# HEALTH SEEKING BEHAVIOUR IN MIZORAM WITH SPECIAL REFERENCE TO AIZAWL DISTRICT

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**Submitted**

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# CHAPTER – I

# INTRODUCTION

## 1. Introductory Statement

### *1.1.1. Interdisplinary Relevance*

Health Geography can be defined as the branch of Human Geography concerned with the geographic aspects of health status and health care systems. It seeks, along with 'sister' disciplines such as Medical Anthropology, Medical Sociology and Health economics to broaden our understanding of various factors which affect the health of populations. The idea that place and location can influence health is a very old and familiar concept in Western medicine. Health Geography is the application of geographical information, perspectives, and methods to the study of health, diseases and healthcare. Health Geography can provide a spatial understanding of population's health, the distribution of disease in an area, and the environment's effect on health and disease. It also deals with access to healthcare and spatial distribution of healthcare providers.

Health issues such as the emergence of infectious diseases, the potential influence of global warming on human health, and the escalating strain and stress of increasing longevity and chronic conditions on healthcare systems are of growing importance in an increasingly peopled and interconnected world. A geographical approach to the study of health offers a critical perspective on these issues, considering how changing relationships between people and their environments influence human health.

The study is considered a sub-discipline in human geography, though it requires an understanding of others fields such as epidemiology, climatology, economics and others sciences. Even though healthcare is public goods, it is not 'pure' while, it is not equally available to all individuals. Demand for public services is continuously distributed across space, broadly in accordance with the distribution of population, but these services are only

provided at discrete locations. Inevitably, therefore, there will be differences in access in terms of the utility of using services, transport cost, travel time, mass media and so on. Geographical factors such as, physical proximity, travel time, location difference etc. are not the only aspects which influence access to healthcare. Other dimensions are social, economic, financial and functional. Social accessibility to healthcare may generally depend on race, age, sex and other social characteristics of individuals as well as the relationship between patient and the doctor. Financial accessibility depends upon the price of a particular healthcare and functional accessibility reflects the amount and structure of provided services. This can vary across different countries or regions of the world.

The geography of healthcare provides the strategy of prophylaxis based on the knowledge of medical geography. For prophylaxis to apply its means of action successfully, data are needed, the most important ones being provided by geography; to protect ourselves from enemy, we must first all know of its location, the site and extent of its permanent territory, the areas it could threaten, possible routes and stopping places and, finally, the weaker border spots to be defended.

Approaches to health and healthcare are also changing. Interdisciplinary research has broadened our understanding of influences on health and disease, encouraging people to think beyond clinical solutions. In particular, factors such as race, socio-economic status, and political power are now widely understood to be important influences on health and healthcare. As a result, many communities are exploring social and political approaches to tackling health problems.

Considering health and healthcare through a geographic lens can inform our understanding of this diversity of issues. The present study focuses on health-seeking behaviour, utilization of healthcare service and spatial distribution of healthcare facilities in Mizoram. With a focus on how and why things vary across space. Geographers are well

placed to consider not only spatial patterns such as disease distributions but also how people organize themselves across space and in relation with environments.

Health is the top most priority in every individual's life. Health is not only basic to lead a happy life for an individual, but also necessary for all productive activities in the society. Good health is a prerequisite to human productivity and the development process. It is essential to economic and technological development. A healthy community is an infrastructure upon which to build an economically viable society. The progress of society greatly depends on the quality of its people. World Health Organization defines as "a state of complete physical, mental, social, and spiritual well-being and not merely the absence of disease or physical infirmity'' (Goel, 2002). Health-seeking behaviour has been defined as any action undertaken by an individual who perceive to have a health problem or be ill for the purpose of finding an appropriate remedy (Olenja, 2003).

Health service utilization has been associated with several socio-demographic factors such as age, gender, and socioeconomic status. One of the main factors associated with health service utilization is that of "health services need," as measured by individuals' health status (Prasad, 2009). Health-seeking behaviour and health care services utilization pattern have been studies and the determinants have been classified into physical, socio-economic, cultural and political context. Number of studies show that trends in utilization of a health-care system, public or private, formal or non-formal, by and large, vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, education, economic status, income, mass media, accessible, employment, severity of illness, availability of physical infrastructure, type and cadre of health provider, accessibility of services at the public health sector facilities (Shaikh and Hatcher, 2004).

*1.1.2. Theoretical Framework*

Health is the top most priority in every individual's life. Health is not only basic to lead a happy life for an individual, but also necessary for all productive activity and development in human society. Health is a prerequisite to human productivity and development. Health is essential for economic, socio-cultural, political and technological development and vi-a-vis. Providing healthcare facilities and healthcare personnel is the basic rights of an individual. A healthy persons and community is the infrastructure upon which to build an economically viable to society. The progress of any nation and society greatly depends on the quality of its people. World Health Organization defines Health as *"a state of complete physical, mental, social, and spiritual well-being and not merely the absence of disease or physical infirmity"* (WHO, 2002).

Health service utilization has been associated with several developmental factors like, income, education, mass media exposure, age, gender and religion. Health-seeking behaviour and healthcare services utilization pattern have been studies and the determinants have been classified into physical, socio-economic, cultural and political context. Number of studies show that trends in utilization of a health-care system, public or private, formal or non-formal, by and large, vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, education, economic status, income, mass media, accessible, employment, severity of illness, availability of physical infrastructure, type and cadre of health provider, accessibility of services at the public health sector facilities (Babar T Shaikh and Juanta Hatcher, 2004).

Designing healthcare policies and programmers require knowledge about healthcare seeking behaviour, so that possible difficulties with early diagnosis and effective treatment can be identified and so that appropriate intervention can be implemented. Early recognition of symptoms, presentation to healthcare families and compliance with effective treatment can reduce morbidity and thereby mortality. Mac Phail and Campbell (2001) begin to explore this

broader context of system and policy implications, as they suggest sexual health policy and practice for young South Africans is influenced by simplistic generalized views head by adults, thereby excluding the very groups they wish to target. It is these sorts of ideas that need to be teased out of work on health-seeking behaviour more explicitly.

Health is essential for social and economic development; it is therefore seen as a resource for everyday living and sought after all. The link between health and human behaviour is a major area of interest in public health. Studies on health-seeking behaviour have shown the numerous influences on an individual's health behaviour. These influences include past experience with health services, perception about quality and efficiency of health services and community level (Sule, et al, 2008). The decision to seek health is also influenced by an individual's educational and economic status, the extent to which he is worried about the symptom and duration of experiencing the symptom (Katung, 2001). The choice of the health provider consulted for a symptom is also linked to the perceived cause of the symptom (Ahmed et al, 2001).

Therefore, health and health-seeking behaviour is not just medical field rather it is developmental aspects broadly, which demand serious involvement of social scientist. That is why people used to say 'health is wealth' and in there way it can also be said level of development is reflected in level of health or infirmity and decision of people on healthcare utilization. Development is prerequisite to empower people to seek healthcare at the right time.

### 1.2. Statement of problem

The main research problem to be dealt with present research is that what are the major factors determining people's health-seeking behavior in Mizoram in general and Aizawl district in particular? Do people seek healthcare only when they felt sick or they do routine check-up even without having any complications. From literatures it appears that some

factors influencing the health-seeking behaviour of people are accessibility, education, mass media, income, age, gender, sex, the social status of women, type of illness, perceived quality of the service etc. The present study is also tries to explore are these factors responsible or not in the context of Aizawl, Mizoram.

**Health-seeking Behaviour:**

**1.3.1. Definition**

Health-seeking behaviour refers to the decision or an action taken by an individual to maintain to have good health and to prevent illness. It has been define as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy.

Health-seeking behaviour is preceded by a decision-making process that is further governed by individuals and/or household behaviour, community norms, and expectations as well as provider related characteristics and behaviour

Health-seeking behaviour has been defined as a "sequence of remedial actions that individuals undertake to rectify perceived ill-health." In particular, health-seeking behaviour can be described with data collected from information such as the time difference between the onset of an illness and getting in contact with a healthcare professional, type of healthcare provider patients sought help from, how compliant patient is with the recommended treatment, reasons for choice of healthcare professional and reasons for not seeking help from healthcare professionals (Shehrin S. M.Shehri ed. al, 2009).

The decisions made encompasses all availability healthcare options like visiting a public or private, modern or traditional healthcare facilities, self-medification and use of home remedies or not to be utilized the available healthcare services. Health-seeking behaviour is a result of a complex interaction of provider, patient, illness and household characteristics. It is

influenced by a variety of socio-economic variables, such as physical accessibility, income, expenditure, health services, diseases pattern, education and mass media.

Health is essential for social and economic development; it is therefore seen as a resource for everyday living and sought after by all. The link between health and human behaviour is a major area of interest in public health. Health-seeking behaviours are the activities undertaken by individuals in response to disease symptoms experienced (O'Reilly and Browne, 1997). Studies on health-seeking behaviour have shown the numerous influences on an individual's health behaviour. These influences include past experiences with health services, perception about quality and efficiency of health services and influences at the community level (Sule, 2008). The choice of the health provider consulted for a symptom is also linked to the perceived cause of the symptom (Ahmed, 2001).

### 1.4. Overview of Literature

Health is the major pathway to human development, which is the cornerstone for a healthy, wealthy and prosperous life. Health is also a well reflected and self-evident in the proverbial saying "Health is Wealth". There is no magical mechanism, which can bring good health overnight. It is a gradual process, which takes time and hinges on many things. As a multifaceted aspects health has been defined by WHO as "a state of complete physical, mental and social well-being and is not merely the absence of disease or infirmity". The health of an individual or of a community is concerned not only with physical and mental status but also with social and economic relationship (Chakrabarty, 1999). What is considered being healthy in one society might not be considered healthy in another society (Mishra & Majhi, 2004).

Ackernocht, (1947) has rightly pointed out: "Disease and its treatment are only in the abstract purely biological process. Actually, such facts as to whether a person gets sick at all.

What kind of disease he acquires and what kind of treatment he receives depend largely on social factors". The common trust, customs and practices connected with health and disease have found to be intimately related with the treatment of disease (Majhi, 2004). In order to bring holistic development of a society the cultural dimension of the health of a community should be given importance. The health problems of rural especially of the tribal need special attention because the tribal people have a distinctive health problem, which is mainly governed by their traditional beliefs, practices and ecological conditions (Benjamin and Onwujekwe, 2004). This reflects a growing interest across the social sciences in the contested concept of social capital. Attempts are now being made to develop this, as yet under-utilised idea, to incorporate knowledge about health-seeking behaviour into health service delivery strategies in a way which is sensitive to the local dynamics of the community. This may be an extremely positive development. The whole area of knowledge around health-seeking behaviour is rendered of little value if not incorporated into management and system developments. The fact that health-seeking behaviour is 'not even mentioned' in widely used medical textbooks (Steen and Mazonde, 1999), perhaps reflects that many health-seeking behaviour studies are presented in a manner which delivers no effective route forward. This results in an unfortunate loss for medical practice and health systems development programmes, as the proper understanding of health-seeking behaviour could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts.

Researchers have long been interested in what facilitates the use of health services, and what influences people to behave differently in relation to their health. There have been a plethora of studies addressing particular aspects of this debate, carried out in many different countries. They can simplistically be divided into two types, which roughly correspond with a division identified by Tipping and Segall, (1995). Firstly there are studies which emphasized

the ‘end point’ (utilization of the formal system, or health care seeking behaviour); secondly, there are those which emphasize the ‘process’ (illness response, or health-seeking behaviour).

There is often a tendency for studies to focus specifically on the act of seeking ‘health care’ as defined officially in a particular context. Although data are also gathered on self-care, visits to more traditional healers and unofficial medical channels, these are often seen largely as something which should be prevented, with the emphasis on encouraging people to opt first for the official channels (Ahmed, 2001). The studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service (Tipping and Segall, 1995).

Sara Mackian, 2003 reviewed by mapping out the factors behind such patterns, there are two broad trends. Firstly there are studies which categorize the types of barriers or determinants which lie between patients and services. In this approach, there are as many categorisations and variations in terminology as there are studies, but they tend to fall under the divisions of geographical, social, political, economic, cultural and organisational factors. Secondly, there are studies that attempt to categorise the type of processes or pathways at work. Bedri, (2001) identifies five stages where decisions are made, and delay may be introduced, towards the adoption of ‘modern care’. There are four ‘sub pathways’ that people may follow, from seeking modern medical care immediately, to complete denial and ignoring of symptoms.

Despite the ongoing evidence that people do choose traditional and folk medicine or providers in a variety of contexts which have potentially profound impacts on health, few studies recommend ways to build bridges to enable individual preferences to be incorporated into a more responsive health care system. For example, Ahmed (2001) concluded: “efforts should be made to raise community awareness regarding the importance of seeking care from

trained personnel and the availability of services". Nonetheless, there is now growing recognition of the need to be more sensitive to the realities of health care seeking behaviour. Thus increasingly health care seeking behaviour studies are coming to the conclusion that traditional and unqualified practitioners need to be recognised as 'the main providers of care' (Rahman, 2000) in relation to some health problems in developing countries. In acknowledgement of the fact that untrained non-Western practitioners remain a strong favorites, Outwater (2001) interviewed traditional healers about their knowledge and relationship with 'modern' medicine and explored in far more depth the preferences of women who attended traditional healers and unofficial sources of health care.

Through this, they recognised, as have others (Moses 1994) that some groups appear to 'wander' between practitioners rather than seek care through one avenue or provider. Similarly, Rahman, (2000) found that different facilities will be frequented for different needs, according to a complex interplay of factors, sometimes regardless of the intended purpose of those facilities. Thus there is growing acknowledgement that health care seeking behaviours and local knowledge need to be taken seriously in programmes and interventions to promote health in a variety of contexts (Runganga, 2001). With this broader appreciation of behaviour, some have suggested the need to improve integration of private sector providers with public care (Needham et al., 2001). Calls have been made for explicit recognition of the potential to combine the two worlds by involving unofficial providers in official training and service provision (Outwater, 2001). However, Ahmed concedes that whilst extending training to such providers may enhance their services, training in itself will not change practice. For this, managerial and regulatory intervention is needed. Thus the provision of medical services alone in efforts to reduce health inequalities is inadequate (Ahmed, 2000). Clearly, any research interest in health care seeking behaviour, focusing on endpoint utilisation, needs to address the complex nature of the process involved, cognisant

of the fact that the particular 'endpoint' uncovered may be multi-faceted and not correspond to the preferred endpoints of service providers.

The second body of work, rooted especially in psychology, looks at health-seeking behaviours more generally; drawing out the factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviours or their use of medical care and treatment. Thus whilst in the former literature health care seeking behaviour is conceptualised as a 'sequence of remedial actions' taken to rectify 'perceived ill-health' (Ahmed, 2000), in the second approach the latter part of the definition, responding specifically to perceived ill-health, may be dropped, as a wider perspective on affirmative, health-promoting behaviours is adopted. A number of 'social cognition models' (Conner and Norman, 1996) have been developed in this tradition, to predict possible behaviour patterns. These are based on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care and personality (Conner and Norman, 1996). The underlying assumption is that behaviour is best understood in terms of an individual's perception of their social environment.

A number of genres of model exist, and variations have been developed around them. One of the most widely applied is the 'health belief model'. Sheeran and Abraham, (1996) categorise the range of behaviours that have been examined using health belief models into three broad areas: preventive health behaviours, sick role behaviours and clinic use. In this type of model, individual beliefs offer the link between socialisation and behaviour. One of the earliest examples was Hochbaum's, (1958) study of the uptake of screening for TB, where he discovered that a belief that sufferers could be asymptomatic was linked to screening uptake. Health belief models focus on two elements: 'threat perception' and 'behavioural evaluation' (Sheeran and Abraham, 1996). Threat perception depends upon perceived susceptibility to illness and anticipated severity; behavioural evaluation consists of

beliefs concerning the benefits of a particular behaviour and the barriers to it. 'Cues to action' and general 'health motivation' have also been included (Becker, 1977).

The health belief model has been criticised for portraying individuals as a social-economic decision maker, and its application to major contemporary health issues, such as sexual behaviour, have failed to offer any insights (Sheeran and Abraham, 1996). The second genre of the model is linked to the general assumption that those who believe they have control over their health are more likely to engage in health-promoting behaviours (Normand and Bennett, 1996). The 'health locus of control' construct is therefore utilised to assess the relationship between an individual's actions and experience from previous outcomes. The most popular of these is 'the multidimensional health locus of control measure' (Wallston, 1992). However, this approach to social cognition models has been criticised for taking too narrow an approach to health and because the amount of variance explained is low (Norman and Bennett, 1996). Other approaches, including 'protection motivation theory' and 'theory of planned behaviour' have equally met with mixed reception (Boer, 1996).

The literature on demand for health care has come up with myriads of factors affecting such health-seeking behaviour. At the level of health care provider, the quality of medical care in terms of technical efficiency as proxies by the availability of drugs has been cited as a key determinant of demand for health care (Sahn, 2003). Lack of adequate health information has been associated with variations in health care utilization at various health facilities, and especially between rural and urban sector as noted by Thompson, (2003) when using Kazakhstan data in analyzing the health-seeking behaviour of rural and urban households. There are studies that have analyzed the role of information on the demand for medical care (Hsiech and Lin, 1997). Using probity results, Kenkel, (1990) indicated that more informed consumers are likely to visit a physician. Some studies found that prices are not important determinants of medical care (Birdshall and Chuhan, 1986 ), while other

studies found that prices are indeed important determinants of demand for medical care (Mwabu, 1986). Gender issues in the access to health services have been incorporated in a number of studies, while other studies found that prices are indeed important determinants of demand for medical care (Deborah, 1989).

Mwabu et al., (1993) found that distance and user fees were both factors that reduced demand for health care, but men were less constrained than women. Hutchison, (1999) found that individuals in households with women with higher levels of education were more likely to use curative care. Still, on education and gender (Wong, et al., 1987) found that for both rural and urban mothers, the likelihood of choosing public clinic as the most frequently used option increases as education level increases. Cisse, (2006), in an analysis of health care utilization in Cote D'Ivoire, found that household headship, education level, drug prices, and income and distance to be positively related to health care utilization. The effect of household size on the demand for healthcare has been found to be positive and significant (Sarma, 2003), though Sahn, et al., (2003) observed that large households sought care from non-hospital facilities. It is clear that there are multitudes of correlates that affect demand for health care but what is not clear is whether these factors influence demand for health care as the spatial regional diversity.

**Factors affecting health-seeking behaviour:**

A variety of factors have been identified as the leading causes of poor utilization of primary health care services: including poor socio-economic status, lack of physical accessibility, cultural beliefs and perceptions, low literacy level of the mothers and large family size. Review of the global literature suggests that these factors can be classified as cultural beliefs, socio-demographic status, women's autonomy, economic conditions, physical and financial accessibility, and disease pattern and health service issues. The decision to engage with a particular medical channel is influenced by a variety of socio-

economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service (Tipping and Segall, 1995).

### *1.4.1. Cultural and socio-demographic factors:*

Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities. The advice of elder or head in the house is also very instrumental and cannot be ignored. These factors result in a delay in treatment seeking and are more common amongst Mizos, not only for their own health but especially for children's illnesses. Family size and parity, educational status and occupation of the head of the family are also associated with health-seeking behaviour besides age, gender and marital status. However, cultural practices and beliefs have been prevalent regardless of age, socio-economic status of the family and level of education. They also affect awareness and recognition of the severity of illness, gender, availability of service and acceptability of service. (Shaikh and Hatcher, 2004).

### *1.4.2. Economic factors:*

The economic polarization within the society and lack of social security system make the poor more vulnerable in terms of affordability and choice of health provider. Poverty not only excludes people from the benefits of health care system but also restricts them from participating in decisions that affect their health, resulting in greater health inequalities. Possession of household items, cattle, agricultural land and type of residence signify not only the socio-economic status but also give a picture of livelihood of a family.

In most of the developing countries of South Asia region, it has been observed that magnitude of the household out of pocket expenditure on health is at times as high as 80 per cent of the total amount spent on health care per annum. Economic ability to utilize health services has not been very different in Pakistan. For health expenditure in Pakistan, 76 per

cent goes out of pocket. This factor also determines the ability of a person or a family as a whole to satisfy their need(s) for health care. Cost has undoubtedly been a major barrier in seeking appropriate health care in Pakistan. Not only the consultation fee or the expenditure incurred on medicines count but also the fare spent to reach the facility and hence the total amount spent for treatment turns out to be cumbersome. Consequently, household economics limit the choice and opportunity of health-seeking (Shaikh and Hatcher, 2004).

### *1.4.3. Income / expenditure:*

The first styled fact is that household in low-income countries spends a significant portion of their resources on remedial health care. Banerjee, (2009) find out of pocket health expenditure represents about 10 per cent of total household expenditure among slums dwellers in Hyderabad. In Rajasthan, India, Banerjee et al. (2004) find that only 3 per cent of patients at public health facilities have at least one diagnostic test performed on them, but 38 per cent nevertheless get prescribed an injection or a drip. Such low-quality medical care is common throughout the developing world. Using data on medical care quality collected through both vignettes and direct observation in India, Indonesia, Tanzania, and Paraguay, Das, (2008) show not only that the competence of doctors in low-income countries is low, but also that the quality of care patients receives is even lower than would be expected given their doctor's competence, especially among the poor .

### *1.4.4. Physical accessibility:*

Accessibility plays a huge role for health-seekers, especially where the topography is rouged and transportation cost is high to reach healthcare facilities. Access to a primary health care facility is projected as a basic social right. Dissatisfaction with primary care services in either sector leads many people to health care shop or to jump to higher level hospitals for primary care, leading to considerable inefficiency and loss of control over efficacy and quality of services. In developing countries, the effect of distance on service use

becomes stronger when combined with the dearth of transportation and with poor roads, which contributes towards increase costs of visits. Availability of the transport, physical distance of the facility and time taken to reach the facility undoubtedly influence the health-seeking behaviour and health services utilization. The distance separating patients and clients from the nearest health facility has been remarked as an important barrier to use, particularly in rural areas. The long distance has even been a disincentive to seek care especially in case of women who would need somebody to accompany. As a result, the factor of distance gets strongly adhered to other factors such as availability of transport, the total cost of one round trip and women's restricted mobility (Shaikh and Hatcher, 2004).

***1.4.5. Health services and disease pattern:***

The under-utilization of the healthcare services in public sector has been almost a universal phenomenon in developing countries. On the other hand, the private sector has flourished everywhere because it focuses mainly on 'public health goods' such as antenatal care, immunization, and family planning services, treatment for tuberculosis, malaria and sexually transmitted infections. Still higher is the pattern of use of private sector allopathic health facilities. This high use is attributed mostly to issues of acceptability such as easy access, shorter waiting time, longer or flexible opening hours, better availability of staff and drugs, better attitude and more confidentiality in socially stigmatized diseases. However, in private hospitals and outlets, the quality of services, the responsiveness and discipline of the provider has been questionable. Client-perceived quality of services and confidence in the health provider affect the health service utilization. Also whether medicine is provided by the healthcare facility or has to be bought from the bazaar has an effect, (Shaikh and Hatcher, 2004).

### *1.4.6. Education:*

Education, low literacy, lack of awareness, and low status of women affects health-seeking behaviour. It may be due to lack of health education, non-availability of drugs and low literacy rate in rural areas. The communication factor also creates a barrier due to differences in language or cultural gaps and it can also affect the choice of a specific health provider or otherwise. The type of symptoms experienced for the illness and the number of days of illness are major determinants of health-seeking behaviour and choice of care provider. In case of a mild single symptom such as fever, home remedies or folk prescriptions are used, whereas, with multiple symptoms and the longer period of illness, biomedical health provider is more likely to be consulted. Traditional beliefs tend to be intertwined with peculiarities of the illness itself and a variety of circumstantial and social factors. This complexity is reflected in the health-seeking behaviour, including the use of home-prescriptions, delay in seeking bio-medical treatment and non-compliance with treatment and with referral advice. The attitude of the health provider and patient satisfaction with the treatment play a role in health-seeking behaviour. The decision to seek help is also influenced by an individual's educational and economic status, the extent to which he is worried about the symptom and duration of experiencing the symptom (Katung, 2001).

### *1.4.7. Mass Media:*

Information technology, print media, electronic media, newspaper, magazine, T.V etc can influence the health-seeking behaviour of the people. It is expected that awareness level will be higher among the people who watch T.V and listening to the radio about health programme. Internet access can improved their understanding of medical conditions and treatment options, gave them more confidence in talking to doctors about health concerns, and assisted them in obtaining the treatment they otherwise might not have received (Pena-Purcell, 2008).

A study by Yanovitzky and Blitz (2000) indicates that mass media and interpersonal communication may be complementary in determining mammogram utilization and preventive health behaviour. While physician advice may be particularly important for women who regularly visit a physician, mass media communication channels are particularly important for women, (Yanovitzky and Blitz, 2000). While many studies have examined the relationship between health information exposure to particular mass media channels and specific health-related behaviours across the general population, there is little evidence on the impact of exposure to mass media-based health information across different channels on the health decision-making and medical advice-seeking behaviour. It was hypothesized that Hispanic adults who report obtaining a lot of health-related information from the media (radio, Internet, television, newspapers or magazines) are more likely to report that this information affected a decision about how to treat an illness/medical condition, led them to ask a doctor or other medical professional new questions, and changed the way they thought about diet or exercise than those who report receiving little or no health-related information from media sources. It was further hypothesized that quantity of media-based health information would be the strongest predictor of health decision-making and medical seeking behaviour among this population, above and beyond the influence of health literacy (Pena-Purcell, (2008).

Therefore, we assumed, based on the earlier literature that people who are listening radio or watching television would be more aware of health and health related issues compared with people who never listen radio or hardly watch television.

### 1.5. Objectives:

1. To understand health-seeking behaviour of Mizoram in general and Aizawl district in particular.

2. To examine the geographical patterning of health-seeking behaviour in Aizawl District.

3. To find out the influence of development factors on health-seeking behaviour in Aizawl district.

### 1.6. Research Questions

*There are five important research problems to be dealt with as stated below:*

(1) What is the status of health-seeking behaviour in Mizoram?

(2) How far developmental factors, such as female literacy, urbanization, accessibility, mass media exposure and family income are responsible for health-seeking behaviour in Aizawl district?

(5) How far spatial factors like – attitude, accessibility or distance of a village from the nearest healthcare facilities and place of residence determined people's health-seeking behaviour.

### 1.7. Study Area

The present study area of Mizoram has been chosen due to its unique characteristic, which convinced the researcher to find out the ground reality. A very tiny state of Mizoram is the second rank holder in term of literacy per cent in India next to Kerala. According to 2011 census, the state secured 9.58 per cent of literacy rate (93.72 per cent male and 89.40 per cent female respectively). In term of urbanization, Mizoram holds the second rank (51per cent, 2011) next to Goa. So, under normal circumstances, high literacy rate and high urbanization should have the positive impact on the health-seeking behaviour in particular area.

Inequality of income, poor accessibility due to geographical difficulties, unemployment and Mizoram holding the highest per of schedule tribe population among the

Indian states (94.5 per cent) overwhelmingly above the national average of 8.1 per cent might have negative impacts on people's health-seeking behaviour. Therefore, it is extremely interesting to explore how these positive and negative characters influence people's health-seeking behaviour in Mizoram.

Among the eight districts of Mizoram, Aizawl district has been selected as the study area. Aizawl district is selected because there are some important healthcare facilities that are found only in this particular district compared with other districts. The interesting characteristics about Aizawl are that: almost all the healthcare facilities of Mizoram are concentrated in Aizawl district. The district is the most urbanized among the eight districts while there are still very backward and underdeveloped rural villages in some pocket within the district. The district became the second highest literate district in India as well as in Mizoram after Serchhip district. The study area of Aizawl District consists of five Rural Development Blocks. Aizawl is the capital of Mizoram situated in the central part of the state on the hill crest, steep slopes and small valleys. It is situated on the north-south elongated range, which acts as the main hill from which many ridges and slopes are extending towards the eastern and western directions. The topography is highly undulating and rugged. The altitude varies from 800 to 1300 metres above mean sea level. It falls between $23^{o}52'$N latitudes and $92^{o}$ 49' E longitudes. It covers an area of 156.97 sq. km, as per 2001 census the population is 22,828 persons.

Aizawl district is selected for the study area based on the fact that the district is the second largest district in terms of geographical area with relatively better accessibility or transport network compared with other districts of the state. The Aizawl district is the most urbanized among the eight districts of Mizoram, it shares 36.48 per cent of the state's population as well as having the highest population density with 112 persons per sq.km

(Census, 2001). In terms of literacy, the district is the second highest literate district not only in Mizoram but also in India with 97.67 per cent of literacy rate (Census of India, 2011).

Regarding healthcare facilities in Mizoram, there are 12 Government Hospitals and 16 non-government hospitals, 12 Community Health Centre (CHC), 57 Primary Health Centre PHC), 370 Sub-Centre (SC). Out of these about half of higher healthcare facility i.e. hospital, are concentrated in Aizawl district that too in the Aizawl city alone. Therefore, it is interesting to research the relationship between the above variables and people's health-seeking behaviour in the state.

In the complex decision to seek medical attention, the cost is a significant factor. This study focuses on costs, direct and indirect, involved in a visit by an individual to a health provider. Costs include the cost of care, cost of transportation, time spent at the health provider, and inability to work while at the health provider.

Other main focuses of this study include the roles that distance from health providers and perceived quality of health provider options play in the household's decision of health provider. Understanding the demand side of healthcare will better inform the supply side in the hopes of providing greater access to and utilization of health services in Mizoram.

**1.8. Data Base and Methodology**

For the present research both qualitative and quantitative methods is used. A Stratified Sample design is also used. The analysis is confined to the key indicators such as level of education, income, occupation, BPL family, accessibility, mass media exposure, availability of healthcare facilities, gender and place of residence.

The analysis of Mizoram, in general, base on several collected data from government sub-centre, hospital, and public data. The study area is divided into five areas base on administrative division of rural development block. Secondary data includes-Statistical hand book of Mizoram-2014 & 2016, Socio-economic statistical handbook of Mizoram-

2014&2016. Census of India-2011, Annual report, Health and Family Welfare and other government documents. Books, journal, e-journals, and other internet sources are also utilized.

For primary information, Questionnaires has been prepared in purposive sampling design is made. While formulating the sample some important factors are under consideration, such as- equal spatial representation, inclusion of different size of settlements within the district to make sure rural and urban characters are not missed out along with size of population.

While considering the selection of villages literacy rate and spatial variation are also under consideration to represent all part of the R.D as well as part of the district to understand the geographical patterning. From each village 15 percent of the households were identified for collecting survey. Regarding primary sources, household's questionnaires are prepared in both English and Mizo. The information is collected on the usual places where household members go for treatment when they get sick, the distance of health care facilities from the village, education level, income, mass media exposure, do the family enjoy BPL, APL status etc.

The collected data is properly tabulated. Both descriptive and inferential statistics with the help of statistical software is used. It is also used Jenks (Natural Breaks) for classification. People's health-seeking behaviour of Mizoram, in general, is studied base on information collected from districts hospitals and other healthcare centre.

**Multi-stage stratified sampling will be adopted:**

1. To collect information on people's health-seeking behaviour all the existing five Rural Development Block is covered for better convenience and to represent spatial variations.

2. From these five Rural Development blocks, three villages/towns are selected base on population size to represent the high, medium and low population of the blocks.

3. Literacy rates of different villages are also under consideration, such as low, medium and high literacy villages to compare and contrast their characteristics on how they varied in their health-seeking behaviour.

4. A separate or additional stratification is made for Tlangnuam Rural Development block as it encompassed the whole Aizawl city. For this particular RD block or Aizawl city, we adopted geographical entity of altitudinal variation by selecting localities based on their altitudinal locations, such as-two localities from the higher altitude, two localities from medium altitude, and two localities from low altitude to get the better representation of spatial variation within the city.

### 1.9. Chapterization

*The manuscript of this thesis is organized into the following chapters.*

The **first chapter** includes introduction, scope of the study, review of the literature, and statement of the problem, study areas, objectives, database and methodology.

**Chapter two** consists of a general introduction and demographic characters of the background of study area covering the whole Mizoram and Aizawl district.

**Chapter three** discusses Health-seeking behaviour in Mizoram. It analyses inter-district variations of health-seeking behaviour

**Chapter four** analyzes the Socio-Economic backgrounds of healthcare-seekers in Aizawl district. This includes education, income and general health perception of Aizawl district.

Also inter-block differences and rural-urban variation of healthcare-seekers in Aizawl district

**Chapter five** focuses on the spatial variation of health-seeking behaviour in Aizawl district. It covers the inter-blocks and rural-urban variations on health-seeking behavior in Aizawl district.

**Chapter six** discussed about how development factors influenced health-seeking behaviour in Aizawl district.

The **last chapter** provides findings and conclusion of the present study.

# CHAPTER – II

# THE STUDY AREA

## 2.1. Introduction

This chapter provides a detailed background of the study area and has been dealt in two broad sections. The first section provides a description of physiographic and relief features of the state. It also includes a comprehensive overview of the demographic profile of Mizoram including inter-district variation in population growth, population density, population distribution and sex ratio. Literacy level, households' characteristics and health indicator of the population of Mizoram are also incorporated. The second section provides developmental indicators of Aizawl districts based on the latest secondary information. This includes developmental parameters like education, conditions of transport and communications, availability of healthcare etc.

## 2.2. Mizoram: Physiography

Mizoram lies between $21^{o}$ 15' – $24^{o}$ 35' N latitudes and $92^{o}$15' – $93^{o}$ 29' E Longitudes. It has the total geographical area of about 21087 square kilometres. The topography of Mizoram exerts direct influence on the distribution of various phenomena through altitude, ruggedness and slope. The physical set-up of Mizoram is composed dominantly by a series of mountainous parallel ranges inclined north to south direction with increasing the elevation from west to east. The ranges are separated from one another by narrow deep river valleys. More than 20 hills range or peaks of varying elevation range from 40 metres at Bairabi to 2157 metres at Phawngpui. There are only a few and small patches of flatlands, which are mostly intermontane plains.

Gradually, evolution of land and varied formations in a short geological history of the region has left distinct imprints on the structure and relief of the area. On the basis of relief, drainage, lithologic and structural set-up, the landforms of Mizoram may be divided into the following three units: (i) The Eastern High Mountain Regions; (ii) The Western Low-mountain Region; (iii) The Intermontane Flat Lands.

### *2.2.1. The Eastern High-mountain Regions*

The Eastern High-mountain Region runs in the north-south direction in the eastern part of Mizoram bordering Myanmar. These mountain ranges are about 200km long and 40 km wide. This region is the highest elevation ranging from 747metres (near Zokhawthar) to 2157 metres at the peak of Phawngpui (Blue Mountain). The average height is 1444 metres above mean sea level. As it consists of several ridges it can be further sub-divided into the following:

***(1) Sialkal-Hrangturzo Range:*** The two hill ranges together forms the easternmost and the highest hill ranges in the state along with Manipur and Myanmar. It has the second highest peak in Mizoram 'Lengteng' with an altitude of 2149metres. In fact, the Sialkal range

along the Manipur border forms a watershed between south flowing R. Tiau along the Myanmar border in the east and R.Tuipui in the west. The average height of this range varies from 1200 to 1800 metres from the mean sea level.

***(2) Chalfilh-Tawih-Lurh-Phawngpui Range:*** Chalfilh and Tawih ranges may be considered to have its continuation through Lurh Range and Phawngpui Range in the South-eastern parts along the Myanmar border. This range is affected by the confluence of R. Tuichang and R. Mat which tributaries to the south-flowing river R.Chimtuipui (Kolodyne) as well as R. Tuipui. The Chalfilh and Tawi Ranges have an elevation of 1800m and 1900m above respectively.

***(3) Kawnpui-Aizawl-Hmuifang range:*** These ranges formed the central axis of the state. It is separated from the eastern Chalfilh-Tawih Ranges by the valley of north-flowing river Tuirial and south-flowing R.Mat. The ridges tops are generally wider and slopes relatively gradual comparing to the eastern ranges. These ranges have many large settlements as the national highway No. 54 from Silchar to Saiha.

### *2.2.2. The Western Low-mountain Region*

The western low-mountain ranges exist as a natural boundary between Mizoram and Tripura in the northwest and Bangladesh in the southern areas. It extends from Kanhmun in the north to Reng hill in the south for about 200 km. It comprises a series of parallel ranges and is not contiguous, rather intersected by deep gorges and valleys. The average altitude is about 738m above sea level. The region can be divided into the following:

***(1) Hachhek-Mamit Range:*** Hachhek Range forms the natural boundary to the states of Mizoram and Tripura located in the western end of Mamit District of Mizoram. It is separated from the valley of R. Tut and Marlui. Their continuity is broken by the headwaters

of R.Teirei and westerly course of R.Deh and R.Tuichawng that debouch the Chittagong Hill Tracts in Bangladesh.

***(2) Reiek Range:*** Reiek Range between north flowing R. Tlawng and R.Tut is bounded in the north by their influence. It runs southward almost as a continuous range till the southern boundary of Mizoram is crossed. The highest ridges in this range vary from a height of 900 metres to 1200 metres. Despite low absolute relief, both western and especially the eastern slopes present a very rugged and hostile condition. It hampers the accessibility to settlements in this part.

***(3) Thorang Ranges:*** This region is interspersed with a number of peaks and valley ridges. It extends from Thorang peak in the north to Tlabung in the South. Its average altitude ranges from 21metres near Tlabung to 1390 metres at Thorang peak respectively. R. Khawthlangtuipui and its tributaries constitute the most prominent geomorphic feature in this region.

***(4) Uiphum Ridges:*** Uiphum ridge lies in the southern verge of the state and forms an important topographic region. The region is characterized by low relief and broken ridges. R. Tuichawng and small streams are found in this region. Uiphum peak runs in the north south direction parallel to Saichal peak in the Chittagong hill tract.

### *2.2.3. The Intermontane Flat-Lands:*

The intermontane flatlands in Mizoram do not form any continuous patch. They are widely scattered. The Champhai valley in the eastern part of Champhai district, Thenzawl plains in the southern part of Aizawl, Vanlaiphai spread over in Serchhip and Lunglei District represents Chamdur plains in the eastern part of Saiha District represents the few flat lands which plays a vital role in the state economy. Champhai plain is the biggest plain in

Mizoram. It spread in almost 50 square km. The second largest plain is North Vanlaiphai in Serchhip District.

Besides the above mentioned intermontane plains, numerous small patches may be identified in northern, western and central parts of the state. Thus, Tuisenhnar in the vicinity of Khawzawl, Zawlpui in Mat river basin, Phaisen of R. Chhimluang to the west Bilkhawthlir, Hortoki, Dilzau, Medium and Bairabi in the northern part of R.Tlawng basin are some of the flat patches.

### *2.2.4. The Lakes*

The lakes formed only a few natural at places, where hills and ridges served as the natural embankment on all sides. The large lakes to be mentioned in the state are Palak, Tamdil and Rengdil. There are smaller lakes such as Rungdil, Diltlang, and Vachadil. It is believed that the lakes in Mizoram are the result of an earthquake or flood.

### *2.2.5. Geology*

The landform in Mizoram is believed to have started evolving during the Tertiary era. Geologist believed that the area belongs to geosynclines that existed during the Eocene period between the Chittagong Hill Tracts of Bangladesh in the west and the Arakan Yoma of Myanmar in the east. The lithology of the hills is the thickness of detrital sediments with the alternate occurrence of argillaceous and arenaceous deposits. The upper sandstone with occasional clays bands and overlain by recent alluvium represents the fluvial deposits. It attains a thickness of about 950 metres. The oldest rocks in the state having a thickness of about 3,000 metres are believed to have a marine origin Oligocene period. Barail series of rocks represents the oldest formation in Mizoram. They are mostly found along R. Tuichang and R. Tuivai in the eastern part of the state.

### *2.2.6. Climate*

Climate is probably the most important factor of all geographical influences affecting man. The potential economic activity, crop producing ability, of a given area is dependent primarily upon the existing climatic and soil conditions. Mizoram generally enjoys a sub-tropical climate of monsoon type. The temperature conditions, however, are moderated due to altitudinal variations and alignment of the hill ranges. Two distinct seasons may be recognized in Mizoram, one with the abundance rainfall extending generally from later of April to the early part of October, on the other hand, almost a dry period from October to March. There is also marked variation in spatial distribution of rainfall in the state. The area in the south of central highlands receives the highest amount of rainfall. The annual range of temperature is generally below 20o C. the winter is cool and summers at its height only warm.

## 2.3. Demographic Profile

Demography is the study of population and allied attributes such as rural and urban composition, growth rate, the density of population, distribution pattern and sex ratio etc. Growth and distribution pattern of population impinge on the behaviour of movement with special emphasis on social bearings. It also influences the economy, polity, ecology, environment and the society. Mizoram's socio-demographic profile is no less impressive and is measured by a reference to the last three census years of 19991, 2001 and 2011. The indicators of the socio-demographic profile are many and varied.

Table-2.1 shows that in 1991, Mizoram supports a small size of the population numbering 686756 persons (0.081 per cent of India's population). After decades Mizoram's population increased to 888573 (0.086 percent of India's) in 2001 and 1,091,014 (0.09 percent of India's population) in 2011. In terms of growth, Mizoram has been recording a higher rate of growth than of national average between 1981-2011 periods, though there is a

discernible decline in the rate of growth in Mizoram during 1991-2011 keeping in the line with the national average. However, the place of the decline appears to be more in Mizoram compared to that of India as a whole. In a state characterized by extreme variation in local relief and generally mountainous character, the density of population is bound to below as much as of the state is difficult for habitation and do not provide suitable- land for cultivation.

**Table-2.1. Mizoram and India: Socio-demographic characteristics**

| Years | 1991 | | 2001 | | 2011 | |
|---|---|---|---|---|---|---|
| **Area** | **India** | **Mizoram** | **India** | **Mizoram** | **India** | **Mizoram** |
| **Total Population** | 846421436 | 686756 | 10228737436 | 888573 | 1210193422 | 1091014 |
| **Decadal growth rate (%)** | 23.87 | 39.7 | 21.54 | 28.82 | 17.64 | 22.78 |
| **Density of Population** | 267 | 33 | 325 | 42 | 382 | 52 |
| **Sex Ratio** | 927 | 921 | 933 | 935 | 940 | 975 |
| **Percent 0-6 years** | 17.9 | 18.6 | 15.9 | 16.2 | 13.12 | 15.17 |
| **Literacy rate (%)** | 52.2 | 82.3 | 64.8 | 88.8 | 74.04 | 91.58 |
| **Literacy rate (M) (%)** | 64.1 | 85.6 | 75.3 | 90.7 | 82.14 | 93.72 |
| **Literacy rate (F) (%)** | 39.3 | 78.6 | 53.7 | 86.7 | 65.46 | 89.40 |

**Source: Census 2011 and Annual Report (2005-2006) Health and Family Welfare Department, Directorate of Health Services, Mizoram.**

However, a recent increase in population, particularly induced by urbanization has resulted in an increase in the density of population from 33 persons per sq. km in 1991, 42 people per sq. km in 2001 and 52 people per sq. km in 2011. But the land-man ratio in the state is far below the national average of 382 persons per sq. km. contrary to expectation; there was a great deficit of women in Mizoram compared to India as a whole in the year 1991 as revealed from a sex ratio of only 921 as against the national average of 927.

However, the sex ratio registered an impressive gain in Mizoram by 2001 and 2011 with an improvement to 935 and 975 respectively compared to India's 933 in 2001 and 940 in 2011. Child sex ratio (0-6 years) is a sensitive demographic indicator for future population dynamics. Relatively Mizoram record a much a better sex ratio than India average for three consecutive decades of 1991, 2001 and 2011 figures. In the field of literacy, Mizoram's performance is commendable and is far ahead of most other states of India. This extraordinary high literacy rate in Mizoram is largely contributed by an impressive women literacy rate unlike in India as a whole and in the rest of the country which suffers from low female literacy. For example, 1991 census records 64.1 per cent male literates in India as against only 39.3 per cent female literate. In the same period, 85.6 per cent males and 78.6 per cent females in Mizoram are enumerated as literate. In the subsequent decades, the distinction between the male and female rate at the national level was not much improved while Mizoram achieved near total literacy (Table- 2.3). Lack of male-female disparity in literacy attainment distinguishes Mizoram and speaks volumes about the literacy situation in the state.

As a whole, socio-demographic profile of Mizoram is quiet satisfaction when compared with the national average. The performance is significantly better in the areas of sex ratio, literacy attainment and work participation, all indicating lack of gender discrimination – a prerequisite for women's empowerment and reproductive rights. The only concern that remains is a higher than desirable rate of population growth that goes contrary to women's empowerment and reproductive health. The recent decline in the rate of population growth holds some promise for a low growth regime to set in the near future.

### *2.3.1. Distribution and Growth*

Mizoram with the total population of 109720 in 2011Census supports one of the smallest populations compared with other states of India. The pattern of population

distribution in a region is mainly dependent on the past changes in the population characteristics in terms of location, distribution, density, growth and mobility. The intra-state variation in the population is enormous (table-2.2). So is the case with the rate of population growth. Inter-district variation in population distribution reveals that (table- 2.3 the single district of Aizawl (404,054 persons) contained more than a third (37 per cent) of the state's total population. Two other districts namely Lunglei (125, 370 persons) with 11.5 per cent of the state's total account for nearly 26 per cent of the total. Nearly65 per cent of the population of the state is confined to these three districts. The remaining five districts support a small 35 per cent of the state's population. With Saiha (5.2 per cent), Kolasib (7.6 per cent), and Mamit (7.9 per cent) districts contained around a fifth of the state's total population. While Lawngtlai accounted for a little over 10 per cent population of the state, Serchhip being the second smallest district in terms of geographical area accounted for the least population (64,875 persons) in Mizoram supporting only 5.9 per cent. It is significant that there is little correlation between altitude and population concentration in the state. Areas of high altitude do support a larger population.

***Table- 2.2. Mizoram: Inter-District Variation of Population Growth***

| **State/District** | Population 2011 | Decadal Growth Rate (%) | | |
|---|---|---|---|---|
| | Person | 1981-1991 | 1991-2001 | 2001-2011 |
| **Mizoram** | 1,091,014 | 39.7 | 28.82 | 22.78 |
| **Aizawl** | 404,054 | 57.23 | 39.24 | 24.07 |
| **Champhai** | 125,370 | 32.31 | 29.77 | 16.31 |
| **Kolasib** | 83,054 | 26.82 | 36.01 | 25.92 |
| **Lawngtlai** | 117,444 | 52.68 | 34.78 | 34.08 |
| **Lunglei** | 154,094 | 28.79 | 23.1 | 12.29 |
| **Mamit** | 85,757 | 23.57 | -3.49 | 36.59 |
| **Saiha** | 56,366 | 47.72 | 33.16 | 19.71 |
| **Serchhip** | 64,875 | 20.36 | 18.45 | 19.12 |

***Negative growth due to large-scale temporary migration of particular tribe to Tripura in 1997.**

***Source: Director, Census Operation-2011***

Table- 2.2 reveals a generally declining trend in population growth in almost all districts except Kolasib district during 1981-2011. The rate of population growth in Kolasib increased from 26.82 per cent in 1991 to as high as 36.01 per cent in 2001 and again declined to 25.92 per cent in 2011. This anomalous trend could be due to immigration from neighboring state of Manipur, especially of the Hmar people during this period. This unprecedented increase in the face of a large-scale decline in the rate of growth across the state cannot be attributed to natural increase. On the other hand, Mamit district, recorded negative growth rate (-3.49 per cent) in 1991-2001 suggesting an absolute decline in its population. This could have been due to large-scale temporary out-migration of Tuikuk or Reang people from the district to the bordering state of Tripura in the year 1997. Understandably, Aizawl the most urbanized district recorded 57.23 per cent growth rate during 1991-2001 and 24 per cent in 2011. The general decline in the population growth rate across the state, irrespective of intra-state differences in physical and cultural milieu may have been due to mass awareness of family planning, the high growth rate in the literate segment, improvement and progress in the field of medicine and technology associated with better economic conditions.

### *2.3.2. Population Density*

The state of Mizoram is sparsely populated. It ranks one of the lowest populated states of India. The population of Mizoram according to 2011 was 52 persons per sq. km. However, there is significant variation in the density of population both in space and time. Table- 2.3 shows the population density in all the eight districts of Mizoram arranged according to the ranks during 1991, 2001 and 2011 census. The fact that the spatial pattern in density distribution underwent alteration is brought out by the fact that the ranks of several districts changed within a span of two decades. Only Aizawl district maintained its ranks during the last three decades. All other districts changed their relative position with regard to

the density. Broadly two density regions may be identified based on 2011 figures: (1) Areas of high density, with a land-man ratio of over 40 people/sq.km and (2) Areas of low density where the ratio is less than 40 persons /sq.km. Areas of high density consist of Aizawl (113 person/sq.km), Kolasib (60 person/sq.km), Lawngtlai (46 person/sq.km), Serchhip (46 person/ sq.km) and Saiha (40 person per/sq.km).

***Table- 2.3. Mizoram: Population Density, 1991-2011***

| **District** | **Population Density** | | | | | |
|---|---|---|---|---|---|---|
| | 1991 | Rank | 2001 | Rank | 2011 | Rank |
| **Aizawl** | 62.08 | 1 | 86.70 | 1 | 113 | 1 |
| **Kolasib** | 32.44 | 4 | 47.72 | 2 | 60 | 2 |
| **Saiha** | 32.64 | 3 | 43.64 | 3 | 40 | 4 |
| **Serchhip** | 21.10 | 8 | 37.90 | 4 | 46 | 3 |
| **Champhai** | 33.24 | 2 | 34.03 | 5 | 39 | 5 |
| **Lunglei** | 24.56 | 5 | 30.25 | 6 | 34 | 6 |
| **Lawngtlai** | 21.19 | 7 | 28.79 | 7 | 46 | 3 |
| **Mamit** | 21.35 | 6 | 20.75 | 8 | 28 | 7 |
| **Mizoram** | 32.71 | | 42.15 | | 52 | |

**Source: Statistical handbook of Mizoram, 2002, Directorate of Economic & Statistics**

Areas of low density are Champhai (39 person/sq.km), Lunglei (34 person per sq. km) and Mamit (28 person/sq.km) districts.

### *2.3.3. Sex Ratio*

Sex composition holds an important place for demographic analysis. Separate data for male and female are important for various types of planning and for the analysis of other demographic characteristics such as mortality, marital status and economic characteristics etc. (Chandna, 2002). According to census records, changes in sex ratio in Mizoram have been quite dramatic. In 1901, the sex ratio of Mizoram's population was as high as 1113 with a large surplus of women in the state's population. This surplus female population further increased to a sex ratio of 1119 in the following decade. Since then, however, the story has been that of a continuous and progressive decline in the proportion of female in the total population. The females though exceeded the male population till about

1961. The sex composition witnessed a qualitative change since the year 1971 when the state for the first time experienced a deficit of females in its population and the sex ratio stood at 945 as against a figure of 1008 in the previous decade. There has been a marginal improvement in the sex ratio since 1991. The drastic fall in the proportion of the female in the state's population in the year 1971 may have been due to the impact of the great famine and the consequent food crisis in Mizoram in 1957. However, this drastic change in sex composition needs more in-depth studies. Compared to many other in Mizoram do not face much discrimination and indeed are better placed than a majority of women in many Indian states when it comes to mortality by sex and as far as health indicators are concerned.

Interesting rural-urban differences in sex ratio was observed in Mizoram. Contrary to most other states, rural sex ratio revealed a greater deficit of women than that of the urban areas had a much higher sex ratio of 951 females per 1000 males (2001 census). This means that the sex-selective migration to urban areas is missing in Mizoram. On the contrary, more females migrate to urban areas than males. This situation is unique and takes place largely due to lack of gender discrimination in available urban occupations in the state.

**Table- 2.4. Mizoram: Sex Ratio (No. of female per 1000 male)**

| **District** | 1991 | Rank (1991) | 2001 | Rank (2001) | 2011 | Rank(2011) |
|---|---|---|---|---|---|---|
| **Champhai** | 969 | 1 | 955 | 1 | 981 | 2 |
| **Aizawl** | 917 | 5 | 954 | 2 | 1009 | 1 |
| **Saiha** | 939 | 3 | 954 | 3 | 978 | 3 |
| **Serchhip** | 959 | 2 | 953 | 4 | 976 | 4 |
| **Lunglei** | 910 | 6 | 922 | 5 | 944 | 7 |
| **Kolasib** | 924 | 4 | 913 | 6 | 956 | 5 |
| **Mamit** | 885 | 8 | 902 | 7 | 924 | 8 |
| **Lawngtlai** | 891 | 7 | 901 | 8 | 945 | 6 |
| **Mizoram** | 924 | | 935 | | 975 | |

**Source: Census of India, 2011**

Based on sex composition of the population in Mizoram in the year 2011, two broad areas may be identified (Table- 2.4); areas with higher sex ratio i.e. over 975 females per 1000 males. The former includes districts located in the eastern part of the state such as

Aizawl (1009), Champhai (981), Saiha (978) and Serchhip (976) characterized by less deficit of women and the later confined to four districts mostly located in the western part including Lunglei (944), Kolasib (956), Lawngtlai (945) and Mamit (924).

As mentioned earlier, there have been significant changes in the rank of the districts with regard to their sex composition. For example, Aizawl district held fifth rank in 1991 census and improved its position to the second rank in 2001 census largely as a result of improvement in the proportion of female in the total population of the district. Only Champhai and Saiha district maintained their relative position while the remaining districts change their position within the decade. However, it is gratifying that half of the districts in the state had a sex ratio of over 975 female per 1000 males which is higher than the national average.

**2.3.4. Literacy**

Literacy is considered a sensitive index of the place at which the socio-economic transformation takes place. Analysis of the literacy pattern, especially literacy is immense significance for population geographers as it has an intrinsic relationship with women's health-seeking behaviour. Basic literacy, i.e., the ability to read and write, is the fundamental aspect of the ability of individuals to fully participate and take advantage of socio-economic development, health and nutritional advancements (NFHS-3, 2005). It is important to relate the crucial positive role played by literacy in a spatial analysis.

Education in Mizoram has seen several challenges before attaining its present status. The British, particularly the Welsh mission made a remarkable contribution in the field of education which certainly helped Mizoram achieve its present commendable status. Formal education was unknown prior to 1894 when the first Christian missionaries set its foot in Mizoram. The oral tradition of knowledge and learning had been practiced and handed down from generation from generation mostly within the family and Zawlbuk. The first

Christian missionaries, when reaching Aizawl, ventured to prepare Mizo alphabets in Roman script and started a school in their small hut in Aizawl by 1897. Only a few Mizo enrolled for the preliminary lessons. The first persons to get their education were mainly the chiefs and their sons as they were mainly the chiefs and their sons as they were the most privileged and respected people in the community, which they believed would have far-reaching impact for the growth and development of education to the common people. Later, the government primary schools were opened in Aizawl in the year 1898. By the turn of the twentieth century, there were six lower primary schools in different localities in Aizawl. According to 1901 census, there were 761 literates including 25 females. In 1903, the first lower primary school examination was conducted and in which 19 candidates succeeded.

Table-2.5 revealed that by 1951 when the first five-year plan was introduced in the country, the state of Mizoram attained 31.13 overall literacy rates with 16.70 per cent women and 46.15 per cent men being literate. Early education in Mizoram was characterized by a huge gender gap of around 30 per cent (Table-2.5). Significantly, however, the gender gap reduced at a fast pace with each passing decade as the art of reading and writing diffused quite rapidly among the Mizo women. This is evident from the rate of growth in female literacy rate which far exceeded that of male literacy rate since the year 1961.

***Table- 2.5. Mizoram: growth of Literacy and Gender Gap***

| **Year** | Male | Female | Total | Gender Gap |
|---|---|---|---|---|
| **1951** | 46.15 | 16.7 | 31.13 | 29.98 |
| **1961** | 62.25 | 40.34 | 51.24 | 21.91 |
| **1971** | 70.15 | 54.75 | 62.71 | 15.4 |
| **1981** | 79.07 | 68.6 | 74.26 | 10.47 |
| **1991** | 84.06 | 78.09 | 82.27 | 5.97 |
| **2001** | 90.69 | 86.13 | 88.49 | 4.56 |
| **2011** | 91.58 | 93.72 | 89.40 | 4.32 |

**Source: Compiled from Census of India- 2011**

Mizoram generally experienced an exceedingly high growth rate of literacy in the following three decades from 1971-2011 with a faster rate in female literacy. In the last census (2011) Mizoram ranked the second most literate state among the Indian union with a record 91.58 per cent literate population. It is noteworthy that female literacy growth during this entire period (1961-2011) was faster than the rate of growth registered by the males in Mizoram. This has resulted in a gender gap presently being merely 4.32 per cent. It is quite likely that the people in the state will soon be fully literate and there shall be no gender gap. The generally high literacy rate among women of the state is expected to have a positive impact on the health of mothers and their health-seeking behaviour.

### 2.3.5. Inter-District Variation

In spite of a spectacular achievement in the field of literacy in the state as a whole, there is significant variation at lower levels of spatial aggregation, particularly at districts –fact considerable importance to a geographical analysis. An attempt has been made to highlight inter-district variation in literacy attainment in Mizoram for the better understanding of the role of literacy and its relationship with the health of people, especially reproductive health.

***Table- 2.6. Mizoram: Inter-District Variation in Literacy (%) - 2011***

| **District** | Literacy | Rank | Males | Females |
|---|---|---|---|---|
| **Aizawl** | 98.50 | 2 | 99.02 | 98 |
| **Serchhip** | 98.76 | 1 | 99.24 | 98.28 |
| **Champhai** | 93.51 | 4 | 94.80 | 92.20 |
| **Kolasib** | 94.54 | 3 | 95.50 | 93.53 |
| **Lunglei** | 89.40 | 5 | 92.74 | 85.85 |
| **Saiha** | 88.41 | 6 | 91.00 | 87.80 |
| **Mamit** | 85.96 | 7 | 90.15 | 81.37 |
| **Lawngtlai** | 66.41 | 8 | 74.58 | 57.62 |
| **Mizoram** | 91.58 | | 93.72 | 89.40 |

**Source: Statistical handbook of Mizoram, 2002, Directorate of Economics & Statistics, Mizoram**

Table- 2.6 shows distributional of literacy rate in different districts of Mizoram. According to 2011 census, Mizoram achieved the status of being the second most literate state among the Indian states recording 91.58 per cent next only to Kerala. Around 93.72 per cent males and 89.40 per cent females could read and write. However, this impressive performance is understood by a dismal performance in a few pockets along with highly spectacular performance elsewhere. The overall literacy rate status achieved in Aizawl and Serchhip districts (over 98 per cent). Lawngtlai appears to be a depressed area as far as literacy development in the state is concerned. There is little difference in male-female literacy rates in those districts with high overall literacy, but the gap increases in districts which have low overall literacy rate. This suggests that overall literacy rate is largely a response to female literacy rate. Female literacy rate ranges from a low 457.62 per cent in Lawngtlai district to a high 98.28 per cent in Aizawl district. Relatively low female literacy rate (below 86 per cent) is characteristic of Lawngtlai and Mamit; Medium female literacy rate (86-90 per cent) is characteristic of Lunglei while high female literacy (above 90 per cent) is confined to Saiha, Champhai, Aizawl and Serchhip districts.

It is evident that the districts located in the western and southern part of the state are generally backward in terms of general as well as female literacy rate. This inter-districts variation in literacy development, particularly in female literacy rate is of significance when one examines the issue of reproductive health and the role of awareness regarding this important issue.

**2.4. Health Indicators**

This section analyses the basic health indicators in Mizoram in order to assess the general condition of health as well as the availability of healthcare services in Mizoram. Comparisons are also made with the national level on the basic health indicators to assess the overall performances. In spite of general backwardness of the state, table- 2.7 clearly brings

out the fact that the performance of the state is better than country's average in nearly all the indicators considered. Mizoram recorded significantly lower birth and death rate than national average. Mizoram's record of 5.1 death rate places it in a select few states of India achieving the lowest level in such an important indicator of healthy situation. The situation with regard to infant mortality and the maternal mortality rate is even more satisfactory in Mizoram with a ratio of 14.1 and 163 respectively. This spectacular achievement may partly be attributed to high level of literacy in the state and lack of significant socio-economic inequality as well as multi-culture and diversified population in contrast to the prevalence of social and economic inequalities as well as multi-culture and diversified population in India as a whole 'since the outcome indicators of health (mortality, morbidity and life expectancy) are all directly influenced by the standards of living of a given population' (Deogaonkar, 2004). As with other countries, most of the maternal deaths in India can be prevented. Many are due to a lack of appropriate care during pregnancy and childbirth and to inadequate services for identifying and managing complications (World Bank).

**Table- 2.7. Mizoram: Basic Health Indicators**

| **Items** | Mizoram |
|---|---|
| **Birth Rate*Birth Rate*** | 20.12 |
| **Death Rate**** | 5.87 |
| **Government Hospital** | 12 |
| **Private Hospital & NGO** | 20 |
| **Community Health Centre (CHC)** | 12 |
| **Primary Health Centre (PHC)** | 57 |
| **Sub Centre (SC)** | 365 |

*the average annual number of births during a year per 1,000 populations at midyear. Also known as the crude birth rate.
**the average annual number of deaths during a year per 1,000 populations at midyear. Also known as the crude death rate.
***The number of deaths of infants under 1 year of age from a cohort of 1,000 live births.
****Express maternal deaths per 100,000 live births.

Source: Statistical Abstract of Mizoram-2015

Healthcare services and availability of health professional are critical factors in ensuring better health. The state has 12 Government hospitals, 20 Private and Non-government Organization hospitals, 12 Community Health Centers, 57 Primary Health

Centre and 365 Sub-Center across the state of Mizoram. It is to be noted that Mizoram has done fairly well in terms of basic health indicators.

### 2.4.1. Birth and Death Rate

This section analyses inter-district variation in the basic health indicators, such as birth and death rates across the districts of Mizoram. It also analyses rural-urban differences in the rates to understand rural-urban disparity if any. As it is evident from (Table- 2.9) there are significant inter-district variations in both birth and death rates. Based on these variations, two demographic regions emerge: high birth rate region and low birth rate region. Low birth rate region includes districts having the birth rate of less than 20 and districts like Kolasib (17.86 percent) and Mamit (18.1 percent) represents a region of low birth rate. High birth rate region includes the remaining districts- Lunglei (26.16 percent), Champhai (21.85 percent), Saiha (21.11 percent), Serchhip (20.94 percent) and Aizawl (20.71 percent).

Overall, rural birth-rate is only marginally the higher and higher rural birth rate is not uniform across the districts. Significantly, rural areas in Aizawl, Lunglei and Saiha experience a lower birth rate than their urban counterparts. The rural birth rate is significantly lower in the highly urbanized district of Aizawl. This situation is unique as most other regions in the country experience a much higher birth rate in rural areas display in general higher birth rate is indicative of a positive association between urbanization and birth rate.

**Table- 2.8. Mizoram: Inter-District variations in Birth and Death Rates**

| District | Birth Rate | | | Death Rate | | |
|---|---|---|---|---|---|---|
| | Total | Rural | Urban | Total | Rural | Urban |
| **Aizawl** | 20.71 | 15.44 | 25.98 | 5.16 | 3.98 | 6.34 |
| **Champhai** | 17.86 | 24.1 | 19.61 | 4.58 | 4.74 | 4.42 |
| **Kolasib** | 17.86 | 23.88 | 11.85 | 4.63 | 4.4 | 4.87 |
| **Lawngtlai** | - | 17.87 | - | - | 5.1 | - |
| **Lunglei** | 26.16 | 22.93 | 29.39 | 5.54 | 4.89 | 6.19 |
| **Mamit** | 18.1 | 20.41 | 15.79 | 2.4 | 2.76 | 2.05 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Saiha** | 21.11 | 18.39 | 23.84 | 4.16 | 4.22 | 4.1 |
| **Serchhip** | 20.94 | 23.64 | 18.24 | 4.02 | 5.41 | 2.63 |
| **Total** | 21.95 | 20.03 | 23.87 | 5.07 | 4.57 | 5.58 |
| **Source: Statistical handbook of Mizoram, 2002, Directorate of Economics 7 Statistics.** | | | | | | |

Barring Mamit district that has the lowest death rate in the state, there is great uniformity in death rate across districts of Mizoram. The death rate is as low as 2.4 per thousand persons in Mamit and ranges between 4 - 5 per thousand in the remaining districts. Death rates generally higher in rural areas except for the two most urbanized districts of Aizawl and Lunglei where urban death rate exceeds that of the rural.

Variation in birth and death rate in Mizoram is not explained in terms of rural-urban differences and may be attributed to nature of population distribution and physiographic constraints. Wherever there is a heavy concentration of people, both birth and death rates are relatively higher.

### 2.4.2. Age Sex Differential in Mortality

A total of 4697 deaths were registered in 2003 as compared to 4401 death in 2002 (Males - 2723, Females -1678). On the basis of age differential the highest death was found among the old age group of 70 years and above that accounted for 20.72 per cent of all deaths, followed by the age group of 25 to 34 years with 10.03 per cent.

**Table- 2.9 Mizoram: Death by Age Group and Sex (2003)**

| **Ages** | Male | Percent | Female | Percent | Total | Percent |
|---|---|---|---|---|---|---|
| **Below 1 year** | 147 | 5.11 | 138 | 7.59 | 285 | 6.07 |
| **1 to 4** | 225 | 7.82 | 202 | 11.11 | 427 | 9.09 |
| **5 to 14** | 160 | 5.56 | 126 | 6.93 | 286 | 6.09 |
| **15 to 24** | 335 | 11.64 | 131 | 7.20 | 466 | 9.92 |
| **25 to 34** | 355 | 12.33 | 116 | 6.38 | 471 | 10.03 |
| **35 to 44** | 282 | 9.80 | 129 | 7.09 | 411 | 8.75 |
| **45 to 54** | 270 | 9.38 | 141 | 7.75 | 411 | 8.75 |
| **55 to 64** | 267 | 9.28 | 161 | 8.85 | 428 | 9.11 |
| **65 to 69** | 141 | 4.90 | 104 | 5.72 | 245 | 5.22 |
| **70 & above** | 533 | 18.52 | 440 | 24.19 | 973 | 20.72 |

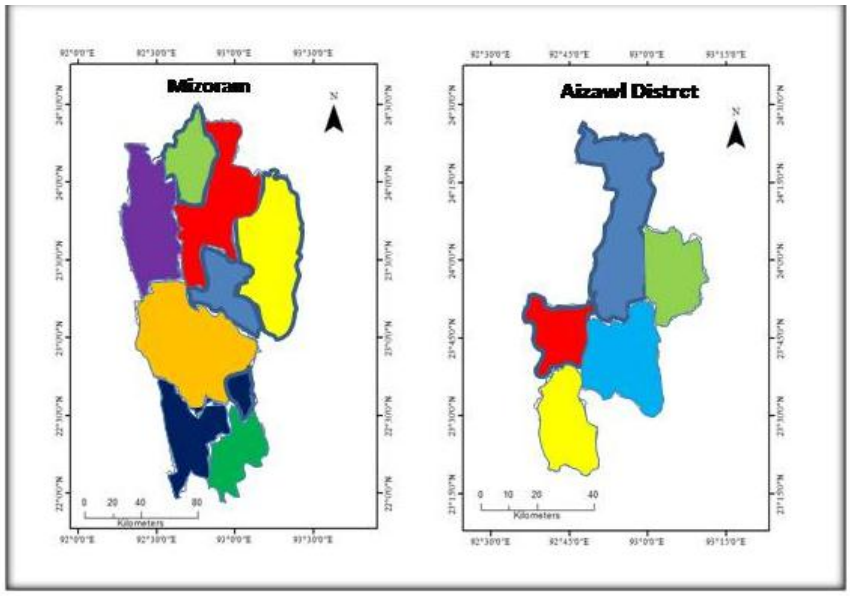
| | | | | | | |
|---|---|---|---|---|---|---|
| **Age not Stated** | 163 | 5.66 | 131 | 7.20 | 294 | 6.26 |
| **Total** | 2878 | 100 | 1819 | 100 | 4697 | 100 |
| Source: Report on Situation Analysis of Women & Girls in Mizoram, National Commission for Women, New Delhi, 2005. | | | | | | |

It is evident from table-2.9 that more males died in the year 2003 compared to the females. It is noteworthy that the proportion of female deaths was more than that of the males in early age groups of 14 or less and in older age group of over 65 years of age. Significantly however, fewer females died in the reproductive age cohorts compared to the males. This is contrary to expectation as more females normally die in the reproductive age. If the data is reliable, this is a positive development in the state that shows fewer deaths due to reproductive problems.

**2.5. Selected Site of the Study Areas**

This section provides the very basic developmental variables of selected sites of the study areas. As mentioned in the methodology, five RD block, medium and small villages are selected from Aizawl district. Selected developmental variables include – educational institution, healthcare facilities, transport and communication in each and every selected villages and towns.

Therefore, we selected five Rural development block such as- Tlangnuam, Aibawk, Thingsulthliah, Phullen, Darlawn on the based of spatial location, socio-economic and education.





The total population of Aizawl district is 293,416 persons (2011 census).

In Aizawl district, there is five Rural Development Blocks – Tlangnuam, Aibawk, Thingsulthliah, Darlawn and Phullen. The five R.D Blocks, four medium and four small villages are selected for the study area. The higher range of Durtlang and Zarkawt, Middle elevation of Dinthar and Bethlehem, lower elevation of Chite and Sairang are included in Tlangnuam block.

# CHAPTER – III

# HEALTH-SEEKING BEHAVIOUR IN MIZORAM: INTER-DISTRICT VARIATION

## 3.1. Introduction

Chapter three discusses on the general overview of inter-district variations of health-seeking behaviour in Mizoram. It encompassed discussion on prevalence of sickness, family check-up in time of illness, number of household members visit health institution for treatment during the last one year, consultation of health personnel, performance of service providers, number of patients visiting different healthcare givers during the last one year, observation of healthcare facilities, common diseases, prevalence of death and number of times patients visit health institution for treatment.

## 3.2. Prevalence of sickness

Habitat, population, and behavior form the vertices of triangle that encloses the state of human health. Habitat is that part of the environment within which people live, that which directly affects them. Houses and workplaces, settlement patterns, naturally occurring biotic and physical phenomena, health care services, transportation systems, schools, and government are parts of the habitat. Infectious insults consist of the pathogens - agents that cause disease. Every person is infected at all times with many billions of viruses, bacteria and protozoa that cause no harm, such as intestinal bacteria. Change in present status can cause a normal being relationship to alter and become pathogenic.

During the survey, people are asked whether any of their family members got sick in their life time to understand the prevalence of sickness across the districts. Table-3.1 depicts that sickness among families in Mizoram is extremely common with an

average of 90.8 %. In Kolasib and Serchhip districts more than 98% families' experiences sickness while In Mamit and Lunglei districts more than 95% families experiences sickness. On the other hand Aizawl and Saiha districts are the least that experiences sickness within the family.

| Table-3.1. District-wise: Is anybody ever got sick in your family | | | |
|---|---|---|---|
| **District** | Yes | No | Total |
| **Aizawl** | 73.9 | 26.1 | 100 |
| **Champhai** | 91.9 | 8.1 | 100 |
| **Kolasib** | 98.5 | 1.5 | 100 |
| **Lawngtlai** | 92.8 | 7.2 | 100 |
| **Lunglei** | 95.2 | 4.8 | 100 |
| **Mamit** | 95.4 | 4.6 | 100 |
| **Saiha** | 80.8 | 19.2 | 100 |
| **Serchhip** | 98.2 | 2.1 | 100 |
| **Mizoram** | 90.8 | 9.2 | 100 |
| **Source : Field survey-2016 & 2017** | | | |

*Thus, it is evident from this research that Kolasib and Serchhip districts are the unhealthiest districts while Aizawl and Saiha are the healthiest districts in Mizoram.*

### 3.4. Health-seeking Behaviour

Health-seeking Behaviour refers to decision or an action taken by an individual to maintain, attain, or regain good health and to prevent illness. The decisions made encompasses all available health care options like visiting a public or private, modern or traditional healthcare facilities, self-medication and use of home remedies or not to utilize the available healthcare services. Health-seeking Behaviour is a result of a complex interaction of provider, patient, illness and household characteristics. It is influenced by a variety of socio-economic variables, physical accessibility, income or expenditure, health services and diseases pattern, education and mass media. Planning for health care services provision depends on health needs and health-seeking behaviour of population.

Determining the healthcare seeking behaviour is essential to provide need based health care services to the population.

Table-3.2 shows the inter-district variations of family members going for health check-up in time of illness such as Aizawl District (91.7 %), Champhai (71.8 %), Kolasib District (66.8 %), Saiha District (66.9 %), Lawngtlai District (64.7 %), District (51.7%), Mamit District (51.5%), and Lunglei District (61.8 %).

**Table-3.2 District-wise: Family member go for check-up in time of illness**

| District | Yes | No | Total |
|---|---|---|---|
| **Aizawl** | 91.7 | 8.1 | 100 |
| **Champhai** | 71.8 | 28.2 | 100 |
| **Kolasib** | 66.8 | 33.2 | 100 |
| **Lawngtlai** | 64.7 | 35.3 | 100 |
| **Lunglei** | 61.8 | 38.2 | 100 |
| **Mamit** | 51.5 | 48.5 | 100 |
| **Saiha** | 66.9 | 33.7 | 100 |
| **Serchhip** | 51.7 | 48.3 | 100 |
| **Mizoram** | 65.9 | 34.2 | 100 |

**Source : Field survey-2016 & 2017**

Aizawl District scored the highest number of family members that went for health check-up in time of illness while Mamit and Serchhip record the least percentage of family members that went for health check-up in time of illness.

*Present research clearly shows that seeking health care is quite common in Aizawl District (91.7 % compared to other districts of Mizoram and far better than state average of 65.9% while Mamit and Serchhip records the least percentage of family members that went for health check-up in time of illness with 51.5 % and 51.7% respectively.*

### 3.5. Reason for not check up in time of illness

Present section discusses on the reasons why people are not seeking health care, which includes problems such as cost too much, transport problem, improper road, required for household work, no proper healthcare facilities, not interested in check-up, require for work on agriculture field or family affairs, business- shop, retail shop, grocery etc. require for outside work, for payment in cash or kind.

**Table-3.3. District-wise: Reason for not check up in time of illness**

| District | Cost Too much | Too Far | Transport Problem | Improper road | Require for household work | No proper HC facility | Not interested in check-up | RA | RP | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Aizawl** | 66.7 | 25.6 | 33.3 | 35.9 | 0 | 0 | 33.3 | 0 | 0 | 100 |
| **Champhai** | 76.9 | 21.3 | 58.6 | 43.2 | 42 | 65.1 | 5.3 | 34.3 | 20.7 | 100 |
| **Kolasib** | 38.4 | 12.7 | 16.6 | 26.7 | 15.3 | 38.8 | 18.9 | 17.3 | 13.4 | 100 |
| **Lawngtlai** | 61 | 72.3 | 37.9 | 48.6 | 54.2 | 11.3 | 50.8 | 15.3 | 6.2 | 100 |
| **Lunglei** | 62.4 | 77.8 | 45 | 66.1 | 70.9 | 17.5 | 66.7 | 12.7 | 5.8 | 100 |
| **Mamit** | 69.8 | 61.3 | 62.1 | 54 | 72.2 | 58.9 | 13.3 | 45.6 | 0 | 100 |
| **Saiha** | 88.1 | 94.5 | 85.3 | 31.2 | 52.3 | 64.2 | 33.9 | 0 | 22 | 100 |
| **Serchhip** | 45.5 | 41.1 | 36.8 | 35.8 | 29.9 | 25.9 | 0.3 | 18.1 | 15.6 | 100 |
| **Mizoram** | 63.6 | 50.8 | 46.9 | 42.7 | 42.1 | 35.2 | 27.8 | 17.9 | 10.5 | 100 |

**RA= Required for work on agricultural field or family business (shops, retail shops, grocery etc.) RP= Required for outside work for payment in cash or kind**

**Source : Field survey-2016 & 2017**

Table-3.3 shows the average percent of reasons for not check-up in time of illness. Such as: cost too much (63.6 %), it's too far (50.8 %), transport problem (46.9 %), improper road (42.7 %), require for household work (42.1 %), no proper HC facilities (35.2 %), not interested in check-up 27.8, require for work on agriculture field or family, business shop, retail shop, grocery etc. (17.9 %) and require for outside work for payment in cash or kind (10.5 %).

### 3.6. Recent Health-seeking Behaviour

There are intra-district variations in the reasons why people don't go for check-up in time of illness in Mizoram. Cost too much is the biggest hurdles for Aizawl (66.7%), Champhai (76.9%) and Serchhip (45.5%) districts whereas 'too far' become the biggest problems for Lawngtlai (72.3%), Lunglei (77.8%) and Saiha (94.5%) districts.

Another major hurdle that stop people from seeking healthcare are inaccessibility, require for household work and lack of healthcare facilities. In order to validate information we collected, recent health-seeking behaviour is discussed in this section, considering health check-up during the last one year as recent.

**Table-3.4. District-wise: Visit health institution for treatment during the last 1 year**

| District | Yes | No | Total |
|---|---|---|---|
| **Aizawl** | 51.04 | 50.83 | 100 |
| **Champhai** | 59.51 | 40.49 | 100 |
| **Kolasib** | 32.5 | 67.5 | 100 |
| **Lawngtlai** | 62 | 38 | 100 |
| **Lunglei** | 51 | 49 | 100 |
| **Mamit** | 73.6 | 26.4 | 100 |
| **Saiha** | 66.9 | 33.1 | 100 |
| **Serchhip** | 32.4 | 67.6 | 100 |
| **Mizoram** | 53.6 | 46.6 | 100 |

**Source : Field survey-2016 & 2017**

Table-3.4 reveals that a good number of 53.6% visit health institution during the last one year in Mizoram while a little over 46% are not visiting health institutions. Mamit district (73.6 %) records the highest proportion of family members visiting health institution for treatment during the last one year, followed by Saiha District (66.9 %), Lawngtlai District (62 %), Champhai District (59.1 %), Lunglei District (51 %), Aizawl District (51 %), Kolasib District (32.5 %) and Serchhip District (32.4 %).

### 3.7. Consultation of health personnel

Another important aspect of health care and health-seeking behaviour is to whom the patient went for check-up. It is critical to know whether patients are consulting proper heath personnel or just traditional healers or unskilled persons.

Table-3.5 shows district-wise consultation of health personnel. A good number of 82.7% patients consulted doctor or nurse while 14.2 % consulted NM/LVM/supervisor/health worker and 12.5% consulted traditional health /DAI.

A negligible proportion of 0.1% consulted Anganwadi worker. Patients who consulted government doctors are: In Aizawl district 97.3 %, Lawngtlai district 93.9 %, Kolasib district 92.9 %, Serchhip district 88.2 %, Saiha district 80.9 %, Champhai district 76.26 %, Lunglei district 71.8 %, Mamit district 61.1 %.

Table-3.5. District-wise: Whom did you see

| District | Govt. doctor / nurse | ANM/LVH/ Supervisor/ Health worker | Traditional Healer/DAI | Anganwadi worker | Total |
|---|---|---|---|---|---|
| Aizawl | 97.3 | 2.7 | 0 | 0 | 100 |
| Champhai | 76.26 | 23.02 | 0.72 | 0 | 100 |
| Kolasib | 92.5 | 5 | 4.6 | 0 | 100 |
| Lawngtlai | 93.9 | 4.8 | 26.4 | 0.6 | 100 |
| Lunglei | 71.8 | 10.2 | 52.9 | 0 | 100 |
| Mamit | 61.1 | 50.2 | 1.8 | 0 | 100 |
| Saiha | 80.9 | 9.3 | 9.7 | 0 | 100 |
| Serchhip | 88.2 | 8.1 | 3.7 | 0 | 100 |
| Mizoram | 82.7 | 14.2 | 12.5 | 0.1 | 100 |

**Source : Field survey-2016 & 2017**

Aizawl district records the highest number of patients visiting doctor or nurse (97.3%), followed by Lawngtlai and Kolasib district whereas Mamit and Lunglei records the least percentage of patients visiting doctor or nurse. Patient who consulted ANM / LVH / supervisor / health worker are:

Mamit district 50.2 %, Champhai district 23.02%, Lunglei district 10.2%, Saiha district 9.3%, Serchhip district 8.1%, Kolasib district 5%, Lawngtlai district 4.8% and Aizawl district 2.7%.

Consultation of Traditional healer / DAI is most common in Lunglei district with 52.9 %, followed by Lawngtlai district 26.4 %, Saiha district 9. 7 %, Kolasib district 4 .6 %, Serchhip district 3.7 %, Mamit district 1.8 %, Champhai district 0.72 %, Aizawl district nil.

*Table-3.5 shows that majority of patients consulted government doctors and nurse with 82.7 %. It was followed by consultation of health workers or health supervisors (14.2 %) and traditional healers (12.5%).*

### 3.8. Performance of Service Providers

Other important parameters considered for this present study is observation of service providers by patients. The attitude and responses given by health personnel can really encourage or discourage the patient to visit again or make them reluctant in future. Table-3.6. discusses about how the hospital staff talk to the patient-whether they welcome them or not across the district.

**Table-3.6. District-wise: Did the staff talk to him/her**

| **District** | Nicely | Not nicely | Total |
|---|---|---|---|
| **Aizawl** | 89.1 | 10.9 | 100 |
| **Champhai** | 78.5 | 21.5 | 100 |
| **Kolasib** | 64.5 | 35.5 | 100 |
| **Lawngtlai** | 76.7 | 23.3 | 100 |
| **Lunglei** | 87.4 | 12.6 | 100 |
| **Mamit** | 64.7 | 35.3 | 100 |
| **Saiha** | 68.4 | 31.6 | 100 |
| **Serchhip** | 53.7 | 55.6 | 100 |
| **Mizoram** | 72.9 | 28.3 | 100 |

**Source : Field survey-2016 & 2017**

Table-3.6 depicts that a good average percentage of 72.9% talked or responded patients nicely while 28.3% did not response nicely in Mizoram. Among the districts Aizawl district records the best response to the patients (89.1 %), followed by Lunglei district (87.4 %), Champhai district (78.5 %), Lawngtlai district (76.7 %), Saiha district (68.4 %), and Mamit district (64.7 %) Kolasib district (64.5 %) and Serchhip district (53.7 %).

### 3.9. Care Givers

Inclusion of the Care Giver component in this study is mainly for understanding types of health problems and health-seeking behaviour of patients across the district. Based on what doctor or specialist they consulted, we can somewhat

understand common problems in Mizoram. The study period includes consultation of doctors during the last one year or recent health-seeking behaviour.

| **Table 3.7. District-wise; No. of patients visiting different care givers during the last one year** | | | | | | |
|---|---|---|---|---|---|---|
| **District** | Physiotherapist | Radiotherapist | Surgeon | Dietician | Stoma Nurse | Total |
| **Aizawl** | 32.95 | 36.4 | 10.23 | 7.95 | 0 | 100 |
| **Champhai** | 75.5 | 6.1 | 0 | 4.1 | 0 | 100 |
| **Kolasib** | 8.2 | 37.7 | 32.8 | 21.3 | 0 | 100 |
| **Lawngtlai** | 85.3 | 9.5 | 3.5 | 5.2 | 0 | 100 |
| **Lunglei** | 16.7 | 33.3 | 25 | 8.3 | 0 | 100 |
| **Mamit** | 78.1 | 9.8 | 4.9 | 7.3 | 0 | 100 |
| **Saiha** | 50 | 6.1 | 1.8 | 2.6 | 0.9 | 100 |
| **Serchhip** | 92.7 | 0 | 7.3 | 0 | 0 | 100 |
| **Mizoram** | 54.9 | 17.4 | 10.7 | 7.1 | 0.1 | 100 |
| **Source : Field survey-2016 & 2017** | | | | | | |

Table-3.7 shows that consultation of internist or non-specialist doctor become the most common in Mizoram with 54.9% average, followed by consultation of physiotherapist (17.4%), radiotherapist or cancer-doctor (10.7%), surgeon(10.5%), dietician (7.1%) and stoma nurse (0.1%).

Consultation of physiotherapist become common in the three district of Kolasib (37.7%), Aizawl (36.4%) and Lunglei (33.3%).This is an emerging trends and an indication of the prevalence of stressed life in the state, especially in these three districts. Physiotherapist is relatively new among the Mizo. Consultation of radiotherapist or cancer-related health personnel become most common in the same three districts of Kolasib, Lunglei and Aizawl compared with other districts while there is no record as such in the district of Champhai. Consultation of surgeon is most common in Saiha district, followed by Lunglei Kolasib and Champhai while most of them consulted internist across the district with Serchhip district topped the ranked (92.7%), followed by Lawngtlai district (85.3%), Mamit district (78.1%), Champhai district (75.5%), Saiha district (50%),

Aizawl district (32.95%), Lunglei district (16.7%) and Kolasib district (8.2%). There is no record of consultation of surgeon in the districts of Mamit, Serchhip and Kolasib.

Another interesting story is that consultation of dieticians become quite common in Mizoram compared with the last 5 or 10 years back. During that time we hardly knew about dietician in the state and especially in a medical field. However, present research reveals that a good number of people are visiting dietician, which indicates economic prosperity in one way apart from importance of balance diet diagnosis from medical point of view. The new generation tries to control their diet to prevent obesity & weight related health issues like diabetes.

### 3.10. Observation of healthcare facilities

Cleanliness is another important component that contributes for health and healthcare. Present study questioned patient's observation about cleanliness of healthcare facilities across the districts. The district-wise cleanliness of health facilities are classified as: very clean; somewhat clean, not clean and no response / don't know.

**Table-3.8. District-wise: Cleanliness of health facilities**

| District | Very Clean | Somewhat Clean | Not Clean | No response Clean | Total |
|---|---|---|---|---|---|
| **Aizawl** | 38.2 | 52.44 | 7.72 | 1.63 | 100 |
| **Champhai** | 47 | 43.44 | 7.1 | 3.01 | 100 |
| **Kolasib** | 40.2 | 50 | 8.8 | 1 | 100 |
| **Lawngtlai** | 37.4 | 52.4 | 7.2 | 3 | 100 |
| **Lunglei** | 34.1 | 55.7 | 9.3 | 0.8 | 100 |
| **Mamit** | 23.7 | 57.1 | 18.8 | 0.3 | 100 |
| **Saiha** | 36.6 | 50 | 13.4 | 0 | 100 |
| **Serchhip** | 29.6 | 50.9 | 13.9 | 5.6 | 100 |
| **Mizoram** | 35.9 | 51.5 | 10.8 | 1.9 | 100 |

**Source : Field survey-2016 & 2017**

In Mizoram 35.9% reported that healthcare facilities are very clean while 51.5% said it was somewhat clean and 10.8% reported that it was not clean. Among the eight districts Champhai district got the best observation as 47% patients reported that the healthcare facilities are very clean, followed by Kolasib (40.2%), Aizawl (38.2%) and Lawngtlai (37.4%) while Mamit district got the poorest observation of patients as only 23.7% reported healthcare facilities are very clean, followed by Serchhip with just 29.6% do the same observation. 'Somewhat clean' got highest score throughout the districts as all the district healthcare facilities got more than 50% on this regards except Champhai district.

On the other end, healthcare facilities of Mamit district got the poorest observation by patients as 18.8% observed that healthcare facilities are not clean, followed by Serchhip and Saiha with a little over 13% observed that healthcare facilities are not clean at all.

*Therefore, it can be concluded that, health care facilities in all the eight districts are 'somewhat clean' as 41.5% comment that way while Champhai district healthcare facilities are the best according to patient observation as 47% comment 'very clean' and Mamit district healthcare facilities are getting the poorest comments and observation in terms of cleanliness.*

### 3.11. Sufficiency of Healthcare Facilities

We structured questionnaires by ranking healthcare facilities status, such as adequate, poor, very poor, very good and no response. Table-3.9 gives the detail

information of the observation of family members on healthcare facilities across the state.

| **Table-3.9. District-wise: Sufficiency of government healthcare facility** | | | | | | |
|---|---|---|---|---|---|---|
| **District** | Adequate | Poor | Very Poor | Very Good | No Response | Total |
| **Aizawl** | 41.9 | 27.2 | 2.7 | 22.2 | 6.02 | 100 |
| **Champhai** | 44.7 | 36.8 | 12.7 | 1.9 | 6.6 | 100 |
| **Kolasib** | 63.7 | 31 | 3.1 | 1.8 | 0.4 | 100 |
| **Lawngtlai** | 44 | 44.4 | 8.4 | 0 | 3 | 100 |
| **Lunglei** | 32.8 | 38.8 | 3 | 22 | 3.4 | 100 |
| **Mamit** | 39.3 | 35.8 | 4.5 | 1.1 | 0 | 100 |
| **Saiha** | 41.2 | 35.9 | 15.8 | 3.7 | 1.5 | 100 |
| **Serchhip** | 32.7 | 53.5 | 15 | 0 | 0 | 100 |
| **Mizoram** | 42.5 | 37.9 | 8.2 | 6.6 | 2.6 | 100 |
| **Source : Field survey-2016 & 2017** | | | | | | |

As shown in table-3.9, in the entire eight districts a good number of people are generally feel adequate of the healthcare facilities they are getting from government health centre. Inter-district variation are also not much observed as it ranges from as low as 32% in Serchhip and Lunglei to as high as 63.7% in Kolasib district. However, another good number of them are feeling government healthcare facilities are 'poor', which ranges from as low as 27.2% in Aizawl district to as high as 53.5% in Serchhip district. The observation on 'very good' and 'very poor' are not getting much comment. As far as 'very poor' is concerned Saiha and Champhai district get maximum percentage while Aizawl and Lunglei got minimum percentage on the other hand Aizawl and Lunglei score maximum mark on 'very good' while Serchhip and Lawngtlai got zero mark on the same.

*Therefore, it can be concluded that 42 % observed that government healthcare facilities are 'adequate'; 37.9% observed as 'poor'; 8.2 % observed as 'very poor' and*

*6.6% observed as 'very good'. Healthcare facilities in Aizawl and Lunglei district got highest satisfactory level 'very good' while healthcare facilities in Saiha and Serchhip districts got least satisfactory level. However, highest number of patients across the districts feels that government healthcare facilities are 'adequate' with 42.5%.*

### 3.12. Problems of Utilizing Healthcare Facilities

Present researches also examined what are the specific problems faced by healthcare seekers in the state by offering probably reasons in the questionnaires such as- lack of equipment, medicines, poor performance of medical personal, too far, irregular doctor.

**Table-3.10. District-wise: Sufficiency of government healthcare facility**

| District | Lack of equipment, medicines | Poor performance of medical personal | Too far | No problems | Irregular Doctor | No response | Total |
|---|---|---|---|---|---|---|---|
| **Aizawl** | 10.37 | 6.02 | 2.28 | 80.91 | 0.21 | 0 | 100 |
| **Champhai** | 47.6 | 28.3 | 9.3 | 5.6 | 12.0 | 4.8 | 100 |
| **Kolasib** | 54.9 | 31.6 | 6 | 5.5 | 0.9 | 1.1 | 100 |
| **Lawngtlai** | 46.2 | 42.3 | 52.3 | 0 | 0 | 0 | 100 |
| **Lunglei** | 24.6 | 45.9 | 56.7 | 21.8 | 0.4 | 0 | 100 |
| **Mamit** | 45.5 | 42.3 | 45.1 | 36.8 | 39.8 | 0 | 100 |
| **Saiha** | 49.8 | 20.1 | 29.4 | 0 | 1.5 | 0 | 100 |
| **Serchhip** | 16.2 | 59.2 | 39.3 | 0 | 0 | 0 | 100 |
| **Mizoram** | 36.9 | 34.5 | 30.0 | 18.8 | 6.8 | 0.7 | 100 |

**Source : Field survey-2016 & 2017**

As shown in table-3.10, there are three major constrains faced by healthcare seekers across the state of Mizoram, such as lack of equipment/medicines(36.9%), performance of medical personal (34.5%) and healthcare facilities are too far (30%). There are differences in the type of problems faced by different districts. For example: lack of equipment/medicines become the biggest problems for Aizawl, Champhai,

Kolasib and Saiha district whereas poor performance of medical personal become the biggest hurdles for Serchhip and on the other hand 'too far' become the most pertinent problems for Lawngtlai, Lunglei, and Mamit districts (table-3.10).

*This study reveals that there are three major constrains faced by healthcare seeker across the state of Mizoram, such as lack of equipment/medicines (36.9%), poor performance of medical personal (34.5%) and healthcare facilities are too far (30%). However, the types of problems faced by various districts are again differed from one another.*

### 3.13. Common Diseases

Present study questioned about the common diseases or health problems faced by family members to identify prevalence of common diseases in Mizoram. There are 24 common health problems identified during the survey.

Table-3.11 shows that Cough and fever (80.1%) become the most common disease suffered by family members in Mizoram, followed by Kidney problem (31.0%), Ulcer (17.2%), Cancer (10.2 %), Malaria (7.3 %), Nerve problem (6.9%), Polio (6.5 %), Liver pain (6.1%), Asthma (5.6 %), T.B (4.2 %), Diabetes (4.2%), Diarrhea (3.8 %), Goiter (2.6%), Jaundice (2.1%), Pneumonia (1.1%), Hepatitis (1.1%), Deafness (0.6%), Blindness (0.5%), Typhoid (0.5%), Septicemia (0.4%) and Stroke (0.3%).

**Table-3.11. Which is the most common disease suffered by your family**

| Disease | Aizawl District | Champhai District | Kolasib District | Lawngtlai District | Lunglei District | Mamit District | Saiha District | Serchhip District | Mizoram |
|---|---|---|---|---|---|---|---|---|---|
| **Cough & Fever** | 70.92 | 95.86 | 55.8 | 93.6 | 88.2 | 87.1 | 82.8 | 66.3 | 80.1 |
| **Kidney problem** | 2.37 | 42.94 | 7.5 | 65.9 | 70.7 | 23.4 | 19.3 | 16 | 31.0 |
| **Ulcer** | 1.78 | 2.64 | 11.5 | 38 | 40.7 | 14.3 | 16.6 | 12 | 17.2 |
| **Cancer** | 0.59 | 9.6 | 6.9 | 22.3 | 11.8 | 11.3 | 10.4 | 8.4 | 10.2 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Malaria** | 2.37 | 4.14 | 5.8 | 19.7 | 2.9 | 15.2 | 4.7 | 3.8 | 7.3 |
| **Nerve problem** | 0.3 | 0.56 | 0 | 20.9 | 25.1 | 1.8 | 1.5 | 5.2 | 6.9 |
| **Polio** | 0 | 0 | 51.8 | 0 | 0 | 0 | 0 | 0 | 6.5 |
| **Liver pain** | 5.04 | 7.16 | 5.5 | 12.4 | 7.5 | 7.1 | 0 | 3.8 | 6.1 |
| **Asthma** | 4.15 | 2.26 | 1.5 | 16.1 | 7.9 | 3 | 3.3 | 6.5 | 5.6 |
| **TB** | 1.19 | 0.75 | 3.8 | 14.9 | 0.2 | 5.7 | 3.9 | 3.3 | 4.2 |
| **Diabetes** | 3.86 | 5.27 | 0.2 | 7 | 5.4 | 4.1 | 1.5 | 6 | 4.2 |
| **Diarrhea** | | 1.32 | 0 | 12.9 | 0 | 9.4 | 0 | 2.7 | 3.8 |
| **Goiter** | 0.59 | 0 | 19.7 | 0 | 0.2 | 0 | 0 | 0 | 2.6 |
| **Jaundice** | 2.08 | 2.26 | 0 | 7.6 | 0 | 2.1 | 3 | 0 | 2.1 |
| **Pneumonia** | 0 | 0 | 0 | 4 | 2.1 | 0.9 | 1.8 | 0.3 | 1.1 |
| **Hepatitis** | 0 | 0 | 0 | 8.4 | 0.2 | 0 | 0 | 0 | 1.1 |
| **Deafness** | 0.3 | 0 | 4.2 | 0 | 0 | 0 | 0.3 | 0 | 0.6 |
| **Blindness** | 0.3 | 0 | 3.8 | 0 | 0 | 0 | 0 | 0 | 0.5 |
| **Typhoid** | 0 | 0 | 2.7 | 0 | 0 | 0.5 | 0.6 | 0 | 0.5 |
| **Septicemia** | 0.3 | 0 | 0 | 0 | 0.4 | 0.9 | 0.9 | 0.3 | 0.4 |
| **Stroke** | 0.59 | 0 | 0 | 0 | 1.5 | 0 | 0.3 | 0 | 0.3 |
| **Total** | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 |
| **Source : Field survey-( 2016 & 2017)** | | | | | | | | | |

*It is interesting to find out that cough and fever is most common diseases with 80 %, followed by kidney problem (31 %), Ulcer (17.2%), Cancer (10.2%), Malaria (7.3%) and Nerves problems (6.9%). Apart from this, Kidney problems, Ulcer and Nerve problems are unusually high in Lawngtlai and Lunglei districts compared with other districts of Mizoram while Asthma and TB are also disproportionately high in Lawngtlai district compared with other districts.*

### 3.14. Prevalence of Death

Knowledge about prevalence of death is important to identify reasons of death as well as patient's health-seeking behaviour. Table-3.12 reveals that 23.4% families in Mizoram already experienced death of their family members while a fairly good number of 77% reported of not experiencing any death in family.

| Table-3.12. District-wise: Is there anyone of your family member died | | | |
|---|---|---|---|
| **District** | Yes | No | Total |
| **Aizawl** | 21.16 | 78.84 | 100 |
| **Champhai** | 17.7 | 86.06 | 100 |
| **Kolasib** | 17.5 | 83.4 | 100 |
| **Lawngtlai** | 31.7 | 68.3 | 100 |
| **Lunglei** | 19.9 | 80.1 | 100 |
| **Mamit** | 28 | 72 | 100 |
| **Saiha** | 26.3 | 73.7 | 100 |
| **Serchhip** | 24.9 | 75.1 | 100 |
| **Mizoram** | 23.4 | 77.2 | 100 |
| **Source : Field survey- 2016 & 2017** | | | |

*Among the eight districts of Mizoram-Lawngtlai district records highest number of death (31.7%), followed by Mamit (28%), Saiha (26.3%), Serchhip (24.9%), Aizawl (21.5%), Lunglei (19.9%), Champhai (17.7%) and Kolasib (17.5%) districts.*

### 3.15. Reason of Death

We already discussed common diseases in the previous section. Present section is to identify reasons of death and what are their relationships with common diseases. It is expected that most common diseases might be the commonest cause of death. There are 18 types of reasons of death identify in this study.

Table-3.13 shows that Cancer (34.5%) is the most common diseases suffered by Mizoram, followed by Liver pain (7.8%), Malaria (7.3%), Pneumonia (4.6%), Jaundice (4.5%, ), Accident (4.5%), Asthma (3.9%), Ulcer (3.8%), Septicemia (3.0%), Kidney problem (2.9%), Stroke (2.9%), Internal bleeding (2.5%), Cough and fever (1.3%), Old age (1.0%), Diabetes (0.9%), T.B (0.7%), Typhoid (0.4%) and Seizure (0.1%).

| Table- 3.13. Mizoram: District-wise: Reason of family member who died | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Reason of death** | Aizawl District | Champhai District | Kolasib District | Lawngtlai District | Lunglei District | Mamit District | Saiha District | Serchhip District | Mizoram |
| **Cancer** | 21.53 | 40.43 | 35.4 | 39.6 | 57.3 | 33.1 | 26.3 | 22.7 | 34.5 |
| **Liver pain** | 18.75 | 3.19 | 2.5 | 15.7 | 3.1 | 10.5 | 1.8 | 6.6 | 7.8 |
| **Malaria** | 5.56 | 1.06 | 13.9 | 10.1 | 7.3 | 18 | 0.9 | 1.4 | 7.3 |
| **Pneumonia** | 2.78 | 1.06 | 0 | 9.4 | 10.4 | 6 | 5.3 | 1.9 | 4.6 |
| **Jaundice** | 2.78 | 9.57 | 1.3 | 8.8 | 1 | 8.3 | 4.4 | 0 | 4.5 |
| **Accident** | 5.56 | 3.19 | 16.5 | 4.4 | 1 | 3.8 | 0.9 | 0.5 | 4.5 |
| **Asthma** | 3.47 | 9.57 | 0 | 4.4 | 6.3 | 3.8 | 2.6 | 0.9 | 3.9 |
| **Ulcer** | 3.47 | 6.38 | 3.8 | 0 | 1 | 0 | 13.2 | 2.4 | 3.8 |
| **Septicemia** | 2.78 | 3.19 | 5.1 | 5 | 2.1 | 3 | 2.6 | 0.5 | 3.0 |
| **Kidney problem** | 2.08 | 6.38 | 6.3 | 1.3 | 1 | 3 | 3.5 | 0 | 2.9 |
| **Stroke** | 5.56 | 2.13 | 6.3 | 0.6 | 6.3 | 1.5 | 0.9 | 0 | 2.9 |
| **Internal bleeding** | 7.64 | 1.06 | 5.1 | 0 | 0 | 0 | 6.1 | 0 | 2.5 |
| **Cough &Fever** | 0 | 8.51 | 0 | 0 | 0 | 0 | 1.8 | 0 | 1.3 |
| **Old age** | 5.56 | 0 | 0 | 0 | 2.1 | 0 | 0 | 0 | 1.0 |
| **Diabetes** | 1.39 | 0 | 0 | 0.6 | 1 | 0 | 2.6 | 1.9 | 0.9 |
| **TB** | 0.69 | 1.06 | 3.8 | 0 | 0 | 0 | 0 | 0 | 0.7 |
| **Typhoid** | 0.69 | | 0 | 0 | 0 | 0.8 | 0.9 | 0.5 | 0.4 |
| **Seizure** | 0 | 1.06 | 0 | 0 | 0 | 0 | 0 | 0 | 0.1 |
| **Total** | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | | | | | | |

*Therefore, present study uncovered that cancer become the most common reasons of death among family members (34.5 %) followed by Liver pain (7.8 %), Malaria (7.3 %), Pneumonia (4.6%) and Jaundice (4.5 %).*

### 3.16. Place of Death

Place of death reflect health-seeking behaviour of people except accidental death. Hospital death shows that family members are seeking healthcare, however, home death doesn't necessarily means that the person is not visiting healthcare.

| Table-3.14.District-wise: Place of Family members died | | | | |
|---|---|---|---|---|
| **District** | Home | Hospital | Other | Total |
| **Aizawl** | 30.77 | 59.23 | 10 | 100 |
| **Champhai** | 42.55 | 52.13 | 5.32 | 100 |
| **Kolasib** | 26.6 | 60.8 | 12.7 | 100 |
| **Lawngtlai** | 39.6 | 56.6 | 3.8 | 100 |
| **Lunglei** | 79.2 | 18.8 | 2.1 | 100 |
| **Mamit** | 67.2 | 28.7 | 4.1 | 100 |
| **Saiha** | 62.4 | 34.1 | 3.5 | 100 |
| **Serchhip** | 43.4 | 49.4 | 7.2 | 100 |
| **Mizoram** | 49.0 | 45.0 | 6.1 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | |

Table-3.14 reveals that family members died at Home (49.0%) is more common than those that died at the Hospital (45.0%). The average numbers of family members died at home are exclusively high in the three districts of Lunglei (79.2%), Mamit (67.2%) and Saiha (62.4%) compared with the remaining districts. On the other hand, Kolasib (60.8%), Aizawl (59.23%) Lawngtlai (56.6%) and Champhai (52.1%) districts are having relatively more number of family members that died in the hospital.

### 3.17. Health-seeking Behaviour

To specifically know the prevalence of health-seeking behaviour, present research make an enquiry on whether family members visit healthcare facilities or not before he/ she dies.

| **Table-3.15. District-wise: Family members visit hospital** for **treatment before he / she die** | | | |
|---|---|---|---|
| **District** | Yes | No | Total |
| **Aizawl** | 74.62 | 25.38 | 100 |
| **Champhai** | 79.63 | 94.44 | 100 |
| **Kolasib** | 59.5 | 40.5 | 100 |
| **Lawngtlai** | 44.7 | 55.3 | 100 |
| **Lunglei** | 29.2 | 70.8 | 100 |
| **Mamit** | 31.1 | 68.9 | 100 |
| **Saiha** | 53.4 | 43.2 | 100 |
| **Serchhip** | 66.3 | 33.7 | 100 |
| **Mizoram** | 54.8 | 54.0 | 100 |
| **Source : Field survey- 2016 & 2017** | | | |

Table-3.15 shows that more number of families in Mizoram visit health facilities before family members died (54.8%). The number of family members visited hospital before deaths in different districts of Mizoram are: Champhai (9.63%), Aizawl (74.62%), Serchhip (66.3 %), Kolasib (59.5%), Saiha (53.4%), Lawngtlai (44.7%), Mamit (31.1%) and Lunglei (29.2%).

The family members who do not visited hospital for treatment before he / she die are high in Lunglei (70.8%), Mamit (68.9%), Lawngtlai (55.3%), Saiha (43.2%), Kolasib (40.5%), Aizawl (25.38%) and Champhai (20.37%).

*Therefore, the number of family members who visited hospital for treatment before family member die in Mizoram (54.8 %) is higher than those who do not visit hospital before family member die (45.2%). Among the districts, Champhai (79.63%) and Aizawl (74.62%) record the highest proportion of visiting hospital before family member die. On the other hand Lunglei (70.8%) and Mamit (68.9%) districts records the highest number of family members who do not visit hospital before family member die.*

**3.18. Number of Times Visit Health Institution by Patient**

This section is supplementing the above analysis of family members visiting health institution before he/ she dies**.** However, finding out the number of times the person visit health institution before he / she dies may not make much sense as it will depend on the seriousness of the health problems suffered by individual, types of diseases, financial position, availability of healthcare facilities and location as well. This information, however, will give the general pictures of the health-seeking behaviour of patients.

| Table-3.15.District-wise: Place of Family members Died | | | | | | | |
|---|---|---|---|---|---|---|---|
| **District** | 1 time | 2 times | 3 times | 4 times | 5 times | More Than 5 | Total |
| **Aizawl** | 7.52 | 18.8 | 18.05 | 21.8 | 5.26 | 13.53 | 100 |
| **Champhai** | 9.3 | 34.88 | 23.26 | 13.95 | 4.65 | 0 | 100 |
| **Kolasib** | 8.3 | 16.7 | 0 | 16.7 | 8.3 | 50 | 100 |
| **Lawngtlai** | 22.2 | 28.9 | 22.2 | 13.3 | 11.1 | 2.2 | 100 |
| **Lunglei** | 11.1 | 22.2 | 16.7 | 22.2 | 22.2 | 5.6 | 100 |
| **Mamit** | 27 | 16.2 | 16.2 | 16.2 | 8.1 | 16.2 | 100 |
| **Saiha** | 12.5 | 21.9 | 25 | 6.3 | 12.5 | 21.9 | 100 |
| **Serchhip** | 12.7 | 32.7 | 21.8 | 10.9 | 10.9 | 10.9 | 100 |
| **Mizoram** | 13.8 | 24.0 | 17.9 | 15.2 | 10.4 | 15.0 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | | | | |

Table-3.15. shows that visiting healthcare facilities two times (24%) is the most common one in Mizoram followed by three times (17.9%), four times (15.2%), more than five times (15 %, one time (13.8 %). However, there is inter variations on number of times visited hospital by patients.

### 3.19. Reasons for not visiting Health Institution

The above section discussed the regularity of visiting why patients are not visiting health institutions, whether because of poverty/no money or because healthcare facilities are too far or because of ignorance or just because of health institution by patients. On the other hand present section examines delayed treatment. It is also necessary to clarify that the reasons are in many cases multiple reasons rather than a single reason.

| Table-3.16. District-wise: Reasons for visiting health institution by patient | | | | | | |
|---|---|---|---|---|---|---|
| **District** | No Money | Too far | Ignorance | Delay treatment | No response | Total |
| **Aizawl** | 33.33 | 2.22 | 35.56 | 28.89 | 0 | 100 |
| **Champhai** | 47.06 | 17.65 | 17.65 | 17.65 | 0 | 100 |
| **Kolasib** | 52.2 | 26.1 | 26.1 | 4.3 | 0 | 100 |
| **Lawngtlai** | 42.1 | 34.2 | 19.3 | 20.2 | 1.7 | 100 |
| **Lunglei** | 91.2 | 61.8 | 44.1 | 22.1 | 0 | 100 |
| **Mamit** | 71.4 | 47.6 | 32.1 | 22.6 | 0 | 100 |
| **Saiha** | 60 | 28.3 | 3.3 | 20 | 0 | 100 |
| **Serchhip** | 67.9 | 25 | 39.3 | 7.1 | 0 | 100 |
| **Mizoram** | 58.1 | 30.4 | 27.2 | 17.9 | 0.21 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | | | |

Table-3.16. depicts the district wise reasons for not visiting health institution by patients. Among the reasons-poverty or no money became the most problematic cause (58.1%), followed by too far (30.4%), ignorance (27.2%), delay treatment (17.9%) and no response (3.8%).

*It can be concluded that poverty is the main reasons that stop patient to visit health care facilities, followed by spatial distance of heath care facility and ignorance of the people in Mizoram*

### 3.20. Recent Health-seeking Behaviour

Health seeking behaviour during the life time and recent behaviour can be differed from place to place and by individual due to Question was simply asked whether family members were hospitalized during the last one year. Table-3.17 shows that the number of family members hospitalized during the last 1 year.

**Table-3.17. District-wise: Family members hospitalized during Last 1 year**

| District | Yes | No | Total |
|---|---|---|---|
| **Aizawl** | 23.55 | 76.45 | 100 |
| **Champhai** | 14.69 | 85.31 | 100 |
| **Kolasib** | 18.4 | 81.6 | 100 |
| **Lawngtlai** | 16.7 | 83.3 | 100 |
| **Lunglei** | 15.6 | 84.4 | 100 |
| **Mamit** | 8 | 92 | 100 |
| **Saiha** | 20.7 | 79.3 | 100 |
| **Serchhip** | 38.1 | 61.9 | 100 |
| **Mizoram** | 19.5 | 80.5 | 100 |

**Source : Field survey- 2016 & 2017**

The district-wise numbers of family member hospitalized during the last year were as follow: Serchhip (38.1%), Aizawl (23.55%), Saiha (20.7%), Kolasib (18.4%),

Lawngtlai (16.7%), Lunglei (15.6%), Champhai (14.69%) and Mamit (8%) districts. Present section considered only recent health-seeking behaviour of family members to validate information collected.

*Therefore, the number of family members hospitalized during the last one year are highest in Serchhip district (38.1%),followed by Aizawl (23.55 %) and Saiha (20.7%) districts while Champhai, Lunglei and Lawngtlai records highest number of family members not hospitalized during the last one year. The average percentage of family members hospitalized during the last one year in Mizoram is 19.5%.*

### 3.21. Place of Health-seeking Behaviour

Place of health-seeking is another important factors that shows the attitude of each health seekers. It depends on the availability of healthcare facilities, economic status and various other factors.

**Table-3.18. District-wise: Mizoram: District-wise: Place of healthcare sought by patients**

| District | Govt. .hospital | Private Hospital | PHC/ CHC | Non respondents | Other home | Private Clinic | Sub-centre | Home | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Aizawl** | 67.27 | 26.36 | 0.91 | 3.36 | 0 | 1.82 | 0 | 0 | 100 |
| **Champhai** | 53.9 | 15.4 | 29.5 | 0.0 | 0.0 | 0 | 1.3 | 0.0 | 100 |
| **Kolasib** | 83.1 | 16.9 | 0 | 0 | 0 | 0 | 0 | 0 | 100 |
| **Lawngtlai** | 65.2 | 39.3 | 6.3 | 1.82 | 24.1 | 0 | 13.4 | 4.5 | 100 |
| **Lunglei** | 70.7 | 13.3 | 2.7 | 0 | 0 | 13.3 | 0 | 0 | 100 |
| **Mamit** | 71.4 | 25.7 | 0 | 0 | 0 | 2.9 | 0 | 0 | 100 |
| **Saiha** | 68.7 | 13.4 | 13.4 | 0 | 0 | 0 | 0 | 4.5 | 100 |
| **Serchhip** | 46.5 | 8.7 | 17.3 | 27.6 | 0 | 0 | 0 | 0 | 100 |
| **Mizoram** | 65.8 | 19.9 | 8.8 | 3.9 | 3.0 | 2.3 | 1.8 | 1.1 | 100 |

**Source : Field survey- 2016 & 2017**

Table-3.18 reveals district-wise comparison of place of healthcare sought by patient. It can be easily noticed that majority of Mizoram population sought healthcare

from government hospital with 65.8% while another 19.9% sought healthcare from private hospital and the remaining people sought healthcare from other places like PHC, CHC, Private clinic and health sub-center.

### 3.22. Problems of Health-seeking Behaviour

Identification of problems that prevent people to seek healthcare is extremely important to solve their problems and to make policy for government and individual. When asking people why they do not seek healthcare their responses are-not necessary, cost too much, better care at home, too far, transport problem, lack of knowledge and poor quality of healthcare facilities (table-3.19).

**Table-3.19. Districts-wise: Reasons not sought for healthcare**

| District | Not necessary | Cost too much | Better care at home | Too far | Transport problem | Lack of knowledge | Poor quality service | Total |
|---|---|---|---|---|---|---|---|---|
| **Aizawl** | 83.9 | 8.9 | 3.9 | 0 | 0 | 1.67 | 0 | 100 |
| **Champhai** | 85.5 | 3.0 | 00 | 0 | 0 | 0 | 4.7 | 100 |
| **Kolasib** | 62.7 | 27.1 | 0 | 5.1 | 5.1 | 0 | 0 | 100 |
| **Lawngtlai** | 60.9 | 27.2 | 0 | 31.8 | 16.1 | 7.7 | 20.8 | 100 |
| **Lunglei** | 28.6 | 68.7 | 65.3 | 41.8 | 48.1 | 16.2 | 0 | 100 |
| **Mamit** | 67.2 | 8.5 | 12.2 | 0 | 7.7 | 2.7 | 0 | 100 |
| **Saiha** | 59.8 | 13.9 | 21.6 | 12.8 | 11.5 | 0.7 | 0 | 100 |
| **Serchhip** | 43.7 | 22.3 | 26.9 | 15.9 | 9.4 | 1.9 | 0.3 | 100 |
| **Mizoram** | 61.5 | 22.5 | 16.2 | 14.7 | 12.2 | 3.9 | 3.2 | 100 |

**Source : Field survey- 2016 & 2017**

Table-3.19 shows inter-district variations on the reasons for not seeking healthcare. Majority of them reported that it is not necessary (61.5%) while a little over 22% said that the cost is too much and16.2%, reported better care at home while 14.7 % reported too far and 12.2% of them cited transport problem.

*Therefore, there are many factors preventing people to seek healthcare and out of which, poverty is the main reason, followed by better care at home, distance and transport problems.*

### 3.23. Awareness of Government Healthcare Scheme

Government policy of healthcare scheme can be a booster for healthcare seeker if they know the scheme thoroughly. Awareness is the first step to deliver goods and services in the society.

**Table-3.20. Mizoram: District-wise: Do you know Govt. healthcare schemes**

| District | Yes | No | Total |
|---|---|---|---|
| **Aizawl** | 89.2 | 10.8 | 100 |
| **Champhai** | 92.28 | 19.02 | 100 |
| **Kolasib** | 96.5 | 3.3 | 100 |
| **Lawngtlai** | 97.4 | 2.6 | 100 |
| **Lunglei** | 95.4 | 4.6 | 100 |
| **Mamit** | 64.4 | 35.4 | 100 |
| **Saiha** | 91.3 | 8.7 | 100 |
| **Serchhip** | 97.3 | 2.7 | 100 |
| **Mizoram** | 90.5 | 10.9 | 100 |

**Source : Field survey- 2016 & 2017**

Table-3.20 shows the district-wise knowledge of healthcare scheme in Mizoram. Awareness level of government healthcare scheme is so much all over the state with more than 90% people being aware of it. Awareness levels in the eight districts of Mizoram are as follows: Lawngtlai (97.4%), Serchhip (97.3%), Kolasib (96.5%), Lunglei (95.4%), Champhai (92.28%), Saiha (91.3%), Aizawl (89.2%) and Mamit (64.4%) districts.

### 3.24. Availing Government Healthcare Scheme

Merely awareness may not help healthcare seekers. This section analyses number of family availing government healthcare scheme.

| Table-3.21. District-wise: No. of family who availed Govt. healthcare scheme | | | |
|---|---|---|---|
| **District** | Yes | No | Total |
| **Aizawl** | 21 | 78.4 | 100 |
| **Champhai** | 7.04 | 92.96 | 100 |
| **Kolasib** | 29.4 | 70.6 | 100 |
| **Lawngtlai** | 5.4 | 57.3 | 100 |
| **Lunglei** | 5.7 | 94.3 | 100 |
| **Mamit** | 4.8 | 72.2 | 100 |
| **Saiha** | 13.8 | 86.2 | 100 |
| **Serchhip** | 24.9 | 75.1 | 100 |
| **Mizoram** | 14 | 78.4 | 100 |
| **Source : Field survey- 2016 & 2017** | | | |

Table-3.21 shows great inter-district variations on the number of families availing government healthcare scheme. Number of family availing government healthcare scheme across the districts ranges from as many as 29.4% in Kolasib district to as low as 4.8% in Mamit district. The extent of inter-district variations in detail is as follow: Kolasib (29.4%), Serchhip (24.9%), Aizawl (21.0%), Saiha (13.8%), Champhai (7.04%), Lunglei (5.7%), Lawngtlai (5.4%) and Mamit (4.8%) districts.

*Present research therefore reveals that only 14% families are availing healthcare scheme in Mizoram and 78.4% are not availing the scheme. Therefore, it exist great variation on the number of families availing government scheme, which ranges from as many as 29.4% in Kolasib district to as low as 4.8% in Mamit district.*

### 3.25. Awareness of child healthcare

This section is an attempt to study maternal and child healthcare in Mizoram. If family is having Immunization card for children, they are considered as taking vaccine and vice-versa.

| Table- 3.22. Mizoram: District-wise: Any Immunization card for your child | | | | |
|---|---|---|---|---|
| **District** | Yes | No | No children | Total |
| **Aizawl** | 89.4 | 2.5 | 8.1 | 100 |
| **Champhai** | 95.2 | 3.5 | 2.5 | 100 |
| **Kolasib** | 87.2 | 5.5 | 7.3 | 100 |
| **Lawngtlai** | 93.2 | 4.8 | 2 | 100 |
| **Lunglei** | 73.9 | 10 | 21.6 | 100 |
| **Mamit** | 71.6 | 10 | 0.6 | 100 |
| **Saiha** | 83.6 | 14.9 | 1.5 | 100 |
| **Serchhip** | 96 | 4 | 16.8 | 100 |
| **Mizoram** | 86.3 | 6.7 | 7.5 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | |

Table-3.22 shows the district- wise Immunization card for child healthcare in Mizoram. Out of eight districts Serchhip scored highest number of family having vaccination card (96%), followed by Champhai (95.2%), Lawngtlai (93.2%),Aizawl (89.4%), Kolasib (87.2%), Saiha (83.6%), Lunglei (73.9%) and Mamit (71.6%) districts.

*The overall performance of giving* Immunization *card for children in Mizoram is somewhat good as more than 86% reported of having it. Serchhip (96%) topped the ranked and Mamit (71.6%) at the lowest ranked.*

### 3.26. Place of delivery

Place of delivery of new born baby is another indicator of maternal health-seeking behaviour. Government of India suggested work for 100% institutional delivery for the last couple of years. This section includes place of delivery during the life time of mother. Table-3.23 shows that institutional delivery do not much varied across the districts, which range from 70.5% in Lawngtlai district to 93.14% in Aizawl district.

On the other hand home delivery is also quite common in Mizoram with much more variations among the districts, which vary from as low as 5.3% in Champhai district to as high as 29.5% in Lawngtlai district.

| Table-3.23.Mizoram:District-wise: Place of delivery | | | |
|---|---|---|---|
| **District** | Institution | Home delivery | Total |
| **Aizawl** | 93.14 | 6.86 | 100 |
| **Champhai** | 94.7 | 5.3 | 100 |
| **Kolasib** | 78.3 | 13.6 | 100 |
| **Lawngtlai** | 70.5 | 29.5 | 100 |
| **Lunglei** | 73.3 | 26.7 | 100 |
| **Mamit** | 76.4 | 23.6 | 100 |
| **Saiha** | 77.3 | 22.7 | 100 |
| **Serchhip** | 75.6 | 24.5 | 100 |
| **Mizoram** | 79.9 | 19.1 | 100 |
| **Source : Field survey- 2016 & 2017** | | | |

The detail information of various districts on institutional delivery is: Champhai (94.7%), Aizawl (93.14%), Kolasib (78.3%), Saiha (77.3%), Mamit (76.4%), Serchhip (75.6%) and Lawngtlai (70.5%) districts.

*Therefore, institutional delivery in Mizoram is fairly high with the average percentage of 79.9% while home delivery is also still common with the state average of 19.1%. Inter-district disparities on institutional delivery are not much while disparities on home delivery across the districts are quite visible.*

### *3.26.1. Recent Place of Delivery*

Recent information on place of delivery is validating the information collected as up-to-date is always important to know the present status. Therefore, present section focuses only on the last delivery of the mother. Table-3.24. shows last birth delivery in the hospital. There is a glaring inter-district variation on both institutional delivery and

home delivery while institutional delivery is quite common than home delivery in Mizoram.

| Table- 3.24. Mizoram: District-wise: Does your last birth delivered in the hospital | | | | |
|---|---|---|---|---|
| **District** | Yes | No | No children | Total |
| **Aizawl** | 97.8 | 2.2 | 0 | 100 |
| **Champhai** | 95.4 | 3.6 | 1.0 | 100 |
| **Kolasib** | 93 | 2.6 | 7.7 | 100 |
| **Lawngtlai** | 66.5 | 33.5 | 0 | 100 |
| **Lunglei** | 36.3 | 63.7 | 0 | 100 |
| **Mamit** | 68.3 | 31.7 | 0 | 100 |
| **Saiha** | 74.6 | 25.4 | 0 | 100 |
| **Serchhip** | 89.2 | 10.8 | 0 | 100 |
| **Mizoram** | 77.6 | 21.7 | 1.1 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | |

The detail of inter-district variations of institutional delivery is as follows: Aizawl (97.8%), Champhai (95.4%), Kolasib (93%), Serchhip (89.2%), Saiha (74.6%), Mamit (68.3%), Lawngtlai (66.5%) and Lunglei (36.3%) districts.

*Therefore, present research finds out that institutional delivery is quite common in Mizoram (77.6%) while a good number of mothers still practice home delivery (21.7%). There is a huge inter-district variation on home delivery while the variation is lesser in the case of institutional delivery as far as recent birth is concerned.*

### 3.27. Problems of Maternal Health-seeking

As stated earlier there are some mothers who delivered their baby at home. Present section identifies the reasons why these mothers are not delivering their baby at health institution. Is it because they Preferred to deliver at home or hospital is too far or healthcare facilities are not available or due to poverty etc. *Out of the six possible*

*reasons, prefer to have at home got maximum score with 47.8%, followed by too far (20.0%), healthcare facility not available (18.7%), no medical personal at home (12.1%) and no money (7.9%).*

**Table- 3.25. Aizawl: Reasons not delivered in the hospital**

| District | Prefer to have at home | Too far | Healthcare facility Not available | No Medical personnel | Medical personal at home | No Money | Total |
|---|---|---|---|---|---|---|---|
| **Aizawl** | 74.5 | 0 | 0 | 12.8 | 12.8 | 0.0 | 100 |
| **Champhai** | 8.5 | 14.9 | 55.3 | 14.9 | 4.3 | 2.5 | 100 |
| **Kolasib** | 61.5 | 5.1 | 0 | 10.3 | 23.1 | 0 | 100 |
| **Lawngtlai** | 41.4 | 33.6 | 14.8 | 9.4 | 0.8 | 0 | 100 |
| **Lunglei** | 44.4 | 49.0 | 23.4 | 17.2 | 1.1 | 0.0 | 100 |
| **Mamit** | 47.8 | 10.9 | 10.1 | 31.2 | 8 | 12.3 | 100 |
| **Saiha** | 26.8 | 43.9 | 37.8 | 1.2 | 13.4 | 42.7 | 100 |
| **Serchhip** | 77.8 | 2.8 | 8.3 | 0 | 5.6 | 5.6 | 100 |
| **Mizoram** | 47.8 | 20.0 | 18.7 | 12.1 | 8.6 | 7.9 | 100 |

**Source : Field survey- 2016 & 2017**

Types of problems are different from one district to another. For example: For Aizawl and Serchhip districts ‘prefer to have at home’ become the main reason for mother not delivering their baby in the hospital whereas ‘too far’ and ‘healthcare facility not available’ are not problems at all for Aizawl and ‘no medical personnel’ is not a problem for Serchhip district.

Similarly, for Saiha district ‘poverty’ becomes one of the biggest reasons preventing a mother to deliver her baby in the hospital while it is not at all the case for districts like Aizawl, Kolasib, Lawngtlai and Lunglei.

### 3.28. Postnatal checkup

Study on maternal healthcare is not complete without inclusion of postnatal care. Generally mothers are supposed to go regularly for check-up after delivery even without having delivery related complications. It is evident from table-3.26 that postnatal check-up is fairly high in Mizoram (74.8%) while good number of mothers (24.2%) still not went for postnatal check-up. Among the districts-Aizawl and Champhai records maximum proportion of mother going for postnatal check-up with over 90% while Mamit (46%) and Lunglei (52.2%) record the least number doing the same.

**Table- 3.26. Mizoram: District-wise: Did you/the child receive any check-up after delivery**

| District | Yes | No | No Children | Total |
|---|---|---|---|---|
| **Aizawl** | 90.9 | 9.1 | 0 | 100 |
| **Champhai** | 90 | 7.7 | 1 | 100 |
| **Kolasib** | 76.9 | 17.3 | 7.4 | 100 |
| **Lawngtlai** | 82.2 | 17.8 | 0 | 100 |
| **Lunglei** | 52.2 | 47.8 | 0 | 100 |
| **Mamit** | 46 | 54 | 0 | 100 |
| **Saiha** | 70.6 | 29.4 | 0 | 100 |
| **Serchhip** | 89.5 | 10.5 | 0 | 100 |
| **Mizoram** | 74.8 | 24.2 | 1 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | |

The detail information of postnatal check-up in various districts are as follow: Aizawl (90.9%), Champhai (90.9%), Serchhip (89.5%), Lawngtlai (82.2%), Kolasib (76.9%), Saiha (70.6%), Lunglei (52.2%) and Mamit (46%) districts.

#### *3.28.1. Place of postnatal care*

Place of postnatal care is another important indicator of mother's health-seeking behaviour. Initially question included 'home care' – seeking postnatal care at home. However, it was found out that nobody seeks postnatal care at home and therefore, it was excluded from the table.

| Table- 3.27. District-wise: Place of postnatal care | | | | | |
|---|---|---|---|---|---|
| **District** | Govt. Hospital | PHC | Private Clinic | Sub-center | Total |
| **Aizawl** | 77.8 | 0 | 13.6 | 8.5 | 100 |
| **Champhai** | 29.15 | 10 | 9.79 | 51.06 | 100 |
| **Kolasib** | 46.1 | 0 | 1.4 | 52.5 | 100 |
| **Lawngtlai** | 5.6 | 45.9 | 25.1 | 14.5 | 100 |
| **Lunglei** | 17.8 | 4.7 | 50.5 | 3.3 | 100 |
| **Mamit** | 18.5 | 66.5 | 14 | 1 | 100 |
| **Saiha** | 5.7 | 61.5 | 28.9 | 3.9 | 100 |
| **Serchhip** | 24.8 | 36.6 | 80.9 | 2.7 | 100 |
| **Mizoram** | 28.2 | 28.1 | 28.0 | 17.2 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | | |

The district-wise places of postnatal care are classified in to government hospital, PHC, private clinic, sub-center. It is interesting to explore that there are equal proportionate share among places of postnatal care like government hospital, PHC and private clinic with 28 % average. Apart from hospital, postnatal care is also common at sub-center with an average of 17.2%. There is an inter-district disparity at the place of postnatal care.

It appears from table-3.27 that place of postnatal care mainly depends on the type of availability of health care institution. If there is no hospital, mother went to PHC and if PHC is not available mother went to sub-center so on and so forth.

### *3.28.2. Promptness for Postnatal Check-up*

How soon mother went for check-up after delivery is another important indicator of mother's health-seeking behaviour. It may also depend on delivery complications of mother and the new born baby.

| Table- 3.28. District-wise: Promptness for postnatal check-up | | | | | | |
|---|---|---|---|---|---|---|
| **District** | Within 2-3 days | Within weeks | Within 3 months | No checkup | No children | Total |
| **Aizawl** | 4.4 | 79.6 | 8.3 | 7.6 | 0 | 100 |
| **Champhai** | 14.9 | 69.2 | 5.9 | 7.7 | 1.0 | 100 |
| **Kolasib** | 1.4 | 71.8 | 19.5 | 2.2 | 5.1 | 100 |
| **Lawngtlai** | 0.9 | 58.3 | 29.9 | 10.9 | 0 | 100 |
| **Lunglei** | 0.7 | 14.6 | 36.8 | 47.8 | 0 | 100 |
| **Mamit** | 5.5 | 26 | 68.5 | 0 | 0 | 100 |
| **Saiha** | 14.5 | 18 | 3.9 | 63.6 | 0 | 100 |
| **Serchhip** | 5.7 | 54.7 | 39.6 | 100 | 0 | 100 |
| **Mizoram** | 6.0 | 49.0 | 26.6 | 30.0 | 0.8 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | | | |

Table-3.28. shows that maximum mother went for postnatal check-up within weeks after delivery (49.0%), followed by within 3 months (26.6%) and within 2-3 days (6.0%) while a good number of 30% do not go for postnatal check-up. There is a huge inter-district variation on the time, the mother go for postnatal check-up (table-3.28.2.).

### *3.28.3. Problems of Postnatal care Seeking*

As seen in the last table-3.29, there are some mothers who do not go for postnatal check-up. This section explores the reason behind why they did not go for check-up after delivery.

| Table- 3.29. Reason not seeking Postnatal care | | | | | | |
|---|---|---|---|---|---|---|
| **District** | No need | Too far | Financial Problem | Hospital/PHC\/CHC Not available | Medical personnel available at home | Total |
| **Aizawl** | 55.8 | 17.3 | 21.2 | 0 | 5.8 | 100 |
| **Champhai** | 100 | 0 | 0 | 0 | 0 | 100 |
| **Kolasib** | 29.9 | 57.1 | 19.5 | 59.7 | 1.3 | 100 |
| **Lawngtlai** | 22.7 | 50 | 43.9 | 34.8 | 1.5 | 100 |
| **Lunglei** | 33.7 | 36.2 | 35.7 | 0 | 6.1 | 100 |
| **Mamit** | 80.9 | 0 | 10.2 | 6.4 | 0.9 | 100 |
| **Saiha** | 35.8 | 43.2 | 38.9 | 33.7 | 5.3 | 100 |
| **Serchhip** | 31.4 | 22.9 | 28.6 | 5.7 | 11.4 | 100 |
| **Mizoram** | 48.8 | 28.3 | 24.7 | 17.5 | 4.0 | 100 |
| **Source : Field survey- 2016 & 2017** | | | | | | |

Table-3.29. shows that maximum number of mother reported that postnatal care is not needed (48.8%), followed by too far (28.3%), financial problem (28.3%), hospital/PHC/CHC not available (17.5%) and medical personnel available at home (4.0%).

### 3.29. Mass Media Exposure

Mass media exposure is another determinant of people's health-seeking behaviour. Those who read newspaper, magazine or watch TV at least once a week are considered as regularly exposed to mass media while the rest are considered as not regularly exposed to mass media. It is also expected that those who regularly exposes to mass media may go for health check-up regularly or check-up in time of illness as mass media is a good source of information about healthcare.

**Table-3.30. District-wise: Read/Watch news paper, Radio or T.V**

| **District** | Yes | No | Total |
|---|---|---|---|
| **Aizawl** | 100 | 0 | 100 |
| **Champhai** | 97.55 | 2.45 | 100 |
| **Kolasib** | 85.4 | 14.6 | 100 |
| **Lawngtlai** | 81.5 | 18.5 | 100 |
| **Lunglei** | 86.3 | 13.7 | 100 |
| **Mamit** | 73.8 | 26.2 | 100 |
| **Saiha** | 75.5 | 24.5 | 100 |
| **Serchhip** | 91.9 | 8.1 | 100 |
| **Mizoram** | 86 | 13.5 | 100 |

**Source : Field survey- (2016 &2017)**

Table-3.30 *shows that mass media exposure is quite high in Mizoram as 86.5% exposes to mass media. Among the districts, Aizawl scored 100% mass media exposure,*

*followed by Champhai (97.55%), Serchhip (91.9%), Lunglei (86.3%), Kolasib (85.5%), Lawngtlai (81.5%), Saiha (75.5%) and Mamit (73.8%) districts*.

### *3.29.1. Regularity of Mass Media Exposure*

Mere exposure to mass media may not make much sense to the people. What is more important is the regularity of people exposes to mass media. Table-3.31 classified mass media exposure, such as-read news paper/magazine or watches TV or listens to radio at least once a week, at least once a month and at least once a year. Reading news paper/magazine or watch TV or listen radio at least once a week is considered as regularly exposes to mass media.

Table-3.31 shows that the overall performance of mass media exposure is very low as merely 36% are regularity exposes to mass media in Mizoram while the highest proportion of 41.9% exposes to mass media only once a month and more than 22% of them are exposes to mass media just once a year.

**Table-3.31. District-wise: Regularity of Mass media exposure**

| District | At least Once a week | At least Once a month | Once a year | Total |
|---|---|---|---|---|
| **Aizawl** | 98 | 2 | 0 | 100 |
| **Champhai** | 39.2 | 44.4 | 16.4 | 100 |
| **Kolasib** | 51.3 | 41.5 | 7 | 100 |
| **Lawngtlai** | 7.3 | 53.3 | 39.4 | 100 |
| **Lunglei** | 44.2 | 26 | 29.8 | 100 |
| **Mamit** | 22.4 | 48.6 | 28.3 | 100 |
| **Saiha** | 8.6 | 70.1 | 21.3 | 100 |
| **Serchhip** | 16.7 | 49 | 34.3 | 100 |
| **Mizoram** | 36.0 | 41.9 | 22.1 | 100 |

Source : Field survey-2016 & 2017

*Looking at regularity of mass media exposure, Aizawl district distinguishes itself by scoring 98% exposes to mass media regularly, followed by Kolasib and Lunglei districts with 51.3% and 44.2% respectively. On the other hand Lawngtlai and Saiha districts show least exposure to mass media with only 7.3% and 8.6% respectively.*

**3.30. Concluding Statement**

From the overall discussion of inter district variations on health-seeking behaviour and the general factors associated with it are concerned, these are the following important findings:-

*First, the present research clearly shows that seeking health care is quite common in Aizawl district 91.7 % compared with other districts of Mizoram and far better than state average of 65.9% while Mamit and Serchhip records the least percentage of family members who went for check-up in time of illness with 51.5 % and 51.7% respectively.*

*Second, there are intra-district variations in the reasons why people don't go for check-up in time of illness. Cost too much is the biggest hurdles for Aizawl (66.7%), Champhai (76.9%) and Serchhip (45.5%) districts whereas 'too far' become the biggest problems for Lawngtlai (72.3%), Lunglei (77.8%) and Saiha (94.5%) districts. Another major hurdle that stop people from seeking healthcare are inaccessibility, require for household work and lack of healthcare facilities.*

*Third, out of the six possible reasons, preference to have at home got maximum score with 47.8%, followed by too far (20.0%), healthcare facility not available (18.7%), no medical personal at home (12.1%) and no money (7.9%).*

*Fourth, it is evident that mass media exposure is quite high in Mizoram as 86.5% are exposes to mass media. Among the district Aizawl scored 100% mass media*

*exposure, followed by Champhai (97.55%), Serchhip (91.9%), Lunglei (86.3%), Kolasib (85.5%), Lawngtlai (81.5%), Saiha (75.5%) and Mamit (73.8%) districts. Looking at regularity of mass media exposure, Aizawl district distinguishes itself by scoring 98% exposes to mass media regularly, followed by Kolasib and Lunglei with 51.3% and 44.2% respectively. On the other hand Lawngtlai and Saiha districts show the least exposure to mass media with 7.3% and 8.6% respectively.*

# CHAPTER-IV

# SOCIO-ECONOMIC BACKGROUND OF HEALTH-SEEKERS IN AIZAWL DISTRCT

## 4.1. Introduction:

This chapter discusses on the socio-economic background of health-seekers in Aizawl district. Information on socio-economic background is extremely important as the socio-economic condition of an individual usually determine their health-seeking attitude. Discussion starts with the level of education of household head, occupation of household head, annual income of household, indulgence of smoking and drinking. The discussion has been categorized based on inter-block variations on socio-economic parameters like education and annual income, followed by rural-urban variation on their socio-economic status.

## 4.2. Level of Education of household head

Education is a proven factor determining health-seeking attitude of the people. Therefore, knowing the status of level of education of household head is pre-requisite to understand the health-seeking behavior of family members. While conducting the field survey-2016 & 2017, the level of education has been divided into-below class-X, class-XII passed and who complete graduate and above. Graduate an above included master degree holders and other professional courses. We clubbed all these together mainly because master degree holders and professional course complete persons are negligible numbers to form a separate heading to compare with other categories.

According to census of India-2011, the average literacy rate of Aizawl District is 98.27 %, which become the second most literate district in India and Mizoram after

Serchhip district. However, when level of education of household head is taken into consideration, most of them are below class-X. As shown in Table-4.1 as many as 71.1% family head are below class-X, while 11.7% are class-XII passed and merely 17.1% are bachelor or above, including professional courses.

Table-4.1. Aizawl District: Level of Education of Household head

| Sl. No | Aizawl District | Below CL-X | CL-XII | Graduate & above Including Professional | Total |
|---|---|---|---|---|---|
| 1 | Khawpuar | 86.1 | 10.6 | 3.3 | 100 |
| 2 | Daido | 85.4 | 10.1 | 4.5 | 100 |
| 3 | Lailak | 85.1 | 10.6 | 4.3 | 100 |
| 4 | N.Khawlek | 84.6 | 10.2 | 5.2 | 100 |
| 5 | Darlawn | 82.7 | 13.5 | 3.81 | 100 |
| 6 | Chawilung | 82.2 | 10.3 | 7.5 | 100 |
| 7 | Lenchim | 81.2 | 9.4 | 9.4 | 100 |
| 8 | Kelsih | 80.3 | 13.4 | 6.3 | 100 |
| 9 | Darlawng | 79.3 | 13.2 | 7.5 | 100 |
| 10 | Aibawk | 76.2 | 15.2 | 8.6 | 100 |
| 11 | Thingsulthliah | 75.4 | 16.5 | 8.1 | 100 |
| 12 | Phullen | 74 | 14.3 | 11.7 | 100 |
| 13 | Bethlehem | 54 | 10.2 | 35.8 | 100 |
| 14 | Sairang | 53.1 | 11.2 | 35.7 | 100 |
| 15 | Dinthar | 52.2 | 10.7 | 37.6 | 100 |
| 16 | Chite | 51.4 | 11.5 | 37.1 | 100 |
| 17 | Durtlang | 51.2 | 10.8 | 38 | 100 |
| 18 | Zarkawt | 45.9 | 10.4 | 43.7 | 100 |
| | Average | 71.1 | 11.7 | 17.1 | 100 |

**Source : Field survey-2016 & 2017**

Table-4.1 shows village-wise level of educational attainment of household head in Aizawl District. Table-4.1reveals that out of 18 villages Khawpuar village has maximum percentage of household head whose education is below class-X with 86.1%, followed by Daido (85.4%), Lailak (85.1%), N. Khawlek (84.6%), Darlawn (82.7%). On the other extreme Zarkawt, one locality of the state capital, Aizawl shows that merely 45.9% household head are below class-X level education while as many as 43.7% are graduates or above (Table-4.1).

*It can be concluded that as far as inter-village education is concerned, there exist huge disparities between them. Also it can be asserted that even though the Aizawl district*

*became the second highest literate district in India, majority of them are below class-X level educated while merely 11.2% passed class-XII and just 17.1% passed bachelor degree or above.*

### 4.3. Occupation

The World Health Organization defines the social determinants of health as the "conditions in which people are born, grow, live, work and age." In 2011, the World Health Organization argues "the distribution of money, power and resources at global, national and local levels" creates these conditions. Socio-Economic Status (SES), gender, race, and education are factors of health-seeking behaviour that are influenced by the social determinants of health.

The occupation of households head is classified into: farmer, government servant, business man/women, house wife, medical practitioner, student, engineer, carpenter and daily labourer. These are the common occupational activities found in the state of Mizoram.

Table-4.2. Aizawl District: Occupation of household head

| Aizawl District | Farmer | Govt. | Business | House wife | Medical practisioner | Student | Engineer | Carpenter | Daily Laborers | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Darlawn | 83.1 | 11.4 | 7.2 | 4.5 | 0.1 | 0.1 | 0 | 1.3 | 1.2 | 100 |
| Khawpuar | 82.3 | 10.2 | 6.1 | 5.2 | 0.1 | 0.4 | 0 | 1.2 | 1.3 | 100 |
| Lailak | 81.5 | 9.9 | 2 | 5.6 | 0.7 | 0.7 | 0 | 1.1 | 1.3 | 100 |
| Sairang | 79.8 | 42.4 | 27.7 | 2.6 | 2.1 | 0.4 | 0 | 0 | 0.2 | 100 |
| Lenchim | 73.2 | 16.3 | 3 | 1.3 | 0.5 | 1.1 | 0 | 0.3 | 0.7 | 100 |
| Thingsulthliah | 72.4 | 17.5 | 10.4 | 1.4 | 0.4 | 1.1 | 0 | 0.2 | 0.3 | 100 |
| Darlawng | 72.2 | 17.2 | 6.4 | 2.1 | 0.3 | 1.1 | 0 | 0.1 | 0.2 | 100 |
| N.Khawlek | 71.4 | 15.3 | 11.1 | 1.6 | 0.1 | 0.1 | 0 | 1.1 | 0 | 100 |
| Phullen | 70.5 | 16.2 | 12.2 | 2.1 | 0.2 | 0.2 | 0 | 1.2 | 0 | 100 |
| Daido | 69.6 | 15 | 8.2 | 1.1 | 0.1 | 0.1 | 0 | 1.3 | 0 | 100 |
| Chawilung | 61.1 | 12.9 | 22.7 | 1.8 | 0 | 0.1 | 0 | 0 | 1.5 | 100 |
| Aibawk | 59.4 | 15.2 | 24.2 | 2.2 | 11.3 | 0.1 | 0 | 0 | 0.8 | 100 |
| Kelsih | 58.2 | 15.4 | 22.4 | 2.4 | 0.2 | 0.1 | 0 | 0 | 0.4 | 100 |
| Chite | 11.2 | 42.2 | 28.4 | 1.2 | 2 | 1.4 | 1 | 0.1 | 0.2 | 100 |
| Durtlang | 10.4 | 42.2 | 28.1 | 1.3 | 4.1 | 1.1 | 1 | 0.2 | 0.2 | 100 |
| Dinthar | 7.4 | 44.5 | 30.2 | 1.5 | 2.9 | 1.2 | 1 | 0.1 | 0.3 | 100 |
| Bethlehem | 5.2 | 43.4 | 31.2 | 1.3 | 2.1 | 1.3 | 1 | 0.1 | 0.2 | 100 |
| Zarkawt | 0 | 45.1 | 30.4 | 1.4 | 5.4 | 1.2 | 2 | 0.1 | 0.1 | 100 |
| Average | 53.8 | 24 | 17.3 | 2.2 | 1.8 | 0.6 | 0.3 | 0.4 | 0.4 | 100 |

Source : Field survey-2016 & 2017

Table-4.2 reveals that farming is the most common occupational type in Aizawl district with the average percentage of 53.8%, followed by government servant (24%) and business (17.3%) while other occupational types are meager in numbers. Among the study area, Darlawn Village has maximum percentage of farmer (83.1 %) followed by Khawpuar Village (82.3 %) and Lailak Village (81.5 %). On the other hand Zarkawt (45 %), Dinthar (44.5 %), and Bethlehem (43.4 %) recorded maximum percentage of people engaged in government services. There is a negative correlation between farmer concentrated areas and government servant concentrated areas.

Moreover, business people are concentrated in more urban areas compared with rural villages. Maximum percentage of business people are found in Bethlehem, Zarkawt, Dinthar and Chite-all are within Aizawl city whereas minimum percentage of business people are found in Lailak, Lenchim and Khawpuar (table-4.2)-all are in the rural remote area.

*It is observed that there are three broad types of occupations in Aizawl district such as farmer, government servant and business. Out of these three, agriculture farming is the most common occupational type with 53.8% engaged in this activity, followed by government service (24%) and business 917.3%).*

**4.4. Annual Income**

To understand socio-economic condition and how it has been related with health-seeking attitude, annual income of family is so vital. Table-4.3 shows the overall annual income of family of each villages/towns. The annual income of the family has been

classified into below Rs 100000/-, Rs 100000-200000/- Rs 200000-300000 and Rs 300000 & above.

| Table-4.3. Aizawl District: Annual income of the household | | | | | | |
|---|---|---|---|---|---|---|
| Aizawl District | Below 100000 | Rs.100000-200000 | Rs.200000-300000 | Rs.300000 & above | Total | Average |
| Daido | 45.8 | 42.4 | 2 | 0 | 100 | 91567 |
| N.Khawlek | 51.5 | 45.5 | 3 | 0 | 100 | 92470 |
| Lailak | 48.9 | 45.1 | 6 | 0 | 100 | 93000 |
| Phullen | 35.6 | 53.2 | 10 | 1.2 | 100 | 93379 |
| Lenchim | 52.8 | 45.2 | 2 | 0 | 100 | 94524 |
| Khawpuar | 49.8 | 46.2 | 4 | 0 | 100 | 95000 |
| Darlawng | 41.7 | 54.3 | 4 | 0 | 100 | 95620 |
| Darlawn | 44.5 | 43.5 | 10.5 | 1.5 | 100 | 96544 |
| Kelsih | 38.6 | 51.2 | 9 | 1.2 | 100 | 123123 |
| Chawilung | 54.6 | 42.4 | 3 | 0 | 100 | 123231 |
| Aibawk | 32.4 | 52.2 | 14 | 1.4 | 100 | 125427 |
| Thingsulthliah | 38.2 | 52.4 | 8 | 1.4 | 100 | 125879 |
| Sairang | 31 | 47.5 | 20 | 1.5 | 100 | 224474 |
| Dinthar | 0 | 38.1 | 52.4 | 9.5 | 100 | 234200 |
| Bethlehem | 0 | 37.7 | 52.2 | 10.1 | 100 | 242400 |
| Chite | 0 | 40.6 | 51.2 | 8.2 | 100 | 250000 |
| Zarkawt | 0 | 34.6 | 53.2 | 12.2 | 100 | 253020 |
| Durtlang | 4.5 | 45.7 | 45.6 | 4.2 | 100 | 254320 |
| ***Average*** | ***31.6*** | ***45.4*** | ***19.4*** | ***3.5*** | ***100*** | ***150454*** |
| Source : Field survey-2016 & 2017 | | | | | | |

As shown in table-4.3 the average annual income of Aizawl district is Rs 150454/-. Among the categories, the annual income category of Rs 100000-200000/- got maximum percentage with 45.4%, followed by the category of Rs 100000/- with 31.6% while the category of Rs 300000/- got minimum percentage with just 3.5%.

Among the villages/localities Durtlang, Zarkawt and Chite record highest annual income with Rs 254320/-, Rs 253020/-and Rs 250000/-respectively. On the other extreme, Daido, N.Khawlek and Lailak villages record minimum annual income with Rs 91567/-, 92470/- and 93000/- respectively.

*Therefore, it can be concluded that the average annual income of Aizawl district is Rs 150454/-.Among the categories, the annual income category of Rs 100000-200000/- got maximum number while the average annual income of Rs 300000/- record minimum number.*

## 4.5. Indulgence in Smoking and Drinking

This section is a general introduction of the behavior of people in relation to smoking and drinking alcohol, which are universally proven fact of unhealthy practices, particularly smoking. The intention of including the topic is to make us understand the health problems and their seeking behavior in relation to smoking and alcohol drinking.

### *4.5.1. Aizawl District: Smoker*

As shown in tabe-4.4, smoking is extremely high in Aizawl district. The average percentage of smoker in Aizawl district is 64.5%, which is quite high, higher than national average of 42.6% but still lower than Mizoram average of 83.2% (NFHS-4).

It is clear from table that among the 18 villages/localities Lailak village record maximum percentage of smoker (78.3%), followed by Lenchim (77.9%), Daido (75.1%), Khawpuar (74.2%),Darlawn (73.4%), Chawilung (73%), Darlawng (72.4%), N.Khawlek (72.2%), Phullen (71.1%) and Thingsulthliah (70.2%). These are the top ten highest smoking villages.

Table-4.4. Aizawl District: No. of Smoker

| Sl. No | Aizawl District | Smoker | Non-smoker | Total |
|---|---|---|---|---|
| 1 | Lailak | 78.3 | 21.7 | 100 |
| 2 | Lenchim | 77.9 | 22.1 | 100 |
| 3 | Daido | 75.1 | 24.9 | 100 |
| 4 | Khawpuar | 74.2 | 25.2 | 100 |
| 5 | Darlawn | 73.4 | 26.6 | 100 |
| 6 | Chawilung | 73.06 | 26.94 | 100 |
| 7 | Darlawng | 72.4 | 27.6 | 100 |
| 8 | N.Khawlek | 72.2 | 27.8 | 100 |

| | | | | |
|---|---|---|---|---|
| 9 | Phullen | 71.1 | 28.9 | 100 |
| 10 | Thingsulthliah | 70.2 | 29.8 | 100 |
| 11 | Kelsih | 69.4 | 30.4 | 100 |
| 12 | Aibawk | 68.2 | 31.8 | 100 |
| 13 | Sairang | 56.1 | 43.9 | 100 |
| 14 | Chite | 47.1 | 52.9 | 100 |
| 15 | Bethlehem | 46.4 | 53.6 | 100 |
| 16 | Zarkawt | 46.2 | 53.8 | 100 |
| 17 | Durtlang | 45.5 | 54.5 | 100 |
| 18 | Dinthar | 45.2 | 54.8 | 100 |
| ***Average*** | | ***64.5*** | ***35.4*** | ***100*** |
| Source : Field survey-2016 & 2017 | | | | |

The least smoking localities are all within Aizawl city, such as Dinthar (45.2%), Durtlang (45.5%), Zarkawt (46.2%), Bethlehem (46.4%) and Chite (47.1%).

*It can be concluded that smoking in very much common in Aizawl district as majority of the population (64.5%) are still smoke Aizawl is while merely 35.4% claimed themselves are free from smoking*.

### *4.5.2. Aizawl District: Regularity of Smoke*

This section again divided all smokers into two group-regular smokers and occasional smokers since all smokers are not regular smoker. Table-4.5 clearly shows that majority of smokers are smoking regularly, which consists of 66.3% of smokers while merely 33.6% are smoking occasionally.

Table-4.5. Aizawl District: Regularity of Smoke

| Sl. No | Aizawl District | Smoke | Smoke Occasionally | Total |
|---|---|---|---|---|
| 1 | Daido | 80.4 | 19.6 | 100 |
| 2 | Lailak | 80 | 20 | 100 |
| 3 | Khawpuar | 78.2 | 21.8 | 100 |
| 4 | Darlawn | 76.4 | 23.6 | 100 |
| 5 | Lenchim | 75.2 | 24.8 | 100 |
| 6 | N.Khawlek | 74.2 | 25.8 | 100 |
| 7 | Phullen | 72.5 | 27.5 | 100 |
| 8 | Darlawng | 71.5 | 28.5 | 100 |
| 9 | Chawilung | 71.1 | 28.9 | 100 |
| 10 | Kelsih | 70.3 | 29.7 | 100 |
| 11 | Thingsulthliah | 70.2 | 29.8 | 100 |

| | | | | |
|---|---|---|---|---|
| 12 | Aibawk | 69.5 | 30.5 | 100 |
| 13 | Sairang | 61.44 | 38.56 | 100 |
| 14 | Zarkawt | 49.2 | 50.8 | 100 |
| 15 | Dinthar | 49.1 | 50.9 | 100 |
| 16 | Durtlang | 48.5 | 51.5 | 100 |
| 17 | Chite | 48.3 | 51.7 | 100 |
| 18 | Bethlehem | 48.2 | 51.8 | 100 |
| ***Average*** | | ***66.3*** | ***33.6*** | ***100*** |
| Source : Field survey-2016 & 2017 | | | | |

Daido village has maximum percentage of regular smoker (80.4%), followed by Lailak, Khawpuar, Darlawn, Lenchim, N.Khawlek, Phullen, Darlawn, Chawilung and Kelsih. These are the top ten villages recording higher percentage of 'regular smoker'. On the other hand, Localities in Aizawl; city like Bethlehem, Chite, Durtlang, Dinthar and Zarkawt are recoded least numbers of 'regular smoker' (table-4.5).

In contrary, wherever villages having high percentage of 'regular smoker' record minimum percentages of 'occasional smokers'. For example: Daido has the highest percentage of 'regular smoker' while it also record the least percentage of 'occasional smokers'. Similarly, Bethlehem records minimum percentage of 'regular smoker' whit it has maximum percentage of 'occasional smokers'.

*It can be concluded that smoking is extremely common in Aizawl district. Majority of them are not occasional smoker but regular smoker as many as 66.3 % reported that they smoke regularly.*

### *4.5.3. Prevalence of Alcohol Drinking*

It is the general perception that drinking alcohol is not good for health, especially regular drinking of it. It is a proven fact that some diseases or health complication are related with drinking alcohol, for example liver problems and pancreatitis. The present study briefly highlighted about number of alcohol drinkers in Aizawl district.

It appears from table-4.6 that alcohol drinking is common in Aizawl district as 26.5% are drinking alcohol. Among the sample villages Phullen village top the list as 34% drink alcohol, followed by Darlawn, Aibawk, Daido, Lailak, Khawpuar, N.Khawlek, Thingsulthliah, Kelsih and Chawilung. These villages are the top ten villages pertaining to alcohol drinking. On the other hand, localities within Aizawl city record minimum percentage of alcohol drinker, such as Dinthar, Durtlang and Zarkawt (table-4.6).

Table-4.6. Aizawl District: Do you drink alcohol?

| Sl. No | Aizawl District | Yes | No | Total |
|---|---|---|---|---|
| 1 | Phullen | 34 | 66 | 100 |
| 2 | Darlawn | 30.8 | 69.2 | 100 |
| 3 | Aibawk | 29 | 71 | 100 |
| 4 | Daido | 28.5 | 71.5 | 100 |
| 5 | Lailak | 28.1 | 71.9 | 100 |
| 6 | Khawpuar | 27.2 | 72.8 | 100 |
| 7 | N.Khawlek | 27.2 | 72.8 | 100 |
| 8 | Thingsulthliah | 26.8 | 73.2 | 100 |
| 9 | Kelsih | 26.2 | 73.8 | 100 |
| 10 | Chawilung | 25.5 | 74.5 | 100 |
| 11 | Darlawng | 25.2 | 74.8 | 100 |
| 12 | Sairang | 25 | 75 | 100 |
| 13 | Bethlehem | 24.7 | 75.3 | 100 |
| 14 | Chite | 24.6 | 75.4 | 100 |
| 15 | Lenchim | 24.2 | 75.8 | 100 |
| 16 | Zarkawt | 24.2 | 75.8 | 100 |
| 17 | Durtlang | 23.5 | 76.5 | 100 |
| 18 | Dinthar | 23.5 | 76.5 | 100 |
| **Average** | | **26.5** | **73.4** | **100** |

Source : Field survey-2016 & 2017

*Therefore, it can be concluded that drinking alcohol in Aizawl district is common as 26.5% drink alcohol while 73.4% are restrain from alcohol drinking. It also appears that drinking alcohol is more common in rural area than urban areas.*

### *4.5.3. Regularity of Alcohol Drinking*

This section is the additional input of the above discussion on alcohol drinking. Alcohol drinkers are again divided into two groups-'regular drinkers' and 'occasional

drinkers'. Table 4.7 shows that 'regular alcohol drinkers' consists of 18.19% whereas occasional drinkers consist of 78.3%.

| Table-4.7. Aizawl District: Regularity of alcohol drinking | | | |
|---|---|---|---|
| Aizawl District | Regularly | Occasionally | Total |
| Sairang | 22.04 | 77.96 | 100 |
| Lenchim | 20.9 | 20.9 | 100 |
| Thingsulthliah | 20.7 | 79.3 | 100 |
| Darlawng | 20.2 | 79.3 | 100 |
| Aibawk | 20.1 | 79.9 | 100 |
| Bethlehem | 20.1 | 79.9 | 100 |
| Dinthar | 19.3 | 80.7 | 100 |
| Zarkawt | 19.2 | 80.8 | 100 |
| Durtlang | 18.5 | 81.5 | 100 |
| Chite | 18.4 | 81.6 | 100 |
| Chawilung | 18.2 | 81.8 | 100 |
| Darlawn | 17.5 | 82.5 | 100 |
| Kelsih | 17.5 | 82.5 | 100 |
| Phullen | 17.2 | 82.8 | 100 |
| Khawpuar | 16.2 | 83.8 | 100 |
| Lailak | 15.8 | 84.2 | 100 |
| Daido | 15.5 | 84.5 | 100 |
| N.Khawlek | 14.4 | 85.6 | 100 |
| **Average** | **18.19** | **78.3** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Sairang notified town recorded the highest percentage of 'regular alcohol drinker' with 22.04%, followed by Lenchim village with 20.9% and Thingsulthliah with 20.7%. On the other Khawlek villages, Daido village and Lailak village are recording minimum percentage of 'regular alcohol drinker' with 14.4%, 15.5% and 15.8% respectively.

*Thus, it has been found that 'occasional alcohol drinkers' (78.3%) are relatively higher in number compared with 'regular alcohol drinkers' (18.19%) in Aizawl district. Sairang records the highest percentage of 'regular alcohol drinker' while N.Khawlek village record the least.*

### 4.6. Inter-Block Variation on Level of Education

Education is a proven factor determining health-seeking attitude of the people. Education helps to promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationship, personal, family and community well being. Merely high literacy rate is not enough to take into consideration as a determining factor in the context of a highly literate state like Mizoram. Therefore, level of education is used for parameter that may have influenced on the health-seeking behaviour of the people in Mizoram.

Table-4.8 shows block-wise level of educational attainment of household head in Mizoram. The block-wise level of education of head of the family is classified into: below class – X, class-XII standard and graduate & above, including professional.

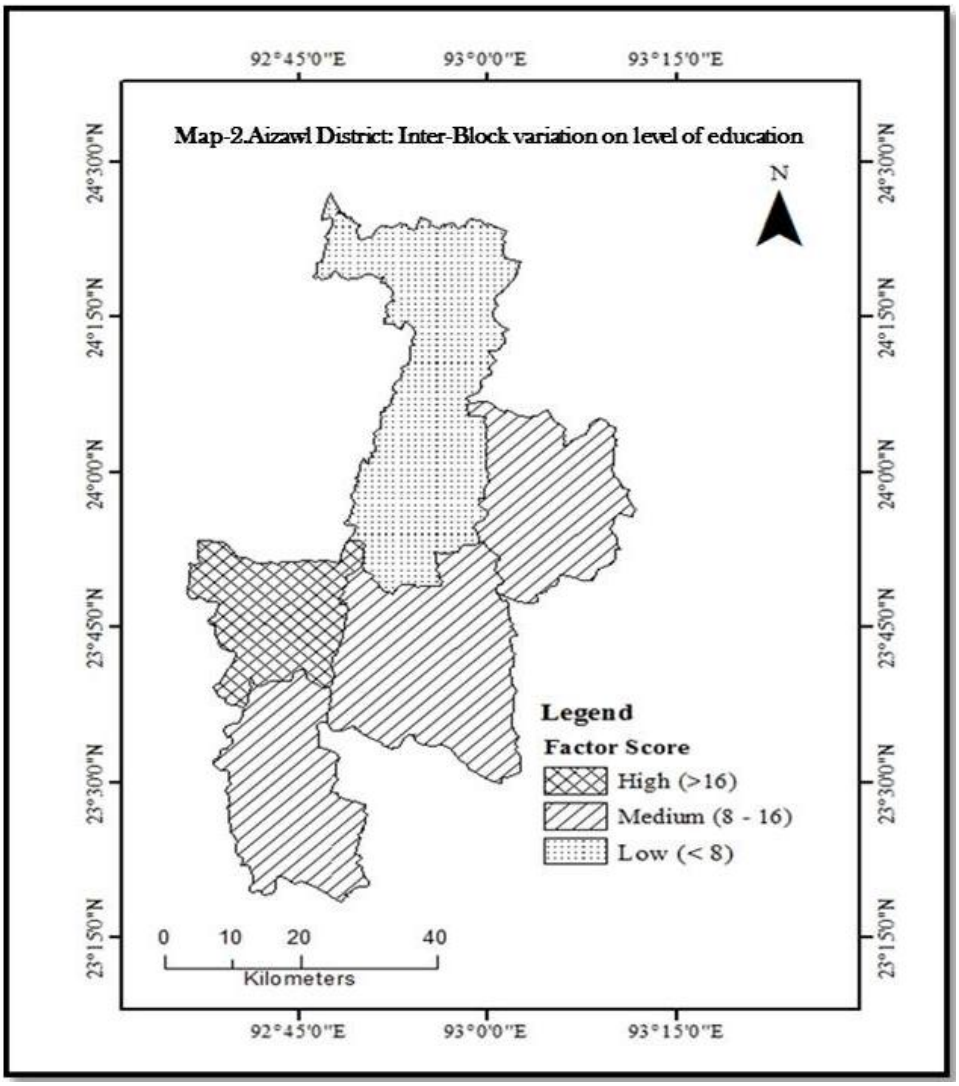
Table-4.8. Inter-Block variation of Education of Household Head (%)

| R.D Block | Below CL-X | Below CL-XII | Graduate & above including Professional | Total |
|---|---|---|---|---|
| Darlawn | 84.63 | 13.15 | 2.22 | 100 |
| Phullen | 76.3 | 15.3 | 8.4 | 100 |
| Aibawk | 73.31 | 20.76 | 5.93 | 100 |
| Thingsulthliah | 66.73 | 24.84 | 8.4 | 100 |
| Tlangnuam | 51.3 | 10.8 | 38 | 100 |
| **Average** | **70.45** | **16.97** | **12.59** | **100** |

Source : Field survey-2016 & 2017

Out of the total five Rural Development Blocks, Darlawn block has maximum percentage of household head whose educational level below class-X (84.63%), followed by Phullen (76.3%), Aibawk (73.31%), Thingsulthliah (66.73%) and Tlangnuam (51.3%). On the other hand Tlangnuam block record the highest percentage of household head go complete bachelor degree or above, including professional with 38%, followed by Thingsulthliah and Phullen with 8.4% each while Aibawk and Darlawn blocks record minimum percentage of household head who passed bachelor degree or above.

Interestingly, Thingsulthliah and Aibawk blocks record the highest percentage of family head that passed class-XII with 24.84% and 20.76% respectively while Tlangnuam block record minimum percentage on the same educational level.




*Therefore, the education level of Aizawl district is by and large low as merely 12.6% household head are reported of having bachelor or above degrees whereas as many as 70.5% of household head are below class-X educated. Among the five RD blocks, Tlangnuam score highest number of family head having higher level of education as 38%*

*reported that they are having bachelor degree or higher. In contrary, Darlawn RD block record the lowest number of graduate degree holders among family head.*

### 4.7. Inter-Block Variation of Occupation in Aizawl District

Type of occupation can significantly contribute for health-seeking attitudes of people. The present research also considers the type of occupation of household head assuming that the types of occupation might be related with health-seeking attitude of the family members.

**Table-4.9. Block-wise Occupation of household head in Aizawl District**

| R.D Block | Farmer | Govt. Servant | Business | House Wife | Medical Practitioner | Student | Other | Engineer | Carpenter | Daily Labourer | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Darlawn | 82.3 | 10.5 | 5.1 | 5.1 | 0.1 | 0.4 | 0 | 0 | 1.2 | 0.2 | 100 |
| Thingsulthliah | 72.6 | 17 | 6.6 | 1.2 | 0.4 | 1.1 | 0.7 | 0 | 0.2 | 0.4 | 100 |
| Phullen | 70.5 | 15.5 | 10.5 | 1.6 | 0.2 | 0.2 | 0 | 0 | 1.2 | 0 | 100 |
| Aibawk | 59.58 | 14.5 | 23.1 | 2.15 | 0.2 | 0.1 | 0 | 0 | 0 | 0.9 | 100 |
| Tlangnuam | 19 | 43.3 | 30 | 1.56 | 3.1 | 1.1 | 0 | 1 | 0.2 | 0.2 | 100 |
| **Average** | **60.79** | **20.16** | **15.06** | **2.32** | **0.8** | **0.58** | **0.14** | **0.2** | **0.56** | **0.34** | **100** |

Source : Field survey-2016 & 2017

Table-4.9. depicted that block-wise occupation of household head is categorized into the following- farmer, government servant, business, housewife, medical practitioner, student, engineer, carpenter and daily labourer.

It can be found out that the most common type of occupation in Aizawl district is agriculture farming as 60.79% household heads engaged in agriculture, followed by government servant with 20.1% average and followed by business with 15.06%.

Other types of occupation includes - housewife (2.32 %), medical practitioner (0.8 %), student (0.58 %), carpenter (0.56 %), daily labourer (0.34 %) and other (0.14 %).

Among the five RD blocks, Darlawn block record the maximum percentage of farmer with 82.3%, followed by Thingsulthliah and Phullen with 72.6% and 70.7% respectively. Maximum numbers of government servant and business people are concentrated in Tlangnuam RD block, which is basically within the capital city of Aizawl.

As many as 43.3% government servant and 30% business people are found in Tlangnuam RD block.

*Therefore, it can be concluded that there are three major types of occupation in Aizawl district, such as farmer with 60.79%, followed by government servant with 20.16% and business people with 15.06%. Among the five RD blocks maximum numbers of farmers are found in Darlawn RD block (82.3%) while maximum numbers of government servant and business people are concentrated in Tlangnuam RD block with 43.3% and 30% respectively.*

### 4.8. Inter-Block variations of Annual Income in Aizawl District

Occupation and annual income of family are complimenting each other in analysing the socio-economic conditions of people. Annual income might be more specific in an attempt to understand the family economic condition. However, collection of data on income is sometime problematic as many farmers could not report their actual income for they don't have visible regular income in the form of cash. Therefore, researcher has to deal with a very systematic manner to chalk out the actual income by converting the value of different items/kinds of household consumption/expenditure into money value so as to make quantitative analysis.

The annual income of household is categorized into four, such as income below Rs. 100000, Rs. 100000-200000, Rs. 200000-300000 and Rs. 300,000 & above.

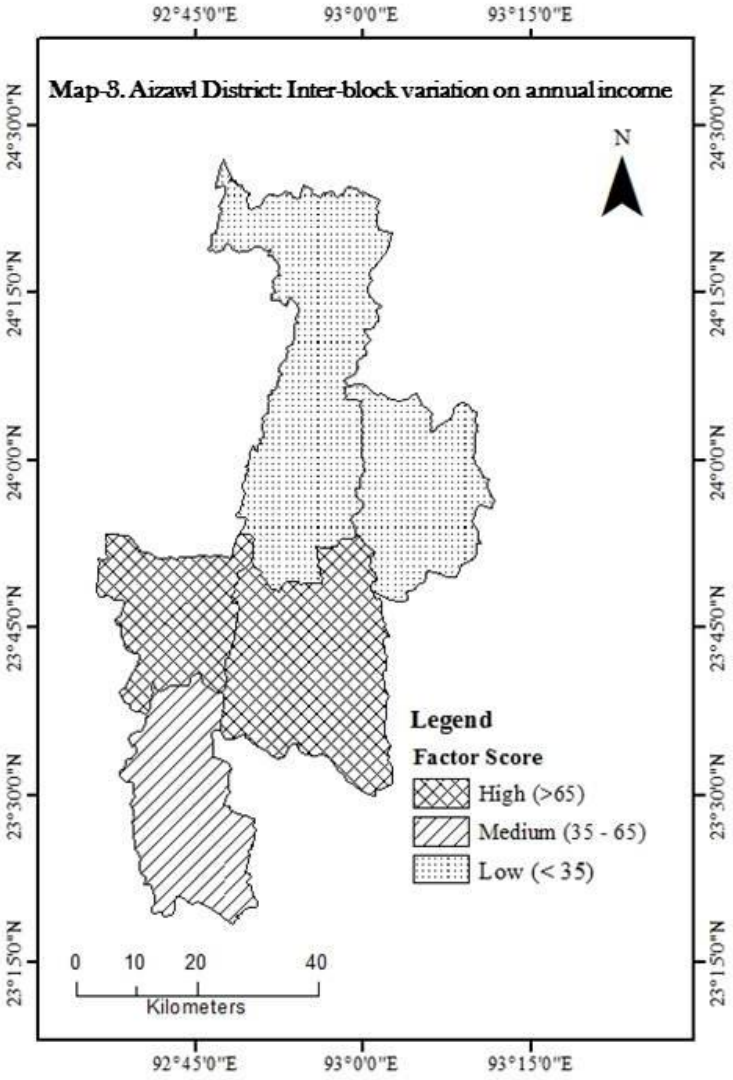
**Table-4.10. Block-wise: Annual income of the household**

| **Aizawl R.D Block** | Below Rs. 100000 | Rs.100000-200000 | Rs.200000-300000 | Rs.300000- & above | Total | Average |
|---|---|---|---|---|---|---|
| **Tlangnuam** | 1.7 | 7.7 | 35.9 | 4.3 | 100 | 243069 |
| **Aibawk** | 1.1 | 29.4 | 30.6 | 2.4 | 100 | 123,927 |
| **Thingsulthliah** | 2.5 | 28.1 | 28.4 | 2.0 | 100 | 105351 |
| **Phullen** | 2.2 | 25.7 | 30.5 | 0.4 | 100 | 92472 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Darlawn** | 3.3 | 25.6 | 29.5 | 0.4 | 100 | 94848 |
| **Average** | **2.16** | **23.3** | **30.98** | **1.9** | **100** | **131933** |
| Source : Field survey-2016 & 2017 | | | | | | |

Table-4.10 shows that, among the four group of income Rs.200000-300000 became the most common among the family in Aizawl district as 30.98% reported that their family income is fall in this category, followed by the category of Rs.100000-200000/-.

*Among the five RD blocks Tlangnuam RD block became the richest block as the average family income is Rs 243069/- followed by Aibawk and Thingsulthliah RD blocks with Rs. 123927/-and Rs.105351/-respectively. Phullen and Darlawn became the poorest among the five RD block with the average annual income of Rs. 92472/- and Rs. 94848/- respectively. Taking together of all the blocks, the average annual income of Aizawl district is Rs 131933/-.*




### 4.9. *Inter-Block variation in Smoking*

It is well known that smoking greatly effects human health. It can causes lung cancer, heart attack and many other complications. Therefore, present section highlighted the condition of family on smoking, which is ultimately expected to link with their health and health-seeking behaviour.

Table-4.11 shows that as many as 67.91 % of household head are smokers in the study area. Among the five blocks, Darlawn records the highest proportion of smoker with 75.3 % while Tlangnuam records the least number of smokers with 47.75 % respectively.

| Table-4.11 Block-wise: No. of Smoker | | | |
|---|---|---|---|
| R.D Block | Smoker | Non-smoker | Total |
| Darlawn | 75.3 | 24.7 | 100 |
| Thingsulthliah | 73.5 | 26.5 | 100 |
| Phullen | 72.8 | 27.8 | 100 |
| Aibawk | 70.22 | 29.78 | 100 |
| Tlangnuam | 47.75 | 52.25 | 100 |
| **Average** | **67.91** | **32.2** | **100** |
| Source : Field survey-2016 & 2017 | | | |

*Therefore, it is found out that smoking is quite common throughout the blocks of Aizawl district as 67.9% are smokers while merely 32.2% are non-smokers. Among the blocks Darlawn record highest percentage of smoker (75.3%) while Tlangnuam record the least percentage (47.75%).*

### *4.10.1. Block-wise: Regularity of Smoke*

Smoking is not only common in Aizawl district but also majority of smoker are 'regular smokers'. As many as 69.45% are regular smoker in Aizawl district while 32.20 % are reported of smoking occasionally may be because of high educated peoples. Out of the five RD blocks, Darlawn tops the rank with 78.2% smokers while Tlangnuam RD block record the least percentage of smoker with 50.79%.

| Table-4.12. Block-wise: Regularity of Smoke | | | |
|---|---|---|---|
| Aizawl | Smoke | Smoke Occasionally | Total |
| Darlawn | 78.2 | 21.8 | |
| Phullen | 75.7 | 24.3 | 100 |
| Thingsulthliah | 72.3 | 27.7 | 100 |
| Aibawk | 70.3 | 29.7 | 100 |
| Tlangnuam | 50.79 | 49.21 | 100 |
| R.D Block | | | 100 |
| **Average** | **69.45** | **30.54** | **100** |
| Source : Field survey-2016 & 2017 | | | |

*Table-4.12. shows that Darlawn (78.2 %) and Phullen (75.7 %) block recorded the highest percentage of regular smokers whereas Tlangnuam (50.79 %), Aibawk (70.3 %) and Thingsulthliah (72.3 %) are having minimum percentage of regular smokers.*

### *4.10.2. Inter-Block variation on Alcohol Drinking*

Drinking alcohol is prevalent in the study area but less common compared with smoking. A good number of 27.03% are reported of drinking alcohol in Aiawl district while 72.96% are not indulged in alcohol drinking.

Table-4.13. Block-wise: Do you drink alcohol?

| Blocks | Yes | No | Total |
|---|---|---|---|
| Phullen | 29.9 | 70.1 | 100 |
| Darlawn | 28.7 | 71.3 | 100 |
| Aibawk | 26.9 | 73.1 | 100 |
| Thingsulthliah | 25.4 | 74.6 | 100 |
| Tlangnuam | 24.25 | 75.73 | 100 |
| **Average** | **27.03** | **72.96** | **100** |

Source : Field survey-2016 & 2017

Table-4.13 depicts that the variations of alcohol drinkers among the blocks are not much as it ranges from as low as 24.25% in Tlangnuam RD block to 28.7% in Darlawn RD block.

### *4.10.3. Block-wise: Regularity of Alcohol Drinking*

It appears from Table-4.14 that most of the alcohol drinkers drink regularly with an average of 18.19 % in Aizawl district while occasional drinker were as high as 81.8%.

Table-4.14. Block-wise: Regularity of alcohol drinking

| R.D Block | Regularly | Occasionally | Total |
|---|---|---|---|
| Aibawk | 20.6 | 79.4 | 100 |
| Tlangnuam | 19.59 | 80.41 | 100 |
| Thingsulthliah | 18.6 | 81.4 | 100 |
| Darlawn | 16.5 | 83.5 | 100 |
| Phullen | 15.7 | 84.3 | 100 |
| **Average** | **18.19** | **81.8** | **100** |

Source : Field survey-2016 & 2017

*Among the blocks, Aibawk (20.6 %) and Tlangnuam (19.59 %) records maximum proportion of people who drink alcohol 'regularly' while Thingsulthliah (18.6 %), Darlawn (16.5 %) and Phullen (15.7 %) records minimum proportion of drinkers who drink alcohol 'regularly'.*

**4.11. Rural-Urban Variations of Education in Aiawl District**

Understanding rural-urban variations on socio-economic condition is vital to fully comprehend the health-seeking attitude of the people. It is assumed that rural are more backward and poorer than urban area resulting in their health-seeking behaviour with lesser performance. For present study, it is decided to take at least 15% household sample from rural and urban areas.

Educational attainment is a proven factor determining human behaviour whether it is about their social well being or health-seeking behaviour. The present study considers the level of education of household head to understand rural-urban variations in educational attainment and which might be reflected in their health-seeking behaviour. After collecting information about education level, we broadly divided into three categories, such as passed class-X standard, passed class-XII and who attained graduate level and above. The third category clubbed variety of educational qualification like B.A, B.Com, B.Sc., M.A, M.Com, M.Sc and other professional courses like Engineering, Medical etc. as one category.

To represent rural area, the average of level of education of household head from each sample villages, such as- Khawpuar, Daido, Lailak, N. Khawlek, Chawilung, Lenchim, Kelsih, Darlawng are taken into consideration. To represent urban area, we considered all the five rural development block headquarters, even though most of them

are literally rural area, apart from notified town of Sairang and sample localities within Aizawl city. This categorization is purely for the present research to have an in-depth and contextual understanding of Aizawl city.

Table-4.15. Aizawl District: Level of Education of Household head (%)

| | | Rural | | | |
|---|---|---|---|---|---|
| Sl. No | Aizawl District | Below CL-X | CL-XII | Graduate & above Including Professional | Total |
| 1 | Khawpuar | 86.1 | 10.6 | 3.3 | 100 |
| 2 | Daido | 85.4 | 10.1 | 4.5 | 100 |
| 3 | Lailak | 85.1 | 10.6 | 4.3 | 100 |
| 4 | N.Khawlek | 84.6 | 10.2 | 5.2 | 100 |
| 5 | Chawilung | 82.2 | 10.3 | 7.5 | 100 |
| 6 | Lenchim | 81.2 | 9.4 | 9.4 | 100 |
| 7 | Kelsih | 80.3 | 13.4 | 6.3 | 100 |
| 8 | Darlawng | 79.3 | 13.2 | 7.5 | 100 |
| | *Rural average* | *83.56* | *11.0* | *6.0* | |
| | **Urban** | | | | |
| 9 | Darlawn | 82.7 | 13.5 | 3.8 | 100 |
| 10 | Aibawk | 76.2 | 15.2 | 8.6 | 100 |
| 11 | Thingsulthliah | 75.4 | 16.5 | 8.1 | 100 |
| 12 | Phullen | 74 | 14.3 | 11.7 | 100 |
| 13 | Bethlehem | 54 | 10.2 | 35.8 | 100 |
| 14 | Sairang | 53.1 | 11.2 | 35.7 | 100 |
| 15 | Dinthar | 52.2 | 10.7 | 37.6 | 100 |
| 16 | Chite | 51.4 | 11.5 | 37.1 | 100 |
| 17 | Durtlang | 51.2 | 10.8 | 38 | 100 |
| 18 | Zarkawt | 45.9 | 10.4 | 43.7 | 100 |
| | *Urban average* | *61.61* | *12.4* | *26.0* | |
| **Rural & Urban average** | | **71.1** | **11.7** | **17.1** | **100** |

Source : Field survey-2016 & 2017

Table-4.15 shows that majority of the household heads are not pass class-X both in rural and urban area. This clearly depicted that there is a high dropout rate throughout the district. As many as 61.6% in urban area are below class-X standard while exceedingly high percentage of 83.5% in rural area are not passed class-X standard.

Only 12.4% of urban household head attained class-XII level education while just 11% of rural household head attained the same educational level. While urban area scored 26% household head that are graduated and attaining other higher courses merely 6% household head who attained the same educational level in the case of rural area.

Table-4.15 *clearly shows the rural-urban differences in term of level of education and the existence of a huge gap between the two on the level of education. It also reflected*

*the overall high dropout rate in Aizawl District in spite of the fact that Aizawl district becomes the second highest literate district in India, after Serchhip district.*

### 4.12. Rural-Urban Variations on Occupation

Occupation is another important indicator of economic status of a person. It directly or indirectly shows the average economic condition of family, which in turn influences their attitude, perspectives and social well being, including their health-seeking behaviour. The present research asked the occupation of household head in rural and urban areas so as to understand and correlates their health-seeking attitudes.

**Table-4.16. Aizawl District: Occupation of household head**

| Name | Urban Average | Rural Average |
|---|---|---|
| **Student** | 1.4 | 0.3 |
| **Farmer** | 36.9 | 75.8 |
| **Govt. Servant** | 36.4 | 14.2 |
| **House wife** | 3.2 | 1.8 |
| **Business** | 18.6 | 3.5 |
| **Engineer** | 0.3 | 0.0 |
| **Medical Practitioner*** | 1.9 | 0.1 |
| **Daily labourer** | 0.2 | 3.1 |
| **Carpenter** | 0.3 | 1.2 |
| **Other** | 0.7 | 0.0 |
| **Total** | 100.0 | 100.0 |

**Medical practitioner includes-health worker, nurse and doctor*

Source : Field survey-2016 & 2017

The occupational types of Aizawl District population can be broadly classified into three, such as **farmer, government servant and business.** Out of 10 types of occupations, these three categories shared more than 96% of household occupation in the district while the remaining seven types of occupations together shared merely around 4 %. Out of the top 3 categories, farmers shared maximum number with 36.9% in urban area and 75.8% in rural area respectively, followed by government servant with 36.4% in urban area and

14.2% in rural area. There is a huge gap between rural and urban area in the case of business. Urban area shared as much as 18.6% while rural areas shared only 3.5%.

There are rural-urban variations in all the occupations and there exist a sharp divide in case of farmer, government servant and business as well. While 36.9% of urban population engaged in farming activity as many as 75.8% population in rural areas are engaged in the same activity. Similarly, there is a huge gap between rural and urban residence in the case of government servant and business occupations as well (Table-4.16).

Another interesting fact is that household head who are still students are more in urban areas than rural area. This somehow shows the better economic status of urban areas as they can still continue their education even after marriage compared with rural students.

*Table-4.16 clearly shows that more than 96 % of Aizawl District populations are depend on agriculture, government services and business while all other remaining occupational types are not much found in the state. Among these top 3, agriculture faming become the most widely practiced in the state.*

**4.13. Aizawl District: Rural-Urban gap on Annual Income**

Income and expenditure is one of the best indicators of economic status of a person or family. In any socio-economic research, income and expenditure form a centre stage to understand economic status of family, community or country, which usually propelled a better understanding about social status and overall development of a region. The present research too carefully study about economic condition of Aizawl District using this important tool. The lowest income or expenditure is standardized to Rs 21600/- as this is presently used by government of India to divide people belonging to the category of below poverty line and above poverty line.

| Table-4.17. Aizawl District: Annual income of the household | |
|---|---|
| **Rural areas** | |
| Village/Town | Average Annual Income |
| Chawilung | 123231 |
| Daido | 91567 |
| Darlawng | 95620 |
| Kelsih | 123123 |
| Khawpuar | 95000 |
| Lailak | 93000 |
| Lenchim | 94524 |
| N.Khawlek | 92470 |
| *Rural Average* | *101066.9* |
| **Urban areas** | |
| Aizawl District | Average Annual Income |
| Durtlang | 254320 |
| Zarkawt | 253020 |
| Chite | 250000 |
| Bethlehem | 242400 |
| Dinthar | 234200 |
| Sairang | 224474 |
| Thingsulthliah | 125879 |
| Aibawk | 125427 |
| Darlawn | 96544 |
| Phullen | 93379 |
| *Urban average* | *189964.3* |
| ***Rural & Urban average*** | ***150454.3*** |
| Source : Field survey-2016 & 2017 | |

Table-4.17. reveals that there is a huge gap between rural and urban areas in term of income. The average annual income of urban Aizawl District is Rs 189964/- while it is merely Rs 101066.9/-in the case of rural Aizawl District, which means there is a gap of Rs 88897.1/- between the two.

Table-4.17 also shows that there are more intra-urban differences than intra-rural differences in the annual income. In other word, rural households are somewhat proportionate in their income while urban households show lots of variations among them

*The above section clearly reflects that there is s huge gap between rural and urban area as well as intra-urban and lesser intra-rural variations as far as annual income is*

*concerned. The average annual income of rural* Aizawl District *is* Rs 101066.9/-/- *while the average income of urban* Aizawl District *is Rs 189964/-.*

### *4.14.1. Rural-Urban variation on Prevalence of Smoking*

Smoking is a well known fact that harmful for health. The present research includes number of smokers both in rural and urban Aizawl District.

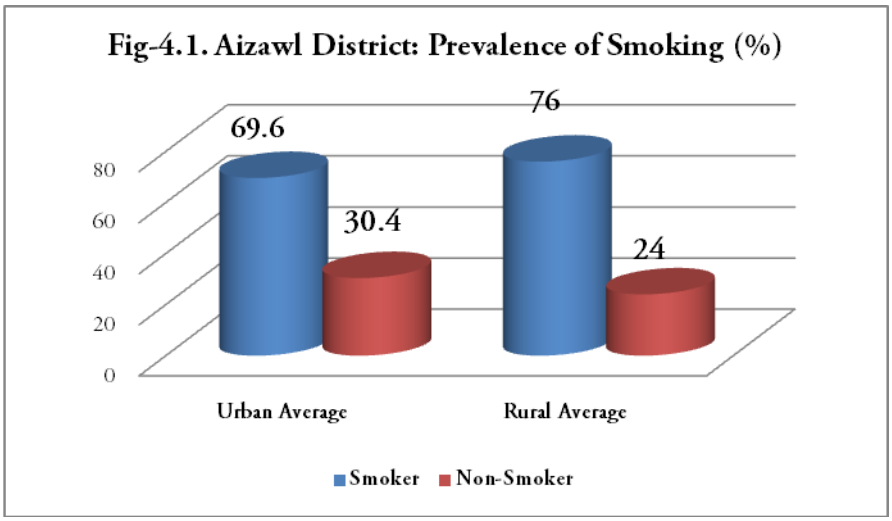
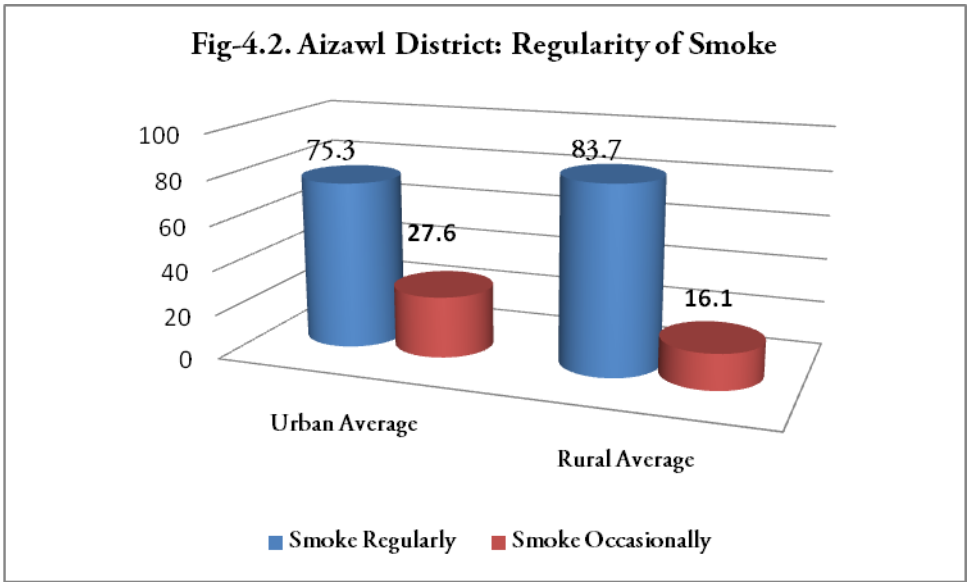



Figure-4.1 reveals that smoking is quite common in both rural and urban areas. It is observed that smokers are more in rural Aizawl District (76%) compared with urban Aizawl District (69.6%). At the same time a good number of non-smokers are also exist in both rural and urban areas with 24% and 30.4% respectively.

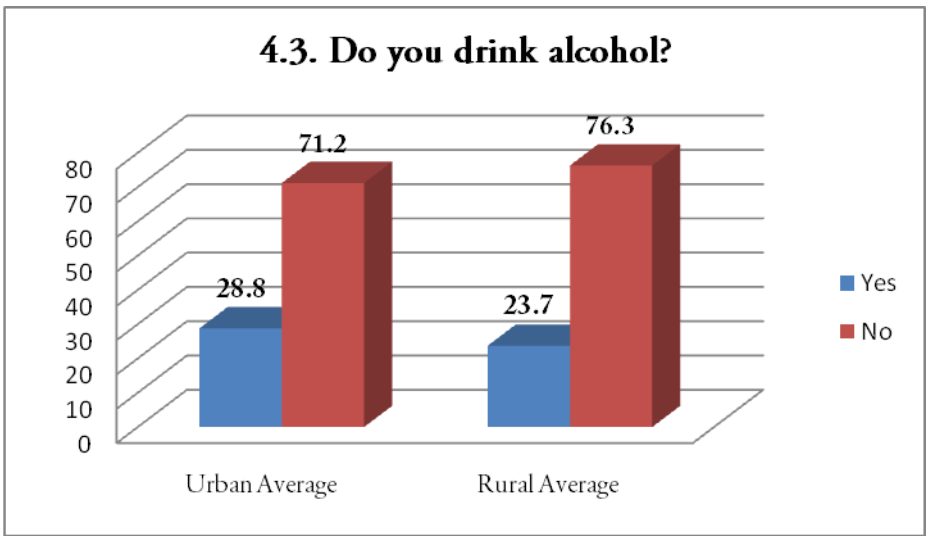



When asking regularity of smoke among smokers, a fairly high number of them reported that they smoke regularly both in rural and urban area. As shown in figure-4.1 as many as 83.7% rural residence reported that they smoke regularly while a little lesser number of urban residence (75.3%) reported the same. In rural area 16.1% of them smoke occasionally whereas 27.6% of them smoke occasionally in urban Aizawl District.

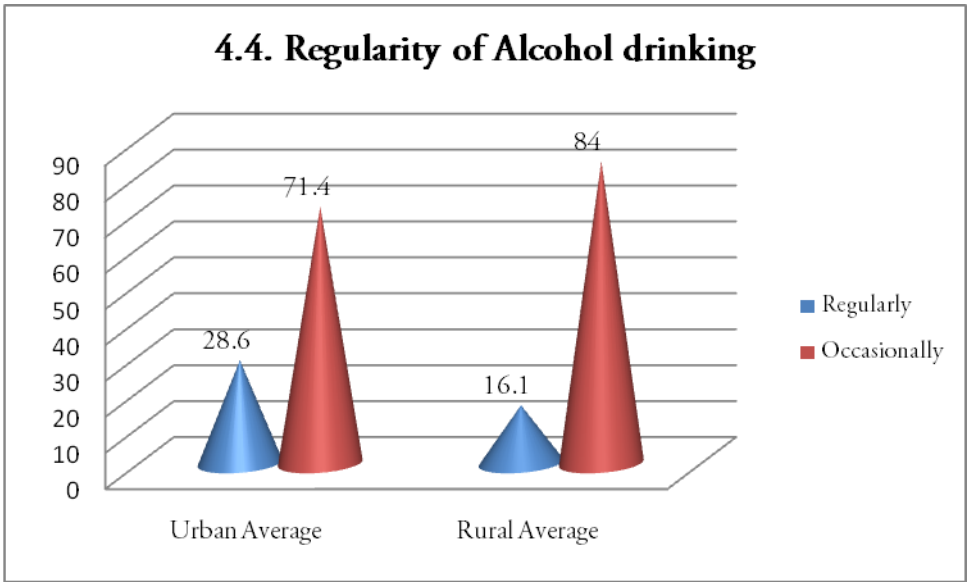
*It is clear from the research that indulgence of people in smoking is quite prominent in both rural and urban Aizawl District. As many as 69.6% urban residence and 76% rural residence are smoker in Aizawl district and a very high proportion of 75.3% in urban area and 83.7% in rural area are regular smoker.*

### *4.14.2. Rural-Urban variation on Prevalence of Drinking Alcohol*

Drinking alcohol is one responsible factor that causes health problems world-wide and majority of drinkers are usually over-drinker. Even in the context of Aizawl District, alcohol drinking causes many social and health problems and in the recent year many people lost their lives due to excessive drinking of alcohol. The present study highlights general information about the prevalence of alcohol drinking in rural and urban areas.




Drinking alcohol in Aizawl District is lesser compared with smoking. However, figure-4.3 shows that a good number of people are indulged in alcohol drinking in both rural and urban areas. It is interesting to find that unlike smoking, drinking alcohol is more common among urbanites than rural folks with 28.8% and 23.7% respectively.




When asking regularity of alcohol drinking, as many as 28.6% of alcohol drinkers in urban areas are reported of drinking regularly and 71.4% reported drinking occasionally

whereas in the case of rural areas 16.1% drinkers reported of drinking regularly and a good number of 84% drink occasionally.

*It is interesting to find out that drinking alcohol is common in* Aizawl District *as more than 28% in urban area and a little over 23% in rural area are indulged in alcohol drinking. It is also observed that both in alcohol drinking and regularity, urbanites are more indulged than rural folks in the district.*

**4.15. Conclusion**

From the overall discussion of the socio-economic condition across Aizawl district, the following conclusion can be made, such as:-

*As far as educational attainment is concerned, there is a huge inter-village gap, inter-block variation and rural-urban disparities in Aizawl district. It is interesting to find out that even though Aizawl district became the second highest literate district in India, majority of the household heads have below class-X level education (71.1%) while merely 11.2% passed class-XII and just 17.1% passed bachelor degree or above. There exist dropout rate in Aizawl District.*

*It is observed that there are three broad types of occupations in Aizawl district such as* ***farmer, government servant and business****. Out of these three, agriculture farming is the most common occupational type with 53.8% engaged in this activity, followed by government service (24%) and business (17.3%). It is also clearly explored that more than 96 % of Aizawl District populations are depend on agriculture, government services and business while all other remaining occupational types are not much found in the state.*

*As far as income is concerned, it can be concluded that the average annual income of Aizawl district is Rs 150454/-. The average annual income of rural Aizawl district is Rs*

*101066.9/-/- while the average annual income of urban Aizawl District is Rs 189964/-. Among the categories, the annual income category of Rs 100000-200000/- got maximum proportion while the average annual income of Rs 300000/- record minimum proportion. It is also found out that there is huge gap between rural and urban area as well as intra-urban and lesser intra-rural variations as far as annual income is concerned.*

*It can be concluded that smoking in very much common in Aizawl district as majority of the population (64.5%) are smoker while merely 35.4% claimed themselves are free from smoking. Among the smoker 66.3 % of them are regular smokers while* 33.6% are occasional smokers. *It is clear from the research that indulgence of people in smoking is quite prominent in both rural and urban Aizawl District. As many as 69.6% urban residence and 76% rural residence are smoker in Aizawl district and a very high proportion of 75.3% in urban area and 83.7% in rural area are regular smokers.*

*It is also reveals that drinking alcohol in Aizawl district is quite common as 26.5% of them are drinking alcohol while 73.4% are restraining from alcohol drinking. It also appears that drinking alcohol is more common in rural area than urban area. However, as far as 'regularity of alcohol drinking is concerned, urban residence are more indulged than rural folks in the district.*

*It has also been found out that 'occasional alcohol drinkers' (78.3%) are relatively higher in number compared with 'regular alcohol drinkers' (18.19%) in Aizawl district. Sairang record the highest percentage of 'regular alcohol drinker' while N.Khawlek village record the least. Among the blocks, Aibawk (20.6 %) and Tlangnuam (19.59 %) records maximum proportion of people who drink alcohol 'regularly' while Thingsulthliah*

*(18.6 %), Darlawn (16.5 %) and Phullen (15.7 %) blocks records minimum proportion of drinkers who drink alcohol 'regularly'.*

# CHAPTER - V

## HEALTH-SEEKING BEHAVIOUR IN AIZAWL DISTRCT

### 5.1. Introduction

The present chapter analyses on the main theme of the research. It focuses on the health-seeking behaviour of people living in Aizawl district. The main components of the chapter are- prevalence of sickness in Aizawl district, whether family members are going for check-up in times of illness or not? To find out the reasons why family members were not went for check-up even if they have health complications. The chapter also discusses on the resent health-seeking behaviour of the study area, especially during the last one year. Analysis also included performance of service providers like doctor, nurse and health workers. The present chapter also covers major determinants of health-seeking behaviour in Aizawl district, maternal and child health as well as common diseases and prevalence of death and its reasons. The analysis can broadly be categorized into rural-urban variations or inter-villages differences in health-seeking behaviour as well as inter-block variation on health-seeking behaviour and its related issues in the district. It is also important to mention here that all the five blocks headquarters of Aizawl districts were considered as 'urban area' apart from localities within Aizawl city and notified town of Sairang. Even though all the Rural Development Block headquarters are literally 'rural area' except Tlangnuam, which is located within Aizawl Municipal area. This is done solely for the

present study as we intend to make contextual analysis and regional understanding of the selected study area.

### 5.2. Prevalence of sickness

The first and foremost important issue we had dealt in the research is to know the prevalence of diseases or sickness in the study area. Information on this regard has been collected through sample questionnaire in the household level. Table-5.1 highlighted information of all the sample villages/town on the prevalence of sickness. The question asked family head or whoever available during the survey about the family history of sickness. We also compared rural-urban variation on this regards.

Table-5.1. Aizawl District: Is anybody ever got sick in your family

| **Rural areas** | | | |
|---|---|---|---|
| Village/Town | **Yes** | **No** | **Total** |
| Chawilung | 95.5 | 4.5 | 100 |
| Daido | 92.8 | 7.2 | 100 |
| Darlawng | 94.2 | 5.8 | 100 |
| Kelsih | 96.1 | 3.9 | 100 |
| Khawpuar | 95.5 | 4.5 | 100 |
| Lailak | 96.4 | 3.6 | 100 |
| Lenchim | 93.5 | 6.5 | 100 |
| N.Khawlek | 91.5 | 8.5 | 100 |
| ***Rural Average*** | ***94.4*** | ***5.5*** | ***100*** |
| Urban areas | | | |
| Aizawl District | Yes | No | Total |
| Durtlang | 68.1 | 31.9 | 100 |
| Zarkawt | 68.2 | 31.8 | 100 |
| Bethlehem | 68.2 | 31.8 | 100 |
| Dinthar | 68.51 | 31.49 | 100 |
| Chite | 69 | 31 | 100 |
| Sairang | 72 | 28 | 100 |
| Thingsulthliah | 95.8 | 4.8 | 100 |
| Aibawk | 97 | 3 | 100 |
| Darlawn | 97 | 3 | 100 |
| Phullen | 94.1 | 5.9 | 100 |
| ***Urban average*** | ***79.7*** | ***20.2*** | ***100*** |
| **Rural & Urban average** | **86.3** | **13.7** | **100** |

Source : Field survey-2016 & 2017

Table-5.1 reveals that sickness is extremely common in Aizawl district as 86.3% of the samples households are reported of having experience health complications in their life time. Only 13.7% are not experiencing sickness in their life time.

Looking at the above table, it is also clear that there exist a huge variation of sickness between rural and urban residence. As many as 94.4% rural residents experienced sickness whereas relatively fewer proportions of 79.7% urban residences are reporting the same case.

Among the sample villages/town Aibawk and Darlawn (97%) record the highest percentage of sickness, followed by Lailak village (96.4%), Kelsih, Thingsualthliah and Khawpuar villages whereas Durtlang locality (68.1%) record the least proportion of sickness, followed by Zarkawt, Bethlehem and Chite localities, which are all located within Aizawl Municipal area.

*It can be concluded that sickness is fairly common in both rural and urban areas of Aizawl district. As many as 86.3 % families are reported of experiencing illness in their life time while merely 20.2% in urban areas and 5.5 % in rural areas are reported of not having experienced illness in their life time.*

**5.3. Health-seeking Behaviour in time of illness**

This section highlights the general information about health-seeking behaviour of family member in time of illness. Table-5.2 shows whether family members went for check-up or not in time of illness. A fairly high proportion of 76.7% in Aizawl district reported of visiting healthcare facilities or healthcare providers in time of illness whereas 23.4% were not went for check-up even if they have health problems.

Looking at rural-urban variation on the performance of health-care seeker, there is a wide gap between the two as rural people reported that 66.3% of them went for check-up when they have health complications while a more higher proportion of 84.6% of urban dwellers were reported the same.

| Table-5.2. Aizawl District: Family member go for check up in time of illness | | | |
|---|---|---|---|
| **Rural areas** | | | |
| Village/Town | **Yes** | **No** | **Total** |
| Chawilung | 72.4 | 27.6 | 100 |
| Daido | 63.0 | 37.0 | 100 |
| Darlawng | 71.5 | 28.5 | 100 |
| Kelsih | 72.5 | 27.5 | 100 |
| Khawpuar | 58.8 | 41.2 | 100 |
| Lailak | 61.4 | 38.6 | 100 |
| Lenchim | 67.0 | 33 | 100 |
| N.Khawlek | 64.5 | 35.5 | 100 |
| ***Rural Average*** | ***66.3*** | ***33.6*** | ***100*** |
| **Urban areas** | | | |
| Aizawl District | Yes | No | Total |
| Durtlang | 96.5 | 3.5 | 100 |
| Zarkawt | 97.2 | 2.8 | 100 |
| Bethlehem | 95.7 | 4.5 | 100 |
| Dinthar | 95.5 | 4.5 | 100 |
| Chite | 96.4 | 3.6 | 100 |
| Sairang | 91.8 | 8.2 | 100 |
| Thingsulthliah | 72.4 | 27.6 | 100 |
| Aibawk | 73.5 | 26.5 | 100 |
| Darlawn | 62.2 | 37.8 | 100 |
| Phullen | 65.1 | 34.9 | 100 |
| ***Urban average*** | ***84.6*** | ***15.3*** | *100* |
| **Rural & Urban average** | **76.5** | **23.4** | **100** |
| Source : Field survey-2016 & 2017 | | | |

As far as inter-village and inter-town variation on health seeking behaviour is concerned, it is interesting to note that Durtlang, where one of the oldest hospital of Mizoram is located, record the highest proportion who seek healthcare in time of illness. Looking at the intra-urban variation, there was a minimal variation among them while there was wide-gap among the villages. The family member who went for check-up in time of illness in the urban areas is high, such as Durtlang (96.5%), Zarkawt (97.2%), Bethlehem (95.7%), Dinthar (95.5%) and Chite (96.4%). This is due to the concentration heath facilities in urban areas. It is worthy to mention here that around half of hospitals in Mizoram are located within Aizawl city.

The family member who went for check-up in times of illness is comparatively lesser in rural area. This are mainly due to poor utilization of primary health care services: including poor socio-economic status, lack of physical accessibility, cultural beliefs and perceptions, low literacy level of the household head and large family size.

*It can be concluded that illness is prevalent in the study area of Aizawl district. It is also sad to find out that health complications were so prevalent for as many as 76.5% of families in rural and urban areas are reported of experiencing sickness in their life time. However, out of which only 84.63% in urban areas and just 66.3% in rural areas went for check-up in time of illness. It is so sad that as many as 33.6% in rural areas and 23.4% in urban areas are not at all seeking health care in time of illness.*

**5.4. Factors determining health-seeking behaviour**

Literatures show that there are various factors that stop people to seek health care when they felt sick. The most common factors we take into account present research includes-poverty or cost too much, location and distance problems or healthcare facilities, located too far, problems of accessibility or transport problem, inaccessibility or improper road, required for household work, no proper heath facilities, ignorance or not interested in check up, required for work on agricultural field, required for outside work for payment in cash or kind. Table-5.3 shows nine determining factors of health-seeking behaviour, which includes accessibility problems, household work, engagement in agriculture activities or engagement in business, poverty and poor healthcare infrastructure.

| Table-5.3. Aizawl District: Reason for not check-up in time of illness | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Village/ Town | Cost Too much | Too Far | Transport Problem | Improper Road | Require for household Work | No Proper HC facilities | Not interest in check-up | RA | RP | Total |
| ***Rural areas*** | | | | | | | | | | |
| Chawilung | 63.5 | 38 | 15 | 9 | 4.5 | 5.6 | 8 | 2.1 | 3.1 | 100 |
| Daido | 62.4 | 26 | 14 | 8 | 3.5 | 5.4 | 6 | 1.5 | 3.2 | 100 |
| Darlawng | 58.3 | 24 | 12 | 7 | 4.5 | 6 | 6 | 1.2 | 2.1 | 100 |
| Kelsih | 53.4 | 30 | 7 | 0 | 3.1 | 0 | 8 | 0.1 | 1.2 | 100 |
| Khawpuar | 42.5 | 35 | 15 | 7 | 6.2 | 7.4 | 7 | 2.1 | 2.4 | 100 |
| Lailak | 41.6 | 24 | 15 | 8 | 5.6 | 8 | 4 | 1.3 | 1.3 | 100 |
| Lenchim | 41.5 | 34 | 13 | 8 | 4.5 | 7.5 | 8 | 1.5 | 1.3 | 100 |
| N.Khawlek | 38.4 | 22 | 13 | 5 | 4.6 | 5 | 7 | 1.2 | 1.3 | 100 |
| ***Rural Average*** | ***50.2*** | ***29.1*** | ***13*** | ***6.5*** | ***4.6*** | ***5.6*** | ***6.8*** | ***1.4*** | ***1.9*** | ***100*** |
| ***Urban Areas*** | | | | | | | | | | |
| Darlawn | 58.2 | 34 | 18 | 8 | 2.5 | 6.2 | 6 | 2.2 | 21 | 100 |
| Sairang | 52.5 | 0.21 | 0.36 | 0.36 | 0.42 | 0.22 | 0.5 | 1.2 | 0.4 | 100 |
| Aibawk | 52.5 | 24 | 8 | 0 | 3.2 | 0 | 6 | 0.3 | 1.4 | 100 |
| Phullen | 36.6 | 24 | 10 | 4 | 3.3 | 6.4 | 5 | 0.5 | 1.2 | 100 |
| Thingsulthliah | 35.2 | 20 | 12 | 4 | 3.4 | 4 | 8 | 1.4 | 1.2 | 100 |
| Chite | 27 | 0.45 | 0.48 | 0.48 | 0.39 | 0.72 | 0.3 | 1.2 | 0.2 | 100 |
| Dinthar | 26 | 0.25 | 0.46 | 0.46 | 0.36 | 0.63 | 0.4 | 1.2 | 0.2 | 100 |
| Durtlang | 25 | 0.24 | 0.55 | 0.45 | 0.38 | 0.76 | 0.2 | 1.2 | 0.2 | 100 |
| Bethlehem | 24 | 0.35 | 0.67 | 0.43 | 0.36 | 0.72 | 0.3 | 1.2 | 0.1 | 100 |
| Zarkawt | 22 | 0.3 | 0.18 | 0.52 | 0.37 | 0.51 | 0.1 | 1.2 | 0.1 | 100 |
| ***Urban Average*** | ***35.9*** | ***10.4*** | ***5.1*** | ***1.9*** | ***1.5*** | ***2*** | ***2.7*** | ***1.2*** | ***2.6*** | ***100*** |
| **Rural & Urban Average** | **42.3** | **18.7** | **8.6** | **3.9** | **2.8** | **3.6** | **4.5** | **1.3** | **2.3** | **100** |
| RA=Required for work on agricultural field or family business (shops, retail shops, grocery etc.) | | | | | | | | | | |
| RP=Required for outside work for payment in cash or kind | | | | | | | | | | |
| Source : Field survey-2016 & 2017 | | | | | | | | | | |

Table-5.3 clearly reveals that amongst the determining factors poverty or cost too much is the most common reasons that stop people to seek healthcare as 42.3% reasoned poverty as the main obstacle for them to prevent health-seeking in time of illness. After poverty problem of accessibility or distance of healthcare facilities is another big hurdles for health–seekers in Aizawl district for as many as 18.7% reported it as the main factor that stop them from health-seeking. In addition, accessibility of transport problems also contributed for another important factor that averted people from health-seeking in the district. There are other factors that are responsible to block people from health-seeking includes- not interested in check-up (4.5%), improper road (3.9%), no proper healthcare

facilities (3.6%), required for household work (2.8%), required for outside work for payment in cash or kind (2.3%)and required for work on agricultural field or family business (shops, retail shops, grocery etc.) with1.3%.

The problems are more or less similar in both in rural and urban areas, except the intensity is difference. Poverty or cost too much is the main obstacle for healthcare seekers in both rural and urban area with 50.2% and 35.9% respectively. In the same manner, accessibility of distance of healthcare facilities is the second factor that stops people from health seeking with 29.1% in rural and 10.4% in urban area. Transport problems or availability of vehicles in time of illness is another major factor for both rural (13%) and urban (5.1%) area. There are some striking differences of rural and urban residences. For example: while the problem of improper road seems very much common in rural area, the same case is not much valid in the context of urban area. Similarly, require for household work and no healthcare facilities seems a big hurdles for healthcare seekers whereas it not for urban areas (table-5.3)

*Therefore, it is clearly reveals that poverty or cost too much is the most common reasons that stop people to seek healthcare both in rural and urban areas with 50.2% and 42.3% respectively. Accessibility is another major factor that obstructs people form health seeking. As many as 31.2% faced accessibility problems by taking together of all accessibility factors such as too far (18.7%), transport problem (8.6%), improper road (3.9%).In rural area accessibility problems is more significant in stopping people to search health care than urban areas. Apart from these, problem of unavailability of healthcare facility is also clearly observed for controlling health-seeking behaviour of the people in Aizawl District.*

## 5.5. Recent Health-seeking Behaviour

Previous section discussed general health-seeking behaviour and problems in their life time. In order to get latest information of the health-seeking behavior of the study area we asked information and health-seeking activities during the last one year.

Health-seeking behaviour has been defined as a "sequence of remedial actions that individuals undertake to rectify perceived ill-health." In particular, health-seeking behaviour can be described with data collected from information such as the time difference between the onset of an illness and getting in contact with a healthcare professional, type of healthcare provider patients sought help from, how compliant patient is with the recommended treatment, reasons for choice of healthcare professional and reasons for not seeking help from healthcare professionals.

In the broadest sense, health-seeking behaviour includes all behaviours associated with establishing and maintaining a healthy physical and mental state, (Primary Prevention). Health-seeking behaviours also include behaviours that deal with any digression from the healthy state, such as controlling (Secondary Prevention) and reducing impact and progression of an illness (Tertiary prevention).

**Table-5.4. Did any of HH member visit Health institution for treatment during the last one year**

| **Rural areas** | | | |
|---|---|---|---|
| **Village/Town** | Yes | No | Total |
| **Darlawng** | 49.5 | 50.5 | 100 |
| **Lenchim** | 48.2 | 51.8 | 100 |
| **Kelsih** | 47.2 | 52.8 | 100 |
| **Aibawk** | 47.2 | 52.8 | 100 |
| **Chawilung** | 47 | 53 | 100 |
| **N.Khawlek** | 42.5 | 57.5 | 100 |
| **Daido** | 40.6 | 59.4 | 100 |
| **Khawpuar** | 38.2 | 61.8 | 100 |
| **Lailak** | 38.2 | 61.8 | 100 |
| ***Rural Average*** | ***44.2*** | ***55.7*** | ***100*** |
| **Urban Areas** | | | |
| **Aizawl district** | Yes | No | Total |
| **Zarkawt** | 53.4 | 46.6 | 100 |
| **Sairang** | 52.6 | 47.4 | 100 |

| | | | |
|---|---|---|---|
| **Dinthar** | 52.5 | 47.5 | 100 |
| **Chite** | 52.4 | 47.6 | 100 |
| **Bethlehem** | 52.1 | 47.9 | 100 |
| **Durtlang** | 52 | 48 | 100 |
| **Thingsulthliah** | 50.8 | 49.2 | 100 |
| **Aibawk** | 47.2 | 52.8 | 100 |
| **Phullen** | 43.2 | 56.8 | 100 |
| **Darlawn** | 39.1 | 60.9 | 100 |
| ***Urban Average*** | ***49.5*** | ***50.4*** | ***100*** |
| ***Rural & Urban Average*** | **47** | **52.9** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.4 shows that 47.0 % of them are visiting health institution for treatment during the last one year whereas a higher proportion of 52.9% are not visiting healthcare facilities during the last one year.

Rural-urban variation of visiting health institution during the last one year is also not much varied. There are 44.2% rural residence visiting health institution in the one year while 49.5% in the case of urban residence.

It is interesting to mention here that people in district visit health institution only when they have complications and even when they have minor complication they avoid health care as far as possible, especially in rural area. Many people reported that they avoid visiting healthcare facilities or health personnel by apprehension of finding out their problems, which might lead to lot of expenditure for treatment. This clearly validates the finding that 'poverty' is the main hurdles for people living in Aizawl district.

### 5.6. Consultation of health personnel

Another significant factor in the study of health-seeking behaviour is to identify to whom the sick person went for treatment. This also reveals the attitude of patients as well as availability of medical personnel in his reach

Health status indicators that requires clinical consultation, patients may consults government doctor, nurse, ANM/LVH/Supervisor/Health Worker, Traditional healer/DAI,

Anganwadi worker. Effective clinician communication skills are well recognized as beneficial for both patients and clinicians.

| Table-5.5. Aizawl District: Whom did you see | | | | | |
|---|---|---|---|---|---|
| **Rural areas** | | | | | |
| **Village/Town** | Govt. doctor/nurse | ANM/LVH/ Supervisor/ Health worker | Traditional healer/DAI | Anganwadi worker | Total |
| **N.Khawlek** | 93.2 | 4.6 | 2.2 | 0 | 100 |
| **Darlawng** | 92.6 | 4 | 3.4 | 0 | 100 |
| **Kelsih** | 92.6 | 7.04 | 0.3 | 0 | 100 |
| **Daido** | 92.5 | 4 | 3.5 | 0 | 100 |
| **Chawilung** | 91.8 | 6.4 | 1.8 | 0 | 100 |
| **Lenchim** | 91.5 | 5 | 3.5 | 0 | 100 |
| **Khawpuar** | 81.6 | 10.4 | 8 | 0 | 100 |
| **Lailak** | 80.8 | 9 | 10.2 | 0 | 100 |
| ***Rural Average*** | ***89.5*** | ***6.3*** | ***4.1*** | ***0*** | ***100*** |
| **Urban Areas** | | | | | |
| **Urban / City** | Govt. doctor/nurse | ANM/LVH/ Supervisor/ Health worker | Traditional healer/DAI | Anganwadi worker | Total |
| **Durtlang** | 100 | 0 | 0 | 0 | 100 |
| **Zarkawt** | 100 | 0 | 0 | 0 | 100 |
| **Bethlehem** | 100 | 0 | 0 | 0 | 100 |
| **Dinthar** | 100 | 0 | 0 | 0 | 100 |
| **Chite** | 100 | 0 | 0 | 0 | 100 |
| **Sairang** | 100 | 0 | 0 | 0 | 100 |
| **Phullen** | 93.9 | 5.2 | 0.9 | 0 | 100 |
| **Thingsulthliah** | 93.4 | 6 | 0.6 | 0 | 100 |
| **Aibawk** | 93.1 | 6.9 | 0 | 0 | 100 |
| **Darlawn** | 82.4 | 11.2 | 6.4 | 0 | 100 |
| ***Urban Average*** | ***96.28*** | ***2.93*** | ***0.79*** | ***0*** | ***100*** |
| **Rural & Urban Average** | **93.1** | **4.5** | **2.3** | **0** | **100** |
| Source : Field survey-2016 & 2017 | | | | | |

Table-5.5. shows the health-seeking behavior of pertaining to consultation of health personnel. An exceedingly high number of 93.1 % patients consulted government doctor or nurse while 4.5 % consulted NM/LVM/supervisor/health worker and 2.3 % consulted traditional healer/DAI.

There exist slight variations between rural and urban health-seekers. For example: while consultation of government doctor/nurse is high, consultation of ANM/LVH/ Supervisor/ Health worker is comparatively higher in rural area than urban area. This reflects the more availability of medical doctors in urban areas compared to rural ones. It is

also interesting to highlight that consultation of traditional healer is more common in rural area 94.1%) compared with urban area (0.79%).

Especially consultation of medical doctor is 100% within Aizawl city where doctors are available 24 hours compared with other places.

*Therefore, it can be concluded that majority of patients are consulting government doctors and nurses with 96.2 % in urban area and 89.5 % in rural area respectively. Consultation of health worker and health supervisor are more common in rural area (6.3 %) than urban area (4.5%) as well as consultation of traditional healer is comparatively more prevalence in rural area (4.1 %) than urban area (2.3 %).*

**5.7. Performance of Service Providers**

The present segment highlighted about the performance of service providers in rural and urban areas. This is another way of looking the behaviour of healthcare providers towards patients. It is included in the present study to mainly understand how far service providers make commitment and dedication to their profession, which, in turn, might influence the health-seeking behaviour of people.

To meet increasing performance demands, service providers need the ability to make dynamic connections from any point in the network to any tool. Service providers may need to improve their performance, in quality of care and boost cost effectiveness.

Table-5.6. Aizawl District: Did the staff talk to him/her

| **Rural areas** | | | |
|---|---|---|---|
| Village/|Town | Nicely | Not nicely | Total |
| N.Khawlek | 76.2 | 24.5 | 100 |
| Daido | 75.5 | 24.5 | 100 |
| Kelsih | 74.6 | 25.4 | 100 |
| Chawilung | 74.5 | 25.5 | 100 |
| Lailak | 73.2 | 26.8 | 100 |
| Khawpuar | 71.5 | 28.5 | 100 |

| | | | |
|---|---|---|---|
| Lenchim | 64.2 | 35.8 | 100 |
| Darlawng | 63.5 | 36.5 | 100 |
| ***Rural Average*** | **71.2** | **28.4** | **100** |
| **Urban Areas** | | | |
| Aizawl District | Nicely | Not nicely | Total |
| Chite | 96.1 | 3.9 | 100 |
| Dinthar | 90.1 | 9.9 | 100 |
| Bethlehem | 89.6 | 10.4 | 100 |
| Durtlang | 89.4 | 10.6 | 100 |
| Sairang | 89.3 | 10.7 | 100 |
| Zarkawt | 88.5 | 11.5 | 100 |
| Phullen | 78.4 | 21.6 | 100 |
| Aibawk | 77.4 | 22.6 | 100 |
| Darlawn | 72.5 | 27.5 | 100 |
| Thingsulthliah | 65.8 | 34.2 | 100 |
| ***Urban Average*** | ***83.7*** | ***16.29*** | ***100*** |
| ***Rural & Urban Average*** | **78.3** | **21.6** | **100** |
| Source : Field survey-2016 & 2017 | | | |

When asked patient about their interaction with health personnel, 71.2 % rural folks are reporting that health personnel are taking him nicely while 83.7 % do the same report in the case of urbanites. On the other hands 28.4 % of rural residence is reporting health personnel are not talking him nicely while more 16 % reported the same in urban area.

*Thus, it is found out that service providers are by and large performed well in Aizawl district. However, complaints about service providers are more common in rural areas than urban areas.*

### 5.8. Health Care Givers

Identifying healthcare giver and consultation of medical specialties significantly reflected types of diseases and complication among the general populations. It also reflects availability and awareness of patient about healthcare facilities.

Table-5.7 highlighted common healthcare providers like Medical Officer (MO) or Medicine specialist, physiotherapist, radiotherapist, surgeon, and dieticians and stoma nurse. It is necessary to clarify that almost all the district hospitals and PHCs has only Medical Officer (MO), whose qualification is MBBS, and no medicine specialist.

However, rural folks were not able to differentiate MBBS and specialist; therefore, we considered the two in similar manner for the sake of present research.

| Table -5.7. Aizawl District: No. of patients visiting different care givers during the last one year | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Rural areas** | | | | | | | |
| **Village/Town** | Medicine specialist/ MO* | Physiotherapist | Radiotherapist | Surgeon | Dietician | Stoma Nurse | Total |
| **Chawilung** | 75.3 | 5.8 | 5.7 | 3.7 | 0 | 0 | 100 |
| **Daido** | 77.5 | 4.3 | 9.4 | 3.1 | 0 | 0 | 100 |
| **Darlawng** | 79.5 | 6.4 | 8.3 | 3.6 | 8 | 0 | 100 |
| **Kelsih** | 75.4 | 5.4 | 6.2 | 4.2 | 6.4 | 0 | 100 |
| **Khawpuar** | 78.2 | 2.1 | 6.6 | 4.4 | 6.6 | 0 | 100 |
| **Lailak** | 78 | 2.4 | 6.7 | 2.7 | 0 | 0 | 100 |
| **Lenchim** | 60.4 | 5.6 | 7.9 | 3.1 | 0 | 0 | 100 |
| **N.Khawlek** | 77.4 | 4.2 | 9.5 | 3.6 | 9.4 | 0 | 100 |
| ***Rural Average*** | ***75.2*** | ***4.5*** | ***7.5*** | ***3.5*** | ***7.6*** | ***0*** | ***100*** |
| **Urban Areas** | | | | | | | |
| **Durtlang** | 61.2 | 9.5 | 9.5 | 11.5 | 9.6 | 0 | 100 |
| **Zarkawt** | 60.6 | 10.1 | 9.7 | 12.4 | 9.4 | 0 | 100 |
| **Bethlehem** | 60.8 | 9.6 | 9.4 | 12.2 | 9.5 | 0 | 100 |
| **Dinthar** | 61.4 | 9.4 | 9.6 | 11.4 | 9.6 | 0 | 100 |
| **Chite** | 62.1 | 9.5 | 9.5 | 10.5 | 9.4 | 0 | 100 |
| **Sairang** | 61.2 | 9.3 | 9.9 | 17 | | 0 | 100 |
| **Thingsulthliah** | 79.8 | 6.6 | 8.4 | 3.8 | 8.1 | 0 | 100 |
| **Aibawk** | 75.8 | 5.6 | 6.4 | 4.4 | 6.2 | 0 | 100 |
| **Darlawn** | 78.4 | 2.4 | 6.8 | 4.6 | 6.4 | 0 | 100 |
| **Phullen** | 77.6 | 4.4 | 9.6 | 3.8 | 9.2 | 0 | 100 |
| ***Urban Average*** | ***67.8*** | ***7.64*** | ***8.88*** | ***9.16*** | ***8.6*** | ***0*** | ***100*** |
| **Rural & Urban Average** | **71.1** | **6.2** | **8.2** | **6.6** | **8.2** | **0** | **100** |

*In most cases patient consult Medical Officer (MO) in PHC or district hospital and wherever there are medicine specialist they consulted. For convenience, we treat them as same cause patient could hardly able to differentiate them, even though MO were MBBS while Medicine specialist were MD.

Table-5.7. shows that majority of the patients are consulting Medical officer (MO) or medicine specialist (71.1%) in Aizawl district. Interestingly, the percentage of consultation of radiotherapist and dieticians are similar with 8.2% each, followed by consultation of surgeon (6.6%) and physiotherapist (6.2%).

Consultation of healthcare providers has more or less similar pattern in both rural and urban area. However, consultation or MO or medicine specialist is fairly high in rural areas (75.2%) than urban average (67.8%). It is also interesting that consultations of all medical personals are more common in urban area than rural area. This shows that awareness on healthcare is more in urban area than rural area.

*Therefore, it is found that consultations of care-givers are common all over the district. Visiting medicine specialist become the most common practiced in Aizawl District, followed by consultation of radiotherapist and dietician. It is also observed that there is an increasing awareness and consultations of physiotherapists and dietician in Aizawl district, particularly during the last couple of years.*

## 5.9. Observation of healthcare facilities

Perception and observation of healthcare facilities by patients is another important parameter to understand the overall performance of healthcare seekers. Whether patients are satisfy with the available facilities or not? Are they happy and find the health institution clean or not, can really influence their health-seeking attitude.

Table-5.8. Aizawl District: Cleanliness of health facilities

| Aizawl District | Very Clean | Somewhat Clean | Not Clean | No response | Total |
|---|---|---|---|---|---|
| Chawilung | 19.19 | 72.95 | 8 | 0 | 100 |
| Daido | 38.3 | 51.6 | 7.3 | 2.8 | 100 |
| Darlawng | 40.1 | 50.4 | 8.5 | 1.2 | 100 |
| Kelsih | 20.3 | 69.1 | 9.4 | 1.2 | 100 |
| Khawpuar | 34.1 | 56.3 | 9.3 | 0.3 | 100 |
| Lailak | 34 | 55.6 | 9.2 | 1.2 | 100 |
| Lenchim | 39.3 | 49.4 | 9.2 | 2.1 | 100 |
| N.Khawlek | 36.5 | 52.4 | 7.1 | 4 | 100 |
| ***Rural Average*** | ***32.7*** | ***57.2*** | ***8.5*** | ***1.6*** | ***100*** |
| Urban areas | | | | | |
| Durtlang | 58.8 | 48.2 | 6.9 | 0 | 100 |
| Zarkawt | 44.5 | 47.3 | 6.5 | 1.7 | 100 |
| Bethlehem | 43.6 | 46.4 | 6.8 | 0 | 100 |
| Dinthar | 42.1 | 48.2 | 6.7 | 3 | 100 |
| Chite | 43.2 | 47.2 | 6.6 | 3 | 100 |
| Sairang | 42.5 | 55.2 | 8.32 | 0 | 100 |
| Thingsulthliah | 41.2 | 52.4 | 8.7 | 0 | 100 |
| Aibawk | 19.4 | 70.2 | 9.5 | 0.9 | 100 |
| Darlawn | 34.2 | 55.2 | 9.4 | 1.2 | 100 |
| Phullen | 37.4 | 53.2 | 7.2 | 2.2 | 100 |
| ***Urban Average*** | ***41.0*** | ***52.2*** | ***7.7*** | ***1.0*** | ***100*** |
| **Rural & Urban average** | **38.2** | **53.4** | **8** | **1..4** | **100** |

Source 4.1.3 : Field survey-2016 & 2017

Table-5.8 reveals that just 38.2% patients reported that the healthcare facilities are ‘very clean’ while a fairly high number (53.2 %) of them opined that healthcare facilities are somewhat clean and onlyb8 5 of them found the healthcare facilities are ‘not clean’.

Rural people are unhappy towards the cleanliness of the healthcare facilities as only 32.7% of them said it is ‘very clean’ while a more proportion of 41% do said the same in urban area. Maximum percentage of both rural and urban people observed that the healthcare facilities are ‘somewhat clean’ with 57.2 % in rural area and 53.2% in urban area respectively. A lesser number of 8 % in urban Aizawl District are reporting the healthcare facilities are not clean while a higher number of 8.5 % in rural area are reporting the same. *The research found out that the overall observations about healthcare facilities in Aizawl District are somewhat satisfactory.*

**5.10. Sufficiency of Healthcare Facilities**

Health facilities are places that provide health care such as hospitals, clinics, outpatient care centers, and specialized care centers. A health facility is, in general, any location where healthcare is provided. Health facilities range from small clinics and doctor's offices to urgent care centers and large hospitals with elaborate emergency rooms and trauma centers. The number and quality of health facilities in a country or region is one common measure of that area's prosperity and quality of life.

Perception about adequacy of healthcare facilities is significant to influence health-seeking behaviour of people. It is assumed that if people are satisfying the healthcare facilities, they might visit the facility more frequently with trust and vice-versa. The present study limited its research on government healthcare only.

| Table-5.9. Aizawl District: Sufficiency of government healthcare facility | | | | | | |
|---|---|---|---|---|---|---|
| **Rural areas** | | | | | | |
| Aizawl District | Very Good | Adequate | Poor | Very Poor | No Response | Total |
| Chawilung | 2.3 | 44.4 | 35.8 | 3.9 | 13.6 | 100 |
| Daido | 2.7 | 44 | 39.6 | 9.8 | 3.9 | 100 |
| Darlawng | 4.3 | 47.2 | 37.6 | 6.1 | 4.8 | 100 |
| Kelsih | 1.2 | 44.5 | 38.2 | 3.4 | 12.7 | 100 |
| Khawpuar | 2.1 | 48.1 | 43.1 | 4.2 | 2.5 | 100 |
| Lailak | 1.7 | 49.8 | 41.6 | 3.7 | 3.2 | 100 |
| Lenchim | 4.4 | 48.8 | 37.4 | 6 | 3.4 | 100 |
| N.Khawlek | 3.2 | 46.2 | 41.2 | 7.2 | 2.2 | 100 |
| ***Rural Average*** | ***2.7*** | ***46.6*** | ***39.3*** | ***5.5*** | ***5.7*** | ***100*** |
| **Urban areas** | | | | | | |
| Durtlang | 26.2 | 47.4 | 23.1 | 0.5 | 2.8 | 100 |
| Zarkawt | 25.5 | 47.5 | 23.2 | 0.2 | 3.6 | 100 |
| Bethlehem | 25.6 | 46.2 | 23.4 | 0.3 | 4.5 | 100 |
| Dinthar | 26.8 | 47.5 | 24.5 | 0.4 | 0.9 | 100 |
| Chite | 26.8 | 47.5 | 23.2 | 0.5 | 2 | 100 |
| Sairang | 22.1 | 47.8 | 21.8 | 1.1 | 7.2 | 100 |
| Thingsulthliah | 4.2 | 47.4 | 37.2 | 6.2 | 5 | 100 |
| Aibawk | 1.3 | 44.6 | 36.4 | 3.2 | 14.5 | 100 |
| Darlawn | 2.2 | 48.2 | 42.2 | 4.1 | 3.3 | 100 |
| Phullen | 3.1 | 45.4 | 40.4 | 8.2 | 2.9 | 100 |
| ***Urban Average*** | ***16.3*** | ***46.9*** | ***29.5*** | ***2.4*** | ***4.6*** | ***100*** |
| **Rural & Urban average** | **10.3** | **46.8** | **33.8** | **3.8** | **5.1** | **100** |
| Source : Field survey-2016 & 2017 | | | | | | |

Table-5.9 exhibits that people living in urban area are more satisfy than rural folks as far as healthcare facility is concerned. This is probably due to concentration of healthcare facilities in the urban areas. A good number of 16.3 % living in urban area are reporting that government healthcare facilities are ‘very good’ while a meager 2.7% do report the same in rural area. A similar number of a little over 46% reported government healthcare facilities are ‘adequate’ both in rural and urban areas. It appears that a higher proportion of rural people are not satisfied with government facilities as 39.3% reported that the facilities are ‘poor’ while 29.5 % of urban residence does the same report.

*Thus, it is reveals that as far as government healthcare facilities in Aizawl district is concerned just 10.3% find it ‘very good’, a higher proportion of 46.8% find it*

*'adequate' and a little over 33% find it 'poor'. Therefore, the highest proportion felt that the healthcare facilities in Aizawl district are 'adequate'.*

### 5.11. Problems of Healthcare Facilities

The present portion discusses major problems face by healthcare seeker in rural and urban Aizawl District. Common problems include–healthcare facilities are too far, poor performance of medical personnel, lack of equipments or medicines and irregularity of medical doctor. All these factors are important for healthcare-seekers.

Table-5.10. Aizawl District: Sufficiency of government healthcare facility

| **Rural areas** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aizawl District | Lack of equipment, medicines etc | Poor performance of medical personal | Too far | No problems | Irregular Doctor | No response | Total |
| Chawilung | 8.26 | 23.7 | 28.7 | 34.47 | 2.6 | 0 | 100 |
| Daido | 30 | 24.4 | 40.4 | 4.1 | 0.1 | 0 | 100 |
| Darlawng | 26.4 | 28.6 | 30.3 | 10.4 | 2.3 | 0 | 100 |
| Kelsih | 9.2 | 25.5 | 29.3 | 33.5 | 2.4 | 0 | 100 |
| Khawpuar | 32.5 | 24.1 | 42.6 | 1.8 | 2 | 0 | 100 |
| Lailak | 33.4 | 24.3 | 42.7 | 1.8 | 1.8 | 0 | 100 |
| Lenchim | 22.9 | 31.6 | 29.3 | 11.5 | 2.5 | 0 | 100 |
| N.Khawlek | 30.2 | 24.2 | 40.3 | 4.3 | 1.4 | 0 | 100 |
| ***Rural Average*** | ***24.1*** | ***25.8*** | ***35.4*** | ***12.7*** | ***1.8*** | ***0*** | ***100*** |
| ***Urban areas*** | | | | | | | |
| Durtlang | 4.5 | 0.5 | 0 | 95.2 | 0 | 0 | 100 |
| Zarkawt | 4.6 | 0.6 | 0 | 94.7 | 0 | 0 | 100 |
| Bethlehem | 4.4 | 0.4 | 0 | 94.8 | 0 | 0 | 100 |
| Dinthar | 4.7 | 0.2 | 0 | 95.3 | 0 | 0 | 100 |
| Chite | 4.3 | 0.4 | 0 | 95.6 | 0 | 0 | 100 |
| Sairang | 6 | 0.6 | 0 | 92.9 | 0 | 0 | 100 |
| Dinthar | 4.7 | 0.2 | 0 | 95.3 | 0 | 0 | 100 |
| Chite | 4.3 | 0.4 | 0 | 95.6 | 0 | 0 | 100 |
| Sairang | 6 | 0.6 | 0 | 92.9 | 0 | 0 | 100 |
| Thingsulthliah | 24.5 | 29.5 | 30.5 | 10.5 | 2.4 | 0 | 100 |
| Aibawk | 8.73 | 25.8 | 29.2 | 33.4 | 2.5 | 0 | 100 |
| Darlawn | 32.8 | 24.2 | 42.5 | 1.8 | 1.9 | 0 | 100 |
| Phullen | 30.4 | 24.3 | 40.2 | 4.2 | 1.5 | 0 | 100 |
| ***Urban Average*** | ***10.7*** | ***8.2*** | ***10.9*** | ***69.4*** | ***0.6*** | ***0*** | ***100*** |
| **Rural & Urban Average** | **15.8** | **14.9** | **20.2** | **47.28** | **1.11** | **0** | **100** |

Source : Field survey-2016 & 2017

As display in table-5.10, among the major problems, distance of healthcare facility got maximum proportion as 20.2% are reasoned of this, followed by lack of equipment and

medicine (15.8%), and poor performance of medical personnel (14.9%). In is interesting to note that as many as 47.28% of them reported that they have no complains.

Looking at inter-rural variations, there is a slight difference of problems between rural and urban Aizawl district. For example: accessibility problem or distance of healthcare facilities become one of the biggest challenges in rural area (35.4 %) where as it is not that much a problem in the case of urban area (10.9 %). Similarly, poor performance of medical personnel become one of the biggest problems in rural area where as it is not that so in the case of urban Aizawl district with 24.2 % and 8.2 % respectively. However, it is interesting to find that lack of medicines and medical equipments become one of the common problems suffered by both rural (24.1 %) and urban people (10.7 %) with almost the same degree. Another important constrains faced by rural and urban people is irregularity of doctor with 1.8 % and 1.1 %) respectively.

*Therefore, as far as constraints in utilizing healthcare facility is concerned, rural folks suffer more problems than urbanites. It is also observes that accessibility become the biggest constraints in rural areas whereas lack of equipment and medicines become the biggest constraints in urban area.*

**5.12. Common diseases**

Understanding common diseases and how they are responded by patients is another interesting area of research. The present section focuses on the common diseases suffered by people living in Aizawl district even though diseases might varied with manifestations in adults and adolescents.

Social environment is a major determinant of health and disease patterns in any community. It may be needed for a purposeful avoidance of deprivation in the

social and physical environment as prerequisites for the prevention and control of diseases. Generally, low socio-economic status has been found to relate to an increased risk in many diseases. It may also require the planning and implementation of interventions to prevent the socially affected diseases. The deterioration of environment may created many diseases come out in the study area.

We are identifying 21 major diseases including physically challenged problems like goiter, blindness and deafness in the study area. Since the table is bulky to compare rural and urban area, it has been separated and discussed individually for better convenience, though an attempt has been made to compare rural-urban variation at the end of the table-15.11(a) & (b).

**Table-5.11 (a). Which is the most common disease suffered by your family**

| | **Rural areas** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Disease | Chawilung | Daido | Darlawng | Kelsih | Khawpuar | Lailak | Lenchim | N. Khawlek | **Rural Average** |
| Cough & Fever | 96 | 93.5 | 55.8 | 95.72 | 88.3 | 88.1 | 55.9 | 93.6 | **83.3** |
| Kidney problem | 42.94 | 65.9 | 37.5 | 42.94 | 68.5 | 68.9 | 37.6 | 65.8 | **53.7** |
| Ulcer | 2.63 | 27 | 11.5 | 2.65 | 25.4 | 26 | 11.6 | 28 | **16.8** |
| Asthma | 8.28 | 16.2 | 10.7 | 8.24 | 17.8 | 18 | 10.3 | 16.1 | **13.2** |
| Cancer | 9.9 | 22.4 | 6.9 | 9.5 | 11.5 | 12.1 | 7 | 22.3 | **12.7** |
| Diarrhea | 3.3 | 12.9 | 10.3 | 3.34 | 13.4 | 13.2 | 10.1 | 12.8 | **9.9** |
| TB | 0.74 | 14.8 | 3.4 | 0.76 | 13.3 | 13.1 | 4.2 | 14.9 | **8.1** |
| Nerve problem | 0.58 | 0.8 | 0 | 0.54 | 25 | 25.2 | 0 | 0.9 | **6.6** |
| Liver pain | 7.07 | 5.2 | 5.6 | 7.25 | 7.6 | 7.4 | 5.4 | 5.3 | **6.3** |
| Malaria | 4.03 | 9.8 | 5.8 | 4.25 | 2.6 | 3.2 | 6.1 | 9.7 | **5.6** |
| Jaundice | 2.29 | 7.6 | 4.2 | 2.23 | 5.3 | 5.1 | 0.2 | 7.5 | **4.3** |
| Hepatitis | 0 | 8.4 | 0 | 0 | 0.3 | 0.1 | 4.1 | 8.5 | **2.6** |
| Deafness | 1.3 | 3.5 | 4.3 | 1.3 | 2.5 | 2.4 | 0 | 3.4 | **2.3** |
| Typhoid | 0 | 3.5 | 2.7 | 0 | 3.4 | 3.3 | 0 | 3.4 | **2** |
| Pneumonia | 0 | 4.5 | 0.2 | 0 | 3.5 | 3.3 | 0 | 4 | **1.9** |
| Diabetes | 1.31 | 0.2 | 0.3 | 1.23 | 0.6 | 0.6 | 0.1 | 0.4 | **0.5** |
| Goiter | 0 | 0 | 0.3 | 0 | 0.2 | 0.2 | 4 | 0 | **0.5** |
| Blindness | 0 | 0 | 0 | 0 | 0 | 0 | 2.7 | 0 | **0.3** |
| Septicemia | 0 | 0.3 | 0 | 0 | 0.3 | 0.2 | 0 | 0.2 | **0.1** |
| Polio | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Stroke | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | **0** |
| **Average** | **8.6** | **14.12** | **7.60** | **8.56** | **13.79** | **13.83** | **7.59** | **14.13** | **10.99** |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | **100** |

Table-15.11(a) clearly reveals that cough& fever is the most common diseases in rural Aizawl district 983.3%), followed by kidney problem (53.7%), ulcer (16.8%), asthma (13.2%), cancer (12.7%), diarrhea (9.9%), TB (8.1%), nerve problem (6.6%), liver pain (6.3%) and malaria (5.6%). These are the top ten diseases suffered by rural Aizawl district.

Taken together of all the diseases among the villages, N.Khawlek record the highest proportion or in other word, N.khawlek village suffered most (14.23%), followed by Daido (14.12%), Lailak (13.83%), Khawpuar (13.79%) and Chawilung (8.6%).

Looking at the urban situation regarding common diseases, cough & fever (78.7%) become the most common diseases, followed by kidney problem (21.9%), asthma (7.7%), cancer (7.4%), ulcer (7%), diarrhea (6.4%), liver pain (6%), TB (4%), malaria (3.8%), jaundice (3.1%) and nerve problem (2.8%).

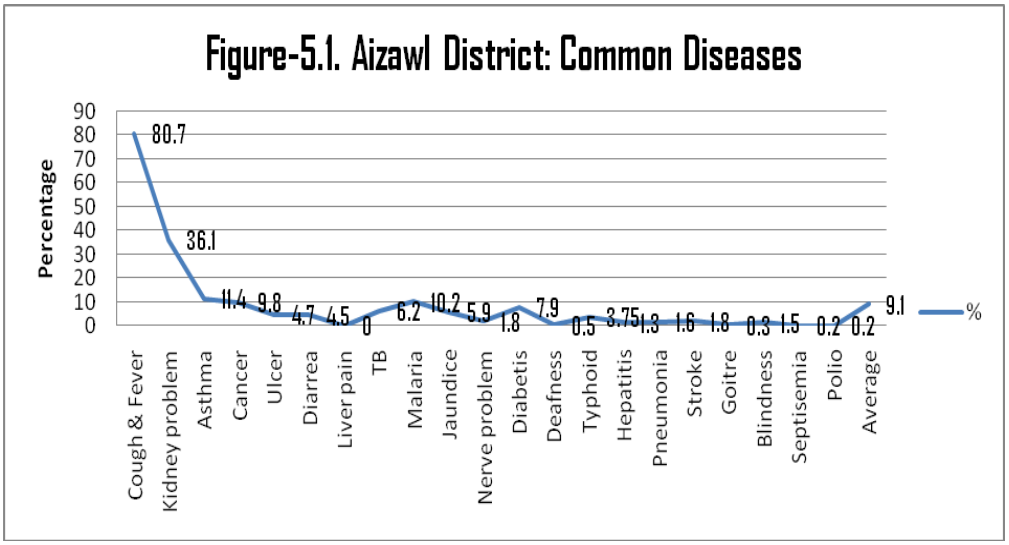
**Table-5.11(b). Which is the most common disease suffered by your family**

| **Urban areas** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Disease | Durtlang | Zarkawt | Bethlehem | Dinthar | Chite | Sairang | Thingsulthliah | Ai Bawk | Darlawn | Phullen | **Urban Average** |
| Cough & Fever | 70.2 | 74.2 | 78.7 | 75.4 | 75.5 | 79.5 | 55.8 | 95.86 | 88.2 | 93.7 | **78.7** |
| Kidney problem | 0.7 | 0.5 | 0.5 | 0.6 | 0.7 | 1.1 | 37.5 | 42.94 | 68.7 | 66 | **21.9** |
| Asthma | 3.2 | 4.2 | 4.4 | 4.4 | 4.1 | 4.1 | 10.5 | 8.26 | 17.9 | 16 | **7.7** |
| Cancer | 3.3 | 4.5 | 4.3 | 4.2 | 4.1 | 4.1 | 6.9 | 9.4 | 11.8 | 22.2 | **7.4** |
| Ulcer | 0.2 | 0.3 | 0.3 | 0.4 | 0.5 | 0.3 | 11.5 | 2.64 | 25.7 | 29 | **7** |
| Diarrhea | 3.7 | 4.1 | 4.2 | 4.1 | 4.2 | 4.3 | 10.2 | 3.32 | 13.3 | 12.9 | **6.4** |
| Liver pain | 5.8 | 5.8 | 5.8 | 5.5 | 5.3 | 6.3 | 5.5 | 7.16 | 7.5 | 5.7 | **6** |
| TB | 1.3 | 1.3 | 1.3 | 1.4 | 1.4 | 1.5 | 3.8 | 0.75 | 13.2 | 14.3 | **4** |
| Malaria | 2.4 | 2.7 | 2.4 | 2.4 | 2.3 | 3.9 | 5.8 | 4.14 | 2.9 | 9.6 | **3.8** |
| Jaundice | 1.8 | 1.4 | 2.5 | 2.4 | 2.0 | 2.0 | 4.1 | 2.26 | 5.2 | 7.7 | **3.1** |
| Nerve problem | 0.2 | 0.3 | 0.4 | 0.4 | 0.4 | 0.4 | 0 | 0.56 | 25.1 | 1 | **2.8** |
| Diabetes | 3.5 | 4.1 | 4.1 | 4.5 | 4.3 | 4.0 | 0.2 | 1.27 | 0.6 | 1.2 | **2.7** |
| Deafness | 0.4 | 0.3 | 0.3 | 0.3 | 0.4 | 0.3 | 4.2 | 1.3 | 2.6 | 3.3 | **1.3** |
| Typhoid | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2.7 | 0 | 3.5 | 3.9 | **1** |
| Hepatitis | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 | 0 | 0.2 | 8.3 | **0.8** |
| Pneumonia | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0 | 3.4 | 3.5 | **0.7** |
| Stroke | 0.6 | 0.9 | 0.6 | 0.6 | 0.7 | 0.7 | 0 | 0 | 0 | 0 | **0.4** |
| Goiter | 0.2 | 0.6 | 0.6 | 0.6 | 0.7 | 0.7 | 0.2 | 0 | 0.2 | 0 | **0.3** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Blindness | 0.4 | 0.4 | 0.3 | 0.3 | 0.3 | 0.3 | 0 | 0 | 0 | 0 | **0.2** |
| Septicemia | 0.4 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0 | 0 | 0.4 | 0.4 | **0.2** |
| Polio | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 | 0 | 0 | 0 | **0** |
| **Average** | **4.7** | **5.1** | **5.3** | **5.1** | **5.1** | **5.4** | **7.6** | **8.6** | **13.8** | **14.2** | **7.4** |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Among the urban area, Phullen suffered maximum number of health complications with 14.2%, followed by Darlawn (13.8%), Aibawk (8.6%) and Thingsulthliah (7.6%). Localities, within Aizawl city record minimum health problems, such as Durtlang, Zarkawt, Dinthar, Chite and Bethlehem (table-5.11(b).

In continuation of the table-5.11(a) & (b), the following figure-5.1 shows the average common diseases of rural and urban area of Aizawl. Figure-5.1 clearly displays that cough & fever (80.7%), kidney problem (36.1%), asthma (11.4%), cancer (9.8%), ulcer (4.7%) and diarrhea (4.5%) become the topmost suffered health complications in Aizawl district.



| Table-5.11(c). Common diseases in Aizawl district | |
|---|---|
| Aizawl district (average) | % |
| Cough & Fever | 80.7 |
| Kidney problem | 36.1 |
| Asthma | 11.4 |
| Cancer | 9.8 |
| Ulcer | 4.7 |
| Diarrhea | 4.5 |
| Liver pain | 0 |
| TB | 6.2 |
| Malaria | 10.2 |
| Jaundice | 5.9 |
| Nerve problem | 1.8 |
| Diabetes | 7.9 |
| Deafness | 0.5 |
| Typhoid | 3.75 |
| Hepatitis | 1.3 |
| Pneumonia | 1.6 |
| Stroke | 1.8 |
| Goiter | 0.3 |
| Blindness | 1.5 |
| Septicemia | 0.2 |
| Polio | 0.2 |
| Average | 9.1 |
| Total | 100 |

It is interesting to find out that cough and fever is the most common diseases both in rural and urban Aizawl District with 24.4 % and 25.9 % respectively, followed by kidney problem with 25.5 % in urban area and 25.8 % in rural area. The third common disease suffered by Aizawl District is ulcer with 10.4 % in urban area and 20.5 % in rural area. The top ten common diseases suffered by Aizawl District include asthma, diabetic, jaundice, liver pain, malaria and TB (Table-5.11).

*Thus, it is found out that there are more than 21 different types of diseases are currently suffered by people of Aizawl district. Out of which cough and fever top the rank, followed by kidney problem, asthma, cancer and ulcer.*

**5.13. Prevalence of Death**

This section discourses about prevalence of death in a family. It is an attempt to compare the occurrences of death in rural and urban area. It seems that many occurrences

of death were preventable as reported by family members who experienced death in their family. It was also reported by some families during the survey that some patients were died due to wrong medication, which we are unable to prove technically in this research. This kind of death seems more prevalence in rural areas like Primary Health Center (PHC).

Table-5.12 shows number of families experiencing death in their life time. It was revealed that 26.1% families in Aizawl district were experiencing death in their life time while majority of them (73.8%) were not experienced the same.

| Table-5.12. Aizawl District: Is there anyone of your family member died | | | |
|---|---|---|---|
| Rural areas | | | |
| Village/Town | Yes | No | Total |
| Lailak | 31.5 | 68.5 | 100 |
| Khawpuar | 30.5 | 69.5 | 100 |
| N.Khawlek | 30.2 | 69.8 | 100 |
| Daido | 29.2 | 70.8 | 100 |
| Darlawng | 29.2 | 70.8 | 100 |
| Lenchim | 28.5 | 71.5 | 100 |
| Kelsih | 22.1 | 77.9 | 100 |
| Chawilung | 20.1 | 79.9 | 100 |
| *Rural Average* | *27.6* | *72.3* | *100* |
| *Urban Average* | | | |
| Urban/city | Yes | No | Total |
| Darlawn | 33.7 | 66.3 | 100 |
| Phullen | 32.1 | 67.9 | 100 |
| Thingsulthliah | 31.1 | 68.9 | 100 |
| Aibawk | 25.7 | 74.3 | 100 |
| Sairang | 23.5 | 76.5 | 100 |
| Dinthar | 21.2 | 78.8 | 100 |
| Durtlang | 21.1 | 78.9 | 100 |
| Bethlehem | 20.6 | 79.4 | 100 |
| Chite | 20.5 | 79.5 | 100 |
| Zarkawt | 20.4 | 79.6 | 100 |
| *Urban Average* | *24.99* | *75.01* | *100* |
| **Rural & Urban average** | **26.1** | **73.8** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.12 expresses that death is more prevalence in rural area than urban area with 27.6 % and 24.9 % respectively. Family that doesn't experience death among their family member is also differed as it was 72.3% in rural while 75% in urban area.

*Thus, we can conclude that death is more common among the rural folks than urban residence in Aizawl District. However, the overall experience of death among families of Aizawl district was not so high.*

**5.14. Reason of Death**

After knowing the prevalence of death, the next question we were asking to family members was-why? What are the reasons of death? The present study identified 18 common causes of death in Aizawl district, those are- cancer, internal bleeding, stroke, accident, malaria, jaundice, old age, asthma, TB, diabetic, ulcer, pneumonia, typhoid, liver pain, septicemia, kidney problem, cough fever and nerve problem.

Looking at the last column of table-5.13(a) clearly shows cancer is the main cause of death in rural Aizawl district with a significantly high proportion of 44.5% especially compared with other causes of death it is overwhelmingly clear that cancer is the prime factor that leads death to people of Aizawl district, followed by Malaria (8%), liver pain (5.8%) and pneumonia (5.8%). It is so sad to uncover in the research that a fairly high number of 5.7% death were accident, particularly road accident, which is preventable in most cases. Other common causes of death are asthma, jaundice, stroke, septicemia, kidney problem, and ulcer.

**Table- 5.13 (a) Mizoram: Reason of family member who died in Rural area**

| | **Rural areas** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Reason of death | Chawi lung | Kel sih | Dar lawn | Len chim | N.Khaw lek | Dai do | Dar lawn | Lai lak | Khaw puar | **Average** |
| Cancer | 39.4 | 39.6 | 35.2 | 35.6 | 39.2 | 40 | 57.3 | 57.2 | 57.3 | **44.5** |
| Malaria | 1.05 | 1.1 | 13.4 | 14.4 | 10.2 | 10 | 7.3 | 7.4 | 7.3 | **8** |
| Liver pain | 3.25 | 3.1 | 2.6 | 2.4 | 15.4 | 16 | 3.1 | 3.4 | 3.1 | **5.8** |
| Pneumonia | 1.04 | 1.1 | 0 | 0 | 9.3 | 9.5 | 10.4 | 10.5 | 10.4 | **5.8** |
| Accident | 3.21 | 3.1 | 16.7 | 16.3 | 4.2 | 4.6 | 1 | 1.6 | 1 | **5.7** |
| Asthma | 9.43 | 9.7 | 0 | 0 | 4.3 | 4.5 | 6.3 | 6.4 | 6.3 | **5.2** |
| Jaundice | 9.53 | 9.6 | 1.4 | 1.2 | 8.6 | 9 | 1 | 1 | 1 | **4.7** |
| Stroke | 2.25 | 2 | 6.2 | 6.4 | 0.5 | 0.7 | 6.3 | 6.4 | 6.3 | **4.1** |
| Septicemia | 3.26 | 3.1 | 5.2 | 5 | 4 | 6 | 2.1 | 2.3 | 2.1 | **3.7** |
| Kidney problem | 6.45 | 6.3 | 6.2 | 6.4 | 1.4 | 1.2 | 1 | 1.6 | 1 | **3.5** |
| Ulcer | 6.42 | 6.3 | 3.5 | 4.1 | 0 | 0 | 1 | 1.6 | 1 | **2.7** |
| Cough &ever | 8.52 | 8.5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1.9** |
| Internal bleeding | 2.32 | 0.2 | 5.3 | 4.9 | 0 | 0 | 0 | 0 | 0 | **1.4** |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| TB | 1.2 | 0.9 | 3.5 | 4.1 | 0 | 0 | 0 | 0 | 0 | **1.1** |
| Old age | 0 | 0 | 0 | 0 | 0 | 0 | 2.1 | 2.3 | 2.1 | **0.7** |
| Diabetes | 0 | 0 | 0 | 0 | 0.5 | 0.7 | 1 | 1.5 | 1 | **0.5** |
| Seizure | 1.3 | 0.8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0.2** |
| Typhoid | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Average** | **5.5** | **5.3** | **5.5** | **5.6** | **5.4** | **5.7** | **5.6** | **5.7** | **5.6** | **5.5** |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Source : Field survey-2016 & 2017 | | | | | | | | | | |

Looking at the prevalence of death among villages, Daido and Lailak villages record highest proportion (5.7%), followed by Lenchim (5.6%), Khawpuar (5.6%) and Chawilung and Darlawn whereas Kelsih and N.Khawlek record the least proportion of death with 5.3% and 5.4% respectively.

Table-5.13 (b) show reasons of deaths in urban area of Aizawl district. In complimentary with rural record, urban area also reported that cancer is the main causes of death with 30%, followed by liver pain (11.6%), Malaria (7.7%), accident (6.2%), stroke (4.7%), jaundice (4.4%), asthma (4.3%), pneumonia 94.1%) and internal bleeding (4%).

**Table- 5.13 (b) Aizawl District: Reason of family member who died in Urban area**

| **Urban areas** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Reason of Death | Durtlang | Zarkawt | Bethlehem | Dinthar | Chite | Sairang | Thingsulthliah | Aibawk | Darlawn | Phullen | **Urban average** |
| Cancer | 14.83 | 22.46 | 23.42 | 21.6 | 24.7 | 21.45 | 35.4 | 39.5 | 57.3 | 39.6 | **30** |
| Liver Pain | 24.12 | 23.34 | 24.12 | 23.6 | 24.2 | 25.33 | 2.5 | 3.19 | 3.1 | 15.7 | **16.9** |
| Malaria | 7.15 | 7.21 | 6.54 | 7.23 | 7.82 | 6.89 | 13.9 | 1.06 | 7.3 | 10.1 | **7.5** |
| Accident | 7.14 | 7.42 | 7.18 | 7.15 | 7.45 | 6.5 | 16.5 | 3.19 | 1 | 4.4 | **6.8** |
| Stroke | 6.24 | 6.72 | 6.45 | 6.25 | 6.24 | 5.6 | 6.3 | 2.13 | 6.3 | 0.6 | **5.2** |
| Jaundice | 3.54 | 3.67 | 3.45 | 3.21 | 3.42 | 4.13 | 1.3 | 9.57 | 1 | 8.8 | **4.2** |
| Asthma | 2.68 | 2.72 | 2.42 | 2.45 | 2.32 | 3.49 | 0 | 9.57 | 6.3 | 4.4 | **3.6** |
| Pneumonia | 0.24 | 0.16 | 0.22 | 0.35 | 0.89 | 3.48 | 0 | 1.06 | 10.4 | 9.4 | **2.6** |
| Internal Bleeding | 9.82 | 9.45 | 9.42 | 9.36 | 9.65 | 11.22 | 5.1 | 1.06 | 0 | 0 | **6.5** |
| Septicemia | 3.54 | 3.56 | 3.42 | 3.25 | 3.23 | 4.42 | 5.1 | 3.19 | 2.1 | 5 | **3.6** |
| Kidney Problem | 1.27 | 1.75 | 1.54 | 1.45 | 1.27 | 3.46 | 6.3 | 6.38 | 1 | 1.3 | **2.5** |
| Ulcer | 2.65 | 2.48 | 2.52 | 2.36 | 2.78 | 3.29 | 3.8 | 6.38 | 1 | 0 | **2.7** |
| Die of old age | 6.21 | 6.23 | 6.42 | 6.72 | 6.42 | 5.5 | 0 | 0 | 2.1 | 0 | **0.9** |
| Cough & fever | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8.51 | 0 | 0 | **6.5** |
| T.B | 0.82 | 0.84 | 0.85 | 0.87 | 0.89 | 1.07 | 3.8 | 1.06 | 0 | 0 | **0.7** |
| Seizure | 0 | 0 | 0 | 0 | 0 | 14.83 | 0 | 1.06 | 0 | 0 | **0.6** |
| Diabetes | 0.85 | 0.83 | 0.86 | 0.84 | 0.85 | 1.11 | 0 | 0 | 1 | 0.6 | **3.9** |
| Typhoid | 0.81 | 0.89 | 0.87 | 0.86 | 0.88 | 1.03 | 0 | | 0 | 0 | **1** |
| ***Average*** | ***5.11*** | ***5.54*** | ***5.54*** | ***5.42*** | ***5.72*** | ***6.82*** | ***5.56*** | ***5.70*** | ***5.55*** | ***5.55*** | ***5.87*** |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | **100** |

Among the sample urban areas, Sairang record highest proportion of death (6.8%), Chite (5.72%) and Aibawk (5.7%) while Durtlang and Dinthar record the least percentage of death with 5.1% and 5.4% respectively.

Looking at table-5.13(c), the main reason of death in rural and urban area of Aizawl is cancer with 36.9% with rural area record higher proportion of death due to cancer (44.5%) compared with urban area (30%).

**Table-5.13 (c). Aizawl District: Reason of death (rural&urban average)**

| Reason of Death | Urban &Rural average (%) |
|---|---|
| Cancer | 36.9 |
| Liver Pain | 11.6 |
| Malaria | 7.7 |
| Accident | 6.2 |
| Stroke | 4.7 |
| Jaundice | 4.4 |
| Asthma | 4.3 |
| Pneumonia | 4.1 |
| Internal Bleeding | 4 |
| Septicemia | 3.6 |
| Kidney Problem | 3 |
| Ulcer | 2.6 |
| Die of old age | 2.4 |
| Cough & fever | 1.3 |
| T.B | 1 |
| Seizure | 0.9 |
| Diabetes | 0.6 |
| Typhoid | 0.2 |
| **Average** | **5.52** |
| Total | 36.9 |

The present research revealed that cough and fever is the common diseases whereas cancer is the main reasons of death. Even though there are differences in rural and urban Aizawl District, the gap is not that much in different reasons of death.

It is worth mentioning here that death due to liver pain is mostly associated with alcohol drinking in the context of Aizawl District. Therefore, it is already established in the previous discussion on the prevalence of alcohol wherein urbanites are more indulged than rural folks and it appears that alcohol cause death also higher in urban area than rural area.

*Therefore, it is found out that out of 18 reasons of death, the top five common reasons of death are-cancer (36.9%), liver pain (11.6%), malaria (7.7%), accident (6.2%) and stroke (4.7%). Among the sample villages Daido and Lailak village record highest proportion (5.7%) of death while Kelsih and N.Khawlek record the least proportion of death with 5.3% and 5.4% respectively.In other word, Kelsih and N.Khawlek are the healthiest villages while Daido and Lailak are the unhealthiest villages. Similarly, Sairang (6.8%), and Chite record highest proportion of death (5.72%) among urban area while Durtlang (501%) and Dinthar (5.4%) record the least percentage of death.*

**5.15. Place of Death**

In order to understand the health-seeking behaviour of Aizawl district living in urban and rural area the present study incorporates places of death, such as hospital, home and other. Even though death in the hospital is by and large assumed as positive indicator of healthcare seekers, it is not always a positive indicator as sometimes some patients choose to die at home after there is no hope in the hospital. Most old age patients, when asked, indicated that they would prefer to die at home.

Table-5.14 shows places of died of family members, such as hospital or health institution, home and other places.

**Table-5.14. Aizawl District: Place of Family members died**

| **Rural areas** | | | | |
|---|---|---|---|---|
| Aizawl District | Home | Hospital | Other | Total |
| Lailak | 70.3 | 20.2 | 9.5 | 100 |
| Khawpuar | 70.2 | 24.5 | 3.5 | 100 |
| Lenchim | 39 | 54.8 | 6.2 | 100 |
| Chawilung | 37.8 | 55.7 | 6.5 | 100 |
| Daido | 35.3 | 53.2 | 11.5 | 100 |
| Darlawng | 35.3 | 56.4 | 8.3 | 100 |
| Kelsih | 34.5 | 56.3 | 9.2 | 100 |
| N.Khawlek | 34.3 | 55.6 | 10.1 | 100 |
| *Rural Average* | *44.5* | *47* | *8.1* | *100* |
| Urban areas | | | | |
| Aizawl District | Home | Hospital | Other | Total |
| Darlawn | 70.1 | 25.6 | 4.3 | 100 |
| Sairang | 38.02 | 54.6 | 7.38 | 100 |
| Thingsulthliah | 35.5 | 53.6 | 10.9 | 100 |

| | | | | |
|---|---|---|---|---|
| Bethlehem | 34.5 | 65.2 | 0.3 | 100 |
| Chite | 34.5 | 64.2 | 1.3 | 100 |
| Zarkawt | 34.2 | 65.2 | 0.6 | 100 |
| Dinthar | 34.2 | 64.5 | 1.3 | 100 |
| Aibawk | 34.2 | 55.4 | 9.2 | 100 |
| Phullen | 34.2 | 55.5 | 10.3 | 100 |
| Durtlang | 33.5 | 66.2 | 0.3 | 100 |
| *Urban Average* | *38.2* | *57* | *4.5* | *100* |
| **Rural & Urban average** | **41.1** | **52.6** | **6.1** | **100** |
| Source : Field survey-2016 & 2017 | | | | |

Among the sample villages 'died at home' is very common in Lailak and Khawpuar with more than 70% reported of having died family members at home while N. Khawlek record minimum with 44.5% 'died at home'. Died in the hospital is not much common in rural Aizawl district as merely 47% died at hospital while almost the same proportion of 44.5% died at home.

Among the urban sample, Darlawn record maximum percentage of death at home with more than 70%. In contrast, Durtlang, Dinthar and Zarkawt record maximum number of 'hospital death'.

*Altogether, it can be concluded that death in the hospital is more common in Aizawl district than death at home with 52.6% and 410.1% respectively while death at other places is minimal with 6.1%. This is mainly due to availability of hospital in urban area while it was not in the case of rural area.*

*Obviously, rural area recorded more percentage of death at home (44.5 %) than urban area (38.2 %). Apart from hospital and home, urban area recorded more percentage of death neither hospital nor home with 8.1% compared with rural area with 4.5%.*

### 5.16. Treatment in the Hospital before died

In an attempt to understand the health-seeking behaviour of people we asked question on whether the patient visit hospital for treatment before he/she died or not.

Table-5.15 shows that more percentage of 57.9% patients were visiting hospital for treatment before he/she die in Aizawl district while a fairly high proportion of 42% were still not visiting hospital for treatment before he/she die.

Among rural villages a little over 50% patients are visiting hospital before they die while as many as 49.6% were not visiting hospital before they die. Among urban residence, a relatively high proportion of 64% patients were visiting hospital before they die whereas 35.9% were not visiting hospital before they die.

**Table-5.15. Aizawl District: Family members visit hospital** for **treatment before he / she die**

| Rural areas | | | |
|---|---|---|---|
| **Village/Town** | Yes | No | Total |
| **Kelsih** | 70.2 | 29.8 | 100 |
| **Chawilung** | 70.19 | 29.81 | 100 |
| **Darlawng** | 58.2 | 41.8 | 100 |
| **Lenchim** | 58.2 | 41.8 | 100 |
| **N.Khawlek** | 43.5 | 56.5 | 100 |
| **Daido** | 42.5 | 57.5 | 100 |
| **Khawpuar** | 30.5 | 69.5 | 100 |
| **Lailak** | 29.2 | 70.8 | 100 |
| ***Rural Average*** | *50.3* | *49.6* | *100* |
| Urban areas | | | |
| **Urban /City** | Yes | No | Total |
| **Durtlang** | 73.4 | 26.6 | 100 |
| **Chite** | 72.5 | 27.5 | 100 |
| **Zarkawt** | 72.4 | 27.6 | 100 |
| **Dinthar** | 72.4 | 27.6 | 100 |
| **Sairang** | 72.2 | 27.8 | 100 |
| **Bethlehem** | 71.5 | 28.5 | 100 |
| **Aibawk** | 71.5 | 28.5 | 100 |
| **Thingsulthliah** | 59.1 | 40.9 | 100 |
| **Phullen** | 44.2 | 55.8 | 100 |
| **Darlawn** | 31.2 | 68.8 | 100 |
| ***Urban average*** | *64* | *35.9* | *100* |
| **Rural & Urban average** | 57.9 | 42 | 100 |
| Source : Field survey-2016 & 2017 | | | |

*It can be concluded that visiting hospital before patient's die is not so common in Aizawl district. Expectedly, more proportion of urban residence was visiting hospital before they die compared with rural residence.*

## 5.17. Number of times visit health institution by patient

To know more about health-seeking behavior of patients, family members were asked how many times they visit healthcare facilities before the patient died.Table-5.16 shows detail information of number of visit of healthcare facilities by patient before they die both in rural and urban areas.

Table-5.16. Aizawl District: Number of times visit health institution by patient

| **Rural areas** | | | | | | | |
|---|---|---|---|---|---|---|---|
| District | 1 time | 2 times | 3 times | 4 times | 5 times | More Than 5 | Total |
| Chawilung | 9.2 | 31.8 | 22.08 | 15.5 | 3.9 | 17.5 | 100 |
| Daido | 21.9 | 29.8 | 21.5 | 12.8 | 10.6 | 3.4 | 100 |
| Darlawng | 8.4 | 17.2 | 26.8 | 16.2 | 8.4 | 23 | 100 |
| Kelsih | 9.4 | 33.4 | 24.2 | 12.5 | 5.4 | 15.1 | 100 |
| Khawpuar | 11.3 | 22.4 | 16.3 | 21.6 | 22.4 | 6 | 100 |
| Lailak | 10.8 | 21.9 | 17.3 | 22.8 | 21.9 | 5.3 | 100 |
| Lenchim | 8 | 16.4 | 23.3 | 17.8 | 8 | 26.5 | 100 |
| N.Khawlek | 22.4 | 28.5 | 22.6 | 13.6 | 11.3 | 1.6 | 100 |
| *Rural Average* | *12.6* | *25.1* | *21.7* | *16.6* | *11.4* | *12.3* | *100* |
| **Urban areas** | | | | | | | |
| Durtlang | 8.2 | 13.2 | 22.4 | 29.6 | 8.5 | 15.1 | 100 |
| Zarkawt | 8.3 | 13.1 | 22.3 | 28.4 | 8.4 | 16.5 | 100 |
| Bethlehem | 8.4 | 13.2 | 22.4 | 29.4 | 8.2 | 15.4 | 100 |
| Dinthar | 8.6 | 14.1 | 22.2 | 28.5 | 8.2 | 15.4 | 100 |
| Chite | 8.5 | 14.2 | 22.2 | 29.4 | 8.1 | 13.6 | 100 |
| Sairang | 7.5 | 12.6 | 24.5 | 34.1 | 7.2 | 14.1 | 100 |
| Dinthar | 8.6 | 14.1 | 22.2 | 28.5 | 8.2 | 15.4 | 100 |
| Chite | 8.5 | 14.2 | 22.2 | 29.4 | 8.1 | 13.6 | 100 |
| Sairang | 7.5 | 12.6 | 24.5 | 34.1 | 7.2 | 14.1 | 100 |
| Thingsulthliah | 8.5 | 16.5 | 27.4 | 16.1 | 8.5 | 23 | 100 |
| Aibawk | 9.3 | 34.8 | 23.5 | 13.8 | 4.6 | 13.9 | 100 |
| Darlawn | 11.2 | 22.3 | 16.5 | 22.2 | 22.3 | 5.5 | 100 |
| Phullen | 22.3 | 28.4 | 22.5 | 13.5 | 11.4 | 1.9 | 100 |
| *Urban average* | *9.3* | *17.1* | *22.6* | *25.9* | *9.1* | *13.6* | *100* |
| **Rural & Urban average** | **10.8** | **20.2** | **22.3** | **22.3** | **10** | **13.1** | **100** |

Source : Field survey-2016 & 2017

Table-5.16 clearly reveals that visiting healthcare facilities of three or four times by patient before they die became the most common with 22.3%, followed by visiting two times (20.2%) and more than 5 times (13.1%).

There is slight rural-urban variation as visiting hospital two times by patient before he/she die become the most common in rural area (25.1%) whereas visiting three or four times were the most common in the case of urban patients.

It is observes that number of visiting health institution decreases, especially it is noticed that there is a drastic falls after the second visit in rural area. While there were no much variation in urban area on this regards.

*This clearly shows that urban dwellers are more active in seeking healthcare. This may be due to availability and easy accessibility of health institution in urban area compared with rural area. What is common between rural and urban area is that in most cases they/patients visits at least two or three times before he/she die.*

## 5.18. Reasons for not visiting Health Institution

The above discussion clearly reveals the performance of rural and urban dweller as far as health-seeking is concerned. This section focuses on the main reason of why people/patient are not visiting health institution before he/she die. There are four major reasons that obstruct health-seekers in Aizawl District as shown in the table-5.17

**5.17. Reasons for not visiting Health Institution**

| **Rural Areas** | | | | | | |
|---|---|---|---|---|---|---|
| Village/Town | No Money | Too far | Ignorance | Delay Treatment | No Response | Total |
| N.Khawlek | 26.4 | 34.2 | 19.3 | 17.6 | 2.5 | 100 |
| Darlawng | 23.8 | 26.2 | 26.2 | 20.4 | 3.4 | 100 |
| Daido | 23.3 | 35 | 20.4 | 18.7 | 2.6 | 100 |
| Lenchim | 19 | 28.9 | 27.3 | 21.6 | 3.2 | 100 |
| Kelsih | 17.4 | 17.4 | 27.6 | 25.4 | 12.2 | 100 |
| Chawilung | 16.7 | 19.5 | 28.5 | 26.8 | 8.5 | 100 |
| Khawpuar | 15.9 | 37.5 | 24.2 | 20 | 2.4 | 100 |
| Lailak | 14.7 | 38.7 | 24.9 | 19.6 | 2.4 | 100 |
| ***Rural Average*** | ***19.6*** | ***29.6*** | ***24.8*** | ***21.2*** | ***4.6*** | ***100*** |
| **Urban Areas** | | | | | | |
| Aizawl District | No Money | Too far | Ignorance | Delay Treatment | No Response | Total |
| Sairang | 28.6 | 6.5 | 33.2 | 9.1 | 9.5 | 100 |
| Phullen | 25.2 | 33.4 | 23.2 | 20.9 | 2.3 | 100 |
| Chite | 24.1 | 2.4 | 18 | 2.3 | 1.2 | 100 |
| Bethlehem | 22.4 | 1.7 | 14 | 1.5 | 0.6 | 100 |
| Dinthar | 22.4 | 2.3 | 16 | 1.4 | 0.6 | 100 |
| Durtlang | 19.5 | 1.5 | 15 | 0.2 | 0.4 | 100 |
| Aibawk | 19.4 | 16.4 | 26.3 | 25.6 | 12.3 | 100 |
| Zarkawt | 18.6 | 0.6 | 13 | 0.5 | 0.3 | 100 |
| Darlawn | 18.4 | 36.2 | 27.2 | 20.1 | 10 | 100 |
| Thingsulthliah | 16 | 25.2 | 25.4 | 27.9 | 13.2 | 100 |
| Urban Average | 20.3 | 22.7 | 24.1 | 22.9 | 7.9 | 100 |
| ***Rural & Urban Average*** | ***19.9*** | ***27*** | ***24.5*** | ***21.9*** | ***5.9*** | ***100*** |

Source : Field survey-2016 & 2017

Table-17 clearly shows that accessibility problem or 'too far' become the main hurdles that stop patient to seek healthcare in Aizawl district with 27%, followed by ignorance (24.5%), delay treatment (21.9%), poverty or 'no money' (19.9%) while 5.9% did not response the question.

Among rural villages problem of accessibility or 'too far' is more problematic, especially in villages such as Lailak (38.7 %), Khawpuar (37.5 %), Darlawn (36.2 %), Daido (35 %) and Khawlek (34.2 %). In urban area 'ignorance' is one of the main reasons determinging healthcare-seekers.

Table-5.17 displays that poverty or no money is the major factor that prevent patients to seek healthcare. An exceedingly high number of 19.6 % rural folks reported poverty as the main reason that stops them from seeking healthcare while a similarly high number of 19.9 % do the same reason in urban area.

Another important factor preventing people from health-seeking is geographical distance or health care facilities are too far. This is problem is more common in rural area (29.7%) compared with urban area (22.7 %). Besides, ignorance of patient of patient's family in search of healthcare facility and delay treatment becomes quite visible as important significant hurdles in both rural and urban Aizawl District (Table-5.17).

*Therefore, it can be concluded that poverty is the main factors stopping patients to search healthcare in Aizawl District, followed by geographical distance of healthcare facility and ignorance of people along with delay treatment.*

**5.19. Hospitalization**

This section emphasis on the family members hospitalized during the last one year. It is an attempt to gather the most recent information on health-seeking behavior apart from

health-seeking behaviour in their life time. Thus, we questioned number of family members hospitalized during the last one year.

| Table-5.18. Aizawl District: Family members hospitalized during last 1 year | | | |
|---|---|---|---|
| **Rural area** | | | |
| Study Area | Yes | No | Total |
| Chawilung | 45.5 | 54.5 | 100 |
| Kelsih | 44.5 | 55.5 | 100 |
| Darlawng | 35.72 | 64.28 | 100 |
| Lenchim | 34.5 | 65.5 | 100 |
| Daido | 22.64 | 77.71 | 100 |
| N.Khawlek | 22.5 | 77.5 | 100 |
| Khawpuar | 15.5 | 84.5 | 100 |
| Lailak | 13.55 | 86.45 | 100 |
| ***Rural Average*** | ***29.3*** | ***70.7*** | ***100*** |
| **Urban area** | | | |
| Study Area | Yes | No | Total |
| Bethlehem | 53.5 | 46.5 | 100 |
| Sairang | 53.2 | 46.8 | 100 |
| Zarkawt | 52.5 | 47.5 | 100 |
| Durtlang | 52.2 | 47.8 | 100 |
| Dinthar | 52.1 | 47.9 | 100 |
| Chite | 51.5 | 48.5 | 100 |
| Aibawk | 46.2 | 53.7 | 100 |
| Thingsulthliah | 35.5 | 64.5 | 100 |
| Phullen | 23.5 | 76.5 | 100 |
| Darlawn | 16.4 | 83.6 | 100 |
| Urban average | 43.6 | 56.3 | 100 |
| **Rural & Urban average** | **37.3** | **62.7** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.18 displays that urban area reported of having more number of family members hospitalized during the last one year than rural area with 43.6 % and 29.3 % respectively. There are two probably reasons for this; (1) May be because urban areas are comparatively unhealthier than rural area and (2) Since there is no hospital in the rural area people are hardly hospitalized if otherwise they are too serious. The later one seems more relevant to the question as there was no proper hospital in rural areas.

*Taken together of rural and urban areas, 37.3% family reported that their family members were hospitalized during the last one year while 62.7% was not hospitalized in the same year. Recent hospitalization is more common in urban area than rural area.*

### 5.20. Place of Healthcare sought by patients

This part focuses on place of healthcare sought by patients who live in both rural and urban areas. Option includes government hospital, private hospital, private clinic, PHC/CHC, home, parent's home, dispensary, and sub-centre.

Table-5.19. Aizawl District: Place of healthcare sought by patients

| ***Rural areas*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| District | Govt. hospital | Private Hospital | CHC/PHC | Non respondents | Private Clinic | Sub-center | Total |
| Kelsih | 77.4 | 15.2 | 0 | 1.3 | 5.3 | 0.8 | 100 |
| Chawilung | 76.8 | 15.9 | 0 | 1.1 | 5.1 | 1.1 | 100 |
| Darlawng | 66.2 | 4.5 | 21 | 1 | 6.1 | 1.2 | 100 |
| Lenchim | 65.7 | 5.3 | 19 | 1 | 5.8 | 9 | 100 |
| N.Khawlek | 62.4 | 3.4 | 25.2 | 1.6 | 4.2 | 3.2 | 100 |
| Daido | 61.6 | 3 | 23.3 | 2.3 | 4 | 5.8 | 100 |
| Lailak | 58.6 | 2.7 | 26.5 | 3.3 | 5.2 | 3.7 | 100 |
| Khawpuar | 58.2 | 3.2 | 25.2 | 3.1 | 5.2 | 5.1 | 100 |
| *Rural Average* | *65.8* | *6.6* | *17.5* | *1.8* | *5.1* | *3.7* | *100* |
| ***Urban areas*** | | | | | | | |
| District | Govt. hospital | Private Hospital | CHC/PHC | Non respondents | Private Clinic | Sub-centre | Total |
| Aibawk | 76.5 | 15.4 | 0 | 1.2 | 5.2 | 1.7 | 100 |
| Thingsulthliah | 65.5 | 4.9 | 20 | 1 | 6.1 | 2.5 | 100 |
| Durtlang | 64.42 | 9.5 | 9.2 | 1.2 | 7.6 | 2.3 | 100 |
| Chite | 63.54 | 9.4 | 9.4 | 1.3 | 6.2 | 2.4 | 100 |
| Phullen | 63.2 | 3.2 | 24.4 | 1.5 | 4.1 | 3.6 | 100 |
| Tlangnuam | 62.77 | 9.5 | 15 | 2 | 7.5 | 3.2 | 100 |
| Bethlehem | 62.56 | 9.3 | 9.2 | 1.5 | 6.3 | 2.3 | 100 |
| Zarkawt | 62.54 | 10.3 | 9.6 | 1.1 | 7.7 | 2.1 | 100 |
| Dinthar | 62.52 | 9.3 | 9.4 | 2.1 | 6.4 | 2.4 | 100 |
| Sairang | 61.04 | 9.2 | 9.2 | 4.8 | 7.7 | 7.7 | 100 |
| Darlawn | 58.4 | 3.1 | 25.4 | 3.2 | 5.2 | 4.7 | 100 |
| *Urban average* | *65.274* | *7.22* | *16.96* | *1.78* | *5.62* | *3.14* | *100* |
| **Rural & urban average** | **65.6** | **6.86** | **17.3** | **1.8** | **5.3** | **3.5** | **100** |

Source : Field survey-2016 & 2017

It is clearly reveals from table-5.19 that majority of both rural and urban residence are seeking healthcare at government hospital with 65.8 % rural and 65.2 % urban. The second most visited health-seeking place is Primary health Centre (PHC), a p0unlic sector

healthcare generally located in rural development block headquarters with 17.3%. The important place of health seeking place is private hospital (6.86%), followed by Private clinic (5.3%) and Sub-Centre (3.5%).private hospital in case of urban people with 7.2 % while it is PHC/CHC in case of rural people with 17.5 %. When they got sick some people living in rural area are visiting sub-centre (3.7%).

*The research found out that majority of the population seek healthcare at government hospital (65.27%) and government set up Primary Health Centre (PHC), followed by private hospital and private clinic. This somewhat reflects the economy of the people of the district. Many families reported that they did not afford private hospital and private clinic. However, informal places like home, parent's home or other home as a place of health-seeking is not reported in Aizawl district. This is an indication of positive development among the general masses in Aizawl district.*

### 5.21. Problems of Health-seeking Behaviour

There are many factors responsible for determining healthcare-seekers in Aizawl district. The common causes identified in this research are poverty or cost too much, better care at home, too far, transport problem, lack of knowledge, poor quality service.

This section looks like a repetition of the previous discussion on reasons of not visiting healthcare. The main difference is that in the previous discussion questions are asked to the patients or when people get sick including their past life. However, in this section we asked question only the last one year or recent problems faced by people.

Table-5.20 Aizawl District: Reasons not sought for healthcare

| Rural areas | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| District | Not Necessary | Cost too much | Better care at home | Too far | Transport problem | Lack of knowledge | Poor quality service | Total |
| Lailak | 23.2 | 71.2 | 0 | 43.2 | 45.2 | 13.3 | 5.2 | 100 |
| Khawpuar | 24.2 | 70.2 | 0 | 42.4 | 46.1 | 12.2 | 4.5 | 100 |
| Lenchim | 45.4 | 26.5 | 0 | 26.2 | 25.2 | 15.5 | 5.4 | 100 |
| Chawilung | 44.4 | 26.2 | 0 | 24.2 | 16.2 | 7.2 | 6.2 | 100 |
| N.Khawlek | 59.2 | 25.4 | 0 | 45.2 | 15.2 | 6.4 | 3.4 | 100 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Kelsih | 45.2 | 24.4 | 0 | 0 | 4.2 | 5.5 | 5.5 | 100 |
| Daido | 60.1 | 23.2 | 0 | 43.1 | 14.3 | 7.3 | 4.2 | 100 |
| Darlawng | 56.2 | 23.1 | 0 | 32.3 | 26.5 | 14.2 | 4.5 | 100 |
| ***Rural Average*** | ***44.7*** | ***36.2*** | ***0*** | ***32*** | ***24.1*** | ***10.2*** | ***4.8*** | ***100*** |
| *Urban areas* | | | | | | | | |
| District | Not Necessary | Cost too much | Better care at home | Too far | Transport problem | Lack of knowledge | Poor quality service | Total |
| Darlawn | 28.6 | 68.7 | 0 | 41.8 | 48.1 | 16.2 | 3.4 | 100 |
| Phullen | 60.9 | 27.2 | 0 | 31.8 | 16.1 | 7.7 | 2.8 | 100 |
| Thingsulthliah | 62.7 | 27.1 | 0 | 25.1 | 25.1 | 14.2 | 2.3 | 100 |
| Aibawk | 85.5 | 23 | 0 | 0 | 0 | 4.5 | 4.7 | 100 |
| Sairang | 84.73 | 11.81 | *23.1* | 0 | 0 | 3.43 | 0 | 100 |
| Bethlehem | 84.34 | 8.45 | 22.42 | 0 | 0 | 1.52 | 0 | 100 |
| Dinthar | 84.25 | 8.38 | 23.21 | 0 | 0 | 1.3 | 0 | 100 |
| Chite | 84.32 | 8.35 | 23.42 | 0 | 0 | 1.42 | 0 | 100 |
| Zarkawt | 84.21 | 8.34 | 23.46 | 0 | 0 | 1.21 | 0 | 100 |
| Durtlang | 84.31 | 8.31 | 21.35 | 0 | 0 | 1.2 | 0 | 100 |
| ***Urban average*** | ***74.38*** | ***19.96*** | ***13.69*** | ***9.87*** | ***8.93*** | ***5.26*** | ***1.32*** | ***100*** |
| **Rural & Urban average** | **61.2** | **27.2** | **7.6** | **19.7** | **15.7** | **7.7** | **2.89** | **100** |
| Source : Field survey-2016 & 2017 | | | | | | | | |

The reasons not sought for healthcare are classified in to - not necessary, cost too much, better care at home, too far, transport problem, lack of knowledge, poor quality service.

The main reasons people didn't seek healthcare during the last one year was that 'they don't get sick or not necessary' as 61.2% reported that they don't need to seek healthcare during the last one year. Among the obstacles-poverty of 'cost too much' is the main reason (27.2%), followed by accessibility or 'too far' (19.7%) and transport problem (15.7%).

The problems and intensity faced by rural and urban area are slightly difference. Poverty or 'cost too much' is the main obstacle in both rural and urban areas with 36.2% in rural and 19.9% in urban area, similarly the intensity of the accessibility problems are more in rural area with 32% while it is 9.8% in urban area.

Another interesting finding of the research is that a good proportion of 13.7% urban families reported that they don't visit healthcare facilities during the last one year due to 'better health care at home' while there is no such report in the case of rural area.

Problems and reasons controlling health-seeking behaviour are different between rural and urban area. For example: Poverty, distance of healthcare facility or too far, transport problem and lack of knowledge are very much common hurdles for healthcare seeker in rural area while these cases are comparatively minimal in the case of urban dweller (Table-5.20).

*Therefore, we can conclude that rural people are having more reasons and problems on health-seeking than urban area. Poverty, accessibility and lack of knowledge are extremely important factor stopping rural people from seeking healthcare whereas urban areas are not much having the same problems as rural people do.*

**5.22. Awareness of Government Healthcare Scheme**

The Indian government has launched one of the world's largest publicly funded health insurance scheme, set to cover some 500 million poor people. This Healthcare scheme may transform to providing good quality and accessible healthcare to the poor of India. But, the implementation is slow due to lack of insufficient facilities and weak internet connection to access online through healthcare card or gold card. Many patients can't access proper health care facilities due to poor implementation.

The present study tested the awareness level of these schemes to understand the general perception people and partly to learn how far government schemes are successes.

Table-5.21 Aizawl District: Do you know Govt. healthcare schemes

| **Rural areas** | | | |
|---|---|---|---|
| District | Yes | No | Total |
| Lenchim | 96.4 | 3.6 | 100 |
| Darlawng | 95.2 | 4.8 | 100 |
| Kelsih | 95.2 | 4.8 | 100 |
| Chawilung | 94.5 | 5.5 | 100 |
| N.Khawlek | 94.5 | 5.5 | 100 |
| Daido | 93.5 | 6.5 | 100 |
| Khawpuar | 90.6 | 9.5 | 100 |
| Lailak | 89.1 | 10.1 | 100 |
| *Rural Average* | *93.6* | *6.2* | *100* |
| **Urban areas** | | | |

| District | Yes | No | Total |
|---|---|---|---|
| Durtlang | 100 | 0 | 100 |
| Bethlehem | 98.5 | 1.5 | 100 |
| Zarkawt | 98.4 | 1.6 | 100 |
| Thingsulthliah | 97.9 | 2.1 | 100 |
| Sairang | 97.5 | 2.5 | 100 |
| Dinthar | 97.2 | 2.8 | 100 |
| Chite | 97.1 | 2.9 | 100 |
| Aibawk | 96.14 | 3.86 | 100 |
| Phullen | 95.2 | 4.8 | 100 |
| Darlawn | 91.5 | 8.5 | 100 |
| *Urban Average* | *96.9* | *3* | *100* |
| **Rural & Urban average** | **95.5** | **4.5** | **100** |
| Source : Field survey-2016 & 2017 | | | |

It appears that government healthcare schemes are widely known both in rural and urban Aizawl District with 96.9 % urban people reported of knowing it and a fairly high percentage of 93.6 % do know government healthcare scheme in rural area (Table-5.21). This is somewhat good indicator of the success of healthcare scheme in Aizawl District at least in the level of awareness.

**5.23 Availing Government healthcare scheme**

RSBY (Rashtriya Swasthiya Bima Yojana) has been launched by Ministry of Labour and Employment, Government of India to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most of the diseases that require hospitalization.

But due to insufficient matching share for the state government and lack of proper system, many patients can't avail government health care schemes. In order to know more about the effectiveness or government healthcare scheme, this section asked question about number of family member who avails the schemes.

| Table-5.22. Aizawl District: No. of family who availed Govt. healthcare scheme | | | |
|---|---|---|---|
| **Rural areas** | | | |
| District | Yes | No | Total |
| Khawpuar | 13.7 | 86.3 | 100 |
| N.Khawlek | 13.4 | 86.6 | 100 |
| Lailak | 12.7 | 87.3 | 100 |
| Daido | 12.6 | 87.4 | 100 |
| Darlawng | 10.5 | 89.5 | 100 |
| Lenchim | 10.5 | 89.5 | 100 |
| Kelsih | 8.5 | 91.5 | 100 |
| Chawilung | 8.02 | 91.98 | 100 |
| *Rural Average* | *11.2* | *88.7* | *100* |
| **Urban areas** | | | |
| District | Yes | No | Total |
| Dinthar | 25.8 | 74.2 | 100 |
| Bethlehem | 25.7 | 74.3 | 100 |
| Zarkawt | 25.6 | 74.4 | 100 |
| Chite | 25.2 | 74.8 | 100 |
| Durtlang | 24.1 | 75.9 | 100 |
| Sairang | 23.6 | 76.4 | 100 |
| Darlawn | 13.6 | 86.4 | 100 |
| Phullen | 13.5 | 86.5 | 100 |
| Thingsulthliah | 11.5 | 88.5 | 100 |
| Aibawk | 9.5 | 90.5 | 100 |
| *Urban average* | *19.8* | *80.1* | *100* |
| **Rural & Urban average** | **16** | **83.9** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.22 shows that only few of them in rural and urban residence are actually availing government healthcare scheme with 11.2 % and 19.8 % respectively. This is in spite of the fact that a huge number of them in both rural and urban area are aware of the scheme as already discussed in the above section. An exceedingly high number of 80.1% in urban area and 88.7% in rural area are not availing government healthcare scheme.

## 5.24. Awareness of child healthcare

More than 1.5 million children die each year from vaccine-preventable diseases. Vaccinations are the best weapons against the spread of diseases. Study of health-seeking behaviour without involvement of child healthcare is incomplete. This part highlights the general information of the care of children by parents by asking whether they have vaccination card for their children or not. In normal case, they are supposed to have vaccination card, if there are children in the family.

| Table- 5.23. Aizawl District: Aizawl District: Any vaccinations card for your child | | | |
|---|---|---|---|
| **Rural areas** | | | |
| Aizawl District | Yes | No | Total |
| Kelsih | 92.2 | 7.8 | 100 |
| Chawilung | 89.9 | 10.1 | 100 |
| Lenchim | 87.7 | 12.3 | 100 |
| Darlawng | 86.4 | 13.6 | 100 |
| Daido | 84.5 | 15.5 | 100 |
| N.Khawlek | 83.5 | 16.5 | 100 |
| Khawpuar | 73.4 | 26.6 | 100 |
| Lailak | 72.9 | 27.1 | 100 |
| *Rural Average* | *83.8* | *16.1* | *100* |
| **Urban areas** | | | |
| Aizawl District | Yes | No | Total |
| Zarkawt | 94.6 | 5.4 | 100 |
| Bethlehem | 94.5 | 5.5 | 100 |
| Dinthar | 93.7 | 6.3 | 100 |
| Durtlang | 93.5 | 6.5 | 100 |
| Chite | 93.5 | 6.5 | 100 |
| Aibawk | 91.5 | 8.5 | 100 |
| Sairang | 89.7 | 10.3 | 100 |
| Thingsulthliah | 87.5 | 12.5 | 100 |
| Phullen | 81.6 | 18.4 | 100 |
| Darlawn | 72.4 | 27.6 | 100 |
| *Urban average* | *89.25* | *10.75* | *100* |
| **Rural & Urban average** | **86.8** | **13.1** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.23 shows that proportion of family having Immunization card for child healthcare in Aizawl District is generally high. The overall performance of giving Immunization card in Aizawl District is good while, no vaccination of children is more common in those villages such as – Darlawn (27.6 %), Lailak (27.1 %), Khawpuar (26.6 %), Phullen (18.4%), N.Khawlek (16.5%), and Daido (15.5%).

Table-5.23 exhibits that almost all the family who are having children are having vaccination card. In urban area as many as 89.2 % are having vaccination card while 10.7 % are reported of not having it. Similarly, a fairly high number of 83.8 % rural residence are having vaccination card while a little over 16.1 % are not having the card.

*Thus, it can be confidently sum up that child healthcare in both rural and urban Aizawl District is good as far as vaccination is concerned. Almost every family having children are keeping vaccination card with them.*

## 5.25. Place of delivery

It is important that mothers deliver their babies in an appropriate setting, where life saving equipment and hygienic conditions can also help reduce the risk of complications that may cause death or illness to mother and child.

Maternal healthcare is another indispensable area in this study. Government of India is striving towards more and more institutional delivery so as to give the best healthcare to mother and new born baby. Question on their past delivery experiences are asked here.

**Table-5.24. Aizawl District: Aizawl District: Place of delivery**

| **Rural areas** | | | |
|---|---|---|---|
| Aizawl District | Institution | Home delivery | Total |
| Kelsih | 90.5 | 9.5 | 100 |
| Chawilung | 90.1 | 9.9 | 100 |
| Darlawng | 75.6 | 24.4 | 100 |
| Lenchim | 73.8 | 26.2 | 100 |
| Lailak | 73.5 | 26.5 | 100 |
| N.Khawlek | 72.5 | 27.5 | 100 |
| Khawpuar | 70 | 30 | 100 |
| Daido | 68.6 | 31.4 | 100 |
| *Rural Average* | *76.8* | *23.1* | *100* |
| **Urban areas** | | | |
| Aizawl District | Institution | Home delivery | Total |
| Zarkawt | 99.5 | 0.8 | 100 |
| Bethlehem | 99.4 | 0.5 | 100 |
| Chite | 99.2 | 0.8 | 100 |
| Sairang | 99.2 | 0.5 | 100 |
| Dinthar | 98.4 | 1.6 | 100 |
| Durtlang | 98.1 | 1.9 | 100 |
| Aibawk | 91.5 | 8.5 | 100 |
| Thingsulthliah | 76.5 | 23.5 | 100 |
| Darlawn | 73.4 | 26.6 | 100 |
| Phullen | 73.4 | 26.6 | 100 |
| Urban average | 90.86 | 9.13 | 100 |
| **Rural & Urban average** | **84.6** | **15.3** | **100** |

**Source:** Source : Field survey-2016 & 2017

Table 5.24 shows institutional delivery varied across the districts, which range from 68.6% in Daido Village to 99.5 % in Zarkawt. There is much variation of institution deliver in urban and rural people. Home delivery is more common in rural villages such as- Daido (31.4 %), Khawpuar (30 %), N.Khawlek (27.5 %), Phullen (26 %), Darlawn (26.6 %), Lailak (26.5 %), Lenchim (26 %), Darlawng (24.4 %) and Thingsulthliah (23.5 %).

*Table-5.24 displays that institutional delivery is quite common in urban area (90.86 %) compared with rural area (76.8 %). It is also noticed here that home delivery is still high in rural Aizawl District compared with urban residence with 23.1% and 9.1 % respectively. This may be due to non-availability of health institution in rural Aizawl District.*

### 5.25.1. Recent Place of Delivery

Recent place of delivery mean here is the delivery of baby in the last one year. In the study area, recent place of delivery are generally high, but in some village like Khawpuar, Lailak, N. Khawlek, Daido, Chawilung having more home delivery because of unavailability of heralth personnel, accessibility problems to health centre and because of poverty. In order to get the latest information on delivery, we took the most recent place of birth.

Table- 5.24.1. Aizawl District: Aizawl District: Does your last birth delivered in the hospital

| **Rural areas** | | | | |
|---|---|---|---|---|
| District | Yes | No | No children | Total |
| Lailak | 88..6 | 9.3 | 2.1 | 100 |
| Kelsih | 96.5 | 3.5 | 0 | 100 |
| Chawilung | 95.2 | 4.8 | 0 | 100 |
| Darlawng | 94.6 | 5.4 | 0 | 100 |
| Lenchim | 93.2 | 6.8 | 0 | 100 |
| N.Khawlek | 93.2 | 6.8 | 0 | 100 |
| Daido | 92.5 | 7.5 | 0 | 100 |
| Khawpuar | 90.5 | 8.5 | 1 | 100 |
| *Rural Average* | *93.6* | *6.5* | *0.3* | *100* |
| **Urban areas** | | | | |
| District | Yes | No | No children | Total |
| Chite | 99.5 | 0.5 | 0 | 100 |
| Durtlang | 99.4 | 0.6 | 0 | 100 |
| Bethlehem | 99.3 | 0.7 | 0 | 100 |
| Zarkawt | 99.2 | 0.8 | 0 | 100 |
| Dinthar | 99.2 | 0.8 | 0 | 100 |
| Sairang | 98.6 | 1.4 | 0 | 100 |
| Aibawk | 97.5 | 2.5 | 0 | 100 |
| Phullen | 94.8 | 5.2 | 0 | 100 |
| Thingsulthliah | 94.5 | 5.5 | 0 | 100 |
| Darlawn | 91.5 | 8.5 | 0 | 100 |
| *Urban average* | *97.35* | *2.65* | *0* | *100* |
| **Rural & Urban average** | **95.8** | **4.4** | **0.1** | **100** |

Compared with the previous section, rural folks are so improving in institutional delivery. However, the overall institutional delivery is in urban area is still better when considered their last birth. As many as 97.3% urban mothers and a positively high number of 93.6 % rural mothers delivered their last birth at health institution. At the same time, 2.6% urban mother and 6.5 % rural mothers are still not delivered at health institution.

*It is therefore clear that Aizawl District record good institutional delivery while rural residence needs major improvement compared with urban residence.*

## 5.26. Problems of Maternal Health Seeking

This section tries to identify what are the problems stopping mothers from post natal care in Aizawl District. It is observed that rural mothers have more problems than urban mothers.

Table- 5.25. Aizawl District: Reasons not delivered in the hospital

| **Rural areas** | | | | | | | |
|---|---|---|---|---|---|---|---|
| District | Prefer to have at home | Too far | Healthcare facility Not available | No Medical personnel | Medical personal at home | No Money | Total |
| N.Khawlek | 51.3 | 20.5 | 4.4 | 9.2 | 1.6 | 11.6 | 100 |
| Daido | 51.3 | 20.4 | 5.8 | 9.7 | 1.2 | 11.6 | 100 |
| Khawpuar | 54.2 | 18.6 | 6.3 | 8.4 | 0.1 | 12.4 | 100 |
| Lailak | 54.6 | 18.5 | 6.8 | 8.1 | 0.3 | 11.7 | 100 |
| Darlawng | 52.6 | 16.4 | 2 | 5.2 | 1.2 | 22.6 | 100 |
| Lenchim | 52.5 | 16.1 | 2.2 | 5.4 | 1.1 | 22.7 | 100 |
| Chawilung | 52.5 | 15.2 | 2.3 | 8.9 | 1 | 20.1 | 100 |
| Kelsih | 52.5 | 14.7 | 1.3 | 4.9 | 1.2 | 25.4 | 100 |
| *Rural Average* | *52.6* | *17.5* | *3.8* | *7.4* | *0.9* | *17.2* | *100* |
| **Urban areas** | | | | | | | |
| District | Prefer to have at home | Too far | Healthcare facility Not available | No Medical personnel | Medical personal at home | No Money | Total |
| Phullen | 51.4 | 20.3 | 4.2 | 9.3 | 1.4 | 13.4 | 100 |
| Darlawn | 54.4 | 18.4 | 6.1 | 8.1 | 0.2 | 12 | 100 |
| Thingsulthliah | 52.4 | 16.1 | 2.1 | 5.3 | 1.3 | 22.8 | 100 |
| Aibawk | 52.4 | 14.8 | 0 | 0 | 1.1 | 31.9 | 100 |
| Tlangnuam | 53.4 | 2.5 | 4.5 | 6.2 | 3.4 | 18 | 100 |
| *Urban average* | *52.8* | *14.2* | *3.4* | *5.7* | *1.5* | *19.6* | *100* |
| **Rural & Urban average** | **52.7** | **16.3** | **3.6** | **6.8** | **1.16** | **18.16** | **100** |

Source : Field survey-2016 & 2017

The main reason that stopped mother from delivering baby at hospital is that 'they prefer to have at home'. As much as 52.8 % urban mother reasoned that they preferred to have at home while the same proportion of rural mothers (52.6%) gave the same reason. What prompted them have at home is also different. In the case of urban dweller, a considerable number of 1.5% mother said that medical personnel are available at home to take care while merely 0.9 % rural mother claimed that medical personnel are available at home while delivering baby. It appears that in the case of rural mothers the main reason behind increasing home delivery is non-availability of healthcare facilities within their reach cause as many as 26.5% reported this reason (Table-5.25).

Another interesting finding is that rural residence are facing accessibility or the healthcare facilities are too far from their villages as reported by a high number of 17.5 % while the same problem is not severe in the case of urban residence with 14.4%. Moreover, unavailability of medical personnel is also one major factor stopping mother to deliver baby in the hospital.

*Therefore, it is observes that mother preferred to deliver baby at home mainly because there are medical personnel who can assist them at home in urban area whereas it is mainly due to unavailability of hospital in the case of rural residence. While inaccessibility to healthcare facility became one major problem in rural area, the same is not true in the case of urban residence.*

**5.27. Postnatal check-up**

Post- natal care during the first 42 days after delivery is important for identification and management of emergencies. It is the most crucial period for the health and survival

both of the mother and her newborn. Also regular check-up after delivery is required to make sure mother and baby are not facing health complications.

This is an attempt to understand why mothers are not performed check-up after delivery. We got five major problems that stop mother to deliver in hospital. There are some variations between rural and urban residence on the reasons why they do not deliver baby at hospital.

Table- 5.26. Did you/the child receive any check-up after delivery

| **Rural areas** | | | | |
|---|---|---|---|---|
| District | Yes | No | No Children | Total |
| Kelsih | 91.3 | 7.6 | 1.1 | 100 |
| Chawilung | 91.2 | 8.8 | 0 | 100 |
| N.Khawlek | 82.2 | 17.8 | 0 | 100 |
| Daido | 82.1 | 17.9 | 0 | 100 |
| Lenchim | 77.5 | 22.5 | 0 | 100 |
| Darlawng | 76.4 | 16.3 | 7.3 | 100 |
| Khawpuar | 52.3 | 47.7 | 0 | 100 |
| Lailak | 52.1 | 47.9 | 0 | 100 |
| *Rural Average* | *75.6* | *23.3* | *1* | *100* |
| **Urban areas** | | | | |
| District | Yes | No | No Children | Total |
| Durtlang | 100 | 0 | 0 | 100 |
| Zarkawt | 100 | 0 | 0 | 100 |
| Bethlehem | 100 | 0 | 0 | 100 |
| Dinthar | 100 | 0 | 0 | 100 |
| Chite | 100 | 0 | 0 | 100 |
| Sairang | 100 | 0 | 0 | 100 |
| Aibawk | 91.4 | 7.6 | 1 | 100 |
| Phullen | 82.3 | 17.7 | 0 | 100 |
| Thingsulthliah | 76.8 | 16 | 7.2 | 100 |
| Darlawn | 52.2 | 47.8 | 0 | 100 |
| *Urban average* | *90.27* | *8.91* | *0.82* | *100* |
| **Rural & Urban average** | **83.7** | **15.3** | **0.9** | **100** |

Source : Field survey-2016 & 2017

*Table-5.26 reveals that postnatal check-up is quite common in both rural and urban area. Urban area recorded better performance with 90.3 % while a little lesser proportion of rural mother (75.6 %) does the same.*

**5.28. Place of postnatal care**

Of the 2.9 million newborn deaths that occurred in 2012, close to haft of them occurred within the first 24 hours after birth (WHO). Many of these deaths occurred in

babies born too early and too small, babies with infections, or babies asphyxiated around the time of delivery. Labour, birth and the immediate postnatal period are the most critical for newborn and maternal survival. Unfortunately, the majority of mothers and newborns in the study area do not receive optimal care during these periods.

Place of post natal check-up is another important factors that involves in the overall analysis of maternal healthcare seeking behaviour. It is desirable that mother are seeking healthcare after delivery on time and in a proper place.

Table- 5.27. Aizawl District: Place of postnatal care

| Rural areas | | | | | |
|---|---|---|---|---|---|
| District | Govt. Hospital | PHC | Private Clinic | Sub-center | Total |
| Khawpuar | 42.4 | 50.4 | 4.5 | 2.7 | 100 |
| Darlawng | 42.2 | 44.6 | 4.6 | 8.6 | 100 |
| Kelsih | 42 | 44.5 | 3.6 | 9.9 | 100 |
| Lenchim | 41.6 | 53.8 | 4.1 | 0.5 | 100 |
| Lailak | 41.5 | 50.9 | 4.9 | 2.7 | 100 |
| Chawilung | 41 | 44.5 | 4 | 10.5 | 100 |
| N.Khawlek | 34.6 | 45.7 | 5.2 | 14.5 | 100 |
| Daido | 33.7 | 46.2 | 5 | 15.1 | 100 |
| Rural Average | 39.8 | 47.5 | 4.4 | 8 | 100 |
| Urban areas | | | | | |
| District | Govt. Hospital | PHC | Private Clinic | Sub-center | Total |
| Tlangnuam | 48.2 | 46.2 | 4.2 | 1.4 | 100 |
| Aibawk | 43 | 44.6 | 3.8 | 8.6 | 100 |
| Thingsulthliah | 42.5 | 44.7 | 4.5 | 8.3 | 100 |
| Darlawn | 40.6 | 50.2 | 4.7 | 4.5 | 100 |
| Phullen | 35.2 | 45.8 | 5.1 | 13.9 | 100 |
| *Urban average* | *41.9* | *46.3* | *4.46* | *7.34* | *100* |
| **Rural & Urban average** | **40.7** | **47** | **4.5** | **7.8** | **100** |

Source : Field survey-2016 & 2017

In table–5.27 majority of mothers seek post natal care in Government Hospital and Primary Health Center. Fewer women seek sub-center and private clinic.

*It is interesting to explores that highest number of both rural and urban mother done post natal check-up in PHC (47%), followed by hospital (40.7%), sub-center (7.8%) and private clinic (4.5%). The health-seeking pattern is by and large same in both rural and urban area as far as postnatal care is concerned.*

### 5.28.1. Promptness for postnatal check-up

Some women will give birth at home with a skilled attendant; others may not have a skilled attendant present. Some women who give birth in the facility will spend time there following childbirth. Regardless of the place of birth, it is important that someone accompanies the woman and newborn for the first 24 hours after birth to respond to any changes in her or her baby's condition. Many complications can occur in the first 24 hours. Following childbirth at home, it is important that the mother and baby receive a postnatal examination as early as possible, preferably within 24 hours of birth. If the birth was at a facility, mother and baby should receive a postnatal examination before discharge.

Promptness of post natal care is another indicator of mother's health-seeking behaviour. Relatively urban mothers are more prompt in post natal healthcare than rural mother.

Table- 5.28. Aizawl District: Promptness for postnatal check-up

| Rural areas | | | | | | |
|---|---|---|---|---|---|---|
| District | Within 2-3 days | Within weeks | Within 3 months | No checkup | No children | Total |
| Chawilung | 2.5 | 57.9 | 19.4 | 20.2 | 0 | 100 |
| Daido | 2.1 | 60.1 | 16.4 | 21.4 | 0 | 100 |
| Darlawng | 1.3 | 67.1 | 19.3 | 12.3 | 0 | 100 |
| Kelsih | 2.4 | 22.5 | 47.4 | 27.4 | 0 | 100 |
| Khawpuar | 0.7 | 14.5 | 36.5 | 47.8 | 0 | 100 |
| Lailak | 0.7 | 51 | 28.1 | 20.2 | 0 | 100 |
| Lenchim | 0.7 | 51.7 | 27.2 | 20.4 | 0 | 100 |
| N.Khawlek | 0.9 | 51.5 | 29.5 | 10.6 | 0 | 100 |
| *Rural Average* | *1.4* | *47.0* | *27.9* | *22.5* | *0* | *100* |
| Urban areas | | | | | | |
| Durtlang | 4.5 | 91.5 | 3.8 | 0 | 0 | 100 |
| Zarkawt | 4.2 | 91.8 | 3.5 | 0 | 0 | 100 |
| Bethlehem | 4.5 | 91.6 | 3.4 | 0 | 0 | 100 |
| Dinthar | 4.6 | 91.8 | 3.6 | 0 | 0 | 100 |
| Chite | 4.5 | 91.6 | 3.7 | 0 | 0 | 100 |
| Sairang | 4.5 | 90.2 | 5.3 | 0 | 0 | 100 |
| Thingsulthliah | 1.4 | 71.2 | 19.4 | 2.4 | 0 | 100 |
| Aibawk | 2.3 | 22.6 | 47.2 | 27.5 | 0 | 100 |
| Darlawn | 0.6 | 14.4 | 36.4 | 47.5 | 0 | 100 |
| Phullen | 0.8 | 71.4 | 29.8 | 10.9 | 0 | 100 |
| *Urban average* | *3.1* | *72.8* | *15.6* | *8.8* | *0* | *100* |
| **Rural & Urban average** | **2.4** | **61.4** | **21.1** | **14.9** | | **100** |

Source : Field survey-2016 & 2017

The most common period /time of post natal check up in Aizawl district is within weeks as 61.4% reported that, followed by within 3 months after delivery (21.1%) and just 2.4% do postnatal check-up with 2-3days while a14.9% are not done postnatal check-up at all.

A fairly high number of 72.8 % urban mother sought healthcare within a few weeks after delivery whereas 47.0 % rural mothers sought post natal care within the same period of time. Comparatively more number of rural mother delayed post natal check-up than urban mothers with 27.9 % and 15.6 % respectively. No check-up was also common in both rural and urban areas where in rural mother recorded higher number of mother who do not do post natal check-up (22.5 %) than urban mother (8.8%).

*Therefore, it can be concluded that postnatal care is common in Aizawl district especially check-up within weeks and within 3 month while a good proportion of mother do not go for postnatal check-up after delivery. This is mainly because they did not have complications.*

**5.28.2. Problems of Postnatal health care Seeking**

Following childbirth the woman and newborn should be examined within 24 hours by a health worker. WHO recommends that the mother and baby be visited at home by a trained health worker, preferably within the first week after

These visits early in the postnatal period are important for the mother and baby. It is also an important opportunity to ensure the establishment of breastfeeding and address any difficulties with attachment and positioning.

This section tries to identify what are problems stopping mothers from post natal care in Aizawl District. It is observed from table-5.29 that rural mothers have more problems than urban mothers.

Table- 5.29. Reason not seeking Postnatal care

| **Rural areas** | | | | | | |
|---|---|---|---|---|---|---|
| Aizawl District | No need | Too far | Financial Problem | Hospital/PHC\/CHC Not available | Medical personnel available at home | Total |
| Lenchim | 35.1 | 26.34 | 38 | 0.5 | | 100 |
| Lailak | 12.3 | 45.2 | 42.1 | 0.9 | 0 | 100 |
| Daido | 24.8 | 42.9 | 42 | 0.6 | 0 | 100 |
| Khawpuar | 12.4 | 45.3 | 41.4 | 0.8 | 0 | 100 |
| N.Khawlek | 24.3 | 43.2 | 40.5 | 0.4 | 0 | 100 |
| Chawilung | 50.02 | 25.48 | 38.6 | 1.2 | 0 | 100 |
| Darlawng | 34.8 | 25.3 | 38.5 | 0.4 | 0 | 100 |
| Kelsih | 49.2 | 24.5 | 25.1 | 2.3 | 0 | 100 |
| ***Rural Average*** | ***30.3*** | ***34.7*** | **38.2** | ***0.8*** | ***0*** | ***100*** |
| **Urban areas** | | | | | | |
| Aizawl District | No need | Too far | Financial Problem | Hospital/PHC\/CHC Not available | Medical personnel available at home | Total |
| Darlawn | 12.5 | 45.1 | 41.3 | 0.7 | 0 | 100 |
| Phullen | 24.4 | 43.2 | 40.2 | 0.5 | 0 | 100 |
| Thingsulthliah | 34.8 | 25.4 | 38.4 | 0.3 | 0 | 100 |
| Aibawk | 49.4 | 24.9 | 24.5 | 0.5 | 0 | 100 |
| Durtlang | 100 | 0 | 0 | 0 | 0 | 100 |
| Zarkawt | 100 | 0 | 0 | 0 | 0 | 100 |
| Bethlehem | 100 | 0 | 0 | 0 | 0 | 100 |
| Dinthar | 100 | 0 | 0 | 0 | 0 | 100 |
| Chite | 100 | 0 | 0 | 0 | 0 | 100 |
| Sairang | 100 | 0 | 0 | 0 | 0 | 100 |
| *Urban Average* | *72.1* | *13.8* | *14.4* | *0.2* | *0* | *100* |
| **Rural & Urban average** | **53.6** | **23.2** | **25** | **0.5** | **0** | **100** |
| **Source : Field survey-2016 & 2017** | | | | | | |

The reason not seeking post-natal cares are too far, financial problem, Hospital/PHC\/CHC Not available. Table-5.29 shows that 'too far' is so common problem in villages like Khawpuar (45.3 %), Lailak (45.2 %), Darlawn (45.1 %), Daido (42.9 %), N.Khawlek (43.2 %) and Phullen (43.2 %).Financial problem is also high in Daido (42 %), Lailak (42.1 %), Khawpuar (41.4 %), Darlawn (41.3 %), N.Khawlek (40.5 %) and Phullen (40.2 %).

Another significant difference between urban and rural area is that while accessibility become one of the biggest constraints for rural residence (13.8 %) only 34.7

% urban mother reasoned for the same. Financial or poverty is one common area where rural and urban area faced problems.

Besides, it is also observed that there are some small cases where medical personnel are available at home who can take care of post natal complication if the case was not serious. Also, it is worth highlighting that as many as 24.4 % urban mothers and 30.3% rural mothers reported of no need of post natal care.

*This section can be sum-up that accessibility and non-availability of healthcare facilities become the major hurdles for rural mother after delivery while these are not much responsible in the context of urban mothers. On the other hand poverty or financial problems is one factor that both rural and urban mother are facing towards post natal care. Moreover, many mothers are also not having post natal complications and they need not to visit healthcare facilities after delivery*.

**Inter-Block variations of health-seeking behaviour in Aizawl district**

The present section is a comparatives analysis of the inter-block variations of health-seeking behavior across the district of Aizawl. It dealt with healthcare services, healthcare facilities and maternal health-seeking behaviour in Aizawl district. This is an attempt to provide clearer picture of health-seeking attitude of people living in different five rural development blocks of Aizawl district.

**5.29. Block-wise: Prevalence of sickness**

The first information we collected during survey is the general information on whether the family members suffered sickness or not in their live time. Generally, prevalence of sickness is high in Aizawl district with the average block report of 89 %.

During the survey, people were asked whether any of their family members got sick in their life time to understand the prevalence of sickness.

| Table-5.30. Block-wise: Is anybody ever got sick in your family | | | |
|---|---|---|---|
| **Aizawl R.D Block** | Yes | No | Total |
| **Darlawn** | 96.3 | 3.7 | 100 |
| **Aibawk** | 96.2 | 7.6 | 100 |
| **Thingsulthliah** | 94.5 | 5.5 | 100 |
| **Phullen** | 92.8 | 7.5 | 100 |
| **Tlangnuam** | 69 | 31 | 100 |
| **Average** | 88.9 | 11.06 | 100 |
| Source : Field survey-2016 & 2017 | | | |

Table-5.30. depicts that among the five Rural Development blocks sickness among family member is most common in Darlawn RD Block (96.3 %), followed by Aibawk RD Block (96.2%), Thingsulthliah RD Block (94.5 %), Phullen RD Block (92.8%) and Tlangnuam RD Block. It appears that Tlangnuam RD block record the least sickness among the blocks. This is mainly because of relatively more availability or medical facilities in Tlangnuam RD Block and its urban characters.

## 5.30. Block-wise: Health-seeking Behaviour

Another important criterion of health-seeking behavior is that whether people are going for check-up, at least, in time of illness. It appears from table-5.31 that majority of the population across the blocks went for check up in time of illness (72.72 %) while a good bunch of people (27.2%) were not went for health check-up in time of illness.

| Table-5.31. Block-wise: Family member go for check up in time of illness | | | |
|---|---|---|---|
| **Aizawl R.D Block** | Yes | No | Total |
| **Tlangnuam** | 95.5 | 4.25 | 100 |
| **Aibawk** | 72.8 | 27.2 | 100 |
| **Thingsulthliah** | 70.3 | 29.7 | 100 |
| **Phullen** | 64.2 | 35.8 | 100 |
| **Darlawn** | 60.8 | 39.2 | 100 |
| **Average** | 72.72 | 27.23 | 100 |
| Source : Field survey-2016 & 2017 | | | |

Table-5.31 shows the inter-block variations of family members going for health check-up in time of illness such as Tlangnuam (95.5 %), Aibawk (72.8 %), Thingsulthliah (70.3 %), Phullen (64.2 %) and Darlawn (60.8 %).

*Therefore, it can be concluded that among the blocks, Tlangnuam RD Block became the healthiest people and most active in seeking healthcare in time of illness whereas Darlawn became the most unhealthiest and poorest in seeking health care.*

**5.31. Block-wise: Reasons for not check-up in time of illness**

The above discussion needs further clarification as why people did not go for health check-up even if they suffered sickness. The present section tries to explore the reasons across the blocks. The most common reasons identified during the survey are–cost too much, far location of healthcare facilities, transport problem, improper road, require for household work, no proper facilities, not interested in check-up, require for work in agricultural field or family affair, business-shop, require for outside work for payment in cash or in kind.

**Table-5.32. Block-wise: Reason for not check-up in time of illness**

| Aizawl R.D Block | Cost Too Much | Too Far | Transport Problem | Improper Road | Require for household | No Proper HC facility | Not interest in check up | RA | RP | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Darlawn** | 61.4 | 75.8 | 45 | 67.1 | 71.9 | 20.5 | 66.7 | 12.7 | 5.8 | 100 |
| **Aibawk** | 54.74 | 21.9 | 15.1 | 15.5 | 52.3 | 5.1 | 15.3 | 1.2 | 0.7 | 100 |
| **Phullen** | 40.2 | 72.3 | 37.9 | 48.6 | 50.2 | 11.3 | 50.8 | 15.3 | 6.2 | 100 |
| **Thingsulthliah** | 38.4 | 25.3 | 16.6 | 19.6 | 51.3 | 8.8 | 23.4 | 7.3 | 3.4 | 100 |
| **Tlangnuam** | 29.41 | 0.3 | 0.45 | 0.45 | 0.38 | 0.76 | 12.4 | 0..3 | 0.2 | 100 |
| **Average** | 44.83 | 39.12 | 23.01 | 33.35 | 51.87 | 9.29 | 33.72 | 7.36 | 3.26 | 100 |

**RA=Required for work on agricultural field or family business (shops, retail shops, grocery etc.)**

**RP=Required for outside work for outside work for payment in cash or kind**

Source : Field survey-2016 & 2017

Table-5.32. shows that required for household works (51.87%) and poverty or cost too much (44.83%) are major reasons why people were not seeking healthcare even if they felt sick, followed by inaccessibility (too far, transport problems and improper roads), no proper healthcare facilities (9.29), require for work on agricultural field or family business

(shops, retail shops, grocery etc (7.36 %), required for outside work for outside work for payment in cash or kind (3.26%) and as many as 33.72% were not interested in check.

*Among the five blocks Darlawn and Aibawk record highest proportion that prevent them from seeking healthcare while Tlangnuam and Thingsulthliah blcoks record the least on this regards. The reasons of not seeking healthcare is differ from one block to another, especially the problems of Tlangnuam RD Block is minimal in all reasons while Darlawn record highest proportion of health seeking problems among the blocks. Accessibility factor is one of the major obstacles preventing people from health seeking in all the RD Blocks except in Tlangnuam.*

### 5.32. Block-wise: Recent Health-seeking Behaviour

A good number of 53.6% visit health institution during the last one year in Mizoram while the average of Aizawl district with 45.9 %.

**Table-5.33. Block-wise: Did any of HH member visit Health institution for treatment-last 1 year**

| Aizawl R.D Block | Yes | No | Total |
|---|---|---|---|
| **Tlangnuam** | 52.5 | 49.75 | 100 |
| **Aibawk** | 46.9 | 53.05 | 100 |
| **Thingsulthliah** | 49.5 | 50.5 | 100 |
| **Phullen** | 42.1 | 57.9 | 100 |
| **Darlawn** | 38.5 | 61.5 | 100 |
| **Average** | 45.9 | 54.54 | 100 |

Source : Field survey-2016 & 2017

Table- 5.33 reveals that good number of 45.9 % visit health institution during the last one year in the study area while more over 54.54 % are not visiting health institutions. Tlangnuam block (52.5 %) records the highest proportion of family members visiting health institution for treatment during the last one year, followed by Thingsulthliah (49.5 %), Aibawk (46.9 %), Phullen (42.1 %) and Darlawn (38.5 %)

## 5.33. Block-wise: Consultation of health personnel

Consultation of health personnel is another important criterion to understand health-seeking behavior of people. It appears that consultation of health personnel is quite common in across the blocks of Aizawl district as the average number of patients consulted government doctor in Aizawl district is 91.96 %. Practically almost cent percent are consulting medical personnel including health worker, health supervisor and ANM in the rural PHC and sub-center while merely 3.14 % were consulting traditional healer.

**Table-5.34. Block-wise: Whom did you see**

| Aizawl R.D Block | Govt. doctor/nurse | ANM/LVH/Supervisor/Health worker | Traditional healer/DAI | Anganwadi Worker | Total |
|---|---|---|---|---|---|
| **Tlangnuam** | 100 | 0 | 0 | 0 | 100 |
| **Phullen** | 93.2 | 4.6 | 2.2 | 0 | 100 |
| **Aibawk** | 92.5 | 6.78 | 0.72 | 0 | 100 |
| **Thingsulthliah** | 92.5 | 5 | 4.6 | 0 | 100 |
| **Darlawn** | 81.6 | 10.2 | 8.2 | 0 | 100 |
| **Average** | 91.96 | 5.31 | 3.14 | 0.1 | 100 |
| Source : Field survey-2016 & 2017 | | | | | |

*Thus, consultation of health personnel when people got sick was very much common across the block of Aizawl district while few people still consulted traditional healer, especially some pockets of Darlawn RD Block.*

## 5.34. Block-wise: Performance of Service Providers

Another important criterion of health-seeking behavior is the perfomance of service providers. By and large, table-5.35 reveals that medical staff were nice and they perfomed well as 75.83% reported that when they visit helth centre medical personnels were talking nicely' to them while 24.17% reported the opposite.

**Table-5.35. Block-wise: Did the staff talk to him/her**

| Aizawl R.D Block | Nicely | Not nicely | Total |
|---|---|---|---|
| **Tlangnuam** | 90.05 | 9.95 | 100 |
| **Phullen** | 76.7 | 23.3 | 100 |
| **Aibawk** | 75.5 | 24.5 | 100 |
| **Darlawn** | 72.4 | 27.6 | 100 |

| | | | |
|---|---|---|---|
| **Thingsulthliah** | 64.5 | 35.5 | 100 |
| **Average** | 75.83 | 24.17 | 100 |
| Source : Field survey-2016 & 2017 | | | |

Among the RD block of Aizawl district, Tlangnuam block records the best responses to the patients (90.05 %), followed by Phullen (76.7 %), Aibawk (75.5 %), Darlawn (72.4 %) and Thingsulthliah (64.5 %).

*Therefore, health service providers across the five RD blocks are generally performed well wherein Tlangnuam block, located within state capital Aizawl city, got maximum proportion (90%) while Thingsulthliah got minimum performance (64.5%).*

### 5.35. Block-wise: Care Givers

Caregivers are tasked with the important duty of providing support and encouragement for the patients as well as themselves. Communication is important for relationship between a caregiver and patient. It is important to both openly share feelings and remain empathetic to the situation.

**Table- 5.36. Block-wise: No. of patients visiting different care givers during the last one year**

| Aizawl R.D Block | Medicine specialist/MO* | Physio therapist | Radio therapist | Sur geon | Dieti Cian | Stoma Nurse | Total |
|---|---|---|---|---|---|---|---|
| **Thingsulthliah** | 79.5 | 6.2 | 8.2 | 3.8 | 2.3 | 0 | 100 |
| **Darlawn** | 78.2 | 2.3 | 6.7 | 4.5 | 8.3 | 0 | 100 |
| **Phullen** | 77.5 | 4.3 | 9.5 | 3.5 | 5.2 | 0 | 100 |
| **Aibawk** | 75.5 | 5.6 | 6.1 | 0 | 4.1 | 0 | 100 |
| **Tlangnuam** | 60.45 | 9.5 | 9.6 | 12.5 | 7.95 | 0 | 100 |
| **Average** | 74.23 | 5.58 | 8.02 | 4.86 | 5.57 | 0.1 | 100 |
| *In most cases patient consult Medical Officer (MO) in PHC or district hospital and wherever there are medicine specialist they consulted. For convenience, we treat them as same cause patient could hardly able to differentiate them, even though MO were MBBS while Medicine specialist were MD. | | | | | | | |
| Source : Field survey-2016 & 2017 | | | | | | | |

Table-5.36 shows that consultation of medical officer or medicine specialist becomes the most common practice in Mizoram with 74.23 % average, followed by radiotherapist or cancer doctor (8.02 %), physiotherapist (85.58%), dietician (5.57 %), surgeon (4.86 %) and stomata nurse (0.1 %).

### 5.36. Block-wise: Observation of healthcare facilities

Heath facilities are required to maintain utmost cleanliness for minimizing the growth of infective organisms, which can spread between patients, visitors and hospital staff. Cleanliness of health facilities in Aizawl District are classified as very clean, somewhat clean, not clean, no response / don't know on the basis of health facility observation.

**Table-5.37. Block wise: Observation of healthcare facilities**

| Aizawl R.D Block | Very Clean | Somewhat Clean | Not Clean | No response/ Don't know | Total |
|---|---|---|---|---|---|
| **Tlangnuam** | 42.79 | 48.26 | 6.97 | 1.99 | 100 |
| **Thingsulthliah** | 40.2 | 50 | 8.8 | 1 | 100 |
| **Phullen** | 37.4 | 52.4 | 7.2 | 3 | 100 |
| **Darlawn** | 34.1 | 55.7 | 9.3 | 0.8 | 100 |
| **Aibawk** | 19.63 | 70.75 | 9.61 | 0.01 | 100 |
| **Average** | 34.82 | 55.42 | 34.44 | 1.36 | 100 |
| Source : Field survey-2016 & 2017 | | | | | |

Table-5.37 reveals that majority of the people find healthcare facilities are somewhat clean (55.42 %) across the blocks, followed by very clean (34.82%), not clean (34.44 %) while 1.36% were not responding the question.

*Among the block, Tlangnuam block scored highest on the observation of cleanliness of healthcare facilities while Aibawk secored the least on the same. Generally, the cleanliness of health facilities across the block is moderate.*

## 5.37. Block-wise: Sufficiency of Healthcare Facilities

Health facilities are places that provide health care. They include hospitals, clinics, outpatient care centers, and specialized care centre. Sufficiency of health facilities, availability and better access are important for patients. Patient's observation on government healthcare facilities is classified as adequate, poor, very poor, very good and no response.

| | **Table-5.38. Block-wise: Sufficiency of government healthcare facility (%)** | | | | | |
|---|---|---|---|---|---|---|
| **Aizawl R.D Block** | Very Good | Adequate | Poor | Very Poor | No Response | Total |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Darlawn** | 2 | 48.7 | 42.3 | 4 | 3 | 100 |
| **Thingsulthliah** | 4.3 | 47.8 | 37.4 | 6.1 | 4.4 | 100 |
| **Tlangnuam** | 25.5 | 47.3 | 23.2 | 0.5 | 3.5 | 100 |
| **Phullen** | 3 | 45.2 | 40.4 | 8.4 | 3 | 100 |
| **Aibawk** | 1.6 | 44.5 | 36.8 | 3.5 | 4.6 | 100 |
| **Average** | 7.28 | 46.7 | 36.02 | 6.3 | 3.7 | 100 |
| | Source : Field survey-2016 & 2017 | | | | | |

Table-5.38 shows that a good number of people observed government healthcare facilities are ‘adequate’ (46.7 %) while 36.02 %) of them said it is poor and6.3% reported it is very poor. A very few people of 70.28% reported that government healthcare facilities are very good.

*Therefore, government healthcare facilities across the block in Aizawl district are somewhat good and adequate while just few of the observed it that healthcare facilities are very good as well as very poor.*

**5.38. Block-wise: Problems of Utilizing Healthcare Facilities**

Present study also examined what are the specific problems faced by healthcare seekers in the Aizawl district by offering probably reasons in the questionnaires such as- lack of equipment, medical personnel, too far, irregular doctor.

**Table-5.39. Block-wise: Sufficiency of government healthcare facility**

| **Aizawl R.D Block** | Lack of equipment, medicines | Poor performance of medical personal | Too far | No problems | Irregular Doctor | No response | Total |
|---|---|---|---|---|---|---|---|
| **Darlawn** | 32.9 | 24.2 | 42.6 | 0 | 1.9 | 1 | 100 |
| **Phullen** | 30.2 | 24.3 | 40.3 | 4.2 | 1 | 0 | 100 |
| **Thingsulthliah** | 24.6 | 29.9 | 30.2 | 10.8 | 2.4 | 2.1 | 100 |
| **Aibawk** | 8.73 | 25.9 | 29.08 | 33.79 | 2.53 | 0 | 100 |
| **Tlangnuam** | 4.75 | 0.25 | 0 | 94.75 | 0 | 0.25 | 100 |
| **Average** | 20.23 | 20.91 | 28.43 | 48.14 | 1.56 | 0.67 | 100 |
| Source : Field survey-2016 & 2017 | | | | | | | |

As shown in table-5.39 the major constraints faced by health-seekers in the study area are- too far (28.43 %), poor performance of medical personal (20.91 %), lack of equipment and medicines (20.23 %). Lack of equipment/medicines is the highest in

Darlawn (32.9 %), followed by Phullen (30.2 %) and Thingsulthliah (24.6 %) while Tlangnuam (4.75 %) and Aibawk (8.73 %) have sufficient healthcare facilities.

Problem of 'too far' or accessibility is another major obstacles for utilizing healthcare facilities and it is fairly high in Darlawn (42.6 %), followed by Phullen (40.3 %), Thingsulthliah (30.2 %) and Aibawk (29.08 %) while Tlangnuam has no accessibility problems for health-seekers.

*Therefore, among the RD Blocks, Darlawn has maximum problems that obstruct health-seekers, followed by Phullen and Thingsulthliah while Tlangnuam and Aibawk have minimum problems tthat stops healthcare-seekers. It is interesting to note that while accessibility or 'too far' become one of the biggest hurdles for health-seers in all the block Tlangnuam has no accessibility problms at all.*

### 5.39. Block-wise: Common diseases

The present study questioned about the common diseases or health problems faced by family members to identify prevalence of common diseases in Aizawl district. There are 24 common health problems identified during the survey.

**Table-5.40. Which is the most common disease suffered by your family**

| Disease | Tlangnuam | Aibawk | Thingsulthliah | Phullen | Darlawn | Average |
|---|---|---|---|---|---|---|
| Cough & Fever | 75.59 | 95.86 | 55.8 | 93.6 | 88.2 | **81.81** |
| Kidney problem | 0.68 | 42.94 | 37.5 | 65.9 | 68.7 | **43.14** |
| Ulcer | 0.34 | 2.64 | 11.5 | 28 | 25.7 | **13.63** |
| Asthma | 4.07 | 8.26 | 10.5 | 16.1 | 17.9 | **11.36** |
| Cancer | 4.07 | 9.6 | 6.9 | 22.3 | 11.8 | **10.93** |
| Diarrhea | 4.07 | 3.32 | 10.2 | 12.9 | 13.3 | **8.75** |
| TB | 1.36 | 0.75 | 3.8 | 14.9 | 13.2 | **6.8** |
| Liver pain | 5.76 | 7.16 | 5.5 | 5.4 | 7.5 | **6.26** |
| Nerve problem | 0.34 | 0.56 | 0 | 0.9 | 25.1 | **5.38** |
| Malaria | 2.71 | 4.14 | 5.8 | 9.7 | 2.9 | **5.05** |
| Jaundice | 2.03 | 2.26 | 4.1 | 7.6 | 5.2 | **4.23** |
| Deafness | 0.34 | 1.3 | 4.2 | 3.4 | 2.6 | **2.36** |
| Typhoid | 0 | 0 | 2.7 | 3.6 | 3.5 | **1.96** |
| Hepatitis | 0 | 0 | 0 | 8.4 | 0.2 | **1.72** |
| Pneumonia | 0 | 0 | 0.2 | 4 | 3.4 | **1.52** |
| Diabetes | 4.07 | 1.27 | 0.2 | 0.4 | 0.6 | **1.3** |
| Goiter | 0.68 | 0 | 0.2 | 0 | 0.2 | **0.21** |
| Septicemia | 0.34 | 0 | 0 | 0.3 | 0.4 | **0.2** |
| Stroke | 0.68 | 0 | 0 | 0 | 0 | **0.13** |
| Blindness | 0.34 | 0 | 0 | 0 | 0 | **0.06** |
| Polio | 0 | 0 | 0 | 0 | 0 | **0** |
| **Average** | **5.1** | **8.6** | **7.6** | **14.2** | **13.8** | **9.8** |
| Total | 100 | 100 | 100 | 100 | 100 | **Total** |

Source : Field survey-2016 & 2017

It is clear from the table-5.40 that cough and fever is the most common diseases in all the blocks with 81.81 %, followed by kidney problem (43.14 %), ulcer (13.63 %), Asthma (11.36 %), Cancer (10.93 %), Diarrhea (8.75 %), T.B (6.8 %), Liver pain (6.26 %), Nerve problem (5.38 %), Malaria (5.05 %), Jaundice (4.22 %), Deafness (2.36 %), Typhoid (1.96 %), Hepatitis (1.72 %), Pneumonia (1.52 %), Diabetes (1.3 %), Goiter (0.21 %), Septicemia (0.2 %) and stroke (0.13 %).

*Looking at inter-block variation on overall diseases, Phullen got maximum average with 14.2%, followed by Darlawn with 13.8% and Aibawk with 8.6% while Tlangnuam block got minimum diseases/problems with 5.1%.*

**5.40. Block-wise: Prevalence of Death**

Knowledge about the prevalence of death is important to identify reasons of death and health-seeking behaviour.

**Table-5.41. Block-wise: Is there anyone of your family member died**

| **Aizawl R.D Block** | Yes | No | Total |
|---|---|---|---|
| **Darlawn** | 31.9 | 68.1 | 100 |
| **Phullen** | 30.5 | 69.5 | 100 |
| **Thingsulthliah** | 29.6 | 70.4 | 100 |
| **Aibawk** | 22.65 | 77.35 | 100 |
| **Tlangnuam** | 21.25 | 78.75 | 100 |
| **Average** | 27.18 | 72.82 | 100 |
| Source : Field survey-2016 & 2017 | | | |

Table-5.41 reveals that 27.18 % families in Aizawl district already experience death of their family members while a fairly good number of 72.82 reported of not experiencing any death in their family.

Among the blocks Darlawn and Phullen record maximum percentage of death of family members with 31.9% and 30.5%, followed by Thingsulthliah (29.6%) while

Tlangnuam and Aibawk record minimum proportion of death with 2125% and 22.65% respectively.

### 5.41. Block-wise: Reason of Death

Reason of death is differ from place to place. This section is to identify reasons of death and what are their relationships with common diseases. It is also necessary to test whether major diseases suffered by patients, stated above, were the leading causes of death or not.

**Table- 5.42. Block-wise: Reason of family member who died**

| Reason of death | Tlang nuam | Ai bawk | Thingsul thliah | Phul len | Dar lawn | Average |
|---|---|---|---|---|---|---|
| **Cancer** | 21.43 | 39.5 | 35.4 | 39.6 | 57.3 | 38.64 |
| **Liver pain** | 24.11 | 3.19 | 2.5 | 15.7 | 3.1 | 9.72 |
| **Malaria** | 7.14 | 1.06 | 13.9 | 10.1 | 7.3 | 7.9 |
| **Pneumonia** | 0.89 | 1.06 | 0 | 9.4 | 10.4 | 4.35 |
| **Jaundice** | 3.57 | 9.57 | 1.3 | 8.8 | 1 | 4.84 |
| **Accident** | 7.14 | 3.19 | 16.5 | 4.4 | 1 | 6.44 |
| **Asthma** | 2.68 | 9.57 | 0 | 4.4 | 6.3 | 4.59 |
| **Ulcer** | 2.68 | 6.38 | 3.8 | 0 | 1 | 2.77 |
| **Septicemia** | 3.57 | 3.19 | 5.1 | 5 | 2.1 | 3.79 |
| **Kidney problem** | 1.79 | 6.38 | 6.3 | 1.3 | 1 | 3.35 |
| **Stroke** | 6.25 | 2.13 | 6.3 | 0.6 | 6.3 | 4.31 |
| **Internal bleeding** | 9.82 | 1.06 | 5.1 | 0 | 0 | 3.19 |
| **Cough&Fever** | 0 | 8.51 | 0 | 0 | 0 | 1.70 |
| **Old age** | 6.25 | 0 | 0 | 0 | 2.1 | 1.67 |
| **Diabetes** | 0.89 | 0 | 0 | 0.6 | 1 | 0.49 |
| **TB** | 0.89. | 1.06 | 3.8 | 0 | 0 | 2.71 |
| **Typhoid** | 0.89 | | 0 | 0 | 0 | 0.17 |
| **Seizure** | 0 | 1.06 | 0 | 0 | 0 | 0.21` |
| **Total** | 100 | 100 | 100 | 100 | 100 | 100 |

Source : Field survey-2016 & 2017

Table-5.42 shows that Cancer (38.64 %) is the most common reason of family member who died in the study area, followed by Liver pain (9.72 5), Malaria (7.9 %), Accident(6.44 %), Jaundice (4.84 %), Asthma (4.59 %), Pneumonia (4.35 %), Stroke (4.31

%), Septicemia (3.79 %), Kidney problem (3.35%), Internal bleeding (3.19 %), T.B (2.71), cough & fever (1.70 %), Old age (1.67 %), Diabetes, Typhoid (0.17), Seizure (0.21 %).

*There is one unique characters of Tlangnuam block as far as reasons of death are concerned. As displayed in the table-5.42, cancer becomes the main reasons in all the blocks while Liver pain became the number one reason in Tlangnuam block. This is most probably due to the prevalence of alcohol drinking and easy accesses to liquor in Aizawl after legalisation of selling liquor to the public.*

**5.42. Block-wise: Place of Death**

Place of death reflects health-seeking behaviour of people except accidental death. Hospital deaths shows that family members are seeking healthcare, however, home death does not necessarily means that the person is not visiting healthcare but may prefer to die at home.

**Table-5.43. Block-wise: Place of Family members died**

| **Aizawl R.D Block** | Home | Hospital | Other | Total |
|---|---|---|---|---|
| **Darlawn** | 70.2 | 27.1 | 2.7 | 100 |
| **Thingsulthliah** | 36.6 | 50.7 | 12.7 | 100 |
| **Aibawk** | 35.5 | 59.18 | 5.32 | 100 |
| **Tlangnuam** | 34.82 | 53.57 | 10 | 100 |
| **Phullen** | 34.6 | 61.6 | 3.8 | 100 |
| **Average** | 42.34 | 50.43 | 6.9 | 100 |
| Source : Field survey-2016 & 2017 | | | | |

Table-5.43 reveals that family members died at Hospital (50.43 %) is common than those who died at home (42.34 %). The average numbers of family members died at home are exclusively high in Darlawn (70 %), followed by Thingsulthliah (36.6 %), Aibawk (35.5 %), Tlangnuam (34.82 %) and Phullen (34.6 %) blocks.

When it is well understood that person who died at home might visit hospital before he died, but is also a reflection that those who died in the hospital clearly indicated that that person sought healthcare before he die compared with those who died at home. For

example: Darlawn record the highest proportion of death at home indicated that many of them might not visit hospital before they died.

### 5.43. Block-wise: Visiting hospital before he/she die

To prove the above hypothesis that those who died at home might visit hospital or not before they die. Table-5.44 clearly highlights inter-block variations on whether family members who died visited hospital or not before they died. It is clearly proved that maximum percentage of family members who died in Darlawn block were not visiting hospital before they die. As many as 69.7% in Darlawn block were not visiting hospital before they die which is almost equal to total percentage of death at home in the block.

**Table-5.44. Bock-wise: Family members visit hospital for treatment before he / she die**

| **Aizawl R.D Block** | Yes | No | Total |
|---|---|---|---|
| **Tlangnuam** | 72.32 | 27.68 | 100 |
| **Aibawk** | 70.63 | 29.3 | 100 |
| **Thingsulthliah** | 58.5 | 41.5 | 100 |
| **Phullen** | 43.4 | 56.6 | 100 |
| **Darlawn** | 30.3 | 69.7 | 100 |
| **Average** | 55.03 | 44.97 | 100 |

Source : Field survey-2016 & 2017

Table-5.44 shows that more than half of person who died visited hospital before they die in Aizawl district (55.03 %). The number of family members visited hospital before death in different R.D blocks are: Tlangnuam (72.32 %), Aibawk (70.63 %), Thingsulthliah (58.5 %), Phullen (43.4 %) and Darlawn (30.3 %).

*Thus, it appears that there exists a relationship between 'home death' and not visiting hospital while they are still alive and vice versa.*

### 5.44. Block-wise: Number of times visit health institution by patient

This section is supplementing the above analysis of family members visiting heath institution before he/she dies.

| Table-5.45. Block-wise: Number of times visit health institution by patient | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Aizawl R.D Block** | 1 time | 2 times | 3 times | 4 times | 5 times | More Than 5 | Total |
| **Tlangnuam** | 8.25 | 13.4 | 22.68 | 29.9 | 7.22 | 18.56 | 100 |
| **Aibawk** | 9.3 | 34.88 | 23.26 | 13.95 | 4.65 | 0 | 100 |
| **Thingsulthliah** | 8.3 | 16.7 | 22.5 | 16.7 | 8.3 | 50 | 100 |
| **Phullen** | 22.2 | 28.9 | 22.2 | 13.3 | 11.1 | 2.2 | 100 |
| **Darlawn** | 11.1 | 22.2 | 16.7 | 22.2 | 22.2 | 5.6 | 100 |
| **Average** | 11.82 | 23.21 | 21.46 | 19.23 | 10.69 | 15.27 | 100 |
| Source : Field survey-2016 & 2017 | | | | | | | |

Table-5.45 shows that visiting healthcare facilities of two times (23.21 %) is the most common one in the study area, followed by three times (21.46 %), four times (19.69 %), more than five (15.27 %), one time (11.82 %) and five times (10.69 %) before they die. However, there is an inter-block variations on number of times visited hospital by patients.

*Among the blocks, visiting hospital more than 5 times in their life time is most common in Thingsulthliah and Tlangnuam blocks while Aibawk and Phullen recorded minimum numbers. Overall perfomacnce shows that visiting hospital 2 times is most common across the blocks; followed by 3 times before they died.*

**5.45. Block wise: Reasons for not visiting Health Institution**

This section discussed the regularity of visiting health institution by patients before him/her die across the blocks. It also examines why patients are not visiting health institutions, whether because of poverty/ no money or because of ignorance or just because of delay of treatment. It is also necessary to clarify that the reasons are in many cases multiple reasons than a single reason.

| Table-5.46. Block-wise: Reasons for not visiting health institution by patient before he/she die | | | | | | |
|---|---|---|---|---|---|---|
| Aizawl | No Money | Too far | Ignorance | Delay | No response | Total |
| Phullen | 24.9 | 34.2 | 19.3 | 19 | 2.4 | 100 |
| Tlangnuam | 22.6 | 12.3 | 27.2 | 27.9 | 10 | 100 |
| Thingsulthliah | 19.6 | 26.7 | 26.3 | 20.7 | 6.6 | 100 |
| Aibawk | 17.8 | 17.7 | 27.4 | 25.9 | 11 | 100 |
| Darlawn | 16.3 | 37.4 | 24.1 | 19.9 | 2.3 | 100 |
| ***Average*** | ***20.24*** | ***25.66*** | ***24.86*** | ***22.68*** | ***6.46*** | ***100*** |
| Source : Field survey-2016 & 2017 | | | | | | |

Table- 5.46 reveals inter-block comparison of the reasons for not visiting health institution by patient. The overall average of the reasons for not visiting health institution among the blocks shows that accessibility or too far is the main reason (25.66 %), followed by poverty or no money (20.24 %), ignorance (24.86 %), delay of treatment (22.68 %) and no response (6.46 %). 'Too far' as the reason for not visiting health institution by patients is highest in Darlawn Village (37.4 %),followed by Phullen Village (34.2 %), and Thingsulthliah Village (26.7 %) while Tlangnuam block has not much record on the same case.

**5.46. Block-wise: Recent Health-seeking Bahaviour**

Health seeking-behaviour during the life time and recent behaviour can be differed from place to place and by individual due to many factors. The present section tries to understand health-seeking behavior of people during the last couples of years to know their recent behavior on health-seeking.

| Table-5.47. Block-wise: Family members hospitalized during The last 1 year | | | |
|---|---|---|---|
| Aizawl R.D Block | Yes | No | Total |
| Tlangnuam | 52.5 | 47.5 | 100 |
| Aibawk | 45.43 | 54.57 | 100 |
| Thingsulthliah | 35.24 | 64.76 | 100 |
| Phullen | 22.88 | 77.12 | 100 |

| | | | |
|---|---|---|---|
| Darlawn | 15.15 | 84.85 | 100 |
| **Average** | **34.24** | **65.76** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.47 shows that the number of family members hospitalized during the last 1 year. The block-wise numbers of family members hospitalized during the last year were as followed: Tlangnuam (52.5 %), Aibawk (45.43 %), Thingsulthliah (35.24 %), Phullen (22.88%) and Darlawn (15.15 %) blocks.

*As many as 34.24% family members across the blocks were hospitalized during the last one year. Out of the five RD blocks, Tlangnuam block record maximum number of hospitalization (52.5%) while Darlawn got minimum percentage of hospitalization (15.15%).*

**5.47. Block-wise: Place of health-seeking**

Place of health-seeking is important factors that shows the behaviour of health-seekers.It is ideal that patient go to hospital, approached and consult the right medical personnel while traditional or home-visting by patient is not suggested.

**Table-5.48. Block-wise: Place of healthcare sought by patients**

| **Aizawl R.D Block** | Govt. hospital | Private Hospital | PHC/ CHC | Non respondents | Other home | Private Clinic | Sub-centre | Home | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Tlangnuam** | 62.77 | 29.79 | 0 | 0.1 | 0 | 7.43 | 0 | 0 | 100 |
| **Aibawk** | 76.9 | 15.4 | 0 | 1.2 | 0 | 5.2 | 1.3 | 0 | 100 |
| **Thingsulthliah** | 65.8 | 4.9 | 20.0 | 1.0 | 0 | 6.0 | 2.3 | 0 | 100 |
| **Phullen** | 62.4 | 3.2 | 24.3 | 1.8 | 0 | 4.1 | 4.2 | 0 | 100 |
| **Darlawn** | 58.4 | 3.0 | 25.7 | 3.2 | 0 | 5.2 | 4.5 | 0 | 100 |
| **Average** | 63.83 | 11.25 | 15.42 | 1.46 | 0.1 | 5.58 | 2.46 | 0.1 | 100 |
| Source : Field survey-2016 & 2017 | | | | | | | | | |

Table-5.48 reveals block-wise comparison of place of healthcare sought by patient. It is clear that healthcare sought by patient is highest at government hospital (63.83 %),

followed by PHC/CHC (15.42 %), private hospitals (11.25 %), Private clinic (5.58 %), Sub-centre (2.46 %) other and home (0.1 %).

*It can be concluded that people are very much aware of the importance of seeking healthcare across the blocks as 100 % percent are visiting hospital or private clinic and not seek healthcare from parents or traditional healers.*

**5.48. Block-wise: Problems of Health-seeking**

Identification of problems that prevent to seek healthcare is extremely important to solve their problems and to make policy for government and individual. This segment analyses inter-block variation on why people were not seeking healthcare. Probable reasons are given while questioning family members during survey.

**Table-5.49. Block-wise: Reasons not sought for healthcare**

| Aizawl R.D Block | Not Necessary | Cost too much | Better care at home | Too far | Transport problem | Lack of knowledge | Poor quality service | Total |
|---|---|---|---|---|---|---|---|---|
| Darlawn | 25.3 | 70 | 0 | 42.4 | 46.4 | 13.9 | 4.3 | 100 |
| Thingsulthliah | 57.7 | 25.5 | 0 | 27.8 | 25.6 | 14.6 | 4 | 100 |
| Phullen | 60 | 25.2 | 0 | 40 | 15.2 | 7.1 | 3.4 | 100 |
| Aibawk | 58.3 | 24.5 | 0 | 8.06 | 6.8 | 5.7 | 5.4 | 100 |
| Tlangnuam | 84.36 | 8.94 | 3.91 | 0 | 0 | 1.68 | 0 | 100 |
| **Average** | **57.13** | **30.82** | **0.78** | **23.65** | **18.8** | **8.59** | **3.42** | **100** |

Source : Field survey-2016 & 2017

As shown in the table, majority of the reported that ‘they need not to seek healthcare’ (57.13%). Among other reasons poverty or cost too much (30.82%) is the main obstacle, followed by accessibility or too far (23.65 % & transport problem (18.8 %), better care at home (0.78 %), lack of knowledge (8.59 %) and poor quality service (3.42 %).

*Among the blocks, there are some unique characters as shown in the table-5.46 that poverty or cost too much is overwhelmingly high in Darlawn block compared with other blocks. Similarly, no other blocks, except Tlangnuam reported ‘better care at home’ (3.91%) as the main reasons that patients are not seeking healthcare at hospital.*

### 5.49. Block-wise: Awareness of Govt. healthcare scheme

Government policy of healthcare scheme can be a booster for healthcare seeker if they know the scheme thoroughly. Awareness is the first step to deliver goods and services in the society.

**Table-5.50. Block-wise: Do you know Govt. healthcare schemes**

| **Aizawl R.D Block** | Yes | No | Total |
|---|---|---|---|
| **Tlangnuam** | 98.2 | 1.8 | 100 |
| **Thingsulthliah** | 96.5 | 3.3 | 100 |
| **Aibawk** | 95.2 | 4.7 | 100 |
| **Phullen** | 94.4 | 5.6 | 100 |
| **Darlawn** | 90.4 | 9.6 | 100 |
| **Average** | **94.95** | **5** | **100** |
| Source : Field survey-2016 & 2017 | | | |

Table-5.50 shows the block-wise knowledge of health-care scheme in Aizawl district. The awareness level of government healthcare scheme in the study area is exceedingly high (94.95 %). Awareness levels in five blocks are as follows: Tlangnuam (98.2 %), Thingsulthliah (96.5 %), Aibawk (95.2 %), Phullen (94.4 %) and Darlawn (90.4 %)

### 5.50. Block-wise: Availing Government healthcare scheme

Mere awareness of government healthcare scheme is not an indicator. What is more important is how many of them are utilizing it. This section analyses number of family availing government healthcare scheme.

**Table-5.51. Block-wise: No. of family who availed Govt. healthcare scheme**

| **Aizawl R.D Block** | Yes | No | Total |
|---|---|---|---|
| **Tlangnuam** | 25 | 75 | 100 |
| **Darlawn** | 13.7 | 86.3 | 100 |
| **Phullen** | 13.4 | 86.6 | 100 |
| **Thingsulthliah** | 10.5 | 89.5 | 100 |
| **Aibawk** | 8.02 | 91.98 | 100 |
| Average | 14.12 | 85.87 | 100 |
| Source : Field survey-2016 & 2017 | | | |

Table- 5.51reveals that just 12.12% of them across the blocks are availing / utilizing government healthcare scheme. The inter-block variations in details are as follow:

Tlangnuam (25%), Darlawn (13.7 %), Phullen (13.4 %), Thingsulthliah (10.5 %) and Aibawk (8.02 %) blocks.

### 5.51. Block-wise: Awareness of child healthcare

Children immunization is another important indicators relating to health seeking behavior.We asked, during the survey, that whether they have Immunization card for children if at all there is children in the family? As many as 85% families reported that they have vaccination cards while a little over 10% are not having it.

**Table- 5.52. Block-wise: Any vaccinations card for your child**

| Block | Yes | No | No children | Total |
|---|---|---|---|---|
| **Tlangnuam** | 93.25 | 0.75 | 6 | 100 |
| **Aibawk** | 91.2 | 6.3 | 2.5 | 100 |
| **Thingsulthliah** | 87.2 | 8.5 | 4.3 | 100 |
| **Phullen** | 83.2 | 13.7 | 3.1 | 100 |
| **Darlawn** | 72.9 | 24.8 | 2.3 | 100 |
| **Average** | 85.55 | 10.81 | 3.64 | 100 |
| Source : Field survey-2016 & 2017 | | | | |

Table-5.52 shows the block-wise immunization card for child healthcare in Aizawl district. Out of five blocks, Tlangnuam scored highest number of family having vaccination card (93.25 %), followed by Aibawk (91.2 %), Thingsulthliah (87.2 %), Phullen (83.2 %) and Darlawn (72.9 %).

*It can be concluded that child healthcare is common in all the blocks of Aizawl.*

### 5.52. Block-wise: Place of delivery

Maternal healthcare is another important to understand health-seeking behavior of mother. The present section just focuses on the place of delivery, whether it is done in hospital or at home. It is always advised to deliver in the hospital where health personnel are available. Literatures reveals that most deliveries occur in the hospital in the developed countries whereas a good numbers of delivery happened at home in developing and under-developed countries.

| Table-5.53.Aizawl R.D Block-wise: Place of delivery | | | |
|---|---|---|---|
| **Aizawl R.D Block** | Institution | Home delivery | Total |
| **Tlangnuam** | 99.9 | 0.1 | 100 |
| **Aibawk** | 90.7 | 9.7 | 100 |
| **Thingsulthliah** | 75.3 | 24.7 | 100 |
| **Phullen** | 71.5 | 28.5 | 100 |
| **Darlawn** | 72.3 | 27.7 | 100 |
| **Average** | **81.94** | **18.14** | **100** |
| Source : Field survey-2016 & 2017 | | | |

.

Table-5.53 shows that place of delivery in Aizawl district as followed: Tlangnuam (99.9 %), Aibawk (90.7 %), Thingsulthliah (75.3 %), Darlawn (72.3 %) and Phullen (71.5%) blocks. Therefore, present research finds out that institutional delivery is quite common in Aizawl district (81.94 %) while a good number of mothers still practice home delivery (16.2 %).

It can be concluded that institutional delivery is quite common across the blocks of Aizawl district as 81.94% are delivered while 18.14% mother delivered at home. Tlangnuam block top the ranked among block as almost 100% institutional deliver while Darlawn at the bottom with 71.5% institutional delivery.

### 5.52.1. Block-wise: Recent Place of Delivery

To make sure that we got latest information, we asked mother about the place where they had delivered.

| Table-5.54. Aizawl R.D Block-wise: Does your last birth delivered in the hospital | | | | |
|---|---|---|---|---|
| **Aizawl R.D Block** | Yes | No | No children | Total |
| **Tlangnuam** | 99.73 | 0.27 | 0 | 100 |
| **Aibawk** | 96.4 | 2.6 | 1.0 | 100 |

| | | | | |
|---|---|---|---|---|
| **Thingsulthliah** | 94.1 | 1.8 | 7.7 | 100 |
| **Phullen** | 93.5 | 2.4 | 4.1 | 100 |
| **Darlawn** | 90.2 | 5.6 | 4.2 | 100 |
| **Average** | **94.78** | **2.53** | **1.74** | **100** |
| Source : Field survey-2016 & 2017 | | | | |

## 5.53. Block-wise: Problems of Maternal Health Seeking

Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth and 99 % of all maternal deaths occur in developing countries. The large number of maternal mortality, especially in developing countries has been due to low level of maternal health care seeking. Table-5.54 shows inter-block variations of institutional delivery are as follows: Tlangnuam (99.73 %), Aibawk (96.4 %), Thingsulthliah (94.1 %), Phullen (93.5 %) and Darlawn (90.2 %) blocks.

*As far as maternal health-seeking is concerned, we found out that institutional delivery is very common across the blocks of Aizawl district as more than 94% delivered their last birth at hospital while just 2.5% mother delivered at home.*

**Table- 5.55. Block-wise: Reasons not delivered in the hospital**

| **Aizawl R.D Block** | Prefer to have at home | Too far | Healthcare facility Not available | No Medical personnel | Medical personal at home | No Money | Total |
|---|---|---|---|---|---|---|---|
| **Phullen** | 51.4 | 20.4 | 4.8 | 9.4 | 1.4 | 12.6 | 100 |
| **Darlawn** | 54.4 | 18.5 | 6.4 | 8.2 | 0.2 | 12.3 | 100 |
| **Thingsulthliah** | 52.5 | 16.2 | 2.1 | 5.3 | 1.2 | 3.7 | 100 |
| **Aibawk** | 52.5 | 14.9 | 1.2 | 4.9 | 1.1 | 9.4 | 100 |
| **Tlangnuam** | 0 | 0 | 0 | 0 | 5.3 | 5 | 100 |
| **Average** | **42.13** | **13.33** | **2.9** | **5.56** | **1.84** | **8.6** | **100** |
| Source : Field survey-2016 & 2017 | | | | | | | |

It is evident from Table- 5.55 that prefer to deliver at home got maximum score with 42.13 %, followed by too far (13.33%), no money (8.6 %), no medical personal at home (5.56 %), healthcare facility not available (2.9 %) and medical personal at home (1.84 %)

### 5.53.1. Block-wise: Postnatal checkup

Another important component of maternal healthcare is postnatal checkup after delivery. As postnatal care is very important for mother and her baby, the child reciveing check up is nessessary for the child health.

| Table- 5.56. Block-wise: Did you/the child receive any check-up after delivery | | | | | | |
|---|---|---|---|---|---|---|
| | Tlangnuam | Aibawk | Thingsulthliah | Phullen | Darlawn | Average |
| **Yes** | 100 | 91.3 | 76.9 | 82.2 | 52.2 | **80.52** |
| **No** | 0 | 7.7 | 17.3 | 17.8 | 47.8 | **18.12** |
| **No Children** | 0 | 1.0 | 7.4 | 0 | 0 | **1.68** |
| **Total** | 100.0 | 100 | 100 | 100 | 100 | **100.0** |
| Source : Field survey-2016 & 2017 | | | | | | |

It is evident from table- 5.56 that postnatal check-up is fairly high in Aizawl district (80.52 %) while a good number of mothers (18.12 %) still not went for postnatal check-up. Among the R.D blocks – Tlangnuam and Aibawk record maximum proportion of mother going for postnatal check-up with 100% and 91.3 % respectively. While Darlawn (52.2 %), Thingsulthliah (76.9 %) and Phullen (82.2 %), record the least number doing the same. The detail information of postnatal check-up in various block are as follows: - Tlangnuam (1000 %), Aibawk (91.3 %), Phullen (82.2 %), Thingsulthliah (76.9 %) and Darlawn (52.2 %) blocks.

### 5.53.2. Block-wise: Place of postnatal care

The block-wise analysis of the places of postnatal care is classified into- Government hospital, PHC, Private clinic, Sub-center.

| Table- 5.57. Block-wise: Place of postnatal care | | | | | |
|---|---|---|---|---|---|
| **Block** | Govt. Hospital | PHC | Private Clinic | Sub-center | Total |

| | | | | | |
|---|---|---|---|---|---|
| **Tlangnuam** | 48.2 | 46.2 | 4.2 | 1.4 | 100 |
| **Aibawk** | 42 | 4.15 | 3.85 | 50.0 | 100 |
| **Thingsulthliah** | 42.1 | 4.7 | 4.4 | 52.5 | 100 |
| **Phullen** | 34.5 | 45.9 | 5.1 | 14.5 | 100 |
| **Darlawn** | 41.5 | 50.5 | 4.7 | 3.3 | 100 |
| **Average** | 47.68 | 21.05 | 5.77 | 25.64 | 100 |
| Source : Field survey-2016 & 2017 | | | | | |

It is interesting to explore the average place postnatal care in Aizawl district is high in Government hospital (47.68 %), Sub-center (25.64%) and PHC (21.05 %) while private clinic (5.77 %) is low. Place of postnatal care in Government hospital are: Tlangnuam (78.3 %), Thingsulthliah (42.1 %), Aibawk (42%), Phullen (34.5 %), Darlawn (41.5 %) blocks.

### 5.53.3. Block-wise: Promptness for postnatal Check-up

Table-5.58 shows that maximum mother went for postnatal check-up within weeks after delivery (51.87 %), followed by within 3 months (27.42 %) and within 2-3 days (1.98 %) while a good number of 17.74 % do not go for postnatal check-up.

**Table- 5.58. Block-wise: Promptness for postnatal check-up**

| **Aizawl R.D Block** | Within 2-3 days | Within weeks | Within 3 months | No checkup | No children | Total |
|---|---|---|---|---|---|---|
| **Tlangnuam** | 4.5 | 91.8 | 3.9 | 0 | 0 | 100 |
| **Aibawk** | 2.4 | 22.85 | 47 | 27.8 | 0 | 100 |
| **Thingsulthliah** | 1.4 | 71.8 | 19.5 | 2.2 | 0 | 100 |
| **Phullen** | 0.9 | 58.3 | 29.9 | 10.9 | 0 | 100 |
| **Darlawn** | 0.7 | 14.6 | 36.8 | 47.8 | 0 | 100 |
| **Average** | 1.98 | 51.87 | 27.42 | 17.74 | 0 | 100 |
| Source : Field survey-2016 & 2017 | | | | | | |

Tlangnuam block has no postnatal uncheck-up, no check-up as Thingsulthliah (2.2 %), Phullen (10.9 %), Aibawk (27 %) and Darlawn (47.8 %).

### 5.53.4. Block-wise: Problems of Postnatal health care Seeking

| Table- 5.59. Block-wise: Reason not seeking Postnatal care | | | | | | |
|---|---|---|---|---|---|---|
| **Aizawl R.D Block** | No need | Too far | Financial Problem | Hospital/PHC\/CHC Not available | Medical personnel available at home | Total |
| **Tlangnuam** | 100 | 0 | 0 | 0 | 0 | 100 |
| **Aibawk** | 49.54 | 24.96 | 24.5 | 1 | 0 | 100 |
| **Thingsulthliah** | 34.9 | 25.68 | 38.52 | 0.4 | 0 | 100 |
| **Phullen** | 24.5 | 43.1 | 40.9 | 0.5 | 0 | 100 |
| **Darlawn** | 12.4 | 45.2 | 41.6 | 0.8 | 0 | 100 |
| **Average** | 44.26 | 27.78 | 29.10 | 0.54 | 0 | 100 |
| Source : Field survey-2016 & 2017 | | | | | | |

Table- 5.59 shows that maximum number of mother reported that postnatal care is not needed (44.26 %), followed by financial problem (29.10 %), too far (27.78 %), Hospital/PHC\/CHC Not available (0.54 %).

*Therefore, as far as maternal healthcare-whether institutional delivery or post natal care is concerned, all the five RD blocks are performed well, especially institutional delivery.*

## 5.54. Concluding statement

**The discussion of rural-urban variation** in health-seeking behaviour of Mizoram reveals the following:-

*Firstly, it reveals that sickness is extremely common in both rural and urban areas. As many as 86.3 % families are reported of experiencing illness in their family. However, merely 20.2% in urban areas and 5.5 % in rural areas are reported of not having experienced illness in their family.*

*Second study shows that illness is prevalent in both rural and urban areas but a quite number of them are not seeking health care, especially in rural areas. Therefore, it is clearly reveals that poverty or cost too much is the most common reasons that stop people to seek healthcare both in rural and urban areas with 50.2% and 47.1% respectively. A*

*part from poverty inaccessibility or road transport is another prominent factors controlling health-seeking behaviour in both urban and rural areas even though urban areas and rural areas are having differences in the level of intensity of problems. In rural area accessibility problems is more significant in stopping people to search health care than urban areas. Apart from these, problem of unavailability of healthcare facility is also clearly observed for controlling health-seeking behaviour of people in* Aizawl District.

*Thirdly, majority of patients are consulting government doctors and nurses with 96.2 % in urban area and 89.5 % in rural area respectively. Consultation of health worker and health supervisor are more common in rural area (6.3 %) than urban area (4.5%) as well as consultation of traditional healer is comparatively more prevalence in rural area (4.1 %) than urban area (2.3 %).*

*Fourthly, complaints about service providers are more common among rural folks than urbanites in* Aizawl District. *Visiting medicine specialist become the most common practiced in* Aizawl District *while unexpectedly consultation of physiotherapists and dietician becoming more common during the last couple of years in the state.*

*Fifthly, it is reveals that as far as government healthcare facilities is concerned urbanites are more satisfy than rural folks. This is mainly due to concentration of healthcare facilities in towns and cities in* Aizawl District.

*Sixthly, as far as constraints in utilizing healthcare facility is concerned, rural folks suffer more problems than urbanites. It is also observes that accessibility become the biggest constraints in rural areas whereas lack of equipment and medicines become the biggest constraints in urban area. Problems in rural area and urban area are also slightly difference.*

*Seventhly, it is found out that there are more than 21 different types of diseases are currently suffered by* Aizawl District*. Out of which cough and fever top the rank, followed by kidney problem and ulcer while asthma and diabetics become rank* $4^{th}$ *and* $5^{th}$.

*Eighthly, we can conclude that death is more common among urbanites than rural folks in* Aizawl District*. It is found out that cancer become the topmost reason of death in Aizawl District, followed by septicemia and malaria as well as death causes by liver related problems and pneumonia. Death due to septicemia, jaundice, internal bleeding and liver problems are more common in urban areas while malaria, pneumonia and cough and fever are more common causes of death in rural area.*

*Ninthly, it is exhibits that died in the hospital are comparatively higher in urban area than rural area with 47.0 % and 57 % respectively. This is mainly due to availability of hospital in urban area while it was not in the case of rural area. Obviously, rural area recorded death at home (44.5 %) than urban area (38.2 %). Apart from hospital and home, urban area recorded more numbers of death neither hospital nor home with 8.1% compared with rural area with 4.5%.*

*Tenthly, it is interesting to find from Table-5.16 that a fairly high number of patients in urban area are visiting hospital before they died with a record of 64.0 % while relatively a lesser number in rural area do the same with a record of 50.3 %.*

*Eleventh, it can be concluded that poverty is the main factors stopping patients to search healthcare in Aizawl District, followed by geographical distance of healthcare facility and ignorance of people along with delay treatment.*

*Twelfth is found out that majority of people seek healthcare at government hospital, private hospital and primary health centre both in rural and urban areas. However,*

*informal places like home, parent's home or other home as a place of health-seeking is common only in rural area.*

*Thirteenth, it is found that rural people are having more reasons and problems on health-seeking than urban area. Poverty, accessibility and lack of knowledge are extremely important factor stopping rural people from seeking healthcare whereas urban areas are not much having the same problems as rural people do.*

*Fourteenth, it can be confidently sum up that child healthcare in both rural and urban Aizawl District is good as far as vaccination is concerned. Almost every family having children are keeping vaccination card with them. It is therefore clear that Aizawl District record good institutional delivery while rural residence needs major improvement compared with urban residence.*

*Finally, it is observes that mother preferred to deliver baby at home mainly because there are medical personnel who can assist at home in urban area whereas it is mainly due to unavailability of hospital in the case of rural residence. While inaccessibility to healthcare facility became one major problem in rural area, the same is not true in the case of urban residence. It is sum-up that accessibility and non-availability of healthcare facilities become the major hurdles for rural mother after delivery while these are not much responsible in the context of urban mothers. On the other hand poverty or financial problems is one factor that both rural and urban mother are facing towards post natal care. Moreover, many mothers are also not having post natal complications and they need not to visit healthcare facilities after delivery.*

**Inter-Block variations of health-seeking behavior in Aizawl District**

*Therefore, it can be concluded that among the blocks, Tlangnuam RD Block became the healthiest people and most active in seeking healthcare in time of illness whereas Darlawn became the most unhealthiest and poorest in seeking health care.*

*Among the five blocks Darlawn and Aibawk record highest proportion that prevent them from seeking healthcare while Tlangnuam and Thingsulthliah blcoks record the least on this regards. The reasons of not seeking healthcare is differ from one block to another, especially the problems of Tlangnuam RD Block is minimal in all reasons while Darlawn record highest proportion of health seeking problems among the blocks. Accessibility factor is one of the major obstacles preventing people from health seeking in all the RD Blocks except in Tlangnuam.*

*Thus, consultation of health personnel when people got sick was very much common iacross the block of Aizawl district while few people still consulted traditional healer, especially some pockets of Darlawn RD Block.*

*Therefore, health servive providers across the five RD blocks are genrrally perfomed well wherein Tlangnuam block, located within state capital Aizawl city, got maximum proportion (90%) while Thingsulthliah got minimum performance (64.5%).*

*Among the block, Tlangnuam block scored highest on the observation of cleanliness of healthcare facilities while Aibawk secored the least on the same. Generally, the cleanliness of health facilities across the block is moderate.*

*Therefore, among the RD Blocks, Darlawn has maximum problems that obstruct health-seekers, followed by Phullen and Thingsulthliah while Tlangnuam and Aibawk have minimum problems tthat stops healthcare-seekers. It is interesting to note that while*

*accessibility or 'too far' become one of the biggest hurdles for health-seers in all the block Tlangnuam has no accessibility problms at all.*

*Looking at inter-block variation on averall diseases, Phullen got maximum average with 14.2%, followed by Darlawn with 13.8% and Aibawk with 8.6% while Tlangnuam block got minimum diseases/problems with 5.1%.*

*There is one unique charecters of Tlangnuam block as far as reasons of death are concerned. As displayed in the table-5.42, cancer becomes the main reasons in all the blocks while Liver pain became the number one reason in Tlangnuam block. This is most probably due to the prevalence of alcohol drinking and easy accesses to liquor in Aizawl after legalisation of selling liquor to the public.*

*Among the blocks, visiting hospital more than 5 times in their life time is most common in Thingsulthliah and Tlangnuam block while Aibawk and Phullen reconrd minimum numbers of the same. Overall perfomacnce shows that visiting hospital 2 times is most common across the blocks; followed by 3 times before they died.*

*As many as 34.24% family members across the blocks were hospitalized during the last one year. Out of the five RD blocks, Tlangnuam block record maximum number of hospitalization (52.5%) while Darlawn got minimum percentage of hospitalization (15.15%).*

*It can be concluded that people are very much aware of the importance of seeking healthcare across the blocks as 100 % percent are visiting hospital or private clinic and not seek healthcare from parents or traditional healers.*

*Among the blocks, there are some unique charecters as shown in the table-5.46 that poverty or cost too much is overwhelmingly high in Darlawn block compared with other*

*blocks. Similarly, no other blocks, except Tlangnuam reported 'better care at home' (3.91%) as the main reasons that patients are not seeking healthcare at hospital.*

*It can be concluded that child healthcare is common in all the blocks of Aizawl.*

*As far as maternal health-seeking is concerned, we found out that institutional delivery is very common across the blocks of Aizawl district as more than 94% delivered their last birth at hospital while just 2.5% mother delivered at home.*

*Therefore, as far as maternal healthcare-whether institutional delivery or post natal care is concerned, all the five RD blocks are perfomed well, especially institutional devilery.*

# CHAPTER- VI

# DEVELPOMENT FACTORS INFUENCING HEALTH-SEEKING BEHAVOIUR IN AIZAWL DISTRICT

## 6.1. Introduction

This chapter presents an analysis of the core objectives of present research by highlighting the relationship between health and development. How selected developmental factors are influencing the health-seeking behavior of an individual or household in rural and urban areas are discussed in details.

Health is essential for social and economic development; it is therefore seen as a resource for everyday living and sought after by all. Healthy people together build a healthy and prosperous nation. The link between health, level of development and human

behavior is a major area of interest in public health. Studies on health-seeking behavior have shown that numerous numbers of factors are influencing individual's health-seeking behavior. These influences include past experiences with health services, perception about quality and efficiency of health services and influences at the community level (Sule, et al, 2008). The decision to seek help is also influenced by an individual's educational and economic status, the extent to which he is worried about the symptom and duration of experiencing the symptom (Ahmed et al, 2001).

Therefore, health and health-seeking behaviour is not just medical field rather it is developmental aspects broadly, which demand the serious involvement of social scientist. That is why people used to say "health is wealth" and in another way, it can also be said that level of development is reflected in the level of health or infirmity and decision of people on healthcare utilization. Development is prerequisite to empower people to seek healthcare at the right time and at the right place.

Developmental factors influencing the health-seeking behavior of people such as- accessibility, education, income, mass media exposure, gender or maternal health care, type of illness, perceived quality of the serviced etc. is the scope of present research. For better understanding, the determinants of health-seeking behavior are divided into two groups: (1) Physical factor (2) Socio-economic factor

**Physical Factor** includes accessibility which means distance of healthcare facility and condition of road network connection.

Socio-economic factor includes education, income/poverty, mass media exposures and gender or maternal healthcare.

This chapter explores the linkage between people health-seeking behavior and physical as well as social environment. We are using a correlation between development factors and health-seeking behavior of people. To be concise, we divided rural and urban area in the analysis, which finally shows the overall conditions of the state.

Specifically, development factors are considered as independent factors are considered as independent factors whereas health-seeking activities are considered as the dependent variable is accessibility whereas social independent factors are level of education, income/poverty, mass media exposure and one gender aspect, such as maternal health-seeking behavior.

**6.2. Accessibility and Health-seeking Behaviour**

Accessibility indicates both the road condition and distance from town or nearest healthcare facilities like Sub-Center (SC), Primary Health Center (PHC), Community Health Center (CHC) or Hospital. For example: One village might be closer to healthcare facility in geographical distance compared with the other village nearby but because of the poor road condition it might be closer to healthcare facility in geographical distance compared with the other village nearby but because of the poor road condition it might take longer period of time to reach that hospital and vice-versa. Therefore, instead of using the distance of road from nearby healthcare infrastructure or only road condition, we used accessibility – a combination of distance and road conditions.

Another clarification in the methodology adopted for the present chapter is that physical accessibility is translated or converted into numerical forms so that we can deploy statistical methods of correlation to understand the relationship between development and health-seeking behavior.

| Table-6.1. Aizawl District: Ranking and conversion of physical accessibility to numerical form | | | | | | |
|---|---|---|---|---|---|---|
| | Road Condition | | | | | Accessibility |
| Study Areas | 1 = Yes; 0 = No | | | | | |
| Aizawl District | NH | SH | AWR | FWR | KR | |
| Aizawl | 1 | 1 | | | | 160 |
| Aibawk | | 1 | 1 | | | 90 |
| Chawilung | | | | | 1 | 5 |
| Kelsih | | 1 | 1 | | | 90 |
| Darlawn | | 1 | 1 | | | 90 |
| Khawpuar | | | | | 1 | 5 |
| Lailak | | | | 1 | 1 | 15 |
| Phullen | | 1 | 1 | | | 90 |
| N. Khawlek | | | | 1 | | 10 |
| Daido | | | | 1 | | 10 |
| Thingsulthliah | | 1 | 1 | | | 90 |
| Darlawng | | 1 | 1 | | | 90 |
| Lenchim | | | | 1 | 1 | 15 |
| NH=National Highway (90); SH=State Highway(70); AWR=All Weather Road(20); FWR=Fair Weather Road(10); KR=Kuccha Road (5) | | | | | | |

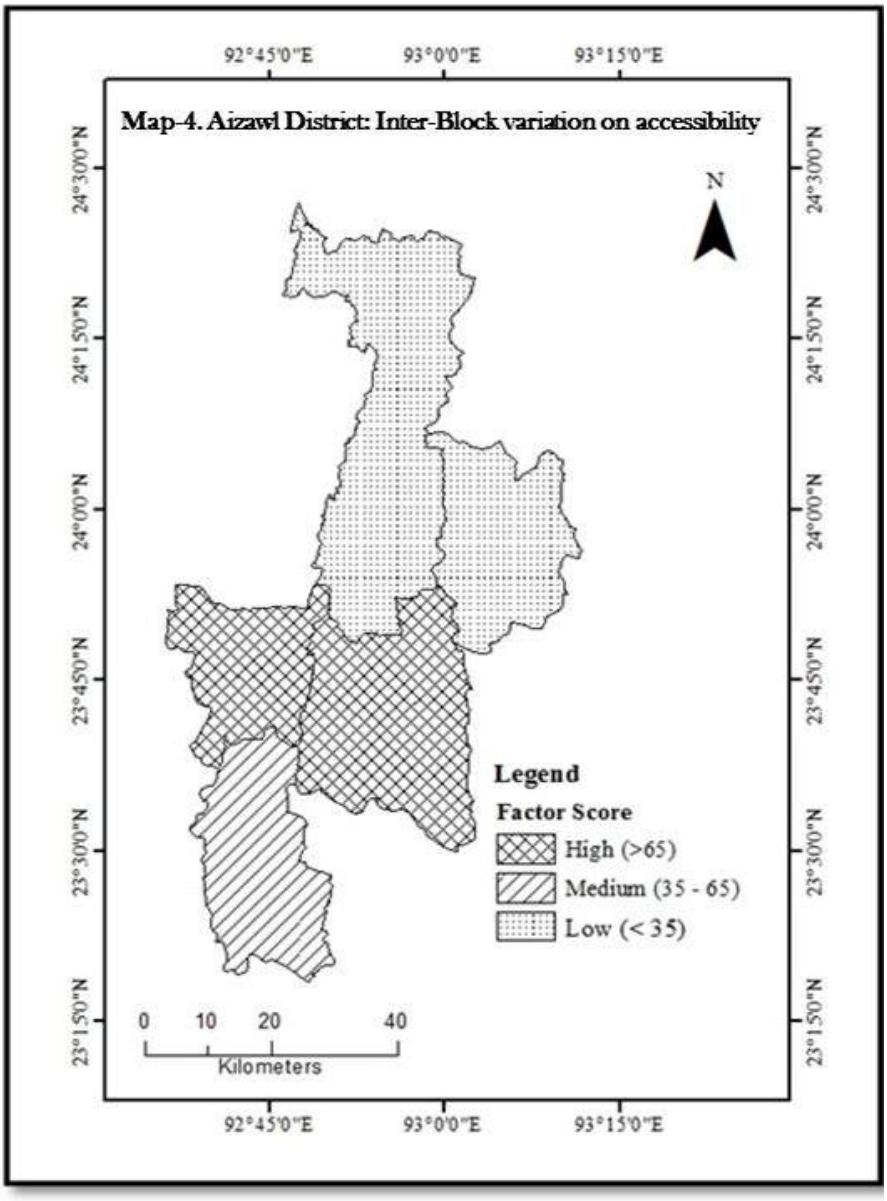
Table-6.1 shows that all the sample towns and villages have been assigned their own respective degree of accessibility in percentage form and ranked it. This has been done based on road connectivity and conditions. We used both secondary and primary information to customize the study areas based on whether that village or town is linked by important road networks like National highway (NH), State highway (SH), District highway (DH), All-weather road (AWR), Fair-weather road (FWR) and Kuccha road (KR) in a numerical form so that statistical too like SPSS will recognize so as to work out the relationship between accessibility and health-seeking behavior. One more explanation about the table-6.1 is that some village or town has equal status based on the degree of connectivity like national, state or district highway but ranked differently. This is due to differences in the ground reality, they may look similar and equal but the observation of on-the-spot-survey reveals their differences. So while ranking their accessibility, knowledge of the reality is also under consideration. Table-6.2 is another indicator of accessibility and this component is also considered while translating accessibility factor into numerical data and ranked in the previous table-6.2. For Table-6.2, ground verification

and census of India- 2011 was utilized. Apart from the roughness or evenness of road, distance also plays an extremely important role for healthcare seekers.

| **Table-6.2. Aizawl District: Distance of Healthcare Facilities** | | | | | | |
|---|---|---|---|---|---|---|
| **Study Areas** | Healthcare Facility and Accessibility | | | | | *Accessibility* |
| **Aizawl District** | SC | PHC | CHC | Hospital | MS | *Indicators* |
| **Aizawl** | 0 | 0 | 0 | 0 | 0 | *0=Within the village /town* |
| **Aibawk** | 0 | 0 | 0 | >10km | 0 | *<Within 5km* |
| **Chawilung** | >10km | >10km | >10km | >10km | >5-10 | |
| **Kelsih** | >10km | >10km | >10km | >10km | 5-10 | *5-10km* |
| **Darlawn** | 0 | 0 | >10km | >10km | 0 | |
| **Khawpuar** | >10km | >10km | >10km | >10km | >10km | *>10km=beyound10km* |
| **Lailak** | >10km | >10km | >10km | >10km | >10km | |
| **Phullen** | 0 | 0 | >10km | >10km | 0 | *SC=Sub Center* |
| **N. Khawlek** | 0 | >10km | >10km | >10km | >10km | |
| **Daido** | 0 | >10km | >10km | >10km | >10km | *PHC=Primary Health Center* |
| **Thingsulthliah** | 0 | >10km | 0 | >10km | 0 | |
| **Darlawng** | 0 | >10km | >10km | >10km | 0 | |
| **Lenchim** | 0 | >10km | >10km | >10km | 0 | *CHC=Community Health Center* *MS=Medical Shop* |

Road accessibility is classified on the basis of Jenks (Natural breaks) as **high, medium and low**.

Whereas, Block-wise of Aizawl district road can be classified as: **High-**Tlangnuam (100%), Thingsulthliah (90%), **medium-**Aibawk (63.33 %) and **low-** Darlawn (33.33 %) and Phullen (31.66 %).




### 6.3. Rural Aizawl: Accessibility and Health-seeking Behaviour

Present section discusses road condition and health-seeking behavior in rural Aizawl district. The main focus here is to find out the relationship between road condition or accessibility and health-seeking behavoiur in rural areas.

Transportation is a vital issue for access to health care, especially in rural areas where travel distances are and access to alternative modes such as transit is less prevalent.

| Table-6.3. Aizawl District: Road Condition and Health-seeking Behaviour (%) | | | | | |
|---|---|---|---|---|---|
| **Sl. No** | Name | Road (coded value in %) | Visit HC during last 1 year | Consult health personnel in time | Visiting hospital for treatment before family member die |
| **1** | Aizawl | 160 | 52.5 | 100 | 72.3 |
| **2** | Aibawk | 90 | 41.3 | 81 | 92.3 |
| **3** | Chawilung | 5 | 52.6 | 70 | 80 |
| **4** | Kelsih | 90 | 42.4 | 80 | 82 |
| **5** | Darlawn | 90 | 19.16 | 30.83 | 35.5 |
| **6** | Khawpuar | 5 | 15.78 | 18 | 36.84 |
| **7** | Lailak | 15 | 10.52 | 20 | 15 |
| **8** | Phullen | 90 | 28.36 | 38 | 40.81 |
| **9** | N. Khawlek | 10 | 15.3 | 10 | 15 |
| **10** | Daido | 10 | 25 | 10 | 20 |
| **11** | Thingsulthliah | 90 | 36.73 | 38.77 | 26.45 |
| **12** | Darlawng | 90 | 34 | 31.42 | 28.57 |
| **13** | Lenchim | 15 | 35 | 15 | 15.6 |
| **14** | Average | 64.7 | 42.41 | 53.45 | 52.45 |
| Source : Field survey-2016 & 2017 | | | | | |

*Table-6.3 shows that Tlangnuam Rural Development Block including Durtlang (95 %), Zarkawt (98 %), Bethlehem (70 %), Chite (73 %) and Kanan (80.1 %) have the highest accessible road, it reflect optimum visit healthcare, consult health personnel in times of illness and visit hospital for treatment before family member dies. On the other hand, Sairang (42 %) have the high accessible road (average 76.3), due to lack of an irregular doctor, low economic condition, the health-seeking behaviour is low. In Aibawk R.D block, between Chawilung and Hmuifang village has the kuccha road, this poor accessible may hamper the flows of health-seeking behaviour in Chawilung village. In Darlawn R.D block, Khawpuar and Lailak village have the kuccha road; this road barrier affects the health-seeking behaviour of the people. The people of Phullen R.D block, particularly N.Khawlek*

*and Daido village also has lack of accessibility, and it may be hampered by the health-seeking behaviour of the people in these areas.*

*Thus, the correlation between accessibility (road) and health-seeking behaviour of Aizawl district is 0.01 level of significant. There is a high positive correlation between accessibility and health-seeking behaviour.*

### 6.4. Aizawl District: Accessibility and Maternal Health-seeking Behaviour.

Compared with urban area of Aizawl district, rural area shows low degree of accessibility and debarred health-seeking behaviour.

**Table-6.4. Correlation between Accessibility (Road) and health-seeking Behaviour**

| | | VAR00005 | VAR00006 | VAR00007 | VAR00008 |
|---|---|---|---|---|---|
| VAR00005 | Pearson Correlation | 1 | .497 | .650* | .489 |
| | Sig. (2-tailed) | | .071 | .012 | .076 |
| VAR00006 | Pearson Correlation | .497 | 1 | .822** | .738** |
| | Sig. (2-tailed) | .071 | | .000 | .003 |
| VAR00007 | Pearson Correlation | .650* | .822** | 1 | .923** |
| | Sig. (2-tailed) | .012 | .000 | | .000 |
| VAR00008 | Pearson Correlation | .489 | .738** | .923** | 1 |
| | Sig. (2-tailed) | .076 | .003 | .000 | |
| | N | 14 | 14 | 14 | 14 |

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

### 6.5. Accessibility and Maternal health-seeking behaviour

This section provides information on road condition or accessibility and health-seeking behaviour in Aizawl District.

| Table-6.5. Aizawl District: Road condition and Maternal Health-seeking behaviour | | | |
|---|---|---|---|
| **Name** | Road | Institutional Delivery | Postnatal check-up |
| **Aizawl** | 160 | 99.9 | 100 |
| **Aibawk** | 90 | 81 | 44.4 |
| **Chawilung** | 5 | 28.1 | 29.4 |
| **Kelsih** | 90 | 27 | 30 |
| **Darlawn** | 90 | 23.33 | 8.33 |
| **Khawpuar** | 5 | 20 | 15 |
| **Lailak** | 15 | 25 | 20 |
| **Phullen** | 90 | 57.1 | 67.34 |
| **N.Khawlek** | 10 | 35 | 40 |
| **Daido** | 10 | 30 | 35 |
| **Thingsulthliah** | 90 | 57.1 | 76.34 |
| **Darlawng** | 90 | 42.8 | 46.42 |
| **Lenchim** | 15 | 40 | 45 |
| Source : Field survey-2016 & 2017 | | | |

Table-6.5 reveals that level of accessibility ranges from 10% to 100% in Aizawl district. Aizawl city (100%) is the most accessible in urban while Aibawk (90%), Kelsih (90%) and Thingsulthliah (90%) village are high degree accessible in rural villages in Aizawl district. Chawilung (10%), Khawpuar (10%), Lailak (10%), N. Khawlek (10%), Daido (10%) and Lenchim (10%) villages are low accessible. Like-wise, institutional deliveries in these villages are Chawilung (28.1%), Khawpuar (20%), Lailak (25%), N. Khawlek (35%), Daido (30%) and Lenchim (40%). Low degree of accessible leads to low institutional delivery.

### *6.5. Aizawl District: Correlation between Accessibility and Maternal Health-seeking Behaviour*

Statistical test clearly shows that there is a positive correlation between accessibility and maternal health-seeking behaviour. Early studies proved that there exist a relationship between maternal healthcare and development factor like accessibility (K.C. Lalmalsawmzauva, 2012).

| Table-6.6. *Aizawl District:* **Correlations between road condition and Maternal Health-seeking Behaviour** | | | | |
|---|---|---|---|---|
| | | VAR00001= Road | VAR00002= Institutional Delivery | VAR00003= Postnatal check-up |
| VAR00001= Road | Pearson Correlation | 1 | .621* | .513 |
| | Sig. (2-tailed) | | .024 | .073 |
| VAR00002= Institutional Delivery | Pearson Correlation | .621* | 1 | .856** |
| | Sig. (2-tailed) | .024 | | .000 |
| VAR00003= Postnatal check-up | Pearson Correlation | .513 | .856** | 1 |
| | Sig. (2-tailed) | .073 | .000 | |
| | N | 13 | 13 | 13 |
| *. Correlation is significant at the 0.05 level (2-tailed). | | | | |
| **. Correlation is significant at the 0.01 level (2-tailed). | | | | |

*It is interesting to find out that all the relationships are positive. The correlation between accessibility and institutional delivery is positive (r=621*) with 0.05 significant level. The relationship between accessibility and postnatal care is also strongly positive (r=856**) with 0.01 significant level. Therefore, wherever there is good accessibility, institutional delivery increases in the District of Aizawl.*

## 6.6. Aizawl district: Level of Education of Household Head &Health-seeking Behaviour

This section discusses the influence of father's educational level on health check-up in time of illness of the family members. We considered father as head of the family who decides for the family. His decision is in turn influence by his level of education. As shown in Table-6.6, 75.3 % of fathers in rural areas are below class- X passed while 12.66 % are class – XII passed and merely 5.45 % are graduates or above. The education level of the head of family below class X is high, this clearly shows that a high drop-out rate in the study area.

| Table-6.7 Aizawl District: Level of Education of Household Head & Health-seeking Behaviour | | | | | |
|---|---|---|---|---|---|
| **Sl. No** | Name | Below Cl X | Cl XII | Graduate & above including professional | Check up in time of illness |
| **1** | **Aizawl** | 51.3 | 10.8 | 38 | 95.5 |
| **2** | **Aibawk** | **66** | 34 | 0 | 90.5 |
| **3** | Chawilung | 78.9 | 15.7 | 0 | 15.7 |
| **4** | Kelsih | 75 | 12.5 | 8.3 | 83.3 |
| **5** | **Darlawn** | 69.2 | 8.3 | 6.6 | 30.8 |
| **6** | Khawpuar | 94.7 | 5.2 | 0 | 10.5 |
| **7** | Lailak | 90 | 10 | 0 | 20 |
| **8** | **Phullen** | 79.6 | 10.2 | 10.2 | 41.6 |
| **9** | N. Khawlek | 70 | 10 | 10 | 12 |
| **10** | Daido | 80 | 10 | 5 | 10 |
| **11** | **Thingsulthliah** | 81.6 | 10.2 | 8.2 | 38.7 |
| **12** | Darlawng | 53.5 | 10.7 | 7.1 | 21.4 |
| **13** | Lenchim | 65 | 15 | 10 | 35 |
| **14** | Average | 75.3 | 12.6 | 5.5 | 33.9 |

There are only 33.9% reported of going for check-up in time of illness of the family members. Aizawl city is the highest number of family members who visit healthcare in time of illness with 90.5 %, followed by Aibawk village 90 %. Khawlek and Daido villages are the least two that visit healthcare in time of illness with 12% and 10% respectively.

### *6.7. Aizawl district: Correlation between Household Head's Education and Health-seeking Behaviour*

Statistical test has been conducted in order to understand the relationship between father's educational level and health-seeking behaviour in the people of Aizawl district.

| Table-6.8. Correlations between Household Head's educational and health check-up | | | | | |
|---|---|---|---|---|---|
| | | VAR00001 | VAR00002 | VAR00003 | VAR00004 |
| VAR00001= Below Cl X | Pearson Correlation | 1 | -.289 | -.631* | -.478** |
| | Sig. (2-tailed) | | .339 | .021 | .099 |
| VAR00002= Cl XII | Pearson Correlation | -.289 | 1 | -.195 | .531 |
| | Sig. (2-tailed) | .339 | | .523 | .062 |
| VAR00003= Graduate & above including professional | Pearson Correlation | -.631* | -.195 | 1 | .518 |
| | Sig. (2-tailed) | .021 | .523 | | .070 |
| VAR00004= Check up in time of illness | Pearson Correlation | -.478 | .531 | .518 | 1 |
| | Sig. (2-tailed) | .099 | .062 | .070 | |
| | N | 13 | 13 | 13 | 13 |
| *. Correlation is significant at the 0.05 level (2-tailed). | | | | | |

It is interesting to find out that there is a strong negative and positive relationship between father's education level and health check-up in time of illness in Aizawl district.

As shown in Table-6.7.there is strong negative relationship between below class-X level of father and health-seeking behaviour in Aizawl district **(r=-.478*) with significant level.** This indicates that family members whose father's education levels below class-X hardly sought healthcare in time of illness.

*Thus, there exist strong positive correlations between class-XII passed and health check-up in Aizawl district* ***(r=531* with 0.05 significance level.*** *This means that family members whose fathers are class-XII passed are prompt to seek healthcare in times of illness. It is also important to mention that those having graduated and above educated fathers is very few in numbers.*

## 6.8. Aizawl District: Level of Education of Household's Head &Health-seeking Behaviour

This section discusses the influence of father's educational level on health check-up in time of illness of the family members. We considered fathers as head of the family who decides for the family healthcare. His decision is in turn influence by his level of education. As shown in Table-6.8, around 75% of fathers in the study areas are below class X passed while only 11.37% are class-XII passed and merely 8.93 are graduates or above.

Unfortunately, from the study areas, 3 villages are not having father or family head who passed graduate and above. This clearly shows a high drop-out rate in rural areas.

**Table-6.9. Level of Education of Household Head's & Health-seeking Behaviour**

| **Name** | Below Cl X | Cl XII | Graduate & above including professional | Check up in time of illness |
|---|---|---|---|---|
| **Aizawl** | 51.3 | 10.8 | 38 | 95.5 |
| **Aibawk** | 69.84 | 19.04 | 12.69 | 90.47 |
| **Chawilung** | 78.94 | 15.78 | 0 | 15.78 |
| **Kelsih** | 75 | 12.5 | 8.33 | 83.33 |
| **Darlawn** | 69.16 | 8.33 | 6.66 | 30.83 |
| **Khawpuar** | 94.73 | 5.26 | 0 | 10.52 |
| **Lailak** | 90 | 10 | 0 | 20 |
| **Phullen** | 79.59 | 10.20 | 10.20 | 41.66 |
| **N. Khawlek** | 70 | 10 | 10 | 10 |
| **Daido** | 80 | 10 | 5 | 10 |
| **Thingsulthliah** | 81.63 | 10.20 | 8.16 | 38.77 |
| **Darlawng** | 53.57 | 10.71 | 7.14 | 21.42 |
| **Lenchim** | 65 | 15 | 10 | 35 |
| **Average** | 73.75 | 11.37 | 8.93 | 38.71 |

From the Table- 6.8, there are only 38.7% reported of going for checked-up in times of illness of the family members. Aizawl city is the highest number of family members who visit healthcare in time of illness with 95.5% followed by Aibawk village

90.45% respectively. Khawpuar, N. Khawlek and Daido are the least three that visit healthcare in time of illness with 10.52%, 10% and 105 respectively.

### 6.9. Aizawl District: Correlation Father between Household Head's Education &Health-seeking Behaviour

Statistical test has been conducted in order to understand the relationship between fathers's educational and level of health-seeking behaviour in the people of Aizawl district.

**Table-6.10. Aizawl District: Correlation Household Head's Education &Health-seeking Behaviour**

**Correlations**

| | | VAR00001 =Below CL-X | VAR00002 = CL-XII | VAR00003= Graduate & above including Professional | VAR00004= Check-up in time of illness |
|---|---|---|---|---|---|
| VAR00001 | Pearson Correlation | 1 | -.315 | -.707** | -.441 |
| | Sig. (2-tailed) | | .273 | .005 | .115 |
| VAR00002 | Pearson Correlation | -.315 | 1 | .133 | .464 |
| | Sig. (2-tailed) | .273 | | .651 | .095 |
| VAR00003 | Pearson Correlation | -.707** | .133 | 1 | .712** |
| | Sig. (2-tailed) | .005 | .651 | | .004 |
| VAR00004 | Pearson Correlation | -.441 | .464 | .712** | 1 |
| | Sig. (2-tailed) | .115 | .095 | .004 | |
| | N | 14 | 14 | 14 | 14 |
| **. Correlation is significant at the 0.01 level (2-tailed) | | | | | |

Table-6.9 shows that there is a negative relationship between below primary level education and health check-up in time of illness. To make it simple-people who are under class-X are hardly or never go for check-up in times of illness with a significant level of 0.01 (r=-441**). The family household father or head educational below class-X is high. Inversely family going for check-up in time of illness is low in the rural village of the study areas.

The father living in the study area who attained class-XII level education has little significant relationship with health check-up in time of illness. Moreover, there is a strong

positive relationship of graduate or above education and health check-up (r=.712**) with 0.01 significant level.

*Therefore, there is a strong positive relationship of graduate or above education and health check-up (r=.712**) with 0.01 significant level.*

## 6.10. Aizawl District: Level of Education of Household Head & Health-seeking Behaviour

As discussed in the previous section, around 73% of Household Head in Aizawl district are below class –X passed while 11% are class – XII passed and merely 8.9 graduate and above. Unfortunately, 3 villages are not having father / family head that passed graduate and above including professional. This clearly shows a high drop-out rate in rural areas of Aizawl district.

**Table-6.11 .Aizawl District: Level of Education of Household Head & Health-seeking Behaviour**

| Name | Below Cl X | Cl XII | Graduate & above including professional | Visit HC during last 1 year | Consult health personnel time | Visiting hospital for treatment before family member die |
|---|---|---|---|---|---|---|
| **Aizawl** | 51.3 | 10.8 | 38 | 52.5 | 100 | 72.3 |
| **Aibawk** | 69.84 | 19.04 | 12.69 | 41.3 | 81 | 92.3 |
| **Chawilung** | 78.94 | 15.78 | 0 | 52.6 | 70 | 80 |
| **Kelsih** | 75 | 12.5 | 8.33 | 42.4 | 80 | 82 |
| **Darlawn** | 69.16 | 8.33 | 6.66 | 19.16 | 30.83 | 35.5 |
| **Khawpuar** | 94.73 | 5.26 | 0 | 15.78 | 18 | 36.84 |
| **Lailak** | 90 | 10 | 0 | 10.52 | 20 | 15 |
| **Phullen** | 79.59 | 10.20 | 10.20 | 28.36 | 38 | 40.81 |
| **N. Khawlek** | 70 | 10 | 10 | 15.3 | 10 | 15 |
| **Daido** | 80 | 10 | 5 | 25 | 10 | 20 |
| **Thingsulthliah** | 81.63 | 10.20 | 8.16 | 36.73 | 38.77 | 26.45 |
| **Darlawng** | 53.57 | 10.71 | 7.14 | 34 | 31.42 | 28.57 |
| **Lenchim** | 65 | 15 | 10 | 35 | 15 | 15.6 |
| **Average** | 73.75 | 11.37 | 8.93 | 31.43 | 41.77 | 43.1 |

As far as visiting healthcare during the last one year is concerned, Chawilung, Aizawl, Aibawk distinguishes itself by reporting people visiting healthcare with 52.6, 52.5 and 52.5 respectively. Whereas, Lailak, Khawpuar and N. Khawlek recorded the three least percentage visiting healthcare during the last one year with 10.52%, 15.78% and 15.3% respectively.

Table-6.10 shows the general discussion of level of household head's education and health-seeking behaviour in Aizawl district. This segment focuses on the relationship of father's education and health-seeking behaviour in Aizawl district using statistical tool. Table-6.11 reveals the negative relationship of below class-X education of household head and their visit during the last 1 year **(r=-.496).** Besides, there is also a negative relationship between below class-X education and other variables like consultation of health personnel in times of illness and visiting a hospital for treatment before family members die without much significance.

**Table-6.12. Aizawl District: Level of Education of Household head & Health-seeking Behaviour**

| | | VAR00001= Below CL-X | VAR00002= CL-XII | VAR00003= Graduate & above Including professional | VAR00004=Visit HC During Last 1 year | VAR00005= consult health personnel in times of illness | VAR00006=Visited hospital for treatment before family Member die |
|---|---|---|---|---|---|---|---|
| VAR00001 | Pearson Correlation | 1 | -.315 | -.707** | -.496 | -.379 | -.189 |
| | Sig. (2-tailed) | | .273 | .005 | .071 | .182 | .517 |
| VAR00002 | Pearson Correlation | -.315 | 1 | .133 | .634* | .503 | .560* |
| | Sig. (2-tailed) | .273 | | .651 | .015 | .067 | .037 |
| VAR00003 | Pearson Correlation | -.707** | .133 | 1 | .501 | .584* | .326 |
| | Sig. (2-tailed) | .005 | .651 | | .068 | .028 | .256 |
| VAR00004 | Pearson Correlation | -.496 | .634* | .501 | 1 | .823** | .739** |
| | Sig. (2-tailed) | .071 | .015 | .068 | | .000 | .003 |
| VAR00005 | Pearson Correlation | -.379 | .503 | .584* | .823** | 1 | .922** |
| | Sig. (2-tailed) | .182 | .067 | .028 | .000 | | .000 |
| VAR00006 | Pearson Correlation | -.189 | .560* | .326 | .739** | .922** | 1 |
| | Sig. (2-tailed) | .517 | .037 | .256 | .003 | .000 | |
| | N | 14 | 14 | 14 | 14 | 14 | 14 |

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

*Thus, it is clearly uncovered that household head's educational levels of below class-X are stopping to seek health care while, class-XII level educational doesn't make any sense in their health-seeking attitude and those attaining graduate and above level are significantly related to their health seeking, thus education is fairly important for people seek healthcare among the urban residence. There is a positive significant relationship between class-XII level education of household head and health-seeking behaviour* ***(r=.560*).at 0.05 significant level****. However, there is a no correlation between graduate and above educated father and their visit to a hospital for treatment before family members die.*

## 6.12. Aizawl District: Level of Education of Household Head& Maternal Health-seeking Behaviour

As discussed in the previous in the previous section and shown in the table-6.12, extremely high number of household head living in Aizawl district are below class-X (73.75%) and only 11.37 % are class-XII passed while just 8.93% are graduate and above educated father of household.

**Table-6.13. Aizawl District: Level of Education of Household Head& Maternal Health-seeking Behaviour**

| Name | Below Cl X | Cl XII | Graduate & above including professional | Institutional Delivery | Postnatal check-Up |
|---|---|---|---|---|---|
| **Aizawl** | 51.3 | 10.8 | 38 | 99.9 | 100 |
| **Aibawk** | 69.84 | 19.04 | 12.69 | 81 | 44.4 |
| **Chawilung** | 78.94 | 15.78 | 0 | 47.36 | 36.31 |
| **Kelsih** | 75 | 12.5 | 8.33 | 62.5 | 41.66 |
| **Darlawn** | 69.16 | 8.33 | 6.66 | 23.33 | 38.33 |
| **Khawpuar** | 94.73 | 5.26 | 0 | 20 | 15 |
| **Lailak** | 90 | 10 | 0 | 25 | 20 |
| **Phullen** | 79.59 | 10.20 | 10.20 | 57.14 | 67.34 |
| **N. Khawlek** | 70 | 10 | 10 | 35 | 40 |
| **Daido** | 80 | 10 | 5 | 30 | 35 |
| **Thingsulthliah** | 81.63 | 10.20 | 8.16 | 57.14 | 76.34 |
| **Darlawng** | 53.57 | 10.71 | 7.14 | 42.85 | 46.42 |
| **Lenchim** | 65 | 15 | 10 | 40 | 45 |
| **Average** | **73.75** | **11.37** | **8.93** | **47.78** | **43.52** |

There is a huge variation on institutional delivery and postnatal check-up. While Aizawl (99.9%), Aibawk (81%) and Kelsih (62.5%) recorded high number of mother delivering their baby in the health institution, Khawpuar (20%), Darlawn (23.33%) and Lailak (25%) poorly performed in this regards. Similarly, there exists a wide variation in Aizawl division in post natal check-up in Mizoram. Whereas, Aizawl (100%), Thingsulthliah (76.34%) and Phullen (67.34%) recorded of having high post natal check-up, Khawpuar (15%), Lailak (20%), and Daido (35%) poorly performed in this regards.

## 6.12. Correlations between Household Head's Education and Maternal Health-seeking Behaviour

In order to strengthen the above analysis of father's education and maternal healthcare, this section validates the relationship between the two using statistical tool of correlation coefficient.

**Table-6.14. Correlations between Household head's Education and Maternal Health-seeking Behaviour**

| | | VAR00001= Below Cl-X | VAR00002= CL-XII | VAR00003= Graduate & above including Professional | VAR00004= Institutional Delivery | VAR00005 = Postnatal Check-up |
|---|---|---|---|---|---|---|
| VAR00001 | Pearson Correlation | 1 | -.315 | -.707** | -.531 | -.573* |
| | Sig. (2-tailed) | | .273 | .005 | .051 | .032 |
| VAR00002 | Pearson Correlation | -.315 | 1 | .133 | .513* | .121 |
| | Sig. (2-tailed) | .273 | | .651 | .061 | .681 |
| VAR00003 | Pearson Correlation | -.707** | .133 | 1 | .804** | .835** |
| | Sig. (2-tailed) | .005 | .651 | | .001 | .000 |
| VAR00004 | Pearson Correlation | -.531 | .513 | .804** | 1 | .790** |
| | Sig. (2-tailed) | .051 | .061 | .001 | | .001 |
| VAR00005 | Pearson Correlation | -.573* | .121 | .835** | .790** | 1 |
| | Sig. (2-tailed) | .032 | .681 | .000 | .001 | |
| | N | 14 | 14 | 14 | 14 | 14 |

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

It is very interesting to see that there is a strong negative relationship between father or household head who didn't passed class –X and institutional delivery and

negative correlation between below class – X and postnatal check up **(r=-.573*) with 0.05 significant level.**

*Another interesting finding is that there is a positive correlation between below class-X educated father and institutional delivery* ***(r=.513*) with 0.05 significant level.*** *Not only that, for the first time, father who passed graduate and above, including professional degree is strongly and positive correlated with* ***institutional delivery (r=.804**) and postnatal care (.835**) with 0.01*** *significant level.*

### 6.13. Aizawl District: Annual Income & Health-seeking Behaviour

Income is one of the finest indicator of poverty or richness of individual or country, which has many relationship including their health and health-seeking behaviour. If people are too poor, they have limited choice and decision in their life course. Present study includes the average annual income of household in Aizawl district to understand their general social well being and particularly to find out how family income influences their health-seeking behaviour. Particularly, we seek to find out how family income influence people's health-seeking behaviour like health check-up in time of illness, whether they visit healthcare during the last one year, do they consult health personnel in time of illness and do they visit hospital for treatment before family members die.

**Table-6.15. Aizawl District: Annual Income &Health-seeking Behaviour**

| **Name** | Average Annual Income | Check up in time of illness | Visit HC during last 1 year | Consult health personnel time | Visiting hospital for treatment before family member die |
|---|---|---|---|---|---|
| **Aizawl** | 243069 | 95.5 | 52.5 | 100 | 72.3 |
| **Aibawk** | 138016 | 90.4 | 41.3 | 81 | 92.3 |
| **Chawilung** | 97842 | 15.7 | 52.6 | 70 | 80 |
| **Kelsih** | 135925 | 83.3 | 42.4 | 80 | 82 |
| **Darlawn** | 94279 | 30.8 | 19.2 | 30.8 | 35.5 |
| **Khawpuar** | 92425 | 10.5 | 15.7 | 18 | 36.8 |
| **Lailak** | 97842 | 20 | 10.5 | 20 | 15 |
| **Phullen** | 99853 | 41.6 | 28.3 | 38 | 40.8 |
| **N. Khawlek** | 84284 | 10 | 15.3 | 10 | 15 |
| **Daido** | 93279 | 10 | 25 | 10 | 20 |
| **Thingsulthliah** | 125925 | 38.7 | 36.73 | 38.7 | 26.4 |

| | | | | | |
|---|---|---|---|---|---|
| **Darlawng** | 95845 | 21.4 | 34 | 31.4 | 28.5 |
| **Lenchim** | 94284 | 35 | 35 | 15 | 15.6 |
| **Average** | 114836 | 38.7 | 31.4 | 41.7 | 43.1 |

The average annual income of Aizawl district is Rs. 114836 /-. From the sample villages taken in Aizawl District, Aizawl city (Rs. 243069/-), Aibawk (Rs. 138016/-), Kelsih (Rs. 135925/-) and Thingsulthliah (Rs. 125925/-) are the top most high income villages with more than one lakh annual income whereas, Khawpuar (Rs.92425/-), N. Khawlek (Rs.84284/-), Daido (Rs.93279/-) and Darlawn (Rs. 94279/-) villages are the poorest four with less than Rs. 95000/- annual income.

The average number of health check-up in time of illness is only 31.43% in Aizawl district. In Aizawl district, Aizawl city and Aibawk distinguishes themselves with high number of check-up in time of illness with 95.5% and 90.47% respectively. Whereas, the remaining 10 villages are poorly performed especially Daido, Khawlek and Khawpuar, village with 10 %, 10% and 10.52% respectively.

Visiting healthcare during the last one year is also decline (30.66%) compared with health check-up in time of illness. Aizawl (52.5%), Chawilung (52.6%), and Kelsih (42.4%), Aibawk (41.3%) are quite high while, Lailak (10.52%), N.Khawlek (15.3%), Khawpuar (15.78%) and Darlawn (19.16%) are at the bottom line in this regards.

Consultation of health personnel is relatively higher in Aizawl district with 41.77%. Aizawl city (100%), Aibawk (81%), Kelsih (80%), and Chawilung (70%) recorded quite satisfactory performance whereas Daido (10%), Khawpuar (10%), and Lenchim (15 %) and Khawlek (18%) recorded to have minimal performance.

## 6.14. Aizawl District: Annual Income &Health-seeking Behaviour

It is interesting to find out from table-6.16 that there is a strong correlation between annual income and health check-up in time of illness (r=810**) with 0.01 significant level.

***Table-6.16. Aizawl District: Correlation between Annual Income &Health-seeking Behaviour***

| | | VAR00001 | VAR00002 | VAR00003 | VAR00004 | VAR00005 |
|---|---|---|---|---|---|---|
| VAR00001 | Pearson Correlation | 1 | .810** | .623* | .790** | .550* |
| | Sig. (2-tailed) | | .000 | .017 | .001 | .042 |
| VAR00002 | Pearson Correlation | .810** | 1 | .624* | .846** | .727** |
| | Sig. (2-tailed) | .000 | | .017 | .000 | .003 |
| VAR00003 | Pearson Correlation | .623* | .624* | 1 | .823** | .739** |
| | Sig. (2-tailed) | .017 | .017 | | .000 | .003 |
| VAR00004 | Pearson Correlation | .790** | .846** | .823** | 1 | .922** |
| | Sig. (2-tailed) | .001 | .000 | .000 | | .000 |
| VAR00005 | Pearson Correlation | .550* | .727** | .739** | .922** | 1 |
| | Sig. (2-tailed) | .042 | .003 | .003 | .000 | |
| | N | 14 | 14 | 14 | 14 | 14 |
| **. Correlation is significant at the 0.01 level (2-tailed). | | | | | | |
| *. Correlation is significant at the 0.05 level (2-tailed). | | | | | | |

It is interesting to find out from table-6.16 that there is a strong correlation between annual income and health check-up in time of illness (r=.810**) with 0.01 significant level, Visit HC during last 1 year (r=.623*) with 0.01 significant level as well as consultation of health personnel in times of illness (r=.790**) with 0.01 significant level and Visiting hospital for treatment before family member die (r=.550*) with 0.05 significant level respectively. In other words, if annual income is high people are engaged more in health-seeking activities and vice-versa.

*As far as maternal healthcare is concerned, this research clearly reveals that there is a strong significant relationship between annual income and maternal health seeking behaviour in both rural and urban.*

## 16.5. Conclusion

*Table-6.3 shows that Tlangnuam Rural Development Block including Durtlang (95 %), Zarkawt (98 %), Bethlehem (70 %), Chite (73 %) and Kanan (80.1 %) have the highest accessible road, it reflects optimum visit healthcare, consult health personnel in times of illness and visit hospital for treatment before family member dies. On the other hand, Sairang (42 %) have the high accessible road (average 76.3), due to lack of an irregular doctor, low economic condition, the health-seeking behaviour is low. In Aibawk R.D block, between Chawilung and Hmuifang village has the kuccha road, this poor accessible may hamper the flows of health-seeking behaviour in Chawilung village. In Darlawn R.D block, Khawpuar and Lailak village have the kuccha road; this road barrier affects the health-seeking behaviour of the people. The people of Phullen R.D block, particularly N.Khawlek and Daido village also has lack of accessibility, and it may be hampered by the health-seeking behaviour of the people in these areas.*

*Thus, the correlation between accessibility (road) and health-seeking behaviour of Aizawl district is 0.01 level of significant. There is a high positive correlation between accessibility and health-seeking behaviour.*

*It is interesting to find out that all the relationships are positive. The correlation between accessibility and institutional delivery is positive (r=621*) with 0.05 significant level. The relationship between accessibility and postnatal care is also strongly positive (r=856**) with 0.01 significant level. Therefore, wherever there is good accessibility, institutional delivery increases in the District of Aizawl.*

*Thus, there exist strong positive correlations between class-XII passed and health check-up in Aizawl district* ***(r=531* with 0.05 significance level.*** *This means that family*

*members whose fathers are class-XII passed are prompt to seek healthcare in times of illness. It is also important to mention that those having graduated and above educated fathers is very few in numbers.*

*Therefore, there is a strong positive relationship of graduate or above education and health check-up (r=.712**) with 0.01 significant level.*

*Thus, it is clearly uncovered that household head's educational levels of below class-X are stopping to seek health care while, class-XII level educational doesn't make any sense in their health-seeking attitude and those attaining graduate and above level are significantly related to their health seeking, thus education is fairly important for people seek healthcare among the urban residence. There is a positive significant relationship between class-XII level education of household head and health-seeking behaviour* ***(r=.560*).at 0.05 significant level****. However, there is a no correlation between graduate and above educated father and their visit to a hospital for treatment before family members die.*

*Another interesting finding is that there is a positive correlation between below class-X educated father and institutional delivery* ***(r=.513*) with 0.05 significant level.*** *Not only that, for the first time, father who passed graduate and above, including professional degree is strongly and positive correlated with* ***institutional delivery (r=.804**) and postnatal care (.835**) with 0.01*** *significant level.*

*As far as maternal healthcare is concerned, this research clearly reveals that there is a strong significant relationship between annual income and maternal health seeking behaviour in both rural and urban.*

# CHAPTER-VII

## FINDINGS AND CONCLUSIONS

This chapter consists of findings, conclusion and suggestion. In fact, it is a collection of major findings of every chapter, except chapter one. Arrangement of the text is also made on the based on chapter findings so as to understand easily.

### Background of the study Areas

There are five Rural Development block in Aizawl district, medium, small villages and Rural Development block are selected from Aizawl district. Selected developmental variables include – educational institution, healthcare facilities, transport and communication in each and every selected villages and towns. Therefore, we selected five Rural development block such as- Tlangnuam, Aibawk, Thingsulthliah, Phullen, Darlawn in Aizawl district on the based of spatial location, socio-economic and education.

### Health-Seeking Behaviour in Mizram: Inter-District variation

From the overall discussion of inter district variations on health-seeking behaviour and the general factors associated with it are concerned, these are the following important findings:-

First, the present research clearly shows that seeking health care is quite common in Aizawl district 91.7 % compared with other districts of Mizoram and far better than state average of 65.9% while Mamit and Serchhip records the least percentage of family members who went for check-up in time of illness with 51.5 % and 51.7% respectively.

Second, there are intra-district variations in the reasons why people don't go for check-up in time of illness. Cost too much is the biggest hurdles for Aizawl (66.7%), Champhai (76.9%) and Serchhip (45.5%) districts whereas 'too far' become the biggest problems for Lawngtlai (72.3%), Lunglei (77.8%) and Saiha (94.5%) districts. Another major hurdle that stop people from seeking healthcare are inaccessibility, require for household work and lack of healthcare facilities.

Third, out of the six possible reasons, preference to have at home got maximum score with 47.8%, followed by too far (20.0%), healthcare facility not available (18.7%), no medical personal at home (12.1%) and no money (7.9%).

Fourth, it is evident that mass media exposure is quite high in Mizoram as 86.5% are exposes to mass media. Among the district Aizawl scored 100% mass media exposure, followed by Champhai (97.55%), Serchhip (91.9%), Lunglei (86.3%), Kolasib (85.5%), Lawngtlai (81.5%), Saiha (75.5%) and Mamit (73.8%) districts. Looking at regularity of mass media exposure, Aizawl district distinguishes itself by scoring 98% exposes to mass media regularly, followed by Kolasib and Lunglei with 51.3% and 44.2% respectively. On the other hand Lawngtlai and Saiha districts show the least exposure to mass media with 7.3% and 8.6% respectively.

Fifthly, it is exposed that alcohol drinking is common in all the eight districts of Mizoram with 24.9% average that drink regularly. Among the districts-Kolasib and Champhai records maximum proportion of people who drink alcohol regularly while Serchhip and Aizawl records minimum proportion of drinkers who drink alcohol regularly.

Sixthly, present research clearly shows that seeking health care is quite common in Aizawl district (91.7%) compared with other districts of Mizoram and far better than state

average of 65.9 % while Mamit and Serchhip records the least percentage of family members went for check-up in time of illness with 51.5 % and 51.7 % respectively.

Seventhly, there are intra-district variations in the reasons why people don't go for check-up in time of illness. Cost too much is the biggest problems for Lawngtlai (72.3%), Lunglei (77.8%) and Saiha (94.5%) districts. Another major hurdle that stop are inaccessibility, require for household work and lack of healthcare facilities.

Eighthly, out of six possible reasons, prefer delivery baby at home got maximum score with 47.8 %, followed by too far (20.0 %), healthcare facility not available (12.1 %), no medical personal at home (12.1 %) and no money (7.9%).

It is evident that mass media exposure is quite high in Mizoram as 96.5 % exposes to mass media. Among the districts, Aizawl scored 100 % mass media exposure, followed by Champhai (97.55 %), Serchhip (91.9 %), Lunglei (86.3 %), Kolasib (85.5 %), Lawngtlai (81.5 %), Saiha (75.5 %) and Mamit (73.8 %) districts.

**Socio-economic background of health-seeking behavior of Aizawl District**

The socio-economic background of health-seekers in Aizawl district can be summarized as the following important findings:-

Firstly, as far as educational attainment is concerned, there is a huge inter-village gap, inter-block variation and rural-urban disparities in Aizawl district. It is interesting to find out that even though Aizawl district became the second highest literate district in India, majority of the household heads have below class-X level education (71.1%) while merely 11.2% passed class-XII and just 17.1% passed bachelor degree or above. There exist dropout rate in Aizawl District.

Secondly, it is observed that there are three broad types of occupations in Aizawl district such as **farmer, government servant and business**. Out of these three, agriculture farming is the most common occupational type with 53.8% engaged in this activity, followed by government service (24%) and business (17.3%). It is also clearly explored that more than 96 % of Aizawl District populations are depend on agriculture, government services and business while all other remaining occupational types are not much found in the state.

Thirdly, as far as income is concerned, it can be concluded that the average annual income of Aizawl district is Rs 150454/-. The average annual income of rural Aizawl district is Rs 101066.9/-/- while the average annual income of urban Aizawl District is Rs 189964/-. Among the categories, the annual income category of Rs 100000-200000/- got maximum proportion while the average annual income of Rs 300000/- record minimum proportion. It is also found out that there is huge gap between rural and urban area as well as intra-urban and lesser intra-rural variations as far as annual income is concerned.

Fourthly, it can be concluded that smoking in very much common in Aizawl district as majority of the population (64.5%) are smoker while merely 35.4% claimed themselves are free from smoking. Among the smoker 66.3 % of them are regular smokers while 33.6% are occasional smokers. It is clear from the research that indulgence of people in smoking is quite prominent in both rural and urban Aizawl District. As many as 69.6% urban residence and 76% rural residence are smoker in Aizawl district and a very high proportion of 75.3% in urban area and 83.7% in rural area are regular smokers.

Fifthly, it is also reveals that drinking alcohol in Aizawl district is quite common as 26.5% of them are drinking alcohol while 73.4% are restraining from alcohol drinking. It

also appears that drinking alcohol is more common in rural area than urban area. However, as far as 'regularity of alcohol drinking is concerned, urban residence are more indulged than rural folks in the district.

Sixthly, it has also been found out that 'occasional alcohol drinkers' (78.3%) are relatively higher in number compared with 'regular alcohol drinkers' (18.19%) in Aizawl district. Sairang record the highest percentage of 'regular alcohol drinker' while N.Khawlek village record the least. Among the blocks, Aibawk (20.6 %) and Tlangnuam (19.59 %) records maximum proportion of people who drink alcohol 'regularly' while Thingsulthliah (18.6 %), Darlawn (16.5 %) and Phullen (15.7 %) blocks records minimum proportion of drinkers who drink alcohol 'regularly'.

**Health-Seeking behaviour in Aizawl District**

Present research reveals that the health-seeking behavior of the people living in Aizawl District as summarized as the following:-

Firstly, it reveals that sickness is extremely common in both rural and urban areas. As many as 86.3 % families are reported of experiencing illness in their family. However, merely 20.2% in urban areas and 5.5 % in rural areas are reported of not having experienced illness in their family.

Secondly study shows that illness is prevalent in both rural and urban areas but a quite number of them are not seeking health care, especially in rural areas. Therefore, it is clearly reveals that poverty or cost too much is the most common reasons that stop people to seek healthcare both in rural and urban areas with 50.2% and 47.1% respectively. A part from poverty inaccessibility or road transport is another prominent factors controlling

health-seeking behaviour in both urban and rural areas even though urban areas and rural areas are having differences in the level of intensity of problems. In rural area accessibility problems is more significant in stopping people to search health care than urban areas. Apart from these, problem of unavailability of healthcare facility is also clearly observed for controlling health-seeking behaviour of people in Aizawl District.

Thirdly, majority of patients are consulting government doctors and nurses with 96.2 % in urban area and 89.5 % in rural area respectively. Consultation of health worker and health supervisor are more common in rural area (6.3 %) than urban area (4.5%) as well as consultation of traditional healer is comparatively more prevalence in rural area (4.1 %) than urban area (2.3 %).

Fourthly, complaints about service providers are more common among rural folks than urbanites in Aizawl District. Visiting medicine specialist become the most common practiced in Aizawl District while unexpectedly consultation of physiotherapists and dietician becoming more common during the last couple of years in the state.

Fifthly, it is reveals that as far as government healthcare facilities is concerned urbanites are more satisfy than rural folks. This is mainly due to concentration of healthcare facilities in towns and cities in Aizawl District.

Sixthly, as far as constraints in utilizing healthcare facility is concerned, rural folks suffer more problems than urbanites. It is also observes that accessibility become the biggest constraints in rural areas whereas lack of equipment and medicines become the biggest constraints in urban area. Problems in rural area and urban area are also slightly difference.

Seventhly, it is found out that there are more than 21 different types of diseases are currently suffered by Aizawl District. Out of which cough and fever top the rank, followed by kidney problem and ulcer while asthma and diabetics become rank $4^{th}$ and $5^{th}$.

Eighthly, we can conclude that death is more common among urbanites than rural folks in Aizawl District. It is found out that cancer become the topmost reason of death in Aizawl District, followed by septicemia and malaria as well as death causes by liver related problems and pneumonia. Death due to septicemia, jaundice, internal bleeding and liver problems are more common in urban areas while malaria, pneumonia and cough and fever are more common causes of death in rural area.

Ninthly, it is exhibits that died in the hospital are comparatively higher in urban area than rural area with 47.0 % and 57 % respectively. This is mainly due to availability of hospital in urban area while it was not in the case of rural area. Obviously, rural area recorded death at home (44.5 %) than urban area (38.2 %). Apart from hospital and home, urban area recorded more numbers of death neither hospital nor home with 8.1% compared with rural area with 4.5%.

Tenthly, it is interesting to find from Table-5.16 that a fairly high number of patients in urban area are visiting hospital before they died with a record of 64.0 % while relatively a lesser number in rural area do the same with a record of 50.3 %.

Eleventh, it can be concluded that poverty is the main factors stopping patients to search healthcare in Aizawl District, followed by geographical distance of healthcare facility and ignorance of people along with delay treatment.

Twelfth, it is found out that majority of people seek healthcare at government hospital, private hospital and primary health centre both in rural and urban areas. However,

informal places like home, parent's home or other home as a place of health-seeking is common only in rural area.

Thirteenth, it is found that rural people are having more reasons and problems on health-seeking than urban area. Poverty, accessibility and lack of knowledge are extremely important factor stopping rural people from seeking healthcare whereas urban areas are not much having the same problems as rural people do.

Fourteenth, it can be confidently sum up that child healthcare in both rural and urban Aizawl District is good as far as vaccination is concerned. Almost every family having children are keeping vaccination card with them. It is therefore clear that Aizawl District record good institutional delivery while rural residence needs major improvement compared with urban residence.

Finally, it is observes that mother preferred to deliver baby at home mainly because there are medical personnel who can assist at home in urban area whereas it is mainly due to unavailability of hospital in the case of rural residence. While inaccessibility to healthcare facility became one major problem in rural area, the same is not true in the case of urban residence. It is sum-up that accessibility and non-availability of healthcare facilities become the major hurdles for rural mother after delivery while these are not much responsible in the context of urban mothers. On the other hand poverty or financial problems is one factor that both rural and urban mother are facing towards post natal care. Moreover, many mothers are also not having post natal complications and they need not to visit healthcare facilities after delivery.

**Block-wise variation on Health-seeking Behaviour**

Firstly, it can be concluded that among the blocks, Tlangnuam RD Block became the healthiest people and most active in seeking healthcare in time of illness whereas Darlawn became the most unhealthiest and poorest in seeking health care.

Secondly, Among the five blocks Darlawn and Aibawk record highest proportion that prevent them from seeking healthcare while Tlangnuam and Thingsulthliah blocks record the least on this regards. The reasons of not seeking healthcare is differ from one block to another, especially the problems of Tlangnuam RD Block is minimal in all reasons while Darlawn record highest proportion of health seeking problems among the blocks. Accessibility factor is one of the major obstacles preventing people from health seeking in all the RD Blocks except in Tlangnuam.

Thirdly, consultation of health personnel when people got sick was very much common across the block of Aizawl district while few people still consulted traditional healer, especially some pockets of Darlawn RD Block.

Fourthly, health service providers across the five RD blocks are generally performed well wherein Tlangnuam block, located within state capital Aizawl city, got maximum proportion (90%) while Thingsulthliah got minimum performance (64.5%).

Fifthly, among the blocks, Tlangnuam block scored highest on the observation of cleanliness of healthcare facilities while Aibawk scored the least on the same. Generally, the cleanliness of health facilities across the block is moderate.

Sixthly, among the RD Blocks, Darlawn has maximum problems that obstruct health-seekers, followed by Phullen and Thingsulthliah while Tlangnuam and Aibawk have a minimum problem that stops healthcare-seekers. It is interesting to note that while

accessibility or ‘too far’ become one of the biggest hurdles for health-seekers in all the blocks Tlangnuam has no accessibility problems at all.

Seventhly, looking at inter-block variation on overall diseases, Phullen got maximum average with 14.2%, followed by Darlawn with 13.8% and Aibawk with 8.6% while Tlangnuam block got minimum diseases/problems with 5.1%.

Eighthly, there is one unique characters of Tlangnuam block as far as reasons of death are concerned. Cancer becomes the main reasons in all the blocks while Liver pain became the number one reason in Tlangnuam block. This is most probably due to the prevalence of alcohol drinking and easy accesses to liquor in Aizawl after legalization of selling liquor to the public.

Ninthly, among the blocks, visiting hospital more than 5 times in their life time is most common in Thingsulthliah and Tlangnuam block while Aibawk and Phullen records minimum numbers of the same. An overall performance shows that visiting hospital 2 times is most common across the blocks; followed by 3 times before they died.

Tenthly, as many as 34.24% family members across the blocks were hospitalized during the last one year. Out of the five RD blocks, Tlangnuam block record maximum number of hospitalization (52.5%) while Darlawn got minimum percentage of hospitalization (15.15%).

Eleventh, it can be concluded that people are very much aware of the importance of seeking healthcare across the blocks as 100 % percent are visiting hospital or private clinic and not seek healthcare from parents or traditional healers.

Twelfth, among the blocks, there are some unique characters as shown in the table-5.46 that poverty or cost too much is overwhelmingly high in Darlawn block compared

with other blocks. Similarly, no other blocks, except Tlangnuam reported ‘better care at home’ (3.91%) as the main reasons that patients are not seeking healthcare at hospital.

Thirteenth, as far as maternal health-seeking is concerned, we found out that institutional delivery is very common across the blocks of Aizawl district as more than 94% delivered their last birth at hospital while just 2.5% mother delivered at home.

Fourteenth, as far as maternal healthcare-whether institutional delivery or post natal care is concerned, all the five RD blocks are performed well, especially institutional delivery.

**Development factors influencing health-seeking behavoiur in Aizawl district**

It is clear that Tlangnuam Rural Development Block including Durtlang (95 %), Zarkawt (98 %), Bethlehem (70 %), Chite (73 %) and Kanan (80.1 %) have the highest accessible road, it reflects optimum visit healthcare, consult health personnel in times of illness and visit hospital for treatment before family member dies. On the other hand, Sairang (42 %) have the high accessible road (average 76.3), due to lack of an irregular doctor, low economic condition, the health-seeking behaviour is low. In Aibawk R.D block, between Chawilung and Hmuifang village has the kuccha road, this poor accessible may hamper the flows of health-seeking behaviour in Chawilung village. In Darlawn R.D block, Khawpuar and Lailak village have the kuccha road; this road barrier affects the health-seeking behaviour of the people. The people of Phullen R.D block, particularly N.Khawlek and Daido village also has lack of accessibility, and it may be hampered by the health-seeking behaviour of the people in these areas.

Thus, the correlation between accessibility (road) and health-seeking behaviour of Aizawl district is 0.01 level of significant. There is a high positive correlation between accessibility and health-seeking behaviour.

It is interesting to find out that all the relationships are positive. The correlation between accessibility and institutional delivery is positive (r=621*) with 0.05 significant level. The relationship between accessibility and postnatal care is also strongly positive (r=856**) with 0.01 significant level. Therefore, wherever there is good accessibility, institutional delivery increases in the District of Aizawl.

Thus, there exist strong positive correlations between class-XII passed and health check-up in Aizawl district **(r=531* with 0.05 significance level.** This means that family members whose fathers are class-XII passed are prompt to seek healthcare in times of illness. It is also important to mention that those having graduated and above educated fathers is very few in numbers.

Therefore, there is a strong positive relationship of graduate or above education and health check-up (r=.712**) with 0.01 significant level.

Thus, it is clearly uncovered that household head's educational levels of below class-X are stopping to seek health care while, class-XII level educational doesn't make any sense in their health-seeking attitude and those attaining graduate and above level are significantly related to their health seeking, thus education is fairly important for people seek healthcare among the urban residence. There is a positive significant relationship between class-XII level education of household head and health-seeking behaviour **(r=.560*).at 0.05 significant level**. However, there is a no correlation between graduate

and above educated father and their visit to a hospital for treatment before family members die.

Another interesting finding is that there is a positive correlation between below class-X educated father and institutional delivery **(r=.513*) with 0.05 significant level.** Not only that, for the first time, father who passed graduate and above, including professional degree is strongly and positive correlated with **institutional delivery (r=.804**) and postnatal care (.835**) with 0.01** significant level.

As far as maternal healthcare is concerned, this research clearly reveals that there is a strong significant relationship between annual income and maternal health seeking behaviour in both rural and urban.

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## Abstract

**Background of the study Areas**

There are five Rural Development block in Aizawl district, medium, small villages and Rural Development block are selected from Aizawl district. Selected developmental variables include – educational institution, healthcare facilities, transport and communication in each and every selected villages and towns. Therefore, we selected five Rural development block such as- Tlangnuam, Aibawk, Thingsulthliah, Phullen, Darlawn in Aizawl district on the based of spatial location, socio-economic and education.

**Health-Seeking Behaviour in Mizram: Inter-District variation**

From the overall discussion of inter district variations on health-seeking behaviour and the general factors associated with it are concerned, these are the following important findings:-

First, the present research clearly shows that seeking health care is quite common in Aizawl district 91.7 % compared with other districts of Mizoram and far better than state average of 65.9% while Mamit and Serchhip records the least percentage of family members who went for check-up in time of illness with 51.5 % and 51.7% respectively.

Second, there are intra-district variations in the reasons why people don't go for check-up in time of illness. Cost too much is the biggest hurdles for Aizawl (66.7%), Champhai (76.9%) and Serchhip (45.5%) districts whereas 'too far' become the biggest problems for Lawngtlai (72.3%), Lunglei (77.8%) and Saiha (94.5%) districts. Another major hurdle that stop people from seeking healthcare are inaccessibility, require for household work and lack of healthcare facilities.

Third, out of the six possible reasons, preference to have at home got maximum score with 47.8%, followed by too far (20.0%), healthcare facility not available (18.7%), no medical personal at home (12.1%) and no money (7.9%).

Fourth, it is evident that mass media exposure is quite high in Mizoram as 86.5% are exposes to mass media. Among the district Aizawl scored 100% mass media exposure, followed by Champhai (97.55%), Serchhip (91.9%), Lunglei (86.3%), Kolasib (85.5%), Lawngtlai (81.5%), Saiha (75.5%) and Mamit (73.8%) districts. Looking at regularity of mass media exposure, Aizawl district distinguishes itself by scoring 98% exposes to mass media regularly, followed by Kolasib and Lunglei with 51.3% and 44.2% respectively. On the other hand Lawngtlai and Saiha districts show the least exposure to mass media with 7.3% and 8.6% respectively.

Fifthly, it is exposed that alcohol drinking is common in all the eight districts of Mizoram with 24.9% average that drink regularly. Among the districts-Kolasib and Champhai records maximum proportion of people who drink alcohol regularly while Serchhip and Aizawl records minimum proportion of drinkers who drink alcohol regularly.

Sixthly, present research clearly shows that seeking health care is quite common in Aizawl district (91.7%) compared with other districts of Mizoram and far better than state average of 65.9 % while Mamit and Serchhip records the least percentage of family members went for check-up in time of illness with 51.5 % and 51.7 % respectively.

Seventhly, there are intra-district variations in the reasons why people don't go for check-up in time of illness. Cost too much is the biggest problems for Lawngtlai (72.3%), Lunglei

(77.8%) and Saiha (94.5%) districts. Another major hurdle that stop are inaccessibility, require for household work and lack of healthcare facilities.

Eighthly, out of six possible reasons, prefer delivery baby at home got maximum score with 47.8 %, followed by too far (20.0 %), healthcare facility not available (12.1 %), no medical personal at home (12.1 %) and no money (7.9%).

It is evident that mass media exposure is quite high in Mizoram as 96.5 % exposes to mass media. Among the districts, Aizawl scored 100 % mass media exposure, followed by Champhai (97.55 %), Serchhip (91.9 %), Lunglei (86.3 %), Kolasib (85.5 %), Lawngtlai (81.5 %), Saiha (75.5 %) and Mamit (73.8 %) districts.

**Socio-economic background of health-seeking behavior of Aizawl District**

The socio-economic background of health-seekers in Aizawl district can be summarized as the following important findings:-

Firstly, as far as educational attainment is concerned, there is a huge inter-village gap, inter-block variation and rural-urban disparities in Aizawl district. It is interesting to find out that even though Aizawl district became the second highest literate district in India, majority of the household heads have below class-X level education (71.1%) while merely 11.2% passed class-XII and just 17.1% passed bachelor degree or above. There exist dropout rate in Aizawl District.

Secondly, it is observed that there are three broad types of occupations in Aizawl district such as **farmer, government servant and business**. Out of these three, agriculture farming is the most common occupational type with 53.8% engaged in this activity, followed by government service (24%) and business (17.3%). It is also clearly explored that more than 96 %

of Aizawl District populations are depend on agriculture, government services and business while all other remaining occupational types are not much found in the state.

Thirdly, as far as income is concerned, it can be concluded that the average annual income of Aizawl district is Rs 150454/-. The average annual income of rural Aizawl district is Rs 101066.9/-/- while the average annual income of urban Aizawl District is Rs 189964/-. Among the categories, the annual income category of Rs 100000-200000/- got maximum proportion while the average annual income of Rs 300000/- record minimum proportion. It is also found out that there is huge gap between rural and urban area as well as intra-urban and lesser intra-rural variations as far as annual income is concerned.

Fourthly, it can be concluded that smoking in very much common in Aizawl district as majority of the population (64.5%) are smoker while merely 35.4% claimed themselves are free from smoking. Among the smoker 66.3 % of them are regular smokers while 33.6% are occasional smokers. It is clear from the research that indulgence of people in smoking is quite prominent in both rural and urban Aizawl District. As many as 69.6% urban residence and 76% rural residence are smoker in Aizawl district and a very high proportion of 75.3% in urban area and 83.7% in rural area are regular smokers.

Fifthly, it is also reveals that drinking alcohol in Aizawl district is quite common as 26.5% of them are drinking alcohol while 73.4% are restraining from alcohol drinking. It also appears that drinking alcohol is more common in rural area than urban area. However, as far as 'regularity of alcohol drinking is concerned, urban residence are more indulged than rural folks in the district.

Sixthly, it has also been found out that 'occasional alcohol drinkers' (78.3%) are relatively higher in number compared with 'regular alcohol drinkers' (18.19%) in Aizawl

district. Sairang record the highest percentage of 'regular alcohol drinker' while N.Khawlek village record the least. Among the blocks, Aibawk (20.6 %) and Tlangnuam (19.59 %) records maximum proportion of people who drink alcohol 'regularly' while Thingsulthliah (18.6 %), Darlawn (16.5 %) and Phullen (15.7 %) blocks records minimum proportion of drinkers who drink alcohol 'regularly'.

**Health-Seeking behaviour in Aizawl District**

Present research reveals that the health-seeking behavior of the people living in Aizawl District as summarized as the following:-

Firstly, it reveals that sickness is extremely common in both rural and urban areas. As many as 86.3 % families are reported of experiencing illness in their family. However, merely 20.2% in urban areas and 5.5 % in rural areas are reported of not having experienced illness in their family.

Secondtly study shows that illness is prevalent in both rural and urban areas but a quite number of them are not seeking health care, especially in rural areas. Therefore, it is clearly reveals that poverty or cost too much is the most common reasons that stop people to seek healthcare both in rural and urban areas with 50.2% and 47.1% respectively. A part from poverty inaccessibility or road transport is another prominent factors controlling health-seeking behaviour in both urban and rural areas even though urban areas and rural areas are having differences in the level of intensity of problems. In rural area accessibility problems is more significant in stopping people to search health care than urban areas. Apart from these, problem of unavailability of healthcare facility is also clearly observed for controlling health-seeking behaviour of people in Aizawl District.

Thirdly, majority of patients are consulting government doctors and nurses with 96.2 % in urban area and 89.5 % in rural area respectively. Consultation of health worker and health supervisor are more common in rural area (6.3 %) than urban area (4.5%) as well as consultation of traditional healer is comparatively more prevalence in rural area (4.1 %) than urban area (2.3 %).

Fourthly, complaints about service providers are more common among rural folks than urbanites in Aizawl District. Visiting medicine specialist become the most common practiced in Aizawl District while unexpectedly consultation of physiotherapists and dietician becoming more common during the last couple of years in the state.

Fifthly, it is reveals that as far as government healthcare facilities is concerned urbanites are more satisfy than rural folks. This is mainly due to concentration of healthcare facilities in towns and cities in Aizawl District.

Sixthly, as far as constraints in utilizing healthcare facility is concerned, rural folks suffer more problems than urbanites. It is also observes that accessibility become the biggest constraints in rural areas whereas lack of equipment and medicines become the biggest constraints in urban area. Problems in rural area and urban area are also slightly difference.

Seventhly, it is found out that there are more than 21 different types of diseases are currently suffered by Aizawl District. Out of which cough and fever top the rank, followed by kidney problem and ulcer while asthma and diabetics become rank $4^{th}$ and $5^{th}$.

Eighthly, we can conclude that death is more common among urbanites than rural folks in Aizawl District. It is found out that cancer become the topmost reason of death in Aizawl District, followed by septicemia and malaria as well as death causes by liver related problems and pneumonia. Death due to septicemia, jaundice, internal bleeding and liver problems are more

common in urban areas while malaria, pneumonia and cough and fever are more common causes of death in rural area.

Ninthly, it is exhibits that died in the hospital are comparatively higher in urban area than rural area with 47.0 % and 57 % respectively. This is mainly due to availability of hospital in urban area while it was not in the case of rural area. Obviously, rural area recorded death at home (44.5 %) than urban area (38.2 %). Apart from hospital and home, urban area recorded more numbers of death neither hospital nor home with 8.1% compared with rural area with 4.5%.

Tenthly, it is interesting to find from Table-5.16 that a fairly high number of patients in urban area are visiting hospital before they died with a record of 64.0 % while relatively a lesser number in rural area do the same with a record of 50.3 %.

Eleventh, it can be concluded that poverty is the main factors stopping patients to search healthcare in Aizawl District, followed by geographical distance of healthcare facility and ignorance of people along with delay treatment.

Twelfth, it is found out that majority of people seek healthcare at government hospital, private hospital and primary health centre both in rural and urban areas. However, informal places like home, parent's home or other home as a place of health-seeking is common only in rural area.

Thirteenth, it is found that rural people are having more reasons and problems on health-seeking than urban area. Poverty, accessibility and lack of knowledge are extremely important factor stopping rural people from seeking healthcare whereas urban areas are not much having the same problems as rural people do.

Fourteenth, it can be confidently sum up that child healthcare in both rural and urban Aizawl District is good as far as vaccination is concerned. Almost every family having children

are keeping vaccination card with them. It is therefore clear that Aizawl District record good institutional delivery while rural residence needs major improvement compared with urban residence.

Finally, it is observes that mother preferred to deliver baby at home mainly because there are medical personnel who can assist at home in urban area whereas it is mainly due to unavailability of hospital in the case of rural residence. While inaccessibility to healthcare facility became one major problem in rural area, the same is not true in the case of urban residence. It is sum-up that accessibility and non-availability of healthcare facilities become the major hurdles for rural mother after delivery while these are not much responsible in the context of urban mothers. On the other hand poverty or financial problems is one factor that both rural and urban mother are facing towards post natal care. Moreover, many mothers are also not having post natal complications and they need not to visit healthcare facilities after delivery.

**Block-wise variation on Health-seeking Behaviour**

Firstly, it can be concluded that among the blocks, Tlangnuam RD Block became the healthiest people and most active in seeking healthcare in time of illness whereas Darlawn became the most unhealthiest and poorest in seeking health care.

Secondly, Among the five blocks Darlawn and Aibawk record highest proportion that prevent them from seeking healthcare while Tlangnuam and Thingsulthliah blcoks record the least on this regards. The reasons of not seeking healthcare is differ from one block to another, especially the problems of Tlangnuam RD Block is minimal in all reasons while Darlawn record highest proportion of health seeking problems among the blocks. Accessibility factor is one of

the major obstacles preventing people from health seeking in all the RD Blocks except in Tlangnuam.

Thirdly, consultation of health personnel when people got sick was very much common across the block of Aizawl district while few people still consulted traditional healer, especially some pockets of Darlawn RD Block.

Fourthly, health service providers across the five RD blocks are genrrally perfomed well wherein Tlangnuam block, located within state capital Aizawl city, got maximum proportion (90%) while Thingsulthliah got minimum performance (64.5%).

Fifthly, among the blocks, Tlangnuam block scored highest on the observation of cleanliness of healthcare facilities while Aibawk secored the least on the same. Generally, the cleanliness of health facilities across the block is moderate.

Sixthly, among the RD Blocks, Darlawn has maximum problems that obstruct health-seekers, followed by Phullen and Thingsulthliah while Tlangnuam and Aibawk have minimum problems tthat stops healthcare-seekers. It is interesting to note that while accessibility or 'too far' become one of the biggest hurdles for health-seekers in all the blocks Tlangnuam has no accessibility problems at all.

Seventhly, looking at inter-block variation on averall diseases, Phullen got maximum average with 14.2%, followed by Darlawn with 13.8% and Aibawk with 8.6% while Tlangnuam block got minimum diseases/problems with 5.1%.

Eightly, there is one unique charecters of Tlangnuam block as far as reasons of death are concerned. Cancer becomes the main reasons in all the blocks while Liver pain became the number one reason in Tlangnuam block. This is most probably due to the prevalence of alcohol drinking and easy accesses to liquor in Aizawl after legalisation of selling liquor to the public.

Ninthly, among the blocks, visiting hospital more than 5 times in their life time is most common in Thingsulthliah and Tlangnuam block while Aibawk and Phullen reconrd minimum numbers of the same. Overall perfomacnce shows that visiting hospital 2 times is most common across the blocks; followed by 3 times before they died.

Tenthly, as many as 34.24% family members across the blocks were hospitalized during the last one year. Out of the five RD blocks, Tlangnuam block record maximum number of hospitalization (52.5%) while Darlawn got minimum percentage of hospitalization (15.15%).

Eleventh, it can be concluded that people are very much aware of the importance of seeking healthcare across the blocks as 100 % percent are visiting hospital or private clinic and not seek healthcare from parents or traditional healers.

Twelfth, among the blocks, there are some unique charecters as shown in the table-5.46 that poverty or cost too much is overwhelmingly high in Darlawn block compared with other blocks. Similarly, no other blocks, except Tlangnuam reported 'better care at home' (3.91%) as the main reasons that patients are not seeking healthcare at hospital.

Thirteenth, as far as maternal health-seeking is concerned, we found out that institutional delivery is very common across the blocks of Aizawl district as more than 94% delivered their last birth at hospital while just 2.5% mother delivered at home.

Fourteenth, as far as maternal healthcare-whether institutional delivery or post natal care is concerned, all the five RD blocks are performed well, especially institutional delivery.

**Develpement factors infuencing health-seeking behavoiur in Aizawl district**

It is clear that Tlangnuam Rural Development Block including Durtlang (95 %), Zarkawt (98 %), Bethlehem (70 %), Chite (73 %) and Kanan (80.1 %) have the highest accessible road, it reflects optimum visit healthcare, consult health personnel in times of illness and visit hospital

for treatment before family member dies. On the other hand, Sairang (42 %) have the high accessible road (average 76.3), due to lack of an irregular doctor, low economic condition, the health-seeking behaviour is low. In Aibawk R.D block, between Chawilung and Hmuifang village has the kuccha road, this poor accessible may hamper the flows of health-seeking behaviour in Chawilung village. In Darlawn R.D block, Khawpuar and Lailak village have the kuccha road, this road barrier affects the health-seeking behaviour of the people. The people of Phullen R.D block, particularly N.Khawlek and Daido village also has lack of accessibility, and it may be hampered by the health-seeking behaviour of the people in these areas.

Thus, the correlation between accessibility (road) and health-seeking behaviour of Aizawl district is 0.01 level of significant. There is a high positive correlation between accessibility and health-seeking behaviour.

It is interesting to find out that all the relationships are positive. The correlation between accessibility and institutional delivery is positive (r=621*) with 0.05 significant level. The relationship between accessibility and postnatal care is also strongly positive (r=856**) with 0.01 significant level. Therefore, wherever there is good accessibility, institutional delivery increases in the District of Aizawl.

Thus, there exist strong positive correlations between class-XII passed and health check-up in Aizawl district **(r=531* with 0.05 significance level.** This means that family members whose fathers are class-XII passed are prompt to seek healthcare in times of illness. It is also important to mention that those having graduate and above educated fathers are very few in numbers.

Therefore, there is a strong positive relationship of graduate or above education and health check-up (r=.712**) with 0.01 significant level.

Thus, it is clearly uncovered that household head's educational levels of below class-X are stopping to seek health care while, class-XII level educational doesn't make any sense in their health-seeking attitude and those attaining graduate and above level are significantly related to their health seeking, thus education is fairly important for people seek healthcare among the urban residence. There is a positive significant relationship between class-XII level education of household head and health-seeking behaviour **(r=.560*).at 0.05 significant level**. However, there is a no correlation between graduate and above educated father and their visit to a hospital for treatment before family members die.

Another interesting finding is that there is a positive correlation between below class-X educated father and institutional delivery **(r=.513*) with 0.05 significant level.** Not only that, for the first time, father who passed graduate and above, including professional degree is strongly and positive correlated with **institutional delivery (r=.804**) and postnatal care (.835**) with 0.01** significant level.

As far as maternal healthcare is concerned, this research clearly reveals that there is a strong significant relationship between annual income and maternal health seeking behaviour in both rural and urban.