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Social Capital and Health Seeking Behaviour-A Study among Paniya Tribe

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ABSTRACT

Health seeking behavior is a part of health behavior. Health behavior is a social construct and it is influenced by various socio-demographic and economic factors. Paniya community is the most populated as well as most marginalized tribal community in Kerala. Health seeking behavior of a marginalized community is a product of the degree of social exclusion. This paper tries to analyze the role of social capital in health seeking behavior of Paniya community of Wayanadu, Kerala. **Data and methods:** Case study method is employed to draw conclusions. Previous studies are also used as secondary sources of data. **Conclusion**: within same socio-economic and ethnic community variation in health seeking behavior is due to the variations in social exposure. The social exposure is determined by social capital acquired. **Suggestion:** before planning health programmes for tribal communities, the policy makers have to analyse the level of social capital of the community.

Key Words : Health seeking behavior, Social capital, Paniya community

INTRODUCTION

Health is a significant measure of individual for taking care of his /her social obligations and roles. As disease or ill health leads to dysfunction, people themselves take measures to restore health and remain active. It is true that the concepts like health, sickness and sick role are socially defined and culturally determined. Some people seek the help of professionally qualified medical practitioners for a specific illness. For some, the same has been replaced by traditional healers. Quite interestingly, a small but significant population resorts to self -medication. The most interesting and notable thing here is that the same symptom has not perceived as a disease by certain groups.

Signs and symptoms of a disease were defined by a person, on the basis of his/her age, educational background, level of awareness, and attitude about health and illness. This awareness and attitudes are designed by their social status and cultural values. Hence, health seeking behavior can be viewed as a socially constructed entity. It is an orientation or preferences, to accept a particular system of medicine or institution of treatment by a sick person for the fulfillment of his/her health related needs. Health seeking behavior is influenced by several socio-cultural variables and it may vary according to age, gender, education, income, region, social status and even with availability of health care facilities

Paniya tribe:

Paniya community is the most populated tribal community in Kerala. They are the most backward and most marginalized tribal community in Kerala. Literarily the word Paniya means 'Worker. They are agricultural workers in recent past. Before that they may be hunting and gathering tribe. In the feudal times they were employed as agricultural workers with no or less payment. The male member is addressed as 'Paniyan' and female member as 'Panichi'. Paniya tribe is the largest tribe in Kerala. Mostly seen in northern districts of Kerala, Wayanad, Kannur, Kozhikode, Malappuram and

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Palakkad. It is believed that Paniyas migrated to Tamil Nadu and Karnataka from Wayanad district of Kerala. In Karnataka, Paniyas are seen in Mysore district and in Tamil Nadu in Nilgiri district, both share boundary with Wayanad.

Social backwardness of Paniya community is due to their means of livelihood. They are politically very week. Bonded labor system is prevailed among Paniya. '*Kundal Pani*' is a Waynad model of bonded labor existed among Paniya communities. Every year during festival of *Valliyoor Kavu* temple Paniya was bought by Land Lords. They had to take oath before Valliyoor Kavu Bhagavathy that they would not leave the Land Lord with in the one-year period. They get wage in kind.

Kambalakapani is also a type of exploitation during transplantation of paddy it is a trick played by Land Lords to elicit maximum man power within a short period. Paniya workers with their women, children and elderly employed in the field Preparation of paddy field, collection of paddy seedling and transplanting of seedlings in a large area were covered by the workers. Thudi and Cheeni (traditional drums and pipes used by Paniya community) are played with their traditional songs. Common food, alcohol, tobacco and bettelnuts are served. In a festival mood they cover ten to acres of field with in a day.

Even today main source of income of Paniya is coolie work related to agriculture. In urban area they are engaging coolie works other than agriculture. Manual jobs like loading, unloading etc. are done by Paniyas in urban area. Paniya community is the largest group of workers in MNREGP, among tribal groups. 2307 Paniyas were registered in MNREGP. 17.21% of total unemployed scheduled tribe belongs to Paniya tribe. According to official statistics of government of Kerala, 53.43% of Paniya population belongs to BPL list.

Health issues:

The concept of health, illness and treatment of tribes are entirely different from that of main stream people. Physical health is a very important measure of tribal people for their surveillance. Scientific bio-medical definitions of health and illness are not valid for tribes. Conceptualization of health, culture, social ecology, availability of health care services is some important measures of tribal health. Elder members of community believe that the cause of ill health is evil spirit or hatred of God. Some diseases are treated as blessings of particular Gods. Chickenpox, measles and some fever with rashes are believed as blessings of 'Mariyamma'-a lady Goddess.

Tuberculosis (TB) is very much prevalent among Paniya tribe. But it is not considered as a serious disease. Physical proximities of houses in Paniya colony, habit of chewing betel nuts and spitting here and there, sharing of house with other colony members are very crucial for spreading of Tuberculosis. Interrupted or discontinued treatment is a serious public health problem that it leads to Multi Drug Resistant TB (MDRTB).

Social capital:

Social capital is more or less a novel concept in sociology. Economists and Political scientists use the term in different meanings and in different contexts. For sociologists social capital is a term denoting significant social networks. Social capital is defined as the information, trust and norms of reciprocity inhering in one's social network. For economists the capital is of two type- Physical and human capital. Sociologist focuses on social as well as cultural capital.

Bourdieu (1990) argued that there are three fundamental types of capitals –Economic, social, and cultural capital. Social capital command over relationship with of influence and support people can tap into by virtue of their social position, through family or education. Loury-1997 explains how social capital allows for the development of human and material capital. Social capital is defined as resources, norms, networks with in society that allows for the development of human and material capital, both are measures of health. It operates through in group bindings and bridging with other groups and institutions. Ichino Kawachi *et al.* (1997) conducted studies on impact of social capital on health. Deepa Narayan explains the connection between social capital and poverty. Narayan (1997) opined social capital is embedded in social structure and has public good characteristics. Later, Woolcock (1998) elaborates the idea with macro and micro aspects. At the micro level it is intra community ties or social cohesion. At macro level it refers inter community network. In short social capital refers bonding and bridging ties of a community member have.

WHO defines Health seeking behavior is a part of health behavior. Health behavior includes all behaviors associated with establishing and retaining a healthy state. Positive, preventive and curative aspect of health is included in health behavior. Ill health behavior include

perception of illness, execution of remedial measures and life style change according to it (WHO, 1995). There are two broad frame works for analyzing Health seeking behavior. First one is pathway analysis, which means the process behind the health care seeking behavior. This can be understood qualitatively. The second one is bio-medical model. It is end product oriented and can be studied quantitatively.

The health belief model emphasizes belief about severity and its consequences. Health motivation, benefits of treatment are conditioned by demographic variables like class, gender, religion etc. Ajzen and Fishbein (1968) developed theory of reasoned action for studying Health seeking behavior related to HIV/AIDS research. Later Ajzen (year) modified the theory and re named as theory of planned behavior.

Anderson and Newman (1973) developed health care utilization model categorizing factors responsible for health seeking behavior into 1) *Predisposing factors* like age, gender, religion, formal education, general attitude towards health services knowledge about the illness etc., 2) *Enabling factors*: availability of services, health insurance, social network etc., 3) *Need factors* : perception of severity, number of sick days, missed working days etc., 4) *Treatment actions*: home remedies, drug sellers, traditional healers, privet medical facilities or public health services etc. In this paper last part of the model get more emphasis. That is Health seeking behavior is an orientation planning of preferences and accepting a particular system of medicine or institution of medical care by a sick person for fulfillment of health need. Health seeking behavior is influenced by several socio cultural variables and it may vary according to age, gender, education, income, region, social status and even with availability of health care facilities. Social capital has an influence on health seeking behaviour.

METHODOLOGY

Both primary and secondary data are used in this study. Previous studies and published papers are used as secondary sources. Primary information are gathered from case study method. Two cases with different health seeking behavior are identified from the same colony. Data was collected from Vellamundagrama panchayat of Wayanad district, Kerala. As members of the same colony, the socio-cultural background of both is same. Accessibility of health care infra structures and geographical barriers are the same. The difference in health seeking behavior is the only criteria for selecting as cases. The narrations are recorded and noted by the researcher.

RESULTS AND DISCUSSION

Case 1:

Case 1 narrates the life history of a tribal (Paniya) woman, aged 33 years belongs to a nuclear family consisting of her husband and two children. Though she have high school level of education, she is an active participant in kudumbasree and other non-party political organizations like, Adivasi Skhema Samithi. She has been enrolled to Mahatma Gandhi National Rural Employment Guaranty Programme (MNREGP) and availing its benefits at the fullest sense. She acts as the 'Pulse Polio*' volunteer of the colony and also a key person of proposed agricultural nursery which jointly organizing by tribal development department and agricultural department. Her husband is a manual laborer and, studied up to 5th standard. They have two daughters studying at tribal school in Thiruvananthapuram District. Since both of their kids have been pursuing their studies at Thiruvananthapuram, it is necessary for them to make frequent visit to state capital to meet their children. When Being a part of the governmental programmes, she have had much exposure and awareness to health and hygiene aspects and once she met with any infirmity to any of her kith and kin, she approached the nearby PHC or CHC according to the severity of the illness. When her daughter had a problem with appendicitis she availed the benefits of a higher center for surgical procedure.

Case 2:

Case 2 narrates life history of another tribal (Paniya) woman aged 36 years. She belongs to an extended family with family size 13. She had no formal education. She had habit of drinking and betel leaf chewing. As a female member in the colony she also have membership in Kudumbasree and have employment card of MNREGP. But her participation is meager. Her husband is also an agricultural worker. He had habit of drinking. They have one daughter and a son. At the age of fifteen her daughter stopped her studies at ninth slandered. Their son studding at tribal school nearby town

When their daughter aged 18 had fever, prolonged cough and weight loss they visited ' Manthravadi' (black magic practitioner) at Wayanadu. A forceful intervention of police and health staff, put their daughter in anti TB

treatment regime.

Discussion:

Though the socio-cultural and ethnic backgrounds of two cases are same, the output in health seeking behaviour is different. The above said cases illustrate the stories of extreme behavior in relation to health seeking behaviors. The common treatment options of the community members are 1) no treatment, 2) folk treatment of their own colony members, 3) Nattuvaidian (traditional Kurichia medical practitioner, 4) self-medication from medical shop, 5) Routine medical camp and 6) Primary Health Centre or 7) private clinics. The expected behavior of an informed person is to consult a modern medical institution. As members of same colony, socio-cultural, economic and ethnic characteristics are same for all members. But the only difference is perception of illness and selection of health care. These are determined by their immediate social world. The social capital owned by each member has very significance in this process.

Physical proximity of houses and joint family practice give them the essence of bonding. Their own language-'Paniyabhasha' acts as a cultural tie for bonding. These are more or less common for all members. So the bridging factors are more important..

Formal education is a key aspect of social capital. Education provide an opportunity to connect with outer world both material and abstract. Bain and Hicks (1998) (cited by Krishna and Shrader, 2000) opined that social capital have two components structural and cognitive. The structural components include extent and intensity of associational linksor activity and cognitive components covers perception of support, reciprocity sharing and trust. In the first case the lady have formal education upto ninth standard. She is in connection with educational institution of their daughter. Connection with educational institution in any manner influences the cognitive level of the person. In the second case respondent has no formal education

Kudumbasree and MNREGP provide immense opportunities to empower economically and socially. Micro financing and neighborhood network give economic as well as emotional support for better treatment options. Sharing of experiences and chats during the interval of the work is very significant to widen the world outlook of the members.

Volunteering in governmental interventions whether it is Pulse Polio, Literacy mission, or Janamaithri policing it empower the participant. The volunteer and his/her immediate relatives or friends are influenced by the activity. So it act as a social capital.

Edward, ASuchman (1965) observed that one's medical orientation is influenced by group's structure. For him, there are two types of group's structures. One is parochial and the other, cosmopolitan. Medical orientation of a parochial group member depends up on popular and nonscientific believes. For the cosmopolitans, it is based on scientific attitudes. Parochial group form the idea about medicine on the basis of lay referral system. The lay referral system consist of non -professionals, family members, friends, neighbors etc. lay referral system is enriched by scientific believes for those who participating in above said Programmes.

Conclusion:

When an indigenous community comes in contact with an outer society, cultural assimilation process occurs. Governmental programmes focuses on integration processes. Most of governmental programmes rest up on modern ideas. Modern education, poverty eradication programmes and health programmes help to create more scientific world outlook. Concepts like health, health care and treatment are re constructed by these measures Participation in such programmes provide immense opportunities to inculcate novel ideas on health and health care. Within a same socio-economic and ethnic community variation in health seeking behavior is due to the variations in social exposure. The social exposure is determined by social capital acquired. Modern medicine is the main stream medical system promoted by government through various measures. When the bridging with outer community increased, trend to opt modern medicine is increased. So we have to assessocial capital of the given community before implementing health programmes and also strengthen positive social capital of the community for its better functioning

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