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DECISION MAKING IN HEALTH SEEKING BEHAVIOUR OF MUSLIM WOMEN IN RURAL ASSAM

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ABSTRACT

Healthcare seeking behaviour of Muslim is one of the issue need to be address. In this paper researcher tried to understand the differences in the nature of decision making in health seeking behaviour of Muslim women. The present study is based on intensive fieldwork carried out among 300 married women from two villages- Balirband and Katigorah Part- III, inhabited by Bengali Muslims belonging to upper caste group and Mahimal- a lower caste group of Assam, Indian. The selection of the villages is based on certain parameters such as location in rural area, level of access to health services, income and caste. The findings of this study will help to plan, organize and provide a comprehensive health policy framework for Muslim women in South Asian context. The acceptance and utilization of need-based service is generally assured if the health programs are carried out after knowing the real health status and pattern of health seeking behaviour among the community. The study shows that Muslim women in the first place cannot access health care without an appropriate escort and secondly has to adhere to patriarchal regulations and tradition, restricting a smooth health care and treatment. With regard to decision-making, it has been found that, from among the women who seek treatment, the decision came from the male heads of the family, sometimes from the mother-in laws or other family members.

Key Words: Decision, Healthcare, Treatment, Women, patriarchal regulations and tradition.

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INTRODUCTION

Healthcare seeking behaviour of Muslim is one of the issue need to be address. Muslim are one of the important population group of Assam. The total population of India Muslims number some one and three quarters of a billion souls, and are notable for their total disparity; an inevitable result of so many varying factors. The differences in their population size and dynamics, their ethnic make-up and languages, their natural resources, and the lack of parity in their levels of material wealth, make any attempt at generalization not only impossible but foolhardy. To start with, Muslims can be Shias or Sunnis. If Shia, they can be of any one of a large number of denominations or, if Sunni, they will follow one of the four schools of religious interpretation, Hanafi, Maliki, Shafi, or Hunbali, all of which have differing views on personal status law. Muslim women form a significant part of this Muslim population globally. This study makes a focus on Muslim Women of India with reference to the Gender disparity in healthcare seeking behaviour of Muslim

MATERIAL AND METHOD

The present study is based on intensive fieldwork carried out among 300 married women from two villages- Balirband and Katigorah Part- III, inhabited by Bengali Muslims belonging to upper caste group and Mahimal- a lower caste group of Assam, Indian.

The selection of the villages is based on certain parameters such as location in rural area, level of access to health services, income and caste.

DECISION-MAKING REGARDING SEEKING TREATMENT

It was found that, 194 (64.7%) elders took major health decisions of the family. Grandfather or fathers and the husband are the key players, especially with regard to decisions involving some big expenditure. Only 78 (26%) respondents said that elderly female members (grandmother or mother-in-law) played a role in decision-making. In case of only 16 (5.3%) respondents, other relatives like husband's sister or his father's sister took such decision. It was found that even for the women's health problem the concerned female or her mother were not found to be allowed to take decision as to when and where to seek treatment. They have to depend on and follow the decisions of their mother- in –law, husband or other family members in her marital home. In case of educated and higher income group women, (mostly self-earner) they take decision on their own, but the percentage is very low (4%).

Almost all women from low-income group, having low education before approaching any health provider were found to discuss about it with experienced and elderly female members of the family, unless the condition is considered "serious" enough to seek better advice. "Serious" implies as dangerous or when condition of the patient is life threatening.

Table 1: Decision Makers Regarding Seeking Treatment

Decision makers	**No.**	**Percentages**
Elder male member of family	194	64.7
Elder female member of family	78	26
Relatives	16	5.3
Self	12	4
Total	300	100

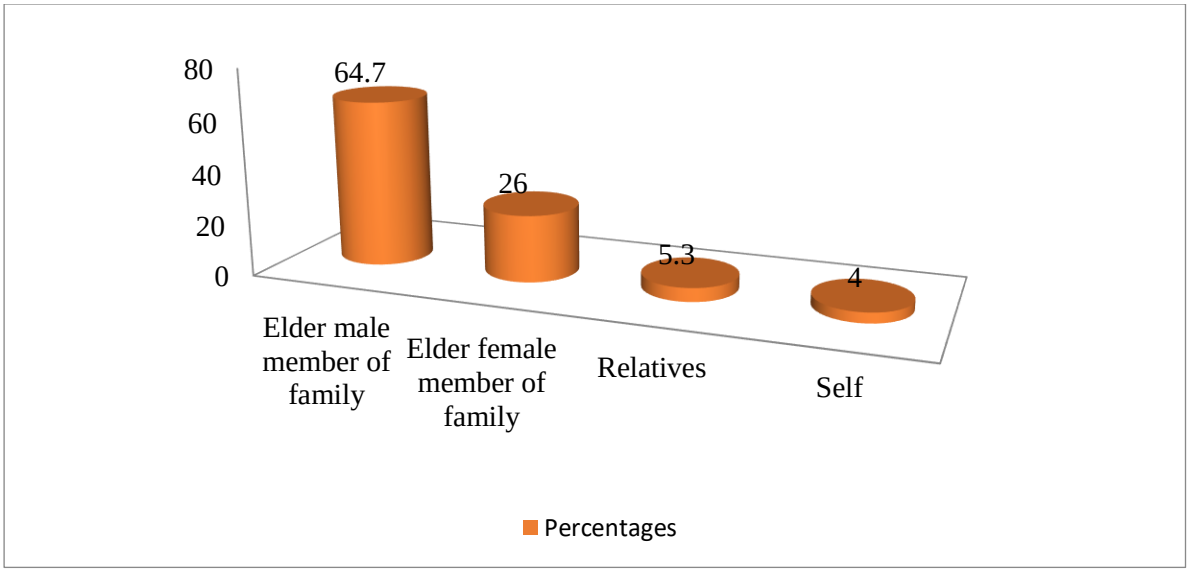

Fig.1: Graphic representation of decision makers regarding seeking treatment

Choice of Health Service Provider

From a total sample of 300, only 210 (70%) respondents seek treatment during any health problem. Others i.e., 90 married women are not availing of any health facility during an illness period. It is important to note here that 48(53.3%) respondents fall under age groups of 50-90, who have crossed the childbearing age and now they do not take their health

issues seriously. In case of any illness period either they take some home remedies or ignore the issue since pregnancy care was considered more important. Among the 70% who seek treatment, maximum consulted drug sellers (41.9%) in the pharmacy for treatment. These sellers are with or without proper qualification regarding which the majority of patients are not concerned. They are consulted as they are easily accessible (within the village, friendly and approachable) and consultation fees are not required. In most cases, medicines on credit are also offered due to which this has become a popular choice as service providers. On the other hand, 47 (22.4%) resort to spiritual or faith healer who gives *tabiz*(amulets) and use local/indigenous religious techniques for curing. Though only 33(15.7%) respondents avail of PHC for general health problems, it has been observed that most women(irrespective of caste affiliation and from lower economic group) visit the PHC for institutional delivery as the services are free and the mother and child receives monetary incentives under Government scheme of JRY. Only 13(6.2%) respondents consulted private MBBS doctors. It is pertinent to mention that all of them belong to the educated UCG who can afford treatment. Around 14(6.7%) and 15(7.1%) used homeopathic treatments and home remedy respectively for general problems.

Table 2: Type of health care providers used for treatment seeking

Type	**LCG**		**UCG**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Drug seller/ Pharmacy/ Village doctor	42	45.2	46	39.3	88	41.9
PHC	11	11.8	22	18.8	33	15.7
Private medical practitioner	-		13	11.1	13	6.2
Homeopathic doctor	7	7.5	7	6	14	6.7
Spiritual/faith healer	24	25.8	23	19.7	47	22.4
Home remedy	9	9.7	6	5.1	15	7.1
Total	93	100	117	100	210	100

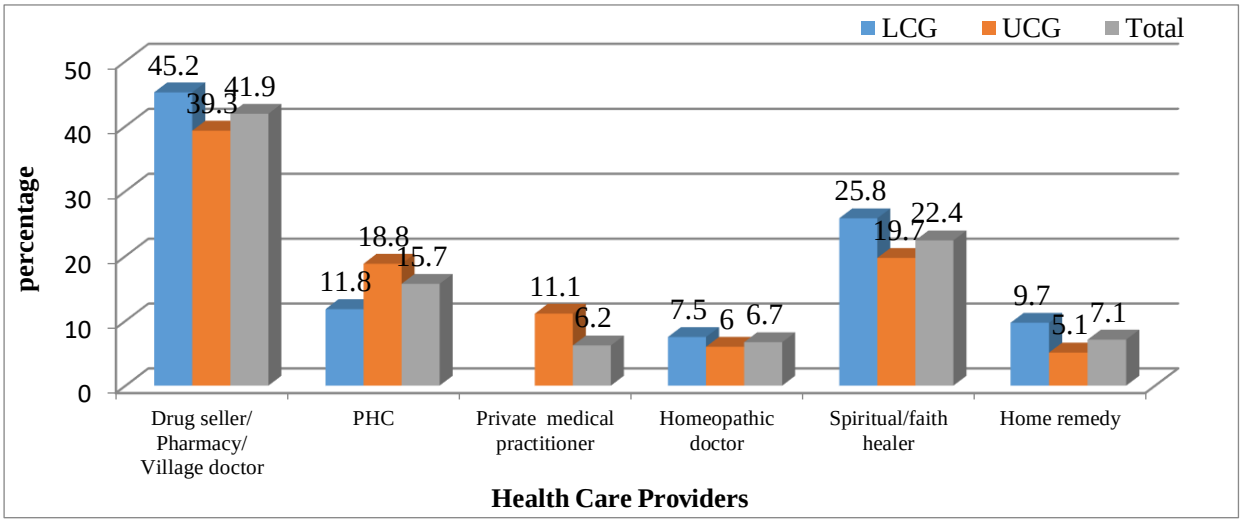

Fig. 2: Graphic representation of health care providers used for treatment seeking

In the study area, it was generally found that people with lower income and low educational status prefer to take treatment from *pir* or faith healer. If the symptoms continue then they take parallel treatment and seek medicines based on previous treatment from pharmacy and wait for improvement. When there is no improvement or if the problem aggravates, then majority of the people approach some allopathic medicine seller of the village irrespective of the provider's qualification. However, when the health condition is severe or uncommon (not known to them), then the people approached the health provider in the PHC. If the PHC doctor refer them to some specialist, than they go to the district hospital. These findings clearly show that due to low economic status maximum number of Muslim women from both the castes prefers to seek treatment from drug sellers such as pharmacy and PHC as the consultation is given free of cost.

Decision regarding the type of provider to be approached for seeking treatment largely depends on the socio-economic status of the family as elicited by majority of the respondents. Poor families generally approach local PHC. Alternately, they also approach the drug seller of the area.

However, the families in upper caste group (UCG) who can afford the expenditure prefer to go to district and private health facilities for seeking treatment, which is approximately 30kms from the village.

Choice of First Line of Health Service Provider

For majority of the respondents who were asked about their choice of health service provider, responded that the drug seller were the first lines of choice for treatment while the spiritual/faith healer was selected by 22.4 per cent.

Table 3: Choice of first line of health service provider

Type	LCG		UCG		Total	
	No.	%	No.	%	No.	%
Drug seller/ Pharmacy/ Village doctor	42	45.2	46	39.3	88	41.9
PHC	11	11.8	22	18.8	33	15.7
Private medical practitioner	-		13	11.1	13	6.2
Homeopathic doctor	7	7.5	7	6	14	6.7
Spiritual/faith healer	24	25.8	23	19.7	47	22.4
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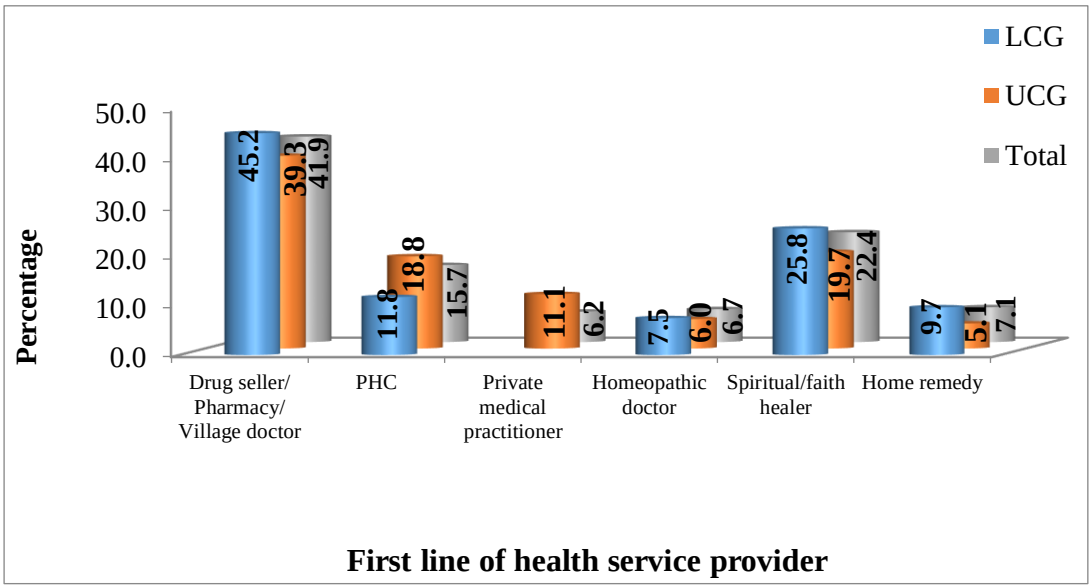

First line of health service provider

Fig. 3: Graphic representation of Choice of first line of health service provider

Here, it is important to note that most of the time the husband or mother-in –law or any male member of the family decides regarding the type of health care provider to be approached. In majority of cases, the women patients do not have any contact with the service provider. All complaints are explained to the male relative who in turn tells the health service provider and gets some remedy for it.

Reasons behind Choice of First Line of Health Service Provider

Respondents said that, they selected the health service provider based on the belief that they were receiving quality healthcare from them. Around 55 (26.2%) of the respondents reported that they chose the first line of care as they were closest to their home. The cost of treatment was another important reason for choosing a particular health service provider. 142(67.6%) reported that those healthcare providers who offer low-cost treatment or provide treatment on credit are preferred. 13(6.2%) selected private MBBS as first line of health service provider because they are economically sound and can afford the expenditure.

Choice of Second Line of Health Service Provider

About the second line, PHC was selected by 71 (33.8%) followed by drug sellers 57(27.1 %.). One can see that the largest number of respondents visiting the PHC is from both the caste groups- LCG 42(45.2%) and 29(24.8%) are from upper caste. It can be said that respondents visit PHC because it is free of cost and members from both castes, especially those from the lower income groups are regular visitors of this facility. Also, when the first line of treatment fails, the number of people seeking better health services increases even through there is no female doctor in the PHC.

Table. 4: Choice of second line of health service provider

Type	**LCG**		**UCG**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Drug seller/ Pharmacy/ Village doctor	26	28	31	26.5	57	27.1

PHC	42	45.2	29	24.8	71	33.8
Private medical practitioner	-	-	22	18.8	22	10.5
Homeopathic doctor	3	3.2	5	4.3	8	3.8
Spiritual/faith healer	19	20.4	26	22.2	45	21.4
Home remedy	3	3.2	4	3.4	7	3.4
Total	93	100	117	100	210	100

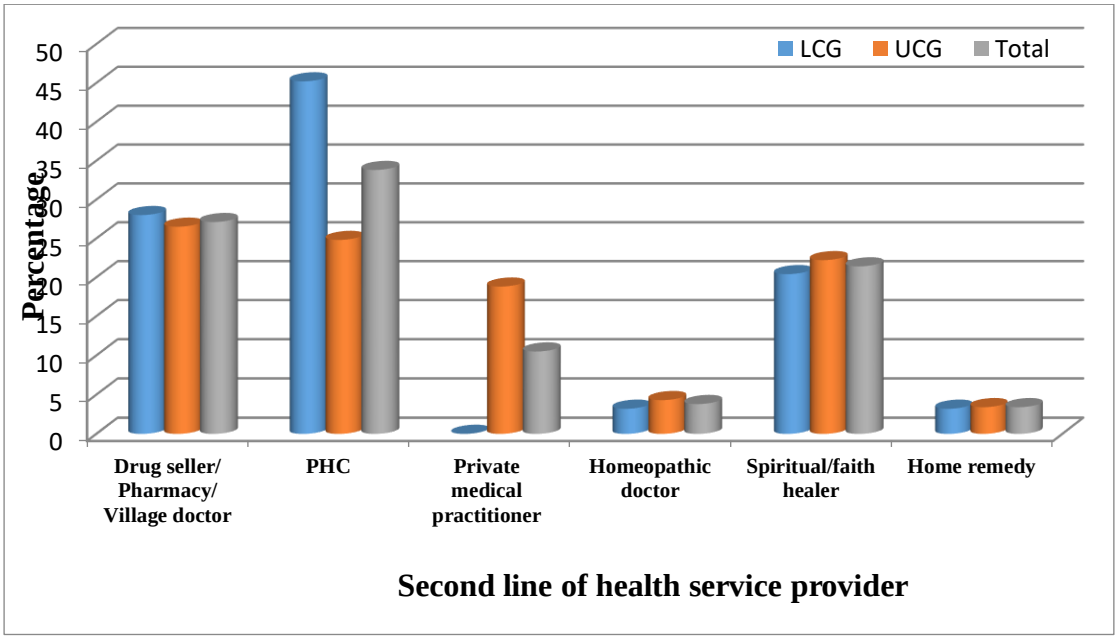

Fig.4: Graphic representation of choice of second line of health service provider

Conclusion: Decision-making, it has been found that, from among the women who seek treatment, the decision came from the male heads of the family, sometimes from the mother-in laws or other family members. In case of women, who are educated and having economic authority make their own decision in seeking healthcare. The low level of control of women over decision-making could be the result of the cultural priority against women (such as being in confinement) that has been in place for decades. At the same time, the subordinate status of women in the study situation acts to limit their autonomy in decision-making. Thus,

patriarchal domination and traditional notions of family norms are some of the limiting factors of access to timely treatment seeking, though the major type of family is nuclear.

Reference

Ali, A N.M. 1974. *Social Relations among the Assamese Muslims in Rural and Urban Situation*. Ph. D. Thesis (unpublished), Gauhati University.

——— ,1976. Kinship and Marriage among the Assamese Muslims.In *Family, Kinship and Marriage among Muslim in India*. Imtiaz Ahmed, ed. New Delhi: Manohar*Book* Service.

——— , 1979. *Social Groups among the Assamese Muslims*. Proceedings of the 66th, Session Part-III of Indian Science Congress, Hyderabad.

Ali, A. N.M. and Bhagabati A.C. 1971.Kinship and Marriage in Rural Assamese Muslim Community.*Jr. Assam Sc. Soc*. 14 (i): 27-32.

Ali, S. 2000. *Gender and Human Rights in Islam and International Law: Equal Before Allah, Unequal Before Men?*.The Hague: Kulwer Law International.

Alland, Alexander. 1964. Native Therapist and Western Medical Practitioners among the Abron of the Ivory Coast. *Transactions of the New York Academy of Sciences* 26: 724-25

——— ,1970. *Adaptation in Cultural Solution: An Approach to Medical Anthropology*. New York: Colombia University Press.

Aloud, Nasser. 2004. *Factors affecting Attitudes towards Seeking and Using Formal Mental Health and Psychological Services among Arab-Muslim Population*. Doctoral Dissertation, Ohio State University.

Ansari, Ghaus. 1960. *Muslim Caste in Uttar Pradesh*. Lucknow: Ethnographic and folk Culture Society.

Aragon, Melissa. 2009. *Determinants of Primary Caregivers' Health Seeking Behaviour in a Tanzanian Peri-Urban Town*. Master's Thesis in the Faculty of Graduate Studies (anthropology), University of British Columbia. Vancouver.

Bailey, Eric J. 1991. Hypertension: An Analysis of Detroit African American Health Care Treatment Patterns. *Human Organization* 50 (3):287-296.

Bang, R. A. and A. Bang. 1991. Why Women Hide Them: Rural Women's View Points on Reproductive Tract Infections. *Manushi* 69:7-30.

Bang, R.A. and A. Bang. 1994. Women's Perception of White Discharge: Ethnographic Data from Rural Maharashtra. In *Listening to Women Talk about their Health Issues and Evidences from India*. Gittlesohn, ed. New Delhi: Har–Anand Publication.

Bank, Leslie A, and J.A. Hislop. 1962. Sanitation Practices and Disease Control in Extending and Improving Areas for Human Habitation. In *Man's Role in Changing the Face of the Earth*. William L. Thomas, ed. Pp. 817-830 Chicago: University of Chicago Press.

Barbhuiya, A.F. Gulenur and Rekha Das.2013.Reproductive Performance and Socioeconomic Correlates among the Bengali Muslim Women of Cachar District, Assam, India. *Golden Research Thoughts* II (IX)Available online at www.aygrt.isrj.net.

Barua Alka and Kathleen Kurz. 2008. Reproductive Health-Seeking by Married Adolescent Girls in Maharashtra. In *Reproductive Health in India: New Evidence*. Michael A. Koenig, Shireen Jejeebhoy, John C. Cleland and Bela Gantra, eds. Pp. 32-46. New Delhi: Rawat Publication.

Field, M.J. 1937. *Religion and Medicine of the Ga People.* London: Oxford University Press.

Foster, George M. 1953. Relationships between Spanish and Spanish-American Folk Medicine.*Journal of American Folklore* 66:201-17.

——— , 1967. '*Tzintzuntzan: Mexican Peasants in a Changing World*. Boston: Little, Brown.

Francis, Thomas. Jr. 1959.The Epidemiology Approach to Human Ecology. *American Journal of Medical Sciences* 237: 677-84.

Freeman, H. and R. Payne 2000. Racial injustices in health care. *New England Journal of Medicine* 342:1045-1047.

Frick, Johann. 1957. Medicinal Uses of Substances Derived from the Animal Organization (In Tsinghai). *Anthropos* 52 (1-2): 177-98.

Gestler, M.W. 1984. *Health Care in Developing Counties*. State College PA: Association of American Geographers.

Gilick, Leonard B. 1967. Medicine as an Ethnographic Category: The Gimi of the New Guinea Highlands. *Ethnology* 631-56.

Grover, N.1965. Man and Plants against Pain. *Economic Botany* 19:99- 112.

Gould, Harold A. 1957. The Implication of Technological Change for Folk and Scientific Medicine. *American Anthropologist* 59(3): 507-16.

——— , 1965. Modern Medicine and Folk Cognition in Rural India. *Human Organization* 4 (3): 201-08.

Guha, A. 1986.Folk Medicine of the Bodo Kacharis- A Plains Tribes of Assam. In *Tribal Health*. Buddhadeb Chaudhuri, ed. Pp-191-199. New Delhi: Inter- India Publications.

Guha, U.C. 1971. *Kachharer Itibritta*. Guwahati.