruses enter into the body through oral-fecal route and then reach the liver. The disease generally last in the body from 15 days to 56 days and cause a mild effect on liver. There is no serum test of the disease. Individuals hail from low economic background have higher rate of infection because of higher rate of exposure to risk factors such as large families, household crowding, inadequate systems for disposal of human waste and lack of clean drinking water. Non-sterile needles and blood borne biological products have also been described but such infections occur rarely. For AVH patient maximum incubation period is six months though forty percent of the patients recover within 2 months. The severity

of illness is age dependent. The Individuals who have attained the age of over 50 years are having more chances of disease.

Hepatitis B Virus:

HBV is a DNA virus of the family hepadnaviridae, 42 nm in diameter. It is estimated that there are approximately 400 million carriers of HBV worldwide. Southeast Asia, China, western pacific and Sub-Saharan Africa are the hyper-endemic regions for prevalence of HBV, where infection is almost universal and about 10 percent-20 percent of the population are chronic carriers. Owing to change in behaviour as well as an effective vaccination programme in developed countries like North America, Western Europe, Australia and in New Zealand. HbsAg infections is falling and have low levels of endemicity.

Blood and blood products, sharing needles for inject-able drugs or sexual or perennial exposures are identified as the sources of transmission of HBV. Other risk factors for HBV infection include working in health care setting, undergoing blood transfusion and dialysis, acupuncture, tattooing and travel abroad.

The incubation from acute exposure to clinical symptoms ranges from 60 to 189 days. About 70 percent patients have sub-clinical anicteric hepatitis, whereas 30 percent of the patient have icteric hepatitis. The prodromal period consists of non-specific constitutional symptoms that could be followed by anorexia, myalgia, fatigue, jaundice and right upper quadrant abdominal pain. Symptoms usually commence with the prodromal phase of the acute illness and may persist for several months. HBV infection can be prevented by three main

strategies: I) behaviour modification to prevent disease transmission and (II) passive immunoprolaxis and (III) active immunisation

The only recommendation for active immunisation is universal vaccination, especially in the areas of highly endemic for HBV. There are only two recommendations for active immunizations. There are two types of vaccines: (i) plasma derived and (ii) ~~yeast~~ yeast derived vaccines. Both types of vaccines are used for safe and highly affective vaccination. Of these, later one is most widely available. Although yeast-derived recombitant vaccines are most widely available both plasma-derived and ^{yeast derived} recombitant HBV vaccines are safe and highly effective both vaccines are administered intermuscularly in a 3 dose schedule (at 0-2 and 6-12 months) and the protective efficacy rates approach 95 percent.

Hepatitis C Virus (HCV):

This enveloped virus is approximately 50 nm in diameter and belongs to the family Flaviviridae. It consists of a positive – standard RNA surrounded by the core, which is surrounded by the envelope proteins (Ei and Eii). The genome of HCV has approximately 9600 nucleotides.¹

HCV has an inherently high mutation rate, which results in considerable heterogeneity throughout the genome. The first designation used to describe genetic heterogeneity is the genotype, which refers to genetically distinct groups of HCV isolates that have arisen during the evolution of the virus. The second component of genetic heterogeneity is known as the quasispecies. Quasispecies are closely related yet heterogeneous sequences of the HCV genome with in a single infected person that results from mutilations during viral replication. The quasi species nature of HCV may be one of the mechanisms by which the virus escapes

immune responses. Worldwide surveillance of HCV based on antibody to HCV, is estimated to be 3 percent. However marked geographical variation exists, ranging from 0.4 percent to 1.1 percent in North America and 9.6 percent--13.6 percent in North Africa.

World wide three different epidemiological patterns of HCV infection can be identified: (i) in countries such as the United States and Australia , most HCV infections are found among persons between 30 and 49 years of age, indicating that most HCV transmission occurred in the relatively recent past, primarily among young adults infected through drug use; (ii) in areas such as Japan or southern Europe, the prevalence of HCV infection is highest in older persons, suggesting that the risk of HCV transmission was greatest in the distant past. In these countries, health care-related procedures, particularly unsafe injection practices with reuse of contaminated glass syringes played a major role in viral spread; and (iii) in countries such as Egypt, high rates of infection are observed in all age groups, suggesting that an ongoing high risk acquiring exists.

The main sources of transmission of HCV are blood transfusion, needle-stick inoculation and sexual contact. As there is no effective vaccine and post exposure prophylaxis against HCV, a major effort should be made to counsel both HCV infected patients and those at risk of infection. Adequate sterilisation of medical and surgical equipments is mandatory. HCV infected patients should be instructed to avoid sharing razors and toothbrushes, and cover any open wounds. In addition safe sexual practices, such as the use of condoms, should be encouraged.¹

¹ Nucleotides :Compound containing phosphoric acid.

Hepatitis D Virus (HDV) :

HDV or the delta agent, discovered by Risotto and colleagues in 1977, is a small 36 nm defective virus that requires the helper function of another virus (HBV). Its genome consists of a single-stranded, positive-sense RNA molecule of 1679—1683 bases. Although the replication of HDV can occur within and allowing their spread from cell to cell. World wide, there are about 15 million persons infected with HDV. Areas of high prevalence include Italy, certain parts of Eastern Europe, the Amazon basin, Colombia, Venezuela, western Asia and some Pacific Islands.

The prevalence of HDV infection is low in the general population and highest among persons with percutaneous exposures, such as injecting drug users (20 percent – 53 percent) and hemophiliacs (48 percent--80 percent). The modes of transmission of HDV are similar to those of HBV infection, and percutaneous exposure is the most efficient. Intravenous drug use is among the commonest modes of HDV transmission. Hemophiliacs and other persons, who receive large amount of pooled blood products are also at increased risk of acquiring HDV infection. Sexual transmission of HDV is less efficient than that of HBV.

Acute HDV infection can occur in a patient with established HBV infection or concurrently with HBV infection. In general, patients with hepatitis D seem to suffer from a more serious disease than those with other forms of viral hepatitis. HDV along with HBV is associated with a higher risk of severe culminant liver disease than is hepatitis caused by HBV alone. In super infection with HDV, chronic progressive liver disease develops in more than 90 percent

patients.² The Preventive method of HDV infection are HBV vaccination and behaviour modification, such as use of condoms to prevent sexual transmission and needle exchange programmed to prevent transmission by intravenous drug use.

Hepatitis E Virus (HEV):

HEV is an icosahedral, non-enveloped virus (approximately 27 – 34 nm in diameter). Geographically distinct isolates of HEV have been classified roughly in to four genotypes: Genotypes 1 (Asian isolates: Myanmar, China, Pakistan and the former Soviet Union); genotype 2 (a single isolates from some parts of China and Taiwan), genotype 3 (isolates from North America); and genotypes 4 isolates from some parts of China and Taiwan. Despite the presence of genetically different isolates of HEV, here appears to be only one serotype.

HEV is the most common cause of epidemic enterically transmitted hepatitis. World wide, two geographical patterns can be differentiated: endemic areas of HEV prevalence, in which major outbreaks and a substantial number of sporadic cases occur; and non-endemic regions, in which HEV accounts for a few cases of AVH, mainly among visitors to endemic regions. Endemic disease is geographically distributed around the Equatorial belt, including Central America, Africa and the Middle East, India, Asia, and the Southeast Pacific.

It is transmitted through ore-fecal route. Clinical manifestations of HEV are not differing from HAV. The incubation period after exposure to HEV is 15—60 days. Two phases of illness have been described, a prodromal and pericteric phase characterized by jaundice, dark urine, clay-colored stools, anorexia, nausea.

² RNA: Ribonucleic acid; it is genetic material in certain viruses.

Hemophiliacs : Person with sex linked hereditary disorder of coagulation of blood with prolonged clotting time.

vomiting and abdominal pain. Effective³ prevention relies primarily on improved sanitation, use of purified water, refrain from taking uncooked food, fruits and vegetables.

The hepatitis or jaundice has been epidemic through out the world particularly in the developing countries. It broke out in India during 1955, 1975-76, and during 1978-82 about 52,000 cases and in 1991 about 79,000 cases were reported (Jameel 2001, <http://www.chub.org>, 2001). Considering gravity of health hazard and severity of the disease, the central and state governments have been making attempt to bring awareness among the people by organising campaigns and initiating public health activities for prevention of outbreaks. They have also been disseminating information through posters, advertisements in various communication media. Further hepatitis vaccine has been supplied free of cost and on subsidised rates.

Gallbladder Stone:

An important ailment associated with functioning of liver is gallbladder stone formation. The gall bladder is a small pear shaped sac that stores and concentrates bile. It is connected to liver by hepatic duct. Gallstones are precipitations of bile constituent, usually cholesterol formed in the gall bladder following inflammation of liver. When the virus attacks liver cells the bile flows in excess into the blood stream, and also when the gall bladder is filled with stones or block the entry of bile, the bile goes directly into the blood stream without being stored in the bladder. This resulted in the jaundice. Thus, gallbladder stones and jaundice are associated with the liver (Green, 1974).

³ Icosahedral: Viruses with large number of packed bonding of capsids (Protein sub-unit).
Enveloped Virus :Viruses covered with membranous structure.
Non enveloped virus:Viruses without membranous coverage.

OBJECTIVES OF THE STUDY

In view of the above discussion, the main objectives of the study are as follows:

1. To study the health culture and awareness about jaundice and gallbladder stone in Barak valley
2. To understand the health seeking behaviour of the patients of jaundice and gallbladder stone.
3. To identify the social factors that contribute to the occurrence of jaundice and gallbladder stone.

The Concepts:

In this study the concept of health culture is used in the discussed above. However, it may be pertinent to state the definition as given by Kar who has carried of studies on health culture in the North East India. He writes, "Every culture, irrespective of its simplicity and complexity has its own notion regarding health and health seeking behavior, and this is often referred to as health culture. It is an integral component of the overall culture of the community. The health of any community particularly of a tribal community, by and large, it is a function of the interaction between socio-cultural practices, the genetic attributes and the environmental conditions" (2000:172). Health culture as rightly pointed out by Kar, is universal, but it is also unique in each culture, it is a historical cultural product and it is a complex phenomenon. It is transmitted consciously and unconsciously through the process of socialisation. It undergoes the process of verification and reliability and refinement by the people. Cultural meaning and cultural perception of health, health problems and the consequent behaviour of

communities towards the amenities available for dealing with health problems is defined as health culture. He defines health culture as sub-cultural complex. And views it as an integral component of the over culture of the community (Banarjee, 1982). Health culture is a dynamic aspect and influenced by the socio-economic structure of the society (Sahu, 1991). Health culture is on the other hand perceived from the perspective of environment. According to this postulation, Hassan (1967) has identified the possible etiology for the occurrence of a disease into three groups: 1.The causative agents include virus, bacterium, protozoa, parasitic worm, toxic chemicals, etc. 2.The natural and socio-cultural environmental factors favouring for the development of a disease.3.Man often acts as a host of various causative agents as well as various disease development factors.

The concept of culture is viewed as scientific abstraction through which consistency in the behaviour pattern and dealing of people is to be understood. In the words of Mechanic “the concept of culture is applied in general way to designate totality of interrelated but disjointed and contradictory ideas and activities that characterize the way of life.” (Mechanic,1978:35). He uses the term disjointed because of variations in the behaviour of the people belonging to different sex, occupation, religion etc except the ideals of morals, patterns of work, leisure, child rearing and caring, aspirations and values. Behavioral and dealing consistency with people in any culture is termed as cultural pattern. Cultural pattern is a rough sketch of the way people behave in any particular context because variations in the values, attitude and orientation amongst the different groups are common features of every culture.

The concept of culture is used in studying the comparison of behaviour of different group because ideas and activities are inter-generationally transmitted that influence individual's behaviour and thought pattern. The study of cultural values and orientation characteristic of a particular group aims to observe the dominant theme that influences the day to day behavior of that group not invariably of all cases. The statement of cultural values and orientation characteristics of a particular group is an attempt to specify dominant theme in the groups' adaptive responses. Culture plays a major role in determining the pattern of disease because it shapes the behavior like food habits, pattern of activity, and adoption of preventive measures also.

The cultural approach to health study implicates the relationship between culturally defined element and their practice in the lifestyle of the people as well people's definition of health and their response to illness. It also studies how illness is being perceived by people in accordance with the definition of culture in particular socio-cultural fabric. The social causes of illness are dominated by the cultural elements of a society and interlace with the patterns of life. In this regard Mechanic states: "The culture of a group affects every aspects of growth and development, the acquisition of goals and aspirations, the risk factors to which one is exposed and modes of responses and adaptation. From conception to death, almost every major life experience is conditioned to some extent by cultural beliefs and orientations. Who is eligible to mate, forms of contraception, family size and spacing, feeding and weaning –these and may more depend on social customs and taboos? The mother's acquisition of health values and mothering skill affects the development of the young and may explain in part why mothers in more advantaged classes and those who are better educated experiences lower

infant mortality. Similarly, nutrition is a key factor in health, but food preparation and eating behavior are influenced by cultural norms. Culture determines mode of agricultural productions, food processing and promotion” (Mechanic, 1978:57). An individual is habituated and accommodated with a cultural pattern regarding subsistence, social relations and community obligations. He acquires all the skills including mastery over environment, way to progress and psychological defenses through which he protects his place in his group and his self images. Such conditioning may be more or less consonant with the challenges of daily living: but in case of any sudden social change the individual faces disruption in long accepted patterns of cultural adaptation, and faces disease and death.

In this background, a review of literature has been attempted to find out the findings of various studies on medical sociology, particularly in India medical sociology is particularly a new subject and some studies have been conducted in the above mentioned field.

REVIEW OF LITERATURE:

Though there are a few anthropological or sociological studies focusing on jaundice or gallbladder stone, there have many studies on medical sociology in general and health culture in particular. Foucault’s theory of gaze formulation highlights the process of establishment of medical system as an industry in the feudal capitalist environment. Illich’s study on “Medical Nemesis” (1974) further highlights latent function of professional institutionalization of medicine.

Linkages between health and culture of a community have been focused in the edited works of Benjamin Paul (1955) and in the works of Margaret Mead (1953). Anthropologist Steven Polgar (1962) made a comprehensive review of

literature on relationships between health and culture. There have been many studies in west on cultural influence in drug use and abuse pattern have been focused in a number of studies. Cross cultural research on drug use and abuse has been conducted by many anthropologists. To study the role of culture in drug use and drug abuse; culture is seen as synonymous with presumed membership in a particular ethnic group, nationality, racial group, religious affiliation, class and so forth by non –anthropological perspective. Anthropologists have shed light on the use of cannabis and its role on social structure and culture in Jamaica. In a pioneering work on socio-cultural use of alcohol in 1940 function of alcohol in social structure is pointed out. Settlement pattern in elevated land reduces malaria endemic implicates the function of culturally determine behavior on health. Similarly, storage on night soil before its use as fertilizer; and traditional laundry soaps with molluscicidal properties in schistosomiasis-endemic areas also explicates the role of culture on human health. Changes in lifestyle are accounted as priorities over improvements in medicine. Anthropological study on cultural adaptation to disease is mainly focused on malaria. Individual's behavioural aspects are the focal point in studies in chronic infectious disease. Similarly, numerous studies on human water contact behaviour and schistosomiasis have been undertaken.

A number of studies have been conducted on the function of socio-cultural factor on reproduction and reproductive behaviour or on therapeutic abortion. As many as eight comparative studies on ethnographic literature on reproduction have been undertaken .A few studies on the contribution of reproductive behaviour of pre-industrial societies have been undertaken recently. The pioneering work on general studies on health status of community is conducted at

Singur health centre West Bengal in 1944 (Lal and Sheel, 1944). While in USA such community studies were conducted in the year 1880.

Role of culture in adopting the western medicine has been provided by the studies of Takulia(1969), Dhillon(1969), MckimMarriot(1955), Morris Curstairs (1955), Morris.E Opler(1962), H.A.Gould(1967), Goran Djufelt Staffan, Lindberg and Klass W. Vend Veen(1979), Kochar(1976), Kakar(1977) and Khare's(1963) study focuses on folk medicine. The term Ethno- medicine have been coined by anthropologists to focus on traditional healing practices which are a part of ethnographic studies conducted by S.C.Roy (1915), D. N. Majumdar (1926); N.K.Bose (1972); P. O. Bodding (1925); L. P. Vidyarthi (1969); B. K. Roy Burman (1946); Verrier Elwin (1943); P. Chandra (1957); M. G. Dannely (1927); C. Gopalan et al. (1968); L. Dube (1949); T.B.Naik (1956); M, N. Das (1960); D. K. Sharkar (1958); S. C. Sinha (1958); in different tribal and non tribal societies.

Further studies on health and health related issues like family planning, diet and nutrition, communicable disease like yawns, cholera and small pox have been focused by Elwin 1960-61 and 62; Roy Burman (1963); Saxena and Prasad (1963) and Mann (1968). Dhilon and Kar (1965), and Sahay (1969) have studied about malaria control and function of PHC in Tribal areas of Bihar. Leslie's (1976) study on practice of Ayurveda medicine in India also forms a part of medical anthropology and medical sociology. Some other important studies which also cover the aspect of health culture in Tribal areas are S.C.Roy's study on Oraon Religion and Culture; Redfield (1953), Vidyarthi (1970); Sinha (1959); Roy Burman (1961); Dube (1960); Sahay (1961); Bhowmick, Mahapatra and Sarborwal's study on change in tribal culture.

In order to explicate health culture in India Banarjee has focused on different indigenous aspects of health culture (Banarjee, 1982). Health culture is seen as an integral component of over all culture of a community because certain aspects of culture of community such as child rearing, food and drinking habits, pregnancy and child birth practices are functional to health culture (Sahu, 1991). Different studies on health culture in India explicate the dynamic aspects of health culture in India. More over it also throws light on socio-economic and political aspects as super structure and preponderance over religious and cultural values. Except in case of chronic and non-curable diseases on which religious and cultural values are pre-pondering (Banarjee and Sahu, 1991). The term culturally backward is endorsed to those who are reluctant to accept the western medicines (Hasan, 1967). Many anthropological works on irrational out look focused on tribal people's faith on superstition and rigidity and faith in tradition.

In a study covering 750 women, it was found that the incidences of gallbladder stones formation is less frequent among the vegetarians. Twenty five percent of non-vegetarians compared to vegetarians had gall stones. In a research under taken by Pressing and Abraham, it was found that every year over 5, 00, 000 people are admitted in to the hospitals of Florida for gall bladder disease. Two third of them are treated surgically. In a study among the people of 60 to 90 years, 60 percent of women and 30-50 percent of the men were found to have gall stones ([http\ www.chem-tox\ gall stones](http://www.chem-tox.com/gall_stones)).

There have been studies on health belief and health care practices in the rural and tribal India (Banarjee, 1989; Basu, 1985, 1992; Car stairs, 1959, Deodhar, 1983; Joseph, 1989, Lewis, 1958, Mehta, 1992). Similar studies are carried out in Africa and elsewhere (Akaka and Akinrimisi, 1991; Fajemilehin,

Boluwaji, Reuben and Ogumbodede, 2002; Ogumbodede, 1991). There have also been a number of studies on malnutrition, fertility and mortality in India and also in particular to North-East (Basu, 1985, 1993; Baruah, 1985; Chauhan, 1990; Pandey 1990; Sinha 1986). Tribal health has also been one area where a lot of work has been done (Basu, 1993; Chatarjee, 1993; Mishra, 1997; Sharma and Sharma, 2000; Singh and Mahanti, 1995; Swain, 1994; Yadav, 2000).

Some epistemological studies on indigenous medical practices provide a new arena of studying health culture and health seeking behaviour of people with reference to sanskritisation and parochialisation that reflects the upper caste people's attitude relating to etiology of disease and factors with great tradition and lower caste people's belief on supernatural power of disease. Role of socio-cultural factors are directly or indirectly associated with occurrences of disease is put forward by Hassan (1967). Physicians are unable to understand the cultural and intellectual capacities of people and do not pay any respect for cultural differences which pull them backward to achieve success in providing treatment to the rural masses. Hassan further focuses, medicos must possess adequate knowledge of general concepts of cultural and social organisation of the community. Studies on shamanistic system are focused by Furches (1964) and Harper (1966) who have highlighted communities' perception in regarding shaman as supernatural forces. Multiple role played by shamanas as nurse, guide, friend, analyst and man of console as well as strength have been described by Elwin (1955) in the hill tribes of Sarora.

Lewis (1958) put forwards that those people who are knowledgeable about the indigenous belief and practice of the community give the world view of not only the cause of the disease but also of agricultural production and other aspects

as well. In small scale societies people have faith on herbal medicine made up of locally available herbs in the forest. In ailment, people who are knowledgeable with in the community are consulted for use of the herbal medicine (Dave 1960).

Opler (1963) has stated about people's perception regarding the causes of disease and classified as (i) malfunction of *three dosha*, (ii) faulty diet, (iii) lack of harmony with the supernatural world, (iv) malevolent function of witchcraft, (v) displeasure of deities, (vi) imbalances of forces which control health, and (vii) inappropriate behaviour in physical, social and economic matter.

Mckim Marriot's (1955) study in Kishangarhi village focuses on the problem of resistance created by indigenous medical practitioner in introducing western Medicine. Carstair's study (1955) focuses on the differences of view points of the physician and the village folk with regard to the theory of etiology, techniques of curing and conception of role of physician. E Rao *et. al.* (1954) have pointed out that folkways are impediment for cure and prevention of disease. But indigenous medicines are functional in making the forces of tradition, the confrontation of mythology and legend. They are interwoven with the community artifacts and technique of day to day living which are easily available and cost effective also.

In rural India diseases are believed to occur owing to following reasons: (i) owing to super natural beings, (ii) handy work of magical means, (iii) due to climate change, and (iv) wrong or excessive food. He also observed different health specialists in Korwa society are: (i) *baiga* (religious priest), (ii) *ojha* specialist, and (iii) *panda* (medicine man) who provide magico-religious and herbal treatment. The cause of sickness and healing practices are interwoven with magical belief and practice. The herbal medicines occupy an important position in

the indigenous method of treatment. They consult modern medicine only in case of failure of indigenous treatment (Singh; 08).

Reddy and Reddy (2002) have focused on use of folk medicine even in the disease ascribed to nature. Among the tribal people of Nallamala region of Andhra Pradesh, Reddy and Reddy observed, disease like jaundice, stomach pain, dysentery, headache, cough, fevers occur during rainy seasons are ascribed to natural cause and they are cured only by administering herbal medicine. These medicines are also used for sprain and bone fractures. Reddy, *et. al* (2002) further observed the impact of health and nutritional programme to a great extent among the Yerukalas of Prakasham district of Andhara Pradesh(Quoted by Singh 08:). U.P Singh has studied in detail the population structure and biological micro-differentiation among the Bhojas and Tharus of Uttar Pradesh and Uttaranchal (1953) where he attempted to define health seeking behaviours in terms of ecology and environment concerned. He explained the emerging trends in mortality and its relation with the concept of health, hygiene, sanitation and food habits of that area.

The major theme to look at health culture perspective are housing condition, personal hygiene and out look on causation and prevention of disease are reflected in the study of Barua (1997). She has earmarked rational and supernatural views. Rational views are referred to as normal and common attitude to disease. The people who had rational attitude towards disease, they have regarded disease as consequences of seasonal changes, irregular life style, contagious nature of any ailment etc. On the other hand people with super natural out look consider some supernatural factors to be the cause of various diseases.

The above mentioned studies though provide sufficient data on health beliefs, and practices and so on but do not deal with any particular disease and especially neither the hepatitis nor gallbladder stone formation. Further, not only that any of such study has been conducted in this area, but also any sociological or anthropological study related to diseases is under consideration of study. Even with reference to methodological and theoretical issues about health culture is concerned the above studies do not provide any specific framework. Only enumerating the beliefs and practices has been considered for the study of health culture. It seems that a theoretical perspective has to be developed for proper understanding and explanation of health culture.

THEORETICAL FRAME WORK:

The cultural approach to health and the relationship between culturally defined element and their practice in the lifestyle of the people as well the definition of health and people's response to illness are all the fundamental aspects of society. It also studies how illness is being response by people in accordance with the definition of culture in particular socio-cultural milieu.

Even though the most of the health care system has been studied in functionalist frame work by sociologists, but the scope of symbolic integrationist's perspectives as well as Weber's approach on class status and party can also be highlighted to assess health seeking behavior. Medical sociology has gained respect particularly with on set of epidemiological studies of diseases. The industrial revolution in the west resulted in the urbanisation and rapid long distance transportation. The crowded and unsanitary conditions for the individuals and urban slums have created ample opportunities for attack of cholera, typhoid fever, small pox, plague etc. that took epidemic forms. Systematic studies were

conducted to study the distribution and determinants of disease. Sociological empiricism and positivist approach to study human societies had helped to undertake epidemiological study of disease for formulating policies to control such epidemics. Thus, the socio-economic cultural and political factors are multipart in to the analysis of disease and death in a society. In this approach as Yadavendu states, a person was thought to be a unified whole, and illness as well as disease were regarded as the product of imbalances in the general harmony between the individual and the world. Since life itself was viewed in cosmological terms, the spiritual dimensions were not excluded from the realm of concern health. From primitive to medieval times, these notions generally prevailed and constituted the holistic view of health (2003:5810).

He observed that there is a major shift from this methodological individualism. The shift is due to the emergence of germ theory and mechanistic conception of man. Since the risk factor involved is crucial for control of disease, individuals are to be identified who are agents for the spread of the disease. Individuals are studied in terms of their eating, drinking, smoking and exercise to ascertain whether such habits increase or decrease risk factors of disease. The individuals have to control their own existence and take personal action and improve health (Yadavendu, 2003).

Although Charles H. Cooley's theory of looking glass self study the psychological perspective of stress but it contributes to social situation and physiological damage as well and is relevant to understand the health problem. Cooley's theory of looking glass self concept has three basic components: (1) we see ourselves in our imagination as we think we appear to the other person (2) we see, in our imagination of the other person's judgments of our appearance; and (3)

as a person ,we experience some sort of self feeling, such as pride or humiliation. The contribution of this theory to an understanding of stress is that an individual's perception of itself as a social object is related to the reaction of other people. Quite obviously stress could result from the failure of the observer to reflect a self-image consistent with that of the subject. Thus stress can be seen as having a very definite social and personal component based on perception of a social event.

W. I. Thomas's theory of crisis as residing in the individual's definition of situation explains that the diseases are due to disorder in the situation. Goffman's dramaturgical approach assumes self as sacred object. Stress is induced in a situation when people perceive their chosen face or performance in a given situation to be inconsistent with the concept of self they try to maintain for themselves and others in that situation. Other wise, people might not be so willing to take such great care that they act out lines of behavior considered appropriate to them.

Mechanic (1962b, 1978) views stress that is from the standpoint of both society and the individual and states is the interaction between situation and individual's adaptive ability. Gordon Moss (1973) explains that individual as a member of group faces stress when it can not bear the stress of phenomena that goes against the prevailing values and beliefs.

Weber's concept of health life style signifies the role of consumption pattern of an individual to contribute to health status. Weber has emphasised on the structural condition that is the socio-economic situation as necessary conditions for life style. Weber's thought of life style in general helps to provide a theoretical frame work of "health life style" in particular. Max Weber in his book *Economy and Society* (1968) provides his thought on life style. Ignoring

Marx concept of class as determined on the basis of the place in forces of production is all pervasive to determine individual rank in social hierarchy. Weber held the view that an individual's position in the social hierarchy is also placed by status (prestige) and power (political influence). To Weber an individual status is determined by education and occupation possessed by him or her. Weber conceptualised class as an objective dimension of social life signified by money and property possessed by an individual and status as subjective that consists of the amount of esteem accorded by other people. In Max Weber's notion a status group refers to a group who held same socio-economic position in a society. That is they are knit in a same thread in terms of the possession of material circumstances and education. And share seminal political power. Equality in terms of material position, educational level and political power leads them to share seminal life style that indeed earmark one status group from that of the other. The life style of one status group is distinguishable from other status group. For Weber a particular lifestyle indicates the consumption pattern of goods and services of an individual rather than production as it is presupposed by Marx. And hence this view of life style can apply to the studies of health life style because people adopt a particular life style to improved health condition and longer life expectancy. The purpose of adopting a particular life style implicates consumption process because people want to induce the vitality of life and longer life expectancy influenced by his degree of motivation, effort and capabilities. As Hooted and Field observes that in France health is taken for granted by upper and middle class as a means to vitality and as a means to continue to work among lower class persons (Quoted by Crockerham.1994:83). Thus for all the class group health is something to be consumed whose end may be vitality and enjoyment or a

means to an end. In Weber's view socio-economic condition is necessary for determining life style. Weber uses three distinct terms to express his views of life style: Stylisation of life, life conduct and life chances. Life conduct refers to the activity and practice that people intend to adopt but these activities depend on people's ability to adopt that is what he called life chances. And life chances of an individual in turn mean the economic position as well as educational and occupational status in social relationship. Weber's thought about life style is an indication of individuals position in social hierarchy is typically a combination of three indicators: income, education and occupation. Life style is a reflection of people's status in society and life chances are based on what people consume not produce. More over, Weber (1978) views that although life chance inductive to healthy life style pull greater participation of upper and middle class yet he is optimistic that that life style that originate in amongst the upper stratus of society can cut across all social boundaries. Weber exemplifies his view in the light of Protestant ethic. In West Protestant ethic was spread in to general culture which led to the development of capitalism. But in modern world Protestant ethic is not some thing distinctive as Featherstone observe in western society that although healthy lifestyle such as practice of exercise, game healthy diet and avoidance of unhealthy practices are rooted with upper and middle class people yet are beginning to spread across class boundaries.

Anthropological studies in the area of health came out with causation theory and supernatural causation theory that are found commonly in all human societies (Channa, 1998). These studies only followed systemic approach where medicine is considered as a sub-system and its relationship with other sub-systems of life. In this context, western medical system and traditional system of

health are seen interacting with each other in cultural contact, diffusion and acculturation processes. Attempts have been made to understand treatment and health seeking behaviour through people's response to modern health practices, medical profession and relationship between institutional structures (Ahluwalia, 1974). Ecological approach to human disease and adaptation to disease is yet another anthropological perspective to understand health culture (Alland, 1970).

Crockerham's theory of health life style and the convergence of agency structure would be the most relevant one to study the health culture and health seeking behaviour of people. This approach assumes the influence of both agency and structure in health seeking behaviour of people. The proponent of structure put emphasise on structural condition that play a key role in determining the behaviour of individual but the proponent of agency accentuate on individual who choose their way of life. Emir Bayer and Mische suggests, the three guiding force on which human action is performed are : past patterns of thought and action, imagination of future possible action and capacity to adopt normative judgments amongst alternative possibilities. Bayer and Mische define agency as "the temporally constructed engagement of actors of different structural environments- the temporal-relational context of action-which through the interplay of habit, imagination and judgment, both reproduces and transforms those structure in interactive responses to the problems posed by changing historical situation" (Emirbayer and Mische, 1998:963). On the basis of this definition Crockerham views agency as "process" in which individual influenced by their past oriented towards future and present (Crockerham, 2005). Sewell (1992) provides a definition of structure as " Sets of mutually sustaining schemas and resources that empower or constrain social action and tend to reproduced by that social action."

Crockerham (2005) views schemas as rules and procedures that are subject to change and apply to enactment of social life. Human and non-human resources are two types that can be employed to enhance power. Human resources include physical strength, dexterity, knowledge etc., non-human resources include naturally occurring or manufactured. Resources that empower or constrain (Sewel, 1992) equates with Giddens' concept of duality of structure in his theory of structuration (1984). Empowerment function that resources enhances the options to choose and promote life choices amongst many while constrain refers to limited scope to choose life chances of individual. Thus, both agency and structure are imperative to determine the life style of an individual because agency will never remain free from structure (ibid,05).

Viewed from the above approaches, the present study can not depend on one approach, rather multiple of approaches: Durkheim, Weber's approach, W.I. Thomas' and Crockerham's. Moreover, health seeking behaviour can be studied with the approach of health, life style motivation and health belief model of Irwin Rosen Stock (1966) and cultural of poverty as developed by Randall and Wheeler (1979).

Hypothesis: The study does not possess any hypothesis to be tested, except testing the already formulated correlations between the disease and sex and non-vegetarianism from earlier studies.

METHODOLOGY:

The study depends on a quasi-experimental research design. The study compares the sufferers with non-sufferers of both hepatitis and gallbladder stone. Although it was proposed to collect both primary and secondary data only

primary data have been used. Secondary data were proposed to collect from Silchar medical college and other hospitals on hepatitis and gall bladder stone but due to non maintenance of a detailed record of the patient. Primary data have been collected from different hospitals and nursing homes. The sample design is as follows:

Sample design for the Study

Age	Experimental					Control				
	Hepatitis		Gallbladder stone			Hepatitis		Gall bladder stone		Grand Total
	Male	Female	Male	Female	Total	Male	Female	Male	Female	
6-17	20	20	20	20	80	20	20	20	20	160
18-30	20	20	20	20	80	20	20	20	20	160
31-45	20	20	20	20	80	20	20	20	20	160
45>	20	20	20	20	80	20	20	20	20	160
Total	80	80	80	80	320	80	80	160	160	640

For experimental sample, a total of 160 individuals, 80 males and 80 females for each ailment have been collected from the Silchar Medical College, Red Cross Hospital of Karimganj and Silchar, Green View Nursing Home Silchar, Nightangle Hospital Silchar, Kalyani Nursing Home Silchar, and Karimganj Civil Hospital. Most of the data are collected from Silchar because Silchar is the hub of treatment in Bark valley and people from all the places of the valley conglomerate in Silchar town for the purpose of treatment. A few samples

have been collected from the hospitals of Karimganj because only the poorest of the poor favors to seek treatment for complicated disease like hepatitis and gall bladder stone at Karimganj. Control data, again 160 sample, 80 males and 80 females have been collected randomly from Silchar, Karimganj, Hailakandi, Ramkrishna Nagar, Patharkandi and Dullabcherra as it is already mentioned that people who got admitted in the hospitals of Silchar town hail from different places of Barak valley and it was realized as pertinent to collect control data covering different places of the Valley.

A structured questionnaire was administered to collect the primary data. The questionnaire initially contained period of suffering, the type of treatment is sought, when occurred last time, knowledge on hepatitis and gall bladder stone like what are the sources of hepatitis or gall bladder stone? What are the symptoms? How the disease is detected? Etc. Questions but after the pretest collection data from 30 respondents questionnaire such questions were removed and questions hepatitis or gall bladder stone? Whether bed water is a source of either hepatitis and gall bladder stone? If the disease is spread by physical contact? Is gall bladder an organ of body? Which organ of body is affected by jaundice? were added for eliciting the intended replies. The final questionnaire is appended to the thesis (Appendix – II). The questionnaire contains questions to collect information on personal background like name, age, sex, education, family income, and family education of the respondents. Period of suffering, when suffered last time, the type of treatment is sought, if the patient is for gall bladder stone questions were asked about time of operation. Besides these, questions contain on knowledge on sources and preventions of diseases, method of detection etc. In food habit, type of food they use to consume and frequency of

that food. Questions are also asked pertaining to habit of pan chewing smoking and alcohol consumption, sleeping habit as well as physical exercises.

Qualitative data primarily from four healers from the valley have also been collected. In addition informally few households also interviewed for this data.

Field Work Experience: The field work was started in June 2006 and continued till the May 2007. At the very beginning Nightangle Hospital, Silchar was visited. The hospital authority hearing the purpose of the visit arranged a meeting immediately with the resident doctor who was very co-operative. He took the researcher to each and every patient who was admitted for gallbladder stone operation. On that day five samples were collected for the purpose of pretest. Similarly other hospitals were visited and the doctors had actively co-operated in introducing the patients to the researchers. The hospitals were visited once or twice in a week and collected the sample of three or four respondents in all most every hospital. The doctors were very much interested in my work. In fact, the surgeon of Red Corss Hospital, Silchar used to enquire about the research if missed any week. In Red Cross Hospital a lady attendant used to help a lot. As soon as the researcher reached the hospital she used to give the information regarding the bed number of the patient and used to guide to the patient also. I was collecting information about the patient from doctor-sister duty room every day in every hospital. Hepatitis sample had been collected from Silchar medical college hospital. I have to take permission from the Head of the department of medicine who and other staffs including resident doctor and nurses were very co-operative. I found one or two resident doctor were interested about the purpose and used to make many queries about it.

As regards as respondents were concerned, it was not easy to make them understand about the purpose of my work. In many cases passive co-operation on the part of the respondents could not be obtained. Their uneasiness and reluctance got prominence in their attitudes and feeling uneasy to respond. But there were reverse situations also. There were some respondents who respond very positively. They used to ask about the purpose of data collection. It was found that younger respondents were very much co-operative compared to the older ones. Those female respondents who came from rural areas particularly the middle aged ones showed their reluctance at least initially, though they could be convinced.

It was interesting that some rural or sub-urban males expected some kind of monetary help for the information that they have provided. Sometimes the researcher had to face the question "What will I gain from this? Will I receive any help from government".

Chapterisations:

The tentative ^{chapterisation} contents of the study are as follows:

1. Introduction
2. Barak Valley and Health Culture.
3. Factors Related to Hepatitis.
4. Factors Related to Gall bladder stone.
5. Health seeking behaviour.
6. Discussion and conclusion.

In introduction, desired goal of the study has been given including a brief history and data of both hepatitis and gall bladder stone. An insight on review of

literature and theoretical frame work is highlighted precisely. It also deals with hypothesis and objectives of the study, operational definition of concepts, methodology including research design as well as sampling. This chapter ends with field work experience.

In the first chapter, a brief history of the Barak Valley has been provided. An attempt has been made to highlight the culture in general and the place of hepatitis and gall bladder stone. People's method of understanding different health and disease as well as the action taken against the health and disease has been discussed. Since healer play a catalytic role in disease and sickness, healer's method of understanding hepatitis and gall bladder stone has also been given.

In second chapter, detail discussions on social profile of the hepatitis respondents have been given. In this chapter, discussion has been made on social and other variables of hepatitis. Besides, attempt has been made to focus on food habits of the respondents. Chewing of pan, smoking and drinking alcohol are damaging to health. Thus, it is felt pertinent to highlight on respondent habit on these items has also been discussed.

Chapter three is followed by chapter four. Like the previous chapter, this chapter deals exclusively with social profiles, food habits and habit concerning pan chewing, smoking as well as drinking alcohol. And a comparison has been made between hepatitis and gall bladder stone.

Chapter four deals with health seeking behavior of both hepatitis and gall bladder stone respondents. In health seeking behavior emphasize is given on respondents' sleeping habits. It also focuses on habit of exercise, frequency of occurring disease, period of suffering with disease and.

Chapter five is conclusion. In conclusion, the entire study is summarized and discussed in the light of theoretical framework which is followed by some recommendations and suggestions.