Urban Health Versus Rural Health in Tezpur: A Case Study

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Abstract—*Urban health is the general well being of the population residing in cities and towns whereas rural health is the general well being of the population residing in the villages. The healthcare facilities and usage patterns of the population of an area are determined by the culture, tradition, education and socioeconomic status. Women health is the state of physical and mental welfare of the female population. Women are the focal point of a population and thus the evaluation of the pattern of the health care facilities availed by women is a crucial determinant of the general health of an area. Assam is one of the states of northeast India and Tezpur is a place situated in the Sonitpur district of Assam. To investigate the urban and rural health scenario, sample populations of women of urban and rural descent from Tezpur are selected from the Tezpur University campus and the neighboring Napaam village respectively. Methods employed for investigation are interview, observation and discussion. The paper will try to highlight women health rather the reproductive health of women with special reference to delivery pattern, pre and post delivery practices related to culture and economic condition.*

1. INTRODUCTION

Health is an essential component for a region for its development and internal stability. Assuring a minimum level of health care is vital for a region for its development [1]. Maintaining good health is imperative for every human being. It may be further emphasized that women act as the main healthcare providers throughout much of the world [4] and the health of a family depends, by and large on the ability of a mother to provide the required healthcare for the members. Safe motherhood practices and child survival programs are important in a region having high infant and child mortality [1] like India. The urban health care system includes Urban Health and Family Welfare Centres and Urban Health Posts, funded National Health Programmes like TB, immunization, malaria, etc., urban health component of the Reproductive and Child Health Programme including support for Janani Suraksha Yojana in urban areas, strengthening of health infrastructure like District and Block level Hospitals, Maternity Centres under the National Rural Health Mission, etc [5]. The healthcare in rural areas has been developed as a three tier structure based on predetermined population norms. The sub-centre is the most peripheral institution and the first contact point between the primary healthcare system and the community. Each sub-centre is manned by one Auxiliary Nurse Midwife (ANM) and one male Multi-purpose Worker [MPW (M)] [2].

In Assam, the National rural health mission was launched in 2005. Its introduction became necessary because the health indicators of the region were very poor. Assam has come up with various innovations in an effort to achieve the set targets, a few of them include-

i. Home visits by ANM under the sub-centre to inspect the unreported presence of pregnant women and to immunize the newborns.
ii. Organization of health day: The main objective of organizing health day is to create awareness in the community regarding various services under NRHM – delivery, pre-natal and post-natal care of pregnant women, exemption from all kinds of user charges, free conveyance, necessary treatment up to 30days from the date of birth of a newborn, food, diet etc [6].

The healthcare system of both rural and urban settings is used in accordance to the socioeconomic condition, education, awareness, culture and traditions of the people. It is mandatory to assess the trends and patterns of usage so as to demarcate the advantages and disadvantages of the same for the benefit of the people. This will further enable better planning of the agendas of the healthcare system catering to these diversified regions and to evade the ill effects of the current trends.

2. OBJECTIVES

With regard to the above discussion, the main objective of the study is to investigate the urban and rural health scenario and to examine the reproductive health behavior of the people in accordance to delivery pattern, pre and post delivery practices.

3. METHODS AND METHODOLOGY

The methods adopted for data collection are interview, observation and discussions. Secondary data is collected from reports, internet sources, journals, books etc.

To collect the data, women folk of different age groups, young and old, of rural as well as urban settings are selected.
For the investigation of urban setting women of Tezpur University campus are selected randomly and for rural setting women of Napaam village are selected and ex tea garden labourers are selected as informants.

4. URBAN SETTING: TEZPUR UNIVERSITY

Tezpur University is a central university situated in the outskirts of the Tezpur town (approximately 14 km away). It is a residential campus where the students, faculty members and staff are housed in hostels and quarters. The university campus has its own health centre well equipped with three doctors and adequate supporting staff. Moreover, paediatricians and gynaecologists from the Tezpur town are regular visitors of the health centre.

Whenever women from the university campus conceive, they take medical advice from the gynaecologist and follow all the essential measures that include regular health check up, immunizations, proper course of iron and calcium supplement and the utilization of healthcare facilities in the hospitals of Tezpur town for a safe delivery. All the post delivery practices are also followed accordingly.

Due to their sound economic status, the women of the campus choose good delivery homes for delivery of their child.

5. RURAL SETTING: NAPAAM VILLAGE

Napaam village is situated 15km away from the Tezpur town and shares its boundary with the side wall of Tezpur university campus. The population make up of the area is heterogeneous in nature. Nepali and Bangladeshi immigrants, Assamese locals and ex tea garden labourers are among the residents of the area. As mentioned earlier, ex tea garden labourers are selected as the informants of the study.

In the village there is one health sub-centre where two Asha workers visit once/twice every month. To avail proper healthcare facilities, the people have to go to the Borghat health centre which is 4-4.5km away.

The people of the village are mostly daily wage labourers, kitchen menials in the hostels of Tezpur University or domestic helpers in the quarters of faculty members residing in the campus.

Due to the illiteracy and poor economic conditions, the women of the village do not visit the health centre for medical advice or to avail free iron and calcium supplements distributed to expecting mothers.

When the workers of the local health centre receive information of any case of pregnancy, they visit the house of the expecting mother and try to convince her into taking TT immunization and free iron and calcium supplements distributed by the government. But to the contrary, almost 50% of the villagers do not take any medical advice or medicines. And only 50% of the sample take part in immunizations and visit the Tezpur Civil hospital for a safe delivery. They have an innate fear of allopathic medicines and they believe that these medicines will make their baby invalid or crippled for life.

The women of the village prefer *dais* for a safe delivery of their children at home. *Dais* are midwives with expertise in safe delivery of a baby. They also massage the mother and the newborn with warm mustard oil spiked with garlic for nine consecutive days post delivery. The *dai* is paid a remuneration in the form of nine kilograms of rice, a hen, one saree and two hundred rupees.

At the time of investigation it was observed that the people of the rural setting have more faith on the experience of the *dais* than the medical practitioners.

The *dais* who deliver new life into this world are not allowed to enter their own homes or help in any household work. She is forbidden from touching anyone as she is considered impure. Therefore she observes the ritual of sacrificing the hen paid to her as remuneration so as to break the curse of impurity. It is believed that this ritual has the power to uplift her from the shackles of hell which is synonymous to midwifery.

6. CASE STUDIES

Case 1: Urban setting

Mitali is a faculty member in the department of Sociology, Tezpur University. Her husband is also working as a faculty member in the same university. They are blessed with a 5 year old boy.

During her second pregnancy, Mitali visited the Tezpur University health centre to consult the gynaecologist and got all the essential tests done as advised by the doctor. She paid regular visits to the doctor for her health check up. In her last trimester she was advised to undergo an ultrasound but the results of the ultrasound indicated that everything was normal. Even though the ultrasound results were normal, the couple decided to opt for a caesarian operation in order to avoid the pain of a normal delivery and to proceed according to a convenient time in their schedule.

Case 2: Urban setting

Neha is the wife of a faculty member in Tezpur University who resides in the campus and avails all healthcare facilities available inside the campus.

During her first pregnancy, she took the advice of the gynaecologist and her mother to take regular brisk walks in the morning and the evening. She also joined yoga classes. She opted for a caesarian delivery after weighing out all other options available to her and the child. She requested the gynaecologist for the same. She did not want to go through the

intensive pain of delivery as made evident by the movies. Moreover, she did not want to take the risk of travelling 14kms at the time of labour. So, she was admitted to the hospital at a prefixed date to deliver her baby boy by a caesarian operation. According to her, it was a hassle free delivery.

Case 3: Rural setting

Meena is a middle aged woman living in a joint family in the Napaam village. She is a domestic help who earns two thousand rupees per month and her husband is a daily wage labourer. She has a 2 year old baby boy and recently delivered a girl.

During her pregnancy, she took TT injections as advised by the Asha worker of the nearby sub-centre. She was regular at work till her delivery. She calculated her date of delivery with the help of her mother in law and called the *dai* accordingly. The dai delivered the baby using a pail of hot water, soap and old cloth. She also took eleven rupees to cut the placenta. It was a normal delivery. After the delivery, the *dai* massaged Meena and the child with hot mustatrd oil spiked with garlic for nine consecutive days. Castor leaves were placed on her stomach and pressurized with burning hot charcoal in an iron cauldron. She was fed oil free beaten rice for three days after her delivery. After three days, she was given a normal diet consisting of rice. She resumed work one month after her delivery. Her children are regularly immunized at the Pulse Polio Programme.

Case 4: Rural setting

Basanti is a kitchen menial working in one of the hostels of Tezpur University. She is 20 years old and married to a lorry driver.

When she was pregnant with her first child, she went to the health sub-centre of Napaam and diligently took the TT injections, iron and calcium supplements as advised. When she entered labour, her husband called 108 ambulance and they went to the civil hospital for her delivery. They also availed the Majoni scheme introduced by the government of Assam. It was a normal delivery with two stitches. As she delivered a girl child, they opened a bank account in her name. After she returned home, a *dai* was employed for nine days of massage.

7. DISCUSSION

Data collected from August 2015 to December 2015 revealed that all the four cases of delivery registered in the Tezpur university health centre were caesarian and the seven delivery cases of Napaam village were found to be normal.

From the above information, it is clearly understood that the delivery of babies in rural and urban settings are quite different. Even though the urban and rural settings are placed in the same geographical location but the environment is not the same. The university campus is totally urban in nature with a cosmopolitan ambience but the nearby rural setting is campestral in nature from the houses to the healthcare scenario. Moreover, the residents of the campus are educated whereas the residents of the Napaam village are barely educated if not illiterate.

The question to ponder upon is why does such a difference exist?

In the rural settings, the poor economic conditions, illiteracy, multiple pregnancies deteriorate the health of the women folk but still a consistent normal delivery pattern is evident. On the other hand, the affluent and literate women of the urban setting prefer a caesarian delivery to avoid the natural delivery pain. Even though delivery pain is a form of menstrual pain, women wish to evade the same due to aggravated portrayal in the celluloid. Convenience of time is another reason for prefixed caesarian deliveries.

At the time of investigation, it is observed that delivery by caesarian operation has achieved a status symbol for the urban working women. Moreover the gynaecologists and nursing homes hailing from the vicious money hoarding circle encourage and advise a caesarian delivery for almost all women and since most employing institutions like the university reimburse the costs of a caesarian delivery, expenditure has never posed as a problem in the urban setting. In rural areas, a caesarian operation is unthinkable due to its high costs. And the reliable *dais* have been helping in normal traditional delivery of children since the time of their forefathers. Therefore, it is appalling that the educated urban population with various healthcare facilties at their disposal prefer to avoid a normal and safe delivery unlike the rural population with almost zero awareness and negligible access to healthcare facilities.

The urban woman does not follow a regime of hot oil massage post delivery unlike the women of rural setting who undergo nine days of hot oil massage for the quick recovery of the uterus. It also keeps the mother and the child strong.

There is a close relationship between health problems and socio-cultural and economic conditions. Socio-cultural factors have been accepted as highly important in the multiple etiologies of diseases as well as for the acceptance of modern medicine and medical health practitioners in a community. Hasan [3] describes the importance of socio-cultural implications of modern medicine and public health programmes. It can be said that the system of medicine and healthcare in a cultural system tries to treat health in its own way.

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