

## Health Seeking Behavior of Rajbanshi Community in Katahari and Baijanathpur of Morang District, Nepal

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### Abstract

<b>Introduction</b>	In Nepal there are numbers of ethnics having their own traditional health seeking behavior. Rajbanshi is one of the indigenous people of Morang district whose health seeking behavior varies depending upon their socio-economic status.
<b>Objectives</b>	The objective of the study was to assess the practices of using modern, self and alternative medication on the basis of socio-economic status.
<b>Methods</b>	The study was a cross sectional study of descriptive type. Information has been collected from the field survey by using semi-structured questionnaires containing both open and close ended questions. Total 175 households of two VDCs was selected from the VDCs rosters using random number table for convenience and to cover the expected households. Data were analyzed utilizing the Epi Info 6.0 version.
<b>Results</b>	Modern, Alternative and Self medications were common in Rajbanshi community. Modern medication was popular but was expensive to afford as reported by majority people. Significant proportion of Rajbanshi people having less than 2 bigahas land and uneducated was adopting self medication in Katahari and Baijanathpur of Morang.
<b>Conclusion</b>	There is a relationship between economic, education status and health seeking behavior in Rajbanshi community.
<b>Key words</b>	Health, Behave, Alternative and Self-medication

### Introduction

Health Seeking Behavior is a usual habit of a people or a community that is resulted by the interaction and balance between health needs, health resources, socio-economic and cultural as well as national/ international contextual factors<sup>1</sup> It is behavior of using health services within existing health system or treatment seeking behavior of the latest illness as reported by them. This was categorized as (a) Modern medication such as Hospital, HP/SHP and private clinic (b) Alternative medication such as Ayurvedic and Homeopathic system of medication; and (c) Self-medication such as Dhami/Jhakri (Shaman healers), drug retailers, grocery keepers, drug peddlers, household medicine and other than modern and alternative medication. Kafle and Gartoulla<sup>2</sup> and Gartoula<sup>3</sup> have categorized self medication as Shamanism, Priest, Dhami-Jhakri, herbal, drug retailers, grocery, kit-bag, drug peddler, neighbour, following old medicine prescriptions etc and except the present prescription by qualified medical practitioners. WSMI<sup>4</sup> has indicated as Self-medication is the use of specifically designed, labeled and authorized medicines available legally without prescription for the treatment or prevention of common illnesses, which can be recognized by the people. Traditional medicine is not included in the national

health system. If traditional medicines are legally available without a doctor's prescription, then they are included in what we call self-medication. Alternative medicine is medicine which is outside the regular allopathic medicine<sup>5</sup>. Sometimes it is accepted by national health plans for coverage and sometimes it is not<sup>6</sup>. This would cover for example, acupuncture, ayurvedic, naturopathy, and homeopathic medicine etc

### Methodology

This is a cross sectional and descriptive type of study based on information acquired from field visit carried out in January 2001. Semi structured questionnaire sheets containing both open and close ended question regarding health seeking behavior of the community were administered to 175 sample households of Katahari and Baijanathpur Village Development Committee (VDC) of Morang district. Samples were selected from the VDCs rosters using random number table and respondents were asked relevant questions with the history of illness / disease within three months from interview date. Of those who were ill/sick person of the above criteria

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were consulted for detailed information otherwise only demography was taken for the rest. Data were analyzed utilizing the Epi Info 6.0 statistical package. Data from pre-coded questions were entered into Epi Info 6.0 database. Attempts were made to minimize the potential error using Check file the data entry edit program. The Check file incorporated skip patterns, legal values and range checks that facilitated more rapid and accurate data entry. The participants

were requested for Focal Group Discussion (FGD) to have one and half an hour's sessions for the reason of their self-medication during household visits. Personal contacts with self-medicated population within three months of study period were made to have 8 persons in one FGD and attempted total ten FGD with 80 persons. Verbal consent was taken before taking interviews and FGDs.

## Results

**Table: 1 Education and Sickness (n=175).**

<i>Education</i>	<i>Sickness (n)</i>	<i>Percentage</i>
Educated	45	26.0
Uneducated	130	74.0
Total	175	100.0

Table 1 presents the status of sickness on the basis of educational level in the community. Proportion of falling sick of uneducated was higher as 74.0 percent (130) than educated

26.0 percentage (45). SLC pass and above was considered as educated and SLC failed and below were considered as uneducated in the study.

**Table: 2 Education and Medications (n=175).**

<i>Medications</i>	<i>Uneducated (n=130)</i>	<i>Educated (n=45)</i>	<i>P - Value</i>
Modern Medication	126 (96.9)	42 (93.3)	0.3753
Self-Medication	85 (65.4)	14 (31.1)	0.0000063
Alternative Med.	27 (20.8)	13 (28.8)	0.2635

Table 2 indicates that practice of using self-medication by uneducated Rajbanshi was significantly higher than educated ( $P < 0.05$ ).

**Table: 3 Medications by Economic status (n=175).**

<i>Medication</i>	<i>&lt;2 Bighas land (n=107)</i>	<i>2.1-4 Bighas land (n=22)</i>	<i>&gt;4 Bigha land (n=46)</i>	<i>P - Value.</i>
Modern Medication	104 (97.2)	20 (90.9)	44 (95.6)	0.3871
Self-Medication	68 (63.6)	14 (63.6)	18 (39.1)	0.0160
Alternative Med.	19 (17.7)	7 (31.8)	40 (87.0)	0.0000

Table 3 presents that people having less than 2 *Bighas* land were adopting self medication significantly ( $P < 0.05$ ). Likewise, people having more than 4 *Bighas* land adopting alternative

medication was also significant ( $P < 0.05$ ). People were classified into three categories on the basis of land ownership as (a) Less than 2 *Bighas*, (b) 2.1-4 *Bighas*, (c) More than 4 *Bighas*.

**Table 4: Diseases reported during encounter with the respondents (n=175).**

<i>S.No.</i>	<i>Diseases</i>	<i>Frequency</i>	<i>Proportion Percentage</i>
1	Headache, bodyache, weakness	89	50.8
2	Acute Respiratory Infection (ARI)	77	44.0
3	Fever	54	30.8
4	Eye/ENT/Oral Problems	33	18.8
5	Diarrhoea/Dysentery	24	13.7
6	Gastritis(APD)	24	13.7
7	Skin diseases	13	7.4
8	Tuberculosis	10	5.7
9	Rheumatoid Arthritis	9	5.1
10	Asthma (COPD)	7	4.0

Table 4 shows that symptoms like headache, bodyache, weakness and fever were reported by more than 30 percent respondents. ARI, Diarrhoeal diseases, APD were reported by more than 13 percent respondents. Skin diseases, tuberculosis,

rheumatoid arthritis were reported by more than 5 percent respondents.

**Table 5: Medication sought by the family (n=175).**

<i>Medication</i>	<i>Number</i>	<i>Proportion Percentage</i>
Modern medication	168	96.0
Self-medication	100	57.1
Alternative Medication	40	22.8

Table 5 presents medications sought by the family in any kind of latest illness during past three months. Modern, self and

alternative medications were sought by 96%, 57.1% and 22.8% respectively.

**Table: 6 Expenses for Treatment (n=168).**

<i>S.N.</i>	<i>Topics</i>	<i>Cost in Rupees</i>	<i>Proportion%</i>
1.	Purchasing drugs	598.35	58
2.	Paying fees	201.68	19.5
3.	Transportation	52.30	5
4.	Helper	38.58	3.7
5.	Other	142.77	13.8

Table 6 indicates that bulk amount of expense goes on purchasing drugs (58.0%), followed by paying doctors fees (19.5%). And 5.0 percentage cost goes for transportation, 3.7

percentage for helper and 13.8 percentage for others. Average expenditure per sick respondent was Rs.1031.64

**Table: 7 Affordability as perceived by the Respondents (n=175).**

<i>Affordability</i>	<i>Number</i>	<i>Percentage</i>
Yes	47	26.8
No	128	73.2
Total	175	100.0

Table 7 suggests that 73.2% people were reported inability to afford the cost for treatment.

## Discussion

Katahari and Baijanathpur VDCs are located nearby Biratnagar sub metropolitan city. Private allopathic clinics conducted by paramedics were abundant in the local market, which were familiar also in the community. So, minor injuries and ailments were being treated there. They have also got facility of Koshi Zonal Hospital for emergency and special services. People those who need higher services for emergency, obstetrics and chronic cases, used to go to higher service centers located at Biratnagar, Dharan, Kathmandu and even India. Rajbanshi people were deeply attached with their Self-medication practices. They readily go to Dhami/Jhakri/Shaman due to their cultural factor and because of their perceived satisfaction. During FGD it was noted that lack of adequate money to pay for modern medication also leads them to go for Self-medication. Poor Rajbanshi adopted self medication was significant ( $P=0.05$ ) in Katahari and Baijanathpur VDCs (Table 3). Similarly, practices of using self-medication by uneducated was highly significant ( $P=0.05$ ) in the community (Table 2). Niroula, B.B.<sup>7</sup> noted in *Benighat* that going to a faith healer is a ritual for seeking treatment, but if the illness persists even after two or three visits to a healer, the people of *Benighat* seek modern medicine. Many of them

also use self-medication, with medication bought at the medicine shop. Others try herbal medications they have tried before. However, treatment-seeking behavior is changing with the availability of the modern health care facility in the area. Treatment-seeking behavior is largely determined by types of illness and popular beliefs regarding them. The cultural diversity brought about by caste and ethnic mix and topographical variations extends to health-seeking behavior. Some of the health beliefs may be common to all caste-ethnic groups but some are more specific to a particular caste and ethnicity. Developments in modern medicine and expansion of modern health care facilities have played a very important role in reducing morbidity and mortality in the developing world. Despite a steady penetration of modern health care services, economic underdevelopment has also led to a relatively weak health infrastructure in Nepal. Health improvement programme A Summary report<sup>8</sup> has revealed that 20 percent disadvantaged and 11 percent general population in Eastern development region were getting treatment from traditional healers. However, modern, self and alternative medications were indispensable part of health seeking behavior (Table 5) in Rajbanshi community.

An average treatment cost per case was Rs. 1031.64 (SD=6). They had taken either loan (14%) or had to sell land, animals, grains or personal belongings (53%). The bulky proportion (57.8%) expenses felled on buying drugs and for fees (19.55%) thereafter, for transportation 5 percent, helper 3.74 percent, others 13.84 percent (Table 6). Seventy three percent respondents reported inability to afford the expenses for modern medication (Table 7). The issue of expensive medical treatment and difficulty in affordability was also pointed out during focus group discussions. Therefore, the cost for modern medical treatment was said to be unaffordable for majority of people in Rajbanshi of Kathari and Baijanathpur of Morang. According to public health point of view, it is one of the major causes for poor access to health care services for needy people.

Rajbanshi<sup>9</sup> is one of the 61 ethnic groups in Nepal. Ethnic or Indigenous people are having low health status in the world<sup>10</sup>. Tamang A et.al.<sup>11</sup> described treatment seeking behavior which is determined by perceived causes of reproductive health problems. The family members believe that modern medicines will not work (ineffective) if the patient is not first seen by a faith healer. Visit to a health facility becomes inevitable only when problem gets worse or unbearable. Because of their beliefs on witchcraft, reliance on traditional faith healer (TFH) for treatment is quite strong among all the ethnic communities. Tamang girls would confide their Severe Reproductive Health problems with their mothers who would in turn prescribe herbal/home made remedies. Reliance over Traditional Faith Healer for treatment of problems is also common among Tamang girls. A large proportion of adolescent had experienced menstrual, reproductive or urinary tract disorders and only few had sought care. There is a need to tailor program to suit the needs of specific ethnic groups.

Uneducated Rajbanshis reported more sickness than educated people (Table 1) and they are also using more self medication (Table 2) in Kathari and Baijanathpur in Morang. A number of studies have found a correlation between knowledge and delayed diagnosis. Knowledge includes the ability to recognize symptoms, identify causes and transmission routes, and familiarity with the availability of cure. Although the evidence doesn't conclusively suggest that knowledge independently determines care-seeking behavior, the correlation about knowledge and timing of diagnosis is well documented<sup>14</sup>.

Diseases reported by more than thirty percent respondents were mainly symptoms like headache, bodyache, weakness and fever. ARI, Diarrhoeal diseases, APD were reported by more than 13 percent respondents. Skin diseases, tuberculosis, rheumatoid arthritis were reported by more than 5 percent of respondents (Table 4). Annual Report of Department of Health Services<sup>12</sup> noted top 5 diseases as skin diseases, ARI, diarrhoeal diseases, Intestinal worms and Pyrexia respectively. A study<sup>13</sup> has realized that women could describe only

obvious symptoms of their illness such as headaches, fevers, joint aches and body aches. They were more knowledgeable about pregnancy and delivery related problems than illnesses such as tuberculosis, malaria and typhoid. This lack of knowledge contributed to their delay in seeking care.

Waisbord<sup>14</sup> felt that the TB control community has recognized and addressed system components in which behavior is a key issue. Both diagnosis delay and non-completion of treatment are two central behavioral challenges. Several ongoing national and global initiatives that are part of TB control programs also aim to address behavioral challenges. Programs that offer enablers such as transportation and food subsidies for patients assume that by minimizing costs the numbers of patients seeking diagnosis and care would increase. Murphy EM<sup>15</sup>, argued that in an earlier day, the task of changing health related behavior was thought to be simply a matter of sending health messages such as "Breastfeed your baby!" or "Use condoms!" to those who were perceived to need them—a one direction communication approach. Today, sound health promotion programs no longer rely on one shot exhortations via booklets, posters, or media broadcasts. They encompass extensive research on relevant audiences; skill-building; multi-channelled education and advocacy using influential persons; policy development; community mobilization; and organizational, economic, and environmental change. This approach recognizes that human beings live in a dynamic "social ecology" as well as a physical one. Because poverty, gender inequity, and other disparities are underlying causes of under nutrition, addressing this health problem requires behavior change at multiple levels.

## Conclusion

Modern, self and alternative medications were indispensable part of health seeking behavior of Rajbanshi community in Kathari and Baijanathpur VDCs of Morang. Modern medication was equally popular in both poor and rich or educated and uneducated. But, majority of people had reported modern medication as expensive medication. Uneducated Rajbanshis reported more sickness. Significant number of Rajbanshis having less than 2 Bighas of land and uneducated were adopting self medication in the community.

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**References**

1. M Corlien. Designing and conducting Health System Research Projects, *Health System research training series, WHO/IDRC, 1991.*
2. K. Kafle and Gartoulla RP. Self-medication and its impact on essential drugs scheme in Nepal. WHO. DAP – 10, 1993.
3. Gartoulla RP. An introduction to medical sociology and medical anthropology, RECID, Kathmandu, Nepal. 1998.
4. Reinstein J. World Self Medication Industry (WSMI), UK, www.wsmi.org, 2001.
5. Agarwal SK. A guide to Alternative medicine, Indian board of Alternative Medicine (IBAM), Calcutta, India.
6. Gartoulla RP. Therapy pattern of conventional medicine with other alternative Medicine, RECID, Kathmandu, Nepal, 1998.
7. Niroula BB, Use of health services in Hill villages in Central Nepal, Population Studies Center, University of Pennsylvania, Philadelphia, 1994
8. Subba NR, Poudel D and Karkee S. Health Improvement Programme Summary report, HMG/MoH/Eastern Regional Health Directorate, Britain Nepal Medical Trust, 2003
9. Prospectus, HMG, MLD, National Committee for Development of Nationalities, 2000.
10. Mabuhang BK, Policy Approaches to Indigenous People on Health Issues, *Population and Development in Nepal Journal*, TU CDoPS, Kathmandu, 2000;7
11. Tamang A, Tamang J and Adhikari R. Severity Perceptions of Health Problems and Treatment Seeking Behavior among Adolescent Girls in Nepal, *Conference on Young People's Sexual and Reproductive Health Needs in Asia*, New Delhi, 2004.
12. Annual Report, Ministry of Health, Department of Health Services, Kathmandu, Nepal, 2002.
13. World Bank, Understanding Access, Demand and Utilization of Health Services by Rural Women in Nepal and their Constraints, 2001
14. Waisbord, Behavioral barriers in tuberculosis control: A literature review, The CHANGE Project/Academy for Educational Development, 2005.
15. Murphy EM, Promoting Healthy Behavior, Health Bulletin of Population Reference Bureau, USA, 2005; 2